research in practice

University of East Anglia

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WARWICK THE UNIVERSITY OF WARWICK

2019 Triennial Analysis of Serious Case Reviews:

Police

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Contents

This briefing summarises key themes emerging from the 2019 Triennial Analysis of Serious Case Reviews 2014-17, presenting messages for the police.

A set of PowerPoint slides available at: **seriouscasereviews.rip.org.uk** includes links to related Research in Practice resources which will be useful for learning and development activities based on the findings of this report.

This briefing highlights key messages for all policing professionals, specifically:

- Operational officers and staff – to develop their knowledge, skills and practice to keep children and young people safe.
- Managers and leaders – to foster appropriate cultures for keeping children safe and to develop the right systems for ensuring children are safeguarded at the earliest opportunity.

Introduction

This briefing is based on the findings of *Complexity and challenge: A triennial analysis of serious case reviews 2014-2017* ('the report') (September 2019). The report is the eighth national analysis of serious case reviews (SCRs). View previous reports **here**.

Six practice briefings highlight key safeguarding issues, challenges and implications for practice to emerge from the report for practitioners in:

- Children's social care
- Early help
- Education
- Health
- Police
- Local safeguarding partnerships.

Learning from SCRs can be applied in: Continuing Professional Development (CPD) either through self-directed or team-based learning; organisational learning, including team learning; and reflective revalidation activities. The briefing includes questions and points for reflection throughout. View all the briefings **here**.

Unless otherwise attributed, all quotations in this briefing are taken from the report.

What is a serious case review?

- An SCR is a local review commissioned by the Local Safeguarding Children Board (LSCB) where abuse or neglect are known or suspected and:
  - a child has died, or
  - a child has suffered serious harm and there is concern about the way agencies have worked together to protect the child.
- The purpose is to identify what happened and why, so that systems to prevent harm and protect children can be improved.

A new system – child safeguarding practice reviews

The *Children and Social Work Act 2017* replaces LSCBs with flexible local safeguarding arrangements led by three safeguarding partners: local authorities, the police (Chief Officers of Police) and health (Clinical Commissioning Groups).

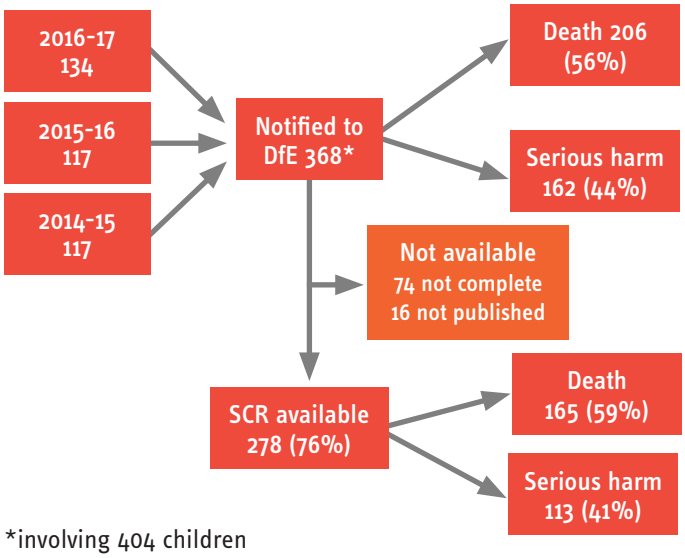
Under the new arrangements SCRs will no longer be commissioned. When a serious incident becomes known safeguarding partners must decide whether to commission a local child safeguarding practice review (LCSPR). The main purpose of an LCSPR is to identify improvements in practice. This means partners must consider whether a case is likely to highlight improvements needed to safeguard children, recurrent safeguarding themes, or concerns about how agencies are working together.

Although the decision to conduct an LCSPR is for local safeguarding partners, they must inform the national Child Safeguarding Practice Review Panel of their decision and rationale.

Part of the Panel's role is to raise issues it considers of complex and national importance. The Panel can decide to commission a national child safeguarding practice review (of a case or cases) – for example, if it considers issues may be raised that require legislative change or changes to current guidance.

The triennial analysis report

Findings are based on a quantitative analysis of all 368 SCRs notified to the Department for Education between 1 April 2014 and 31 March 2017, detailed data analysis of 278 SCR reports that were available for review (74 SCRs had not been completed, 16 had been completed but not published), and qualitative analysis of a sample of 63 SCR reports. The report is also informed by a national survey of LSCBs on the implementation and impact of SCR recommendations.



*involving 404 children

Figure 1: Numbers of SCRs examined

Key themes

- **Complexity:** Complexity and challenge form the underlying theme to the report. Researchers were struck by the complexity of the lives of children and their families, and the challenges faced by practitioners seeking to support them.
- **Service landscape:** The evident challenges for practitioners of working with limited resources, including high caseloads, high levels of staff turnover and fragmented services.
- **Poverty:** One issue that came through more strongly than in earlier analyses was the impact of poverty, which created additional complexity, stress and anxiety in families as well as being an important factor alongside other cumulative harms. Evidence of its impact in neglect cases was particularly prominent.
- **Child protection:** As identified in the previous triennial analysis, 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.

Key data

- **Gender:** More than half (54 per cent) of the SCRs involved boys. The predominance of boys is seen in younger age groups (up to age 10); more girls are the focus of SCRs for children aged 11 and older, which reflects the increasing number about girls affected by child sexual abuse and exploitation.
- **Fatal cases:** 78 of the 206 deaths were a direct result of the maltreatment – equivalent to 26 cases a year; this number has not increased in recent years, averaging 26-28 cases per year.
- **Increase in non-fatal cases reviewed:** The number of SCRs relating to non-fatal serious harm has increased from 30-32 per year across 2009-14 to 54 per year across 2014-17. The increase is associated with physical abuse, child sexual exploitation (CSE) and neglect.
- **Neglect:** Neglect was a feature in three-quarters (74.8 per cent) of all SCR reports examined.
- **Children's ages:** As in earlier analyses, the largest proportion of incidents relate to the youngest children: 42 per cent were under 12 months old; 21 per cent were aged one to five; 5 per cent were aged six to ten; 17 per cent were between 11 and 15 years old; and 14 per cent were aged 16 or above.
- **Ethnicity:** From 2005 onwards, families at the centre of SCRs are predominantly (between 72 and 80 per cent) white, broadly reflecting the overall child population.
- **Disability:** Fourteen per cent of children in these SCRs were reported to have a disability prior to the incidents reported in the SCR.
- **Where children were living:** At the time of the incident most (83 per cent) children were living at home, two per cent were living with relatives, four per cent with foster carers and four per cent were in a residential setting (eg, children's home, mother and baby unit).
- **Who was involved:** Most serious and fatal maltreatment took place within the family home, involving parents or other close family members. Child death and serious harm also occurred in supervised settings. Very little serious maltreatment involved strangers unknown to the child.
- **Social care involvement:** Most children were known to children's social care: 55 per cent had current involvement; 22 per cent were previously known but their case was closed; 16 per cent had never been known to social care.
- **Child protection plans:** In only 54 of the 368 SCRs (15 per cent) was the child on a child protection plan at the time of the incident; 56 (15 per cent) had been the subject of a plan in the past.
- **Categorisation of harm:** Many of the children and adolescents experienced multiple forms of harm. The categorisation system highlights a *primary* cause of harm for each SCR.

Family characteristics – parents

Data on family characteristics were limited in earlier analyses. For the latest report, researchers were able to scrutinise the 278 available SCR reports for information on parent, family and child characteristics.

The most prevalent parental characteristic reported was mental health problems, particularly for the mother (see Table 1). The frequency of alcohol and drug misuse was also much higher in SCR cases than in the general population, where only two to three per cent of children are thought to be living with parents who have a significant drug problem. Parental separation and domestic abuse were also prevalent among families where there had been an SCR (see Table 2).

Parental characteristic	Total and percentage where characteristic reported (n=278)
Alcohol misuse	99 (36%)
Drug misuse	99 (36%)
Mental health problems	153 (55%)
Adverse childhood experiences	102 (37%)
Intellectual disability	36 (13%)
Criminal record (of which violent crime, excluding domestic abuse)	83 (30%) 42 (15%)

Table 1: Parental characteristics noted in final SCR reports (Prevalence rates are a *minimum* for each factor; failure to note a factor in the SCR report may mean it was not present or simply not commented on.)

Family characteristic	Total and percentage where characteristic reported (n=278)
Parental separation (of which, acrimonious)	150 (54%) 41 (15%)
Domestic abuse	164 (59%)
Social isolation	51 (18%)
Transient lifestyle	81 (29%)
Multiple partners	67 (24%)
Poverty	97 (35%)

Table 2: Family characteristics noted in final SCR report

Family characteristics – children

Table 3 sets out a number of child factors noted in the SCRs. Nearly half of SCRs involving children over six years of age reported mental health problems for the child. In around three out of ten cases where the child was aged 11 or over, alcohol misuse (26 of 90) or drug misuse (31 of 90) by the young person was recorded. Children who were the focus of SCRs were often subject to more than one form of maltreatment.

Behaviour/feature	<1 year N=113	1-5 years N=158	6-10 years N=117	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, children aged under 1 year were excluded hence the denominator for this characteristic is 165.

** For alcohol and drug misuse, mental health problems, bullying and CSE, children aged under 6 years were excluded hence the denominator for these characteristics is 107.

Table 3: Child experiences and features

Neglect

Although rarely a primary cause of death, neglect is consistently a major factor in the lives of children who die or are seriously harmed as a result of child maltreatment. Neglect featured in three-quarters (208 of 278) of the SCRs examined and was the primary issue in one in five (19 per cent) serious harm cases.

A high prevalence of adverse parental and family circumstances was documented in the SCRs where neglect was a feature (see Table 4). There is some suggestion these problems can be cumulative: only 11 per cent of cases did not have any of these adversities recorded in the SCR, while 42 per cent documented at least three. Figure 2 shows the overlap of poverty, mental health problems and domestic abuse.

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.

Parental/family adversity	Percentage of 'neglect' SCRs in which adversity a feature (n=208)
Domestic abuse	64%
Mental health problems (parent)	56%
Adverse childhood experiences (parent)	40%
Poverty	39%
Alcohol or drug misuse (parent)	39%
Criminal behaviour (parent)	34%
Transient lifestyle	31%
Multiple partners (parent)	27%
Social isolation	17%

Table 4: Parental and family adversity in SCRs where neglect was a feature (Rates are likely to be an underestimate as they depend on whether a factor was recorded in the SCR report; in some cases the question may not have been asked, in others the SCR author may not have felt the factor was relevant.)

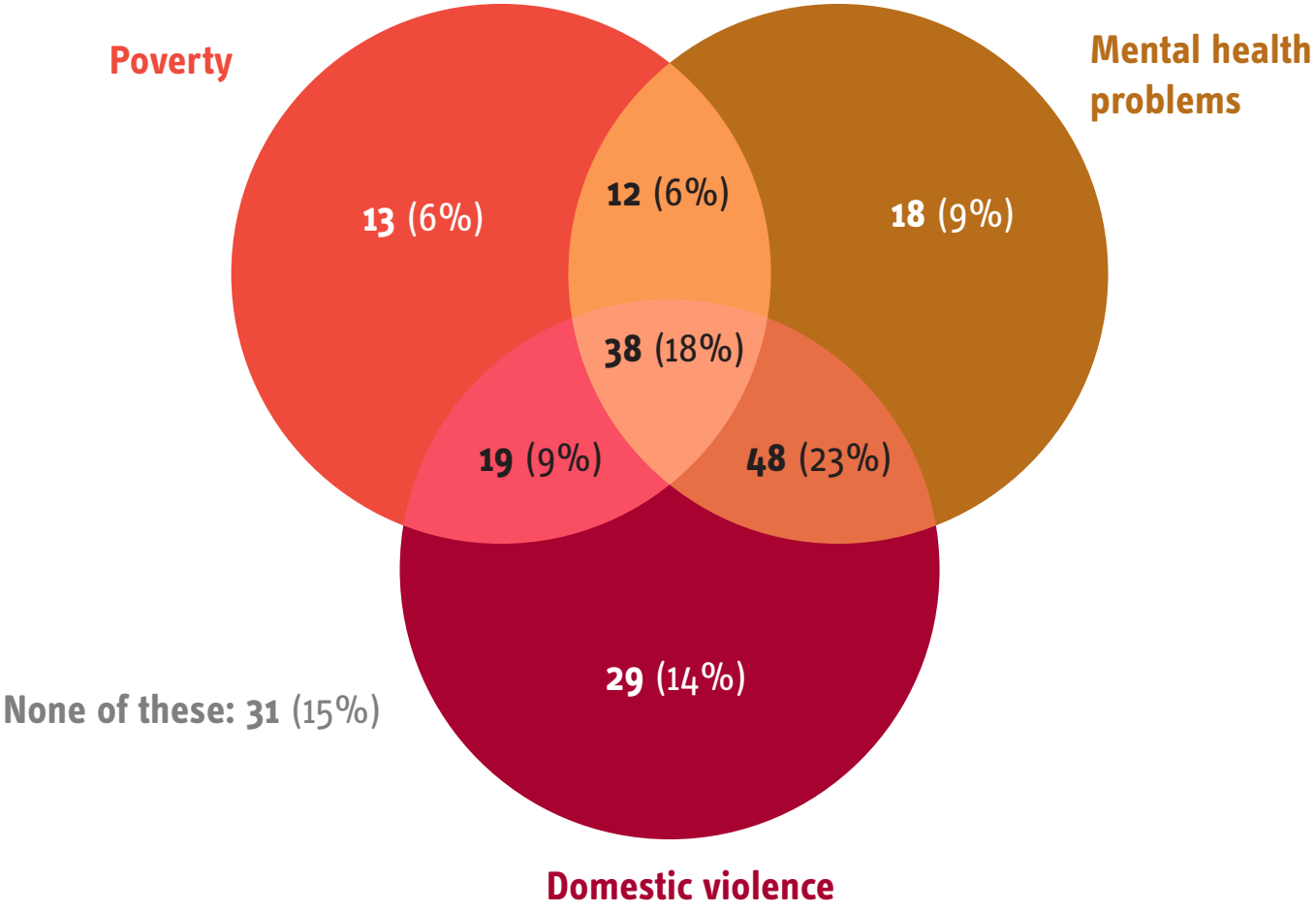


Figure 2: Adverse family circumstances in cases of neglect (n=208)

About this briefing

This briefing highlights key messages from the report for all policing professionals. Its aim is to support:

- Operational officers and staff to develop their knowledge, skills and practice to keep children and young people safe
- Managers and leaders to foster appropriate cultures for keeping children safe and to develop the right systems for ensuring children are safeguarded at the earliest opportunity.

The briefing is structured around learning to emerge in relation to four key themes:

- Neglect, and its relationship to poverty in particular
- Opportunities to intervene
- The vulnerability of adolescents
- Multi-agency working.

It concludes with a short section on implementing and embedding learning and change.

Poverty and neglect: Recognising and responding

'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.'

Neglect is consistently the most common initial category of abuse for children on a child protection plan and consistently a factor in the lives of children who die or are seriously harmed as a consequence of child maltreatment.

Chapter 3 of the report includes an in-depth analysis of a sample of 32 SCRs where neglect was a feature. A significant finding was the frequency with which issues relating to poverty were identified. The majority of children living in poverty do not experience neglect, but where poverty and neglect co-exist, adverse outcomes for children will be escalated.

Poverty leads to additional complexity, stress and anxiety in families, which can in turn heighten the risk of neglect or abuse. There was a high prevalence of adverse parental issues in the SCRs and these risk factors appear to be cumulative.

The impact of impoverishment is not always fully understood or captured effectively in recording and referral processes. Poverty is often perceived as one factor among many affecting families, or an outcome of families' difficulties rather than the cause of their needs and difficulties. This can lead to underlying causes around poor home conditions not being addressed.

Categories of neglect – pathways to harm

The report describes eight pathways through which neglect can lead to serious harm or death. Police officers and other frontline staff should be alert to early signs of these issues.

1. **Severe deprivational neglect** where the 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 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 exploitation** associated with early or continuing physical and emotional neglect.

Learning points

- Incident-logging and referrals should outline concerns using clear, straightforward language that effectively describes difficult issues. In one example, the ambulance service had graphically and accurately described a child's home living conditions as *'unsanitary with a foul smell and a fire hazard'*; however, this was changed in the section 47 strategy meeting minutes to 'poor home conditions', which diluted the description of risk and vulnerability.
- The report found those who work in areas of high deprivation can become desensitised to the warning signs of neglect (eg, poor physical care, smelly and dirty clothes, poor dental care). Police leaders and managers need to ensure frontline staff receive adequate training in how to recognise and respond to signs of vulnerability, including when to refer; this learning should be supported in regular one-to-one supervisory oversight.
- Frontline officers need to remain conscious at all times of the intense shame and stigma experienced by people living in poverty and maintain humane practice approaches to entering children and families' homes.

Cumulative harm

Cumulative harm refers to multiple adverse circumstances and events in a child's life, where children and adults are exposed to multiple risk factors. Complexity and cumulative harm are not unique to situations of neglect, but are generally a feature of families where a child has been neglected.

Neglect was recorded as a feature in 208 SCRs. As Table 4 above shows, there was a high prevalence of adverse parental and family circumstances in those cases. Links between domestic abuse, substance misuse and poverty are complex and often interdependent (Figure 2). While addressing a single issue will not deal with the underlying causes, one issue may present an opportunity to explore the wider safeguarding picture, enabling proactive steps to minimise further impact on the children.

The report highlights a case in which the risk of harm to a child was recognised from intelligence and information regarding parents' criminal convictions and was shared early by police:

'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.'

The level of risk may spiral from a period of low-level underlying concerns followed by a sudden escalation caused by unexpected life events or a change of circumstances, triggering a series of events that swiftly become unpredictable. This was typically seen in neglect cases: all professionals, including police officers, should anticipate and consider spiralling risks and how this may affect parents' ability to care for their child.

Learning point

> Wider recognition of cumulative harm and spiralling risk needs to be addressed through training to become embedded in the thinking of police officers and staff in response to neglect.

Opportunities to intervene

Hearing the voice of children and young people

Frontline police officers attend incidents where they come into contact with children and young people who may be suffering neglect. During every interaction, they need to be 'professionally curious' and recognise when action needs to be taken to protect children and young people from harm.

For example, police officers need to be aware that adolescents who may be perceived as putting themselves at risk of harm are also vulnerable from neglect.

How police officers and staff engage with children and adolescents is important for ensuring their voice informs effective responses. The report highlights factors to be considered when engaging with children of different ages (see Table 5 on next page).

Unborn babies and infants	> Babies and infants are wholly reliant on the adults around them. Responses to incidents regarding the behaviour of the adult must consider the risk to the unborn baby or infant. > Police referrals must be made to ensure risks to the unborn baby or infant can be responded to effectively.
Younger children (aged 6 to 12)	> Children of this age range are more likely to communicate with other trusted adults, such as teachers. Police and partners should consider working with schools to support effective disclosures. > Neighbourhood Policing Teams should build up relationships with schools in their areas.
Adolescents	> **Trust:** Adolescents' earlier lived experiences, as well as their current activities and sense of loyalty to people who may be exploiting them, may well make them mistrustful of professionals. > **Relationship-based practice:** Practice that is centred on a welfare and trauma-informed response, based on relationships to repair disrupted attachment, is most likely to build trust, support desistance of offending and build resilience against exploitation and abuse. > **Children first:** Children, including adolescents, should be seen as children first, and offenders second. Their needs as children should be prioritised. The Youth Justice Board now refers to all young people as 'children' to refocus practice on the fact that they are children. > **Recognising vulnerability:** The report found frontline police officers and youth offending teams often saw older children and adolescents only through a criminal justice lens – as perpetrators – and failed to recognise how their experiences (eg, of neglectful parenting) might contribute to their vulnerability to exploitation. > **Multi-agency response to child arrests:** Whenever a child is arrested, there should be early engagement with partners to ensure a strategy discussion and consideration of a multi-agency response. > **Self-harm:** Police responses to incidents of young people self-harming or expressing suicidal ideation must always consider the wider implications of the child's welfare. A response that goes beyond purely seeking medical attention and managing the immediate risk is required. An appropriate safeguarding referral needs to be made for each incident to ensure the information is shared. > **Training:** Relevant and up-to-date training should be provided to ensure staff are prepared for working with adolescents on issues such as: - Safeguarding in relation to criminal activity involving children and young people - Assessing and intervening to safeguard older children and young people beyond the family home environment - Safeguarding in relation to risks involving the use of technology by young people.

Table 5: Factors to consider when engaging children of different ages

The report also highlights that many SCRs do not address issues relating to ethnicity, including how cultural beliefs and expectations impact on the care and wellbeing of the child, and how to investigate and assess this while also respecting diversity and a family's cultural and religious beliefs. Ethnicity may be recorded, but the implications for the day-to-day lives and experiences of the children are often not explored.

In some SCRs children's lived experiences were not evident. The use of professional jargon or vague stock terms sometimes masked the realities of children's lived experience (as in the example of the dilution of the ambulance service's description on page 9 above).

Learning points

- Police leaders and managers should encourage a professionally curious culture of reflective supervision and investigation to enable the identification and challenge of unconscious bias and assumptions.
- Discussing potential hypotheses with staff, while taking into account vulnerability, uncertainty and harm, will reduce opportunities for bias to unfairly influence outcomes.

Information from family and community

Information from relatives, friends and communities can be invaluable in keeping children safe. However, the report highlights cases where calls made to the police or children's social care did not result in any record of what action was taken and where 'insufficient weight' was given to concerns expressed by neighbours.

'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.'

Learning points

Police should ensure that they:

- Always follow up concerns raised by relatives, neighbours or anonymously.
- Understand the perspective of the child – they should talk to the child on their own wherever possible.

Intervention: Emergency protection and police powers of protection

The report found there is still confusion among both police officers and social workers in these areas.

- **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*, which gives police 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 granted by the family court for up to a maximum of eight days but can be extended for a further seven days. The order gives the applicant (normally the local authority) parental responsibility, but only in so far as to take such action as is reasonably required to safeguard the welfare of the child.

Adolescents

Nearly one in three SCRs (115 of 368) involved children aged 11 years and over. The two most common causes of serious harm in these cases were (i) risk-taking or violent behaviour by the young person, and (ii) child sexual exploitation.

Chapter 4 of the report looks at findings in relation to going missing, exploitation, harmful sexual behaviour and social media/online behaviour using an in-depth qualitative analysis of a sample of 25 cases.

While harm can continue to come from within the family during adolescence, there is increased potential for extra-familial risk and harm. Both virtual and local communities provide spaces for exploitation.

Adolescents for whom there are safeguarding concerns have often had early experiences that include abuse and neglect, time spent in care or separation and loss. They may have witnessed parental domestic abuse, parental substance misuse and parental mental illness.

Such experiences may contribute to feelings of worthlessness and lack of self-efficacy in adolescence. Practice responses to previous harmful experiences can also influence young people's (lack of) confidence in services.

Understanding adolescents' experiences – including family life, adverse early childhood experiences, local community and wider social networks – is necessary for understanding adolescent harm.

Contextual Safeguarding is an approach to safeguarding children and young people which responds to their experience of harm outside the home – for example, online, in parks or at school (see box below).

Complex Safeguarding is a term that has been applied to encompass a range of safeguarding issues related to criminal activity (often organised) involving vulnerable children or adolescents, where there is exploitation and/or a clear or implied safeguarding concern. This might include (but is not limited to) child criminal exploitation, county lines, modern slavery including trafficking and child sexual exploitation (CSE).

Contextual Safeguarding is an approach developed by Dr Carlene Firmin and colleagues at University of Bedfordshire. It provides a framework for local areas to develop an approach that engages with the extra-familial dynamics of risk in adolescence. The primary focus is the need to assess and intervene with extra-familial contexts and relationships in order to safeguard older children and young people.

Further information on Complex and Contextual Safeguarding can be found here.

SCRs suggest professionals in schools, police and social care do not always share information appropriately, however. This means no one is seeing the full picture of multiple difficulties (eg, substance misuse, special educational needs, school exclusion, antisocial or criminal activity, loss and separation).

Learning points

- Police training should cover Contextual Safeguarding and Complex Safeguarding (see box) – exploring and intervening in local contexts and communities (including online) to engage with extra-familial dynamics of risk.
- SCRs involving adolescents demonstrate the need for:
  - Prolonged and persistent engagement to provide effective support
  - A balance of preventative work and crisis management.
- Knowledge of local criminal activity hotspots, when combined with specific concerns for individual children, can inform an effective contextual safeguarding response.
- Adolescents who have grown up in neglectful situations are vulnerable to having their needs, and the risks they face, overlooked. Police need to understand that adolescents who may be perceived as 'putting themselves at risk of harm' are vulnerable from neglect.
- Criminal justice interventions are by their nature often episodic, involving an investigation or response to a particular incident. It is paramount, therefore, that the police have clear internal safeguarding processes in place and that these are understood by all staff.
- Forces need to be clear about how departments interact with one another and ensure specialist child protection resources are available to offer advice and guidance.
- Officers and staff need to be adequately trained to recognise vulnerability of all types and able to refer to appropriate support within the police and/or externally to ensure there is a joined-up response to children and families' needs.

Going missing

A child going missing is a powerful signal that all is not well in their life; it is not enough simply to find them and bring them home.

SCRs found some adolescents went missing either to get away from those exploiting them or because the criminal activity they were being exploited into took them out of their local area.

The local authority has a duty to offer a return interview (to be carried out by an independent trained worker) within 72 hours of any child who goes missing from home or care being found or returning (Department for Education, 2014). This is different from the police 'prevention interview' (formerly a 'safe and well check'), which should be conducted in all 'serious' cases (College of Policing Authorised Professional Practice), such as a child who goes missing repeatedly; however, evidence from the SCRs would suggest this does not always happen.

Two of the reviews concerned young people who had gone missing abroad. When children who are not subject to child protection processes go missing abroad, the investigation is left to the police and the authorities of the country where the child is suspected of being. This can result in a loss of information and potential strategies to protect the child. In one case of a child missing abroad, the child's mother reported her missing and the following day the police informed children's social care. As she was missing abroad, children's social care did not open the case until some months later as they viewed it as a police investigation.

In another case, two brothers who went missing abroad and were killed whilst fighting in Syria were groomed into radicalisation online. The review in this case suggested that there are different responses, depending on where the child is, which can result in inconsistencies in interventions. The review concludes, that Prevent (part of the UK Government counter-terrorism strategy) should be situated within child safeguarding to prevent the child being drawn into terrorist-related activity (HM Government, 2015).

Learning points

- Interviews are an opportunity for the child's voice to be heard and to find out what prompted going missing.
- Some adolescents refuse a return interview; however, if persistently offered (especially by the same person) an interview may be accepted at some point.
- Sharing the evidence gathered in a prevention interview with other agencies will facilitate holistic safeguarding responses.
- A timely multi-agency safeguarding response should not depend on where a child goes missing from or to (eg, abroad).
- Partnership working is essential to tackling radicalisation, as specified in Prevent duty guidance and *Working Together* (HM Government, 2015; 2018).

Criminal exploitation

Criminal exploitation includes young people being exploited into moving drugs (county lines), violence, gangs, trafficking and radicalisation. The report found criminal exploitation was closely linked to school exclusion, going missing, substance misuse and loss and separation.

Young people involved in criminal exploitation should be seen as victims and safeguarded accordingly. However, it is clear that children are sometimes still blamed for 'putting themselves at risk' of exploitation. Police and other staff need always to look beyond immediate presenting behaviours.

Offending behaviour needs to be addressed but also understood in the context of experienced neglect:

'... 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 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.'

Effective information sharing is critical to an effective and appropriate response (see the section on 'Multi-agency working' on page 16 below).

Learning point

- It is important to recognise the relationship between neglect and risk of harm. Behaviours associated with exploitation should be understood first and foremost as indications of vulnerability rather than criminality.

Child sexual exploitation

Child sexual exploitation (CSE) was noted in nearly one in ten (26 of 278) SCR reports available for review.

Despite its high profile, however, professionals were often still slow to recognise and respond to vulnerability to CSE, particularly if the child was a boy.

In one case, a young male went missing and was known to be in the company of an older man (aged about 25). Jack's parents informed the police of his intention to see the older man but the police were not proactive in preventing the incident, referring to the matter as a 'parenting issue'. After he had gone missing the police did identify Jack as high risk. Acting on information from Jack's classmates they were quickly able to locate the address. However, the subsequent response was insensitive and helps explain Jack's 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.'

The report also highlights examples of effective practice involving immediate strategy discussions and multi-agency disruption:

'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.'

Learning points

- The Child Exploitation Disruption Toolkit (Home Office, 2019) is a comprehensive resource for frontline police and staff. It sets out strategies and tactics for disrupting CSE and criminal exploitation.
- Officers need to be alert to the fact that boys may find it more difficult to disclose CSE. However, the risks for male victims of CSE are no less serious than for females. Recent guidance suggests professionals should always ask themselves if their response would be different had the victim been a girl (The Children's Society, 2018a).

Harmful sexual behaviour (HSB)

Harmful sexual behaviour (HSB) 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)

Seven SCRs were examined where adolescents had displayed HSB towards other children. All seven had experienced neglect, but experience of any form of maltreatment can be an indicator for HSB.

Children with HSB are likely to have experienced polyvictimisation and their actions need to be seen within the context of their own maltreatment.

The report highlights difficulties in children getting the right support when a decision not to prosecute was taken. When there are no criminal justice outcomes, it is necessary to provide other support to divert young people from criminal activity.

In one case, a 15-year-old boy was a victim of muggings and stabbings but also part of a group perpetrating sexual assaults on young girls. After the first assault, he did not receive any therapeutic or educational input; this appeared to be partly because the case was not pursued by the Crown Prosecution Service. The family had No Recourse to Public Funds 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 [children's social care] and neither his school nor the GP were aware of the offence.'*

Learning points

- Being a victim and a perpetrator of HSB can be closely related, particularly if offences are committed as part of a group. There must always be a therapeutic and/or safeguarding response in addition to any criminal justice response.
- When a crime is not pursued, information needs to be shared by the police to ensure safeguarding can be addressed through local HSB pathways.
- The report highlights the impact of long delays in investigation and criminal justice procedures, which create uncertainty for the child and other professionals. Police leaders should ensure there is capacity to investigate and analyse digital devices so prosecution decisions are timely.
- Useful guidance on responding to HSB, including technology-assisted HSB, can be found on the **NSPCC website**; the National Institute for Health and Care Excellence (2016) has also published **guidance for those working with children and young people who display HSB**, including neighbourhood and community support police officers.
- HSB can be assisted by use of the internet, via phone or other devices, and can occur in group settings. Shared sexual images can be used for bullying and blackmail to continue abuse.

Social media and technology-assisted harm

Adolescents increasingly use technology and social media to communicate, explore friendships and find information. Those who feel disconnected from family and society, including at school, may turn to social media and online activity in an effort to find a sense of identity and belonging.

Social media also provides fast-changing spaces within which children may be groomed and exploited. Adolescents have access to multiple devices (including those of friends) and can easily set up new accounts, which makes monitoring unrealistic.

Learning point

- It is important professionals receive ongoing education about keeping children safe online – for example, by making use of advice and resources produced by organisations such as **UK Safer Internet Centre**.

Multi-agency working

The report includes a 'topic study' on multi-agency working between the police and other agencies (Chapter 3). It notes that while the police are one of three key safeguarding partners, analysis of SCRs suggests police investigations sometimes 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 particularly so in cases of neglect, where police officers tended to take a 'back-seat role' if immediate risks to the child were not recognised or the information held was insufficient to pursue a criminal investigation.

Learning points

- Clear multi-agency plans at both child in need and child protection levels are central to effective working. This requires all relevant professionals to be involved in drawing up plans, and a continued focus on the needs of the child.
- Partnership working should be collaborative and receptive to 'professional challenge'. Challenging other professionals can be difficult, but it is important not to assume the lead agency has made the best decision. One local area overcame a reluctance among staff to 'escalate' concerns if they disagreed with a decision by renaming the process 'resolving professional differences'.

It is important police staff have knowledge of thresholds in relation to section 17 and section 47 of the *Children Act 1989* and understand local escalation routes/policies.

Section 17 – 'child in need'
A child in need is defined under the *Children Act 1989* as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Children in need may be assessed by a social worker.

Section 47 – 'significant harm'
Where a local authority has reasonable cause to suspect that a child (who lives or is found in their area) is suffering or is likely to suffer significant harm, the local authority has a duty to make such enquiries as it considers necessary to decide whether to take any action to safeguard or promote the child's welfare. Such enquiries should be initiated whenever there is a concern about any form of abuse or neglect. Local authority social workers have a statutory duty to lead enquiries under section 47, supported by the police, health professionals, teachers and other relevant professionals.

'Silo' working

The report identifies 'silo working' as an ongoing problem within (as well as between) agencies, which was evident particularly in relation to the police.

A number of forces have moved away from having specialist child protection investigation teams, usually in response to budget constraints or to improve the spread of those officers who are able to be involved in specialist child protection investigations.

The report suggests this has had a knock-on effect on the quality of safeguarding work, however. In one case, the changes made it harder to ensure good relationships between social workers and police officers, and threatened the quality of joint child protection work.

In other areas, the police service is made up of different teams – eg, uniformed frontline officers and specialist child protection investigators. This breakdown of roles can also cause problems in safeguarding. Partners may not understand differences in knowledge or training between specialisms, and police officers themselves may not fully understand what is required of them in relation to partnership working.

One SCR noted:

'...the strong understanding of child safeguarding within the police safeguarding investigation team ... 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.'

Learning point

> Senior leaders should review their team structures and operations to ensure safeguarding and investigative processes are child-focused, clear and unambiguous.

Information sharing

'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: 190).'

The importance of effective information sharing and communication (between professionals and agencies) was the most frequently cited category when LSCB survey respondents were asked to identify the main learning topics to emerge from SCRs.

The police often hold significant information about parents, carers and other family members, so it is important they are involved at all stages of an investigation. This includes initial inquires through a MASH (Multi-Agency Safeguarding Hub), strategy discussions (see below) and child protection conferences.

Although guidance and legislation supports sharing information to safeguard children, the report highlights the need to continually relearn practice in this area. The report found the police often held information about family members with a history of criminal convictions (in some case violent crime), but this was not routinely shared at each stage of an investigation or in follow-up on cases where children were subject to child protection or child in need plans. This information is crucial to understanding the context of children's lives and hence for effective risk assessment and planning.

Information sharing – good and bad practice

The report highlights examples of both good and bad practice in relation to information sharing by the police.

Examples of good practice included:

- Convictions being recognised as risk factors and shared by the police, along with other intelligence, at an early stage.

Examples of poor practice:

- As in earlier analyses of SCRs, a recurring issue was the lack of safeguarding referrals by police following attendance at incidents, particularly those involving domestic abuse. This can lead to opportunities for intervention being missed.
- In one SCR a family friend was found to be a registered sex offender, posing clear risks to the children. However, the police had not shared information about the offender with the family.
- Where the police do not perceive criminal activity as directly related to child protection, information was not always shared.
- Information was not always shared when it related to offences in another police force area or when offences had taken place within the context of an earlier relationship.
- Risks were sometimes downgraded inappropriately, particularly if large amounts of information were held about parents, including criminal convictions and criminal activity. This led to an ineffective response and work that was reactive rather than proactive.

Learning points

- It is critical that police officers and staff involved in safeguarding children have a solid understanding of their role in sharing information, as set out in the College of Policing Authorised Professional Practice and *Working Together* (HM Government, 2018). This understanding must be revisited regularly, renewed and reinforced.
- Police should be involved not only in providing information, but also actively engaged in evaluating risks and planning.
- It is important for police to check information that may be held in relation to previous relationships (including intelligence from other countries if parents are immigrants) or offences that have taken place in other force areas.
- When information is shared or referrals made (eg, to social care), the language used needs to be clear and unambiguous. It should describe issues explicitly so that the reality of life for the child is made clear and risks are not diluted (see the example of the ambulance service's description in the learning point under on page 9 above).
- Low-level concerns should be recorded. Over time, this helps to build up a picture of life for children.
- Information must be shared about wider risks in order to strengthen joined-up risk assessment and planning.

Strategy discussions

'Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care (including the residential or fostering service, if the child is looked-after), the police, health and other bodies such as the referring agency.' (*Working Together* – HM Government, 2018: 38)

Like the earlier triennial and biennial analyses, the report emphasises the importance of police presence at strategy discussions (sometimes known as strategy meetings). As the nature of a discussion is exploratory – to explore whether there is a risk of significant harm and what action is needed to address it – the police need to be active contributors to evaluate and mitigate risks to the child through a coherent multi-agency plan.

However, in some SCRs the police contribution did not go beyond limited information sharing. This not only reduced the effectiveness of the final plan, but also sometimes led to gaps in information about family members who could present a risk.

Learning point

> Senior police leaders need to ensure staff have the capacity, skills and confidence to be knowledgeable and active participants at strategy discussions.

Achieving Best Evidence (ABE) and intermediaries

Once a decision is made that there is to be a criminal investigation, the police take the lead to ensure evidence can be secured. Interviews from victims and witnesses should be completed in line with national guidance, *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses* (Ministry of Justice, 2011).

However, SCRs indicate this guidance is not always adhered to and the report calls for a sharpening of practice in relation to investigative interviewing – specifically, for a 'step change' to ensure that ABE interviews are a joint agency activity.

Failure to follow the guidance may reflect a tendency (identified in the report) for ABEs to be seen as a single agency activity, rather than a joint one between police and social care in which the interview can be used to secure evidence *and* help children to talk about their experiences (thereby combining different professional expertise appropriately).

In order to achieve the necessary step change, there needs to be an increase in the number of police officers and social workers trained in ABE.

The SCRs also highlight that the police could make better use of intermediaries in child protection cases, especially those children who have intellectual or communication challenges. (Intermediaries work within the justice system to enable vulnerable victims, witnesses, suspects and defendants 'to give complete, coherent and accurate evidence' to the police and courts.)

Learning points

> Investigative interviewing under ABE 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 skilled intermediaries should always be considered for children with additional needs.

> Police leaders should work with leaders in children's social care to try and ensure enough police officers and social workers are trained in ABE.

Implementing learning from SCRs when working with children and families

Applying and embedding learning from SCRs should be a priority, but the regularity with which similar themes appear in the triennial and biennial analyses suggests such efforts have so far had only limited impact.

Findings in the report are consistent with those of the National Police Chiefs' Council's briefing on learning for the police from SCRs (Allnock, 2019), published as part of the NPCC's Vulnerability Knowledge and Practice Programme (VKPP).

That briefing concludes that the police response to safeguarding children has improved significantly over recent years, but acknowledges there are still areas where further development is needed. These include:

- Encouraging greater rigour in information sharing
- Reviewing opportunities for embedding effective structures
- Promoting responsive cultures
- Building capacity by addressing resourcing and skills.

(Allnock, 2019)

The report finds there is generally a greater learning impact when:

- There is an opportunity to reflect on practice while keeping the story of the child at the centre of the discussions.
- Ownership for implementing recommendations is clear. LSCB survey respondents felt recommendations have most impact when targeted at single agency or, to a lesser extent, at *defined* multiple agencies; staff may distance themselves from those addressed more generally to 'all agencies'.
- Multi-agency learning and training bulletins are used. These were popular methods for sharing the recommendations and learning from completed SCRs.

Leadership and organisational culture also feature as significant enablers when trying to deliver impact from SCRs and embed change. In particular, SCRs have *'a useful function as an accountability check on the quality of leadership as well as an opportunity for reflection on practice'*. Many survey respondents felt that what mattered most was having *'a committed, motivated team or champion'* to take recommendations forward.

Reflective questions

Frontline staff should ask:

- Do I understand my role and the powers available to me to safeguard children?
- Do I understand pathways for multi-agency working, including how to escalate concerns about practice or decision-making in my area?
- Am I confident in understanding how to share information in a language that describes the risks, vulnerability and wider lived experiences of a child?

Senior leaders should ask:

- Is my workforce equipped and resourced to respond effectively to the practice deficiencies highlighted in the report?
- Is my force/department helping to foster and promote a culture of learning and innovation? This could include not only learning and improving from poor practice, but also striving to use technological advances to improve safeguarding.

References

Allnock D (2019) *Learning from reviews of death or serious injury as a result of child abuse or neglect. A briefing paper.* Norfolk: National Police Chiefs Council, Vulnerability Knowledge and Practice Programme.

The Children's Society (2018a) ***Boys and young men at risk of sexual exploitation: A toolkit for professionals***. London: The Children's Society.

The Children's Society (2018b) ***Children and young people presenting with harmful sexual behaviours. A toolkit for professionals***. London: The Children's Society.

College of Policing. '**Authorised Professional Practice, Major Investigation and Public Protection**'.

Department of Education (2014) ***Statutory guidance on children who run away or go missing from care***. London: DfE.

Firmin C, Horan J, Holmes D and Hopper G (2019) ***Safeguarding during adolescence – the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding***. Dartington: Research in Practice, University of Bedfordshire, Rochdale Borough Council and Contextual Safeguarding Network.

HM Government (2015) ***Revised Prevent duty guidance: For England and Wales***. London: Home Office.

HM Government (2018) ***Working together to safeguard children***. London: Department for Education.

Home Office (2019) ***Child exploitation disruption toolkit: Disruption tactics***. London: HO.

Ministry of Justice (2011) ***Achieving Best Evidence in criminal proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures***. London: MoJ.

NICE (2016) '**Harmful sexual behaviour among children and young people: NG 55**'. London: National Institute for Health and Care Excellence.

NSPCC (2019) '**Protecting children from harmful sexual behaviour**'. NSPCC learning published online.

Sidebotham P (2012) 'What do serious case reviews achieve?' *Archives of Disease in Childhood* 97 (3) 189-192.

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