research in practice

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2019 Triennial Analysis of Serious Case Reviews:

Children's social care

March 2020

Contents

This briefing summarises themes emerging from the 2019 Triennial Analysis of Serious Case Reviews 2014-17, presenting key messages for child and family social care.

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:

- All practitioners working in child and family social care, and their frontline managers
- Senior managers and strategic leaders
- Child protection conference chairs
- Family court advisers.

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).

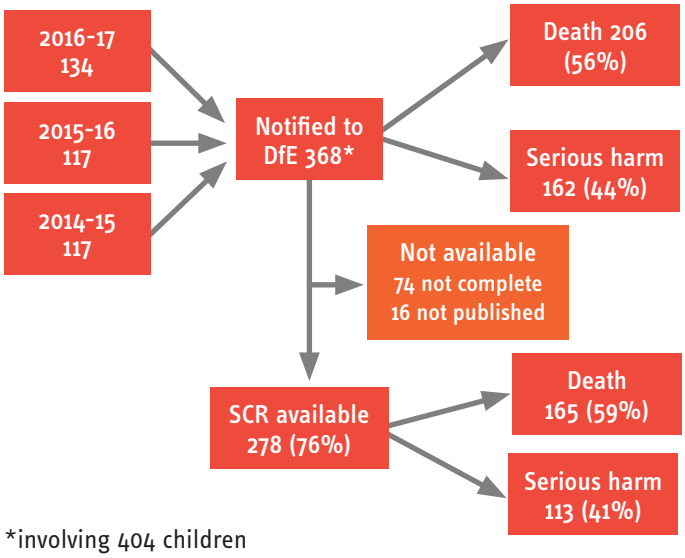
Under the new arrangements SCRs will no longer be commissioned. When a serious incident becomes known safeguarding partners must decide whether to commission a local child safeguarding practice review (LCSPR). The main purpose of an LCSPR is to identify improvements in practice. This means partners must 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.

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.)

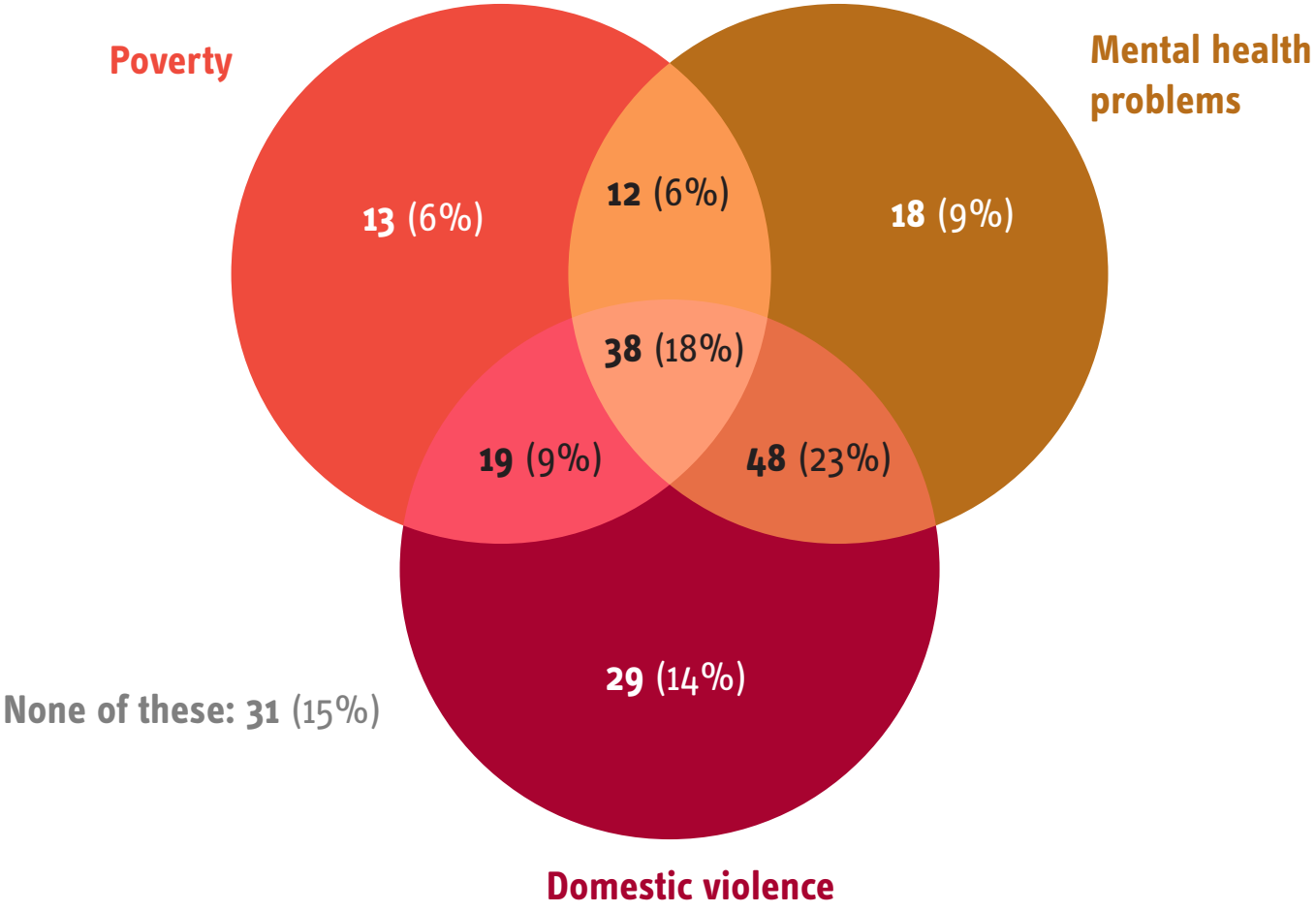


Figure 2: Adverse family circumstances in cases of neglect (n=208)

About this briefing

This briefing is for:

- All practitioners working in child and family social care, and their frontline managers
- Senior managers and strategic leaders
- Child protection conference chairs
- Family court advisers.

It will also be relevant for many practitioners working in early help services and should be read alongside the dedicated Early Help briefing.

This briefing concentrates on learning from key areas in the report that are particularly relevant to social care: poverty and neglect; relationship-based practice; supervision; care and cour t work; adolescents; and multi-agency working.

Neglect and poverty

'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 a factor in the lives of children who die or are seriously harmed as a result of child maltreatment. Evidence from a range of studies from across developed countries shows a strong association between families' socioeconomic circumstances and children's chances of experiencing abuse and neglect.

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 analysis provides insights into:

- The stress and anxiety poverty generates.
- The complex ways in which links between domestic abuse, substance misuse and poverty are often interdependent, so that addressing a single issue does not deal with the underlying causes or other issues present.
- The need for poverty-aware social work practice when responding to concerns about child neglect.

Although the report found poverty was far more prominent than in earlier triennial analyses, recognition of poverty and its impact on parenting was often missing from, or only obliquely referred to, in SCRs. Poverty was often perceived as a co-existing factor among many, or as an outcome not a cause of a family's needs and difficulties.

Parents living in poverty have fewer social, emotional and physical resources to call upon, and shame, hopelessness and previous negative experiences of social work intervention may hinder their seeking or accepting help.

High prevalence of adverse parental and family issues was a common feature of neglect cases. These risk factors appear to be cumulative – there was evidence of multiple risks for many of the families at the centre of the SCRs.

Example: Too narrow a focus

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

Learning points

- Rectifying the physical manifestations of poverty (eg, support with homelessness, household conditions, hunger) and a chaotic lifestyle does not equate with children being safe. Support to meet immediate needs must be part of a holistic response that assesses the child's safety, health and development and parents' capacity to meet their child's needs.
- Practitioners should seek to understand the pathways through which socioeconomic issues interact with other factors to influence parenting and outcomes for children. It is important not to ignore the impacts of poverty, but also not simplistically to attribute the family's problems to economic hardship alone.
- Practitioners must guard against becoming desensitised to the impact of poverty on parenting capacity and children's development and wellbeing. SCRs suggest signs of neglect can become normalised for practitioners working in areas of high deprivation.

Language

SCRs point to reluctance among some practitioners to name neglect, especially if they feel this might be a barrier to engagement. They may also be reluctant to name and discuss poverty for fear of stigmatising the family.

The language used to talk about children's circumstances can both hinder and support effective safeguarding. It can paint a vivid picture of context and risk; conversely, stock phrases can dilute or obscure concerns.

Using clear, straightforward language can help practitioners name and discuss difficult topics, with each other and with families. In one example, the ambulance service had graphically described a child's home living conditions as *'unsanitary with a foul smell and a fire hazard'*; this was changed in the section 47 strategy meeting minutes to *'poor home conditions'*.

Cumulative risk

A common feature in neglect cases was a period of low-level concerns followed by a sudden escalation in risk. This could be in response to unexpected life events or a change of circumstances triggering a series of events that swiftly become unpredictable, as illustrated in the example below.

The example also illustrates a persistent culture among professionals during the antenatal and postnatal period, where the primary focus is often on the needs and circumstances of mothers.

Example: Neglect and spiralling risk

Sam's mother ended her relationship with Sam's father early in pregnancy due to issues related to poor mental health, substance misuse and domestic abuse. She began a new relationship and relocated near her partner's extended family. With her partner working away from home, Sam's mother was lonely and isolated. She expressed 'low mood' before and after the birth.

Professionals were unaware that the stepfather was not Sam's biological father.

During the first six months of Sam's life the number of risk factors within the family increased dramatically: the stepfather experienced an unexpected and traumatic bereavement, both parents were prescribed antidepressants, the step-father lost his job and started to go out drinking during the day and was reportedly using cannabis.

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

One approach to understanding cumulative risk and exercising anticipation is a more effective use of case chronologies, in particular reaching a more comprehensive picture of life for a child through combined or cross-agency chronologies.

Example: Cross-agency chronologies

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

Fathers and father figures

The report finds a continuing dearth of information about men in SCRs; the primary focus of social workers and health practitioners continues to be on the needs, circumstances and perspectives of the mother, even when the mother's partner has a major role in looking after the children.

In one example where children were having overnight stays with their father *'there was no expectation or requirement, for an in-depth assessment of Father's parenting capacity and assessment within his own home environment'*. In the same case, facial bruising of the mother during pregnancy failed to trigger an assessment of her new partner.

This *'lack of professional curiosity or interest'* in father figures not only potentially leaves women and children vulnerable, it can also leave fathers themselves feeling alienated, forgotten and their role in bringing up their children dismissed.

Neighbours and community

Neighbours are often well aware of the difficulties families are experiencing. Some may intervene directly by providing shelter and food to children shut out of the family home or report suspicions of abuse or neglect. However, SCRs suggest the response and any action taken are not always recorded. In one case neighbours made numerous calls to children's social care and the police reporting specific incidents of neglect, but the SCR found '*insufficient weight was given to concerns expressed by neighbours*'.

Learning points

- The use of clear language can paint a vivid picture of context and risks for a child. 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.
- Assessment and support in pre-birth and infancy should include both parents and any other adults in the home so that the contribution they make, the stress they experience and the risks they present are properly understood and addressed.
- Rather than concentrating only on the 'here and now', multi-agency pre-birth planning should ensure a good assessment that includes family history, relationships and roles within the family, and known risk factors, concluding in a strong plan and appropriate level of intervention.
- Analysis of neglect cases underlines the importance of understanding the perspective and role of father figures. In many SCRs, their significance in a child's life was not considered.
- Engaging fathers can be more difficult if their personal history makes them fearful of professionals. One father held information about the possible abuse of his daughter at the hands of her mother and current partner (including photos of bruising) but told the review he feared sharing them with social workers because of his own experience of the care system.
- Concerns reported by neighbours or anonymously should always be accurately recorded, taken seriously and triangulated with other sources of information. If nothing is seen to happen, future concerns may not be reported.
- The complexity of families' situations and the huge volumes of information held can get in the way of identifying the risks children face. Well-researched chronologies, particularly combined chronologies, enable practitioners to see beyond immediate presenting concerns to develop a picture of the family history, significant incidents in a child's earlier life and how present or future circumstances may combine to increase risk.

Reflective questions

- What anti-poverty strategies are available in your area to support children and their families to achieve their potential?
- What effective tools do you know about for working with neglect? How do you identify hidden poverty?
- How might your practice be more inclusive of men in the family? Do appointments and home visiting arrangements take account of adults' working patterns? Do you speak and write to both parents?
- What tools or methodological approaches do you use to assist your analysis of the complexities of the families you are working with?
- How do you decide when a child or young person can be effectively supported by their family and community to achieve their potential without social care involvement?

The wider family – kinship care

In over two-thirds of the families in the qualitative sample of 63 SCRs, a relative had lived with or looked after at least one child. Relatives can be an important source of information and support for children, but SCRs suggest their views are not always sought, as this case illustrates:

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

Where there is a family history of abuse and neglect, the impact of grandparents and other relatives on children's welfare is not always benign, but this was not always fully taken into account:

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

Learning point

- All kinship placements need careful assessment of the parenting capacity and support relatives may require. Lack of assessment and, in some cases, support was evident in a number of SCRs. Proper assessment should not be compromised by court timescales (see 'Care and court work' on page 14).

Relationship-based practice

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

A positive, consistent relationship can result in increased protection for the child. For some parents, their relationship with their key worker *'may be the most significant and supportive relationship in their lives'*.

However, the capacity to build relationships will be adversely affected by frequent staff changes and case reallocation. Other challenges to long-term relational work with families can arise from over-familiarity, over-optimism, loss of focus and drift.

Learning points

- Adults' past experiences of trauma, loss and adversity, including negative experiences of statutory services, may leave them socially isolated, defensive and hostile to/fearful of engaging with child and family services.
- Practitioners need to be robust and compassionate in understanding why parents behave as they do when they try to defend themselves and their family from scrutiny.
- Parents who are offered early help services need to have both the motivation and ability to engage. Parents who are vulnerable or feel overwhelmed may not have the emotional capacity or material resources to be able to take up services or attend appointments.
- In such circumstances, professionals need to take time to understand the underlying issues and to build a trusting relationship. When that happens, offers of help are more readily accepted.
- Models of support should be characterised by long-term planning and a cumulative perspective on safeguarding needs. This includes a historical understanding of family involvement with services and what this means for the ways in which services seek engagement.
- High caseloads and staff turnover, service cuts and fragmentation, all impact on practitioners' ability to support children and families in complex situations. Managers and commissioners need to put structures in place to provide support, time and guidance.

Reflective questions

- What needs to be in place for you to be a robust and compassionate practitioner?
- When working with vulnerable parents who may find building trusting relationships hard, do you consider the gender, ethnicity or other personal characteristics of the allocated social worker?

Supervision

Relationship-based work with families requires robust management and support for practitioners. Effective supervision helps practitioners to navigate complexity and make rigorous analyses of presenting issues. It is the *'mainstay of protective practice'*. (Chapter 3 of the report includes a topic study on the role of supervision.)

However, SCRs suggest there is significant variation between agencies, not only in the levels of support provided, but also in the regularity of supervision and how cases are selected for discussion in supervision.

In some agencies, case selection appears to be left to the practitioner, which can be especially problematic if they are inexperienced. A threshold approach to case selection can provide 'too static' a view of risk, as need and risks fluctuate over time, sometimes on a daily basis.

A consistent message from SCRs is the need to support practitioners to develop an 'ecological' perspective in relation to families – ie, understanding the contexts in which a family lives, the issues and tensions they negotiate daily, roles and relationships within the family, and their interactions with other services.

Reflective supervision

Practitioners also need support in examining their own values and preconceptions and how those inevitably contribute to their interpretation of events and presenting issues.

Language is key to developing empathetic practice, and reflective supervision can support practitioners to recognise the importance of the language they use. In many cases, labelling families or young people as 'not willing to engage' led to opportunities being missed and cases closed inappropriately.

Such terminology runs *'counter to relationship-based practice and discourages exploration of individuals' perceptions, historical experiences of services or their anxieties about accepting support'*.

Supervision also plays an important role in effective planning. Practitioners should be supported to provide planned and structured interventions for which monitoring is in place and contingencies and escalation routes identified.

However, the report finds few examples in the SCRs of plans that were effective as a *'vehicle for providing the purposeful intervention essential to protective practice'*. This raises the question of how well current systems *'prepare professionals in applying planned approaches that have a clear focus on outcomes for the child'*.

Learning points

- Opportunities for protection can only be identified if cases are the subject of active and ongoing review. It is important that the selection of cases for discussion in supervision is not left to practitioners alone.
- Cases with persistent ongoing concerns, but which fall below the threshold for child protection, should be brought to attention and monitored. This is particularly relevant in the context of neglect, where risks may be cumulative over time.
- The use of terms such as 'non-engagement' should be interrogated in supervision. Such jargon discourages exploration of why a person is reluctant to engage. Workers will need support in managing their responses to families' fear of or hostility to involvement with services.
- Supervision should address the risk of confirmation bias – ie, the temptation to accept only views that accord with one's own preconceptions and thereby confirm one's own interpretation of a situation.
- Supervision can be particularly important in providing challenge in the case of families who have been known to the service for years, allowing the facts to be viewed from a different perspective.
- Supervision must provide space to explore the impact of the work on the practitioner's wellbeing – including any feelings of powerlessness, frustration, guilt and anxiety. The aim is to ensure practitioners are supported and protected to work with families and the overwhelming feelings such work often evokes.

Reflective questions

- How are cases selected for discussion in supervision? Have you reviewed that process with your supervisor?
- How are ongoing, low-level concerns monitored over time to keep abreast of the possibility of spiralling risks?
- How does your supervision help you maintain professional curiosity and challenge?

Care and court work

Key messages emerge in the report from an analysis of ten SCRs involving children in care or subject to care proceedings (including children returned to or remaining with parents, and those in special guardianship).

The report highlights the substantial needs of many of these children. The harm that the children have suffered in the past affects their expectations and behaviour, which can make it difficult for carers. This has to be taken into account in assessments and support plans and requires a trauma-informed understanding and approach by practitioners to help the children and those caring for them.

With regard to special guardianship assessments, the report highlights the need to:

- Undertake a thorough investigation of the potential guardian's background and how this might affect their ability to care for the child.
- Ensure assessments are thorough – if necessary, an extension to proceedings should be sought to allow time for a trial placement if the child has not previously lived with the proposed carers.
- Ensure the child's wishes and feelings are taken into consideration. In one case, two brothers – both aged under five – became subjects of special guardianship orders. The report notes:

  'There was a tendency too readily to conclude that distressed behaviour was an inevitable consequence of early neglect and then the changes in the arrangements for the children's care.'

  It was, in fact, a sign of the harm they were currently suffering. Social workers and other practitioners need to take account of the impact of trauma and instability, but not allow this to constrain their assessment of what children may be saying and doing.

The report also discusses practice with regard to supervision orders. A particular concern was that some professionals were unclear about their role and responsibilities for a child on a supervision order (see the case study of Polly in Chapter 5 of the report).

Analysis of the SCRs suggests ethnicity is commonly recorded in case records, but social workers and other practitioners often fail to spell out or explore the implications for children's day-to-day lives and lived experiences.

The report highlights the importance of investigating and assessing the *'impact of cultural beliefs and expectations on the care and wellbeing of the children ... whilst also respecting diversity and the families' cultural and religious beliefs'.*

Learning points

- Greater consideration needs to be given to the challenges many parents and special guardians/carers face and the ongoing support they are likely to need.
- It is important to acknowledge the likelihood that in some cases where children return home for care, placements will not endure – or if they do, children may not fare as well as one would have hoped (Biehal et al, 2015). This should be taken into account in placement planning and support.
- The court's care proceedings timescales should not be allowed to undermine the need for a thorough assessment of all potential carers, including kinship carers. Ongoing support and monitoring post-proceedings are important for kinship carers.
- It is important that assessments consider the child's need at the present time but also what they might need in terms of future support as they grow up.
- Local authorities should ensure they have clear plans for monitoring a supervision order, starting with a child protection plan where appropriate.
- Examination of cases involving children from Black, Asian and minority ethnic (BAME) families reveals the importance of ascertaining *and applying* knowledge about background, culture, religion and 'personal identities' in assessments and planning.

Adolescents

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

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 the vulnerability of adolescents through an in-depth qualitative analysis of a sample of 25 cases. It looks at findings in relation to going missing and exploitation, and offers insights into what *Working Together* (HM Government, 2018) identified as 'new and emerging threats' including technology-assisted harm and radicalisation. Key findings are discussed on pages 16 to 19.

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

However, evidence from the SCRs suggests practitioners in social care, schools and the police are not always sharing information appropriately. This means practitioners are not always able to see the full picture of multiple difficulties in a young person's life.

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 following 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 **here**.

Resources on Contextual Safeguarding are also available from the **Contextual Safeguarding Network**.

Learning points

- Adolescents' early 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.
- Gaining understanding of an adolescent's early years, current and changing family situations and wider social networks, is vital for analysing their lived experience and risk of harm.
- Children who have had traumatic experiences are likely to require long-term support to keep them safe. Adolescent SCRs demonstrate the need for:
  - Persistent and prolonged engagement
  - A balance of preventative work and crisis management.
- Practitioners should consider Complex and Contextual Safeguarding (see box above) when working with young people to keep them safe.

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. A timely multi-agency safeguarding response is required.

The pathway to harm for adolescents is often triggered by episodes of going missing. Those who repeatedly go missing from home, school or care are at increased risk.

The local authority has a duty to offer an independent return interview within 72 hours of any child who goes missing from home or care being found or returning. (This is different from the police 'prevention interview' – formerly a 'safe and well check' – which should be conducted in all 'serious' cases, such as a child who goes missing repeatedly.)

Interviews are an opportunity for the child's voice to be heard and to find out what prompted going missing. Return home interviews should be undertaken by a trained independent worker who is able to take forward actions that emerge.

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

- Sharing the evidence gathered in a return home interview with other agencies will facilitate holistic safeguarding responses.
- Adolescents may sometimes refuse a return interview. However, if persistently offered, especially by the same worker, an interview may be accepted at some point.
- A timely multi-agency safeguarding response should not depend on where a child goes missing from or to (eg, abroad).
- Practitioners can feel unprepared for working with adolescents vulnerable to radicalisation and will need ongoing training and support. Partnership working is essential, 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.

Although adolescents exploited into crime are victims, there is a suggestion that some professionals may see them as partly at fault. The APPG on Runaway and Missing Children and Adults (2017) believes that in some areas of the UK, such a culture exists around children groomed into criminal exploitation by gangs – in the same way that some professionals in the past saw victims of CSE as at fault due to their 'risky behaviour' (Children's Commissioner, 2019; Sidebotham et al, 2016).

Learning points

- Practitioners need to look beyond immediate presenting behaviours. Young people involved in criminal exploitation should be seen as victims and safeguarded accordingly.
- Practitioners need to find ways to 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 should be informed by local young people's experiences.
- Knowledge of criminal activity hotspots in local areas, combined with the specific concerns for individual children, can inform contextual safeguarding responses (see box on page 15).

Child sexual exploitation (CSE)

CSE was noted in one in ten (9 per cent) of the 278 SCR reports available. Despite its high profile, however, practitioners were still slow to recognise vulnerability to CSE. This was particularly so if the child was a boy.

The report also identifies some confusion among practitioners when monitoring children at risk of CSE. *'As there is no specific category for CSE, child protection plans may seem less appropriate than management through a dedicated and specialist CSE team. There is therefore a need to clarify safeguarding pathways for the management of CSE.'*

Learning points

- Practitioners need to be mindful that boys may find it more difficult to disclose CSE but the risks for male victims are no less serious than for females. Recent guidance suggests practitioners should ask themselves if their response would have been different if the victim had been a girl (The Children's Society, 2018).
- Professionals may want to consider the following six principles for working effectively to address CSE:

  1. Young people must be at the centre and should not be held responsible for their harm or their safety.
  2. CSE is complex; therefore the response cannot be simple or linear. Responses need to be based on evidence from a wide range of sources of expertise.
  3. No agency can address CSE in isolation; collaboration is essential.
  4. Knowledge is crucial.
  5. Communities and families are valuable assets and are likely to need support.
  6. Effective services require resilient and supported practitioners.

  (Eaton and Holmes, 2017)

Suicide and self-harm

Outside infancy, suicide was the most common category of deaths related to maltreatment in the analysis (30 cases). Issues relating to suicide and self-harm in young people were explored extensively in the previous triennial analysis (Sidebotham et al, 2016).

Example: Neglect and subsequent suicide

A 15-year-old girl took her own life with a fatal dose of opiates. Born with serious narcotic withdrawal symptoms into a family with a long history of substance misuse, sex work, alcohol-fuelled violence and domestic violence, signs of distress and self-harm were first identified by a schoolteacher when the child was 12 years old. When the teacher asked about cuts on her arms she was told 'when I am feeling this pain, I am not feeling anything else'. Examples of self-harm escalated to the extent that prior to the fatal overdose, 32 episodes had been recorded.

If these incidents of self-harming had been managed as safeguarding concerns there is greater likelihood that professionals would have engaged in a strategy meeting that focused on the nature of risk and supported a much clearer sharing of information.

Learning points

- Non-fatal self-harm is strongly associated with completed suicide and should be referred to health services for thorough assessment and intervention.
- Although difficult when an adolescent moves from one crisis to the next, it is essential to take a holistic perspective to understand underlying causes of the problems as well as reacting to the immediate crisis.

Harmful sexual behaviour (HSB)

Seven SCRs were examined where adolescents had displayed HSB towards other children. All seven had experienced neglect, but neglect alone is not a predictor for the development of HSB.

Children with HSB are likely to have experienced polyvictimisation and their actions need to be seen within the context of their own maltreatment. There must always be a therapeutic and/or safeguarding response in addition to any criminal justice response. 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.

Learning points

- Experience of any form of maltreatment can be an indicator for HSB. Being a victim and a perpetrator can be very closely related, particularly when offences are committed as part of a group; support and safeguarding are required for both aspects.
- The severity of HSB should be understood as being on a continuum. Age and stage of development will influence the perceived severity of the behaviour and relevant interventions.

Social media and technology-assisted harm

Adolescents use technology to communicate and explore friendships, as well as to find a sense of identity and belonging. This may be especially so for young people who feel disconnected from family and society.

One SCR described the case of a young person who had begun to explore his sexual orientation online, which included contact with older men. He had become isolated from his peers who distanced themselves from him when he disclosed his sexual orientation.

Adolescents have access to multiple devices (including those of friends) and can easily set up new accounts, making monitoring unrealistic. So opportunities for educating parents, practitioners and children should be undertaken.

Learning points

- Social media provides fast-changing spaces within which children may be bullied, groomed or exploited. Even practitioners who feel confident about technology use may struggle to support young people in an ever-changing digital world.
- Ongoing and up-to-date education and training for practitioners on how to keep children safe is therefore essential – for example, by making use of advice and resources produced by organisations such as **UK Safer Internet Centre**.
- Practitioners need to be aware of the link between sexting and exploitation. Shared images can expose adolescents to risks and exploitation if images are shared further, as they can be used for bullying or blackmail. Evidence from SCRs suggests the seriousness of such technology-assisted abuse was not always recognised by practitioners.

Loneliness

Separation and loss may leave young people lonely and at increased risk of depression and low self-esteem. Early childhood trauma increases vulnerability and often leaves adolescents poorly equipped to recognise and nurture healthy relationships, leading to loneliness and isolation.

Signs of loneliness can manifest as withdrawal and lack of engagement. Although their use of social media means adolescents are generally more connected than other age groups, social media can also increase feelings of loneliness.

Learning points

- Loneliness is a subjective feeling common among young people and should be explored in assessment.
- The pathway to harm online may be triggered by feelings of loneliness. Isolated adolescents with a need to belong can be more vulnerable to grooming, in particular sexual exploitation and radicalisation.
- Children with caring responsibilities can become particularly isolated from their peers. Additional needs should be addressed through a young carer's assessment; any plans should be shared with other agencies.

Reflective questions

- What do you think is meant by 'persistent and prolonged engagement' (see page 15) to support adolescents?
- What opportunities are there for you to work in that way with children and young people? What are the barriers and how will you overcome them?
- How do you find out about a child's background, culture, religion and personal identity and use the information in planning an assessment of their needs?
- Loneliness is a subjective feeling but one that is common among young people. How are you making sure the possibility of loneliness is properly taken into account in your assessments?

Multi-agency working

Good quality record keeping and communication of relevant issues with other agencies helps to identify patterns of events, concerns, strengths and unmet needs and to provide a clearer picture of all the significant aspects in a child's life. If this does not occur, identifying links between past and current concerns can be missed.

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 report found sharing historical information and sharing information across local authorities remained an issue, although there were examples of good practice. Sharing across health boundaries and local authorities is an added challenge.

Learning point

- Effective multi-agency plans: Clear multi-agency plans, whether at child in need or child protection level, are central to effective working. All relevant professionals (including from specialist agencies and third sector organisations) should be involved in drawing up plans, with a continued focus on the needs of the child as central to any plan.

Strategy or review meetings: These are important information-sharing forums but are only effective if all relevant agencies are invited. In one case, a strategy meeting took place between the social worker and her manager only and the CSE strategy meetings did not include invitations to police, school nurse or GP.

- **Tools:** Assessment and planning tools must be carefully designed to facilitate communication of concerns across agencies. Tools that are not fit for purpose can impede the assessment and identification of risk.
- **Lead professional**: A key element in ensuring effective joint working is a lead professional who acts as main contact for the child or family, coordinates interventions and 'holds' the full picture of the context of the child's life; the lead professional's role was not always clear, however. The role should be embedded at a systems level with checks to ensure the role is appropriately allocated and identified to all involved agencies.
- **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'*.
- **Combined chronologies:** As highlighted earlier, when multiple agencies are working to address different support needs and risks over time, cross-service chronologies (routinely undertaken) are especially valuable, as is the consistent use of clear descriptive language.
- **Professional challenge:** Differences of perspective are to be expected and practitioners should feel able to ask questions about each other's roles and decision-making. In one example, an LSCB found that practitioners were reluctant to 'escalate' concerns because they felt it made partnership working more difficult. The LSCB overcame this by reframing the issue as 'resolving professional differences'; practitioners then felt more able to voice their disagreement with a decision.

Emergency protection and police powers of protection
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.

Achieving Best Evidence (ABE)
The police are the lead agency for any criminal investigation and should be informed immediately whenever there is a suspicion of a crime. Analysis of the SCRs shows this guidance is not always fully adhered to. This may reflect a deeper tension between police and social care about who leads these discussions and whether interviews are designed to enable children to talk about what has happened (the social care perspective) or to adduce evidence designed to secure a prosecution (police view).

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

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

  This particularly applies when a child has communication difficulties or learning disabilities. For children with additional needs, the use of skilled intermediaries should always be given consideration.

Implications for policy and practice

Effective protection requires the ability to better contextualise the lives of vulnerable children. The overarching messages from the report are:

- The complex and cumulative nature of neglect, often in the context of poverty.

- The risk of harm to adolescents, which 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.

- The need to focus on thorough assessments and clear plans.

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Acknowledgements

Author: Penny Sturt with Research in Practice

Editors: Steve Flood and Julie Wilkinson

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Contact us
The Granary, Dartington Hall, Totnes, Devon
TQ9 6EE
Tel 01803 867692 **Email** ask@rip.org.uk

www.rip.org.uk