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2019 Triennial Analysis of Serious Case Reviews:

Local safeguarding partnerships

Contents

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

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 is for:

> Senior staff working with or leading safeguarding partnerships

> Partnerships boards (including LSCBs while they continue to operate)

> Child death review partners and child death overview panel members

> Independent scrutineers, advisors and chairs.

Introduction

This briefing is based on the findings of *Complexity and challenge: A triennial analysis of serious case reviews 2014-2017* ('the report') (March 2020). The report is the eighth national analysis of serious case reviews (SCRs). View previous reports at: **www.seriouscasereviews.rip.org.uk/resources_old/scr-analysis-reports-1998-2011**.

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 at: **www.seriouscasereviews.rip.org.uk**.

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
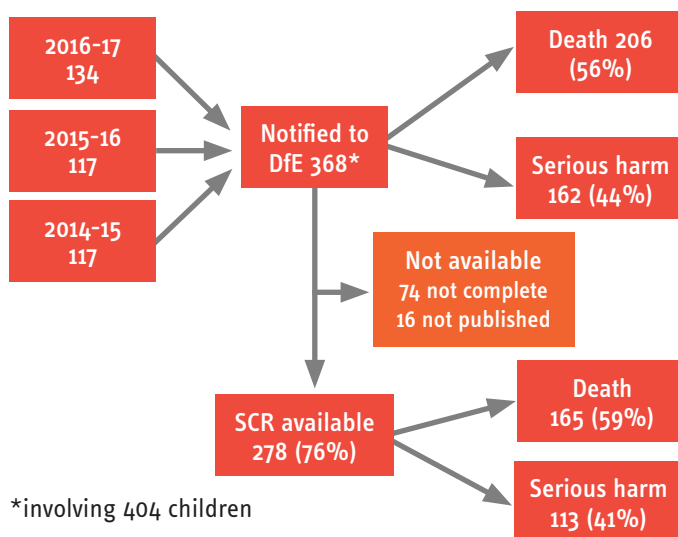
Figure 1: Numbers of SCRs examined

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	83 (30%)
(of which violent crime, excluding domestic abuse)	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	150 (54%)
(of which, acrimonious)	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.

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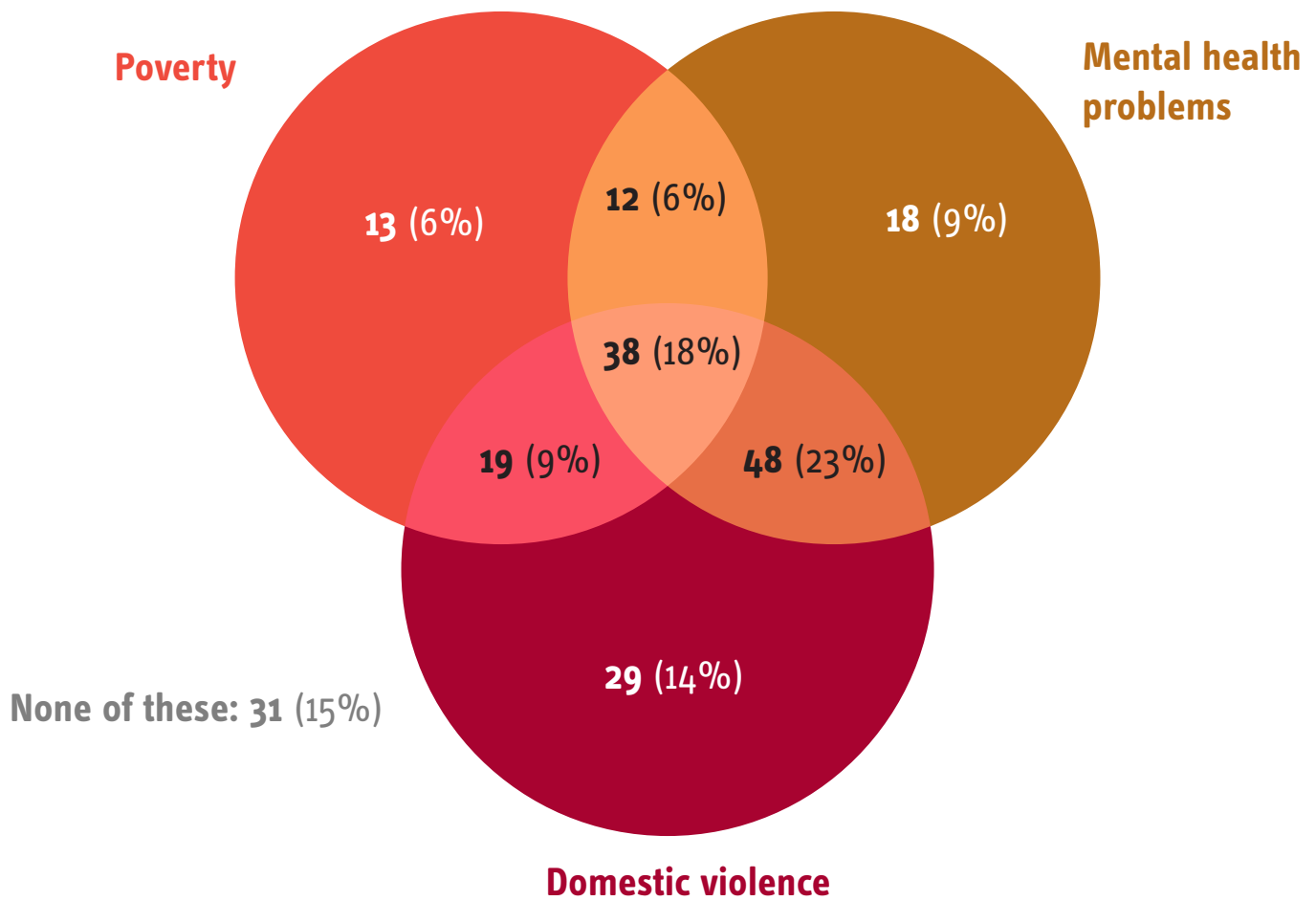
Figure 2: Adverse family circumstances in cases of neglect (n=208)

Poverty

Mental health problems

13 (6%)

12 (6%)

18 (9%)

38 (18%)

19 (9%)

48 (23%)

None of these: 31 (15%)

29 (14%)

Domestic violence

About this briefing

This briefing should help local safeguarding partnerships to:

> Raise awareness of potential safeguarding issues and priorities that need to be addressed at multi-agency level

> Identify and support strategic changes

> Support the future commissioning of services and LCSPRs

> Understand the messages from the report and the implications for development of local policies and procedures

> Identify multi-agency training needs and gaps.

At the end of each section are challenge and assurance questions for partnerships to consider in developing their response to the report. These could form the basis of a workshop supported by the resources at the end of the briefing.

Areas of learning from the main themes

The briefing concentrates on four key areas from the report that are especially relevant for safeguarding partnerships.

> Neglect

> Vulnerable adolescents

> Multi-agency working (information sharing, language and communication)

> Enabling children to have a voice.

The final section aims to support future commissioning of LCSPRs and draws on findings from the national survey of LSCBs. The briefing ends with some final thoughts for policy and practice.

As highlighted in the introduction, the complexity and challenge of safeguarding vulnerable families has to be seen in the context of wider issues. These include more children living in poverty, service cuts, benefit changes and increasing numbers of children in need or in need of protection and more children in care. More than 600,000 children were referred to Children's Services in each of the years covered by the report. Many practitioners were also under pressure from high caseloads and working within a context of service reorganisation and leadership changes. Partnerships should acknowledge the impact this had, and may still be having, on the effectiveness of local systems for keeping children safe.

The introduction includes key data from the report (see Chapter 2 for more detail). A key message is that out of a total of 191,930 children on a child protection plan, only 54 (15 per cent) SCRs were in respect of a child on a plan (a further 56 had previously been on a child protection plan).

Key message Children on child protection plans are generally well protected from the most severe harm. It is children in need or who are on the fringes of intervention where the most serious harm takes place.

? Reflective question

> Are local cuts/changes to services and other organisational pressures having an impact on local systems for keeping children safe? How are these being managed? Are partners adequately involved in these decisions to minimise the impact?

Neglect

How the safeguarding partnership responds to and protects children from the harmful effects of neglect is one of the most challenging and pressing aspects of safeguarding work. Neglect was the category of abuse in 50 out of 84 children (for whom data were available) who were (or had been) subject to a child protection plan. Complexity and cumulative harm were almost invariably a feature of families where children experienced neglect. Chapter 3 of the report includes an in-depth analysis of 32 cases where neglect was a feature; this briefing draws out key learning points.

Impact of poverty
Poverty leads to additional complexity, stress and anxiety in families, which can in turn heighten the risk of neglect or abuse. The impact of impoverishment is not always fully understood or captured effectively in recording or assessment processes.

Children living in poverty often experience poor social, emotional and behavioural outcomes, and impaired cognitive and language development. In one case:

'The primary focus for agencies was to improve the physical conditions of the home .... 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.'

As noted in the introduction, SCR findings in relation to neglect typically include:

> Poor dental hygiene

> Incomplete vaccinations due to missed healthcare appointments

> Poor school attendance

> Developmental delays because of lack of stimulation.

Neglect is also associated with children having more accidents, poor mental health in adolescence and young people being vulnerable to exploitation by others. Other associations include self-harm and poor school achievement.

Learning points
> The links between domestic abuse, substance misuse and poverty are complex and often interdependent (Figure 2). Addressing a single issue will not deal with the underlying cause or other issues present; children were left at risk when short-term solutions addressed only the immediate issues followed by case closure.

> Professionals can become accustomed to working with children living in areas of high deprivation; this can lead to normalisation and desensitisation to warning signs such as poor physical care, smelly and dirty clothes or poor dental care. Supervision/case management has a crucial role in enabling practitioners to identify poverty and work proactively with families.

> Housing services are not generally seen as a safeguarding agency but may have valuable information. Many families were living in unstable and inadequate housing. In the rare instances when housing services did feature in SCRs, their involvement did not result in decisive action. Involvement is made more challenging with the rise of private sector housing where there is no safeguarding point of contact.

> Professionals can be reluctant to name neglect, especially if this could be a barrier to family 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.

> Parents living in poverty often have fewer social, emotional and physical resources to call upon; feelings of shame and hopelessness may hinder their seeking or accepting help.

Key message Rectifying the physical manifestations of poverty and a chaotic lifestyle does not equate with children being safe.

Adolescent neglect

The report considers specific aspects of adolescent neglect. Particular themes emerged in relation to 'vulnerable adolescents' in identifying and responding to neglect, where risks and needs can overlap.

One SCR noted: *'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.'*

In one case, agencies failed to identify a young person with highly complex needs living in chronically neglectful circumstances, as the young person was somehow not known to Children's Services.

The report identifies the need for:

> Joint working agreements for adolescents with complex health needs, especially around transition to Adults' Services.

> Better transition protocols that contain sufficient details to identify young people not in receipt of support from disabled children teams. In one case, there was no system in place for identifying carers' support needs in the transfer to Adults' Services.

Learning points

> There is insufficient understanding of adolescent neglect across the multi-agency network and its link with complex adolescent behaviour. This can result in a fragmented and reactive response to different aspects of behaviour and leave young people at risk of harm.

> Clear pathways for transition to Adults' Services are important to ensure young people receive the care and support they need. Thresholds for child protection can become less clear or invisible for these young people unless specific arrangements for their identification across agencies are put in place.

Key message An incident-based approach to child protection and the identification of neglect has served adolescents poorly. When each involvement with a family is treated as a discrete event, information is not accumulated and professionals do not develop a comprehensive understanding of the child's life experiences.

? Reflective questions

Strategic

> How are local safeguarding partners demonstrating effective working across other partnerships (community safety partnerships, adult safeguarding, housing, health and wellbeing boards, voluntary organisations) in order to ensure a collective approach to neglect and its prevention?

> Do other local strategic plans (such as the Joint Strategic Needs Assessment, Children's Plan, etc.) take account of the local picture of child poverty and neglect and the impact on children who are vulnerable, including adolescents?

> Is there a need to update or develop further the local multi-agency neglect strategy, joint protocols, assessment and planning tools to ensure they are well designed, tested, disseminated and fit for purpose?

> Is the partnership confident that local commissioning of services is informed by local patterns of poverty and economic deprivation, and delivered in a way that enables practitioners to support families living with an increased risk of neglect, alongside other complex needs?

Practice

> Do agency assessments take into account and accurately describe how poverty is impacting on capacity to parent, and what it feels like to be a child in that family and their daily lived experience?

> Do multi-agency practitioners have the right tools to help them recognise and respond to neglect?

> How well embedded are reflective supervision/ case management processes in the key agencies that provide services to children and families where neglect is a feature?

> Is adolescent neglect recognised and effectively acted upon?

> How effective are local transition processes between Children's and Adults' Services? How do you monitor this?

Vulnerable adolescents

> 115 (31 per cent) of the 368 SCR notifications involved children aged 11 or over.

> 65 of those SCRs related to deaths and 50 involved serious harm.

> 47 deaths (72 per cent) were maltreatment related.

> The two most common causes of serious harm in adolescent cases were (i) risk-taking or violent behaviour by the young person, and (ii) child sexual exploitation.

> CSE was noted in 26 (9 per cent) of the 278 SCRs available for review.

Adolescence remains a time of vulnerability for many children, and working with adolescents continues to be a challenge for practitioners when resources are scarce and time-limited.

The report finds local neighbourhoods were a source of significant risk, as young people were often not in school, going missing and seeking a sense of belonging away from the family home. Despite its high profile, there is evidence that practitioners were still slow to recognise and respond to vulnerability to CSE, particularly if the child was male.

SCRs for adolescents provide insights into emerging threats outside the home, including various forms of criminal exploitation (where children and young people may be exploited into involvement in crime) and other exploitation, such as CSE. These require coordinated locality safeguarding responses. Threats include:

> moving drugs

> violence

> gangs

> sexual exploitation

> going missing

> trafficking

> radicalisation.

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).

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 at:
www.researchinpractice.org.uk

Some children and young people were both victims and perpetrators of harm to other children; all needed support and safeguarding. However, the tendency for professionals to see them as *troublesome* rather than *troubled* led to responses that focused more on criminal activity than assessing and managing vulnerability.

Four cases of criminal exploitation were analysed concerning adolescent males aged 14 to 17. Three died from stab wounds and one by suicide. Criminal exploitation in these cases was closely linked to school exclusion, going missing, substance misuse and previous experiences of loss and separation.

Key message Police and their partner agencies need to improve understanding on the front line that adolescent criminal activity may be an indicator of wider exploitation and vulnerability. Responses need to recognise vulnerability and not focus solely on criminal processes.

Learning points

> When an adolescent goes missing it is a powerful signal all is not well; it is not enough to find them and bring them home. Timely multi-agency responses are needed, as are effective return home interviews and prevention interviews (safe and well checks) that analyse the reasons behind missing episodes and if any harm has ensued.

> Prolonged and persistent professional engagement is needed to support adolescents; this will involve a balance of preventative work and crisis management, and needs to be trauma-informed and built on an understanding of relationship-based practice. This has implications for the use of scarce resources.

> Agencies should find ways to understand and record patterns in adolescent group and individual behaviour (including local spaces where exploitation may be occurring) in order to capture a more holistic picture of potential harm; to be effective, this needs to be informed by local young people's experiences.

> Practitioners can feel unprepared for working with adolescents when it comes to relatively new challenges such as knife crime, gangs, radicalisation and technology-assisted harm. Even if they feel confident about technology use, practitioners may struggle to support young people in an ever-changing digital world. Relevant up-to-date training is essential.

> The years between ages 16 and 18 are crucial; children under 18 must still be considered children, as required by legislation (HM Government, 2018).

Reflective questions

> How are local data and knowledge about the community/context where adolescents are vulnerable to criminal and other exploitation being used to identify and disrupt activities?

> How confident are you that joint training and development for practitioners is sufficient, relevant and recognises:

  - Criminal and other forms of exploitation

  - The need for complex and contextual approaches to safeguarding

  - Frameworks for broader community-based assessment

  - The importance of evidence from research and practice innovation on working with vulnerable adolescents?

> Are there adequate data on children who go missing and the effectiveness of the local multi-agency response? (This should include not just compliance data but an assessment of the quality of return interviews and how information is being used to keep children safe.) How are local voluntary specialist services being used to support the work?

> How is technology being utilised to support effective working with adolescents?

Multi-agency working

Problematic multi-agency working continues to result in lost opportunities for protecting children from harm. The number of different agencies involved in delivering care can result in fragmented and uncoordinated care. The potential result, as noted in one SCR, is that *'the ability to clearly identify the needs and risks within the family as a whole becomes more difficult'*.

Where an agency is made up of different frontline organisations or different teams within the same organisation, 'silo-working' may occur within, as well as between, agencies. This was particularly evident in relation to the police, where a number of forces have moved away from having specialist child protection investigation teams in order to extend the spread of officers able to be involved in specialist child protection investigations or as a response to austerity. This has had an impact on the quality of safeguarding work as this extract from an SCR illustrates:

'[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 ... for example, they are not used to attending child protection conferences and do not know exactly what information can and cannot be shared.'

Learning points

> **Assessment and planning tools***:* SCRs highlighted that many assessment and planning tools are not fit for purpose or are used ineffectually. Examples include poor design of incident reports (police), GP registration forms not flagging whether a child is subject to a child protection plan, and inconsistent use or misunderstanding of the Graded Care Profile. New policies or joint working protocols were often not used or sufficiently embedded in practice. Protocols should be supported by rigorous dissemination, regular and repeated workforce training, and monitoring through case management and supervisory processes.

> **Effective multi-agency plans***:* Whether at child in need or child protection level, effective plans depend on all relevant agencies being represented at meetings. There were repeated examples where key professionals, particularly those offering specialist interventions (including voluntary agencies or housing), were not present or not invited.

> **Role of lead professional***:* A key element for ensuring effective joint working is having a lead professional who acts as main contact for the child or family, co-ordinates activities and interventions, and 'holds' the full picture of the context that is the child's reality; however, the role of the lead professional was often not clear.

> **Information sharing:** The risks to children increase if key information from Adults' or Children's Services is lost or not passed on when families move area. Some SCRs illustrate how good information-sharing practice helps to consolidate multi-agency working; others show a reluctance among practitioners to pass on information and confusion about what they can and cannot share. The police often held significant information about parents or family members with a history of criminal convictions (in some cases violent crime), but this was not routinely shared at each stage of an investigation or in follow-up in 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.

> **Eliciting information:** Some services may be less familiar with passing on information than agencies with a lead statutory role and may also be unclear about what information should be shared and when. Although it is a service's responsibility to understand their role in safeguarding children, statutory agencies could be *'more creative in eliciting information other than through formal, documented channels'*.

> **Language:** The language used to talk about children's circumstances can hinder or support effective safeguarding. It can paint a vivid picture of context and risk when making a request for protective interventions; conversely, stock phrases can dilute or obscure concerns. In one example, the ambulance service had graphically and appropriately described a child's home living conditions as *'unsanitary with a foul smell and a fire hazard'*; this was changed in the minutes of the section 47 strategy meeting to *'poor home conditions'*.

Key message 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.

Messages from care and court cases
Chapter 5 of the report highlights key points for agencies working in the family justice system. The increasing number of care proceedings and government pressure to speed up the process have had an impact on outcomes for children, not all of it positive.

Learning points
> Some professionals had limited understanding of the legal framework and were unclear about their roles and responsibility for children on supervision orders (see the case study of Polly in Chapter 5).

> The court's care proceedings timescales should not be allowed to undermine the need for a thorough assessment of all carers, including kinship carers.

> Judges, lawyers and policymakers have many competing imperatives:

  - the principle of 'no order'

  - duties to protect children from harm

  - a legal priority to place children with parents or kin.

While it is important to be thorough and to challenge, they should avoid unfair blame and placing unrealistic expectations on other professionals.

Reflective questions

> Do local referral forms, assessment tools and incident-logging tools 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?

> What assurance processes are in place to ensure that new or revised protocols, such as those on pre-birth assessment or information sharing, are properly embedded in practice?

> How successful is the role of lead professional in your area? Do professionals other than social workers effectively take on the role?

> What are the opportunities for developing stronger relationships with the judiciary at a local level to explore some of the issues raised?

Enabling children to have a voice

The absence of the child's voice and their lived experience is a recurrent theme in the report (and is the subject of a 'topic study' in Chapter 3). Safeguarding partners need assurances as to how well the voices and lived experiences of children of all ages and ability are captured and inform child care plans and reviews.

Responding to the needs of an unborn child presents significant challenges for professionals, and the difficulty they have in undertaking good quality and timely pre-birth assessments is a regular theme. SCRs included examples where mothers left hospital with either no discharge planning or planning that was single-agency and focused solely on the health needs of the baby, rather than wider circumstances. A number of SCRs found health visitors, many whom had very high caseloads, focused only on specific tasks. In one case *'observations do not appear to have extended to critical reflection on what life was like for the child'.*

Children in the middle years (aged 6 to 11 or 12) have greater contact with responsible adults as they enter school, including teachers and school nurses, but this does not always mean their voice (when heard) is understood or responded to correctly.

> **Example** In one case a school nurse observed that an eight-year-old boy (previously subject to a child protection plan) was very tired, unwashed and wearing ill-fitting clothes. He also reported being given biscuits or crisps for tea. This resulted in the social worker being tasked with monitoring the children's evening meals, although *'how [she] was to achieve her task is unclear and no evidence has been provided to confirm that she did so'*. The SCR noted: *'Very few records capture the lived or day-to-day experiences of any of the children.'*

The report also highlights that many SCRs still do not adequately address issues relating to ethnicity. This includes 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 (see also Bernard and Harris, 2018).

Ethnicity may be recorded but the implications for the day-to-day lives and experiences of the children are often not explored and spelled out by social workers and other practitioners; this finding is not new (see Brophy et al, 2003).

As one SCR highlights: *'Being fearful of asking curious questions about past experiences, culture and beliefs for fear of being seen as overly intrusive or ... racist, has a significant impact on the ability of professionals to make assessments and provide services'.*

Learning points

> Understanding the emotional world of a child requires a more rounded rather than incident-led approach; too often the underlying causes and the lived experience of the child are not explored.

> 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.

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

> Practitioners need to be particularly alert to when a pregnant mother's circumstances may be putting the baby at risk, and consider how best to safeguard both mother and baby prior to and following delivery.

> Health visitors are in a good position to help ensure focus is maintained on the lives of infants, particularly when parents' complicated lives may become the dominant focus of professional interventions.

> School staff are well placed to notice a child's distress and worrying behavioural changes; however, they do not always recognise or inquire enough into what lies behind changes in behaviour.

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

> As a partnership, how are you evidencing the lived experiences of infants who are pre-verbal, and children and adolescents with speech and language difficulties? Are their experiences being heard, recorded and understood, and are they contributing to better outcomes and assessment of risks?

> Is there evidence that the specificities of ethnicity and culture in family life and children's experiences are being taken into account in conference reports, reviews and assessments?

> Is there evidence that the timeliness, quality and outcome of pre-birth assessments are contributing to reduction of risk and effective multi-agency working for babies once they are born?

Implications for the future commissioning of LCSPRs

Chapter 4 of *Working Together* (HM Government, 2018) gives named partners more flexibility in considering the type of learning reviews they undertake. Table 5 shows the most commonly adopted methodologies (based on examination of the 278 SCRs available for 2014-17).

Review method	2014-17 n=278)
Traditional with IMRs (Independent Management Reviews) and a chronology	63
SCIE learning together	38
SILP (Significant Incident Learning Process)	16
Welsh Child Practice Review	23
'Hybrid' or 'Unspecified systems-based'	51
Unclear	68
Other	19

Table 5: SCR methodology

The report identifies a number of considerations for local partnerships when commissioning and managing LCSPRs. As part of the triennial analysis, a survey of LSCBs (which included follow-up phone interviews with 20 participants) highlighted some lessons about what types of review were felt to have been most useful and the actual impact or usefulness of the review process itself. Participants drew attention to the importance of:

> Considering from the outset what the Board (partnership) is trying to achieve.

> Not applying one model to every review.

> Effective involvement of family members and practitioners.

> Clear system findings and a limited number of recommendations.

> The skills and quality of the lead reviewer – this had a significant impact on the success of the process and 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 respondent)

There were many types of recommendation but those thought to have the most impact related to training, policy and procedure development, audits and awareness raising. Participants were divided as to whether some types of case were harder to learn from – the greater difficulty relates to implementing change in practice. Reviews where there had been limited agency involvement, or conversely reviews with many agencies involved, were identified as presenting particular challenges for learning and impact. Multi-agency training and the distribution of briefings or bulletins were the most popular methods of disseminating learning.

Learning points
> Participants noted the need for recommendations to be specific, contextual and at a systems level, along with the need to avoid the tendency to '*train issues away'*.

> 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 the recommendations forward.

Impact and change
It was rare to find evidence of national change from reviews, although local change was noted by almost all LSCBs who responded to the survey. Demonstrating change was challenging, however; any evidence came primarily from audits and action plans.

A perceived strength of the review process is that by providing opportunities for reflection on practice, particularly the story of the child at the centre of the review, it can help deliver change. Learning was thought to have added weight and be easier to embed when it came from a local review. Keeping learning real, local and close to home was helped by involving practitioners in the review process. SCRs were also thought to act as an accountability check on the system and the quality of leadership and practice.

Barriers to achieving impact included:

> A preoccupation with process

> Action plans that prompt a tick-box response rather than a focus on systemic change

> Organisational change and a depleted organisational memory

> Shifting priorities.

Identifying persistent barriers can also be an opportunity of finding new ways of embedding change, as the following example demonstrates.

Example: 'Escalation' of concerns and professional challenge

One LSCB addressed problems with staff diffidence about 'escalation' of concerns by reframing the issue as 'resolving professional differences'.

Professionals had made it clear they did not like the word 'escalation'; they felt that to escalate a situation made partnership working difficult. What felt more comfortable was to change the term to 'resolving professional differences'.

This small semantic change altered the sense of professional empowerment. Staff didn't feel empowered to escalate, but they did feel sufficiently empowered to share a professional difference.

? Reflective questions

> Going forward, are you clear about your role in the commissioning and quality assurance of LCSPRs?

> How are/will you be demonstrating independent scrutiny in the process?

> What could you do differently or better to ensure you make the most of the new flexibility and build on what has worked in the past, without sticking to old ways of doing things?

> How will you measure impact and outcomes of LCSPRs and other national reviews?

> Who will lead on dissemination of these messages and act as a conduit for the partnerships if the LSCB no longer plays this role?

Implications for policy and practice

It is important for safeguarding partnerships to reflect on the key messages to come out of the report and assure themselves that those messages are informing local practice. Effective protection requires the ability to better contextualise the lives of vulnerable children while also taking account of the impact of significant pressures on local agencies and the context in which they operate.

The overarching issues from the report found:

> The complex and cumulative nature of neglect, often in the context of poverty, was not understood or recognised.

> The risk of harm to adolescents may be hidden and hard to recognise. There is a need to develop a better understanding of the social and environmental context of the risks and harm adolescents face outside of the family.

> There is a need to focus more on thorough single and multi-agency assessments and clear agency plans at all stages of the process. They should also include better recognition of ethnicity, identity and culture.

References

Bernard C and Harris P (2019) 'Serious case reviews: The lived experience of Black children'. *Child and Family Social Work* 24 (2) 256-263.

Brophy J, Jhutti-Johal J and Owen C (2003) *Significant harm: Child protection litigation in a multi-cultural setting.* Lord Chancellor's Department Research Series, No. 1/03, London: LCD.

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

2019 Triennial Analysis of Serious Case Reviews:

Local safeguarding partnerships