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Learning for the future: final analysis of Serious Case Reviews, 2017-19

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Jonathan Dickens, Julie Taylor, Laura Cook, Jeanette Cossar, Joanna Garstang, Nutmeg Hallett, Eleanor Molloy, Natasha Rennolds, Julia Rimmer, Penny Sorensen, Russell Wate.

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Authors

Professor Jonathan Dickens, Dr Laura Cook, Dr Jeanette Cossar, Natasha Rennolds, Dr Julia Rimmer, Dr Penny Sorensen and Dr Russell Wate are members of the Centre for Research on Children and Families in the School of Social Work at the University of East Anglia.

Professor Julie Taylor, Dr Nutmeg Hallett and Dr Eleanor Molloy are members of the School of Nursing, Institute of Clinical Sciences, University of Birmingham.

Dr Joanna Garstang is a Consultant Paediatrician at Birmingham Community Healthcare NHS Trust and honorary member of the Institute of Clinical Sciences, University of Birmingham.

Disclaimer

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

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Executive summary

This report is an overview and analysis of 235 cases which led to serious case reviews (SCRs) between April 2017 and September 2019, because children or young people had died or suffered serious harm, and abuse or neglect was known or suspected (and, in the non-fatal cases, there was cause for concern as to the way in which agencies had worked together to safeguard the child). The reports for 166 of those cases were available.

There has been a series of government-commissioned periodic reviews of serious case reviews since 2001 (covering cases since 1998), at first biennial and latterly triennial. This is the ninth and final review in that series, because SCRs have now been replaced by a new system of rapid reviews, national reviews and local child safeguarding practice reviews (LCSPRs). Alongside this report, we have prepared a separate overview of the main themes from the 21-year period, 1998-2019 (Dickens, Taylor, Cook, Garstang, *et al*., 2022a).

This report gives an overview of the key characteristics of the 2017-19 cases, and then addresses three themes in particular: the problem of neglect, the challenges of practice, and the task of listening to the voice of the child. These themes have been chosen because they have been perennial issues throughout the history of SCRs, so there is value in looking at them again now, as the SCR process comes to an end. There is then a chapter that focuses on the issue of intra-familial child sexual abuse, taking it as 'case study' that demonstrates so many of the well-established themes in practice. The report concludes by drawing out the messages for the new LCSPR system and highlighting the inescapable challenges and dilemmas of child safeguarding practice.

Chapter 1 sets the scene by giving a summary of the key developments and debates in child safeguarding in England over the period 2017-19 (note, it precedes the Covid pandemic). It describes the changes to the child safeguarding 'architecture' that were introduced in 2018-19 in response to the Wood review of local safeguarding children boards (LSCBs), published in 2016. It contextualises the 2017-19 SCRs by summarising the evidence about levels of demand and resources over that period, and more fundamentally (not exclusive to 2017-19) the complexities and tensions of the work. The primary challenges are to find the right balances between supporting families and protecting children, the needs and rights of the parents and the needs and rights of the child. But there are many others within and alongside them: to give time for change whilst not letting cases drift, to offer high quality services whilst keeping costs down, to build relationships and work in partnership with families but also to 'think the unthinkable' (a phrase used in some SCRs) that the adults may be abusing the child; to be responsive to individual circumstances whilst ensuring equal treatment and fairness for all.

Chapter 2 presents a statistical picture of the 235 cases where there was a serious incident notification (SIN) and we know an SCR was commissioned, drawing on the information in the SINs and the 166 reports. (A purposive sub-sample of 49 cases was used as the basis for our qualitative analyses – the methods are summarised in the chapter and Appendix A.) The chapter gives key data about aspects such as the ages of the children, the types of harm they suffered and the characteristics of their families. It is necessary to exercise some caution about the comparisons with earlier periods, given that some serious cases in the second part of this period would have gone into the new LCSPR system.

There were 131 SCRs relating to deaths in the 30-month period (55%), and 104 to non-fatal serious harm (45%). As in all the previous review periods, the largest proportion of incidents related to the youngest children, with 86 (37%) aged under one year; but the number of SCRs relating to children over the age of 16 has been gradually increasing, and they now make up nearly a fifth of the cases (19% in 2017-19). Sudden unexpected deaths of infants (SUDI) and suicide are again the largest causes of death. Nearly three-quarters of the children were white British, 73%, with 10% Black/Black British and 9% of mixed racial backgrounds. A total of 131 SCRs (57%) involved boys and 103 (43%) girls.

In more than half the SCRs the child at the centre of the review was known to children's social care: 57% had current involvement; 19% were previously known but their case was currently closed; and 23% had never been known to social care. Neglect featured in three-quarters of the reports, and poverty in nearly half.

Domestic violence was reported in 55% of SCRs, as was mental ill-health, particularly for the mother. Parental alcohol or substance misuse were each noted in 34% of SCRs.

Mental health problems were reported for 69% of the young people aged over 11; alcohol misuse was reported for nearly 30% of the over-11s, and drug misuse for over 40%. A quarter of the children in the SCRs were reported to have a disability prior to the incident.

Chapter 3 addresses the problem of neglect, studying a sub-sample of 12 SCR reports. It highlights the 'normalisation' of neglect – that is to say, the extent to which it has become an unremarkable, often unnoticed aspect of children's lives in areas where it is so common, and the relationship between neglect and poverty.

Key findings are that practitioners need to observe and think clearly about the interaction of neglect and deprivation, and address both in their work with families and children. They also need to be sensitive to the impact of culture and race. In many cases the SCR authors noted that not only was neglect misidentified or downplayed, but there was a lack of focus on the daily lived experience of the child(ren). There were examples of children not being seen by professionals, or their

voices not being heard. Effective information-sharing between practitioners and agencies is essential, especially if families or young people are disengaging from services.

Chapter 4 discusses three aspects of professional practice that are at the heart of the SCRs, drawing on a sub-sample of 23 reports. They are: engaging with parents and the complexities of ‘effective challenge’; interprofessional communication and information-sharing; and professional disagreements. The core concept in all three is about communication, whether it is with families or other professionals. Good communication involves listening as well as explaining, and is basis for sensitive practice, effective information exchange, skilled ‘challenge’, clear analysis and planning. For this, workers need to have time, manageable workloads and good support and supervision.

- Workload and the dynamics of professionals’ relationships with families could lead to reluctance to challenge parents’ account of events or to enquire more deeply into the child’s experience. Professionals who feel supported are more likely to have the confidence and professional courage needed to safeguard children.

- The exchange of information is necessary but not sufficient for effective communication. Professionals need opportunities to engage in discussion about cases and to ‘translate’ information for other professionals outside their discipline.

- Discussion and respectful challenge between professionals is key to robust decision-making. Framing this as ‘resolving professional differences’ rather than ‘escalation’ may assist in creating opportunities for constructive interprofessional dialogue.

Chapter 5 focuses on the voice of the child, although a key point is that this does not only involve ‘listening’, but also observing, because children may often show what they are experiencing or thinking through their behaviour, rather than what they say. It draws on a sub-sample of 28 reports. A lack of focus, or loss of focus, on the child’s lived experience was a common theme. Four key messages emerged:

- The importance of attending to the child’s lived experience and examining what this means. Getting a sense of their daily life in different contexts and over time is important, as well as including consideration of how the child is experiencing professional intervention. Professionals need good interagency communication, and the opportunity and skills to engage directly with children and young people.

- The importance of engaging with children, recognising the difficult dynamics that can be involved in working with families where children may be at risk. Seeing

children on their own may maximize the chances of children feeling safe enough to begin to talk about their experiences.

- Professionals need to be curious about children's behaviour and alert to behaviours that may indicate abuse or maltreatment. They should not rely unduly on verbal disclosure or children's denials or minimisation, where there is other cause for concern. Where children do talk about abuse it is important that professionals act on those disclosures.

- Trusting relationships between children and professionals are key to effective safeguarding practice. Organisational and resource pressures must not be allowed to undermine the opportunities for children to establish and maintain trusting relationships with key professionals.

Chapter 6 discusses the learning in the SCRs about child sexual abuse. It focuses on a sub-sample of ten reports. It gives a powerful illustration of the themes about inter-professional working and paying attention to the behaviour of children and young people. It can be hard for children to disclose CSA verbally, but they may show they are experiencing CSA through challenging and sexually inappropriate behaviour. The reports showed that professionals were often reluctant to take protective action without a clear disclosure from children, and that when children did disclose CSA, shortcomings in investigations sometimes resulted in them not being protected and continuing to be abused. The analysis also reminds us that some adults are deliberately deceptive, planning and sustaining their ill-treatment of the children. It is an uncomfortable lesson, and one that child welfare professionals may need help to assimilate into their practice. Safeguarding children in cases involving intrafamilial CSA is difficult and daunting work, and professionals will need training, time, resources, and supervision to be effective.

Chapter 7 concludes the 2017-19 review, and indeed the whole series of periodic reviews of SCRs. It describes two online 'knowledge exchange events' that we held with local child safeguarding professionals to help us reflect on the key learning from SCRs and the messages to take forward to the new LCSPR system. The discussions give an informed and nuanced picture of the effectiveness of SCRs. They showed that SCRs have been taken very seriously and have been used to underpin local changes, but their impact has to be understood alongside all the other drivers for and obstacles to change, notably organisational and legislative reforms, new practice models, workforce issues and resource shortages, and the fundamental policy tensions discussed in Chapter 1.

The lessons from SCRs still have relevance for the new case reviewing system: the importance of good inter-professional working, communication, 'asking the next question', listening to children, recognising signs and symptoms of maltreatment,

effective supervision and so on; but perhaps the most important lessons are not about the details of practice but about the complexity and dilemmas of the work.

The high-profile scandals cause immense distress and anger but as a society we have to accept that safeguarding systems and practitioners cannot reduce the risk to zero. That is because it is impossible: there are no incontrovertible predictors of abuse, some misjudgements are inevitable in any field of human activity, and regrettably some people will deceive workers; but also because it would lead to a level of state intervention in family life that would be unacceptable in our society.

The SCRs show that there is always room for learning, even if the lessons are often the well-known ones; indeed, the repetition makes it all the more important that the messages are heard and acted on by all safeguarding practitioners and managers. But one of the reasons the shortcomings recur is because the challenges are always the same – of balancing need and resources, child protection and family support, empowerment and surveillance. As we move into the new era of LCSPRs, this policy perspective would be a realistic foundation for achievable change.

Chapter 1: Introduction

This report is an overview and analysis of 235 cases which led to serious case reviews (SCRs) between April 2017 and September 2019, because children or young people had died or suffered serious harm, and abuse or neglect was known or suspected (and, in the non-fatal cases, there was cause for concern as to the way in which agencies had worked together to safeguard the child). The reports for 166 of those cases were available. SCRs have now been replaced by a system of rapid reviews, and national and local child safeguarding practice reviews (LCSPRs, discussed below). There has been a series of government-commissioned periodic reviews of serious case reviews since 2001 (covering cases since 1998), at first biennial and latterly triennial. This is the ninth and final review in that series.

The great importance to our whole society of safeguarding our most vulnerable children from harm is clearer than ever, as are the breadth and depth of the challenges that practitioners face in doing it. We completed the draft of this report in April 2022, when we were waiting for the national review into the deeply distressing abuse and deaths of Arthur Labinjo-Hughes and Star Hobson (it has since been published: Child Safeguarding Practice Review Panel, 2022). We were also waiting for the report of the government-commissioned independent review of children's social care, billed as a 'once in a generation opportunity to transform the children's social care system and improve the lives of children and their families' (Independent Review of Children's Social Care, 2021, p. 5). The final report was published in May 2022 (MacAlister, 2022). The country is still recovering from the impact of the Covid-19 pandemic, and policy talk of 'levelling up' is challenged by steep rises in the cost of living. There is much at stake, but also new opportunities to learn and improve practice.

This introduction sets the scene for the account of the 2017-19 serious case reviews and their messages for policy and practice. It gives a summary of the key developments and debates in child safeguarding in England over the period. It starts by outlining the changes to the child safeguarding 'architecture' that were introduced in response to the Wood review of local safeguarding children boards (LSCBs), published in 2016. It goes on to contextualise the 2017-19 SCRs by summarising the evidence about levels of demand and resources over that period, and more fundamentally (not exclusive to 2017-19) the dilemmas and challenges of the work. It ends with an overview of the following chapters in this report.

1.1 The new multi-agency child safeguarding arrangements

Sir Alan Wood's review of the role and functions of LCSBs was critical of them for being costly and ineffective, with a lack of clarity about their role, and not achieving the necessary levels of inter-agency co-operation (Wood, 2016). As regards serious case reviews, the report concluded that:

> *Despite guidance to the contrary, the model of serious case reviews has not been able to overcome the suspicion that its main purpose is to find someone to blame. Although there has been some improvement in the quality of some reviews the general picture is not good enough and the lessons to be learned tend to be predictable, banal and repetitive (Wood, 2016, p. 8).*

It found the SCR system to be 'cumbersome, often too costly and insufficiently independent of the agencies involved' with 'significant variability in the quality of reports and the skills of the authors' (Wood, 2016, p. 18). The report called for a new framework for multi-agency arrangements and to improve learning from serious cases. The government accepted the recommendations (Department for Education 2016). The new arrangements were being planned and implemented over the course of the period covered by this overview.

The necessary legislative changes were made in the Children and Social Work Act 2017, and the national Child Safeguarding Practice Review Panel came into being in 2018. New *Working Together* guidance was published in summer 2018 and has been subsequently updated (HM Government, 2018). There was a transitional period, from June 2018 to September 2019, during which time LSCBs were gradually replaced by local child safeguarding partnerships. During this transitional period, LSCBs could still initiate an SCR up until they became a partnership; after that, they had to use the new LCSPR system. There was a year's grace period after the end of September 2019 for existing SCRs to be completed. At the end of that period, any unfinished SCRs should have been handed over to the safeguarding partnership to decide what to do with them. We understand that some have been 're-purposed' and submitted as LCSPRs.

The new partnerships have three statutory partners – the local authority, local health services (via the clinical commissioning group/s for any areas, any part of which falls within the local authority area) and the police (the chief officer for a police area any part of which falls within the local authority area) (s.16E of the Children Act 2004, as amended by the Children and Social Work Act 2017). The key principle is that the three partners are equally responsible for safeguarding children in their area. The statutory partners are then joined by other 'relevant agencies', which may include (amongst others) schools, other providers of education and training, NHS trusts and foundation trusts, district councils, charities, prisons, youth offending teams and

Cafcass (Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018).

Sir Alan Wood undertook a review of the new multi-agency arrangements, published in May 2021 (Wood, 2021). The review was generally positive, recognising the hard work of partnerships to try to improve safeguarding practice, but that it was still ‘early days’ (noting that much of this activity took place over the period of the Covid pandemic, from March 2020). It called for improved support from central government departments, and commented on the stretched resources for protecting children. It noted in particular the challenges of recruiting and retaining safeguarding professionals across the three statutory agencies (Wood, 2021, p. 6).

1.2 The wider safeguarding context

The years 2017-19 saw continuing high levels of demand for children’s services and within that, child safeguarding activity; and alongside the high inflow and workloads, continuing pressure on local authority budgets. The trends have been reported in the series of Safeguarding Pressures reports produced by the Association of Directors of Children’s Services (ADCS). The challenges and pressures have also been highlighted in a wide range of research, some of which has been commissioned by the Department for Education. This comes from bodies such as What Works Centre for Children’s Social Care, the Office of the Children’s Commissioner, the Care Crisis Review of 2018, and university-based researchers. Ofsted reports and Joint Targeted Area Inspections (JTAIs) also add to our knowledge. The overall picture is one of high demand, tight resources and considerable variation between areas in the delivery, quality and outcomes of children’s social care; but at the heart of it all, the fundamental balances and tensions of offering support to families and protecting children from harm.

1.2.1 Demand and resources, 2017-19

The sixth report in the ADCS safeguarding pressures series shows the challenging picture during the 2017-19 period (Association of Directors of Children’s Services, 2018). It describes an increase in the prevalence and complexity of family problems, especially domestic violence, parental mental ill-health and drug and substance misuse. It notes the increasing needs for services for adolescents, particularly the risks of sexual exploitation. It notes increased demands because of new duties, for example the increased age of responsibilities to care leavers. It also notes reductions in resources, challenges in recruiting and retaining staff, and the high costs of commissioning and managing services provided by external agencies.

Table 1 shows national figures to illustrate the patterns of demand, from the annual DfE *Characteristics of children in need* and *Children looked after in England* reports.

It gives figures for the three years 2017-2020, the period covered by this report, and includes the 2009-10 and 2016-17 data for comparison. The table shows the significant increases since 2010 in all dimensions except the number of children assessed as being 'in need' under s.17 of the Children Act 1989, with the most dramatic increase in the number of s.47 enquiries, which has risen by almost 130%. The increases have slowed since 2017, and there is evidence of a slight decrease recently in some of the dimensions. This may not necessarily reflect a decrease in underlying demand, but rather the way that cases are managed, being filtered and funnelled out of the system earlier (see Hood *et al.*, 2020). An important aspect is to compare the number of s.47 enquiries with the number of children starting on CP plans over the year. In 2010 the ratio was roughly two to one (87,700 enquiries to 44,300 plans starting); by 2020 it was roughly three to one (201,000 enquiries to 66,380 plans starting). These data do not allow us to say whether this is because of an increase in unfounded concerns, better assessments and support to divert cases from a plan, or a raising of the threshold in practice for a plan (or what combination of those), but this would be an important subject for further research (see Bilson and Munro, 2019). If previous trends are repeated, we can expect an increase in referrals and enquiries in the aftermath of the Arthur and Star cases.

Table 1: Patterns of demand and response in local authority children's social care, 2010 and 2017-20

	Referrals over year	Children in need on 31 March	s.47 enquiries over year	CP plans starting over the year	Children looked after on 31 March
2009-10	603,700	375,900	87,700	44,300	64,470
2016-17	646,120	389,040	185,680	66,410	72,600
2017-18	655,630	404,710	198,090	68,770	75,370
2018-19	650,900	399,500	201,200	66,680	78,140
2019-20	642,980	389,260	201,000	66,380	80,000

Sources: DfE annual data on *Characteristics of children in need,* and *Children looked after in England including adoption*

It is also important to note that there are substantial variations between authorities, on all these measures. For example, the national rate of s.47 enquiries over the year in 2019 was 168.3 per 10,000 children, but this ranged from 491.6 (Blackpool) to 46.6 (Essex) (Department for Education 2019, Table C4). Even in years when there was an overall increase, some areas saw a decrease in these numbers.

Alongside this pattern of increasing demand, albeit with variations between areas and over time, the years from 2010 saw reductions in public sector budgets, part of

the austerity programme intended to reform Britain's finances and to change the role of the state in welfare provision.

The National Audit Office (2018) has calculated that local authorities in England experienced a real-terms reduction of government funding of 49% between 2010-11 and 2017-18. In this context, local authorities have had to focus their spending on the most acute services, such as child protection and services for children in care, and make cuts in other areas, notably preventive and early intervention services, such as children's centres (National Audit Office 2019). The ADCS Safeguarding Pressures report of 2018 gives a summary of research into local authority and other agencies' budgets for children, as well as offering its own findings from a survey of 112 local authorities. Amongst the studies they cite is review by the Institute for Fiscal Studies for the Children's Commissioner for England (Kelly *et al.,* 2018). This concluded that total government spending on children in England (including benefits, education spending, services for vulnerable children and healthcare) was 10% lower in real terms in 2017-18 than it had been in 2010/11. As for its own survey, the ADCS found that spending on local authority children's services had exceeded central government funding in 2016-17 and was projected to do so again over the next two years. It concluded:

> *Local authorities have largely responded to the significant financial pressures and reduction in funding from government by prioritising children's services often at the expenses of other services, to ensure children are safeguarded, but also by continually seeking to achieve efficiencies ... the majority report that funding is from local authority budgets or reserves* (Association of Directors of Children's Services, 2018, p. 97).

Cuts in budgets to partner agencies have also had an impact on the availability and quality of services to support children and families. The state of child and adolescent mental health services (CAMHS) has been a particular cause of concern. A House of Commons Health Committee report in 2014 identified 'serious and deeply ingrained problems' at all levels of provision from early intervention through to inpatients (Health Committee 2014, p. 3), and similar concerns have been reported since (e.g. Health and Social Care Committee, 2021; House of Commons Library, 2021).

Underlying need in an area – the level of deprivation – accounts for some of the variation between authorities, but the extent to which it does so is disputed, and organisational cultures, resources and service availability also have a profound impact. For example, Bywaters *et al*. (2018) show a clear gradient between deprivation rates and the rates of children in care or on child protection plans. Poorer areas tend to have more children in care or on plans, and wealthier areas fewer. They found that a child living in the most deprived 10% of communities in England is 13 times more likely to be on a CP (child protection) plan. On the other hand, modelling by the National Audit Office (2019) concluded that only 15% of the

variation between local authorities in the rates of children on CP plans could be accounted for by underlying need, and ascribed almost half to local factors such as

> *… custom and practice in children's social care; local market conditions; geographical peculiarities; historical patterns of demand for children's social care; community composition; and historical funding* (National Audit Office 2019, p. 44).

1.2.2 Dilemmas and challenges in policy and practice

Local practices and customs are certainly important in explaining local variation, but to understand child welfare policy and practice one also has to look at wider national culture, the values and principles that dominate in public life and policy. These are frequently contradictory and often contested. The prime example for child safeguarding work is the balance between supporting families and protecting children. Usually these two objectives run hand-in-hand – practitioners help the children by helping their parents or other carers – but in the most difficult cases, action may have to be taken to remove the children. Deciding when that point has been reached can be one of the hardest decisions for child welfare staff, and requires evidence to satisfy a court. Even after a child has been removed, the preferred approach would usually be to support the family to make the necessary changes to resume care of the child. Before that though, in safeguarding practice the balance can sometimes get distorted. Focusing on the parents' needs and rights (sometimes experienced as overwhelming demands) can mean that the child's needs and rights are overlooked, leaving them at risk of harm; but focusing exclusively on the child can be a defensive reaction to those pressures, a blunt instrument that closes down the possibility of creative thinking about family-based solutions.

The picture is further complicated by other goals that are not always or easily compatible. For example, child welfare services are expected to give time for change whilst not letting cases drift, to offer high quality services whilst keeping costs down, and to provide support but also ensure that individuals and families take on responsibility themselves. Workers are expected to build relationships and work in partnership with families but also to 'think the unthinkable' (a phrase used in some SCRs) that the adults may be abusing the child – to think the best of people and the worst, simultaneously. They are expected to respect confidentiality and share information with other agencies. Services are also expected to protect children from harm and to promote their overall wellbeing (i.e. a specific focus versus a wider goal, reflected in the five aims of inter-agency co-operation specified in s.10 of the Children Act 2004); to be responsive to individual circumstances whilst ensuring equal treatment and fairness for all; and to value cultural and ethnic differences whilst upholding normative child rearing standards (standards that may be viewed as

characteristic of white middle class British culture). There are also expectations of having stable organisations without closed cultures, and flexibility in meeting local needs without creating a 'postcode lottery'.

The role and impact of SCRs in child safeguarding policy and practice need to be understood in this wider context – one that we return to in Chapter 7, the conclusion to this overview. Given the many influences on practice and the competing responsibilities, it ought not to be surprising that the issues tend to come back again and again; indeed, the more surprising thing might be that the tensions are managed and more-or-less effective balances struck in the majority of cases. Serious cases are relatively unusual and should not be seen as typical of all cases; but equally, as 'extreme cases' they can shed powerful light on the regular practices, exposing the routine difficulties and dilemmas. Serious cases are unlikely to be down to solely the failings of individual practitioners or even of the various agencies, though that is not to deny responsibility when practice has been poor, but the difficulties may be better understood and learned from as symptoms of the tensions in a complex and overloaded system – overloaded both with demand and competing expectations.

1.3 Guide to the chapters

In order to capture and convey the learning from the 2017-19 cohort of SCRs, the rest of the report is structured in five chapters. First there is an overview of the key characteristics of the cases, and then we address three themes in particular: the problem of neglect, the challenges of practice, and the task of listening to the voice of the child. We have picked these three themes because they reflect perennial issues throughout the history of SCRs, so there is value in looking at them again now, as the SCR process comes to an end. We then focus on the issue of intra-familial child sexual abuse, as it demonstrates so many of the well-established themes in practice, and highlights the challenges of sustained deception from some offenders. The final chapter draws out the messages for the new LCSPR system.

Chapter 2 is the overview of the key characteristics of the 235 cases where there was a serious incident notification (SIN) and we know an SCR was commissioned. We were able to obtain 166 reports. The chapter gives key data about aspects such as the ages of the children, the types of harm they suffered and the characteristics of their families. We drew on a purposive sub-sample of 49 cases for our qualitative analyses. The chapter gives a summary of the methods we used in the study. A fuller account of the methods is given in Appendix A.

Chapter 3 addresses the problem of neglect. It considers a number of themes around identifying and responding to neglect, the key ones being the 'normalisation' of neglect (that is to say, the extent to which it has become an unremarkable, often unnoticed aspect of children's lives in areas where it is so common) and the

relationship between neglect and poverty (another issue that often goes unnoticed – Morris *et al.* (2018) have called poverty the 'wallpaper of practice'). The SCRs showed that neglect may not always be effectively addressed in practice, but it featured in almost three-quarters of the cases (and poverty in nearly half), and its damaging long-term effects on young people's emotional and social wellbeing were recognised in the SCRs.

Chapter 4 discusses three aspects of professional practice that are at the heart of the SCRs: engaging with parents and the complexities of 'effective challenge'; interprofessional communication and information-sharing; and professional disagreements. The core concept in all three is about communication, whether it is with families or other professionals. Good communication involves listening as well as explaining, and is basis for sensitive practice, effective information exchange, clear analysis and planning. For this, workers need to have time, manageable workloads and good support and supervision.

Chapter 5 focuses on the voice of the child, although a key point is that this does not only involve 'listening', but also observing, because children may often show what they are experiencing or thinking through their behaviour, rather than what they say. A lack of focus, or loss of focus, on the child's lived experience was a common theme across the SCRs. The chapter highlights the importance of engaging with children and young people, and helping them to establish trusting relationships with professionals.

Chapter 6 discusses the learning in the SCRs about child sexual abuse. It is a powerful illustration of the themes from previous chapters about inter-professional working and paying attention to the behaviour of children and young people. It also reminds us that some adults are deliberately deceptive, planning and sustaining their ill-treatment of the children. It is an uncomfortable lesson, and one that child welfare professionals may need help to assimilate into their practice.

Chapter 7 concludes the 2017-19 review, and indeed the whole series of periodic reviews of SCRs. It describes two online 'knowledge exchange events' that we held with local child safeguarding staff to help us reflect on the key learning from SCRs and the messages to take forward to the new LCSPR system. In concluding, the chapter draws attention to the limits of being able to predict which cases will involve serious harm, and returns to the social and policy context, for a further consideration of the limits and challenges they impose.

Chapter 2: Patterns and trends of maltreatment

This chapter describes the main features of the SCRs for the 30-month period April 2017- September 2019. It explores the patterns of maltreatment and shows trends over the past 14 years (2005-19), drawing on previous biennial and triennial reports.

2.1 Sources of information and approach to analysis

The research team endeavoured to locate as many copies of SCR reports as possible for the review period (incident date between April 2017 and September 2019), where these had been completed. For this review period, the majority of reports were supplied to us directly (securely) by the Department for Education. As in previous rounds, however, we also searched the NSPCC national case review repository for SCRs with a relevant incident date.

A spreadsheet containing serious incident notification (SIN) data for the relevant time frame was also compiled for the research team, by the DfE. The SIN data from this spreadsheet, for 1,119 notifications, were refined and adapted in a number of ways which are detailed in the methodology (Appendix A).

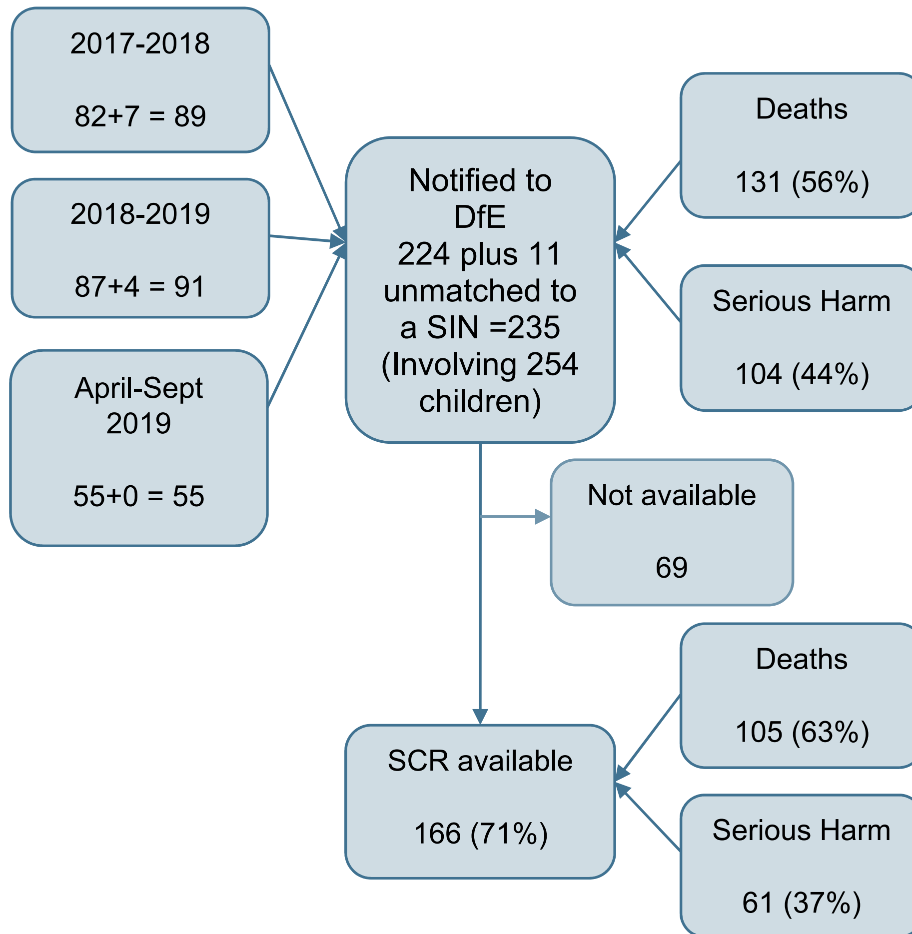
The collated SCRs were then matched to the preceding SIN wherever possible, and duplicates identified and removed. There were an additional 11 SCRs located on the NSPCC repository whose incident date fell within the timeframe, but which could not be matched to a SIN. This was most likely because the DfE had not been informed that a review had taken place. Where a SIN was listed as having proceeded to an SCR but had not yet been located, or where the case was listed as 'awaiting publication' individual safeguarding partnership websites were also searched.

The final dataset used for analysis comprised 235 cases (see Figure 1).

A total of 166 completed SCRs (71% of all SCRs notified) were obtained by the research team by 31 December 2021. These comprised 105 fatal cases and 61 non-fatal, serious harm cases.

Of the 69 cases for which a report was not available, this was either because the SCRs had not been completed (often due to ongoing criminal investigations), or completed but not published, primarily due to concerns about the impact of publication on surviving family members. Towards the end of the timeframe, as the LSCBs became local child safeguarding partnerships, some cases would have gone into the new LCSPR process, so it is important to appreciate that this report focuses only on the SCRs. Ten cases within the 166 had not been published, but the DfE had been provided with a copy which was then made available to the research team for analysis and included here but not listed in Appendix D.

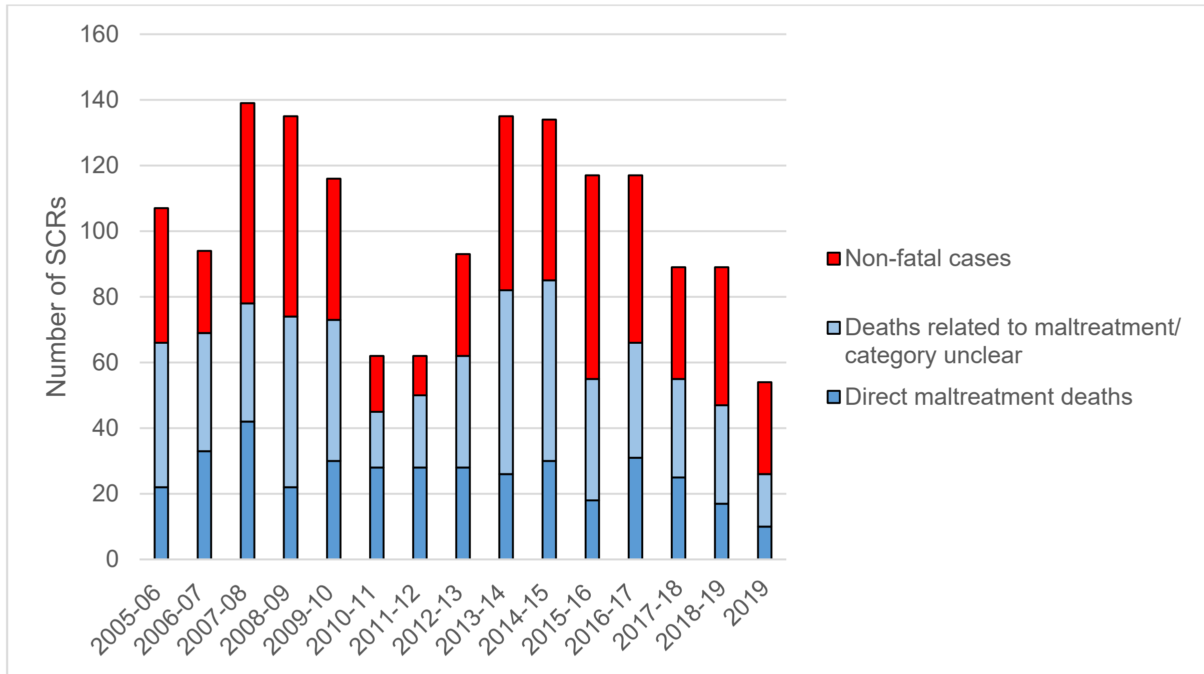
Figure 1: Numbers of serious case reviews



2.2 Number of serious case reviews undertaken 2017-19

This section of the report provides an analysis of all 235 SCRs which relate to an incident that occurred between April 2017 and September 2019 – that is, the 224 reviews notified to the DfE plus the 11 additional SCRs that the research team was able to locate. Comparison with numbers of SCRs per year since 2005 is provided in Figure 2 and Table 2.

Figure 2: Annual numbers of serious case reviews



N.B. The 2019 bar represents only six months, not a full year.

Table 2: Annual number of SCRs

Year	Total number of SCRs	Deaths	Serious Harm	0-17 child population in England (thousands)[1]
2005-06	106	65 (61%)	41 (39%)	11,112
2006-07	83	58 (70%)	25 (30%)	11,110
2007-08	140	79 (56%)	61 (44%)	11,153
2008-09	140	79 (56%)	61 (44%)	11,202
2009-10	105	62 (59%)	43 (41%)	11,232
2010-11	73	56 (77%)	17 (23%)	11,279
2011-12	63	51 (81%)	12 (19%)	11,341
2012-13	95	64 (67%)	31 (33%)	11,423
2013-14	135	82 (61%)	53 (39%)	11,506
2014-15	134	85 (63%)	49 (37%)	11,592
2015-16	117	55 (47%)	62 (53%)	11,678
2016-17	117	66 (56%)	51(44%)	11,785
2017-18	89	55 (62%)	34 (38%)	11,867
2018-19	91	49 (54%)	42 (46%)	11,955
April 2019- Sept 2019	55	27 (49%)	28 (51%)	12,024

The annual data follows the financial year from the beginning of April to the end of March, so for 2019 we only have the first six months' worth of data, before the SCR system ended. The total numbers of SCRs for this period are somewhat lower than the preceding four years, but within range of previous review findings. The fluctuation over the years has, in part, been related to the proportion of non-fatal serious harm cases, with a greater proportion of such cases in years when more SCRs are carried out. Figure 2 shows that there has been relatively little fluctuation over the years in the numbers of deaths directly caused by maltreatment, which had averaged 28 cases per year. In this review period the number has almost halved, but as noted some cases will have gone into the new LCSPR system. Which route they took depended on when the LSCB became a partnership and it is not possible to say

[1] data from Department for Education (2019) Characteristics of children in need: 2018-19, England

what impact this may have had on the profile of the remaining SCRs, so we need to be cautious not to over-interpret the figures from this cohort.

2.3 Geographical distribution of the cases 2017-19

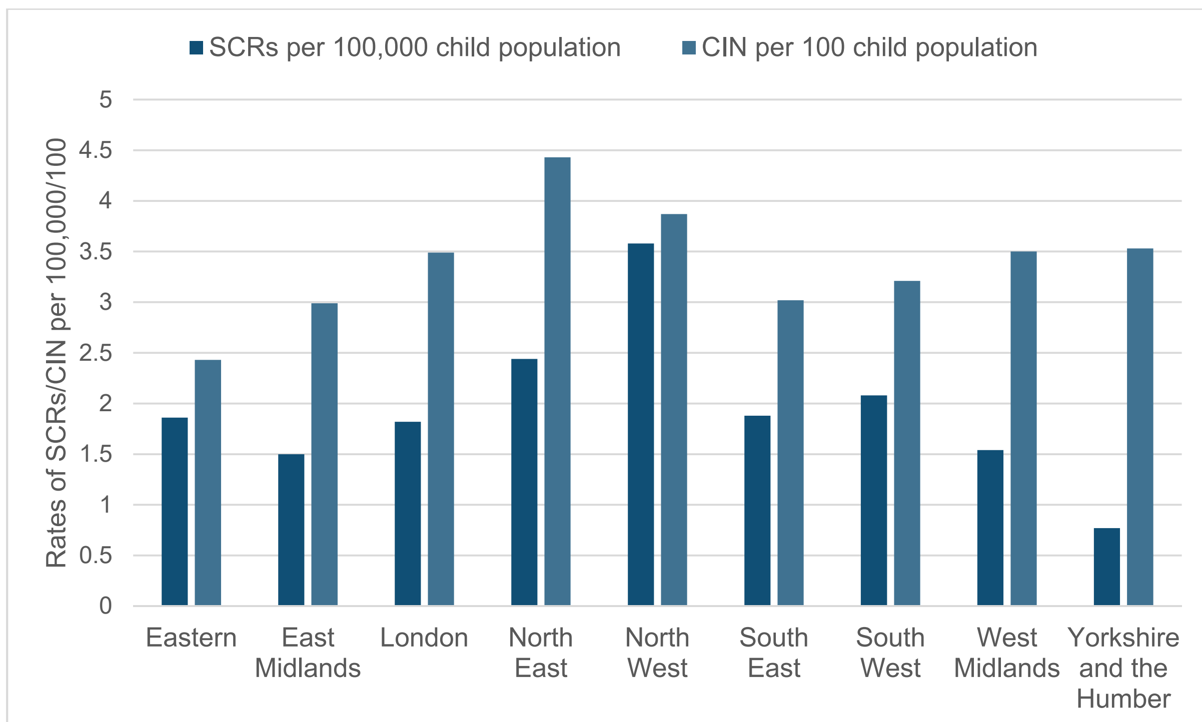
Table 3 and Figure 3 show the geographical distribution of SCRs across the English regions. There is now an even wider discrepancy in the rates of SCRs per 100,000 child population than in the previous review, with a four-fold difference between the lowest and highest regions. The regions with the lowest and highest rates of SCRs per 100,000 remain the same: Yorkshire and Humber (0.77) and the North West (3.58), respectively. As can be seen from Figure 3, the rate of SCRs mostly mirrors the rate of children in need (though note the different scales on the graph) at roughly one SCR per 1,000 children in need. As with the last review, there are the two same outliers, Yorkshire and the Humber, which has a very low rate of SCRs in comparison to the number of children in need, and the North West which has a very high rate. Again, the reasons for these outliers are not clear, but they do persist.

Table 3: Geographical distribution of the cases 2017-19

Region	Death	Serious injury	Total SCRs	SCRs per 100,000 child population	Children in Need[2]	CIN per 100 child population	Child population 0-17[3]
Eastern	16	9	25	1.86	32,710	2.43	1,346,460
East Midlands	6	9	15	1.50	29,930	2.99	1,002,650
London	22	15	37	1.82	70,920	3.49	2,032,430
North East	5	8	13	2.44	23,580	4.43	532,060
North West	35	21	56	3.58	60,460	3.87	1,563,460
South East	21	16	37	1.88	59,470	3.02	1,969,300
South West	9	14	23	2.08	35,570	3.21	1,107,480
West Midlands	14	6	20	1.54	45,530	3.50	1,299,800
Yorkshire and the Humber	3	6	9	0.77	41,340	3.53	1,169,940

[2] data from Department for Education (2019) Characteristics of children in need: 2018-19, England
[3] 2019 ONS population estimates

Figure 3: Geographical distribution of SCRs and children in need



Summary points

- Within the time period 1 April 2017-30 September 2019, 235 cases proceeded to a serious case review and SCR reports were available for 166 of these.
- There has been considerable year-on-year fluctuation in the number of SCRs carried out but over the 14-year period (2005-2018/9) there has been an average of 106 SCRs per year, of which an average of 64 (60%) have been for fatal cases.
- There remains a wide discrepancy in the rates of SCRs per 100,000 child population. There was an over four-fold difference between the lowest and highest regions (Yorkshire and the Humber, 0.77; North West, 3.58).

2.4 The nature of the death or serious harm

All cases have been classified according to the categorisation systems for deaths and serious harm developed in previous periodic reviews (Brandon *et al.,* 2008, 2010, 2020). The research team categorised cases using:

- Details drawn from close reading of 166 serious case reviews available to us;

- For the remaining 69 cases where a review was not available, we used the brief case information notes provided by the DfE to ascertain categories, as far as possible.

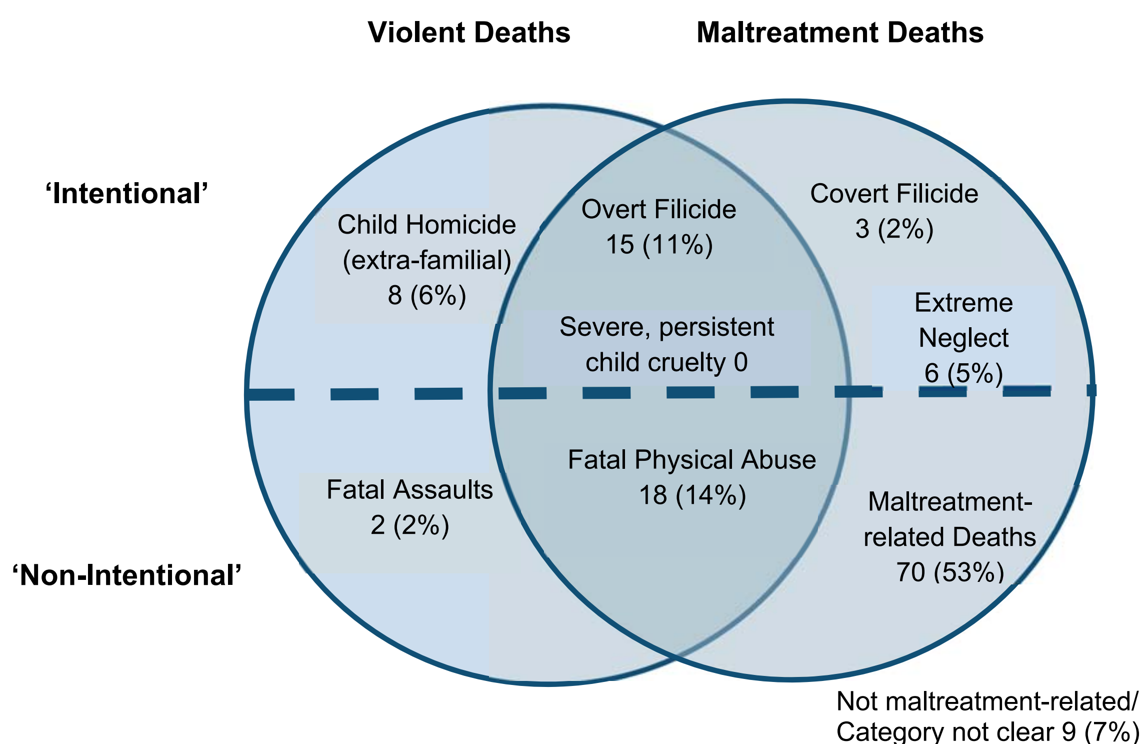
2.4.1 Categories of death

The categorisation of the fatal cases is presented below in Table 4 and Figure 4 following the framework shown in Appendix B. This gives 42 of the SCRs over the 2.5 years cases as direct maltreatment deaths (overt and covert filicide, fatal physical abuse, severe persistent child cruelty, and extreme neglect). This is equivalent to 16.8 cases per year, lower than found in previous overviews, but it is not possible to draw any firm conclusions about this given the changes in the system. The current review is a shorter time period than the last, so frequencies are understandably lower, but there is a notable drop in the proportion of all deaths that were caused by fatal physical abuse (from 22% to 14%)

Table 4: Category of death

Category of death	Number of deaths 2014-17 (%)		Number of deaths 2017-19 (%)	
Fatal physical abuse	46	(22%)	18	(14%)
Overt filicide	17	(8%)	15	(11%)
Extra-familial child homicide	7	(3%)	8	(6%)
Extreme neglect	1	(<1%)	6	(5%)
Covert filicide	6	(3%)	3	(2%)
Not maltreatment related	1	(<1%)	3	(2%)
Extra-familial physical assault	3	(1%)	2	(2%)
Not clear	11	(5%)	6	(5%)
Severe persistent cruelty	9	(4%)	0	
Death related to maltreatment	105	(51%)	70	(53%)
Total	**206**	**(100)**	**131**	**(100)**

Figure 4: Categories of death from 2017-19 SCR data, total cases=131



Sub-categories for the 70 'deaths related to maltreatment' are shown in Table 5. The proportions in each category are here similar to those found in the last review period.

Table 5: Sub-categories for death related to maltreatment

Category of death related to maltreatment	Number of deaths 2014-17 (%)		Number of deaths 2017-19 (%)	
SUDI	37	(35%)	21	(30%)
Suicide	30	(29%)	21	(30%)
Medical (e.g. failure to respond to a child's medical needs)	13	(12%)	8	(11%)
Accident	15	(14%)	7	(10%)
Risk-taking behaviour	3	(3%)	3	(4%)
Late consequences of abuse		n/a	1	(1%)
Poisoning	3	(3%)	1	(1%)
Other	4	(4%)	5	(7%)
Total	**105**	**(100)**	**70**	**(100)**

2.4.2 SCR deaths compared to national child deaths

There were 131 SCRs relating to deaths in the 30-month period. The annual average deaths of children aged up to 18 years reported to Child Death Overview Panels (CDOP) for 2017-19 is 3,473 (NHS Digital, 2019). Over the three years therefore, these 131 deaths relate to less than 2% of all child deaths. CDOP data relate well to SCR data, as CDOPs review all child deaths from birth to 18 years. However, CDOP annual data are for deaths *reviewed* between 1 April and 31 March rather than for deaths actually occurring in that time period.

Since no CDOP data have yet been published for the year ending March 2020, we can here only compare the SCR data for beginning April 2017- end March 2019. During these two years there were 42 SCRs for directly inflicted deaths due to filicide, fatal physical abuse, extreme neglect or extrafamilial homicide and fatal assaults. CDOPs categorised a higher number of child deaths as due to deliberately inflicted injury, abuse or neglect during the same time period, 105, with 80 of these due to homicide (NHS Digital, 2019). However, the CDOP data are not directly comparable because they include all deaths from extrafamilial assaults, which would not necessarily meet the criteria for a serious case review. In addition, CDOPs may classify some deaths related to, but not directly caused by, maltreatment within their category of abuse or neglect.

The most common categories of 'deaths related to maltreatment' in the SCRs were again sudden unexpected death in infancy (SUDI) and suicide, but suicide is now equal to SUDI. However, only a small proportion of these types of death are subject to SCRs. The CDOP data from 2017-19 (NHS Digital, 2019) showed 625 SUDI cases and 180 suicides, therefore only around 3% of SUDI and 9% of suicides are subject to a serious case review. It is therefore important not to assume that SUDI and suicides selected for SCR are representative of these types of deaths more widely. Having said that, previous analysis of SUDI SCR cases showed the majority of deaths involved the combination of parental alcohol or drug misuse and co-sleeping (Garstang & Sidebotham, 2018), which is a frequent finding in SUDI more generally (Blair *et al.*, 2009; and see Child Safeguarding Practice Review Panel, 2021).

2.4.3 Categories of non-fatal serious harm

Categories of serious harm in non-fatal cases are presented in Table 6, alongside comparison data for the previous three review periods. Note that this categorisation system highlights a primary cause of harm for each review and that a young person may experience multiple forms of harm.

The total number of cases of non-fatal serious harm has decreased from the last triennial review period, although higher than the yearly average before that (42 cases per year in 2017-19, compared to 54 cases per year in 2014-17 and 30-32 per year across 2009-14). The largest variation from the previous overview relates to physical abuse, which has fallen as a proportion, and CSE (although based on much smaller numbers). Neglect is more than twice as high as a proportion than it was in 2009-11.

Table 6: Categories of serious harm in non-fatal cases

Category of serious harm	2009-11	(%)	2011-14	(%)	2014-17	(%)	2017-19[4][5]	(%)
Non-fatal physical abuse	31	(52)	50	(52)	83	(51)	44	(45)
Neglect	6	(10)	14	(15)	30	(19)	22	(23)
Child sexual abuse – intra-familial	6	(10)	13	(14)	16	(10)	13	(13)
Child sexual abuse – extra-familial	6	(10)	5	(5)	7	(4)	7	(7)
Risk taking/ violent behaviour by young person	8	(13)	8	(8)	11	(7)	7	(7)
Child sexual exploitation (CSE)	-		5	(5)	11	(7)	2	(2)
Other	3	(5)	1	(1)	4	(2)	3	(3)
Total	**60**		**96**		**162**		**98**	

2.4.4 Source of harm to the child/young person

The close examination of all SCRs allowed the research team to obtain a more complete picture of 'source of harm' to the child. The results (Table 7) reflect previous findings, showing that most serious or fatal child maltreatment occurs within the family home, involving parents or other close family members. Very little serious or fatal maltreatment (eight cases in total) involved strangers unknown to the child. For the 51 cases where the perpetrator was 'not known/not clear', this includes accidents where no one perpetrator had been identified, cases of extra-familial child homicide where no suspect had been charged, cases of SUDI where it was not clear

[4] Note that the 2017-19 figures relate to a 30-month period, rather than three-year triennial period
[5] Excludes six cases where there was insufficient information to decide the category.

whether either parent was responsible for the unsafe sleeping, and cases of death or serious harm from abuse where neither parent had admitted responsibility.

In this report, n= Total number of cases

Table 7: Source of harm to the child/young person

Source of harm (presumed perpetrator)	Death n=131 (%)	Serious Harm n=104 (%)	Total of n=235 (%)
Mother	33 (25)	12 (12)	45 (19)
Mother figure/father's partner	0 (0)	1 (1)	1 (0)
Father	15 (11)	10 (10)	25 (11)
Father figure/ mother's partner	1 (1)	6 (6)	7 (3)
Both parents	13 (10)	26 (25)	39 (17)
Other carer	2 (2)	3 (3)	5 (2)
Other relative	3 (2)	5 (5)	8 (3)
Unrelated known perpetrator	3 (2)	11 (11)	14 (6)
Stranger	4 (3)	4 (4)	8 (3)
Self (e.g. suicide, attempted suicide, misadventure)	23 (18)	9 (9)	32 (14)
Not known/not clear	34 (26)	17 (16)	51 (22)

Although we have no comparative data from previous review periods, and the numbers are small, it is instructive to look in more detail at the sources of harm in both fatal and non-fatal cases.

Taking the fatal cases in the first instance, for the 24 cases we classify as 'intentional' maltreatment deaths (overt and covert filicide and extreme neglect – see Table 4), the presumed perpetrators were predominantly mothers (11 cases), then fathers (7 cases, all overt filicide), then both parents (3 cases). This does not mean that mothers are more likely to kill their children than fathers, because they are much more likely be the main or sole carer for the child. A key factor is the ages of the children. Those who died from intentional maltreatment at the hands of their mothers were predominantly young children in the 1-5 years age bracket (7 of the 11 cases). The children whose intentional maltreatment death was at the hands of their fathers were usually older. These cases were almost all fathers killing sons aged 6-10 (4 of the 6 cases), the remainder being infants under 1.

For the 88 cases we classify as involving 'non-intentional' maltreatment deaths (fatal physical abuse and maltreatment related deaths – see Table 4), there is a greater

range and variety of sources of harm, from both within and outside the family unit. The two categories are better dealt with separately.

For 'non-intentional' deaths from physical abuse, fathers are more often the source of harm than mothers, although numbers are small, seven out of the 18 cases compared to four (and both parents in three cases). This means 14 children were victims of 'non-intentional' fatal physical abuse from one or both parents, who were nearly all infants under 1 year old (12 cases).

For maltreatment-related deaths (see Table 5), 21 out of the 70 (30%) were suicides involving older children. Mothers were identified as the source of harm in 18 of the 70 deaths (26%), and these were predominantly SUDI cases (11 of the 18). Again, we should remember that mothers are likely to be the main or sole carer for the children.

Moving on to the non-fatal serious harm cases, the largest categories are physical abuse and neglect (see Table 6). The main source of harm in these cases was both parents. In the 13 cases of intra-familial child sexual abuse, the source of harm in 7 of them was the father or male partner, alone or with the mother. None were perpetrated by mothers acting alone, although they were involved in three cases alongside the father/male partner. Other carers/relatives account for four of the 13 intra-familial CSA cases, and it was unclear in two cases. There is a fuller discussion of intra-familial CSA in Chapter 6.

2.5 Neglect

There was evidence of neglect in nearly three-quarters of the reports examined (124 of the 166, 74.7%), using our previously defined protocol (see Appendix C). This proportion is almost identical to the 2014-2017 review (74.8%). Features of neglect were apparent in 69 out of 105 (66%) of the fatal cases and 55 out of 61 (90%) of the non-fatal serious harm cases. Findings on neglect from the detailed qualitative analysis of our subsample of cases are presented in Chapter 3.

Neglect was the category of abuse for 40 out of 54 children (74%) who were subject to a child protection plan at the time of or prior to the incident leading to the SCR and for whom the data were available. This is a higher proportion than reported in the previous review (59.5%).

Abuse and neglect are major reasons for referral to social care (Department for Education, 2019). The 'primary need' for over half the children who were receiving services as 'children in need' from local authorities in England on 31 March 2019, was abuse or neglect - 216,290 children out of the total 399,510, that is 54% (Department for Education, 2019). Neglect was the initial category of concern for

25,330 children nationally who had a child protection plan on 31 March 2019, nearly half of the total (48%) (Department for Education, 2019).

Summary points

- There were 131 SCRs relating to deaths in the 30-month period. Of these, 42 were direct maltreatment deaths, equivalent to 17 cases a year, lower than the figure found in previous periodic reviews (26-28 cases per year). This may be partly explained by the change to the new LCSPR system.
- The most common categories of deaths related to maltreatment were sudden unexpected death in infancy (SUDI) and suicide, each with 21 cases.
- The total number of cases of non-fatal serious harm has decreased (from 54 cases per year in 2014-17 to 42 per year in 2017-19). The variation in figures mostly relates to cases of physical abuse and child sexual exploitation (CSE). Neglect has doubled as a proportion since 2009-11.
- Most serious or fatal child maltreatment occurs within the family home, involving parents or other close family members. The SCRs did not often deal with serious or fatal maltreatment that involved strangers unknown to the child (only eight cases).
- As with the last review, neglect featured in three-quarters of the reports (124 of the 166, 74.7%). It was now the category of abuse for a much higher proportion of children who were subject to a child protection plan at the time of or prior to the incident leading to the SCR, than in 2014-17 (nearly 75% compared to nearly 60%).

2.6 Characteristics of the children and families

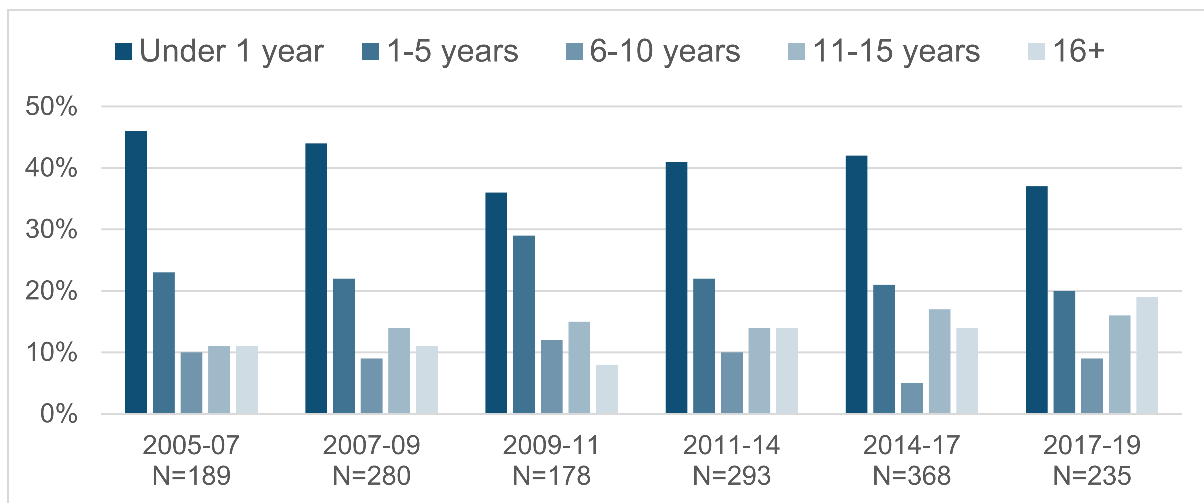
2.6.1 Age and gender of the child

Table 8 and Figure 5 show age bands for the children at the centre of the reviews, with figures for 2017-19 reported in the final column. The proportion of children in each age group is broadly similar to that in previous biennial/triennial periods, although the number of SCRs relating to children over the age of 16 has been gradually increasing (11% from 2005-2009 up to 19% in 2017-19).

Table 8: Age of child at the time of incident

Age	2005-07 N=189 (%)	2007-09 N=280 (%)	2009-11 N=178 (%)	2011-14 N=293 (%)	2014-17 N=368 (%)	2017-19 N=235 (%)
<1	86 (46)	123 (44)	64 (36)	120 (41)	154 (42)	86 (37)
1-5	44 (23)	60 (22)	51 (29)	64 (22)	79 (21)	46 (20)
6-10	18 (10)	26 (9)	21 (12)	28 (10)	20 (5)	20 (9)
11-15	20 (11)	40 (14)	27 (15)	41 (14)	63 (17)	38 (16)
16+	21 (11)	31 (11)	15 (8)	40 (14)	52 (14)	45 (19)

Figure 5: Age of child at the time of incident



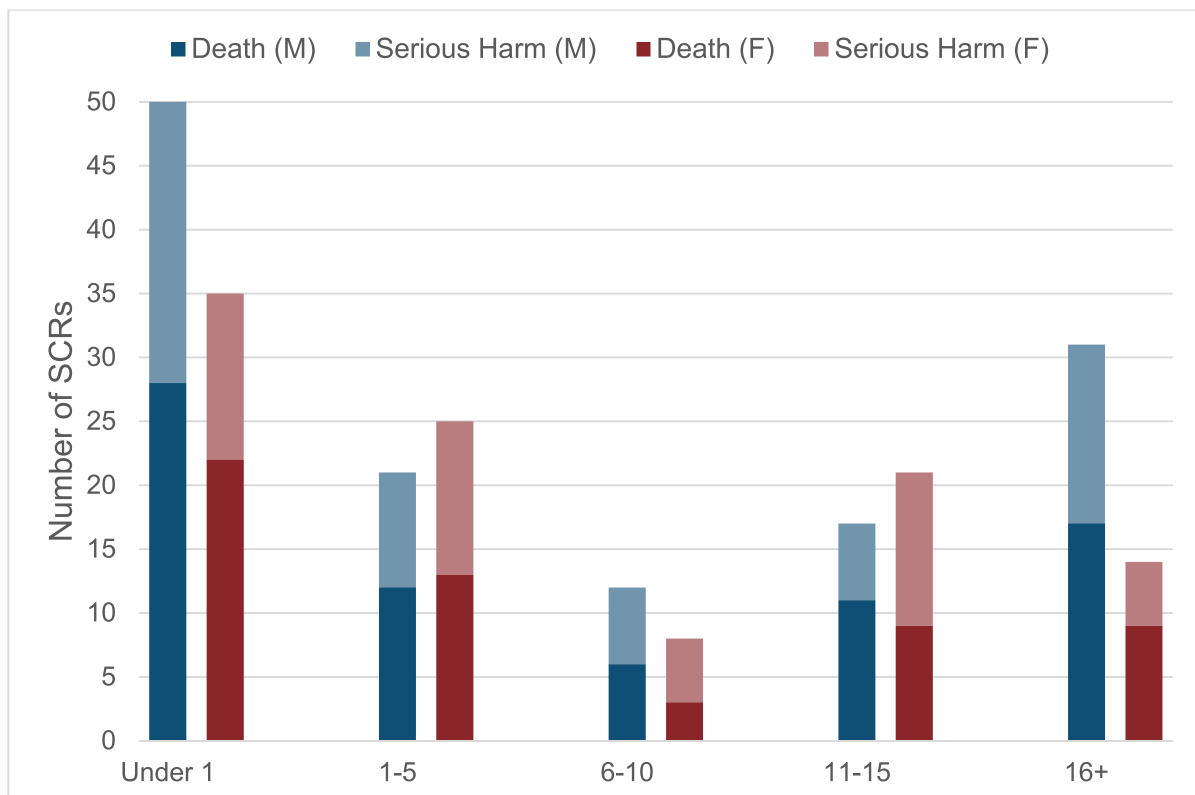
As in all the review periods, the largest proportion of incidents related to the youngest children, with 86 (37%) aged under 1. Of these, 41 (47%) were under 3 months of age, 24 (29%) were aged 3 to 5 months, 14 (16%) were aged 6 to 8 months, and the remaining seven children (8%) were between 9 months and 1 year at the time of the incident.

A total of 131 SCRs (57%) involved boys and 103 (43%) girls. This split is consistent with the general trend in other review periods, the one exception being the 2011-14 cohort where there were more girls. As Table 9 and Figure 6 show, the predominance of boys is because they are the largest group in the under-1 category, although in this cohort they have also become the largest group in the 16-17 year-old category.

Table 9: Age/gender of child at time of harm or fatality

Age group	2014-17 Female n=168 (%)	2014-17 Male n=200 (%)	2017-19 Female n=103 (%)	2017-19 Male n=131 (%)
<1	60 (16)	94 (26)	35 (15)	50 (21)
1-5	34 (9)	45 (12)	25 (11)	21 (9)
6-10	8 (2)	12 (3)	8 (3)	12 (5)
11-15	37 (10)	26 (7)	21 (9)	17 (7)
16+	29 (8)	23 (6)	14 (6)	31 (13)

Figure 6: Age and gender of child, and nature of incident



2.6.2 Ethnicity of the child at the centre of the review

Data for ethnicity are given in Table 10. Note that for 18 of the 235 cases (8%) ethnicity was not stated anywhere, including in the SIN if available (224). The ethnicity breakdown is broadly consistent with previous review periods. Since the data became available in 2005, the children at the centre of the reviews have predominantly been white (between 73% and 80%). The 2021 census data on ethnicity are due to be published in autumn 2022, but in the 2011 census, 79% of all children aged 0-17 in England were of white ethnicity, and therefore 21% from all

other ethnic groups (Office for National Statistics, 2011)[6]. The figures for the 2011-14 cohort of SCRs matched that. The split for the 2017-19 SCRs is 73%-27%. We know that ethnic diversity across the country as a whole has increased since 2011 (Office for National Statistics, 2021)[7], and that the under-18 population is more ethnically diverse than the whole population, but cannot say from this data how the 2017-19 ethnic profile of SCRs relates to the overall child population. This is an important subject for further research (see Bywaters *et al.*, 2016).

Table 10: Ethnicity of the child

Ethnicity	2007-09 N=267 (%)	2009-11 N=172 (%)	2011-14 N=282 (%)	2014-17 N=343 (%)	2017-19 N=217[8] (%)
White/White British	204 (76)	137 (80)	222 (79)	257 (74)	157 (73)
Black/Black British	24 (9)	14 (8)	17 (6)	26 (7)	21 (10)
Mixed	25 (9)	11 (6)	21 (7)	30 (9)	19 (9)
Asian/Asian British	12 (4)	7 (4)	15 (5)	22 (6)	14 (6)
Other ethnic group	2 (1)	3 (2)	7 (2)	8 (2)	6 (3)

2.6.3 Where were the children living?

Information about where the child was living at the time of the incident is displayed in Table 11. This shows that, at the time of the incident, most of the children (81%) were living at home or with relatives but, as in previous years, that death and serious harm can also occur for children living in supervised settings. As noted in the previous review, it is not possible to identify any trends in the children's placement, given the small number of children living outside the parental home.

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

[7]https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019

[8] For 18 (8%) of the 235 cases ethnicity was not stated. This is similar to the 2014-17 review in which ethnicity was not stated in 7% (26/374) of cases.

Table 11: Where living at time of harm or fatality

Where living	2007-09 Frequency (%) N=278		2009-11 Frequency (%) N=177		2011-14 Frequency (%) N=293		2014-17 Frequency (%) N=368		2017-19[9] Frequency (%) N=231	
Living at home	229	(82)	145	(82)	245	(84)	305	(83)	187	(81)
Living with relatives	11	(4)	8	(5)	10	(3)	9	(2)	8	(3)
With foster carers	8	(3)	4	(2)	8	(3)	16	(4)	11	(5)
Hospital, mother and baby unit or residential children's home	15	(5)	8	(5)	10	(3)	14	(4)	9	(4)
Semi-indep endence unit	3	(1)	1	(1)	3	(1)	8	(2)	5	(2)
Other, including YOI	12	(4)	11	(6)	17	(6)	16	(4)	11	(5)

2.6.4 Children's social care involvement

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

In more than half the SCRs the child at the centre of the review was a currently open case to children's social care at the time of the harm or fatality (57%); nearly a fifth were previously known but their case was currently closed (19%); and just under a quarter (23%) had never been known to social care (Table 12). Across the review periods, this represents a small and steady increase in the proportion of SCRs in which the children were currently open to children's social care. It is worth noting,

[9] 2017-2019 = 4 not yet known or missing

however, that these data were more complete in the most recent cohorts, with data on children's social care involvement being available on 205/235 (87%) of cases this time, compared to 285/368 (77%) of cases in 2014-17 and 175/293 (60%) of cases in 2011-14. The apparent rise may reflect this rather than increased identification of children in need/at risk by social care.

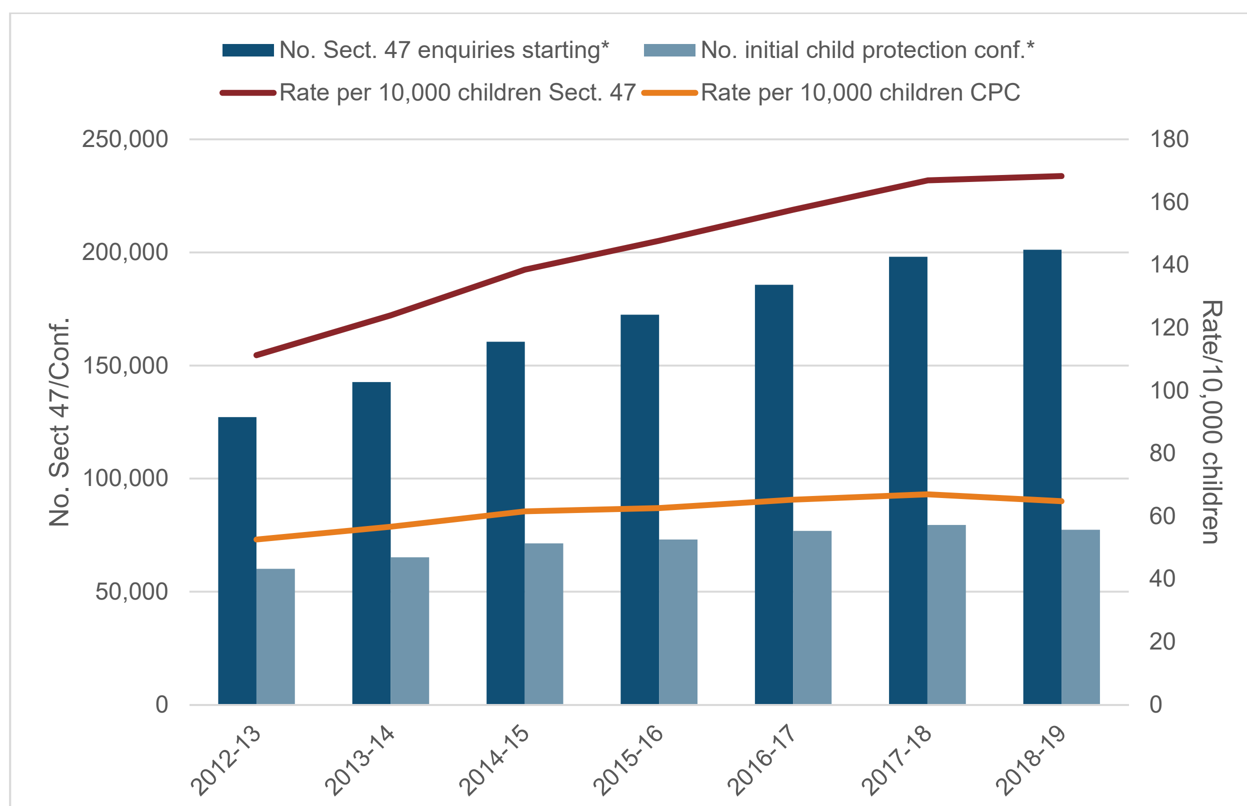
Table 12: Children's social care involvement

CSC involvement	2009-11 Frequency (%) N=138	2011-14 Frequency (%) N=175	2014-17 Frequency (%) N=285	2017-19 Frequency (%) N= 205[10]
Open case	58 (42)	79 (45)	157 (55)	117 (57)
Previously known, closed case	32 (23)	33 (19)	64 (22)	38 (19)
Enquiry or request for information, unaccepted referral, case below threshold for CSC	19 (14)	25 (14)	18 (6)	3 (1)
Never known to CSC	29 (21)	38 (22)	46 (16)	47 (23)

It is important, also, to see these data in the wider context of ongoing social care activity with children and families. There were, on average, 47 children per year who died or suffered serious harm while receiving social care input and become the subjects of SCRs in the 2017-19 period. This needs to be interpreted in the light of around 650,000 children per year referred to children's social care (see Table 3 above). Figure 7 below shows the annual number of s.47 child protection enquiries between 2012-13 and 2018-19, and the rate per 10,000 children; it also shows the annual number of initial child protection case conferences and rate per 10,000 children. The diagram confirms the trend described earlier, that the increase in enquiries has not been matched by the same rate of increase in CP conferences and plans.

[10] There were 24 cases where data was not clear, and 6 cases where there was no information available as to whether the child was known to CSC.

Figure 7: Section 47 child protection enquiries and child protection conferences (Year ending 31 March)



In contrast to the high proportion of children known to social care, a minority were on a child protection plan. At the time of the harm or fatality, 40 of the children (17%) had a child protection plan. A further 30 children had been the subject of a plan in the past (Table 13). These proportions have remained broadly static over the years, at a time when nationally numbers of children with a child protection plan been rising.

Table 13: Index child with a child protection plan (current or past)

Child protection plan status	2005-07 Freq. (%) N=175	2007-09 Freq. (%) N=276	2009-11 Freq. (%) N=177	2011-14 Freq. (%) N=293	2014-17 Freq. (%) N=368	2017-19 Freq. (%) N=235
Never on plan	127 (73)	198 (72)	136 (77)	223 (76)	258 (70)	165 (70)
Current plan	29 (17)	43 (16)	18 (10)	36 (12)	54 (15)	40 (17)
Past plan	19 (11)	35 (13)	23 (13)	34 (12)	56 (15)	30 (13)

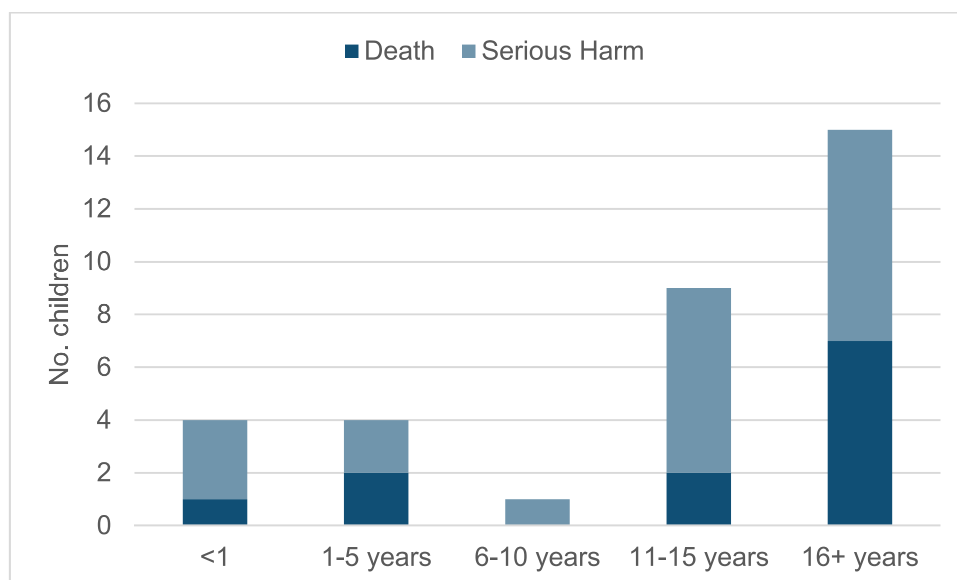
Within the timeframe of this review, a total of 168,640 children became the subject of a child protection plan, of whom 21% had a child protection plan on more than one

occasion (Department for Education, 2020). In that context, the finding that 40 children died or were seriously harmed while on a child protection plan (0.024% of these cases where there is a recognised risk of serious harm, but in the complex policy context described in Chapter 1), arguably suggests that children on child protection plans are generally well protected from the most severe harm.

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

Thirty-three children were or had previously been looked after by the local authority. Of those, 12 had died and 21 were seriously harmed. Nearly three-quarters of these children were aged over 11 years (Figure 8).

Figure 8: Looked after children in SCRs



Summary points

- A total of 131 SCRs (57%) involved boys and 103 (43%) girls.
- As in all the review periods, the largest proportion of incidents related to the youngest children, with 86 (37%) aged under 1 year. The number of SCRs relating to children over the age of 16 has been gradually increasing (11% in 2005-2009 up to 19% in 2017-19).
- The ethnicity breakdown is broadly consistent with previous review periods. Since data on ethnicity became available (2005 onwards), the families at the centre of the reviews have been predominantly white British. How the 2017-19 ethnic profile of SCRs relates to the overall child population will be an important subject for further research.
- At the time of the incident, most of the children (81%) were living at home or with relatives but, as in earlier years, death and serious harm can also occur for children living in supervised settings.
- In the majority of SCRs, children were known to children's social care: 57% had current involvement; 19% were previously known but their case was currently closed; 23% had never been known to social care.
- In contrast to the high proportion of children known to social care, only a minority were on a child protection plan. At the time of the harm or fatality, 40 of the children (17%) had a child protection plan. A further 30 children had been the subject of a plan in the past.
- Thirty-three children (from 166 reports available) were or had previously been looked after by the local authority. Of those, 12 had died and 21 were seriously harmed. Nearly three-quarters of these children were aged over 11 years.

2.7 Background characteristics of the family and child

As with previous periodic reviews, the team scrutinised the SCR reports for information on parent, family and child characteristics.

2.7.1 Parent and family characteristics

The presence of various parent and family characteristics drawn from this analysis is displayed in Table 14 and Table 15. The numbers we present are those in which a particular feature was specifically identified in the SCR. The failure of any particular feature to be noted could indicate that the factor was not present in the family, or was present but not mentioned in the report. As such, these figures represent a *minimum* prevalence for each factor in this cohort. Further, it is important to be cautious in interpreting the comparative prevalence of characteristics in mothers or

fathers, because it may be that there was little information about the father, or that the review did not consider the father's role especially relevant so did not report it.

Table 14: Parental characteristics - frequency noted in SCR final reports (total cases=166)

Characteristic	Mother	Father	Father figure/ mother's partner	Both	Total number (%) where parental characteristic reported
Mental health problems	58	11	1	22	92 (55)
Adverse childhood experiences	27	8	0	22	57 (34)
Alcohol misuse	24	10	1	22	57 (34)
Drug misuse	19	13	0	25	57 (34)
Criminal record	7	34	6	6	53 (32)
Of which, violent crime (excluding domestic violence)	*4*	*19*	*6*	*2*	*31 (19)*
Known to CSC in childhood	19	7	1	11	38 (23)
Intellectual disability	9	5	0	11	25 (15)

Parental characteristics

The most prevalent parental characteristic reported in these SCRs was mental health problems (noted in 55% of SCRs), particularly for the mother but also for the father (and note the 'Both' column). Parental alcohol or substance misuse were each noted in 34% of SCRs. In 34% of SCRs parental adverse childhood experiences were noted and 23% had been known to CSC in childhood. As with all these factors, this is likely to be an underestimate, as many SCRs did not provide details of the parents' backgrounds. Of particular note was the number of SCRs reporting parental criminal records (32% of SCRs, of which over half reported violent crime). The proportions reported for each parental characteristic are almost identical to the 2014-17 review.

Parental mental health problems occur more commonly in the SCR population than the general population: almost 17% of adults in England were estimated to suffer from depression, anxiety or other common mental health problems in 2017 (Public Health England 2021). However, mental health problems occur in similarly high frequencies in families requiring social care support. Poor mental health of the child, parent/carer or another person living in the household were a factor in 43.5% of completed children's social care assessments (Department for Education, 2019).

In 15% of these SCRs, parental intellectual disability was reported to be a feature, a higher proportion than in the general population. Approximately 2% of adults in the UK have a learning disability (from mild to profound), but a further 7% may have borderline learning disabilities impacting on their ability to function in daily life. It is not clear however how many parents have learning disabilities, and it can be difficult to distinguish parents who do have learning disabilities from those who do not (Working Together with Parents Network, 2021).

The frequency of alcohol and substance misuse within this cohort is much higher than in the wider UK population. The Health Survey for England 2019 shows that in the general population only 5% of adult men drank at higher risk levels (over 50 units of alcohol per week) and 3% of adult women (over 35 units per week) (NHS Digital, 2020). The figures within the SCRs are more aligned with those of families involved with children's social care: familial drug misuse was a feature in 21% of completed child social care assessments in England during 2018-19, and alcohol misuse a feature in 18.3% (Department for Education, 2019).

Overall, 129 SCRs (78%) reported at least one of these parental characteristics as being present; 95 (57%) reported two or more; and 46 (28%) at least four.

Table 15: Family characteristics - frequency noted in SCR final reports

Family characteristic	2014-17 Total number (%) where characteristic reported N=278	2017-19 Total number (%) where characteristic reported N=166
Domestic abuse	164 (59)	92 (55)
Poverty	97 (35)	82 (49)
Parental separation	150 (54)	80 (48)
Of which, acrimonious separation	*41 (15)*	*28 (17)*
Social isolation	51 (18)	47 (28)
Transient lifestyle	81 (29)	46 (28)
Multiple partners	67 (24)	46 (28)

As in our previous national analyses, domestic violence/abuse was a common finding (reported in 55% of SCRs). Parental separation was also common (48%, of which over a third were felt to be acrimonious separations). Of particular note, 49% of SCRs noted indicators of poverty or economic deprivation as a feature in the case (notably increased from 35% in 2014-17). Overall, 140 SCRs (84%) reported at least

one of these family characteristics as being present; 112 (67%) reported two or more; and 41 (25%) at least four.

2.7.2 Child characteristics and experiences

A range of child characteristics and experiences were noted in the SCRs as background factors rather than the direct cause of the harm that led to the SCR. Two have been added since the previous triennial review: child criminal exploitation (CCE) and peer on peer violence. Similar to the last review, over two-thirds of the SCRs for children aged 11 and over reported mental health problems for the child (37/54, 69%); alcohol misuse was reported for nearly 30% of the over-11s, and drug misuse for over 40%, see Table 16.

Focusing on the over-11s, over a third were known or suspected to have been subject to some form of child sexual exploitation in the past (20/54, 37%). This is an increase from 24% in the 2014-17 review. We have to be cautious because the numbers are relatively small and it may be a random fluctuation; we cannot say for sure whether the increase reflects greater incidence or greater awareness on the part of practitioners (or what combination of those). This is an important topic for further research (see Karsna and Kelly, 2021). Overall, the data suggest that the children and young people at the centre of SCRs are likely to have experienced other forms of maltreatment prior to the incident that led to the SCR.

Table 16: Child experiences and features

Characteristic	<1 year n=62	1-5 years n=36	6-10 years n=14	11-15 years n=28	16+ years n=26	Total (%) N = 166[11]	
Mental health problems	-	-	1	18	19	38	(56)
Behaviour problems	-	2	4	19	22	47	(45)
Drug misuse	-	-	0	11	12	23	(34)
Bullying	-	-	1	10	10	21	(31)
Child sexual exploitation, CSE	-	-	0	9	11	20	(29)
Disability	5	9	4	12	11	41	(25)
Alcohol misuse	-	-	0	8	8	16	(24)
Peer on peer violence	-	-	0	7	7	14	(21)
Child criminal exploitation, CCE	-	-	0	5	7	12	(18)
Intimate partner violence	-	-	0	3	2	5	(7)

[11] For behaviour problems, we excluded children aged under 1 year (n=104). For alcohol and drug misuse, mental health problems, bullying, CSE, CCE and peer on peer violence we excluded children under 6 years (n=68)

Characteristic	<1 year n=62	1-5 years n=36	6-10 years n=14	11-15 years n=28	16+ years n=26	Total (%) N = 166[11]
Fabricated or induced illness	0	1	0	1	1	3 (2)

A quarter of the children at the centre of the SCRs for this period (41/166; 25%) were reported to have an impairment or disability prior to the incident, shown in Table 16. This is an increase from 14% in the period 2014-17. There was a sharp increase in the numbers of children with a complex/combined disability. Although the numbers in our study are relatively small, the data chime with the strong evidence from other research that disabled children are at greater risk of maltreatment, and practice responses 'at best inconsistent' (Franklin *et al*., 2022: 7).

Table 17: Child disability prior to incident

Nature of disability/impairment	2014-17 Total (%) n=40	2017-19 Total (%) n=41
Complex/combined disability	5 (13)	12 (29)
Social/communication disability	5 (13)	8 (20)
Chronic, disabling condition	7 (18)	8 (20)
Young child with developmental delay	4 (10)	4 (10)
Physical impairment	4 (10)	2 (5)
Intellectual/learning disability	10 (4)	2 (5)
Sensory impairment	1 (3)	0 (0)
Nature of disability unclear or unspecified	4 (10)	5 (12)

Summary points

- The most prevalent parental characteristic reported in the SCRs was mental health problems (noted in 55% of SCRs), particularly in the mother but also in the father or male partner.
- Parental alcohol or substance misuse were each noted in 34% of SCRs. In 34% of SCRs parental adverse childhood experiences were noted. Of particular note was the number of SCRs reporting parental criminal records (32% of SCRs, of which half reported violent crime).
- Mental health problems were reported in 69% of the SCRs for young people aged over 11; alcohol misuse was reported for nearly 30% of the over-11s, and drug misuse for over 40%. More than a third of the over-11s were known or suspected to have experienced some form of CSE in the past, and more than 1 in 5 were reported to have experienced CCE and/or peer on peer violence.
- A quarter of the children in these SCRs were reported to have a disability prior to the incident.

Chapter 3: Neglect in Serious Case Reviews

SCRs over the period covered by this and previous biennial and triennial reviews show that neglect is rarely a direct cause of death or the primary cause of non-fatal serious harm. However, neglect features consistently as a contributing factor to, or in the background of, child death and serious harm. Neglect featured in nearly three-quarters of the 166 SCRs examined for the current 2017-19 overview (124 of the 166, 74.7%), an almost identical proportion to that in the 2014-17 study.

Given its prevalence in SCRs, neglect has been a focus in previous periodic reports (Brandon *et al.*, 2012, 2020; Sidebotham *et al.*, 2016). There was a chapter on it in the 2014-17 review (Brandon *et al*., 2020), which highlighted three themes: poverty; the complex and cumulative nature of neglect; and the invisibility of some children and young people to the system.

We return to the theme of neglect in this final overview, given its frequency, its potentially deep and long-lasting effects and the challenges of identifying and overcoming it. As one of the reviews in our current cohort put it:

> *Chronic neglect can be more damaging than other forms of maltreatment because its impact is the most far-reaching and difficult to overcome. Neglect in the early years will also have consequences for later mental health and social functioning of the individual who is exposed to this. Later interpersonal and social problems demonstrated by the children may all be consequences of the psychological impact of neglect.*

In this chapter, we explore the notion that there continues to be a 'normalisation of neglect' among professionals and safeguarding services, as identified in both the 2011-14 and 2014-17 periodic reviews:

> *The reviews suggest that professionals become 'accustomed to working in areas with large numbers of children and high deprivation'. As a result, there may be a normalisation and desensitisation to the warning signs of neglect such as poor physical care, smelly and dirty clothes, or poor dental care.* (Brandon *et al.*, 2020, p. 63).

The relationship between deprivation and neglect and abuse has been much debated over many (Bywaters *et al.*, 2016; Bywaters and Skinner, 2022). Debates centre on the extent to which poverty may be a cause of neglect, and on how practitioners understand and respond to these issues. Of course, not all poor children are neglected and not all neglected children are poor, but it is widely accepted that poverty is a 'contributory causal factor' for abuse and neglect (Bywaters *et al.*, 2016, p. 33).

For practitioners, a core challenge is how to identify and respond to neglect, often in circumstances where many of the families with whom they work are living in poverty: what are the causes of neglect, what are the signs and symptoms, where should they focus their efforts to help and at what point is it necessary to consider the household conditions and treatment of the child unacceptable.

SCRS show that there may be a lack of willingness, time, or ability to identify indicators of neglect as 'neglect'. Neglect is often unaddressed, and signs of neglect may not always be recognised as such by frontline staff. Multiple indicators of neglect have been summarised from the research (NSPCC, 2022) and should be used by professionals to identify when families and children are suffering or at risk of neglect (see Appendix G for full list).

3.1 Methods

Twelve SCRs from the 2017-2019 cohort were chosen for the in-depth qualitative analysis of these themes. The cases were selected to include a breadth of ages and geographic areas. A higher proportion of those selected were in the age 1-10 years group (n=6), as described in Table 17.

Table 18: Description of cases selected for the in-depth analysis of neglect

	Under 1s	1 to 10 years	11 to 15 years	16+ years
Total SCRs included in qualitative analysis	3	6	1	2
Death	1	1	-	-
Serious Harm	2	5	1	2
CP plan under category of neglect	1	1	-	-
Children with complex physical and/or mental health needs[12]	-	3	1	-
Parents with complex physical and/or mental health needs[1]	3	3	-	1
Geographic spread	West Midlands, East Midlands, East of England	East Midlands, East of England, South East, London	North East	South West, South East

[12] This also includes learning disabilities

3.1.2 Family characteristics

Of the cases included in this qualitative analysis, two children had no other siblings at the time of the incident, although in one case the mother was pregnant. Two others had one sibling. All other children were part of multiple child households, with at least five siblings in some cases, although for some families the number of children was not noted in the SCR.

Poverty was noted as a characteristic of the family background in eight of the 12 SCRs. For the remaining four, there was no information given in the report which would specifically indicate the family were living in poverty.

Based on the age of the child who was the main focus of the SCR in this sub-sample, the children over the age of 12 months spent their entire lives living with neglect to an average age of 9 years and 8 months [age range = 2.5yrs to 18yrs plus]. But it is worth noting that five of these cases involved families of multiple children [n=3-5], and in cases where there were older siblings they may have been exposed to chronic neglect over a much longer period of time.

The qualitative analysis identified five themes:

- Normalisation of neglect: neglect in the context of poverty
- Complexities around identifying neglect
- Information exchange
- Dealing with difference
- Patterns of disengagement and withdrawal from services.

3.2 Normalisation of neglect: neglect in the context of poverty

Historically there has been a noted lack of recognition of the impact of economic hardship by frontline staff on parenting capacity (Brandon *et al.,* 2016) despite the evidence which indicates that living in poverty increases risk to children (Wolfe *et al.*, 2014; Bywaters *et al.*, 2016). A recent review (Bywaters and Skinner, 2022) concludes that 'family poverty and inequality are the key drivers of harm to children', updating Bywaters *et al.* (2016) with a stronger international evidence base. This acceptance was highlighted in the previous triennial review, which described 'the abnormal being normal':

> *The response of many agencies too often suggests that there were limited expectations of the young people, their families and what life was likely to hold for them. The reactions of agencies suggest a high tolerance towards damaging and worrying experiences, parenting and life chances that in other*

> *settings in the community would simply be unacceptable (Brandon et al., 2020).*

The normalisation of neglect among professionals was identified explicitly in a number of SCRs in this review. This normalisation of the neglectful conditions that children have experienced, often long-term and without sustained improvement, means that in many cases the children have been living with neglect for a long period of time.

3.2.1 Desensitisation of professionals to neglect

The normalisation of the neglect which some children experience is most often observed among professionals who are engaged with families in areas of high social and socio-economic deprivation. One SCR selected for this in-depth analysis highlighted specifically that:

> *Professionals had insufficient clarity on the level of neglect. Use of a neglect assessment tool […] in this case would have provided professionals with greater clarity regarding the level and impact of neglect in this family.*

High rates of deprivation are known to present complex challenges to protecting and safeguarding children. Moreover, the endemic levels of poverty in some areas results in a blindness to poor living conditions, where these are seen as normal (Daniel, Taylor and Scott, 2010). As such, identifying neglect becomes more challenging for professionals and levels of concern remain lower than they would in areas with less socio-economic deprivation. As Bywaters and Skinner (2022) note however, it is not only about the levels of poverty in a given area, it is also about the circumstances and context within that environment. One SCR author noted that

> *[There are] a number of reviews underway […] where there has been a delayed response to aspects of neglectful parenting, and in many of these cases the families have experienced significant poverty which appears to inhibit professionals from being assertive in their interactions with parents, meaning they do not respond to clear risks presented to children.*

Neglect is rarely isolated to only experiencing one of its many forms (Appendix H) and it also often accompanied by physical and emotional abuse. It is also a factor in and contributor to ongoing CSE/CSA (Daniel, Taylor and Scott, 2010). One family in our sub-sample had high levels of neglect, with two child protection plans for neglect over seven years. It was only when the children were removed that they talked about the CSA they had experienced as well. These other forms of abuse sometimes become the focus of protecting children, which subsequently contributes to a lack of focus or understanding of the extent and impact of neglect (Daniel, 2015). Poverty, desensitisation to poverty and low levels of parenting expectations may result in

neglect being downgraded, rather than identified and the impact of ongoing neglect being considered in relation to the child's lived experience (Brandon *et al.*, 2020). Moreover, professionals may be reluctant to identify neglect because they feel powerless to do anything about poverty. They may be unwilling to further stigmatise parents by identifying neglect where families are experiencing severe poverty. They may also fear disrupting the relationship between parent and professional in areas where poverty is endemic: the issues may present as 'normal' in the context of that neighbourhood, rather than being seen as neglect. One review author went to visit the local area before writing, stating that 'the poverty in the area is palpable', and then expounds:

> *The area has experienced a higher than national average birth rate and a significant increase in the numbers and proportion of school-age children in the population. One in seven children have a special educational need or disability. When these statistics are combined with high indices of deprivation, poor housing, and a greater proportion of those from Black and minority ethnic groups, the pressure on the provision of health and other services for children and their families is understandable.*

In a different review that was reflecting on a series of other similar SCRs ongoing in the area, the author states:

> *It is thought that one aspect that is relevant may be the levels of poverty in the region, and the difficulties this poses for professionals when intervening with families. In this case it was felt that this family may have presented as normal in [city], given the generally high levels of poverty, which may have led to professionals having lower levels of concern.*

3.2.2 Focusing on practical tasks rather than neglectful parenting

Many practitioners are dealing with the effects of socio-economic hardship and complex cases, often with high parental need. Two of the SCRs pointed out the need for specific training to help practitioners assess the extent to which poverty was contributing to neglect, alongside other causes and forms of neglect. Normalising poverty in areas of high deprivation and times of increased economic need sometimes results in professionals misinterpreting neglect for poverty, and having a focus on providing practical support, e.g., provision of baby goods, rather than seeing the lack of access to appropriate environments as an indicator of neglect.

> *Professionals lost sight of the domestic abuse and violence that had been reported and became focused on the housing situation; the view being that if the family had secure and appropriate housing then "everything would be alright".*

In another:

> *The focus was on young parents and lack of access to things like a steriliser, and the provision of support to parents vs safety of the baby – and not seeing a young parent as a child themselves.*

Contextual poverty, where poverty is related to drug habits or mental ill health, also links to professional perceptions of risk, and risk assessment thresholds. For example, parents with identified current or historic drug or alcohol misuse who are known to adult services may not have their parenting capacity adequately assessed. The risk of their own substance misuse behaviours is not considered in the context of their ability to provide adequate parenting to their child. Two cases specifically highlighted this focus on providing practical support to parents that resulted in the underlying issues being overlooked. In these cases, developmental milestones not being reached were seen as individual issues which required support, rather than being understood as part of a wider picture of parenting and the child's circumstances. This resulted in children who were visible to services being left in conditions of long-term neglect:

> *What is striking about the health professional contacts is that although these were relatively frequent … they were very 'task focused'; for example, on weight, feeding, immunisation or examination of hips. There was scant evidence of a more holistic approach to assessment of [child]'s health, development and lived experience. This is important because it would have provided an earlier, clearer picture, of the inadequacy of parenting and the emergent indicators of child neglect.*

This is also apparent in cases with children who have multiple and complex needs, who are also represented within this sample of cases (see also Chapter 4).

> *Safeguarding and wellbeing needs were not fully considered as part of multi-agency practice at the time, with the professional focus concentrating on managing his disabilities and health needs.*

The fact that disabled children are known to be at higher risk of neglect and abuse is something which is highlighted both in the literature (Taylor, Stalker and Stewart, 2016; Jones *et al.*, 2017), and in previous biennial and triennial reports.

In one traveller family there had been much observational reporting, but consideration of the children's lived experience was missed:

> *The potential signs of abuse/neglect observed by the professionals who visited the family at home were largely left unchallenged, the view was that the parents were doing as well as expected in the circumstances that they were living in and if some permanent accommodation could be found this would help, especially in giving the younger children more space to play in.*

What was absent from the plan was how the impact of the environment…was having a detrimental impact on their development and attainment, and how the cumulative effect was assessed.

Safeguarding concerns were raised anonymously … these were not fully investigated with no visit being undertaken to the home and only one agency being contacted. This seems to have been on the basis that the calls were anonymous. …There may be a need for some reconsideration of the relevance of such information to safeguarding children.

The parents were committed to one another in as much as they had several children together and despite periods of separation always resumed their relationship, and the siblings and parents were perceived to be 'close-knit'. The strengths of this cohesive family unit were neither examined, nor conversely supported.

3.3 Complexities around identifying neglect

Where parents are perceived as being more difficult to work with there has also been a noted unwillingness of professionals to challenge them at the perceived risk of alienating parents (see also Chapter 4). The hope for a constructive relationship with the parents seems to take precedence over a focus on the child's lived experience:

Professionals working in the safeguarding network are reliant on there being an open and honest relationship with the family that they are working with. If this trust and partnership working breaks down the danger is that there is no clear understanding of what is happening within the family, the possible increased risks or the lived experience for the children.

Professional optimism errs on the side of wanting to think the parents are doing the best job possible and wanting to keep the doors of communication open in the practitioner/parent relationship:

Training does not necessarily help practitioners reconcile some of the inherent conflicts in a professional role which requires them both to value diversity and seek to empower the most vulnerable parents, yet take decisive and ultimately disempowering action when child protection concerns become extensive (Brandon et al., 2014).

Such optimism contributes to an unwillingness to name neglect. Moreover, this avoidance may be connected to a practitioner's perception of neglect as being a non-deliberate act, perhaps particularly where there is co-existing poverty. In cases where parents are unable to prioritise the needs of the child, combined with an optimism that for this family, more support and time will result in improvements in

parenting, naming ‘neglect’ may be seen as an accusation or judgement. This tendency may be increased by the context in which children’s services are working, of the increased pressures of wider, more complex caseloads and a reduction in staffing. One SCR asked:

> *Are workload pressures on Children’s Social Care in [city], resulting in all practitioners narrowing their focus and responding purely to the presenting problem, the system therefore deterring wider assessments of need?*

Brandon *et al.* (2014) acknowledged that health and education professionals and social workers often find it difficult to identify indicators of neglect or recognise their severity. Unlike physical abuse, neglect does not usually produce an immediate and noticeable crisis to which there could be a response. In some cases, it is an incident of physical or sexual abuse which triggers further investigation, whereas the underlying problem would have been neglect.

Where parents have their own additional needs, either substance misuse, or mental ill health, physical health needs or learning disabilities, there is the further possibility that even with intensive support they are unable to create and sustain change for their children long-term. This is an issue which has been identified in the SCRs where complex parental needs formed part of the background to long-term neglect:

> *Research also indicates that where parents were themselves abused or neglected in childhood there is an increased risk of maltreating their own children. It has been suggested that the more severe abuse or neglect experienced by parents in childhood, the more difficult it is to resolve losses and traumas, and the greater risk that parents will maltreat their own children.*

3.4 Information exchange

Five of the neglect sub-sample cases highlighted problems caused by a lack of adequate systems for reporting and recording neglect; fragmentation of services; and difficulties in information-sharing policies and processes between services. The higher number of services there are involved in a case may increase the risk of inaccurate and inadequate information-sharing, meaning that there is no coherent overview of the daily lived experience of children and the level of neglect which they are experiencing. One author noted that they had

> *Concerns as to the way in which professionals have worked together in terms of the identification of safeguarding needs and the lack of escalation of these to provide Child […] with an appropriate level of help and protection.*

Another observed:

> *It is possible that staffing problems within Children's Social Care created a decision-making vacuum, and consequently the agencies lost the focus on the need to exchange information effectively. This multi-agency approach should have been the modus operandi of the Core Group; as such it would be expected in the absence of an allocated social worker that monthly meetings would have continued to be held and chaired by a representative of one of the other agencies involved with the children.*

The policies and structures which inhibit the routine sharing of data between health and education services were identified in one SCR (see also Chapter 4). These included the responses to anonymous calls about children, Team Around the Child processes, and the role of children with disabilities teams. The SCR concluded that a more effective system could help in identifying children who are missing education or not accessing health care and facilitate inter-agency communication.

Another SCR found that there were 'two separate systems' for working with a family, both within the local authority children's services department:

> *… one focussed on managing a family in the community who disrupted life for their neighbours and a separate process focused on the child protection system that protected and safeguarded children. Although both came under the remit of children's social care to those outside the system, within children's social care the processes were quite distinct and information shared in one forum was not automatically available to another.*

The pressures on staffing across children's social care and other services can contribute to situations where children are subject to neglect over a long time period, as noted by another SCR author:

> *The homelessness manager perceived that the frequent change of personnel in children's social care meant that a consistent approach, an awareness of how the family operated and what had already been tried unsuccessfully got lost.*

This links with what Brandon *et al*. (2008) referred to as the 'start again syndrome', where current cases were not informed by past history. To deal with overwhelming information, practitioners put aside knowledge of the past to focus on the present. This was a clear finding in the biennial analysis 2003-2005 and we see the same tendency in the current review.

The police and cases of neglect

Police officers will attend incidents on a regular basis where they will come into contact with children and young people who have been neglected and are living in circumstances that are harmful to their welfare. The SCRs expressed concern about the training police officers have in recognising and responding to neglect. This included officers' knowledge, and compliance, in completing a graded care profile (GCP2)[13] assessment tool for neglect. One SCR called for

'*an explicit focus in policy and training on the distinction between neglect caused by poverty and other forms of neglect'.*

A number of police officers do actively look for, recognise, and understand neglectful situations for a child as evidenced in the following comment in one SCR:

'It was agreed by the health visitor and midwife that the police would be asked to undertake a safe and well visit. Police were able to gain access. They saw both Eleanor and her sibling, who appeared well cared for and in good health. Father changed the sibling's nappy and mother fed Eleanor whilst the police were at the address. The police checked cupboards for food and noted that there were age-appropriate toys present. The police subsequently submitted the appropriate safeguarding documentation and passed the information back to the midwife who shared the result with the health visitor'.

3.5 Dealing with difference

Four of the 12 SCRs noted issues around culture and potential gaps in the cultural competence of practitioners. This may manifest in the way in which families are seen through lenses of bias and stereotype. These prejudices inform the way in which parenting is viewed, and the levels of parental expectations.

There may also be a fear of being seen as racist or prejudiced when challenging families who are from different backgrounds (Laming, 2003). One review (concerning working with Pakistani families) referred to this as a '*gap area with little wider awareness and no training available … [this can contribute to a] lack of curiosity and potentially a reluctance to ask or challenge things in case this may be viewed as offensive or not even considered'.*

Where practitioners were supporting families from other countries and/or cultures, the SCRs noted inequalities in offering the appropriate levels of support. Where this

[13] The Graded Care Profile 2 (GCP2) is an assessment tool which helps practitioners measure the quality of care a child is receiving Evaluations of the tool have found it to be helpful in identifying whether a child is at risk of neglect (Smith et al., 2019).

applied to traveller families, biases and assumptions of behaviour led to the children being identified as perpetrators rather than being vulnerable in their own right:

> *Professionals that worked with the family had a varying understanding of how to work with travellers, poor knowledge of cultural beliefs and lifestyle. For some professionals this was the first case that they had worked with traveller families. The visits and interaction with the family became overly focused on recording what they had observed rather than analysing and assessing the impact of the situation in relation to the safety of the children.*

Case study: dealing with difference

A large and complex family of traveller heritage had multiple children of varying ages. The family was well-known to agencies due to their perceived challenging and intimidating behaviour. The family had moved 10 times in 12 years and their travelling heritage influenced how they were perceived in the community.

One female child was raped by her half-brother when she was aged 15. Once reported, there was social care involvement and an SCR was undertaken. However, previous allegations of rape and sexual abuse, which also included physical abuse from another female sibling to terminate a pregnancy, do not seem to have been treated with the same level of urgency.

The mother was known to have multiple mental health needs. The father did not engage with professionals, he was known to be aggressive and there was a history of domestic abuse within the family. Neighbours were attacked by the parents, but would not pursue criminal action against the family for fear of reprisals. Practitioners reported being afraid of the father. Whilst the parents were known to be illiterate, professionals continued in writing to them.

The family felt that people were prejudiced against them because of their heritage. The family refused police involvement in the Team around the Family meetings, though the police were one of the few agencies with information about the sexualised behaviour the children were displaying. This led to a lack of information sharing across services. The family was considered a ‘hot potato’ and passed around quickly:

The risks focussed on in these meetings were around housing and anti-social behaviour, with the older children perceived as part of the problem. Other risks around education, health and emotional wellbeing, domestic abuse, suspected sexual abuse and neglect did not feature.

There was a lack of focus and understanding of the lived experience of the children because all interactions with professionals focused on addressing criminal behaviour and they viewed the children as complicit in such behaviours. Reports of rape,

genital soreness and injury, and displays of sexualised behaviour from all the children were not flagged as indicators of sexual abuse. The difficulties which professionals experienced working with the family continued to 'mask' the neglect. Lack of school attendance was viewed as a compliance issue rather than a symptom of the ongoing neglect.

3.6 Patterns of disengagement and withdrawal from services

Three of the SCRs in the neglect sub-sample referred to children being 'hidden in plain sight'. Children not being brought to health appointments remains a safeguarding issue (Powell and Appleton, 2012). Often combined with lack of professional challenge to parental accounts, this may also be exacerbated by the way in which other universal sources of support, such as health visiting, are 'opt-out' services – that is to say, although they are offered to all they are not compulsory, and parents can decline them.

Such withdrawal affects both children who are hidden from services, and children who are 'hidden in plain sight' – that is, when they are being seen, perhaps for medical outpatient appointments, or where there is apparent cooperation from their parents, but their needs go unrecognised. Some SCRs report elements of good practice in the face of parental resistance: for example, some authors highlighted the tenacity of individual health visitors who continued to try to gain access to see children who they considered to be at risk, rather than accepting lack of engagement as inevitable. Given an increasing workload for practitioners, this persistence in the face of parental withdrawal and refusal to engage may feel hard to achieve (see also Chapter 4).

Case study: parental withdrawal from services

Rosie was admitted to hospital at 3½ years old, having suffered long-term neglect which left her with a life-threatening illness. At the point of her admission, she was found to be severely malnourished and in poor physical health. She was unkempt, socially isolated and developmentally delayed. The ongoing neglect which Rosie experienced means she will need specialist care for the rest of her life.

The family lived in a deprived area and had been receiving support from a range of universal services. Both parents had histories of substance misuse. Rosie's father had a history of previous domestic abuse and there were low levels of wider family support. Rosie's mother later disclosed learning difficulties.

Rosie was seen a number of times by professionals in her first two years, but all appointments were task focused (weight, hip dysplasia, infection) rather than

focusing on Rosie's daily lived experience. Despite a safeguarding referral from midwifery services in the antenatal period, an early assessment of parenting capacity through a pre-birth assessment was missed by children's social care. This may have enabled more protective input for Rosie from birth.

The report author notes that Rosie was:

'neglected by parents whose capacity to parent had almost certainly been limited by their own adverse childhood experiences and multiple known difficulties in their adult lives'.

There was little professional curiosity shown about Rosie's missed appointments, both at the children's centre and for paediatric appointments, or her lack of attendance at any kind of educational or out of home provision. Her weight dropped significantly below normal levels and continued to sit below the expected norms for her age. Children usually begin to bear weight on their legs at two-four months and to walk at between 10-18 months. Rosie was not weight bearing at one year, she was not walking by 20 months, and had failed to meet most of her developmental milestones. However, there was no recording of the Ages and Stages Questionnaire being undertaken at any of the health visitor reviews (which would have been expected), and the parents were resistant to a number of parenting interventions that had been offered.

Although this pattern of parental withdrawal is predominantly relevant to younger children, older children may withdraw themselves and hide the signs of their neglect. One SCR notes the findings of a JTAI (Joint Targeted Area Inspection) report on multi-agency responses to older children who are experiencing neglect (Ofsted *et al.*, 2018), that the neglect can go unseen, and also that this group can be skilled at hiding the impact of neglect:

> *Neglect may present differently in older children and agencies may respond to the symptoms of neglect rather than the cause.*
>
> *The act of reporting the neglect may also be something that is challenging for older children to do. It is crucial to remember that their behaviour, especially changed behaviour, might be a form of communication and an opportunity to open conversations should be noted by professionals in contact with these children.*
>
> *The elder sibling carried the heavy burden about what was happening within the family over a period of many years. This included time when they were enrolled at a faith school. Loyalty to parents and not knowing how to share concerns within the school community was a factor that prevented earlier help-seeking. Teaching staff at the school were perceived as friends of the parents.*

3.6.1 Social networks

Where some children are hidden from services, they may also be hidden from family members. In other cases, the extended family may be concerned yet unable or unwilling to report, or do not understand the level of neglect that the children are experiencing. As one SCR found:

> *There may well have been family members or neighbours concerned about [child]'s welfare, and it is important to understand why no concerns were raised by members of the public. Building social capital (i.e. social networks, neighbourliness) can help to create more cohesive and supportive communities that help to prevent child neglect and other forms of maltreatment (Turney and Taylor, 2014). This becomes especially important in times of austerity, both because of the increased risks to children who live in poverty and because of cuts to public services.*

The lack of social capital isolates children and families from not only their local services, but also from potential avenues of support within the community. There may also be assumptions made about families who are from specific backgrounds in terms of having a wider social network, where this may not actually be the case, or where the family is only on the periphery of this network and not actively seeking support.

3.7 The impact of long-term neglect on the children

Long-term neglect can have far reaching impacts on children's health and emotional and physical well-being. In four cases in our sub-sample children removed after long periods of neglect were found to be in poor health, reflecting the impact of their maltreatment. This was a combination of imprisonment in the home resulting in lack of exercise as well as no or limited access to sunshine and fresh air. Combined with poor nutrition this can result in severe malnourishment, which may have lifelong impact on a child. This is compounded by lack of access to socialisation with other children and adults:

> *All the children had multiple unmet health, education, developmental, nutritional and social needs. They were dressed in ill-fitting shared family clothing and lacked awareness of basic road safety. Lack of daylight had impacted on their vitamin D levels and the inability to engage in outdoor exercise had seriously limited their development of gross motor skills. None of the children could swim or ride a bicycle. One sibling was described as 'hunched and immobile' and displaying signs of rickets.*

The long-term impact of neglect on development is not only more pronounced in the early years, but this is also likely to be a particular risk for children with additional needs, which may be exacerbated by long-term neglect, the ongoing impact of which has been widely recognised (Brandon *et al.*, 2014).

Case study: long-term neglect

Billy had learning difficulties and autism. He had no daily routines at home. He had not been seen by any health professional from a very young age, and on being taken into care at the age of nine, he was very underweight. By the time of the SCR his developmental and communication difficulties were significant.

Billy was the youngest of six children. In his first year of life he was not taken for all his immunisations and missed an audiology appointment. It is not clear if or how the missed appointments were followed up. In addition, Billy's mother was sent a developmental progress questionnaire when he was 2 years old, which was not returned, with no further follow-up by the health visiting service. The SCR said:

[A child] who has significant developmental and communication needs, was effectively 'hidden' from view, having apparently not been seen by any professional since the age of 14 months [to 9 years]. The effect of the toxic stress and maltreatment that all the children suffered has been recognised to have compounded Billy's learning difficulties and his confirmed diagnosis of autism.

The children were seen and removed from the family home following a report from an older sibling who was no longer resident in the country. He was concerned for Billy particularly and remembered ChildLine from his own minimal time in school.

The registered GP was not aware that the children were home schooled – there is no necessity to inform GPs under typical circumstances. The parents did not engage with professionals and withdrew from all services. There was a reliance on parental reporting of any issues, for example, housing services were in regular contact about maintenance, but much of this was telephone based. The Education Welfare Officer took at face value the parental reports of leisure activities outside the home. The children were not spoken to without the parents being present, and Billy in particular was kept quiet and hidden by older siblings when these sporadic visits did occur.

3.8 Recommendations to reduce the risk of normalising neglect

This section draws together the recommendations from across the qualitative sample which focus on reducing the risk of long-term, normalised neglect. The SCRs show the difficulties practitioners sometimes had in noticing the indicators of neglect and

recognising the point at which the threshold for action had been reached. One author suggested that professionals should be supported and trained to make decisions based on '*the observable impact'* of neglect on a child, but that requires them to see the child regularly and to understand what they are observing. Recommendations to help to achieve this were:

Tools

- introducing a recognised neglect tool (for example GCP2) and providing training to key professionals in its use;
- developing the culture and collaborative working arrangements to make such tools more effective;
- ensuring neglect tools are being consistently used across all services by professionals trained in their use.

Information-sharing

- that partner agencies review their information-sharing processes regarding emerging concerns about neglect (including all aspects of health) especially when a child moves within and between local authorities;
- consistent information sharing and clarity on plans and responsibilities, particularly at points of handover, re-opening of cases and case closure;
- prompting professionals to use descriptive language that conveys what they are seeing and what they mean in understandable terms.

Contribution of disadvantage

- an explicit focus in policy and training on the distinction between the effects of poverty and forms of neglect.

Partnership working and leadership

- better implementation of lead professional and case coordination responsibilities;
- review the effectiveness and ability of all partners to deliver the partnership's neglect strategy, and identify any barriers that may prevent this.

Recognition of wider vulnerability factors

- children who live in families where violence and anti-social behaviour are significant factors in the community, should be considered by all professionals who have contact with them as children who are vulnerable to serious harm,

including when the children/young people may be the perpetrators of the violence or antisocial behaviour.

Cultural considerations

- a strategy for improved service provision and competence in working with families in minority ethnic communities;
- to identify and equip all staff with the confidence and skills to enable them to work with clients from cultural and diverse backgrounds, and the competency to challenge other professionals in a non-confrontational manner.

A number of partnerships have introduced 'neglect strategies', and they were referred to in four of the 12 SCRs. There are variations between them, but in broad terms a neglect strategy is intended to show a partnership-wide commitment to reducing neglect by identifying guiding principles and priorities and improving awareness. They may offer definitions of neglect of various kinds, its impact on children at different stages of their development, and measures of success in tackling neglect. They will set out the way in which practitioners should be identifying neglect, and identify the tools that are available for them to use when they suspect or are addressing it. The safeguarding partnerships which were part of the SCRs in the sub-sample named a range of these, including GCP2 (Smith *et al.*, 2019); Signs of Safety (Turnell and Edwards, 1999); the NSPCC Neglect Toolkit; and the Strengths and Difficulties Questionnaire (Goodman, 2001). We are not able to say how well these strategies are working, but note that they operate at a partnership level and as such describe wider objectives and priorities; the challenge, as always, is to ensure that they make a difference at practice level.

Chapter summary

- Neglect has been a long-standing feature of SCRs over many years and has been discussed in previous biennial and triennial reports. There is wider recognition of the ongoing, cumulative impacts of neglect, but the SCRs show that it is not always identified and acted on.

- SCRs show the range of challenges around identifying long-term neglect, particularly understanding the impact of poverty. Neglect and poverty alike can become ‘normalised’ and not noticed.

- Practitioners need to observe and think clearly about the interaction of neglect and deprivation, and address both in their work with families and children. Practitioners also need to be sensitive to the impact of culture and race.

- In many cases the SCR authors noted that not only was neglect misidentified or downplayed, but there was a lack of focus on the daily lived experience of the child(ren). There were examples of children not being seen by professionals, or their voices not being heard.

- Effective information-sharing between practitioners and agencies is essential, especially if families or young people are disengaging from services.

Chapter 4: Professional practice

This chapter focuses on professional practice, identifying three key themes within the SCRs:

1. Engaging with parents – the complexities of ‘effective challenge’
2. Interprofessional communication and information-sharing
3. Professional disagreement, thresholds and escalation

These themes are drawn from an analysis of 23 SCRs which were sampled purposively according to the following criteria: the SCR identified issues around multi-agency working, the SCR raised specific dilemmas in relation to professional practice and reasoning, and/or the SCR examined the organisational aspects of practice with children and families. The 23 cases were analysed thematically to identify recurring patterns in professional practice, resulting in the three themes. A further analysis was conducted to ensure that the results reflected overarching issues within the 166 SCR reports. This chapter identifies several general principles of professional practice (e.g. effective communication and relationship-based practice) which are directly relevant to the specific topics analysed in Chapters 3, 5, and 6. For instance, the theme of the complexities of effective challenge, identifies the psychological barriers that prevent professionals from addressing neglect (Chapter 3) and hearing the voice of the child (Chapter 5). These areas of intersection are identified in the following analysis.

4.1 Engaging with parents: the complexities of ‘effective challenge’

A frequent practice issue identified by SCRs was a lack of ‘effective’ or ‘sufficient’ challenge on the part of professionals. This included occasions where professionals did not question parents’ account of events or where they appeared reluctant to investigate child welfare concerns. Effective challenge is a complex issue which can only be understood in the wider systemic and psychological context of work with families. This section considers effective challenge within this wider context. Examples from SCRs are described where a ‘lack of challenge’ was identified as a key practice issue. Two key barriers to effective challenge were identified:

- Workload issues and lack of time
- Relationship dynamics between professionals and families

4.1.1 Background: the complexities of ‘effective challenge’ in child welfare

The issue of effective challenge must be understood in the context of professionals’ relationships with families. Building a respectful, supportive relationship with parents and understanding their experiences is key to effective safeguarding. There are many challenges in engaging with families in the context of concerns about a child’s welfare. Practitioners must engage in delicate and sensitive dialogue with families, balancing the supportive aspects of their role alongside a sufficiently critical and investigative stance (Platt, 2008). The 2014-17 Triennial Review of SCRs (Brandon *et al.*, 2020, p. 109) emphasised the need for ‘authoritative practice’, combining supportive, relationship-based engagement with families alongside respectful challenge. In practice, this balance can be difficult to achieve. Lack of effective challenge has been a recurrent theme in high-profile child deaths (e.g. Laming 2003) which have identified critical moments where professionals failed to exercise sufficient curiosity and challenge to safeguard children. On the other hand, concerns have been raised about inappropriate and excessive challenge, where professionals adopt a ‘confrontational and at times aggressive communication style’ in their interactions with parents (Forrester *et al.*, 2008, p. 23). This heavy-handed use of challenge can make parents feel ‘feel less than human’ (Smithson and Gibson, 2017), accused and shamed (Featherstone, 2018) and is perhaps symptomatic of a broader, individualistic orientation to child protection which focuses on the detection and management of ‘risky individuals’ rather a support orientation (see Featherstone, Gupta and Morris, 2021). In response to these challenges, concepts such as respectful uncertainty (Laming, 2003, p. 205), healthy scepticism, assertive practice, professional curiosity and ‘confrontational empathy’ (Winter *et al.*, 2019, p. 230) have been used to capture the delicately-balanced, sensitive, relationship-based context in which effective challenge can take place in the context of child welfare concerns.

4.1.2. ‘Lack of effective challenge’ in the SCRs

The term ‘lack of challenge’ appeared frequently in the SCRs and the difficulties in adopting a sufficiently curious, challenging and investigative stance while maintaining partnership with parents was evident. There were instances where the balance appeared to tip towards supportive engagement at the expense of effective challenge. For instance, one SCR highlighted that:

> *Engagement is a legitimate and important objective but an exclusive reliance on engagement, if accompanied by a reluctance to make use of personal, professional and statutory authority, may not serve young people well.*

In that case, professionals prioritised the supportive and engaging aspects leaving the young person's risk-taking behaviour unchecked. ‘Insufficient challenge’ on the

part of professionals was a recurrent issue where there were persistent concerns over a long period, particularly in cases of medical neglect (see also Chapters 3 and 5). In several SCRs, the issue of non-attendance at medical appointments was identified as a missed opportunity for professional challenge and follow-up. For instance, one SCR reviewed the death of Mary, a 13-year-old girl who died following a severe asthma attack. In the years leading up to her death, repeated concerns had been raised about the poor management of her asthma and the conditions of the family home which may have exacerbated her condition. Throughout her life, Mary had not been taken to numerous medical appointments relating to her asthma. Professionals working with her mother adopted a supportive orientation, encouraging attendance rather than questioning absence. The review concluded that:

> *Professionals in the main, made too many allowances for her mother and were insufficiently challenging.*

While some SCRs simply highlighted lack of challenge as an issue, others sought to explore the systemic and psychological barriers which might explain why professionals might have been reluctant to challenge. These barriers are explored in the next section.

4.1.3 Barriers to effective professional curiosity and challenge: workload and time

Workload issues were identified within several SCRs as a barrier to effective professional challenge (see also Chapter 5). Asking questions that are sensitive or challenging is only likely to be successful in the context of an established relationship with the family. Such relationships are typically developed over weeks or months, rather than during a single visit. The workload challenges facing practitioners were highly visible in these SCRs. Practitioners were working in the context of limited resources, high caseloads, and high levels of staff turnover. One SCR concerned the death of a 5-week-old infant as a result of physical abuse. It was noted that the midwife undertaking the postnatal discharge visit had eight visits to complete on that day with a total of 15 minutes allocated for each of these visits. Within a 15-minute slot, there are limitations to the degree of professional curiosity, challenge and relationship-building that can be achieved. Such time restrictions make it difficult for professionals to ask the right questions and go beneath the surface to explore the hidden risks and dynamics of family life. Speaking to the mother alone and engaging with the child's father may have enabled the midwives to pick up on her vulnerabilities and signs of domestic abuse within the home.

However, while workloads and lack of time did impact professionals' use of effective challenge and curiosity, there was also evidence that they worked hard to overcome this barrier. There were frequent examples of dedicated and committed practitioners

strongly motivated to help children and families. For instance, one review noted how professionals persisted in the face of parental non-engagement:

> *The health visitor and family worker tried on numerous occasions to visit the family. They showed good professional curiosity by speaking with neighbours and the landlord. They left messages, wrote letters in the family language and sought to check social media to try to trace and speak to the family...*

What was evident in the examples where professionals did persist, challenge and exercise curiosity was that they had to follow their instincts and 'make time' to do so, often going over and above the allotted time permitted by their agencies.

4.1.4 Barriers to effective professional curiosity and challenge: relationship dynamics between professionals and parents

The dynamics of professionals' relationships with parents could create an additional barrier to curiosity and challenge. Building relationships with families in the context of child welfare concerns is sensitive work and professionals often need to manage parental resistance (Forrester, Westlake and Glynn, 2012, p. 118).

Working with highly resistant, threatening or hostile families is intense, emotionally demanding work (Ferguson *et al.*, 2021) which in some cases can pose real physical risks to workers and their families (Hunt *et al.*, 2016). Professionals' feelings of anxiety, fear and threat can have implications for their ability to effectively safeguard children. Fear of reprisals, violence or malicious complaints can prevent workers from being sufficiently investigative in their work, with the risk that children become invisible and left at risk (Ferguson, 2017).

Parents may reject professional involvement to conceal abuse or neglect, using overt hostility or avoidance strategies such as ceasing communication, pleading ignorance or trivialising the significance of an event (Cleaver *et al.*, 2007). However, it is important to acknowledge other reasons why parents might be labelled by professionals as 'resistant'. Parents may reject professional involvement due to shame, embarrassment, fear and the stigma of involvement with services (Forrester, Westlake and Glynn, 2012; Turney, 2012) and they may experience professionals as 'uncaring, unsupportive and judgemental' (Smithson and Gibson, 2017, p. 572).

In several SCRs, the fact that professionals found it 'difficult' to engage with parents hindered their ability to exercise appropriate curiosity and challenge. For instance, one review suggested that professionals may not have asked key questions as both school and health staff found the father 'too difficult' to engage. In other SCRs, greater detail was provided about the nature of engagement difficulties that contributed to the lack of appropriate challenge and curiosity. For instance, in one case the review identified that the parents' surface account of the situation was not

challenged by professionals. The child's mother held a professional position and appeared to know about child protection procedures. At the same time, it was noted that professionals found mother to be sometimes intense and challenging. The dynamic between professionals and mother was significant. On one hand, professionals recognised mother as a fellow professional which may have made them reluctant to challenge her account of events. Her knowledge of child protection procedures may have led professionals to be falsely reassured. On the other hand, the fact that she was experienced as challenging and intense may have wrong-footed professionals, preventing them questioning her account of events. The review concluded that professionals need opportunities to reflect on how their feelings towards parents may impact on their judgement and practice.

Existing literature suggests that professionals' emotional responses towards parents may shape the extent to which they exercise professional curiosity (Cook, 2017). Professionals are less likely to challenge and adopt an investigative stance where they perceive parents as capable, coherent and congruent even where there is wider evidence indicative of risk (Platt, 2008; Cook, 2017). Several SCRs identified a lack of challenge particularly where parents were perceived by professionals to be highly articulate. One review emphasised that:

> *Highly articulate, plausible and manipulative parents require confident and assertive practice, and a focus on the core issues.*

This is not to suggest that professionals should adopt a cynical approach, rather that it is important to keep a conscious child-focus, ensuring that parents' perspective and account of events is considered alongside other sources of information.

Child protection frequently involves working families who may be hostile or threatening (Ferguson *et al.*, 2021). A particular risk for professional practice arose in hostile relationships where professionals experienced anxiety or fear in relation to the family. Where practitioners' perspectives are included in the SCR report they can shed light on the psychological reasons why professionals may not exercise sufficient curiosity and challenge. For instance, one review captured how professionals experienced interacting with the child's mother:

> *… They describe her as being hostile, unpredictable and extremely argumentative. One professional described how her behaviour on some occasions bordered on being 'vile'.*

While this statement contains a concerning value judgement about the mother (and it is important to acknowledge, as identified earlier, that there are many reasons why parents may respond to professionals in an argumentative or 'resistant' way) the depth of feeling revealed in this statement is significant. Research has demonstrated that where parents evoke fear or anxiety in professionals, they may be reluctant to challenge resulting in the child's experience being lost from view (see also Chapter

5). This been described as the phenomenon of the ‘invisible child’, which occurs when professionals are ‘overcome by the emotional intensity of the work and complex interactions with angry, resistant parents and family friends’ (Ferguson, 2017, p. 1007). The fear experienced by professionals may be due to overt threats of violence from the family or can be more subtle, such as an atmosphere of inchoate threat or intimidation during a home visit. Within these SCRs, there is evidence that working with hostile families could shut down professional curiosity, derailing appropriate challenge and inquiry:

> *Describing their relationships with the family, one worker was reminded that the door would be locked after she went into the house... She was only once able to speak to one child alone, the rest of the time they were seen collectively. There are descriptions of the family as being like a pack.*

In this case, the children were not routinely seen alone and professionals were reluctant to explore the reasons for the children’s, at times obvious, distress. There was a palpable sense of anxiety in professionals’ accounts of their interactions with the family – home visits were suffused with a sense of threat. The dehumanising description of the family as being like a ‘pack’ perhaps represents the visceral sense of physical threat and fear experienced by professionals in the presence of the family. There were long-standing concerns round neglect, antisocial behaviour and non-attendance at school. Later, it emerged that these issues had masked intrafamilial sexual abuse which prompted the SCR (see Chapter 6). Here, we can see a clear demonstration of the phenomenon of the invisible child:

> *This family were in plain sight and yet paradoxically the children were hidden from view. It’s this paradox that this review needs to explore. How a family, so well-known in its local community they were the subject of regular senior management meetings, was able to deflect professionals from safeguarding the children within that family.*

The family had made ‘threats to life against professionals’ and had actively pursued neighbours who had provided evidence against them. As a result, professionals were concerned for their own and others’ safety. Within this context of fear, professionals withdrew from the family and avoided asking challenging questions about the children’s welfare.

Working with families where there are high levels of conflict and violence can lead to professional paralysis (see Ferguson, 2017). Workers’ fears can lead them to become ‘psychological hostages’ (Stanley and Goddard, 2002) seeking to appease parents to preserve their own safety. Such a response, while understandable from a psychological perspective, has serious implications for professionals’ ability to exercise the authority needed to keep children safe. Similarly, in the case described above, it was recorded that mother was not spoken to by professionals to avoid

‘upsetting her’ and the needs of the children slipped from view. In order to maintain a stance of professional curiosity and exercise appropriate and effective challenge, professionals need to feel safe and confident. In this case, the review could find no evidence that safety plans were considered for professionals, despite threats to life being made.

Summary: Supporting professional curiosity and challenge when working with families who evoke anxiety and fear

In order to retain a stance of professional curiosity and child-focus professionals need to feel confident and safe in their work. Organisations need to consider both the psychological and physical safety of practitioners. At a psychological level, they need space and support to discuss and process the powerful emotions evoked by challenging encounters with service users. Supervision and organisational cultures which allow this are important, yet research points to a lack of support for professionals in response to ‘stressful and frightening circumstances’ (Hunt *et al.*, 2016). Organisations must have robust policies for ensuring the safety of professionals including joint-visiting protocols and lone working procedures. Ensuring physical safety also confers a psychological benefit – professionals who feel supported are more likely to have the confidence and professional courage needed to safeguard children.

4.2 Interprofessional communication and information-sharing

Working Together guidance consistently emphasises the importance of effective information sharing between local agencies. Effective information-sharing is one of the key tenets of effective safeguarding practice and is ‘so important that [it must] be re-emphasised and potentially relearnt as people, organisations and cultures change’ (Sidebotham, 2012, p. 190). Several high-profile child deaths, including the case of Victoria Climbié have identified errors, omissions or misunderstandings relating to information-sharing between agencies. Laming (2003, p. 1) characterised this as an ‘elementary’ point and one that should be regarded as fundamental to safeguarding work. However, SCRs show that in practice there are a number of systemic issues and complexities that can prevent effective information-sharing between professionals. This section explores these issues, focusing on two key themes emerging from the SCRs:

- The distinction between information-exchange and effective communication
- The importance of effective communication where families move between areas

4.2.1 The distinction between information exchange and effective communication

A recurrent theme within these SCRs was the distinction between information exchange and effective communication. In many cases, important information was shared between agencies, yet this information was either not understood or else its significance, particularly in terms of risk to the child, was not appreciated by other agencies. For instance, in one case an SCR was prompted when a young person caused significant injury to a younger child. Prior to the incident the young person had exhibited challenging behaviour and had been supported by mental health services for several years. The review identified the young person's diagnosis of conduct disorder as an important risk factor, yet the significance of this diagnosis was not understood by other professionals outside mental health services:

> *Without clarity across the professional network of the conduct disorder diagnosis and its significance, the level of concern reduced... There was no overt articulation by mental health professionals of the implications of this diagnosis...*

In this case, information was shared between professionals about the diagnosis. However, non-specialist professionals needed a clearer account of the nature of the disorder, what it could mean for the young person's behaviour and the potential risks his behaviour could pose to others. Without this understanding, it was difficult for professionals within the young person's network to conduct an adequate risk assessment. This was part of a broader pattern within the SCRs around medical diagnoses. For example, in one case it was noted that a recent health diagnosis had been a factor in a young person taking her own life. Again, the young person's diagnosis had been shared between agencies involved in her care, but its significance was not obvious to other non-specialist professionals. In fact, her medical condition had far-reaching social implications, potentially precluding several activities and sports from which the young person derived enjoyment, relationships and meaning. This suggests that effective information-sharing is more complex than informing other professionals of the facts. Another SCR suggested that:

> *… lots of information was exchanged, but was not shared, interrogated or its importance properly understood... Multi-agency work requires staff to be alert to their own "professional cultures, languages and knowledge base" and to be ready to "translate" this to other professionals.*

Dialogue between professionals is an important tool in generating alternative hypotheses about the meaning of the information. Where there was evidence of good practice in relation to information-sharing, this typically involved interprofessional dialogue. Phone conversations and professional meetings provided important opportunities for professionals to 'translate' information known to them to

other professionals outside their discipline. However, in the context of increased workloads and general pressures on services, such opportunities for dialogue were reduced. This could lead to areas of risk being minimised or missed within the wider professional network. One SCR drew a helpful helpful distinction between information-exchange and effective communication stating that:

> *Information exchange is not the same as good communication. The latter is more nuanced, questioning, collaborative and reflective, and seeks to explore why something is "as it is", but most practice is process driven, fact based, and progressive in nature... After sharing information professionals need to ask themselves and each other "what does this mean..."*

In sum, the SCRs suggest that information-sharing or exchange is necessary but not sufficient for effective interprofessional communication.

Summary: The distinction between information-sharing and effective communication

- Information sharing is necessary but not sufficient for effective interprofessional communication.
- Professionals must be mindful of how other professionals may interpret and understand information they provide.
- When communicating with other agencies, professionals need to 'translate' information for non-specialist professionals. This includes the avoidance of professional jargon and a clear account of what the information means for the child.
- When new information is received, professionals in the child's network need to reflect both individually and collectively on the question: 'what does this mean for the child?'

4.2.3. The importance of effective communication where families move between areas

Effective communication between agencies is particularly important when working with families with a history of transience or mobility. Where families move between local authorities, NHS Trust or Police Force Areas, it is vital that their needs, risks and history are shared with the receiving area to facilitate continuity of service and prevent drift. Where families move between areas, it is necessary for agencies to revisit and clarify responsibilities to avoid families slipping through the net. Where the receiving area treat the family as a 'new' case there is a risk that they will fail to take account of the case history leading to 'start again syndrome' (Brandon *et al.*, 2008). Within the SCRs information-sharing between areas was again a recurrent issue across all services including health, police and children's social care. In one case,

the family moved and the outgoing local authority transferred the case. However, the case was not picked up by the receiving local authority and there was no mechanism to inform the referring authority of this. The review identified that:

> *… with electronic systems being relied on more and less hard copy paperwork that there ought to be a trigger within the electronic recording system that provides for confirmation of receipt from the receiving area.*

This SCR identified that when the transfer took the form of an email or entry into the system rather than a hardcopy, there was a risk that it would simply be missed. A practical solution, as recommended in the SCR above, would be to build an acknowledgment of receipt within the system with a trigger for the previous local authority so that they are notified if the case has not been picked up. However, even if the case transfer is received and electronic information shared successfully, professionals new to the case may lack context and significance to interpret the significance of the case records. As identified earlier in this section, there is a distinction to be made between information-sharing and effective communication. For this reason, it is vital that a case handover discussion occurs between the outgoing and receiving authority.

Key learning: when families move between areas.

Where families move between areas it is important to ensure an effective transition. Local authorities could consider creating an acknowledgement of receipt when the case is picked up by the receiving LA. Local authorities should ensure that a handover discussion occurs between the outgoing and receiving authority.

4.3 Professional disagreement, thresholds and escalation

This chapter has emphasised the importance of respectful, effective professional challenge in work with children and families. The issue of challenge was also a recurrent theme in relation to interprofessional practice. As the review of 2014-17 SCRs puts it:

> *A key aspect of authoritative practice is the exercising of respectful uncertainty or scepticism accompanied by the confidence to offer challenge. This is the case, not just in the context of direct interactions with service users, but also in negotiating joint working arrangements with other services... (Brandon et al., 2020, p. 109).*

Effective multi-agency working is an integral part of supporting families and safeguarding children. However, effective multi-agency work does not always entail agreement. Rather, discussion and respectful challenge between professionals is key to robust decision-making. A common theme in these SCRs was the issue of

insufficient ‘escalation’ of concerns among professionals in response to increasing risk. A frequent issue was unresolved professional disagreement, particularly in relation to the level of risk and threshold. These were often cases where one agency had information that indicated risk to the child, yet this was not accepted or understood by the wider professional network:

> *...The review identified many examples when practitioners should have escalated their concerns and been more critically challenging of decisions made by others that impacted on Child A’s safety and wellbeing.*

A recurrent theme was the difficulty in escalating concerns. Professionals who had justification to challenge decisions found it difficult to make their views heard. A key area of professional disagreement was around the threshold for Children’s Social Care (CSC) involvement. Referrals were often rejected on the grounds that they did not reach the threshold for CSC involvement. Education professionals often found it difficult to initiate CSC involvement. In one case, teachers tried to escalate concerns about the child and were told that these would be discussed at the next CAF meeting. However, subsequent meetings were either cancelled or the representative from CSC did not attend. This left education professionals frustrated and anxious for the child’s safety. The formal processes for escalating their concerns were not always clear to schools. There was a sense among some educators that they were powerless and that their professional judgement was not valued by CSC. As part of the review process, one reviewer spoke to CSC workers to obtain their view on such disagreements:

> *The... Children and Young Peoples Service (CYPS) member on the panel has stated that there is often an expectation by schools for CYPS support although there are other avenues that are available and may be more suitable such as psychology and behaviour specialists. The panel member felt that schools need to be specific as to that support they are requesting.*

The rejection of referrals on the basis of the school not being ‘specific’ about the support required can act as form of gatekeeping and place schools and CSC in a kind of stalemate. The stalemate is compounded where referrals are rejected without explanation or advice, or further information about other available services. In one SCR it was even noted that the school had used pupil exclusion to force CSC involvement in a case where they were increasingly concerned about the safety of a child. Education professionals said that:

> *… where referrals are made by those with substantial experience then the MASH should have the capacity and capability to speak personally to refer in such circumstances.*

In cases where appropriate professional challenge was shut down, the issue of professional power often appeared to play a role. This is discussed in the next section.

4.3.1 Professional hierarchies and local barriers to interprofessional challenge

Often professionals who raised concerns and had tangible evidence of risk were 'overruled' in the decision-making process. In many SCRs, it appeared that professional hierarchies acted as a barrier to constructive interprofessional challenge. For instance, one SCR focused on serious harm caused to a child through over-medicalisation in the context of suspected Fabricated or Induced Illness (FII). A notable feature of the case was that the child had been prescribed a high dose of addictive medication for an unusually long period. In this case, the child's GP, the dispensing pharmacist and other professionals had expressed reservations about the medication but did not feel able to effectively challenge this or escalate their concerns:

> *In the opinion of the review, the GPs were influenced by the hierarchy of medical professionals and felt bound to prescribe a medication prescribed by a specialist paediatrician...despite their continued anxiety about the... prescriptions, they did not follow these through.*

Professionals can feel reluctant to use escalation processes if it means directly challenging senior workers. In the previous SCR analysis (Brandon *et al.*, 2020) it was identified that the terms 'escalation' or 'dispute' can appear unnecessarily adversarial. Reframing the issue as one of 'resolving professional differences' created a sense of professional empowerment 'with staff saying 'no we didn't feel that we were empowered enough to escalate but we do feel that we are empowered enough to share a professional difference' (Brandon *et al.*, 2020, p. 201).

A further barrier to the effective escalation of concerns was a general lack of clarity for practitioners about the local procedures for challenge. As one SCR summarised:

> *Escalation policies are a vital component of safe systems. They provide clear pathways for progressing disputes and problems encountered at an operational level, up organizational hierarchies of governance and accountability...*

The need for effective and clear escalation policies was emphasised in several reviews where professionals were unsure how and where to raise objections. In other cases, these disagreements were dealt with informally rather than through established channels which sometimes had the effect of shutting down constructive dialogue between agencies. For example, in one case a decision was made not to

authorise a child protection medical examination in the context of suspected sexual abuse. Disagreeing with this, the child's GP requested a review of the decision. As a result 'informal' discussions took place between CSC managers and professionals 'from different disciplines' and the decision not to authorise the examination was upheld. However, the GP was not informed of the outcome and the rationale to uphold the decision was not recorded or justified.

There was a further systemic reason why professionals were insufficiently challenging of each other. There was a shared acknowledgement among professionals of the pressures faced by local services in terms of workforce capacity, caseloads and reduced funding. As one SCR noted, there was often

> *… an implicit understanding between agencies as to the pressures they were under.*

This understanding meant that practitioners were often reluctant to challenge decisions they felt to be unsafe or inappropriate in relation to the child. In some cases, this led to a decision not to refer at all as it was understood that thresholds were high due to lack of resources.

Chapter summary

Three key practice issues emerged as common themes in the SCRs:

- Engaging with parents. Workload and the dynamics of professionals' relationships with families could lead to reluctance to challenge parents' account of events or to enquire more deeply into the child's experience. Professionals who feel supported are more likely to have the confidence and professional courage needed to safeguard children.

- Interprofessional communication. The exchange of information is necessary but not sufficient for effective communication. Professionals need opportunities to engage in discussion about cases and to 'translate' information for other professionals outside their discipline.

- Professional disagreement. Discussion and respectful challenge between professionals is key to robust decision-making. Framing this as 'resolving professional differences' rather than 'escalation' may assist in creating opportunities for constructive interprofessional dialogue.

Chapter 5: The voice of the child

This chapter focuses on the voice of the child in work with children and families. The introduction frames the discussion in terms of the key issues and current debates, and describes the sub-sample used for this chapter. The chapter then explores four key themes emerging from the analysis of the SCRs:

- Focusing on the child's lived experience
- Engaging with children and young people
- Noticing, listening to and hearing children and young people
- The importance of trusting relationships

5.1 Introduction

The duty to involve children in safeguarding is embedded in the Children Act 1989, which includes the duty to ascertain children's 'wishes and feelings', although this was initially limited to court proceedings. However, a later amendment (Children Act 2004, s.53) extended the duty to ascertain children's wishes and feelings to earlier stages of social work intervention; when making decisions about services for a child in need (s.17), investigating the circumstances of children at risk of harm (s.47) and providing accommodation for children under the Act (s.20).

Legal provisions temper children's rights by adding the qualifier that the weight to be given to children's views should be assessed in the light of their age and understanding, (s.1 of the Children Act 1989). Ultimately the weight given to the child or young person's views is dependent on adult professional judgement and dilemmas potentially arise if the child's own view contradicts the professional view of what is in their best interests (Archard and Skivenes, 2009).

A shift in language was evident in the Munro Review of Child Protection which refers to the importance of the 'rights' and 'experiences' of children in addition to their 'wishes' and 'feelings' (Munro, 2011a, 2011b) Arguably this is more than a shift in terminology. 'Wishes and feelings', which might be equated with desires rather than sound reason, seem more dispensable than views, rights and experiences (see also Dillon, Greenop and Hills, 2016). Winter (2011) points out the importance of taking into account children's evolving capacities when considering their views. The latest edition of *Working Together* (HM Government, 2018) references the United Nations Convention on the Rights of the Child and refers to the child's right to express their views and to receive information, and suggests a series of principles that should guide professionals' behaviour when working with children and young people. These principles include that adults notice when children are in trouble; that helping professionals form stable and trusting relationships with them; that they are treated with respect and presumed to be competent; that they are heard and understood and

that action is taken to protect them; that they are given information about plans and that decisions are explained, particularly when they are not in accord with the child's wishes; that they are provided with support for themselves; and with advocacy to help put their views across (HM Government, 2018, p. 10).

Previous analysis of the voice of the child in SCRs was undertaken by Ofsted in 2011. A thematic review resulted in five key findings:

> *…in too many cases*
>
> *the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings.*
>
> *agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute.*
>
> *parents and carers prevented professionals from seeing and listening to the child.*
>
> *practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.*
>
> *agencies did not interpret their findings well enough to protect the child (Ofsted, 2011, p. 4).*

These messages continue to resonate. The Child Safeguarding Practice Review Panel's 2020 Annual report includes the importance of understanding what the child's daily life is like as one of its six key practice themes, highlighting that this is not a new theme, but still urgent and difficult (Child Safeguarding Practice Review Panel, 2021).

As described above the language relating to children's involvement has shifted over time from 'wishes and feelings' to a consideration of 'rights' and 'experiences'. Changes in terminology are reflected in the SCRs in the present study to a degree. Paying attention to the child's 'lived experience' was a recurrent theme, most commonly because the child's lived experience had been insufficiently known and understood. However, the extent to which the child was viewed as an active participant who could influence decision making was less often discussed. Several SCRs referred to children's 'wishes and feelings', and some to the 'voice of the child'. The latter terminology was more likely to be used where there was some consideration of the potential for children's views to have influence on decision making and intervention. One SCR specifically utilised a children's rights perspective as a framework for the report.

5.1.1 Methods

A sub-sample of 28 cases was sampled purposively for this qualitative analysis (Table 18). These cases were chosen because either the SCR contained good information about the voice of the child; or conversely the SCR highlighted that the lived experience/voice of the child was missing in the work. We aimed for a sample representative of age group, gender, ethnicity, geographical region, and category of death or serious harm. A range of types of abuse and neglect were apparent with the most prevalent being sexual abuse (11) and neglect (11). Often the children and young people had experienced multiple types of maltreatment.

Table 19: Sample for Voice of the Child analysis

	Under 1s	1 to 10 years	11 to 15 years	16+ years
Total SCRs included in qualitative analysis	6	4	10	8
Death	3	1	4	4
Serious Harm	3	3	6	4
Male	3	3	4	5
Female	2	1	6	3
Not stated	1	0	0	0

Table 20: Sample for Voice of the Child analysis - Ethnicity

	Under 1s	1 to 10 years	11 to 15 years	16+ years
White British	2	3	6	3
Mixed	2	0	0	1
Black/Black British	0	0	0	0
British	0	1	1	2
Asian	0	0	1	0
Traveller	0	0	0	1
Not stated	2	0	2	1

Table 21: Sample for Voice of the Child analysis - Region

	Under 1s	1 to 10 years	11 to 15 years	16+ years
London	2	0	1	3
East Midlands	1	1	2	0
North West	2	1	2	1
South West	1	0	1	1

	Under 1s	1 to 10 years	11 to 15 years	16+ years
North East	0	0	2	1
South East	0	2	0	1
Yorkshire and Humberside	0	0	1	0
East of England	0	0	1	1

All reports had previously been read and front sheets completed for the quantitative analysis. These front sheets provided baseline data and a case synopsis for each review. Open coding was used to identify themes arising from the data. Four key themes were identified and will be discussed in the rest of this chapter.

5.2 Focusing on the child's lived experience

A lack of focus or loss of focus on the child's lived experience was a common theme across the SCRs. The child's lived experience can be understood in a number of ways:

- understanding the child's daily life;
- thinking about all aspects of the child's health, wellbeing and development;
- considering the child's life across different contexts – in the community as well as in the family;
- thinking about the child's history and the impact of their past experiences;
- considering the child's experience of decision making, planning and professional intervention.

5.2.1 The child's daily life

A number of SCRs identified insufficient attention to the child's daily life. This applied across the age range of the children. In some cases there was insufficient focus on the needs of unborn children and infants with inadequate safety planning before the birth of the child.

Professional observation and interaction with babies is crucially important. It is particularly important that professionals are not only able to observe their development but to think about the extent to which their observation is representative of their daily routine. It may be that observations of parenting in a short visit do not give the whole picture, where there are issues such as domestic abuse, substance misuse or episodic mental health difficulties. In the case of a child who was killed by his mother's partner there was known to be a history of domestic abuse and,

> *… that mother's physical care of George was (when observed) 'good enough' should not have diminished concern about the immediate and longer-term*

> *impact of witnessing domestic abuse and experiencing constant unpredictable changes of residence, routines and familial or wider contacts.*

For older children and adolescents it was also the case that their daily life was often not adequately understood. Whilst there was often a lot of professional activity around the child or young person, this did not always give an insight into what their lives were like. In some cases assessment tools were used to gather information, but not integrated with other pieces of information. For example, a young person who was eventually charged with attempted murder had been subject to various assessments from an early age. A school nurse had completed the Strengths and Difficulties Questionnaire, concluding that there were no emotional difficulties. However, this was not considered alongside other known information, such as his disruptive and aggressive behaviour in school, and the fact that at times he had been tearful with professionals and said that he was scared at night.

5.2.2 Thinking about all aspects of the child's health, wellbeing and development

In some SCRS it was apparent that the framing of the work involved viewing the child through a single lens, and losing sight of the whole child, with a failure to consider the possibility or severity of the impact of maltreatment. This was particularly apparent in cases where the child was disabled or suffering from a chronic illness. In one case, a young person who died aged 17 of diabetes complications, there was a failure to consider how his parents' ambivalence about the diagnosis might result in him being left to manage his treatment plan. Health professionals working with him were also unaware that he had experienced domestic abuse throughout his life. His presenting mental health difficulties were attributed to the realisation that his diagnosis had ended his plan to join the military. However, his full home circumstances were not adequately explored. A fuller insight into this young man's life only emerged after his death.

In another case an adolescent was sexually abused over a long period of time by a registered sex offender who was the partner of her mother. Her challenging behaviour was attributed to ADHD, neurodevelopmental disorder and learning disability and there was a lack of curiosity about an alternative narrative even when her behaviour changed (also discussed in Chapter 6). In the assessment her mother was noted to be struggling to manage her daughter's behaviour '*and may lack understanding of her daughter's condition'*. The young person's experiences reflect the fact that the maltreatment of disabled children may be 'hidden in plain sight' (Franklin *et al.*, 2022), with disability seen first, and the possibility of abuse not considered, even though in this case the young person had reported being hit by her mother's partner and had attended the GP repeatedly.

5.2.3 Considering the child's life in different contexts

It is essential to think about children in the different contexts in which they live, including home, school, peer group and community. Contextual safeguarding (Firmin, 2017) is an approach to understanding and responding to young people's experiences of significant harm in the community. One SCR pointed out the challenge in bridging contextual safeguarding approaches with intrafamilial safeguarding, where children are vulnerable in their families and at risk in and to their communities. A number of the SCRs involving adolescents described multiple, cumulative and longstanding difficulties in the children's lives. As adolescents they might come to the attention of the police for offending behaviours.

Frontline police officers who do not work in specialist child abuse or child criminal exploitation units often come into contact with children who are offending, or on the fringes of offending behaviour. The primary concern of these officers is to deal with the offending, they do not always take account that there is still a child who needs safeguarding. The extract below highlights this.

> *The arrests that followed Child I's sharp increase in criminal behaviour were also critical moments. Most can similarly be characterised as missed opportunities. Despite the known indicators, there was little evidence that practice by the police was being driven by a 'safeguarding first' philosophy and a need to protect Child I. Actions were largely reactive and based on a criminal justice response to his offending.*

Intervening in the community as well as with individuals is recognised as important in cases of child criminal exploitation. A number of reviews evidence a need for all agencies, including the police, to move from incident-based or episodic responses to a more ongoing long-term and continuous method of working, making use of multi-agency systems to manage child criminal exploitation. It is not just appropriate to safeguard individual children, in order to protect and divert them from child criminal exploitation, it is also important to disrupt criminal organisations. Otherwise, the exploited child, if they are adequately protected, will just be replaced by another vulnerable child.

5.2.4 Thinking about the child's history and the impact of past experiences

The importance of avoiding an incident-based approach to safeguarding is well documented (Sidebotham *et al.*, 2016; Brandon *et al.*, 2020). Several of the SCRs which related to adolescents underlined the importance of understanding the child and family's history, not only to determine the level of presenting risk and effective safeguarding response, but also to give an insight into the child's experience over time, the impact of their early lives, and their likely needs in the future. The concept

of “poly-victimisation” refers to the experience of a number of different types of abuse over time (Finkelhor, Ormrod and Turner, 2007) and helps professionals to consider the impact on the child of the cumulative harm they have experienced across their childhood and adolescence.

Many of the adolescents who died by suicide or were at risk of CCE/CSE had experienced cumulative harm over many years. For example, one young person had experienced the early death of his father and the traumatic nature of that bereavement had never been explored.

Thinking about the child’s past may also help address the issue of ‘adultification’ – that is, treating children as though they were older than they are (see Davis, 2022). In a number of the SCRs, young people were viewed as ‘streetwise’ ‘resilient’ or ‘mature’ and their true vulnerability was hidden:

> *More attention could have been given to Sasha’s longer-term psycho-social history and the adverse experiences that she had in assessing her ability to manage her situation. This may have enabled more questioning of her apparent resilience and whether in fact, it was genuine or was a facet of a pseudo-maturity.*

5.2.5 The child’s experience of professional intervention

The child’s lived experience includes not only their experience within the family and community but also their experience of professional intervention. Whilst there was much discussion in the SCRs of how much was known about the child’s lived experience in their families, and some discussion about whether professionals had been able to gauge children’s wishes and feelings and how they had been documented, there was much less discussion of how the views of the child were considered in decision making. In one case of a young adolescent who died by suicide there was evidence of workers exploring her views, hopes and worries, ‘*but it is not evident how these influenced the analysis or planning or decision-making*’. In another case where a child died by suicide the social worker understood that the young person was not in agreement with a planned placement move which was judged to be in her best interests:

> *There is inevitably a delicate balance between adhering to the wishes and feelings of a 17-year-old and taking appropriate measures to mitigate known risks in order to safeguard the young person.*

Whilst the review found that the decision to move the young person was justifiable and that the social worker had worked hard to help her understand the decision, it did result in increased reluctance to work with her social worker and greater avoidance by the young person of professionals prior to her taking her own life.

The balance in working with young people between respecting their views and acting in their best interests is a difficult one. There was more discussion in the SCRs involving adolescents of the impact of decision making on the young person and on the young person's views of the decisions. This begs the question of how younger children's views are considered in safeguarding practice. However, even in relation to the adolescents it often seemed as though the young person was being consulted and informed of a decision, but it was not always clear how their views had influenced the decision-making process.

It was rare that reviews included information about the child's views of the service they were receiving, although this was a recommendation in the interim Munro report:

> *Greater weight should be given to how children feel about the service they are receiving: are their views being listened to? Are social workers explaining to them what is happening and why? Do they feel safer as a result of the services they are receiving? (Munro, 2011a, p. 80).*

Some young people find that their experience of services that are meant to protect them can in fact be retraumatising (Jay, 2018). In one case a young person had been disappointed at a decision following police interview that there was insufficient evidence to progress a criminal case against the child's mother for physical abuse. This decision, though potentially upsetting for the young person, was not conveyed to her personally:

> *The Officer in the Case (OIC) advised the maternal grandmother of the outcome of the criminal investigation and informed her that, if Child C wanted to speak to her [the OIC] when she came home from school, she could do. The Police also informed Child C's mother of the outcome. … The OIC informed Children's Social Care that Child C had not taken the decision well and had lost trust in the Police.*

Understanding what life is like for children and young people should include consideration of how prior experiences of professional intervention and of help may impact on their present ability to trust and engage with professionals (Cossar, Belderson and Brandon, 2019).

Key learning: the child's lived experience. It is important that professionals aim to get a holistic sense of the child's lived experience. This involves considering their daily experiences at home and in the community. Professionals need to integrate information from multi-agency sources as well as engaging directly with the child to get a sense of the child's life.

It is important that the child is not viewed solely through one lens, particularly children with special needs or disabilities.

A sense of the child's life over time is important, not only in making judgements about risk, but also to help professionals understand the impact on the child of their experiences to provide suitable support.

Children and young people experience professional intervention as part of their lived experience and professionals should incorporate the child's views about the help they receive into decision-making, planning and intervention.

5.3 Engaging with children and young people

The present study echoed the findings of the Ofsted (2011) thematic review concerning effective engagement with children and young people. There were many instances where children were not seen on their own, where parents controlled access to children, or practitioners became distracted by parents' needs, or where the voices of wider family who could speak up for the child were not sought or heeded.

5.3.1 The importance of seeing children on their own

Although rare, there were some cases where children and young people were not seen at all and were not known to universal services, including one of serious long-term neglect of a disabled child, who had not been seen by health services from a young age and who was home-schooled (see 'Billy' case example, Chapter 3).

Even where there was involvement from services children were not always seen on their own, even when specific concerns had been raised:

> *It is not clear, after there were concerns expressed by the child minder about bruising, whether anyone sat down to explore with the children on their own what was happening, act to undertake any 1:1 work to establish what life was like at home, or establish what Joe or Ben's wishes and feelings might be.*

It was several years later when Joe was an adolescent and going missing every day, that good practice successfully identified what life was like at home, and steps were taken to promote his safety:

> *The police ensured Joe was seen separately from his siblings and his parents. They observed and queried the dynamics in the family home, noting that Joe was obviously underweight, and made a formal referral.*

5.3.2 Professionals' relationships with parents and carers

In several cases the children were not seen on their own due to the dynamics between the social workers and the parents. The subtlety of these dynamics is

explored in Chapter 4. It may be that the professionals are intimidated or afraid, or are less likely to challenge an articulate and plausible parent, or one whom they judge to be cooperative and warm. The dilemmas of the situation were noted in one review where workers felt compromised between maintaining a relationship with the parents which allowed them at least some access to the children, and challenging the parents which tended to result in access being withdrawn. The reviewer concludes:

> *Children's own voices, experiences, wishes and feelings should be the drivers to decision making. Where access to those children is being (however subtly) controlled, concerns should be heightened.*

In some cases the dynamics of the situation were made more complex by the fact that the child was disabled and professionals took the lead of the parent who was the main carer. In one case the mother always had the door open when professionals were with the child.

In some cases professional focus on parental needs could distract from the experience of the child, a finding which echoes the previous triennial review (Brandon *et al.*, 2020). In one case involving young parents, both were vulnerable. The father was care experienced, and the mother had been homeless and had mental health needs. There was a suggestion that the leaving care team might have wanted to avoid stigmatising them with a referral to CSC:

> *Evidence indicated that they were both struggling to develop their independence skills. The focus appears to have been very much on providing support to enable the couple to parent their children; an over identification with the parents rather than focussing on the needs and safety of the children.*

5.3.3 Lack of involvement of wider family

It is important to consider children's networks, including wider family, both as risk and resource. In some cases there was a lack of involvement of wider family members who might have important information to share, or who might be an important resource for the child. These included older siblings, grandparents, and fathers or father figures who were not resident with the mother.

In one case of serious harm to a baby aged four months there was a concerning history. The baby had two older siblings. There had been referrals in relation to the older two children and allegations of domestic abuse by both parents. In this case, both former partners of the mother were said to be afraid of the mother. The older children were not spoken to, and the experience of their fathers was not sought:

> *There was insufficient consideration given to the views of the children's fathers in assessment, particularly as information was provided by external*

agencies that both fathers were fearful of the mother and that their contact with the children would be affected if her wishes were not complied with.

In other cases family members were not included in planning when they could have been a resource for the family (see also Brandon *et al.*, 2020). In one case the maternal grandmother was not told about a father's history of sexual abuse and harmful behaviours and she was not involved in the team around the child meeting.

Wider family members can provide support and protection and become valuable members of the Team Around the Child. Their potential involvement should be discussed with the parents and concerns shared with them. It should be recognised that it can be difficult for family members, e.g. grandparents, aunts and uncles, to 'report' family members to agencies and they need to be approached by practitioners.

5.4 Noticing, listening to and hearing children and young people

Where professionals engage and interact with children it is important that they are able to make sense and act on what children are telling them, whether this is verbal or through their demeanour and behaviours.

5.4.1 Professional curiosity about children and young people's behaviour

Research suggests that it is very difficult for children to disclose abuse and that there are many barriers to them telling adults about what is happening (Collin-Vézina *et al.*, 2015; Cossar, Belderson and Brandon, 2019). The disclosure literature suggests that in many cases children and young people's behaviour will be an indication that something is amiss (Alaggia, Collin-Vézina and Lateef, 2019; Cossar, Belderson and Brandon, 2019). In the SCRs a recurrent theme was the need for professionals to be attuned to what children and young people's behaviour might be signalling. This is an issue that is also highlighted in Chapter 6, about sexual abuse.

Where young people's behaviour changes or where they behave markedly differently in different contexts this should be a reason to be curious. A young person with diabetes presented very differently during inpatient stays compared to how he was at home:

It was found that the child appeared to be relaxed and in good mood when on the ward where the child was observed to eat healthily and slept well at night. This was opposite to how the child presented in their own home environment but the reasons for this were not explored further. Professional curiosity and

exploration of the home environment may have resulted in the identification of domestic abuse, heavy alcohol use and chaotic home life as possible reasons for Child LW's changes in mood.

For young people who are in care or are known to have experienced early harm it may be easy to conclude that difficulties in adolescence are a consequence of their early childhood and subsequent placement moves. However, changes in behaviour may be indicative of current harm. This should at least be considered a possibility, whether or not there is a history of trauma (Brandon *et al.*, 2020). As a young person who took part in the SCR described:

I totally changed [after the sexual abuse started], they never asked about the change in the way I dressed, changes in my eating. I started to self-harm. No one looked between the lines. No one took me away from the house. I had counselling for self-harm, and I kept myself to myself.

At times young people may receive services in relation to their presenting risky behaviours, for example violence, offending or self-harm, but the underlying cause remains unknown and unaddressed (Cossar, Belderson and Brandon, 2019).

5.4.2 Acting on disclosures

It is unsurprising that children and young people find it difficult to say what is happening to them, and professionals should not rely on verbal disclosure to take action to protect them. However, it was notable in some SCRs that even when children and young people did make verbal disclosures, effective action to ensure their safety did not follow.

In some cases action was not taken when children disclosed because the explanation of the parent was taken at face value. For example, one child presented with facial bruising stating that her mother's partner was responsible, and his explanation that it was due to rough play was accepted. In another case two older children both made disclosures of sexual abuse that were not investigated at the time of disclosure, because the parents did not support further investigation.

In a few cases there was an explicit disclosure by a young child, but this resulted in minimal action, for example a child under 5 alleged sexual abuse by an 18 year old relative in clear terms, a case that is also discussed in Chapter 6. The strategy discussion concluded that no immediate child protection issues were raised. The police officer suggested that this was due to the child's young age (4 years old). In such cases, where children speak clearly about what is happening to them but no effective action is taken, this may impact negatively upon them:

… the child (and other children) could remain vulnerable to abuse; partners, carers, children and young person involved could gain the impression that the

allegations were not serious; and by discussing the nature of the allegations, offending behaviours might continue either in a different form, or with more coercion.

Where young people have a history of involvement with services, the prior experience of the help they have received will influence their future help seeking behaviour (Cossar, Belderson and Brandon, 2019). If there are multiple difficulties, children and young people may make decisions about who they can talk to based on their perceptions of how effective the professionals are. Two children placed in kinship care felt that their situation was well known to their social workers but nothing was done:

I told them carer 2 was hitting me. The social worker came up to the bedroom and I told them about the threats to throw me out – nothing got done.

These young people felt that social workers were very aware of their lives but were not doing anything about it. This lack of action could have acted as a barrier to the young people disclosing other aspects of their lives, in this case that one of the carers was sexually abusing them.

5.4.3 Considering barriers to disclosure and minimisation

Noticing and listening to children is complex. There may be barriers for both the children disclosing and for the adults hearing them to listen to and respond protectively. It is important not to over-rely on verbal telling and equally important to consider carefully the reasons why children may deny or minimise what is going on. In one case a young man was thought to be at risk of CSE. His denial that he was at risk was taken at face value. The signs were recognised by professionals, however *'the response was over-influenced by Child M's denial that he had experienced sexual interactions with the adult male'*.

The SCR noted the additional barriers for males to report sexual exploitation. In another case the child retracted her accusation that her mother's partner had hit her, saying that she had made it up. However, she was asked about this in front of her mother, and there had been previous concerns about physical abuse by her mother.

Key learning: listening to children. It is important that professionals to not rely unduly on verbal disclosure by children and young people as there are many barriers to children disclosing abuse. Professionals should be curious about changes in children's behaviour and consider the possibility of abuse and maltreatment.

Professionals should consider the reasons why children might deny or minimise concerns. Children may be strategic about what they say, and older children's preparedness to disclose may be influenced by how effective they feel the

professional response might be, based on their past and current relationships with professionals.

When children do make disclosures it is important that professionals are able to hear them and take effective action. The age of the child should not prevent action where younger children make disclosures indicating possible abuse.

5.5 Trusting relationships

The importance of trusting relationships is well documented in the literature (Cossar, Brandon and Jordan, 2016; Brandon *et al.*, 2020). Engaging with vulnerable children and building supportive relationships was a recurrent theme across the SCRs. There may be opportunities when young people encounter professionals for sensitive work without pre-existing relationships, but professionals need to be alert to those possibilities. Examples are when young people presented on their own to GPs or A&E with symptoms that might prompt concern, or when police encounter young people when they first come into custody or when they are found after being reported as missing, as outlined below from one of the SCRs:

> *They [parents] believe such workers would have been able to exploit the 'reachable moment' of this crisis in the Police station, during the car journey, and then subsequently, and start exploring with Child C the risks to him of his vulnerability to exploitation. But this was not the brief of the Police Officers who were providing a well-intended but basic service in driving Child C back to London.*

Whilst there are opportunities for professionals to capitalise on such 'reachable moments', many SCRs underlined the importance of building relationships:

> *Taking into account what is known about children's ability to tell what is happening to them, and the inhibitors that are not known to others, it is simply unrealistic to expect a child to respond to a question posed by an unknown professional when in reality it is very hard to tell a trusted person.*

The quality of trust was not necessarily established simply by the duration of involvement. In one case siblings had social work involvement for a number of years. Although procedurally they might be seen to be participating, including chairing their own LAC reviews, they felt unable to disclose sexual abuse by a carer. Visits by social workers took place according to statutory timescales, however no meaningful relationship was built with the young people. As one stated in the SCR:

> *I didn't feel the social worker was relevant to me. I was asked the same questions and gave the same answers. They wouldn't show up for another six months. There were too many social workers to know what was happening.*

> *One person may have noticed it and worked it out from my behaviour. It would have helped to be seen on my own, even go for a walk in the park. I think a social worker should get on my level, share themselves, not focus on the process stuff and don't treat me like an item*.

A further learning point from those SCRs concerning adolescents who died by suicide and some who were at risk from CCE was in the number of relationships that they were expected to sustain as risks increased and professionals worked reactively to crisis situations. Whilst some trusting relationships could be identified in the lives of some of these young people they were also expected to make and sustain a number of relationships, with little guidance as to what should be the priority.

5.5.1 Barriers to trusting relationships

The reality in hard-pressed services is that it is very difficult to provide long-term trusting relationships for children and families with professionals, and between professionals working with families. Across the SCRs there were numerous ways in which professional relationships were disrupted. These included children having incident-based assessments by different professionals when cases were closed and reopened. In one case the SCR mentioned the significant pressure the health visiting service was under, with individual caseloads said to be in excess of 600 children.

Within services staffing issues had an impact on case planning, particularly when working with the most complex families and could result in drift and non-completion of tasks. Frequent changes of staff meant that knowledge of families got lost.

Staff changes had a direct effect on young people. One young person who had experienced changes in care throughout his short life, moving to adoption, experiencing a breakdown in adoption, and then a series of five foster placements and a residential setting, experienced fleeting involvement from professionals due to staffing issues. In one year he had three different social workers in three months:

> *There was not one single professional with whom Child CB had frequent close contact that remained 'with him' throughout the period of time considered by this serious case review.*

Another young person found that a trusting relationship with a worker was ended, because the resource was commissioned by an 'edge of care' team based on an intrafamilial system of safeguarding. Since he was not felt to be on the edge of care, the case was closed and the service ended although the young person remained at risk. In the long run, as his offending behaviour worsened, the young person was signposted to an array of specialist services, but an intervention that was working had been lost. The SCR comments:

Child M's views are not often referenced, but he was clear that he enjoyed the work with the [adolescent support unit worker commissioned by the edge of care team] and wanted this to continue. The ASU worker made an impact on Child M, and his presence over a prolonged period could well have helped Child M develop greater self-awareness and empathy for others.

Key learning: trusting relationships. The importance of trusting relationships between children and professionals is key to effective safeguarding. Limited resources lead to organisational practices that make it difficult for professionals to offer relationship-based work. Changes in workers, large caseloads, and incident-based work with cases being closed and reopened undermine trusting relationships between children and professionals. Where numerous agencies are involved with a young person it may be important to prioritise the work so that the young person is not overwhelmed.

Chapter summary

Four key themes emerged in relation to the voice of the child.

- The importance of attending to the child's lived experience and examining what this means. Getting a sense of their daily life in different contexts and over time is important, as well as including consideration of how the child is experiencing professional intervention. Professionals need good interagency communication, and the opportunity and skills to engage directly with children and young people.

- The importance of engaging with children, recognising the difficult dynamics that can be involved in working with families where children may be at risk. Seeing children on their own may maximize the chances of children feeling safe enough to begin to talk about their experiences.

- Professionals need to be curious about children's behaviour and alert to behaviours that may indicate abuse or maltreatment. They should not rely unduly on verbal disclosure or children's denials or minimisation, where there is other cause for concern. Where children do talk about abuse it is important that professionals act on those disclosures.

- Trusting relationships between children and professionals are key to effective safeguarding practice. Organisational and resources pressures must not be allowed to undermine the opportunities for children to establish and maintain trusting relationships with key professionals.

Chapter 6: Intra-familial child sexual abuse

This chapter highlights lessons from the SCRs about safeguarding children from intra-familial sexual abuse. It draws on a thematic analysis of ten cases of child sexual abuse (CSA) from the 2017-19 SCRs. Many of the 'usual' challenges and shortcomings of child safeguarding practice are apparent in the reviews, but two particular features stand out as characteristic of CSA:

- The extent of the deception employed by the perpetrators, and sometimes others in the family, sometimes sustained over a long time (and for some perpetrators, across more than one family);
- The ways that children's 'disclosures', either through what they say or their behaviour, can often be ignored or not recognised, by other family members and by professionals, and not responded to.

The first of these features suggests that CSA should be understood and responded to more like cases in the category of 'severe and persistent cruelty', rather than most cases of neglect or physical abuse (although of course the extreme forms of these become 'severe and persistent cruelty' themselves). The second aspect links it closely with the themes discussed in Chapter 5 on the voice of the child. Some of the themes in the present chapter therefore expand on, and further illustrate, the issues identified there. There is also overlap with Chapters 3 and 4, because there were eight cases where a focus on neglect meant that the signs of CSA were missed, and because issues of professional practice run throughout.

The ten SCRs focused on in this chapter represented a range of ages, family structures and differing vulnerabilities. In three SCRs only one child was featured, three SCRs involved two children, one involved three children, and there were three very large families with one SCR featuring eight children and two referring to 'several children' although it was not clear if all the children had been victims of CSA. The age range was from infancy to fifteen years with six SCRs relating to abuse of pre-pubertal children. Children's gender was only given in eight SCRs. All of these had female victims, with four of them also having male victims. In eight cases perpetrators were male (fathers, mother's partners, other relatives), with one involving mother and her male partner. The identity of one perpetrator was unclear, and could have been either parent; and the gender of a kinship foster care abuser was not stated.

The chapter outlines the findings in the SCRs about the perpetrators, the vulnerabilities of the families and practice shortcomings. It ends by highlighting key principles for practice to better protect children from sexual abuse. The findings echo those of the 2020 JTAI report on intra-familial CSA (Ofsted *et al.*, 2020).

6.1 Perpetrators

It is a challenge for professionals to try to protect vulnerable children and families from perpetrators who deliberately abuse children and who will deceive professionals and others in order to do so. In this respect CSA is an extreme form of abuse. Sometimes neglect or physical abuse is sustained, parents and others seem to take a perverse pleasure in it and are deliberately deceitful, but these are, fortunately, rare. These features are, however, characteristic of CSA, which is likely to make it especially difficult to protect the children. The inherent difficulties are worsened by professional challenges at individual and organisational level.

6.1.2 Perpetrator history

In four SCRs, the perpetrator had previously abused other children; three of these perpetrators were known to services. Perpetrators deliberately deceived professionals and other family members about their actions.

> *Unknown to the family or any of the professionals working with Laura and her mother at the time, [mother's partner] was a registered sex offender, regularly visited by police in his 'home' town (Area 2) in line with multi-agency public protection arrangements (MAPPA). [The mother's partner] repeatedly reported to officers on these occasions that he had no contact with children and was not in a relationship with anyone.*

In the case above, there were errors in Multi-Agency Public Protection Arrangements (MAPPA), contributed to by high workloads and inadequate supervision, which enabled mother's partner to continue abusing for many years:

> *… the risks [mother's partner] posed were not identified or well understood … due to the high numbers of persons requiring to be managed, combined with the administrative burden and the high turnovers of line managers. This, the review team were told, led to an increase in stress and sickness levels for staff, and made it more likely that risks in some situations were not recognised.*

6.2 Vulnerable families

There were pre-existing vulnerabilities in seven families with mothers having mental health problems, learning disability, and experiencing domestic abuse. In two families, children had been placed with extended family due to maternal mental health issues or substance misuse, and children were abused in their care. These vulnerabilities most likely made it easier for perpetrators to gain access to children.

Two children had learning disabilities and attended special school. Their additional vulnerability may have made them an easy target; one young woman, despite relationship and sex education, had not been able to recognise that her mother's partner was abusing her. Behaviour problems in children with learning disability could be seen as due to their underlying condition and other causes not explored.

> *Laura's apparent 'difficult' behaviours as she grew older seemed to be attributed to her ADHD and learning disability diagnosis and a lack of structure and consistency in the home environment. Consequently, the reasons for Laura's difficult behaviours as reported by [mother], were never fully explored, or queried in any depth by professionals involved with the family.*

It is important that professionals do not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting; professionals need to take a holistic approach considering alternative causes. They should remain mindful that young people with learning disabilities are at greater risk of abuse and may only display their distress through their behaviour. Ofsted *et al.*, (2020) suggest disabled children are around three times more likely to be victims than non-disabled children but receive poorer responses from professionals than non-disabled peers.

In three families, older siblings had suffered abuse previously from other perpetrators within the family. This suggests that these families may have been unable or unwilling to identify risks, were not offered or able to access help and support, or at worse had been complicit in the abuse.

One mother did not alert any professional when one of her children told her that a younger one was being abused by a relative. The mother had been abused in childhood by the same relative, and did not feel able to discuss what she had been told with the other child or their social worker.

> *Child B told me about the abuse on the phone, she was supposed to come around and talk about it – I thought it was inappropriate touching. She didn't come round to talk; it never came up again. Child B had been caught shoplifting and I thought she'd made it up so she could come and live with me quicker. Because I didn't tell the SW at the time, I couldn't talk to her. I could have told [previous SW] and asked her to explore it with Child B.*

The child in the above case was scared to disclose as they feared family breakdown and not being believed:

> *I felt I had no privacy and couldn't tell anyone, but at the same time I didn't want to move from my family. I used to put on a happy face to hide my problems. I didn't want people to know. I told Mum about the sexual abuse,*

but I didn't make it clear what had happened. I told Sibling 1, but he didn't believe me cos I'd told so many lies.

6.2.1 Non-engagement with professionals

In four families, parents avoided engaging with professionals making it much more difficult for concerns to be investigated. This included refusing to acknowledge the children's behaviour difficulties, deliberately misleading professionals and outright hostility and physical intimidation. One family did not allow their children's allegations of CSA to be investigated, which resulted in 'No Further Action' decisions from agencies. In some of these families non-abusing parents made strenuous attempts to prevent investigations. This may have been because they themselves were victims of coercive control, domestic violence and neglect, but in at least one case the non-abusing parent was likely to have been complicit in the abuse.

Key learning: Engagement with families is key to effective support and investigation, and when families do not engage professionals need to consider the underlying reasons and likely outcomes for the child. Practitioners need to be aware that deception is a key feature in intrafamilial CSA, and take this into consideration when families do not engage.

6.3 Identifying and responding to child sexual abuse

A frequent difficulty for social workers was identifying that children were being sexually abused, which then prevented effective action being taken. In five families, children only disclosed sexual abuse after they had moved to a place of safety, or when they were directly asked.

Shortly after the children were removed from the family home, they began to talk to care givers and professionals about their previous home life and of being sexually abused.

All five of these children showed behaviour difficulties, most with aggressive, challenging and sexualised behaviour. It could be considered that these children were disclosing through their actions rather than through words.

[The child] showed increasingly aggressive and sexualised behaviour in the classroom. This behaviour included assaulting her peers and teaching staff on a daily basis and had escalated in its frequency and severity in the time frame covered by this review.

Although few children verbally disclosed sexual abuse until they were in a place of safety, children in eight families displayed distress through their behaviour. This could be disruptive or challenging behaviour, inappropriately sexualised behaviour or

both. One case involved two children in a kinship care placement. Both were sexually abused. The behaviour of one of them became so extreme she required placement in a special school for children with emotional and behavioural difficulties. The girl spoke to the SCR author about her experiences, and said that no-one had asked her about the changes in her behaviour, or spoken to her alone:

> *We used to have to be so careful as the family were in the room. We never got offered to be seen alone – maybe we should just have been taken. Social workers could have taken us out, they just used to sit us down at home. I would have loved to have gone out without my siblings. Everything you said to the social worker got repeated back to the carers anyway.*

These siblings were looked after by the local authority and had regular contact with social workers, but were torn between wishing they had a chance to tell the social worker and fear of this. This points to the importance of social workers building relationships with children, so that they can feel secure enough to share their concerns and feelings; this is unlikely to happen without continuity of workers and appropriate caseloads.

> *Despite agency involvement her behaviour within school continued to raise concerns. She was continually aggressive and violent to both staff and other pupils and used sexualised behaviour and language that was inappropriate for her age.*

> *The youngest child had shown signs of sexually reactive behaviour and had possibly re-enacted their own experiences of being abused. Although they did not make a disclosure, they attempted to engage in sexual activity and initiated sexual contact with other adults and children.*

In some cases, professionals did not consider sexual abuse despite concerns about sexualised or challenging behaviour.

> *The issue of the children using sexually explicit language and exhibiting sexualised behaviour was explored in [two] single assessments, at strategy meetings, [two] CIN Meetings, core group meeting and ICPC but only in a superficial way. There was no real analysis of why it was occurring or formal recognition that abuse could be happening in the family setting.*

The review further identified that professionals lacked skills and knowledge in how to manage situations where there was no formal disclosure of sexual abuse; professionals were concerned about the behaviours but felt unable to act. The tendency to wait for a verbal disclosure was also noted in the JTAI report on child sexual abuse within the family environment (Ofsted *et al.*, 2020)

Key learning: children will often use behaviour to tell others that they are being sexually abused, and not use words. Professionals need to recognise this non-verbal disclosure of sexual abuse, not waiting for verbal disclosures to commence investigations.

6.3.1 Lack of response following disclosure

Five children made disclosures of abuse while living at home, four to professionals and one to family, but this did not lead to any meaningful change or effective safeguarding for them.

In three of the cases from this sub-sample, children's social care commenced investigations, but the children remained at home with abuse continuing. There was one case in a family with a history of CSA, where a boy had told his paternal grandparents about a relative 'getting his winky out'. He was spoken to by the social worker but said no more about this except that his relative 'often lied and hurt him every day'. There was a strategy meeting which concluded that '*no child protection enquiries were required as 'no immediate child protection issues were raised' and 'no immediate safeguarding actions' were required'…*.

Assessments were to continue and the allegations explored by the social worker, under a child in need plan. It was not clear how the conclusion that no child protection enquiries were needed was decided upon. It may have been because the police felt there was insufficient evidence for a police investigation and more work was needed before then, but exactly what was required was not recorded. A subsequent allegation of CSA occurred six months later.

But the response to a disclosure should not only be investigative, it also needs to be sensitive and supportive to the child, and to the non-abusing parent/relatives. Getting the balance right is skilled work. In a further case from the qualitative sub-sample, the investigating police officer provided a high level of support to the family. The mother told the review that the officer had 'built trust, had been supportive and had always been available, including throughout the criminal trial …'. In contrast, the mother felt that children's social care 'had a focus on risk of harm only and offered no other support even when support was requested'.

6.4 Neglect as a smokescreen

Neglect was a major factor in eight families, which dominated interactions with professionals who focused on the neglect; the sexual abuse then continued despite ongoing social care investigations or support. Children's behaviour problems were viewed as due to poor parenting and emotional abuse, and sexualised behaviour sometimes ignored.

In one large family with chronic neglect and anti-social behaviour, the children were viewed as a group as perpetrators of criminal activity, and not seen as vulnerable individuals. There were few attempts to talk to them separately or consider the reality of their daily lives where they experienced squalor, no education and fear. There were disclosures of sexual abuse and children showing sexualised behaviour but these were not investigated as the focus remained on the other complex issues.

In another case, although there was considerable social care involvement with the family concerning neglect, criminality and anti-social behaviour, allegations of sexual abuse were not investigated further.

Professionals need to be mindful that child sexual abuse and neglect may occur together, and sexualised or challenging behaviour needs to be explored fully not just attributed to neglect.

6.5 Challenges in CSA investigations

There were clear issues in the investigation and management of CSA in seven of the ten SCRs, relating to poor risk management, inaction and confusion following disclosure or suspicion of abuse, not arranging CSA examinations, not recognising potential physical symptoms of CSA, and delays in obtaining Achieving Best Evidence (ABE) interviews.

6.5.1 Risk management in families with previous CSA

Three cases occurred in families with previous histories of CSA. These featured inadequate or missing risk assessments and lack of information-sharing between agencies on the potential risk posed by perpetrators. The reasons for these shortcomings are not specified, but it should have been recognised that these children were living in high-risk environments.

> *The assessment was never updated or reconsidered in light of new information, such as when an adult female made allegations of sexual abuse against the children's father. This led to the risk of sexual harm to the children being unassessed. There was a need for a holistic assessment to identify any vulnerabilities, family dynamics and needs of the adults and children to determine whether the children could be protected and that the person responsible for protecting the children had the capacity and ability to do so.*

In the case above, there is no information why the local authority did not update risk assessments. Another example relates to a girl in a family where her siblings had been removed due to sexual abuse by her father; following assessment within care proceedings the girl was returned to her mother's care under a supervision order.

The mother then started a new relationship with a man who subsequently abused the child. There was minimal acknowledgement by social care of the risks faced by this child, given the significant abuse that had occurred previously in the family.

> *Given the concerns about [mother], her past history and research about how perpetrators target children and groom families, this information, contained in [Forensic Psychologist's] report did not lead, as it should have done, to a risk assessment on [mother's partner]…*

This contributed to further failures with poor management of the supervision order and 'child in need' plan, failure to develop the court required safety plan and lack of management oversight. The case was viewed as low risk and low priority. This failure to understand risk was further illustrated when the girl retracted an allegation, and despite pre-existing concerns that this might happen and uncertainty around mother's ability to protect her, the retraction was not considered in a multi-agency forum. This resulted in the child remaining at home with her abuser and suffering further abuse.

> *Jane's letter did not spark enough healthy scepticism by CSC professionals, as might be expected, evidenced by the decision not to seek the views of other professionals but to speak only with Jane about her letter…..what was missing was any evidence that the content, context and circumstances of Jane's retraction had been as carefully and well considered by CSC and agency partners as was her initial allegation*.

6.5.2 Inaction and confusion when responding to CSA

In five cases disclosures by children were not adequately investigated: strategy meetings were not held, ABE interviews delayed, concerns were side-lined by focusing on other issues such as neglect and in one case parents refused to let their children be interviewed (the reasons for this are not explored in the SCR).

> *…there is the accumulation of evidence strongly indicating that the youngest child had been either sexually abused, exposed to inappropriate sexual material or witnessed sexual abuse as a third party. The concerns from the primary school, Police intelligence reports and direct experience from the professionals involved with the family needed to be brought together through a Section 47 strategy discussion. In this instance, despite the multi-professional concerns, a Strategy Discussion was not initiated.*

In the same family, an older male child had disclosed sexual abuse from an adult female; this had also been inadequately managed. Possible reasons for this are raised in the SCR, but not answered:

> *Given the strength of the evidence, the decision not to investigate further is unusual and contrary to Police guidance. The decision poses the question about whether there was an unconscious bias because the victim was a male and the perpetrator an adult female, or whether the identity and history of the victim played a part in the decision not to take further action.*

In a family with complex neglect and anti-social behaviour, social workers took no action when other professionals raised concerns about CSA and a 15-year-old girl became pregnant. This information became lost, the children were not considered as vulnerable but instead as perpetrators of criminal activity, and the family viewed as close and supportive rather than coercive.

In one case professionals raised concerns to social care for at least nine months about extreme sexualised behaviour. In this case it seemed professionals were waiting for a verbal disclosure from the child before taking action.

> *Many of the professionals that were spoken to during the review believed that in view of the extreme nature of her behaviour the escalation to a section 47 inquiry came too late and that previous interventions had failed to truly address the issues raised.*

In the above case the child subsequently presented with genital injuries but again professionals were uncertain about what actions could be taken in the absence of a clear disclosure. Not responding placed her at further risk and potentially jeopardised investigations.

> *The paediatrician stated that she had made it clear to those in the [strategy] meeting that she had a high level of suspicion that [the child] presented with injuries of sexual abuse and was advising that a specialist sexual abuse examination needed to be arranged immediately….the children's services manager said there is 'no disclosure, only suspicion of sexual abuse and therefore insufficient evidence to reach threshold for Section 47 …'*

The grounds for a s.47 investigation do include 'reasonable grounds to suspect' that a child is suffering significant harm. The SCR concluded that some professionals had felt the need to have a criminal burden of proof to commence s.47 enquiries, which prevented effective safeguarding and was contrary to *Working Together* guidance. It also contributed to the child remaining at home with her abuser for many months.

In one case involving a 4-year-old child, the strategy meeting decided against an ABE interview but this was subsequently agreed upon when the case was transferred for investigation. The interview took place four months after the allegation was made, although local protocols were for ABE interviews to be arranged within 24 hours of a strategy discussion. The delay is described as 'unavoidable' but no

reason is given. The delay is likely to have had an impact on the child's ability to recall events.

The uncertainty may reflect a difference between police and social care about whether the primary purpose of the interviews is to enable children to talk about what has happened so they can be helped (the social care perspective), or to adduce evidence for possible use in a criminal prosecution (police perspective). The good practice guidance on ABE interviews emphases the importance of careful planning for the interview, and is clear that 'the safety and welfare of victims and witnesses takes primacy over the needs of the investigation' (Ministry of Justice and National Police Chiefs Council, 2022). The SCR on the 4-year-old concluded:

> *Where there are suspicions that a child has been sexually abused the strategy meeting should ensure that a process for determining the need for Achieving Best Evidence interviews should be in place and that planning for any proposed interviews is consistent with best practice.*

In order to ensure that ABE interviews are conducted promptly and effectively there needs to be a sufficient number of police officers and social workers trained to do them. This was raised in the 2014-17 overview of SCRs and continues to be an issue, as found in another case:

> *The detective sergeant who was on duty… stated she does not have enough staff who are trained and experienced in child protection and in undertaking ABE interviews at any time.*

6.5.3 CSA examination

In two of the ten cases there was confusion surrounding the need for specialist CSA examination despite national guidance on the requirements for these:

> *A paediatric forensic assessment is required whenever a child has made an allegation of recent or non-acute (historic) sexual abuse, sexual abuse has been witnessed or if the referring agency has a reasonable cause to suspect sexual abuse has occurred* (Royal College of Paediatrics and Child Health, 2020)

This was illustrated in one case where following disclosure a GP appropriately referred a child to the MASH for a CSA examination to be arranged, but this was deemed unnecessary. The child remained at home and was further abused. The decision not to go ahead with it had been made by a senior manager, although she was not aware at the time of advice that had been given by the designated doctor. But the SCR says that this decision was 'accepted by practitioners of all disciplines without further challenge'.

Some professionals consider CSA examination as unhelpful and potentially traumatising for children, and this may be partly why they do not think these necessary (Morris, Rivaux and Faulkner, 2017). Long delays after the abuse may also influence their views, as noted in one SCR where the medicals took place more than two years after they were first discussed:

> *There is a difference of opinion within the professional network, as to whether the initial decision that medicals were not in the children's best interest was (a) due to the allegations being historic and therefore unlikely to produce credible forensic evidence or (b) whether a decision was made that a medical was not needed.*

There is good evidence that specialist CSA examinations need not be traumatic if they are performed sensitively, and can be very helpful in assuring children, even much later, that they have not been harmed by the abuse (O' Keeffe and McElvaney, 2022).

6.5.4 Physical symptoms

Children in three SCRs presented to GPs with physical symptoms that could have been attributed to sexual abuse. One teenager with a learning disability attended the GP twelve times in three years with genito-urinary symptoms but was never asked about her sexual history; this is contrary to NICE guidance (National Institute for Health and Care Excellence, 2018) and suggests a lack of professional curiosity on the part of the GP, possibly due to not recognising the increased risk of abuse.

In another case, a baby's mother reported that there was blood in his nappy, but did not attend for follow-up. Information that the father had previously abused other young children had not been shared with the GP. It is possible that the bleeding was not due to abuse, but the lack of information prevented a holistic understanding of the situation.

GPs need to be aware of current guidance on when to suspect child abuse, but equally important is that relevant information is shared with them, so that they can consider the context of physical symptoms. In the case above the GP may have been more pro-active about follow-up had they known the risks in the family.

6.5.5 Investigation of other child protection concerns

In eight cases, there were problems with other child protection investigations; these issues contributed to children remaining in homes where they suffered sexual abuse. One child presented with possible non-accidental injury (a bruised eye); the limited enquiries did not detail all adults in the household which may have revealed mother's partner being subject to MAPPA due to previous CSA.

> *Had there been a strategy discussion in response to Laura's injuries, which would be expected practice, further details about [mother's partner] would undoubtedly have been sought.*

Two children were abused by their kinship foster carer, as previously discussed. There were regular Child Looked After reviews but no-one challenged the view of this being a positive placement despite increasing behaviour problems, overcrowding and poor home conditions. These reviews were held at the family home and due to inadequate space school staff were excluded despite being the professionals with most contact with the children.

> *There was lack of critical questioning by all professionals involved at the time and lack of robust monitoring of the care plan and personal education plan. The LAC reviews were at times repetitive and tokenistic and served to progress the positive view of a settled placement.*

Had the initial assessment of these carers been more robust it is likely that the children would never have been placed with them.

> *Carer 1 and Carer 2 did not fulfil the responsibilities expected of kinship carers, however there was lack of challenge and the carers had minimal involvement with the local authority. … The benefit of keeping the children within the family and together appeared to have prevented consideration about whether this was the best placement for the children.*

In three cases, severe neglect had persisted over a long period and had been the focus of child protection investigations. In these cases there were issues such as case drift, lack of focus, little meaningful change for children, poor information sharing and over-optimism; these led to the children remaining at home with their abusers despite thresholds for removal being met. Had the earlier management of non-CSA safeguarding practice been better, the children may have either not been placed with abusers or protected from them significantly earlier.

6.6 How can we better protect children from sexual abuse?

Many perpetrators of CSA are repeat offenders. Obtaining accurate data on repeat offenders is challenged by lack of reporting of abuse but studies have suggested recidivism rates of 13-20% (Marques *et al.*, 2005) or even higher at up to 42% with 10% occurring more than 10 years after the original offence (Hanson, Steffy and Gauthier, 1993). Recent research and research gaps are usefully summarised in an evidence review on the scale and nature of CSA by the Centre of Expertise on Child Sexual Abuse (Karsna and Kelly, 2021). There is helpful information and guidelines for practice in the 2015 report by the Children's Commissioner for England (Office of the Children's Commissioner, 2015) and the 2020 JTAI report (Ofsted *et al.*, 2020).

The cases in our sample suggested re-offending was common. When known perpetrators are living with families there should be robust up-to-date risk assessments, which are regularly reviewed particularly when new information becomes available. Information should be shared with relevant professionals working with such families, so that they can be alert to any potential signs in children particularly as children rarely disclose abuse directly.

In some families, older children had previously been abused and then younger children were abused by different perpetrators. This can be interpreted as perpetrators targeting particularly vulnerable families who may not be adequately supported by social care to recognise risks, or that some parents/carers may actually be hiding the fact that they are complicit in the abuse.

The Child Sex Offender Disclosure Scheme, or ‘Sarah's Law’ allows parents to ask police if someone with access to their children has been convicted or suspected of child abuse; there were no requests made under this scheme for the cases in this analysis. This could be promoted to particularly vulnerable families: those with children with disabilities through special schools and support services, and by social care working with families where children have previously been abused.

When families do not engage with professionals, denying concerns about their children’s behaviour or their home circumstances, it is important for professionals to consider the reasons behind this. While non-engagement may more commonly be due to parents finding it difficult to change entrenched habits, in CSA cases it may also be part of the attempts to deceive. Similarly, professionals need to be able to look beyond neglect and emotional abuse in complex families to consider alternative explanations for challenging behaviour.

Professionals need to recognise sexually inappropriate behaviour as a ‘red flag’ for sexual abuse and consider this fully in a multi-agency forum and be prepared to start detailed investigations without waiting for a verbal disclosure.

In summary, professionals may need to reframe how they work with families where there are concerns of intrafamilial child sexual abuse, being more aware of the likelihood of deception and coercion, and being ready to investigate this. They need to look behind neglect and consider why families may not be engaging with them. Professionals should not wait for direct verbal disclosures to take action but accept that children may only tell through their behaviour. Safeguarding in intrafamilial child sexual abuse is difficult and daunting work for professionals who will need training, time, resources, and supervision to be effective.

Chapter summary

- Deception is a key feature of CSA, with perpetrators and sometimes other family members actively avoiding professional interventions enabling abuse to continue.
- Perpetrators had often abused other children before, but some were able to obtain access to children despite professionals' knowledge of their previous offences.
- Children rarely disclose CSA verbally, but may show they are experiencing CSA through challenging and sexually inappropriate behaviour.
- Professionals were often reluctant to take protective action without a clear disclosure from children.
- When children did disclose CSA, shortcomings in investigations resulted in some children not being protected and continuing to be abused.
- Health professionals sometimes missed physical symptoms that could be related to CSA.
- Chronic neglect occurred in many families, this sometimes became the focus of social care intervention and CSA continued unrecognised.

Chapter 7: Learning lessons and moving ahead

This chapter concludes the 2017-19 review, and indeed the whole series of government-commissioned periodic reviews of SCRs. It links with the separate overview of the history and lessons of SCRs, published at the same time as this report, that we have prepared as part of our commission from the DfE (Dickens, Taylor, Cook, Cossar, *et al.*, 2022a).

We were pleased to be awarded the commission to undertake this final review, giving us a chance to conclude the series of nine reviews, seven of which have been led by teams from the University of East Anglia, with colleagues from the universities of Warwick and latterly Birmingham. Over the last two years we have also had the opportunity to work on the first two annual reviews of local child safeguarding practice reviews (LCSPRs), commissioned by the national Child Safeguarding Practice Review Panel. This gives us a good vantage point to review the lessons that have been learned from SCRs and the messages to go ahead into the new system.

Three broad lessons stand out from our analysis of the 2017-19 SCRs, linked with each of our main chapters:

- The importance of recognising and addressing neglect, especially untangling this from the effects of poverty, to be sure that practitioners are addressing the correct issue in the best way;
- The importance of communication as the basis for effective work with families, children and young people, and other professionals. This underpins information gathering and sharing, analysis and planning, and 'challenge' when necessary. It requires manageable workloads, sufficient time, clear frameworks/guidelines and active supervision;
- The importance of listening to the 'voice of the child', and recognising that children do not always tell in words what they are experiencing or thinking, but may often show it through their behaviour (child sexual abuse powerfully illustrates this).

It has to be said that these are not new messages. They are crucial, but they are well-known, and come round regularly. This leads to one of the frequent criticisms of SCRs, that they were – put bluntly – ineffective.

7.1 Learning lessons from SCRs

SCRs were often criticised for not identifying lessons clearly enough, typically being over-long and descriptive; and because any lessons they did generate did not appear to be learned and children continued to suffer harm. The Wood review of 2016 characterised them as expensive and slow, and their findings being often

repetitive and banal. It can appear like that, but there is merit in a more nuanced view. It is important to be realistic, in two senses: to recognise that SCRs were (and LCSPRs still are) a relatively small part of a huge multi-organisational structure with multiple pressures and requirements, and can only be effective in so far as these complex systems allow them to be; and second, to appreciate the achievements that have been made, often local and unsung, despite those obstacles.

The SCR process has to be set in its organisational and societal contexts, and its effectiveness assessed in the light of them. The complex and often incompatible goals of the system were outlined in Chapter 1. Here, it is worth recalling the huge changes in the organisation of child safeguarding services and the understandings of child abuse and maltreatment that have occurred since 1998, the first year covered by the periodic reviews; and the changes over the period in society and the risks and harms that children, young people and families face.

The organisational changes are discussed more in our historical overview, but to highlight just one here, are the changes to the requirements and structures for managing multi-agency child protection work. There have been numerous revisions to the *Working Together* guidance, and area child protection committees (ACPCs) were replaced by local safeguarding children boards (LSCBs), and they have now been replaced by local child safeguarding partnerships.

In terms of societal change, we live in an increasingly diverse society, but the pressures on young people and families are greater than ever. There are the long-standing challenges of mental ill-health, drug and alcohol misuse, inter-partner violence, but exacerbated by new aspects such as 'county lines' drug dealing, online abuse and exploitation, the risks of social media, sexual exploitation, racism, deprivation and inequality. And although it came after the timespan for this review of SCRs, the Covid pandemic of 2020-21, particularly the lockdowns and school closures, further added to the risks to the well-being of families and children.

For the professionals who work with children and families – such as social workers, health visitors, general practitioners, police officers, teachers – keeping up with the organisational changes and societal pressures is a truly demanding job. The findings of SCRs are just one element in a barrage of information, legislation, guidance, agency requirements, instructions and training, and the messages they give may not always be easily compatible with other priorities – for example, a message to spend more time seeing children alone may not fit easily with the volume of work, or the place of work, or with principles about respecting parents' rights, or indeed respecting children's choices.

7.2 Views from practice

As part of this final overview, we held two online ‘knowledge exchange events’ with representatives of local child safeguarding partnerships, to explore how the reviewing of serious cases and the practices they reflect have changed over time, and what messages there were to help safeguarding partners in their work going forward. The events were organised and hosted by *Research in Practice* and took place in January and February 2022.

Almost a hundred people attended over the two events, covering a wide range of professional roles, including local authority senior managers, safeguarding advisers and social workers; local partnership managers and chairs; designated nurses, midwives and doctors; police officers and independent reviewers. There were no school-based staff. The main professional groups in attendance were from social work and health.

The attendees were divided into smaller groups to facilitate their discussions and were asked to address three questions: what have been the key changes in practice over time; what are the ongoing challenges for practice and for reviews of serious cases; and what impact have SCRs had in their area – and linked with the last question, how do they know. The responses were noted on online ‘jamboards’. There was of course duplication between the groups, but also differences largely reflecting the composition of the groups. Groups were mixed, but some had more from one professional background than others, which showed in the detail of their answers. A selection of the responses is given in the shaded box below. We have kept some of the original wording, to capture the flavour of the lively and well-informed discussions from experienced, committed staff.

Key changes in practice over time

Much more inter-agency working now – a general sense that this is much better, but there are still gaps and room for improvement

Cases have become more complex – greater awareness of extra-familial harm, especially criminal and sexual exploitation

Higher thresholds for services – risk is that children who do not meet the threshold are overlooked

New understandings and approaches – eg impact of trauma, models of strengths-based practice (Signs of Safety model mentioned)

Staffing difficulties – shortages, turnover, sickness rates – loss of knowledge and experience. Large numbers of newly qualified social workers, and agency-employed workers.

Health staff: new roles such as designated lead safeguarding nurse; but changes to role of health visitors – much less contact with families, less continuity; school nurses not as available as before; some said it is still difficult to get involvement from GPs, others said this had improved; changes to maternity services, now much more aware of risks and domestic violence

Changing legislation, especially about information sharing

Much greater role of IT systems – some benefits but many problems

More reliance on voluntary services

Ongoing challenges

In practice:

High workloads – 'staff know what they should be doing, but can't'

Changes to role of health visitors have increased the vulnerability of under-1s – fewer visits to support parents, children are not seen as often

Poor quality IT systems, systems that do not 'talk' to each other

Uncertainty about information-sharing and consent

More short-term funding for projects – unstable

Poverty and deprivation – wider societal issues impact on what can be done at practitioner level

Challenges of inter-agency working especially when boundaries don't align, including the amount of work it involves – 'so many meetings',

Need to build relationships with voluntary/community sector – offer support and training

Cuts in early intervention lead to more CP intervention later

In SCRs:

SCRs are focused on failures, do not show good practice

SCRs still feel accusatory and blaming – 'grind practitioners into the ground'; but others welcomed the greater involvement of practitioners, and said if done well, this can be positive – it can help their learning and provide 'closure', and improve the recommendations

High levels of media interest, and nowadays social media – can spread misinformation, makes it traumatising for practitioners

Same messages come round again and again – ‘feels like Groundhog day’

We know what the answers will be, why do reviews? Use the money to employ more workers

Delay in publishing SCRs because of criminal proceedings – the learning needs to be implemented before that

Courts avoid scrutiny in SCRs

Some have too many recommendations

Messages still not disseminated down to the ‘ground floor’

The risk of messages not being heard because of ‘information overload’ – too many emails, newsletters etc.

SCRs focus on local issues and not the impact of national policies

A tension was highlighted between giving full information to underpin learning, and respect for the families’ privacy and feelings. The impact of SCRs can be limited if they try to sanitise what has happened – they need to avoid professional jargon and ‘say it like it is’. On the other hand, we need to be sensitive to how children and other family members may feel about this, especially when so much information is easily available on the internet and can be spread without control

The impact of SCRs locally and how this is known

SCRs have worked well when focused on a specific theme (e.g. neglect), which has led to new tools or procedures

SCRs have had a negative impact on public perceptions of social care

Have led to increase in child protection referrals

Little impact – ‘same things being churned out’

Lots of change – the challenge is how to sustain it

Messages disseminated in many ways: training sessions, staff supervision, ‘bite size’ learning sessions, single-page briefings, online seminars, powerpoints and ‘Sways’, safeguarding newsletter, ‘challenge events’

Audits to check on progress – e.g. interviewing practitioners and members of the public a year after the SCR to test whether learning has had the intended impact

Greater awareness of contextual safeguarding from an SCR led to work with licensed trade, hotel staff, taxi drivers – free training for them to recognise the signs of sexual exploitation and report it

An SCR that highlighted risks of young parenthood, led to condom distribution, a specialist health visitor for pregnant teenagers, work with young fathers

Positive impact is likely to be slow and incremental

Greater awareness of 'transitional safeguarding' (as young people move across children's and adults' services), worked with neighbouring local authorities to raise awareness

SCRs have kept the issue of child safeguarding high up the national and local agenda, and so helped preserve budgets

The differences of experience and opinion are apparent, and it is unlikely that everyone will recognise or agree with all these assertions (indeed, the contradictions make that impossible). But what the discussions clearly showed is that SCRs have been taken very seriously and have been used to underpin changes, even when they do seem to repeat the same findings; but their impact has to be understood alongside all the other drivers for and obstacles to change, notably organisational and legislative reforms, new practice models, workforce issues and resources; and the fundamental tensions and dilemmas outlined in Chapter 1.

7.3 Moving ahead

The aims of the new LCSPR system are specified in Chapter 4 of *Working Together 2018* (updated 2020)

> *The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving (HM Government, 2018, p. 84).*

A 'serious safeguarding case' is defined as one in which abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed (p. 85); but the emphasis on learning for improvements is critical. All serious cases that are notified to the Panel should have a rapid review within 15 working days; one of the

decisions of that review is whether the case should proceed to an LCSPR. Even if a case meets the criteria, the local partnership does not have to commission one: 'It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice' (p. 87). The aim was to move away from the old model of SCRs, to be much more succinct and analytic, with a clear focus on learning, rather than describing what had happened – to get to the *why* rather than the *what*.

We have undertaken two annual reviews of LCSPRs for the national Panel. The 2020 review reported on 33 LCSPRs, all that were available at the time (Dickens *et al.*, 2021) and the 2021 review on 84, the total that had been completed and submitted to the Panel in the calendar year 2021 (Dickens, Taylor, Cook, Cossar, *et al.*, 2022b).

It is still relatively early days for the new system, and of course it has had to contend with the Covid crisis. There are many of the old problems, of long delays, variable quality, describing what happened rather than analysing why, recommendations that do not lend themselves to 'SMART' action plans, but we found evidence that the new approach is taking hold. The skills and knowledge of the reviewer is the greatest factor for a high-quality report (as it was for SCRs), and partnerships often face difficulties in recruiting suitably skilled reviewers.

The LCSPRs show that many of the issues that undermine the effectiveness of safeguarding practice are to do with serious resource shortages, and this too is a long-standing problem. Children's social care and health services have had to cope with funding cuts and restrictions, and other services that could support families have also been affected.

We held a focus group with representatives of safeguarding partnerships for our review of the 2021 LCSPRs, asking particularly about the steps they had taken to implement the recommendations. There were similar comments about the challenges of the work, and on the limitations and strengths of the new reviewing system (Dickens, Taylor, Cook, Cossar, *et al.*, 2022b). We found again, as we had with the SCR knowledge exchange events, outstanding levels of thoughtfulness, creativity and commitment. The big challenge is the same as it has always been: to ensure that hard-pressed practitioners and first-line managers have the opportunity, guidance and support to put these qualities into effect, on a daily basis.

7.4 A wider perspective

Although serious case reviews (SCRs) have come to an end, the reviewing of serious cases continues, through rapid reviews, LCSPRs and national reviews. The lessons from the past still have relevance for the new system, about inter-

professional working, communication, ‘asking the next question’, listening to children, recognising signs and symptoms of maltreatment, effective supervision and so on; but perhaps the most important lessons are not about the details of practice but about the complexity and dilemmas of the work.

The high-profile scandals cause immense distress and anger – ‘why wasn’t something done?’ – but it is important to remember that practitioners are dealing every day with cases with similar patterns of need and risk, and that the SCRs deal with the extreme and relatively rare cases. The worst cases rarely come with clear signs that make them stand out from the others, until we can see them with hindsight. The well-known risk factors are not guaranteed predictors of serious harm – even the combination of mental health problems, domestic violence and drug or alcohol misuse, termed the ‘toxic trio’ in one of the earlier biennial reviews (Brandon *et al.*, 2010). This was later reframed as the ‘trigger trio’ by the Association of Directors of Children’s Services (2018), but it does not necessarily lead to abuse (Skinner *et al.*, 2021). The concept highlights risks, but it is misleading to think of it as a predictor.

As well as the difficulties of prediction, our social values, policy and legislation, do not allow the removal of children whenever there is the slightest risk of harm; it has to be a level of ‘significant harm’, with evidence to satisfy the courts, and (usually) evidence of the efforts that have been made to engage with and support the child’s family to care for him/her. The social and financial costs of trying to remove every child whenever there is an apparent risk would be intolerable. More than 66,000 children became the subjects of child protection plans during the year 2018-19 (Department for Education, 2019, Table D1); even if half of them could go by agreement to kinship placements, the burden on court proceedings and foster placements would simply overwhelm the system. Furthermore, there would be so many ‘false positives’ – that is, cases where children were removed who would not have been seriously harmed – that it would be a social scandal in its own right, and it would undermine trust between families and child welfare practitioners to such an extent that any work to help families change would become impossible.

The result is that we have a child safeguarding system that is about managing risk rather than eradicating it, with a series of stages, or filters, according to whether a child is assessed as being ‘in need’, in need of protection or on the edge of care proceedings (see the *Working Together* guidance). Practitioners and managers are managing risk all the time, and it is the nature of risk that sometimes there will be bad outcomes. We can and must try to reduce the likelihood of harm, and the SCRs do show some decisions and practice that seem questionable; but to learn from them we need to understand them in context, and the practical reasoning of the staff involved at the time. Practice can be improved, but this also requires significant resourcing for safeguarding partners and the other agencies they work with, to help them support families and protect children; and at least as important, more

investment in the ‘upstream’ services that can prevent need arising in the first place. But even if there were more resources, we have to accept that we cannot reduce the risk to zero. This is because it is impossible (there are no incontrovertible predictors of abuse, some misjudgements are inevitable in any field of human activity, and regrettably some people will deceive workers), but also because it would lead to a level of state intervention in family life that would be unacceptable in our society.

The SCRs show that there is always room for learning, even if the lessons are often the well-known ones; indeed, the repetition makes it all the more important that the messages are heard and acted on by all safeguarding practitioners and managers. But one of the reasons the shortcomings recur is because the challenges are always the same – of balancing need and resources, child protection and family support, empowerment and surveillance. As we move into the new era of LCSPRs, this policy perspective would be a realistic foundation for achievable change.

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Appendix A: Methodology

Introduction

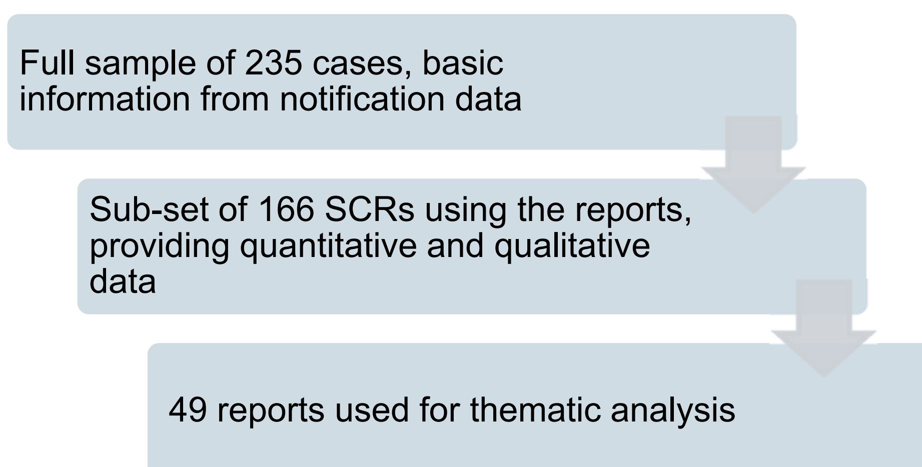
A mixed-methods approach was used for the project. This involved a quantitative analysis of those child protection notifications that led to a serious case review within the specified period, and further quantitative analysis of the sub-sample where final reports were available.

There were an additional number of SCRs (or executive summaries of SCRs) that the research team found on the NSPCC repository relating to an incident within this review period that were a) matched to a case listed in the DfE SIN data as not having proceeded to an SCR, but that in fact did b) that could not be matched to any SIN within the DfE data (N=11). In the latter case this leads to more missing data than in previous rounds, in some categories.

These final reports allowed the researchers to add further details to the database, sometimes based on researcher judgement, which enabled more comprehensive quantitative analysis of the sub-sample of cases.

In addition to this, the layered reading approach, developed in earlier studies (Brandon et al, 2008), was adopted for the qualitative aspect of the study. This involved brief reading of all SCR final reports and completing a brief summary sheet for each report (Appendix E). This layered approach is demonstrated by the diagram below, followed by more methodological detail.

Figure A.1



Notification data and SCR reports

Notification data were provided by the DfE, and were checked for accuracy and completeness, cleaned and formatted on an SPSS (statistical package for the social sciences) database. The research team was provided with an Excel spreadsheet with 1,119 incidents and notifications. From this, all those with an incident date between 1 April 2017 and 30 September 2019, which were listed as having proceeded to a SCR and did (some were in fact LCSPRs), or for which we had an SCR report (even though they were listed as having not having proceeded to SCR) were included (224 cases). Those with an incident date prior to 1 April 2017, or after 30 Sept 2019, those that did not proceed to a SCR, or which proceeded to an LCSPR, and those for which a decision on whether to proceed had not been made, were excluded.

An SPSS database was created from the included cases on the Excel spreadsheet and included incident date, details of the incident, child and family characteristics, child protection plan history and legal status of the child. Additional variable fields were constructed from the information given on each case and certain variables, for example age, were banded. Analysis was undertaken on the completed database of 235 cases, and this forms the core of Chapter 2.

- The majority of the SCR reports were provided by the Department for Education.
- A concurrent search was made of the NSPCC national case review repository and on individual partnership websites for published SCRs. These were matched to the SIN by at least three of the following variables: responsible partnership; child's initials or case reference; incident date; child's age or date of birth; name of reviewer/author; incident details.

A total of 166 completed serious case reviews (71% of all SCRs notified) were obtained by the research team by December 2021 (a list is in Appendix D). These comprised 105 fatal cases and 61 non-fatal serious harm cases.

Of the total 235 notifications that progressed to a full SCR, seven related to more than one child. These were:

- One review involving two unrelated single cases of covert filicide (treated here as two separate cases)
- One review of another covert filicide involving the killing of two children
- One review of familicide in which multiple family members were killed including two children

- Two reviews of intra-familial CSA involving a total of 11 children
- One review of physical abuse of two children
- One review of neglect involving two children

There were, therefore, 254 children involved in the 235 cases.

Additional quantitative information from the 166 final reports

The 166 available reports were read and summarised by the research team and the database updated. Details extracted for the summary sheets included:

- Demographic characteristics (region, age, gender, ethnicity, parents' ages, family size)
- Notes on household composition
- Category of death or serious harm (using categorisation systems developed by the research team for previous studies)
- Source of harm/perpetrator
- Background characteristics of parents and index child, for example substance misuse, mental health problems, domestic abuse, disability
- The presence of neglect (using our previously developed protocol for identifying neglect in SCRs)
- Case synopsis (researcher summary of key details about the case)
- Methodology used by SCR author
- A summary of key lessons / recommendations / learning points

Numeric and categorical data contained in each summary were coded and entered manually into SPSS and accompanying descriptive text summary case information copied across. The final dataset thus combined data drawn from two sources - notification data provided by DfE and our own researcher summaries.

Detailed qualitative analysis of 49 SCR final reports

A sample of 49 final reports was taken from the 166 available, to provide a sub-set for intensive qualitative analysis. The cases in the sub-sample were purposively selected to further explore our chapter themes and to reflect, as far as possible, the notification data in terms of the age/gender/fatal or non-fatal nature of the incident and geographical region. Most cases selected raised particular issues of concern and interest across a number of our themes, and include both those cases that have received public attention as well as less well-known cases. Members of the research team drew on these cases for the subsamples in the focused chapters on neglect, professional practice, the voice of the chid and intra-familial child sexual abuse. Dr Russell Wate QPM used them to review the role of the police; that information is woven into the focused chapters.

Appendix B: Classification of deaths

The classification of death is based on a review of the data on the child protection database of notifications, supplemented, where possible, by reading the SCR overview report for relevant information pertaining to the child's death. A 'best fit' assignation is given where the information is pointing towards one category of death according to the guide below. Where no relevant information is available, or the assignation is not clear from the information given, this is coded as 'category not clear'. Where information is available, the suspected perpetrator(s) is given. In cases of suicide/self-harm, this is assigned as self; in cases of neglect, this is assigned as 'both parents' unless the information points more clearly to one parent or another carer. Where the SCR gives an indication that the likely perpetrator is not known, that is listed as 'not known'. Where the information is missing or unclear, this is listed as 'not clear'.

Categories

1. ***Fatal Physical Abuse***
   Deaths following severe physical assaults (non-accidental injuries) where the suspected perpetrator is a parent or parent figure, and where there is no clear intent to kill or harm the child. Includes deaths from non-accidental head injuries (shaking or shaking-impact injuries), abdominal injuries, and multiple injuries. May include deaths where an implement has been used, but without evidence of intent to kill or harm the child.

2. ***Overt Filicide***
   Deaths where a child is killed by a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. This includes multiple or extended familicide, or where the suspected perpetrator takes or attempts to take his/her own life. Includes deaths in fires with suspicion of arson and the suspected perpetrator is a parent/parent figure. Includes deaths from stabbings and firearms, or severe assaults with evidence of intent to kill the child.

3. ***Covert Filicide***
   Deaths where a child is killed by a parent or parent figure but using less overtly violent means, and with some apparent attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. Includes deaths from abandonment, poisoning, drowning, suffocation or asphyxiation. Includes deaths of newborn babies following concealed pregnancies and deliveries.

4. *Extreme Neglect/Deprivational Abuse*

Deaths where the child dies as a result of severe deprivation of his/her needs with evidence that this has been deliberate, persistent or extreme. Includes deaths as a result of heat or cold exposure, starvation, or extreme, deliberate withholding of basic health care. Exclude deaths in which the neglect appears be a reflection of parental incompetence, related to learning difficulties, physical or mental ill-health, socio-economic deprivation and lack of access to services, or other environmental circumstances.

5. *Severe, persistent child cruelty*

Deaths where a child dies as a result of a physical assault or neglect, and in which there is evidence of previous severe and persistent child cruelty. Includes deaths where a post-mortem examination reveals evidence of previous inflicted injuries (for example, healing fractures) or long-standing neglect in addition to the primary cause of death; and children who have previously been on a child protection plan because of identified physical or emotional abuse or neglect.

6. *Child Homicide*

Deaths where a child is killed by someone other than a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. Includes deaths in fires with suspicion of arson and the suspected perpetrator is someone other than a parent/parent figure. Includes deaths from stabbings and firearms, or severe assaults with evidence of intent to kill or harm the child. Includes deaths following sexual assaults by a non-parent perpetrator. May include gang-related violence where there appears to have been intent to kill the specific victim, but excludes more general gang-related violence.

7. *Fatal Assaults*

Deaths following severe physical assaults where the suspected perpetrator is someone other than a parent or parent figure, and where there is no clear intent to kill or harm the child. Includes peer-on-peer violence without evidence of intent to kill. Includes gang-related violence without evidence of intent to kill the victim.

8. *Deaths Related to Maltreatment*

There are a large number of deaths which are felt to be related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death. Includes sudden unexpected deaths in infancy (SUDI) with clear concerns around parental care but where the death remains

unexplained or is attributed to a natural cause. Includes fatal accidents where there may be issues of parental supervision and care, including accidental ingestion of drugs or other household substances; drownings; falls; electrocution; gunshot wounds; and fires. Includes those children dying of natural causes whose parents may not have sought medical intervention early enough. Includes deaths of older children with previous maltreatment, but where the maltreatment did not directly lead to the death, for example, death from an overwhelming chest infection in a child severely disabled by a non-accidental head injury, suicide or risk-taking behaviours, including substance abuse in young people with a past history of abuse.

Appendix C: Neglect protocol

- Current CP plan or past CP plan for index child under category of neglect.
- Indications of neglect featuring in the background to the case included one or a combination of the following factors:
    - 'Neglect' directly referred to as a feature of the case.
    - Child poorly nourished / failure to thrive,
    - "Poor living conditions" or fuller, more thorough descriptions. (This phrase was also looked for in previous analyses as our best proxy for poverty, which was rarely mentioned).
    - Drug/alcohol misuse in pregnancy,
    - Concealed pregnancy/birth,
    - Persistently not accessing health care for child/ante-natal care/not acting on medical advice/untreated ailments,
    - Repeated missed appointments,
    - Inappropriate supervision of a child, including inappropriate babysitter, supervision while under the influence of alcohol or drugs,
    - Inadequate clothing/hygiene,
    - Sustained reluctance to engage with services,
    - Serious school attendance concerns related to neglect,
    - Child accessing firearm or ingesting a harmful substance (associated with lack of supervision).
    - Evidence of neglect identified after the incident, for example, malnutrition identified at post-mortem examination.

Appendix D: List of 166 SCR reports used for analysis

Local Authority	Child Initials and SCR name	Death or SH
Bedford Borough	JJ (Rosie)	Serious Harm
Birmingham	LNT	Serious Harm
Blackpool	KH (Child CB)	Death
Blackpool	LB (Child CA)	Death
Blackpool	MJ	Death
Bolton	AL	Serious Harm
Brent	AS	Death
Buckinghamshire	MP	Death
Buckinghamshire	Baby N	Death
Buckinghamshire	EB	Death
Bury	SG	Death
Bury	ZBE	Death
Bury	SR	Death
Bury	BW	Death
Cambridgeshire	RM	Death
Cambridgeshire	CNM	Serious Harm
Cambridgeshire	Eleanor	Serious Harm
Central Bedfordshire	AM	Serious Harm
Central Bedfordshire	MH (Joe)	Serious Harm
Cumbria	AGL	Serious Harm
Cumbria	MAM	Death
Darlington	Child C	Death
Darlington	Child F	Serious Harm
Derbyshire	HS	Serious Harm
Dorset	WP (Child A)	Death
Dorset	Child T	Death
Dorset	LMP	Death
Dudley	MB	Death
Dudley	ET	Death
Durham	JJW	Death

Local Authority	Child Initials and SCR name	Death or SH
Durham	RW (Family W)	Serious Harm
Durham	BTM	Serious Harm
Durham	MT	Serious Harm
Durham	DD (Family D)	Death
Ealing	YI	Death
East Sussex	HR	Death
East Sussex	Child T	Death
East Sussex	LS	Serious Harm
Gloucestershire	AD	Serious Harm
Gloucestershire	ET	Serious Harm
Gloucestershire	NDD	Death
Hackney	CS	Death
Hackney	TJA	Death
Hackney	AF (Child P)	Serious Harm
Hampshire	Child A	Death
Hertfordshire	Child J	Death
Hertfordshire	TTM (Child I)	Death
Hertfordshire	SCA (Child K)	Death
Hounslow	AM	Death
Hounslow	MM (Sasha)	Death
Hounslow	RK	Serious Harm
Islington	NB	Death
Kent	JLK	Death
Kirklees	KL	Serious Harm
Knowsley	Child Y	Death
Knowsley	Jane	Serious Harm
Lancashire	AFC (Child LK)	Death
Lancashire	EM	Serious Harm
Lancashire	AP (Child LN)	Death
Lancashire	DR	Death
Leicester	OD	Death
Leicestershire	Child C	Death

Local Authority	Child Initials and SCR name	Death or SH
Lewisham	ATF	Serious Harm
Lewisham	ML	Death
Lewisham	FB (Child Y)	Death
Lewisham	OB (Child X)	Death
Lincolnshire	MB	Death
Luton	NF	Serious Harm
Manchester	ERC	Death
Manchester	JC	Death
Manchester	ERO	Serious Harm
Manchester	Child 01	Serious Harm
Medway	TG	Death
Medway Towns	AL	Death
Merton	SP (Child D)	Death
Middlesbrough	Billy	Serious Harm
Milton Keynes	DG	Serious Harm
Newcastle	Baby A	Death
Newcastle	ALO	Serious Harm
Newham	CD	Death
Norfolk	CL	Serious Harm
Norfolk	DC	Death
Nottingham City	UTS	Serious Harm
Nottinghamshire	JW	Death
Oldham	Child M	Serious Harm
Oldham	MS	Serious Harm
Oldham	Child O	Death
Plymouth	RS	Death
Plymouth	CC	Serious Harm
Portsmouth	EB	Death
Portsmouth	DG	Death
Redbridge	TN (Baby T)	Death
Richmond upon Thames	CF	Death
Rochdale	EB	Death

Local Authority	Child Initials and SCR name	Death or SH
Rochdale	CC	Serious Harm
Rochdale	BS (Child E)	Death
Salford	LM (LC)	Death
Sefton	IMR	Serious Harm
Sheffield	SB	Death
Sheffield	BB	Death
Shropshire	ADS (Child E)	Death
Shropshire	The G Children	Serious Harm
Solihull	UW (Baby A)	Death
Somerset	SC	Serious Harm
Somerset	CJB (Family A)	Serious Harm
South Gloucestershire	SC	Death
Southampton	Connor	Death
Southampton	Danny	Serious Harm
Southampton	Ethan	Serious Harm
Southampton	DC (Family B)	Serious Harm
Southend on Sea	OK	Death
Southwark	NKN	Serious Harm
St Helens	SR Child B	Serious Harm
Staffordshire	RH	Death
Stockport	RL	Death
Suffolk	KD	Death
Suffolk	AR	Death
Suffolk	Mary	Death
Surrey	ES	Serious Harm
Surrey	IS	Death
Surrey	IS	Death
Swindon	DG	Death
Tameside	AM	Serious Harm
Thurrock	CJM	Death
Thurrock	JD	Death
Thurrock	Sam & Kyle	Death

Local Authority	Child Initials and SCR name	Death or SH
Torbay	C74	Serious Harm
Torbay	C66	Death
Torbay	AH	Serious Harm
Trafford	Baby X	Death
Walsall	SRB	Serious Harm
Walsall	MB	Death
Walsall	HS	Death
Waltham Forest	JM	Death
Waltham Forest	Child D	Death
Wandsworth	Grace	Serious Harm
Wandsworth	Child A	Serious Harm
Warrington	MLM (Child R)	Death
Warwickshire	LD	Death
West Sussex	GM (SCR U)	Death
West Sussex	HB (SCR T)	Death
West Sussex	JT (SCR V)	Serious Harm
Wigan	HA	Death
Wigan	Child W	Death
Wigan	Child V	Serious Harm
Wiltshire	ED	Death
Wirral	JNS	Serious Harm
ANON	LG	Serious Harm
ANON	AR	Serious Harm
ANON	SS	Serious Harm
ANON	LS	Serious Harm
ANON	KT	Death
ANON	LK	Death
ANON	CB	Serious Harm
ANON	SL	Serious Harm
ANON	AT	Death

** Details not listed for 10 SCRs ‘not for publication’.*

Appendix E: Brief case summary sheet

SYS Number

UEA/UoB SCR code

LSCB

Date of incident

Age at incident

Gender

Ethnicity

Maternal age: at incident

Paternal age at incident

Partner's age at incident

Household Composition (eg. siblings' age, gender, adult male in house, relationship to child) Number of siblings

☐ **Death**	☐ **Serious Incident**
Category of death:	**Category of serious incident:**
Category of death related to maltreatment:	**If other serious incident add further detail:**
If other category of death related to maltreatment, add detail:	

Presumed perpetrator:

Familicide:

Known to CSC?

Highest Level of CSC involvement: **Current Level of CSC involvement:**

If past/current child protection plan for child, what category/s?

Parental characteristics

Alcohol misuse:
Drug misuse:

Mental health problems:

Adverse childhood experiences:

Parent known to CSC in childhood

Intellectual disability:

Criminal record:

Violent crime (other than DV):

Parental separation:

Acrimonious separation:

Domestic abuse:

Social isolation:

Transient lifestyle:

Multiple partners:

Poverty:

Child/Young person characteristics

Disability: If yes, add detail:

Fabricated or induced illness:

Behaviour problems:

For older children and young people

Alcohol misuse:

Drug misuse:

Mental health problems:

Intimate partner violence:

Bullying;

CSE:

CCE:

PoP Violence:

Any evidence of neglect? (see indicators checklist)

Case Synopsis

Method of SCR:

Key lessons and recommendations

Number of recommendations / learning points in report

Possible further analysis – Yes/No/Maybe

Voice/lived experience of child:

What might be of interest:

Appendix F: Researcher summary

Researcher Summary of Overview Reports (adapted from 2005-07 work)

The purpose of the summary is to produce notes which help us in the three dimensions of our study: a) to understand the story of the children and the families, b) how professionals worked with/responded to the family, and worked with/responded to each other; and c) the clarity and quality of the SCR. This will help us with the ongoing analysis and the overview in the final report. We will explore the dimensions in more detail for the cases in the in-depth sample.

The summary of each overview report should include the following:

- Summarise the story using some standard 'systemic' headings eg features of the case, the family and professional involvement using the 'Case Summary Template'(below)

- Note down useful quotes

- Give an overview of the quality of the report (no need to do a separate Quality assessment form for this study).

CASE SUMMARY TEMPLATE

Key features of the case

Child and Family background

Child's needs/characteristics/behaviour

Mother's/carer's history/profile/parenting capacity

Father's/carer's history/profile/parenting capacity

Wider family and environment

Professional involvement

Which agencies were involved in the build up to the incident?

What efforts did professionals make to engage with child/family members? E.g. response to missed appointments etc. Please differentiate between the different agencies

How did family members cooperate with professionals? (Different for different family members? E.g. mother/father/child? Same or different with different professionals?

How did professionals work together/share information?

Did any professional/ sector have a better grasp/analysis than others of what was happening and risks to the child? If so did they act on this? Any challenge to other professionals?

How have failings/deficits in inter-agency working been addressed – e.g. robust follow up investigation or not?

Analysis of interacting risk and protective factors to include:

Summary of risk and protective factors and supports

Analysis of family/professional cooperation

A hypothesis about the nature, origins and cause of the need/problem/concern.

What could have been done differently? (think Pathways to Harm model: predisposing risks/vulnerabilities not recognised/addressed, preventative or protective actions that could have been taken)

Quality of the SCR

- Observations on the structure and quality of the overview report
    - Ready for publication (e.g. anonymised, or redacted)?
    - Length (page numbers)
    - Easy to understand? (structure, jargon, acronyms)
    - How well does the report balance *description* and *analysis*?
    - Does it give a clear and full picture of what went wrong and why?
    - Does the report reflect the child as a person?

- Number of recommendations, who aimed at and clarity

Appendix G: NSPCC Indicators of Neglect

Indicators of neglect have been defined by the NSPCC including:

- living in an unsuitable home environment, for example in a house that isn't heated throughout winter
- being left alone for a long time
- be smelly or dirty
- wear clothing that hasn't been washed and/or is inadequate (for example, not having a winter coat)
- seeming particularly hungry, seem not to have eaten breakfast or have no packed lunch/lunch money.

Children who are suffering from neglect may also suffer from poor health, including:

- untreated injuries
- medical and dental issues
- repeated accidental injuries due to lack of supervision
- untreated and/or recurring illnesses or infections
- long term or recurring skin sores, rashes, flea bites, scabies or ringworm
- anaemia

Younger babies and young children may also present with:

- frequent and untreated nappy rash
- failure to thrive (not reaching developmental milestones and/or not growing at an appropriate rate for their age).

Older children, who are experiencing neglect may display unusual behaviour, or their behaviour may change. You may notice or become aware that a child:

- has poor language, communication or social skills
- withdraws suddenly or seems depressed
- appears anxious
- becomes clingy
- is aggressive
- displays obsessive behaviour
- shows signs of self-harm
- is particularly tired
- finds it hard to concentrate or participate in activities
- has changes in eating habits
- misses school

- starts using drugs or alcohol
- is not brought to medical appointments such as vaccinations or check-ups.

From NSPCC (2022) Neglect webpage: https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/

Appendix H: What is neglect?

1. ***Severe deprivational neglect*** where neglect was the primary cause of death or serious harm; neglect of the child's basic needs leads to impairments in health, growth and development; severe illness or death may result from malnutrition, sepsis, or hypothermia among others.

2. ***Medical neglect:*** failure to respond to a child's medical needs (acute or chronic) and necessary medication; such failure may lead to acute or chronic worsening of a child's health.

3. ***Accidents which occur in a context of neglect and an unsafe environment:*** hazards in the home environment and poor supervision may contribute.

4. ***Sudden unexplained death in infancy (SUDI) within a context of neglectful care and a hazardous home environment***: deaths may occur in dangerous co-sleeping contexts, or where other recognised risk factors are prominent and not addressed.

5. ***Physical abuse occurring in a context of chronic, neglectful care:*** the primary cause of serious harm or death may be a physical assault, but this occurs within a wider context of neglect.

6. ***Suicides and self-harm in vulnerable adolescents*** with mental health problems associated with early or continuing physical and emotional neglect.

7. ***Vulnerable adolescents harmed through risk-taking behaviours*** associated with early or continuing physical and emotional neglect.

8. ***Vulnerable adolescents harmed through criminal exploitation*** associated with early or continuing physical and emotional negle

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