research in practice

University of East Anglia

crcf Centre for Research on Children & Families

UNIVERSITY OF BIRMINGHAM

Triennial analysis of serious case reviews (SCRs) 2022. Learning for the future:

Messages for the police from SCRs conducted 2017–19

December 2022

Contents

Part 1: Introduction and key data

About this briefing

This briefing is based on the findings of ***Learning for the future: Final analysis of serious case reviews 2017-19*** (Dickens et al., 2022a) – the ninth and final national periodic analysis of serious case reviews (SCRs). The research was commissioned by the Department for Education and was led by a team from the University of East Anglia's Centre for Research on Children and Families, supported by colleagues from the School of Nursing at the University of Birmingham.

Between 1998 and 2011, periodic analyses of SCRs were usually published every two years and thereafter every three years.

The ninth report covers SCRs published between April 2017 and September 2019, when SCRs were replaced by a new system (see page 4) – so 30 months rather than three years. All SCRs covered in the report pre-date the start of the Covid-19 pandemic.

Alongside the 2017-19 periodic analysis, the research team has published a complementary report (Dickens et al., 2022b) that looks at continuities and changes in SCR findings since 1998 (i.e. across all nine periodic analyses). Both reports, earlier periodic analyses and sector briefings are available on the website (**https://scr.researchinpractice.org.uk**).

Who this briefing is for

This briefing[1] highlights key messages for policing professionals, specifically:

- All frontline and operational officers and staff and specialist public protection staff, including child safeguarding staff, domestic abuse staff within public protection, sex offender managers, and all police staff involved in MAPPA and MARAC processes, and staff involved in Sarah's law and Clare's law applications.
- Senior officers and leaders – to foster appropriate cultures for keeping children safe and to develop the right systems for ensuring children are safeguarded at the earliest opportunity.

This is one of four briefings based on the findings of the 2017-19 analysis. The briefings draw out key safeguarding issues, challenges and implications for practitioners and frontline managers, senior managers and system leaders in:

- Children's social care
- Education and early/family help
- Health
- Police.

Each briefing comprises two parts: a generic introduction common to all four briefings; and a sector-specific section with targeted learning and findings. However, as safeguarding is a multi-agency responsibility, professionals, managers and sector leads in particular are likely to find relevant information in each of the four briefings; they are encouraged to read all four if they can.

Learning from the briefings can be applied in Continuing Professional Development (CPD) either through self-directed or team-based learning; organisational learning, including team learning; and reflective revalidation activities. Each briefing includes learning points to inform local reflection and action.

1 A note on language and quotations: The briefings use a number of terms to refer to those who work with children and families, including 'practitioner', 'professional', 'officer', 'worker' and 'staff'. To some extent, these reflect the terms most commonly used within particular agencies but also those used by SCR and other authors who are quoted. Their use is largely synonymous and no distinction is intended. Italicised quotes throughout the briefings are taken from individual SCR reports quoted by the research team in their periodic analysis (Dickens et al., 2022a); unless otherwise attributed, any other quotations are taken from the periodic analysis itself or the accompanying report on themes and trends across SCRs 1998-2019 (Dickens et al., 2022b).

What is a serious case review?

Serious case reviews (SCRs) were local reviews commissioned by the Local Safeguarding Children Board (LSCB). A serious case is one in which:

- abuse and neglect are known or suspected to have taken place, and:
  - a child has died, or
  - a child has suffered serious harm, and there is concern about the way in which local agencies worked together to protect the child.

The purpose of an SCR was to establish what happened and why so that improvements could be made in the future to prevent harm and protect children.

The new system

SCRs have now been replaced by a new system of rapid reviews, local child safeguarding practice reviews (LCSPRs) and national reviews. The *Children and Social Work Act 2017* replaced LSCBs with local safeguarding partnerships led by three statutory partners – the local authority, local health services, and the police – who share equal responsibility for safeguarding children in their area. The Act also made provision for the phased introduction of a new system for undertaking reviews of serious cases.

Under the new system, the local safeguarding partnership undertakes a rapid review into all serious incidents and considers whether the threshold has been met for a local child safeguarding practice review (LCSPR). The purpose of an LCSPR is to identify lessons for practice improvements. This means the three local partners must decide whether a case is likely to highlight lessons to be learnt about the way in which local agencies and professionals work together.

Transitional arrangements were in place between June 2018 and September 2019. These allowed LSCBs to initiate SCRs until a local safeguarding partnership was in place; once the new partnership arrangement was established, a local area had to use the LCSPR system.

Local safeguarding partnerships must inform the national **Child Safeguarding Practice Review Panel** (CSPRP) of all decisions to commission an LCSPR. The panel can decide to commission a national child safeguarding practice review (of a case or cases) if it considers issues may be raised that require changes to current guidance or legislation.

The 2017-19 analysis report

Findings in the 2017-19 analysis are based on quantitative analysis of 235 SCRs undertaken between April 2017 and September 2019 (224 reviews notified to the Department for Education and 11 additional SCRs located by the research team) and detailed data analysis of 166 SCRs that were available for review.[2]

Discussion in the 2017-19 analysis report is organised (on a chapter by chapter basis) around three broad themes:

- **Neglect**: As in earlier review periods, neglect featured prominently in the lives of most of the children who became the subject of an SCR. Neglect remained a challenge for practitioners across all sectors both in terms of identification and response. Through an in-depth qualitative analysis of 12 SCRs, the report examines the 'normalisation' of neglect – an issue also identified in the 2011-14 and 2014-17 periodic reviews.
- **Professional practice:** A thematic analysis of 23 SCRs was undertaken to identify recurring patterns in professional practice. These are discussed under three headline themes: working with parents, including effective challenge; sharing information and communicating with other professionals and agencies; and professional disagreements and the 'escalation' of concerns.
- **Voice of the child:** Key issues discussed include the need to focus on the child's lived experience, to think about children holistically (rather than aspects of wellbeing in isolation), and to engage with children and young people, including by building trusting relationships. A qualitative analysis of 28 SCRs was undertaken to explore these issues.
- All three of these broad themes are then discussed in an additional chapter on the research team's findings of a thematic analysis of ten SCRs in which **intrafamilial child sexual abuse** was a feature.

Key messages set out in this and the other briefings are drawn from across the report as a whole and from the research team's accompanying report (Dickens et al., 2022b) on themes and trends across the 21 years of SCRs (see page 6).

2 In 69 cases, the full review was not available to the research team, but the team had access to brief case information notes which included key quantitative data.

Themes and trends across SCRs 1998-2019

The second report (Dickens et al., 2022b), which was undertaken to identify trends, changes and challenges in SCRs since 1998, highlights many entrenched issues as contributory factors in serious cases across the years. These are discussed more fully in Part 2 of the briefing, but include:

- Enduring challenges to **relationship-based practice:** these include heavy caseloads and high staff turnover as critical contributory factors leading to episodic and incident-focused intervention and support, with cases sometimes being closed without good evidence that anything had changed.
- **Assessment quality:** both the practice of assessment and the quality of written information and analysis are areas of concern. This includes an apparent **'reluctance or inability' to revise and update assessments in the light of new information** or to see children's situations from a **holistic perspective** – for example, missing signs of maltreatment by focusing too heavily on a child's disability or not recognising signs of other maltreatment when a child is suffering neglect.
- Practitioners **losing sight of the child:** this includes not recognising the significance or underlying meaning of children's behaviour (including offending behaviour), taking insufficient account of children's views and not seeing children alone. Practitioners can also lose sight of children in other ways – for example, by not responding in an appropriate and timely way when children are missing school, go missing from home or are not brought to health appointments.
- A lack of sustained **professional curiosity:** this applies to practitioners from all disciplines. SCRs found that practitioners had often been too ready to accept parental accounts, for example, or did not show sufficient curiosity about the lived reality of a child's life.
- Problems with **information sharing** and **inter-agency communication:** shortcomings in inter-professional working are also evident, with **unresolved professional disagreements** a common feature of SCRs over the years, especially in relation to risk, thresholds and the need for escalation.
- Finally, a high proportion of SCRs across the years have been for **children who were not receiving support from children's social care.** Some were previously known to social care, but a large number had no previous involvement. This underlines the importance of high-quality 'front door' assessments and the critical roles of universal and early (family) help, education, health and the police in safeguarding children.

Many of the themes and challenges highlighted by the research team are echoed in the findings of the **Independent Review of Children's Social Care** (MacAlister, 2022) and the CSPRP's (2022) **National review into the murders of Arthur Labinjo-Hughes and Star Hobson**, which were published in May 2022 (after the 2017-19 periodic analysis was written). The research team's findings should also be read alongside the CSPRP's series of thematic reviews (CSPRP, 2020a, 2020b, 2021b) and annual reports (CSPRP, 2021a) and the research team's independent annual reviews of LCSPRs (Dickens et al., 2021; 2022c).

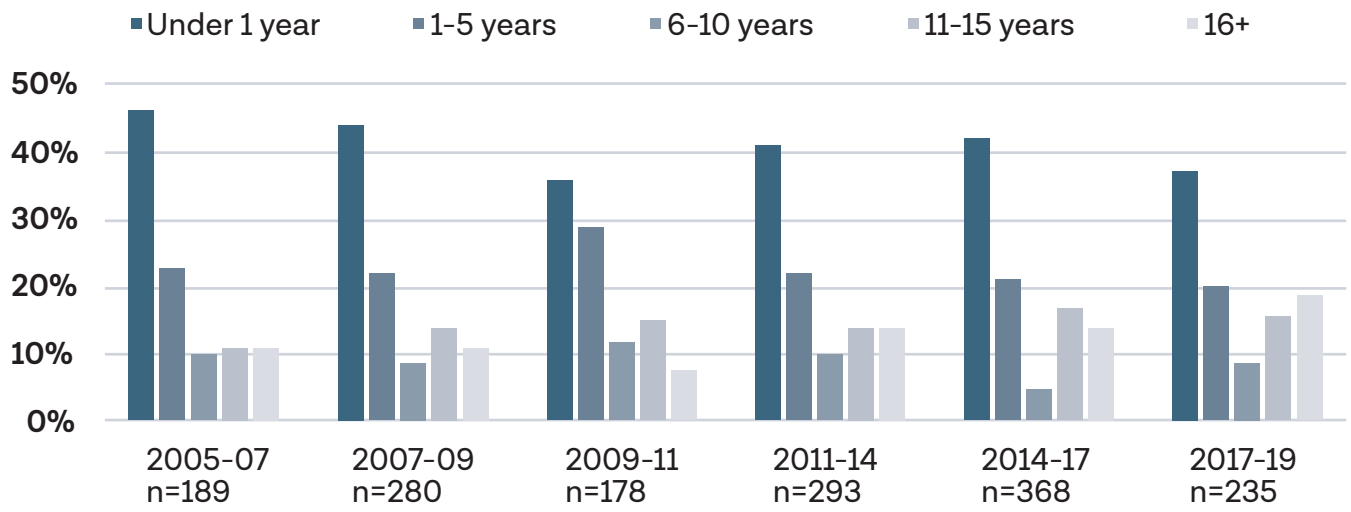
In their analysis of trends since 1998, the research team reflect on why periodic analyses of SCRs have so often identified repeat messages (Dickens et al., 2022b). They note that safeguarding practice is not only inherently complex, challenging and often ambiguous, it is also directly affected by a range of factors, including national policy and legislation, nationally set budgets, competing social policy priorities and imperatives, and organisational change. Persistent challenges – such as heavy workloads, the availability of sufficient and experienced staff, and the range of available services (including early or family help) – are often, at least in large part, beyond local control. All these factors affect the ability of teams and practitioners to assess, intervene and make well-informed decisions. So, while findings from SCRs can and must help to inform team and individual practice, action is also needed at a system level. Learning messages in these briefings are therefore intended to inform and support a sector and system-wide response, as well as practice at team and individual level.

Key data from the 2017-19 SCRs

Key data from the analysis of the 2017-19 SCRs are set out below, including observations of where that data differ from earlier review periods.

- **Children's ages** (see Figure 1):
  - ***Infants:*** As in previous review periods, the largest proportion of SCRs related to the youngest children: 86 (37%) incidents involved a child under 12 months old and 46 (20%) involved children between one and five years old.
  - ***Adolescents:*** Nearly one in five (19%) SCRs were for a child aged 16 or over; this continues a gradual upwards trend – in 2005-07, just over one in ten (11%) SCRs was in respect of a child aged 16 or over.
- **Gender:**
  - More than half (57%) of all SCRs in the 2017-19 review period involved boys.
  - The predominance of boys was most pronounced among children aged under 12 months (50 boys, 35 girls) and children aged 16 and over (31 boys, 14 girls).

Figure 1: Ages of children who were the subject of SCRs for each of the past six review periods (i.e. 2005 to 2019)



> **Fatal cases:**

- Over the 30-month review period, 131 of the 235 SCRs concerned the death of a child.[3]
- ***Deaths resulting from maltreatment:*** 42 of the 131 deaths were a direct result of maltreatment – i.e. overt or covert filicide (where a parent/parent figure kills a child by violent means), fatal physical abuse, severe persistent cruelty, or extreme neglect (Table 1). This is equivalent to 17 cases a year, which is lower than earlier review periods (26-28 deaths a year); however, some cases during 2017-19 will have gone into the LCSPR system so no firm conclusions can be drawn from this reduction.
- ***Deaths related to maltreatment:*** A further 70 deaths were categorised as 'related to maltreatment' (i.e. there was evidence of mistreatment, but it cannot be considered a direct cause of the child's death). The most common sub-categorisations (shown in Table 2 below) were suicide and sudden unexpected death in infancy (SUDI).

3 The average annual number of child deaths reported to Child Death Overview Panels (CDOP) during 2017-19 was 3,473, so the 131 fatal SCRs relate to fewer than 2% of all child deaths (NHS Digital, 2019). For the 24 months ending March 2019, CDOP categorised 105 deaths as due to deliberately inflicted injury, 80 of which were due to homicide. CDOP data are not directly comparable because they include all deaths from extrafamilial assault, which may not meet the criteria for an SCR; also, CDOP may categorise some deaths related to (but not necessarily directly caused by) maltreatment within their category of abuse or neglect.

Table 1: Categories of death 2014-19 SCRs

Category of death	Number of deaths 2014–17 (%) n=206	Number of deaths 2017–19 (%) n=131
Fatal physical abuse	46 (22%)	18 (14%)
Overt filicide	17 (8%)	15 (11%)
Extrafamilial 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%)
Extrafamilial physical assault	3 (1%)	2 (2%)
Severe persistent cruelty	9 (4%)	0
Not clear	11 (5%)	6 (5%)
Death related to maltreatment (see Table 2)	105 (51%)	70 (53%)

Table 2: Sub-categories of death related to maltreatment 2014-19 SCRs

Category of death related to maltreatment[4]	Number of deaths 2014–17 (%) n=105	Number of deaths 2017–19 (%) n=70
SUDI (sudden unexpected death in infancy)	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%)

* The category terminology here (and in Table 3) mirrors the longstanding categories used by the SCR research team; 'risk-taking' is not meant to imply any apportioning of blame to the child or young person.

> **Non-fatal cases:**

- Across the 2017-19 reporting period, there was a yearly average of 42 SCRs relating to cases of non-fatal serious harm; this is lower than the average for 2014-17 (54 cases a year) but higher than earlier periods (30-32 cases a year between 2009 and 2014).
- The most common categories of serious harm were physical abuse (42% of non-fatal SCRs), neglect (21%) and intrafamilial child sexual abuse (13%). These are broadly similar proportions to earlier review periods, although the number of cases involving neglect has risen steadily – see Table 3.

4 Only a small proportion of SUDI and deaths by suicide were subject to SCRs. CDOP data for 2017-19 show 625 SUDI cases and 180 deaths by suicide (NHS Digital, 2019), so only around 3% of SUDI and 9% of suicides were subject to an SCR.

Table 3: Categories of serious harm in non-fatal SCRs 2009-11 to 2017-19

Category of serious harm*	2009-11 (%) n=60	2011-14 (%) n=96	2014-17 (%) n=162	2017-19** (%) n=98***
Non-fatal physical abuse	31 (52%)	50 (52%)	83 (51%)	44 (45%)
Neglect	6 (10%)	14 (15%)	30 (19%)	22 (23%)
Child sexual abuse – intrafamilial	6 (10%)	13 (14%)	16 (10%)	13 (13%)
Child sexual abuse – extrafamilial	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 abuse – child sexual exploitation	-	5 (5%)	11 (7%)	2 (2%)
Other	3 (5%)	1 (1%)	4 (2%)	3 (3%)

* Categorisation records the primary cause of harm; children may have experienced multiple forms of harm.
** The 2017-19 figures relate to a 30-month (rather than full three-year) period.
*** Excludes six cases where there was insufficient information to decide the category.

> **Neglect:**

- There was evidence of neglect in three-quarters (124 of 166) of all SCR reports examined; features of neglect were apparent in two-thirds (66%) of fatal cases and nine in ten (90%) non-fatal cases.
- Neglect was the primary cause of harm in 21% of non-fatal cases in 2017-19, more than twice as high as in 2009-11 (10% of cases).

> **Ethnicity:**

- Where known, ethnicity of the children involved in SCRs was broadly consistent with earlier review periods: 73% of children were white/white British, 10% black/black British, 9% mixed race, and 6% Asian/Asian British. (In 18 (8%) of the 235 SCRs, ethnicity was not stated anywhere.)

> **Disability:**

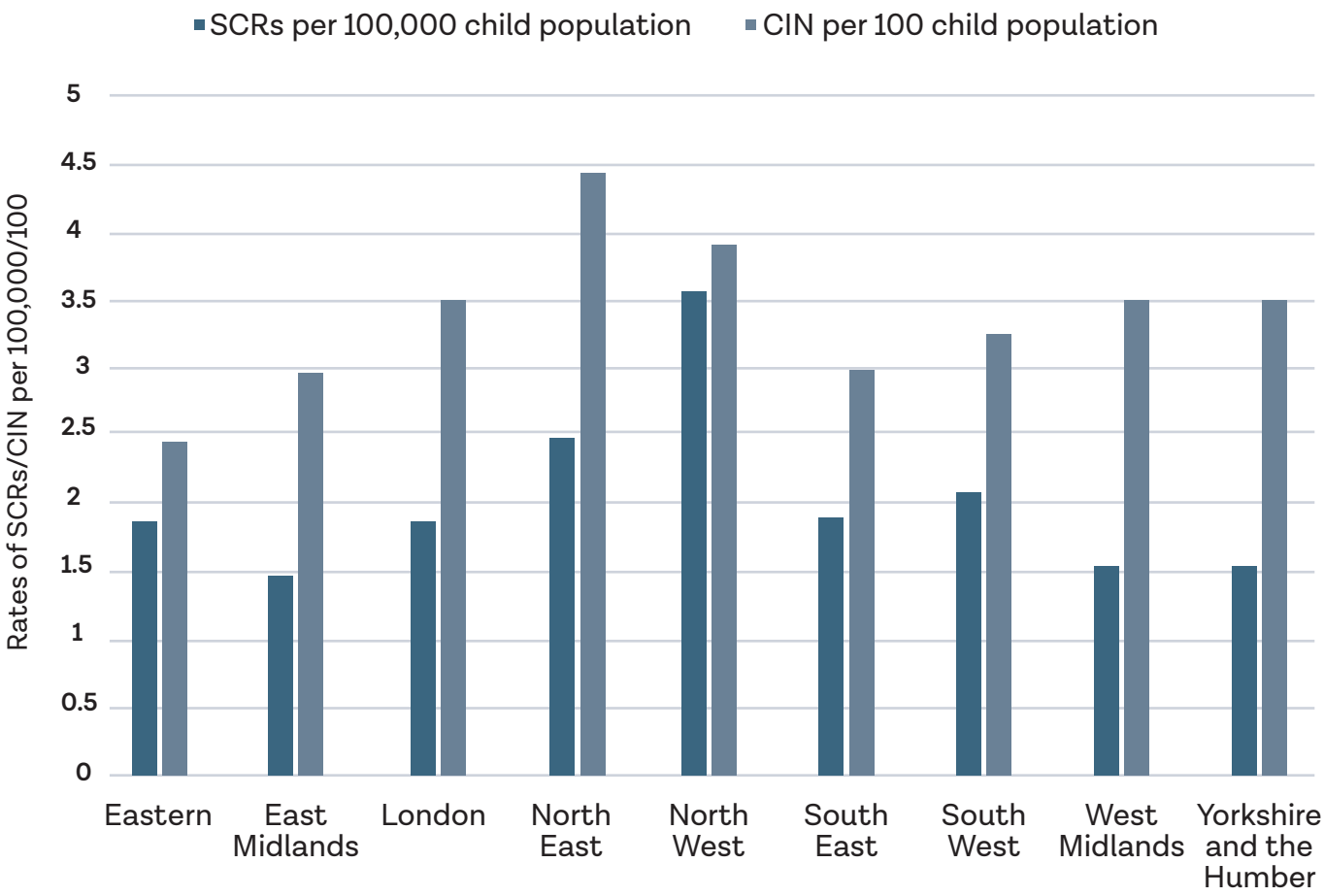
- One in four (25%) children at the centre of the SCRs analysed in depth were reported to have an impairment or disability at the time of the incident – up from 14% in 2014-17.
- In particular, there was an increase in the numbers of children with a social/communication disability or complex/combined disability.

> **Where children were living:**

- At the time of the incident, most children were living in the parental home (81%) or with relatives (3%), and 5% were living with foster carers.
- Although overall numbers are small, death and serious harm also occurred when children were living in a supervised setting; for example, 4% of children were in hospital, a children's residential home, or a mother and baby unit.

- **Who was involved:**
  - Most serious and fatal maltreatment involved parents or other close family members. Only eight SCRs related to serious or fatal maltreatment involving strangers unknown to the child.
  - In the 24 cases classified as 'intentional' maltreatment deaths (i.e. filicide or extreme neglect), the presumed perpetrators were mothers (11 cases), fathers (7 cases) and both parents (3 cases). Those who died at the hands of their mother were predominantly young children (aged 0–5); those whose intentional maltreatment was at the hands of their father were usually older.
  - In non-fatal cases, both parents were the main source of harm for physical abuse and neglect.
- **Social care involvement/non-involvement:**
  - Nearly one in four (23%) children who were the subject of an SCR had never been known to children's social care – a slightly higher proportion than in earlier review periods (proportions fluctuated between 16% and 22% between 2009 and 2017).
  - More than half (57% of SCRs) of the children were known to children's social care at the time of the incident (i.e. their case was open), and a further one in five (19%) were previously known (i.e. their case was closed).
  - At the time of death or serious harm, 40 of the 235 children (17%) had a child protection plan and a further 30 (13%) had been the subject of a plan in the past.
  - Full information for category of plan was not available; where known, the majority of plans were recorded under neglect, followed by emotional abuse, physical abuse and sexual abuse.
- **Geographical distribution:**
  - There are significant discrepancies in the geographical distribution of SCR cases, including a more than four-fold difference between the regions with the lowest and highest numbers. The reasons for this geographical variation are not clear, but the variations have been persistent over time.
  - In 2017-19, Yorkshire and the Humber had 0.77 SCRs per 100,000 child population, and the North West had 3.58 SCRs. The same two regions also had the lowest and highest rates of SCRs respectively in 2014-17, but the discrepancy had grown wider by 2017-19.
  - Broadly speaking, SCRs nationally reflect the number of children in need at a ratio of around one SCR per 1,000 children in need, but the ratio is not consistent across regions – see Figure 2.

Figure 2: Geographical distribution of 2017-19 SCRs and children in need



Parental and family characteristics

The most common parental characteristic reported in the SCRs examined in depth was mental health problems, particularly among mothers. Substance misuse also featured strongly and at a higher frequency than in the general population; alcohol misuse and drug misuse were each recorded in one in three SCRs. In one in three (32%) cases, at least one parent had a criminal record, including for a violent crime (19% of SCRs) other than domestic abuse.

Table 4 shows the frequency with which various parental characteristics featured in the SCRs. Broader family characteristics are set out in Table 5. These figures represent the minimum prevalence; factors may have been present but not recorded in the report, and some SCRs contained limited information about fathers.

Table 4: Parental characteristics: 2017-19 SCRs

Parental characteristic	Mother	Father*	Father figure/ mother's partner*	Both parents	Total number of SCRs in which the characteristic was reported (n=166)
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 (4)**	34 (19)**	6 (6)**	6 (2)**	53 (32%)
Known to children's social care as a child	19	7	1	11	38 (23%)
Intellectual disability	9	5	0	11	25 (15%)

* Lower numbers for fathers/father figures (e.g. for mental health problems) may reflect that limited information was available, or that reviews did not always consider the father's role especially relevant.
** Numbers in brackets indicate how many parental convictions were for violent offences.

In 2017-19, indicators of poverty or economic deprivation were noted as a feature of the case in one in two (49%) SCRs – a significant increase from 35% of SCRs in the 2014-17 analysis. Domestic abuse was reported to have been a feature of family life in more than one in two (55%) SCRs. Parental separation also featured in almost half (48%) of the 2017-19 cases, including 17% of cases in which the separation was recorded as having been acrimonious.

Table 5: Family characteristics: 2017-19 SCRs

Family characteristic	Number of SCRs in which characteristic was reported (n=166)
Domestic abuse	92 (55%)
Poverty	82 (49%)
Parental separation	80 (48%)
Social isolation	47 (28%)
Multiple partners	46 (28%)
Transient lifestyle	46 (28%)

Child characteristics

Child characteristics for older children (i.e. aged 11 and over) noted in the SCRs are shown in Table 6. This includes two characteristics added since the 2014-17 analysis: that the child had direct experience of (i) child criminal exploitation or (ii) peer-on-peer violence; each of these was evident in around one in four SCRs involving older children. Table 6 focuses on older children because most of the characteristics (with the exception of disability) did not feature in the reported lives of younger children.

Among younger children (i.e. aged 0 to 10 years), the most common child characteristic evident was disability, which was recorded in: 5 of the 62 (8%) SCRs relating to children under 12 months old; 9 of 36 (25%) SCRs relating to children aged between one and five; and 4 of 14 (28.5%) SCRs involving children aged six to ten. Behaviour problems were evident in 6 of 50 SCRs for children aged between one and ten.

The only other child characteristics noted for SCRs involving children aged ten or under were fabricated/induced illness (1 case), mental health problems (1 case) and bullying (1 case).

Table 6: Child characteristics: 2017-19 SCRs

Characteristic*	**Age 11-15** (n=28)	**Age 16+** (n=26)	**Number of adolescent SCRs in which the characteristic was reported** (n=54)
Behaviour problems	19	22	41 (76%)
Mental health problems	18	19	37 (68.5%)
Disability	12	11	23 (43%)
Drug misuse	11	12	23 (43%)
Bullying	10	10	20 (37%)
Child sexual exploitation	9	11	20 (37%)
Alcohol misuse	8	8	16 (30%)
Peer-on-peer violence	7	7	14 (26%)
Child criminal exploitation	5	7	12 (24%)
Intimate partner violence	3	2	5 (9%)
Fabricated or induced illness	1	1	2 (4%)

* These characteristics are known or suspected background factors rather than the direct cause of harm that led to the SCR

Part 2: Learning for the police

Recognising and responding to neglect

As with earlier periodic analyses, loss of focus on neglect in the context of poverty was a key feature of the 2017-19 SCRs. This was most often observed among those working with families in areas of high social and economic deprivation, where professionals could become de-sensitised to endemic levels of poverty or feel powerless to do anything in the face of poverty. In these circumstances, neglect could in effect become 'normalised'. As one SCR where neglect was a feature highlighted:

> ***... 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.***

Concerns were expressed in some SCRs about the adequacy of training for police officers in recognising and responding to neglect. One SCR author called for *'an explicit focus in policy and training on the distinction between neglect caused by poverty and other forms of neglect'.*

However, good practice was showcased in another SCR, which described police officers actively looking for, recognising and understanding neglectful situations for a child.

> ***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.***

SCRs also report that neglect and its impact could be inadvertently downplayed when professionals had concerns related to poverty (e.g. poor housing, debt) or had developed low expectations of parents in the local area. This sometimes led to their misinterpreting neglect for poverty and focusing exclusively on parents' need for practical support. Some professionals might also have been reluctant to stigmatise parents or appear judgmental by identifying neglect in families.

> ***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 ....***
>
> ***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".***

Providing practical support is important, not only because it meets families' needs, but also because it helps to build the trust and relationships with families that provide the essential foundation for relationship-based practice and support. However, practical help should never be at the expense of looking at other issues and risks within the family.

Learning points

- Neglect rarely occurs on its own (Daniel et al., 2010). It is commonly accompanied by physical or emotional abuse and is often a factor in child sexual abuse or exploitation.
- Neglect can sometimes mask other forms of harm. In 8 of the 10 SCRs (examined in depth by the research team) in which intrafamilial child sexual abuse was a feature, neglect had 'dominated' interactions with professionals; sexual abuse then continued despite ongoing social care investigations or support.
- Police officers often attend incidents where they come into contact with children who are experiencing neglect and living in circumstances harmful to their welfare. It is important that all frontline officers receive effective training to understand the interaction between neglect and deprivation and to recognise and respond to neglect.
- The use of assessment tools for neglect can be helpful, but these need to be used consistently across all services and by professionals who have been trained in their use. Their use is likely to be more effective when sector and service leaders work together to develop a local culture of collaborative working.

Paying attention to the child's lived experience

Children's lived experience can be understood in a number of related ways:

- Understanding the reality of the child's daily life.
- Thinking about all aspects of the child's wellbeing, health and development, not just one aspect in isolation.
- Considering the child's life in different contexts – so, for example, in the community as well as at home and at school.
- Reflecting on the child's history and past experiences and how they may be continuing to affect the child's life (including their cumulative impact).
- Thinking about how the child may be experiencing professionals' decisions, actions and interventions.

Many SCRs found that the lived reality of the child's day-to-day life was not well understood. This was a persistent theme across the 2017-19 cases: professionals had not paid enough attention to or explored what daily life was like for the child or young person.

Children were often viewed through a single lens (professionals focused only on offending behaviour or on a child's disability, for example) or they were sometimes 'hidden in plain sight' (for example, professionals focused on the needs of adults in the family – such as mental health needs or for help with substance use – or on parents' criminal behaviour). In these cases, professionals either didn't focus or lost focus on the child's lived experience.[5]

5 This is consistent with a meta-analysis of SCRs (Allnock et al., 2020), which found that police officers sometimes missed opportunities to talk to children to ascertain their views, experiences, wishes and support needs. Sometimes, officers made assumptions about the way a child presented instead of speaking to them directly; and sometimes officers lacked the confidence to do so, especially in cases of very young children.

In some cases, children's involvement in antisocial or criminal behaviour led to them being perceived primarily as perpetrators of criminal activity. This was the case even when the offending was being led by adults within the child's family.

> ***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 the case discussed above, the family was of Traveller heritage. As described later, biases and preconceptions appear to have played a role in the children's significant vulnerability and needs being downplayed.

In the following example, there were long-standing concerns around neglect, antisocial behaviour and non-attendance at school. Later, it emerged that these issues had masked intra-familial sexual abuse, which prompted the SCR.

> ***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.***

Recognising the meaning and significance of behaviour

As in earlier periodic reviews, the 2017-19 SCRs highlighted situations in which the voice of the child was not heard. Crucially, 'hearing' involves not only listening to what the child or young person says, but also observing – children rarely disclose abuse directly, so the only indication that something is amiss may be their behaviour.

> ***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.***

Police officers often come into contact with young people who present with so-called 'risky' behaviours, such as violence or other types of offending, going missing from home and self-harm. Some behaviours, such as aggressive and challenging behaviour, may be indicative of abuse, but these non-verbal signs are often missed or attributed to other causes. The primary concern of frontline police officers who do not work in specialist child abuse or child criminal exploitation units is generally to deal with offending behaviour, and they may not always take into account that there is a safeguarding need:

> ***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.***

In many cases, the underlying causes of children's behaviour remained unknown and unaddressed. This was the case for one young person who was not seen alone when he was younger and previous safeguarding concerns were raised (by a childminder). It was only when he was going missing every day as an adolescent that police officers identified what life was like at home, and steps were taken to promote his safety. This is an example of good practice within the police:

> ***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.***

Learning points

- All professionals, including police officers, need to be attuned to what children and young people's behaviour might be signalling. Due to limited contact, frontline officers may not know if a young person's behaviour has changed or if they behave differently in different contexts. Nevertheless, it is crucial that officers know where to go to report their observations and concerns, and that they receive adequate support to do this; close working with multi-agency partners is key.
- Where children do talk about abuse or neglect, professionals need to act on the disclosure. When police officers have contact with a family, it is important that they speak to the child on their own wherever possible.
- Professionals should not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting; it may be, but professionals need to take a holistic approach that considers possible alternative causes.

Adolescents, cumulative harm and relationships

A number of SCRs relating to adolescents highlighted the importance of understanding the child and family's history in order to determine the level of presenting risk and effective safeguarding response.

Thinking about the child's past may also help to address the issue of 'adultification', where children are treated as though they are older than they are.[6] Young people were sometimes perceived 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.***

Relationships and capitalising on 'reachable moments'

The importance of engaging children and building supportive and trusting relationships is a recurring theme across the SCRs and all the periodic analyses.

One SCR highlights an example of good practice by an investigating police officer who 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 …'*. By 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 Recent evidence suggests Black children may be at increased risk of 'adultification' (VKPP, 2020, p. 3)

Although SCRs highlight the importance of building supportive relationships with children and young people over time, opportunities to engage children can also arise when there is no pre-existing relationship. Police officers are in a good position to capitalise on these 'reachable moments' – for example, when young people come into custody or when they are found after having been reported missing, as in the following SCR.

> ***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.***

One message to emerge from the SCRs concerning adolescents who died by suicide, and some who were at risk from child criminal exploitation, was the large number of relationships that they were expected to sustain as risks increased and different professionals worked reactively to crisis situations. This could leave young people feeling overwhelmed. It may be helpful for local agencies to work with the young person to establish which relationships are most supportive and, where possible, maintain those relationships.

Learning points

- All professionals who have contact with children living in areas where violence and antisocial behaviour are significant factors within the community should consider those children vulnerable to serious harm. This includes young people who may themselves perpetrate some of the violence or antisocial behaviour.
- Where multiple agencies are involved in a young person's life, agencies may need to liaise to ensure that the young person is not overwhelmed by having too many practitioners involved at the same time; this means it may be necessary to prioritise different elements of support for the young person.
- Professionals need to consider how children's past experiences may affect their ability to trust and engage with them. Police officers in particular need to consider the potential impact on the child of the decisions they take and how those decisions are communicated.
- 'Poly-victimisation' refers to the experience of different types of abuse over time (Finkelhor et al., 2007) and can help professionals to consider and respond to the impact of cumulative harm that young people have experienced across their childhood and adolescence.
- Potentially, police officers are in a good position to intervene in the community and with individuals in cases of child criminal exploitation, although reduced resources for neighbourhood policing makes this more challenging. Police leaders should endeavour to work with other agencies and move from incident-based or episodic responses to a more ongoing, long-term and continuous method of working.
- It is essential that police officers think about children in the different contexts in which they live. Police training should cover contextual safeguarding[7] (Firmin, 2017), which is an approach to understanding and responding to experiences of significant harm beyond a young person's family. Contextual safeguarding recognises that the different relationships that young people form in their community, at school and online can feature violence and abuse.

7 For more information on contextual safeguarding see: www.contextualsafeguarding.org.uk

Lack of action following disclosure or evidence of abuse

Even when children or young people did make a disclosure, SCRs found that this did not always result in action being taken to safeguard them. In some cases, disclosures by children were not adequately investigated: strategy meetings weren't held, achieving best evidence (ABE) interviews were delayed, concerns were side-lined by a focus on other issues such as neglect and in one case parents refused to let their children be interviewed. In one family, an older male child had disclosed sexual abuse by an adult female, but this was not adequately investigated:

> ***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.***

One SCR discussed a young person's reaction to a decision (following a police interview) that there was insufficient evidence to progress a criminal case against the child's mother for physical abuse. Although this was likely to be an upsetting decision, it was not conveyed to the girl personally and resulted in her no longer trusting the police.

> ***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 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.***

Inaction following children's minimisation or denial

Sometimes, professional inaction followed a child's denial or minimisation of abuse. There are a number of reasons why children might deny or minimise the abuse or neglect they experience. These include previous experiences of how professionals have behaved and how trustworthy professionals appear, as well as fear of the perpetrator.

In one case, a young man was thought to be at risk of child sexual exploitation. Although professionals recognised signs of exploitation, the boy's denial that he was at risk was taken at face value. The SCR noted: *'The response was over-influenced by Child M's denial that he had experienced sexual interactions with the adult male.'* In another case, a child retracted her accusation that her mother's partner had hit her, saying that she had made it up. However, she was asked about the accusation in front of her mother rather than on her own.

ABE interviews

There was evidence in some SCRs of the police and children's social care taking different approaches to interviews with children when child sexual abuse was alleged, as in this case.

One SCR describes how a strategy meeting about a four-year-old child decided against an ABE interview, but an interview was subsequently agreed when the case was transferred for investigation. Although local protocols were for ABE interviews to be arranged within 24 hours of a strategy discussion, the interview took place four months after the allegation was made. The delay, which is described as 'unavoidable' (although no reason is given), is likely to have had an impact on the child's ability to recall events.

The uncertainty in this case may reflect a difference between police and social care about whether the interview's primary purpose is to enable the child to talk about what has happened so they can be supported (social care perspective) or to gather potential evidence for use in a criminal prosecution (police perspective). ABE good practice guidance emphasises the importance of careful planning for the interview and is clear that the safety and welfare of victims 'takes primacy over the needs of the investigation' (Ministry of Justice & National Police Chiefs Council, 2022). The SCR 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 is a national issue; it was identified as a concern in the 2014-17 periodic analysis (Brandon et al., 2020) and continued to be a concern during 2017-19, as this SCR made clear:

> ***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.***

Learning points

- The police response to a disclosure of sexual abuse should not only be investigative; it also needs to be sensitive and supportive to the child and to any non-abusing parent or relatives. This is skilled work; police officers need specialist training and support to get the balance right (Ministry of Justice & National Police Chiefs Council, 2022).
- Sexually inappropriate behaviour should always be recognised as a 'red flag' for sexual abuse and investigated in a multi-agency forum without waiting for verbal disclosure. The Brook Sexual Behaviours Traffic Light Tool and training may be particularly helpful for supporting frontline officers.
- All professionals, including police officers, need to recognise the difficulties children (especially boys) may face in disclosing sexual abuse verbally. Children may also be strategic in what they say. Older children's readiness to disclose may be influenced by how effective they expect the professional response to be, based on their past and current relationships with professionals.
- Police leaders should work in collaboration with children's social care leaders to ensure that enough police officers and social workers are trained in ABE. Wherever possible, this should be through joint training as it provides an invaluable opportunity for police and children's social care practitioners to build relationships and better understand each other's role.

Professional responses to perpetrators of child sexual abuse

Many perpetrators of child sexual abuse are repeat offenders. This was evident in a number of SCRs, where the perpetrator had previously abused other children. Many SCRs that involved sexual abuse described inadequate or missing risk assessments and a lack of or poor information sharing between agencies.

> ***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.***

In some families, older children had previously been abused, and younger children were then abused by different perpetrators. This suggests that perpetrators had deliberately targeted vulnerable families, who may not have been able (or willing) to recognise risks or who were not able to access help; at worst, some families may have been complicit in the abuse.

In four of the ten SCRs (examined in depth by the research team) that featured intrafamilial child sexual abuse, the perpetrator had previously abused other children. In three of those cases, the perpetrator was known to services but had deliberately deceived professionals and other family members, as in this case.

> ***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). The SCR notes that high workloads and inadequate supervision were contributory factors and this enabled the 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.***

Learning points

- Police have a key role in reviewing and updating risk assessments of known perpetrators. It is important that the police share information with other agencies and professionals working with a family if a known perpetrator moves in with that family.
- The Child Sex Offender Disclosure Scheme, or 'Sarah's Law',[8] allows parents to ask the police if someone with access to their children has been convicted or suspected of child abuse. No requests were made under the scheme in any of the SCR cases analysed in depth for the 2017-19 review. Police are in a good position to promote the use of Sarah's Law to other professionals working with vulnerable families.

8 For information about the Child Sex Offender Disclosure Scheme, see https://www.gov.uk/guidance/find-out-if-a-person-has-a-record-for-child-sexual-offences

Cultural difference and engaging and challenging parents

Some SCRs identified potential gaps in professionals' cultural competence when working with parents from diverse backgrounds. 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*'. In the following example, professionals' biases and assumptions when working with a family of Traveller heritage led to the children being largely identified as perpetrators rather than being seen as vulnerable in their own right.

A large family of Traveller heritage with complex needs and multiple children were well-known to local agencies because of their perceived challenging and intimidating behaviour. One child was raped by her half-brother when she was 15. Once reported, there was social care involvement and an SCR was undertaken, but previous allegations of rape and sexual abuse, which 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 significant mental health needs. The father would not engage with professionals and was known to be aggressive, and there was a history of domestic abuse within the family. Neighbours had been attacked by the parents but would not pursue criminal action for fear of reprisals.

Among agencies, the family was considered a 'hot potato' and passed around quickly. Although the police had information about the children's sexualised behaviour, the family refused police involvement in Team Around the Family meetings, and this led to a lack of information sharing across services.

> ***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 in the family described above because all interactions with professionals focused on addressing criminal behaviour, in which the children were seen as complicit. The challenges that professionals experienced working with the family continued to 'mask' the neglect.

> ***Professionals who 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.***

Learning points

- Police officers need to be supported, including through effective supervision (College of Policing, 2022), to develop the confidence and skills to work with families from culturally diverse backgrounds. They should be encouraged to maintain a professionally curious culture that challenges unconscious bias and culturally insensitive assumptions.
- Engagement with families is key to effective support and investigation; when families do not engage, professionals need to consider the underlying reasons and likely outcomes for the child, while maintaining a sufficient level of challenge to parents.
- Parents' non-engagement or denial of concerns (e.g. about their children's behaviour or their home circumstances) may be due to embarrassment, shame or fear or because they find it hard to change entrenched habits; but in cases of child sexual abuse, non-engagement may be part of an attempt to deceive.

Sharing information and communicating effectively

> ***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…"***

A number of SCRs suggest that professionals in the police, schools, health and social care do not always share information appropriately. This means that there is sometimes a lack of insight into the multiple difficulties that families are facing (e.g. substance misuse, special educational needs, school exclusion, antisocial or criminal activity, loss and separation).

Effective multi-agency working and communication are crucial for supporting families and safeguarding children. This is especially important when a family is being supported by multiple services, as inadequate information sharing may mean that 'there is no coherent overview of the daily lived experience of children'. One SCR author recorded 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.***

One SCR highlighted that the police had held important information about the sexualised behaviour that some of the children in one family were displaying. But because the parents refused to have the police involved in Team Around the Family meetings, that information was not shared with other agencies. As a result, meetings focused on housing and antisocial behaviour '*with the children perceived as part of the problem*'. Other risks, including domestic abuse, suspected sexual abuse and neglect '*did not feature*'.

Inadequate (or missing) risk assessments of the potential risks posed by perpetrators, and the sharing of these, was a recurrent feature of SCRs where there was child sexual abuse.

One SCR related to a girl whose siblings had been removed from the family 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 minimal acknowledgment was further illustrated when the girl retracted the allegation. 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 [children's social care] 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.***

The importance of effective communication

A key theme identified in the 2017-19 periodic analysis was the distinction between sharing information and communicating effectively. In some cases, important information was shared between agencies, but this information was either not understood or else its significance was not clear. There were a number of cases where one agency had information that indicated risk to the child, but this was not accepted or understood by the wider professional network:

> ***… 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.***

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 trusts 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.

Learning points

- The language used when sharing information needs to be clear and unambiguous and describe the reality of life for the child. Police should not only share information, but also be actively engaged in communicating what the information means in terms of safeguarding children. Dialogue between professionals is crucial for asking questions and generating alternative hypotheses about the meaning of information.
- It is crucial that police officers have a solid understanding of their role in sharing information, as set out in *Working Together* (HM Government, 2018) and College of Policing Authorised Professional Practice.

Professional disagreement and escalation of concerns

> ***...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.***

The periodic analysis highlights difficulties in the 'escalation' of concerns in response to increasing risk, with professionals often finding it hard to 'make their views heard' when they had reasons for challenging decisions. A key area of professional disagreement was around the threshold for children's social care involvement. Referrals from other agencies to social care were often rejected without explanation or without providing information about alternative sources of support.

One SCR describes how, following disclosure of child sexual abuse, a GP appropriately referred the child to the MASH (multi-agency safeguarding hub) to arrange a medical examination. However, this was deemed unnecessary. The SCR reports that this decision was '*accepted by practitioners of all disciplines without further challenge*'. The child remained at home and was then further abused.

Professionals who raised concerns and had evidence of risk were sometimes 'overruled' in the decision-making process. SCRs found that professionals could also be reluctant to use escalation processes if it meant directly challenging more senior professionals (within and across agencies). In some cases, formal processes for escalating concerns were not clear. Another reason for the lack of professional challenge was 'a shared acknowledgement among professionals of the pressures faced by local services in terms of workforce capacity, caseloads and reduced funding'. This meant that practitioners were reluctant to challenge decisions, and, in some cases, this led to a decision not to refer at all.

Learning points

- Discussion and respectful challenge is integral to collaborative working. Police officers need to have (and be supported to have) the skills and confidence to challenge decisions and escalate concerns where there is tangible evidence of a safeguarding risk.
- Crucially, collaborative working also means *all* professionals being open to challenge and ready and willing to answer questions about their decisions or judgments.
- The police often hold significant information about parents, carers and other family members and need to be involved at all stages of an investigation of safeguarding concerns.
- It is important that officers do not assume that the lead safeguarding agency has always made the best decision.
- Officers need to be aware of formal escalation policies. Evidence from SCRs suggests that where disagreements are dealt with informally rather than through formal channels, constructive dialogue between agencies may be shut down.
- Professionals may be reluctant to use 'escalation' processes if it means challenging senior workers. The 2014-17 periodic analysis found that the terms 'escalation' and 'dispute' can feel adversarial, but reframing the issue as 'resolving professional differences' rather than 'escalation' may assist in creating opportunities for constructive inter-professional dialogue (Brandon et al., 2020).

A system-wide response

In their analysis of change and continuities since 1998, the research team highlight that safeguarding practice is affected by multiple factors, including national policies, competing social priorities and budgetary constraints, among others (Dickens et al., 2022b). So, while it is concerning that SCRs over the years have repeated many of the same messages for practice, it should be remembered that the work practitioners are undertaking is inherently 'complex, often ambiguous and highly challenging'. Reviewers always have the benefit of hindsight.

The research team also emphasise that SCRs generally describe 'unusual events'. They are the 'hard cases'. Compared to all children referred to children's social care (over 650,000 referrals in 2018-19 alone) or the number on child protection plans (over 52,000 on 31 March 2019), there are relatively few SCRs; in other words, the safeguarding system works most of the time for most children.

Many persistent challenges, including heavy workloads, staff recruitment and retention, and the limited availability of preventative or early intervention support and services are beyond the control of individual practitioners and their teams. But two knowledge exchange events hosted by Research in Practice in early 2022 highlighted that much work does go on at local level to implement findings from SCRs.

The research team stress that it is the 'wider messages' from SCRs that have proved hardest to implement. These are messages about the importance of:

- practitioners having manageable workloads
- a sufficient and sufficiently experienced workforce
- a broad range of services being in place to support children and families, including at an early stage
- challenging but supportive supervision that facilitates the 'subtle skills of practice', including 'clear and courageous thinking to "ask the next question"' (both of families and fellow professionals)
- getting the right balance between support and investigation
- supportive IT systems
- effective inter-agency working and communication.

Messages are often difficult to implement because the conditions to achieve many of them lie beyond local level – they require national understanding, prioritisation and funding. SCRs sometimes mention these challenges, but more often they concentrate on local systems; 'the problem is that without national change, the impact will always be restricted'.

Thus, while findings from SCRs can help to inform individual and team practice, action at a system level is crucial. Learning messages in these briefings are therefore intended to inform a system-wide response.

References

Allnock, D., Dawson, J, & Rawden, H. (2020). *The role of police in responding to child and adult vulnerability: A meta-analysis of 126 reviews of death and serious harm*. National Policing Vulnerability Knowledge and Practice Programme.
www.vkpp.org.uk/assets/Files/Publications/VKPP_police_response_MetaAnalysis.pdf

Brandon, M., Sidebotham, P., Belderson, P., Cleaver, H., Dickens, J., Garstang, J., Harris, J., Sorensen, P., & Wate, R. (2020). *Complexity and challenge: A triennial analysis of SCRs 2014-2017*. Department for Education.
https://seriouscasereviews.rip.org.uk/

Brook. (n.d.). *Sexual behaviours traffic light tool*.
www.brook.org.uk/training/wider-professional-training/sexual-behaviours-traffic-light-tool/

Child Safeguarding Practice Review Panel. (2020a). *It was hard to escape: safeguarding children at risk from criminal exploitation*.
www.gov.uk/government/publications/safeguarding-children-at-risk-from-criminal-exploitation

Child Safeguarding Practice Review Panel. (2020b). *Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm*.
www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

Child Safeguarding Practice Review Panel. (2021a). *Annual report 2020: Patterns in practice, key messages and 2021 work programme*.
www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2020

Child Safeguarding Practice Review Panel. (2021b). *'The myth of invisible men': safeguarding children under 1 from non-accidental injury caused by male carers*.
www.gov.uk/government/publications/safeguarding-children-under-1-year-old-from-non-accidental-injury

Child Safeguarding Practice Review Panel. (2022). *Child protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson*.
www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson

College of Policing. (2020). *Authorised professional practice: Information management*.
www.college.police.uk/app/information-management

College of Policing. (2022). *Effective supervision: Guidelines*.
www.college.police.uk/guidance/effective-supervision

Daniel, B., Taylor, J. and Scott, J. (2010). Recognition of neglect and early response: Overview of a systematic review of the literature. *Child & Family Social Work, 15*(2), 248–257.
https://doi.org/10.1111/j.1365-2206.2009.00670.x

Dickens, J., Taylor, J., Cook, L., Cossar, J., Garstang, J., Hallett N., Molloy, E., Rennolds, N., Rimmer, J., Sorensen, P., & Wate, R. (2022a). *Learning for the future: Final analysis of serious case reviews 2017-19*. Department for Education.

Dickens, J., Taylor, J., Cook, L., Cossar, J., Garstang, J. & Rimmer, J. (2022b). *Serious case reviews 1998-2019: Continuities, changes and challenges*. Department for Education.

Dickens, J., Taylor, J., Cook, L., Garstang, J., Hallett, N., Okpokiri, C., & Rimmer, J. (2022c). *Annual review of local child safeguarding practice reviews*. Child Safeguarding Practice Review Panel. www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

Dickens, J., Taylor, J., Garstang, J., Hallett, N., Rennolds, N., & Sorensen, P. (2021). *Annual review of LCSPRs and rapid reviews*. Child Safeguarding Practice Review Panel. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984770/Annual_review_of_LCSPRs_and_rapid_reviews.pdf

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect, 31*(1), 7–26. https://doi.org/10.1016/j.chiabu.2006.06.008

Firmin, C. (2017). *Contextual safeguarding: An overview of the operational, strategic and conceptual framework*. Institute of Applied Social Research, University of Bedfordshire. Available at: www.csnetwork.org.uk/assets/documents/Contextual-Safeguarding-Briefing.pdf

HM Government. (2018). *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. Department for Education. www.gov.uk/government/publications/working-together-to-safeguard-children--2

MacAlister, J. (2022). *The independent review of children's social care: Final report.* https://childrenssocialcare.independent-review.uk/final-report/

Ministry of Justice, & National Police Chiefs' Council. (2022). *Achieving best evidence in criminal proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures.* Ministry of Justice. www.gov.uk/government/publications/achieving-best-evidence-in-criminal-proceedings

NHS Digital. (2019). *Child death reviews: Year ending 31 March 2019.* https://digital.nhs.uk/data-and-information/publications/statistical/child-death-reviews/2019

VKPP. (2020). *Spotlight on exploitation, county lines, threats and weapons: Learning from two serious case reviews*. National Policing Vulnerability Knowledge and Practice Programme. www.vkpp.org.uk/publications/publications-and-reports/

research in practice

University of East Anglia

crcf Centre for Research on Children & Families

UNIVERSITY OF BIRMINGHAM

Research in Practice
The Granary Dartington Hall
Totnes Devon TQ9 6EE

tel 01803 867692
email ask@researchinpractice.org.uk

Authors: Steve Flood and Julie Wilkinson

With grateful thanks to:
Debbie Allnock, Phil Brewer and Kay Wallace

Research in Practice is a programme of The Dartington Hall Trust which is a company limited by guarantee and a registered charity. Company No. 1485560 Charity No. 279756 VAT No. 402196875

Registered Office:
The Elmhirst Centre, Dartington Hall, Totnes TQ9 6EL

www.researchinpractice.org.uk