research in practice

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

Messages for health from SCRs conducted 2017–19

December 2022

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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

All professionals working in healthcare services have an important role to play in protecting children from harm. This briefing[1] is for all health professionals, including:

- Designated and named safeguarding leads
- All doctors, including general practitioners (GPs) and paediatricians
- All nurses, including mental health nurses, practice and community nurses, midwives, public health nurses, health visitors, school and nursery nurses, and health support workers
- Mental health early help providers and children and young people's mental health services teams
- Dentists, pharmacists, physiotherapists, speech and language therapists, occupational therapists
- System leaders, commissioners and wider stakeholders, including clinical leads, Directors of Public Health, integrated care boards and partnerships, and private providers and agencies.

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 SCRs 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 LCSPRs (Dickens et al., 2021; 2022c).

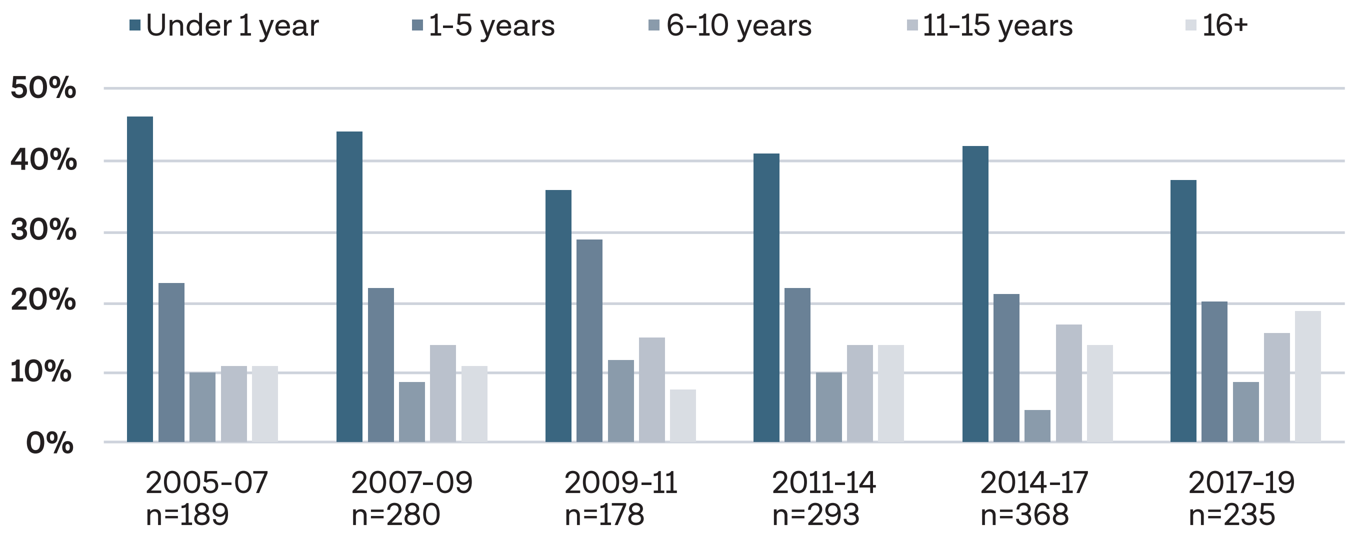
In their analysis of trends since 1998, the research team reflect on why periodic analyses of SCRs have so often identified repeat messages (Dickens et al., 2022b). They note that safeguarding practice is not only inherently complex, challenging and often ambiguous, it is also directly affected by a 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 differs 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

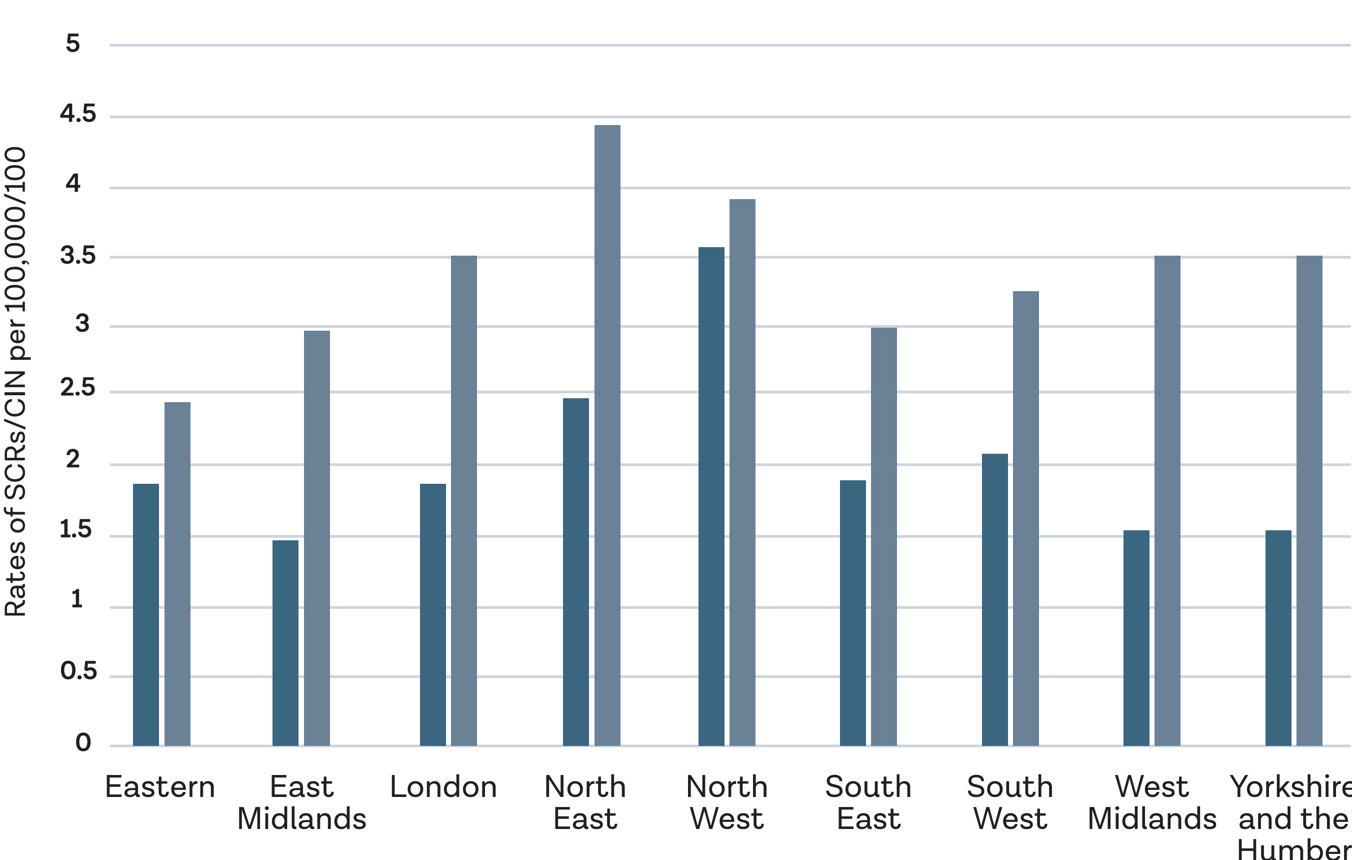
Category of serious harm*	2009-11 (%) n=60	2011-14 (%) n=96	2014-17 (%) n=162	2017-19** (%) n=98***
Non-fatal physical abuse	31 (52%)	50 (52%)	83 (51%)	44 (45%)
Neglect	6 (10%)	14 (15%)	30 (19%)	22 (23%)
Child sexual abuse – intrafamilial	6 (10%)	13 (14%)	16 (10%)	13 (13%)
Child sexual abuse – extrafamilial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

Recognising and responding to neglect

Neglect continues to feature prominently in the lives of most children who become the subject of an SCR. While neglect is rarely a direct cause of death or primary cause of non-fatal harm, it is consistently a contributory factor to both. Yet despite its potentially deep and long-lasting effects, identifying neglect and recognising its severity remains a challenge for practitioners across all sectors, including those who work in health services.

In some cases, children who were 'visible' to health services were left in conditions of long-term neglect because practitioners did not see the wider picture. For example, when children had multiple or complex needs, practitioners' focus on managing disabilities or health needs sometimes meant safeguarding was overlooked.

> ***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.***

Also, the risk to children was not always considered when parents had needs related to substance misuse or their mental health.

> ***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'.***

> ***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.***

Health professionals had sometimes focused exclusively on discrete or immediate tasks. For example, SCRs found that failure to meet developmental milestones was not necessarily understood as part of a broader picture of the child's life at home, as in the following case.

> ***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.***

Normalisation of 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'. Neglect and its impact could then be inadvertently downplayed as practitioners focused on securing or providing practical support for associated problems, as in this case.

> ***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.***

Providing practical help 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.
- Older children in particular can become adept at concealing familial neglect (Ofsted et al., 2018).
- Complex parental needs – including chronic health conditions, drug or alcohol use, poor mental health, and learning disabilities – were common aspects of family life in cases of children who experienced neglect.
- Local adoption of a standardised neglect assessment tool or tools for use by practitioners across all services, including health, may help to improve awareness and identification of neglect. It is essential that training is provided in the use of any adopted tools.
- The use of neglect assessment tools is likely to be more effective when sector and service leaders work together to develop a local culture of collaborative working. Some local areas are implementing a local neglect strategy, which includes the use of recognised neglect assessment tools by all professionals.
- When neglect is recognised, it can sometimes come to mask other forms of harm; practitioners need to be alert to the possibility of other forms of maltreatment also. For example, 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 – and the sexual abuse had continued.

Acting on missed appointments

Not following up non-attendance at health appointments was identified as a missed opportunity to safeguard children in a number of SCRs, as illustrated by the following three examples.

A 13-year-old who died following an asthma attack had missed numerous asthma-related medical appointments throughout her life. Professionals had repeatedly raised concerns about the mother's poor management of her daughter's condition and the poor home environment, which may have exacerbated the asthma. But professionals sought to adopt a supportive approach and to encourage attendance rather than question or challenge non-attendance. The SCR concluded: ***'Professionals in the main made too many allowances for her mother and were insufficiently challenging.'***

A child with learning difficulties and autism was taken into care when he was nine years old, having not been seen by any health professional since the age of 14 months. During his first 12 months, the boy was not taken for all his immunisations and an audiology appointment was missed. When he was two years old, a developmental questionnaire was sent to the boy's mother; it was not returned, and there was no follow-up by the health visiting team.

> ***[A child] who has significant developmental and communication needs, was effectively 'hidden' from view... The effect of the toxic stress and maltreatment ... has been recognised to have compounded Billy's learning difficulties and his confirmed diagnosis of autism.***

At three and a half years old, Rosie was admitted to hospital having suffered long-term neglect. She was severely malnourished, developmentally delayed and socially isolated. As a consequence of the neglect, Rosie will need specialist care for the rest of her life. Rosie's family lived in a deprived area and had been receiving support from a range of universal services. Both parents had histories of substance misuse and the father had a history of domestic abuse. The midwifery service had made a safeguarding referral before Rosie was born, but an early assessment of parenting capacity through a pre-birth assessment was missed by children's social care.

The SCR found that professionals had shown little curiosity about a series of missed appointments, including paediatric appointments and at the children's centre, or about her lack of attendance at any kind of educational or out-of-home provision. Rosie was not weight-bearing at 12 months or walking by 20 months, but there was no recording of the Ages and Stages Questionnaire being undertaken at any health visitor reviews. Some parenting interventions had been offered, but Rosie's parents were resistant.

Maintaining professional curiosity

The non-follow up of missed appointments and apparent lack of reflection on possible reasons for non-attendance may suggest a lack of appropriate professional curiosity. But SCRs also acknowledge that heavy workloads and time constraints are likely to have had an adverse impact on professionals' readiness or ability to practise effective challenge and curiosity.

One SCR concerning the death of a five-week old baby noted that the midwife undertaking the postnatal discharge visit had eight visits to make on that day with only 15 minutes' visiting time allocated to each family. 'Such time restrictions make it difficult for professionals to ask the right questions and go beyond the surface to explore the hidden risks and dynamics of family life.' In this case, speaking to the mother alone may have enabled the midwife to 'pick up on her vulnerabilities and signs of domestic abuse within the home'.

SCRs also include evidence of practitioners working hard to overcome these barriers. They highlight frequent examples of strongly motivated practitioners going the extra mile when they suspected a child may be at risk. What was evident in these examples of professional curiosity and persistence was that practitioners not only followed their instincts in trying to see the children, but they made time to do so – often going over and above the allotted time expected by their agencies. One review noted how practitioners 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....***

SCRs found that the dynamics of professionals' relationships with parents could sometimes create an additional barrier to curiosity. Existing literature suggests that professionals' emotional responses towards parents may shape the extent to which they exercise professional curiosity (Cook, 2017), and professionals are less likely to challenge a parent who they perceive as capable and coherent, even if there is wider evidence indicative of risk. One SCR also found that school and health practitioners may have avoided asking key questions because they found the father 'too difficult' to engage.

Learning points

- Children not being brought to health appointments remains a safeguarding issue (Powell & Appleton, 2012). Health professionals' curiosity and concern should always be aroused when children are not brought to appointments. Health providers should ensure that systems are in place to follow up on children who miss appointments.
- While patterns of parental withdrawal from health and other services predominantly affect younger children, professionals should also be alert to the possibility of older children withdrawing themselves.

Physical symptoms

There was evidence in some SCRs that health professionals had not shown sufficient curiosity about children's physical symptoms and had missed symptoms that were potentially related to child sexual abuse. In one case, for example, a teenager with a learning disability went to see her GP 12 times with genito-urinary symptoms over a three-year period, but the girl was never once asked about her sexual history.

In another case, a baby's mother reported that there was blood in her child's nappy, but the mother failed to attend a follow-up visit with the GP. The father had previously abused other young children, but that information had not been shared with the GP. The bleeding may not have been the result of abuse – but the lack of information at the GP's disposal prevented a holistic understanding of the situation.

Learning points

> Health practitioners, including GPs, need to be aware of current guidance on when to suspect possible child abuse. Equally, crucial information that children may be at risk should be shared with GPs (by children's social care, for example) so that GPs can consider physical symptoms in context.

Paying attention to the child's lived experience

As in earlier periodic reviews, SCRs highlighted that the voice of the child often went unheard. Crucially, 'hearing' involves not only listening to the child but also observing, because children commonly show what they are experiencing or thinking through their behaviour rather than what they say. In many SCRs, the lived reality of the child's day-to-day life was not sufficiently understood or explored. This was a persistent theme across the 2017-19 SCRs: professionals either lacked or lost focus on the child's lived experience. 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 development, health and wellbeing, 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, including the cumulative effect, and how they may be continuing to impact the child's life.
- Thinking about how the child may be experiencing diagnoses, treatment, interventions, decision-making and planning.

Thinking about all aspects of health and wellbeing

It was evident in some SCRs that professionals had grown accustomed to perceiving the child through a single lens. They had lost sight of the whole child and had either not considered the possibility of maltreatment or not recognised its severity. This was a risk in particular for children who were disabled or living with a chronic health condition, who are more at risk of abuse (Ofsted et al., 2020).

The vulnerabilities of some children may have made them an 'easy target'. For example, one young woman with a learning disability did not recognise that she was being abused by her mother's partner despite having received relationship and sex education. Disabled children's maltreatment can sometimes be 'hidden in plain sight' (Franklin et al., 2022), with disability seen first and the possibility of abuse not considered. In the following example, this was so even though the young person had reported being hit by the mother's partner and had attended the GP repeatedly.

> ***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.***

In the next example, health professionals did not have a full picture of a teenage boy's life at home and had also not foreseen that parental ambivalence about his health condition may have left him trying to manage his treatment plan alone.

> The SCR for a 17-year-old who died following complications from diabetes highlighted that health professionals had not taken into account that his parents' ambivalence towards their son's diagnosis might result in his being left to manage his own treatment plan. Health professionals were also unaware that the boy had experienced domestic abuse throughout his life, and they attributed his mental health difficulties to his realisation that the diagnosis had ended his ambition to join the military. The boy's home circumstances were not adequately explored, and a fuller insight into his life emerged only after his death.

As mentioned earlier (see page 15), some SCRs found that when children did not reach development milestones, this was seen as an 'individual issue' that required support 'rather than being understood as part of a wider picture of parenting and the child's circumstances'. In other cases, practitioners had used assessment tools but had considered the results only in isolation, as in this assessment of a boy's emotional difficulties.

> One young person who was charged with attempted murder had been subject to numerous assessments from an early age. After completing the Strengths and Difficulties Questionnaire, a school nurse concluded that the boy had no emotional difficulties. But the findings were not considered in the context of other known information, including the boy's aggressive and disruptive behaviour at school, his tearfulness and the fact that he had told practitioners he was scared at night.

Learning points

- Practitioners should aim to develop a holistic sense of each child's lived experience. As well as engaging with the child directly, this means integrating information from different sources, including other agencies.
- It is important that practitioners are supported to work holistically to view children's lives and experiences in the round and not exclusively through one lens. SCRs suggest that this is a risk in particular for children who have special educational needs and/or disabilities.
- Practitioners should remain mindful that children and young people with learning disabilities are at greater risk of abuse. Disabled children are around three times more likely than their non-disabled peers to be abused and are also more likely to receive a poor response from professionals (Ofsted et al., 2020).

Adolescents – children's lives in multiple contexts

Professionals often had a limited understanding of the daily lives of adolescents who became the subject of SCRs. While it is important to consider the different contexts to every child's life, SCRs suggest that this was often challenging in relation to older children in particular. In many cases, adolescents had been at the centre of extensive professional activity, but this had not always provided significant insight into what their lives were like. A number of SCRs describe multiple, longstanding and cumulative difficulties in adolescents' lives, yet those issues had sometimes been considered only in isolation.

It is important for practitioners to understand the child's past as this can have an impact on the way children behave when they get older. Thinking about the child's past may also help address the issue of 'adultification', where children are treated as though they are older than they are.[5] 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.***

Many adolescents who died by suicide or who were at risk of child criminal exploitation or child sexual exploitation had experienced cumulative harm over many years. A finding to emerge from the SCRs concerning adolescents who died by suicide, and some who were at risk from child criminal exploitation, was the number of relationships that they were expected to sustain as risks increased and professionals worked reactively to crisis situations; this could leave the young person 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.

5 Recent evidence suggests Black children may be at increased risk of 'adultification' (VKPP, 2020, p. 3)

Learning points

- It is important that practitioners seek to develop a sense of a child's life over time. Not only will this help practitioners to make a judgment about risk, but it will also help them to understand the cumulative impact of the child's experiences.
- 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 as being 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 – as with some young people who were at risk from child criminal or sexual exploitation and some young people who died by suicide – liaison may be required to ensure that the young person is not overwhelmed by having too many involved at the same time; therefore, it may be necessary to prioritise the work.
- The behaviour of young people who are known to have experienced early harm or who are living in care may be attributed too readily to early childhood experiences or placement moves. Practitioners need to be alert to the possibility that a young person's behaviour may also be an indication of current harm.

Recognising the meaning and significance of behaviour

A recurrent theme in the SCRs was the need for professionals to be alert and attuned to what a child or young person's behaviour might be signalling. Children generally find it difficult to disclose abuse directly and in many cases will communicate their distress through their behaviour. There are many reasons why children find this difficult, for example they may fear family breakdown or they may fear not being believed.

When a child or young person's behaviour is markedly different in different contexts, that should also be a reason for practitioners to exercise their professional curiosity, as in the following example.

A young person with diabetes presented very differently during inpatient stays compared to how he was at home. In hospital, he appeared relaxed and in a good mood, ate healthily and slept well. At home he was the opposite, but the reasons were not explored. '***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 LWs changes in mood.'***

Child sexual abuse

In the ten SCRs (examined in depth by the research team) that featured intrafamilial child sexual abuse, few children disclosed the abuse until they had been moved to a place of safety. But children in eight of the ten families had expressed their distress through aggressive, challenging or sexualised behaviour.

One young person who had been sexually abused was invited to contribute directly to the SCR. She said:

> ***'I totally changed [after the 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.'***

Some SCRs found that practitioners did not always consider sexual abuse despite concerns about a child's sexualised behaviour, which should always be seen as a red flag for possible sexual abuse.

> ***The issue of the children using sexually explicit language and exhibiting sexualised behaviour was explored in [two] single assessments, at strategy meetings, [two] CIN [child in need] meetings, core group meeting and ICPC [initial child protection conference] 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.***

Learning points

- Children often use behaviour rather than words to tell others they are in distress or being abused. Professionals need to remain curious about children's behaviour, particularly when there is a change in behaviour or if children behave differently in different contexts.
- If they are concerned about a child's behaviour, health professionals should not wait for verbal disclosure. They should follow local procedures and share their concern about possible maltreatment with safeguarding colleagues or within the local multi-agency forum.
- Inappropriate sexualised behaviour should always be recognised as a red flag for possible abuse.

Building relationships with children and young people

The importance of engaging children and building supportive and trusting relationships is a recurring theme across the 2017-19 SCRs and all the periodic analyses. The reality is that for many practitioners working in overstretched services, it can be very difficult to establish and sustain relationships with children and young people and family members. For example, one SCR noted that health visitors were carrying individual caseloads of more than 600 children. SCRs also provide evidence of numerous ways in which potential relationships were disrupted, including children having incident-based assessments with cases routinely closed and reopened.

Trust is not automatically established by duration of relationship. Children and young people may decide which practitioners they can talk to, based on how effective and supportive they perceive those practitioners to be. In one case, two children living in kinship care said that the social worker had known that they were living in an abusive situation but did not act:

> ***'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.'***

Opportunities may also arise to engage children when there is no pre-existing relationship, and health professionals should be alert to the possibility of these 'reachable moments'. Examples include young people attending a GP's surgery or A&E department on their own and with symptoms that warrant concern, or when police encounter a young person who had gone missing or who is in custody for the first time.

Learning points

- Trusting relationships are key to effective safeguarding. Employing organisations, including health services, should make every effort not to allow resource pressures to undermine opportunities for establishing and maintaining relationships and try to avoid frequent changes in practitioner.
- Seeing children alone can optimise the chances of children feeling safe enough to talk. Health professionals, including GPs, school nurses, counsellors and other therapists, may be more likely to see children alone and should be sensitive to the possibility that children may want to talk.
- Practitioners should not over-rely on verbal disclosure where there is cause for concern, nor on children's denials or minimisation. When children do talk about abuse and maltreatment, they must be listened to.

Communicating effectively with other professionals – more than sharing information

Difficulties around information sharing have long been recognised as a characteristic of interagency and interprofessional working, and they have been persistently highlighted in the SCR periodic analyses. A recurring theme in the 2017-19 SCRs was the crucial distinction between sharing information and communicating effectively. In many cases, important information had been shared between agencies, but that information or its implications had not been fully understood by practitioners in other agencies. This was part of a broad pattern around medical diagnoses, in particular: non-health specialists did not always understand the significance of the information at their disposal, and this left them unable to assess risk adequately.

One SCR was prompted when a young person caused significant injury to a younger child. The young person had been exhibiting challenging behaviour prior to the incident and had been supported by mental health services for several years. The review found that his diagnosis of conduct disorder was an important risk factor, but its significance and implications had not been understood by professionals outside mental health services.

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

A recent health diagnosis was a factor in a young person taking her own life. Although the diagnosis had been shared between agencies involved in her care, its significance and far-reaching social implications were not obvious to non-specialists. The diagnosis had the potential to preclude the young person from participating in a number of sports and activities from which she derived significant personal meaning, as well as enjoyment and social relationships.

Where there was evidence of good practice, this typically involved regular interprofessional dialogue, including meetings and telephone conversations. However, SCRs found that such opportunities were often restricted by heavy workloads.

When families move

Making sure information is communicated properly is also vital when families move between local authority, NHS trust or police force areas. SCRs highlight the importance of information being shared with the receiving authority so that practitioners can form a holistic view of a child's contacts with professional services over time. In the SCRs, this was a recurring issue across all services, including health, police and children's social care. After one local authority transferred a case electronically, no mechanism was in place to alert the outgoing authority that the case had not been picked up by the receiving authority.

Learning points

> Health professionals should remain ever mindful of how practitioners in other disciplines may understand or interpret the information they provide. This means avoiding professional jargon and giving a clear account for non-specialists of what the information means for the child, including the implications of health diagnoses.

> On receiving new information, all professionals in the child's network should reflect individually and collectively on the question: 'What does this mean for the child?'

> Having regular meetings and telephone conversations can enable professionals to 'translate' or interpret information for those in other disciplines. They are also opportunities for asking questions and generating alternative hypotheses. Health providers should do all they can to support practitioners in having such opportunities.

> When health services receive information about a child moving, they should consider who else needs to know and what action needs to be taken.

Professional disagreements and escalation of concerns

Effective multi-agency working is integral to supporting families and safeguarding children. However, multi-agency working does not always entail agreement. Discussion and respectful challenge are a key part of collaborative working and robust decision-making, but unresolved professional disagreements were a frequent issue within SCRs, especially in relation to risk and thresholds. Practitioners were not always clear about local procedures for challenge or 'escalating' their concerns.

In many SCRs, prevailing professional hierarchies appear to have acted as a barrier to constructive interprofessional challenge. This can be a challenge within health services in particular.

One SCR described a child being seriously harmed through over-medication (fabricated or induced illness was suspected). It found the GP, dispensing pharmacist and other professionals had all expressed reservations about the high dose of addictive medication that had been prescribed for an unusually long period. But none felt able to challenge the specialist paediatrician or to escalate their concerns effectively. The SCR concluded that GPs had been ***'influenced by the hierarchy of medical professionals'*** and had ***'felt bound to prescribe ... despite their continued anxiety'.***

Several SCRs emphasised the need for clear escalation policies to be in place because professionals had often been unsure of how or where to raise objections. Sometimes, disagreements were dealt with informally rather than through formal established channels, which could result in dialogue effectively being shut down – as in this example.

A child's GP disagreed with a decision that had been taken not to authorise a child protection medical examination. As a result, 'informal' discussions took place between children's social care managers and professionals 'from different disciplines'. The decision not to authorise the examination was upheld, but the outcome and rationale were not recorded and the GP was not informed of the decision.

The following example also underlines the need for clear and effective processes to be in place.

Professionals had been raising concerns with children's social care for at least nine months about a child's extreme sexualised behaviour, but it appears that social care were waiting for a verbal disclosure 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.***

The child later presented with genital injuries, but again there was uncertainty about what action could be taken in the absence of a clear disclosure.

> ***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 SCR concluded that some practitioners had felt the need to have a criminal burden of proof to begin Section 47 enquiries. This prevented effective safeguarding, was contrary to *Working Together* guidance (HM Government, 2018) and contributed to the child remaining at home with her abuser for many months.

Learning points

- Discussion and respectful challenge are integral to collaborative working. Effective interprofessional working means staff being supported and having the confidence to ask questions and pursue concerns if they are unhappy with the decisions or actions of others. Crucially, it also means all professionals being open to challenge and answering questions about their decisions or judgments.
- In order to help resolve professional differences, employing organisations should work together to create an inter-agency culture, supported by clear and widely understood guidelines, that makes it easy for professionals to raise any concerns around decision-making.
- Professionals may be reluctant to use 'escalation' processes if it means challenging senior clinicians. The 2014-17 periodic analysis found that the terms 'escalation' and 'dispute' can feel adversarial, but reframing the issue as 'resolving professional differences' created a sense of professional empowerment, with staff saying: '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 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.

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