Department for Education

Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014

Final report

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Introduction

A serious case review (SCR) is a local enquiry carried out where a child has died or been seriously harmed and abuse or neglect are known or suspected, and there is cause for concern about professional working together. This study is the fifth consecutive analysis of serious case reviews in England undertaken by the same research team dating back to reviews from 2003-2005. The study considers a total of 293 SCRs relating to incidents which occurred in the period 1 April 2011- 31 March 2014. These most recent reviews are also analysed in the context of learning from SCRs over the ten years since 2003-2005. The aim of the study is to provide evidence of key issues and challenges for agencies working singly and together in these cases. It is also to provide the government with evidence of what is changing as a result of their reforms, and to identify areas where further change may be required to support organisations to learn from serious case reviews and to keep children safe.

Key Findings: What do SCRs tell us about the child protection system?

The pattern of serious case reviews over time shows that once a child is known to be in need of protection, for example with a child protection plan in place, the system is working well. There has been an increase in the number of serious case reviews carried out since 2012, but this has been against a backdrop of a steady year-on-year increase in child protection activity. There has been no change in the number of child deaths linked directly to maltreatment and, if anything, a reduction in the fatality rates for all but the older adolescent age group. Furthermore, only a small minority of children at the centre of a serious case review (12%) had a current child protection plan at the time of their death or serious harm. This is at a time when nationally numbers of children with a child protection plan have been rising dramatically.

There are still, however, pressure points at the boundaries into and out of the child protection system, where cases are ‘stepped up’ from universal and targeted services and ‘stepped down’ from child protection and children in need. While fewer than half of SCRs revealed *current* involvement with children’s social care, almost two thirds of the children had at some point been involved with children’s social care at least to the level of child in need. With hindsight, it is apparent that many of these children’s cases had either been closed too soon or lacked the ongoing support services and monitoring that the children and families needed. This highlights the need for long-term planning and support where children have known risks or vulnerabilities and especially where they have already suffered maltreatment.

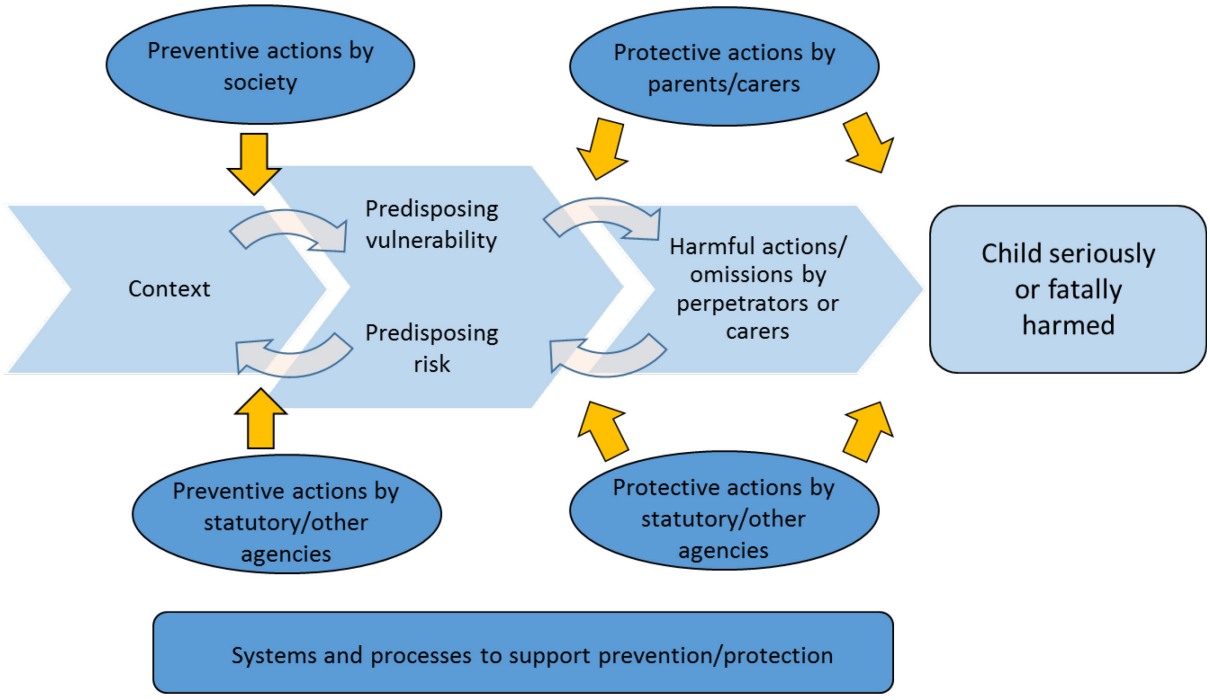
While these most recent SCRs suggest there may be a good awareness of risk factors among staff across universal, early help and specialist services, they also suggest that practitioners are not always rigorous in assessing and following through on all identified risks including domestic abuse. Where the threshold for children's social care involvement is not met, there may be little analysis of risks of harm. Support plans may be unclear and can easily drift.

It is important to note, however, that throughout our review we encountered examples of creative and effective child safeguarding. For many of the children, the harms they suffered occurred in spite of all the work that professionals were doing to support and protect them.

Background

For this study we have used a systems methodology to look beyond learning at an individual practitioner level, to understand the deeper systems issues that may have contributed to the child's death or serious harm, while setting this understanding within the wider context of the case. We have extended our previous work by considering the cases within a framework that looks at opportunities for prevention/protection, within the concept of pathways to harm, as illustrated in the diagram below. This has provided a helpful shift away from individual blame to the intended focus on opportunities for improvement within our systems for safeguarding children.

Pathways to harm, prevention and protection



Findings

Pathways to harm – children, parents and the wider environment

Most, but not all, serious and fatal child maltreatment takes place within the family with children living at home or with relatives. Pathways to harm include the context of the child's and the parents' characteristics, vulnerabilities and risks which interact with their environmental circumstances.

Children and young people are vulnerable in different ways at different ages. Both the youngest infants and older children (adolescents) stand out as being particularly at risk of harm for different reasons. Babies and young children are inherently vulnerable and dependent, and features which mark them out as especially fragile place them at higher risk of abuse and neglect. Low birth weight babies and those requiring special care because of, for example, illness or the impact of maternal drug misuse, potentially pose challenges to their parents over and above the considerable demands of any new-born infant. By adolescence the impact of long-standing abuse or neglect may present in behaviours which place the young person at increased risk of harm. Almost two thirds of the young people aged 11-15, and 88% of the older adolescents, had mental health problems. Some young people responded to adversity by engaging in risk-taking behaviour including drug and alcohol misuse and offending. A particularly vulnerable group are disabled children where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.

There is cumulative risk of harm to a child when different parental and environmental risk factors are present in combination or over periods of time. We previously noted this particularly in relation to domestic abuse, parental mental ill-health, and alcohol or substance misuse, but it also includes other risks such as adverse experiences in the parents' own childhoods, a history of violent crime, a pattern of multiple consecutive partners, acrimonious separation, and social isolation. When presented with any of these risk factors, practitioners should explore whether there may be other cumulative risks of harm to the child, as well as any protective factors. The impact of all domestic abuse is harmful to children and a step-change is required in how we understand and respond to domestic abuse. There is a need to move away from incident-based models of intervention with domestic abuse to a deeper understanding of the ongoing nature of coercive control and its impact on women and children, and also on men.

In terms of the child's environment, transient lifestyles and inappropriate housing can adversely impact on the safety, health and wellbeing of children of all ages, including adolescents who may be living in unsafe accommodation outside of the family home. Although families are usually a supportive and protective element in a child's life, for some the wider family context can instead present additional risks. Professionals should work with the extended family but be alert to the fact that not all family networks will be supportive.

Being at school can promote good overall development and provide a buffer against adversities for the child both within and beyond the home. Children who are not regularly in school, due to poor attendance, home schooling or exclusion, can be vulnerable due to their 'invisibility' and social isolation. Where neglect or maltreatment is already occurring, absence from school increases the child's risk of further harm. 'Managed moves' between schools have the potential to damage supportive and established relationships that children have with peers and school staff.

Pathways to prevention and protection

Most children were not involved with the child protection system through a child protection plan or a court order, although many were receiving services as 'children in need'. Many of these children and families had also been known to children's services in the past, and as such should be considered by agencies as having recognised and potentially long-lasting vulnerability or risk.

Hearing the voices of children and families

A key theme in the SCRs was ensuring a focus on children's needs and identifying vulnerable families. 'Hearing the voice of the child' is crucial but so too is hearing the voice of the immediate and wider family. Hearing children requires safe and trusting environments for children to be seen individually, speak freely, and be listened to. The voices of adolescents are of equal importance to those of younger children, but they may struggle to express their needs or feelings, or to engage effectively with services, and there are dangers of older adolescents falling between child and adult services. Importantly, children and young people may demonstrate 'silent' ways of telling about abuse and neglect through verbal and non-verbal emotional and behavioural changes and outbursts.

As with professionals, family members may be kept in the dark and be unaware of or unable to recognise potential risks, not know where to go with their concerns, or not have their concerns taken seriously. This was a particular issue for parents of young people being sexually exploited. Like children, family members can be intimidated by perpetrators or worried about the consequences of reporting concerns including the breakdown of relationships and the potential removal of children. They may be fearful and mistrustful of child protection services especially if they have had previous negative experiences. There are particular issues in relation to hearing the father's voice in situations of separation and during private law proceedings.

Family members might, however, also be covering up abuse or neglect. Balancing parental support, building on resilience and progress, while maintaining an attitude of respectful uncertainty is a challenge. Treating parents with openness and respect allows professionals to build a trusting relationship within which challenge can be made. This includes an attitude of professional curiosity which requires professionals to think beyond

the usual remit of their own professional role and to consider, holistically, the circumstances of the child and family.

Communication and information sharing

Effective safeguarding work depends on collaborative multi-agency working and no single professional retains all of the required knowledge or skills. Communication is essential for collaboration but is inevitably one of the key points of breakdown. There is evidence of uncertainty amongst practitioners about how and when to share information, despite national guidance. Breakdown in communication can happen where there is an absence of local safeguarding systems, barriers to effective co-working or failure to recognise or act upon safeguarding opportunities. Effective communication requires practitioner skills and a culture that promotes information sharing as well as clear systems and guidance that enables information to be critically appraised and used to guide decision making and planning. Information received must be triangulated and verified and child protection agencies must feedback promptly to referrers and others participating in safeguarding.

Assessment and thresholds

As in our previous biennial analyses, differences in perceived thresholds for child protection intervention could lead to frustration or breakdown in effective working, resulting in children falling through the gaps or their needs not being met. Assessments contribute to effective decision making and action to protect children. Assessments may be needed at the point of early help not just once child protection risks have been identified. The Common Assessment Framework (CAF), or Early Help Assessment (EHA), can help to explore risks and vulnerability and embed a holistic approach to the family. But to work effectively, there need to be clear thresholds and clear pathways for escalation and de-escalation. The CAF was not always seen as robust enough and the reliance on parental consent and willingness meant it was not always used in the cases where it was needed. Some professionals also linked CAF with social deprivation and did not use it for children from more affluent families, who were nevertheless in need of support.

Children's social care assessments need to be planned, comprehensive and timely and involve all professionals working with the family. Opportunities for improvement were identified in adequately appraising relevant information, minimising delays, and improving clarity in the assessment processes. Professionals tended to see assessment as a one-off event rather than an ongoing process, relying at times on a single visit and single sources of information. This made it difficult to keep an open mind to different explanations for any presenting feature. This included cases where abuse was discounted for a particular concerning presentation, which should not be taken as confirming that the child had not suffered or would not suffer serious harm.

At child protection conferences an incomplete or inadequate assessment could undermine the plans for subsequent protection and support. In these cases child protection or child in need plans often continued ineffectually without progress being made or, more worryingly, cases could be closed and 'stepped down' specifically because of a lack of progress. The fact that a decision has been made to end a child protection plan does not necessarily mean that all risks to the child have ceased and this may also apply when the case moves out of children's social care into early help or universal services.

Reluctance to take responsibility

As in our previous analyses, professionals often hung back expecting others to act, or passed on information thinking their responsibility ended at that point. Assumptions could be made about the actions or views of others, including those of parents or carers, without checking them out first. This way of thinking could be prompted by professionals' narrow view of their responsibility in a case, solely from the perspective of their own discipline.

Agency structures, processes and cultures

While the move to embracing systems approaches to carrying out SCRs appears to have led to a greater depth of analysis, in most cases this has still maintained an emphasis on professional failings, even in many of those SCRs which purported to use systems methods. We have endeavoured, instead, to capture the creative thinking emerging on ways to promote good practice and foster prevention and protection**.**

Building effective structures

The changing shape of agencies, with new commissioner-provider structures in health and the broadening scope of children's safeguarding, meant that the configuration of services was a key issue both in social care and in health. Some SCR recommendations looked towards reconfiguration, emphasising that any redesign should meet the needs of children and families effectively. This included ensuring staffing structures reflected appropriate knowledge, skills and experience.

Reviews highlighted the complexity and fragmentation of primary care health services which rely on a mixture of independent, public and private contractors, and where professionals are often working in relative isolation. The inevitable transitions within primary care services, such as those between midwifery and health visiting, and between health visiting and school nursing, mean that local teams need to ensure that there are appropriate structures in place for smooth transition, and that information is recorded and passed on. For vulnerable families in particular, any transition should be planned so appropriate support is maintained.

Complexity and fragmentation were even more of an issue in secondary health care services and in the interplay between primary and secondary care. Navigating between complex agency structures can prove difficult for both professionals and families. Clear coordinated care pathways for families with particular vulnerabilities are needed to help ensure parents and children receive timely and accessible help. Local services need clear signposting and clear criteria for referral and acceptance/rejection of cases.

Coping with limited resources

In contrast to previous biennial reviews, resource issues were regularly flagged up in these latest SCRs. This may reflect the ongoing impact of the economic climate and the difficult balance between rising public expectations of services and finite resources. It may also reflect a shift towards more rigorously exploring the systems issues underlying individual failings.

The steady increase in child protection activity since 2009 has occurred during a time when many services have remained static or been cut, thus leading to increased workloads for individual practitioners and teams. High and unmanageable workloads can result in delays in provision of services, higher thresholds for accepting referrals, or a lower quality of service being provided. Agencies tended to adopt short-term pragmatic solutions, rather than considering the ongoing needs of families. These ways of managing can threaten effective working, jeopardise the quality of assessments, and prompt delays and bureaucratic obstacles.

Some recommendations addressed workload issues through effective scheduling and configuration of services; through strengthening systems for staff support and supervision; or for ensuring adequate administrative support. The impact of increasing workloads in the face of limited resources places an imperative on leaders and managers within all agencies to think creatively about how their systems and structures can effectively support front-line workers.

Embedding responsive cultures

There is a need for a shift in emphasis from incident or episodic service provision to a culture of long-term and continuous support. Professionals working with children and families need to be given managerial permission and encouragement to recognise the long-term, ongoing nature of vulnerability and risk particularly in relation to neglect and emotional abuse.

The serious case reviews often reflected highly complex cases with multiple risks and vulnerabilities, often extending over considerable periods of time. This complexity was exacerbated by the interactions between multiple professionals working with the family, often in isolation from one another. As identified in our previous analyses, the complexity and dynamics within the family could be mirrored in the involvement and responses of professionals. In many ways it is not surprising that the more complex a case, the more

complex the inter-agency working becomes. Authoritative practice is an appropriate response to such complexity and managers and service leads have a responsibility to model authoritative practice in their own leadership. Principles of authoritative practice include allowing professionals to exercise their professional judgement in light of the circumstances of particular cases. They also include encouraging a stance of professional curiosity and challenge from a supportive base and each professional taking responsibility for their role in the safeguarding process, while respecting and valuing the roles of others. This needs to occur alongside relationships of trust with children, young people and parents which need to be carefully developed and maintained.

The quality of serious case reviews

Since June 2010, there has been a requirement to publish SCRs which has brought both challenges and changes to the review process and the production of the final report. The process of the serious case review and the shape of the final report depend largely on the review methodology adopted and at least nine different review types were apparent in the SCRs we studied.

Criticisms of SCR reports have focused on the emphasis on detail at the expense of clarity and analysis, with suggestions that briefer, more proportionate, SCRs might reduce delay and the long wait for the learning. SCR reports studied here were much shorter than predecessor reviews with an average length of 48 pages; earlier SCR reports were often in excess of 100 pages. Delays were apparent at particular points in the SCR process and reasons for delays included: complex negotiations around the decision about whether to initiate the review; hold ups during the process; and delays in releasing the report for publication, often because of concerns about the impact on family members.

Our previous study highlighted the large number of recommendations with an average of 47 per review. This time, more than two thirds of SCRs had fewer than 10 recommendations and almost all had fewer than 20. However, there is still great variation in the quality of recommendations.

Different methodological approaches, particularly systems models, result in different approaches to the number and nature of recommendations. Not all SCRs have recommendations and many systems-model SCRs offer learning points or findings and questions for the LSCB to consider instead. The widespread adoption of systems approaches to reviews appears to have led to a greater focus on learning lessons, and of separating out lessons to be learned from specific recommendations. Several of the systems-methods SCRs present findings in an easily accessible way, which relate the findings clearly to the case, and appear to promote much deeper analysis and thinking by practitioners, managers and Board members. However, even within these, there was variation in how the findings were presented and how relevant they were. Furthermore,

there were some circumstances where the findings identified specific issues for which it would have been appropriate for the SCR to make recommendations to the Board.

Our review suggests that good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies.

Conclusion

In most SCRs, even when the author specifically commented that a child's death could not have been predicted or prevented, they nevertheless were able to identify learning points, and often areas for improvement in the structures or processes of the organisations and individuals working in child welfare and protection. This implies that there were actions which could be taken to reduce the risk of future child deaths or of harm to other children.

We therefore suggest an approach that steers away from trying to pronounce on whether a death or serious harm could have been predicted or prevented, to acknowledging that there is always room for learning and improvement in our systems. We owe it to children and their families to identify those lessons, disseminate the learning, and implement appropriate actions for improvement.

Such an approach embraces the model of pathways to harm and protection adopted in this report. It recognises that children are harmed within contexts of risk and vulnerability and that there are many opportunities for prevention and protection, even without being able to accurately predict which children may be harmed, when or in what manner. It affirms the very positive work being done by professionals working with families to support and challenge, and acknowledges the need for an authoritative approach, combining authority, empathy and humility. Most of all, it challenges the culture of blame and failure, and helps us move instead to a narrative of 'progress and hope', affirming what has been achieved, and taking hold of the opportunities to learn and improve.

Chapter 1: Introduction

1.1 The child protection landscape

The public and professional understanding of child protection continues to be influenced by the deaths of young children in appalling circumstances. Recent high-profile deaths have included Daniel Pelka who was tortured at the hands of his mother and step-father, and Hamza Khan whose death from starvation was undiscovered for two years. Recent years have also seen a widespread concern about serious harm to potentially large populations of young people from child sexual exploitation. Such diverse cases come under the auspices of a serious case review where the imperative is to learn from the plight of these children and young people, improve services to children and families and to reduce the incidence of deaths or serious harm. To improve transparency and public confidence in the child protection system, there is a requirement to publish serious case reviews (SCRs).

A serious case review is a local enquiry undertaken by the Local Safeguarding Children Board (LSCB). It is carried out where a child has died and abuse or neglect are known or suspected and, additionally in cases of serious harm, there are concerns about inter-agency working. 'Serious harm' replaced the term 'serious injury' in Working Together 2013, and in the 2015 edition, serious harm is defined to include a potentially life-threatening injury and serious and /or likely long-term impairment of development resulting from abuse or neglect (HM Government, 2015, p.76). While there are strict criteria for conducting a serious case review, LSCBs should also consider holding reviews on cases which do not meet these criteria, in particular to review instances of good practice and consider how these can be shared and embedded.

It is now almost five years since the publication of the Munro Review of Child Protection (Munro 2010, 2011a, 2011b) and during this period there have been a number of government reforms and some changes to the child protection system, although key legislation has remained unchanged. In line with recommendations from the Munro Review there has been a stripping back of bureaucracy, and a degree of local autonomy informing both day to day practice and wider policy. Within children's social care, initial and comprehensive assessments have been combined into a single assessment.

Financial austerity and Government spending reviews have seen successive waves of reduction in the amount of central funds available to local authorities while giving local authorities a degree of control about how to spend these reduced funds. The requirement to retain statutory provision has seen deep cuts to many non-statutory support services although local authorities are required to publish their plans for providing early help. Local authorities have been facing pressures from two sides: from cuts in funding and from increased levels of poverty and deprivation (Ofsted, 2014). The changing landscape of service provision over recent years provides a backdrop to the way that agencies work together and to the universal, specialist and statutory services that children and families

receive. At the same time poverty and deprivation have been affecting the daily lives of children with levels of child poverty expected to rise rather than fall (Social Mobility and Child Poverty Commission, 2014).

Stripping back of bureaucracy has also affected the guidance for agencies working together to protect children. The revised editions of Working Together in 2013 and 2015 have been substantially slimmed down with the guidance on undertaking serious case reviews now based on principles rather than prescription, taking up nine pages in the 2015 edition of Working Together, in comparison with twenty three pages of detailed guidance in the 2010 edition (HM Government, 2010; 2013; 2015). Working Together 2013 also indicated that LSCBs were free to decide how best to conduct SCRs and could use any learning model for these reviews 'which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro' (HM Government, 2013, p.67).

Working Together 2013 also instituted a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. This panel has produced two annual reports which underline the importance of serious case reviews for maintaining public trust in the child protection system and for learning (DfE, 2014a; 2015). However the 2015 report acknowledged that SCRs are costly and made it clear that a proportionate approach to carrying out the review needs to be adopted to enable the aims of the SCR to be met without incurring excessive cost or workload. The 2015 report also reiterated that the point of publishing SCRs is not to punish but to learn, and sees the reinstatement of the regular national analyses of SCRs as a means of ensuring that the SCR system has the impact intended.

1.2 The project

Although the University of East Anglia together with the University of Warwick have undertaken four successive two-yearly national analyses of serious case reviews for the government since 2003-05, there has been a three year gap since our last study of cases from 2009-11. The period under scrutiny for our fifth analysis is the three years 1 April 2011 - 31 March 2014, and straddles two editions of Working Together: the edition from 2010 and the edition published in 2013, both of which have different guidance for carrying out a serious case review. The way the changes in guidance affect the SCR process is considered in greater detail in Chapter 9.

This study examines themes and trends emerging from the three years in question (2011-14) as well as the cumulative learning since 2003 when our team was first involved in the national analysis of SCRs (Brandon et al, 2008; 2009; 2010; 2012). With the addition of the cases from 2011-14, we now have a continuous database of just over

1,100 cases drawn from notifiable incidents which became a serious case review dating back to 2003[1]. We are also extending our earlier analysis of SCR recommendations and action plans undertaken for the most recent biennial analysis (Brandon et al, 2012) in line with the specific recommendation from the first annual report of the national panel of independent experts on serious case reviews.

1.2.1 Aims

The primary aim of the current study is to provide child protection professionals and others working in these areas with evidence of key issues and challenges in cases where children have died, or have been seriously harmed, and there are concerns about how agencies have worked together. In addition, the study endeavours to provide the government with evidence of what is really changing as a result of their reforms, and to identify areas where further change may be required to support organisations to learn from SCRs and keep children safe.

1.2.2 Objectives

1. To analyse data (both quantitative and qualitative) from the DfE-held child protection database (CPD) and SCR reports with an incident date between 1.4.2011 and 31.3.2014.
2. To identify common themes and trends across all 2011-14 reports and in the context of wider themes and trends in SCRs from 2003-14 drawing out implications for policy makers and practitioners.
3. To review the quality of SCR reports and the recommendations made, analysing the extent to which SCR authors clearly define and address recommendations.
4. Key findings are being published separately but simultaneously in a series of accessible, user-friendly summaries for professionals in the field and for LSCBs.

1.2.3 Pathways to harm, pathways to protection – our approach

The approach taken to this triennial review of serious case reviews builds on our preceding analyses. In addition, an analytic framework has been developed, drawing on systems methodology and our previous approach to identifying relevant themes. For this study we have used a systems methodology to look beyond the detail of learning at an individual practitioner level to understand the deeper systems issues that may have led to the child's death or serious harm, and setting this understanding within the wider context of the case. We aim to discern themes linked to practitioners' working at different levels of services e.g. in primary or secondary care (health) or early help and 'above the threshold cases' (children's social care/social work). A particular extension of our

[1] Most calculations in this report are from the 940 cases from 2005 onwards however, because of better availability of data from DfE from this date.

previous work has been to consider the cases within a framework that looks at opportunities for prevention/protection within the concept of pathways to harm. This builds on our previous ecological-transactional approach, to consider the opportunities for intervention within the overall context of the case and any recognised or unrecognised elements of vulnerability and risk.

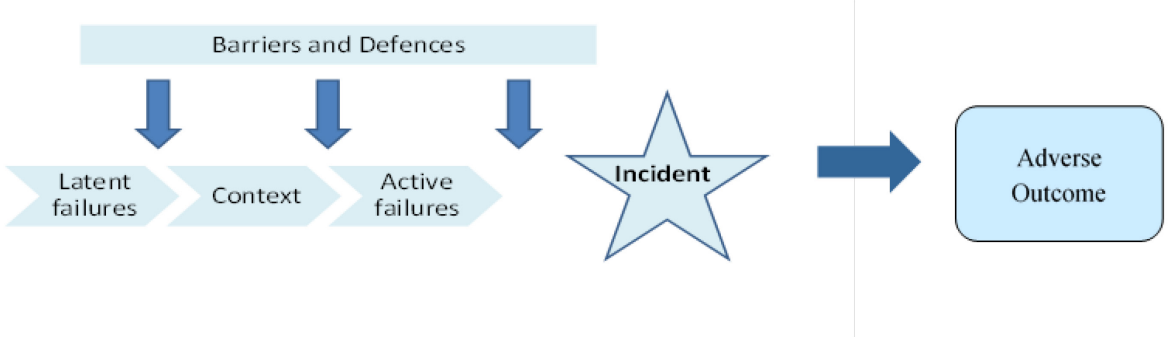
The model we have used builds on current understanding and application of systems principles to learning from adverse events. Reason's model of understanding adverse events (Reason, 1990) has provided a very valuable framework for moving beyond individual failures to recognising the interactions between humans and systems. This model, while originating in the fields of engineering, has been very appropriately adapted by Vincent and others to understand adverse events within healthcare settings (Vincent, Taylor-Adams et al, 1998; Vincent, 2010) and by Munro and others to apply to children's social care (Munro, 2005; Fish, Munro et al, 2008). Such systems approaches are recommended but not the required framework for undertaking serious case reviews:

> *"LSCBs may use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro."* (HM Government, 2015, p.74)

This interest in systemic approaches has provided a helpful shift away from individual blame to focus on the flaws inherent in our systems for safeguarding children, and therefore a context for learning and recommendations.

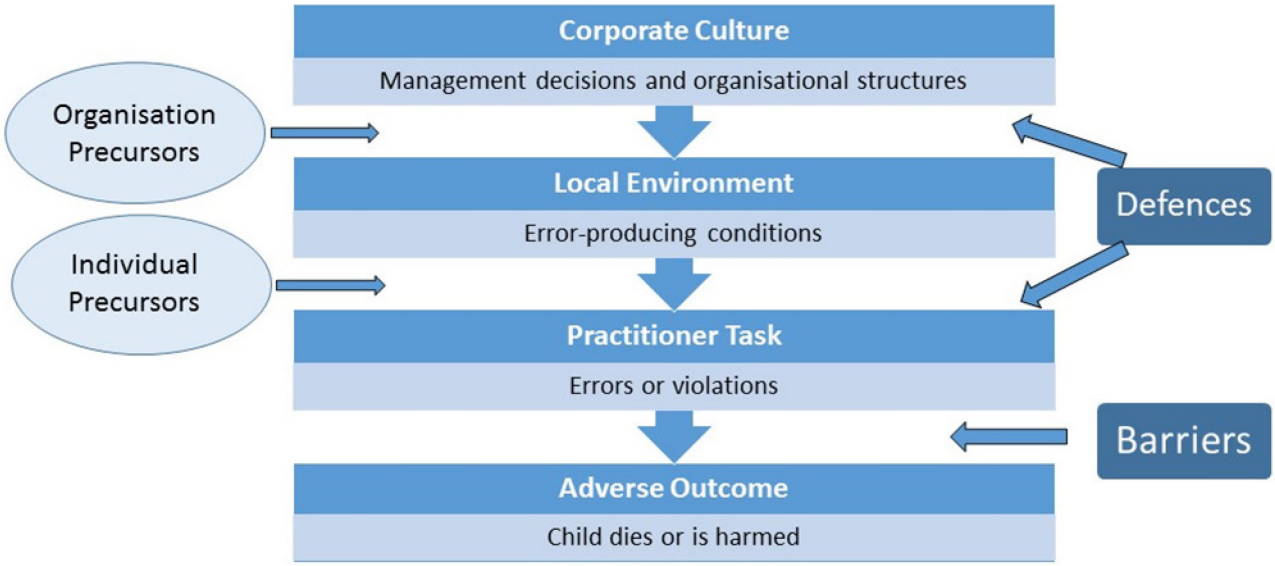
The systems approach can be summarised in the following diagram (Figure 1). The basic underlying premises are that latent failures in our systems provide the context within which active failures (errors or violations) by individuals may occur and result in specific incidents leading to adverse outcomes. This pathway may be somewhat mitigated by various barriers and defences. In considering how to prevent adverse outcomes, the emphasis is on identifying and remedying both active and latent failures, and on strengthening the barriers and defences that might prevent these failures resulting in harm.

Figure 1: A systems approach



This can be expanded to highlight different levels of latent failures as demonstrated in Figure 2 below:

Figure 2: Levels of system failures



While this provides a very helpful and appropriate framework for identifying weaknesses in our systems and the potential for learning and action to improve our systems, there is a danger in applying it without adaptation to incidents of serious or fatal child maltreatment.

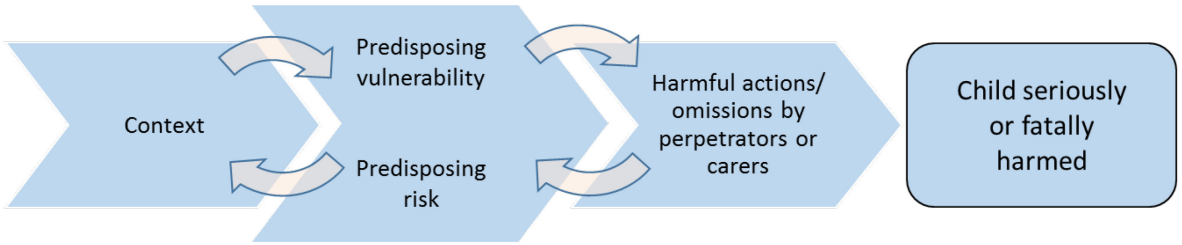
An adverse event in engineering (e.g. an aeroplane crash, the collapse of a building) or in health care (e.g. an incorrect amputation or administration of the wrong drug) can be appropriately traced back to the underlying engineering or health care systems, and the interactions between individuals (e.g. the pilot, the doctor), the environment (e.g. weather conditions, busy emergency departments) and the system (e.g. design flaws in the building, inadequate protocols for checking drugs). However, when it comes to a child seriously or fatally harmed through maltreatment, the fundamental process leading to the adverse outcome is the harmful action(s) of a person or persons (the perpetrator) external to any of the systems. Thus, there is a further pathway of harm interacting with, but extrinsic to, any of our individual or inter-agency systems for safeguarding.

With that in mind, any approach that does not take account of this fundamental underlying pathway can only go so far in seeking to prevent future harm to children. The pathway of harm thus consists of the interaction between the child's vulnerability and any risks posed by the parents, carers or others; this interaction takes place within the context of the wider social, physical and cultural environment within which the child and family live. Such interactions may result in harmful actions or omissions by perpetrators or carers, which, in turn, may lead to the child being seriously or fatally harmed.

In this model (Figure 3), it is important to recognise that not all child maltreatment consists of discrete incidents of harm. Thus there may be ongoing contexts of harmful

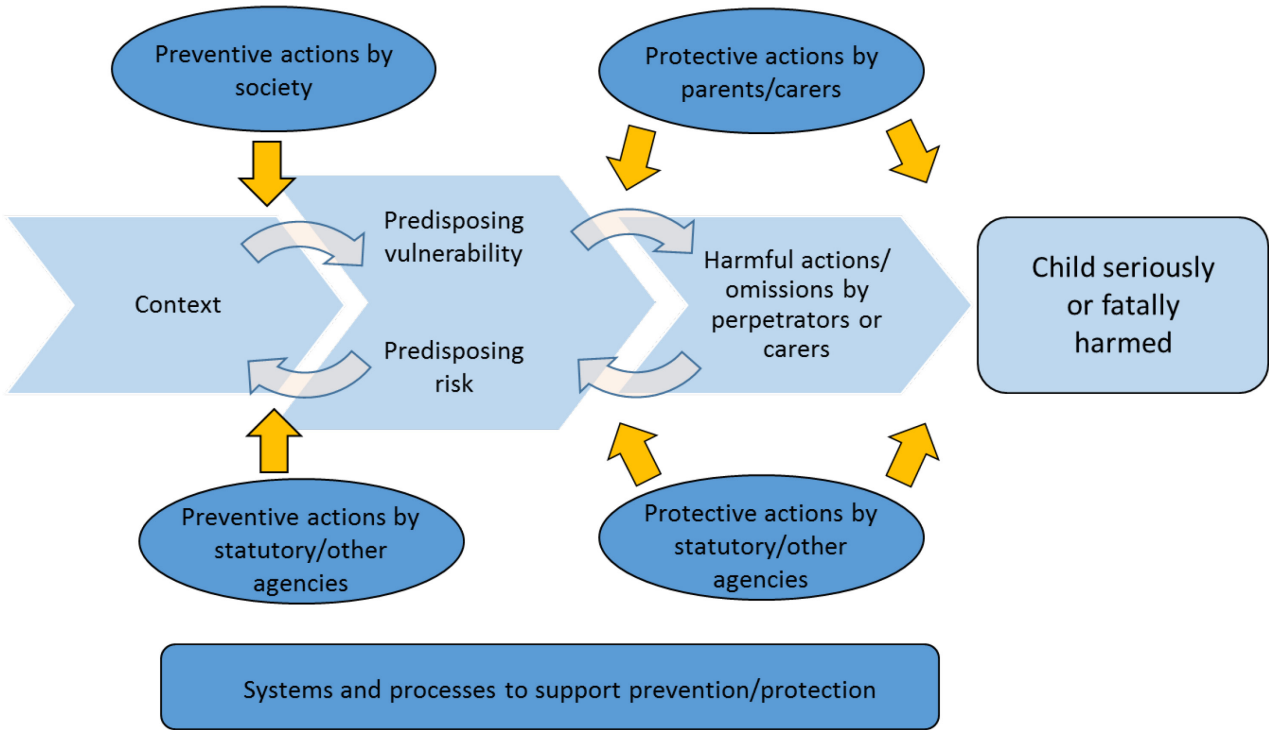
actions or omissions by carers; and fluctuations in the degree of vulnerability and risk; changes in the background context; and reductions as well as exacerbations of risk. This is illustrated by the curved arrows in the model.

Figure 3: Pathways to harm in child maltreatment



Along those pathways to harm, different professionals and wider society will also interact with the child and family. This provides different opportunities for protection from harm, particularly where the vulnerability of the child, or risks posed by the parent/carer or others are identified, or where there is early evidence of harmful actions or omissions by the perpetrators or carers. The aim in such situations is to protect the child from serious harm by means of appropriate interventions. Similarly, at an earlier stage, there may be opportunities for prevention, aiming to slow down, stop or reverse any progression along the pathway to harm, to reduce vulnerability or risk, or to prevent harmful actions or omissions. Much of this preventive work will take place outside any formal child protection systems. These preventive and protective interactions between professionals, parents and wider society, along with the underlying systems and processes which may support them, are illustrated in Figure 4.

Figure 4: Pathways to prevention and protection



This model, therefore, has provided the framework within which we have approached the analysis of cases in this triennial review. In the thematic analysis, we have tried to identify not just any active or latent failures reported in the reviews, but also to consider the interaction between professionals and parents; the opportunities for prevention or protection that arose at different points along the pathway to harm; and the underlying systems and processes that might either get in the way of or support more effective prevention and protection.

1.3 Guide to Chapters

Chapter 2 provides an overview of the cases included in this triennial review, and over time since 2005, and sets basic demographic and other details in the context of wider activities to safeguard children.

Chapter 3 gives an overview of the nature and circumstances of serious or fatal harm, and the background context within which these cases were situated.

Chapter 4 looks at the pathways to harm, particularly exploring issues around predisposing vulnerability and risk in the children, parents and family.

Chapter 5 looks in depth at the adolescents in this cohort, particularly exploring the issues raised in cases of child sexual exploitation and of suicide and self-harm.

Chapter 6 explores opportunities for prevention and protection that arise when working with individual cases, focusing on early intervention, recognition of vulnerability and risk, and practitioner engagment at an individual case level. This chapter will be of relevance

to all professionals working with children and families or with adults with parenting responsbilities.

Chapter 7 explores opportunities for protection of children through the multi-agency working arena, focusing on working with cases once vulnerability, risk, or early evidence of harm have been identified.

Chapter 8 considers the underlying systems and processes that may hinder or support effective prevention and promotion work. It identifies some of the creative thinking that is emerging on ways to promote good practice and improve opportunities for prevention and protection.

Chapter 9 reviews the quality of the serious case reviews and the recommendations arising from these.

Chapter 10 provides a summary of the key lessons arising from this triennial review in the light of the learning from the eleven years of national analyses.

Chapter 2: Patterns of serious and fatal child maltreatment

The focus of this chapter is to describe the patterns and key features of the circumstances that led to the serious case review. In many cases the review related to a single incident of serious or fatal harm, however in some of the serious harm cases there was no single incident that led to the review, but rather an ongoing context or pattern of harm, or allegations that related to previous, historic incidents. We highlight the latest findings and then place them within the context of data obtained in the previous three biennial reviews, undertaken by the same research team, covering the period 2005-11.

2.1 Sources of information and approach to analysis

The 293 serious case reviews considered here all relate to deaths or serious harm which occurred in the three year time period 1st April 2011 to 31st March 2014. All had been notified to Ofsted for inclusion on the Department for Education (DfE) Child Protection Database (CPD). From the CPD notification schedules, the researchers created an SPSS database (statistical package for the social sciences) and data relating to the child, the family and the incident were inputted to this database, and statistical analysis undertaken on the 293 notifications which met the time criteria for inclusion in this triennial review. For comparison, statistics from the previous three biennial reviews are given. Our composite database now comprises almost all[2] of the notified serious case reviews held in England since 2005, totalling 940 cases.

For each of the 293 serious case reviews, a search was made of the NSPCC national case review repository and on individual LSCB websites for published final reports. In total 175 final reports were obtained through this route by mid-October 2015. A letter was subsequently sent to the relevant 65 LSCB chairs requesting an update on the status of the remaining 118 SCRs. Fifty one chairs responded, providing details of 87 further SCRs, of which:

- 2 had been stepped down and did not progress to an SCR
- 2 were incorporated in another SCR
- 31 were not completed, often being delayed by court proceedings / other inquiries
- 28 had been published recently, or published locally, but not made available on the NSPCC repository
- 23 had not been published following discussions with the National Panel
- 1 had been published anonymously, without identifying the LSCB

[2] A small proportion of notifications (in each of the biennial review periods) had been made some time after the incident, and were therefore not available for inclusion at the time of the analysis. Our total of 940 is therefore marginally lower than the true figure.

The sub-sample of 175 reflects the full set of 293 reports as far as gender, the fatal/non-fatal proportion of cases, and the age band of the child. Full details of methodology are given in Appendix A.

2.2 The number of serious case reviews undertaken 2011-14

There were 293 notifications which met the timeframe criterion for inclusion in our study: 63 in 2011-12, 95 in 2012-13, and 135 in 2013-14 (Figure 5)

Between 2011 and 2014, approximately two-thirds (67%) of reviews related to a child/young person who died, and a third (33%) to non-fatal harm (Table 1)

The number of SCRs undertaken increased over the three years of this review, from 63 in 2011-12 to more than double that number (135) in 2013-14. The increase was particularly marked in relation to reviews relating to serious harm, rather than death, where the number undertaken more than quadrupled from 12 to 53 (Figure 5).

Figure 5: Number of serious case reviews conducted

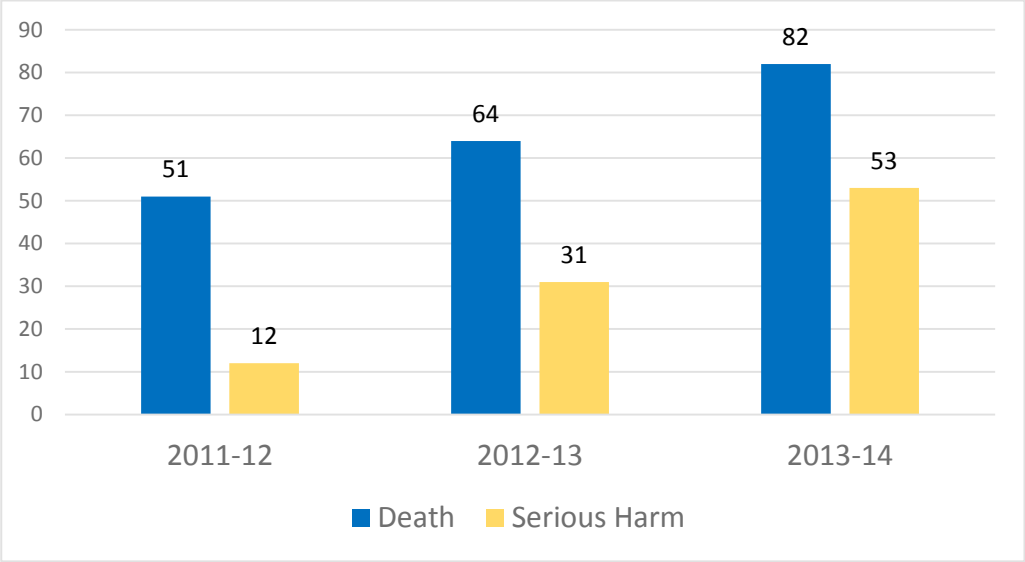


Table 1 below sets these latest triennial figures in the context of serious case reviews undertaken since 2005, and addressed by the research team in the previous three biennial reviews. Data for the most recent period, 2011-14, are given in the final column, to the right. It is important to bear in mind that absolute numbers in the final column relate to three years, while all previous data relate to two-year periods. For this reason, and in all subsequent tables, the percentage data for the three year period provide a better comparison with the earlier, biennial data than do absolute numbers.

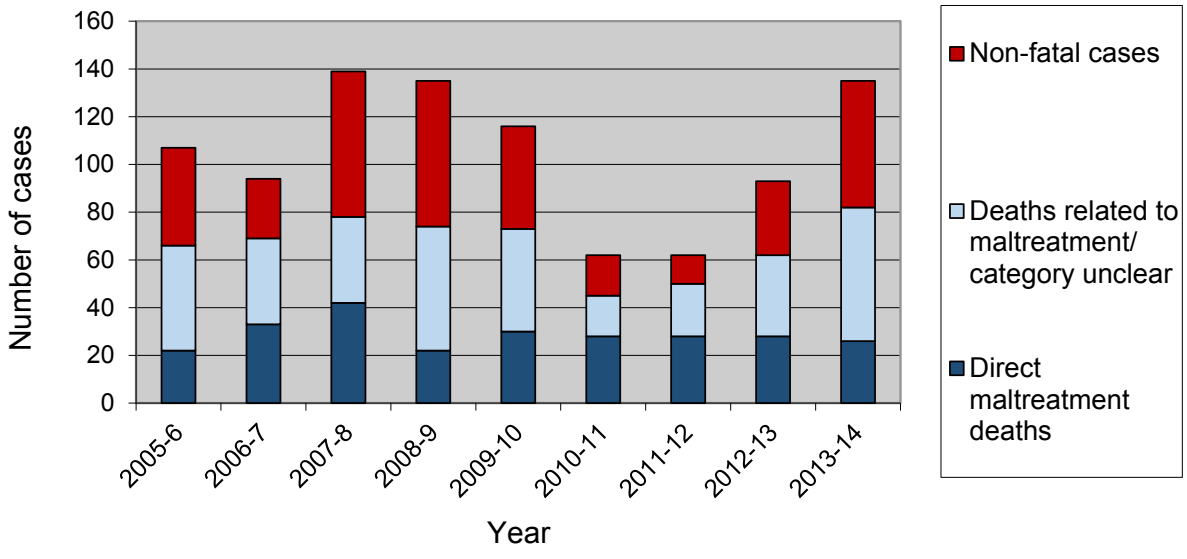
Table 1: Death / serious harm

	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)	Frequency 2011-14 (n=293)
Death	123 (65%)	158 (56%)	118 (66%)	197 (67%)
Serious harm	66 (35%)	122 (44%)	60 (34%)	96 (33%)

Figure 6 demonstrates that there is considerable year-on-year fluctuation in the number of reviews, particularly in relation to non-fatal cases, with peaks in 2007-09 and 2013-14, and troughs in 2006-07 and 2010-12. The fluctuations in the number of reviews of fatal cases are less marked, with an average of 78 per year. This discrepancy is even more pronounced when comparing those deaths ***directly*** due to maltreatment (e.g. fatal non-accidental head injuries, overt homicides) with those related to but ***not directly*** caused by maltreatment (e.g. suicides of young people, or SUDI (sudden unexpected death in infancy) with concerns about parental care).

Deaths directly due to maltreatment average 34 per year, ranging from 22-42; maltreatment-related deaths average 44, ranging from 17-56. For the three years from 2011-14, there has been no change in the number of SCRs for direct maltreatment deaths (26-28 per year); the apparent increase in the number of SCRs is entirely accounted for by an increase in the numbers of non-fatal cases and those deaths in which maltreatment may be a factor but not the direct cause of death.

Figure 6: Serious case reviews 2005-14: fatal and non-fatal cases by year



Comparing the three years with the highest numbers of SCRs (2007-09 and 2013-14) with the three years with the lowest numbers of SCRS (2006-07 and 2010-12):

1. There is a higher proportion of non-fatal cases in the high-incidence years (statistically significant)
2. There is no significant difference in the age/gender profile between high- and low-incidence years
3. There is a higher (and statistically significant) proportion of 'community context' cases (as opposed to 'within-family') in the high-incidence years
4. There is a significantly higher proportion of deaths related to maltreatment (for example suicide and SUDI but where the maltreatment cannot be considered as a direct cause of death) compared to direct maltreatment deaths (fatal physical abuse, filicide and fatal neglect) in the high-incidence years

In the pre-2013 versions of *Working Together*, there was potentially an element of discretion, on the part of the LSCBs, as to whether to conduct a serious case review in the case of serious, but non-fatal, harm. There was far less discretion with regard to fatal incidents, although even in cases of death there were decisions to be made as to whether an SCR was appropriate. For example deaths from co-sleeping would lead to a review if maltreatment and/or neglect were deemed to be factors, but many SUDI deaths would not lead to a review; suicides of a looked after child, or in a residential provision for children or a young offenders institution, are required to lead to a review, but many suicides by young people in the community are not investigated by the SCR process if maltreatment or neglect are not judged to be critical factors in his/her life.

However, Working Together 2013 required that a serious case review be undertaken in every case where the criteria fitted, which arguably led to the larger number of SCRs instigated by the third year of the current review (2013-14). The tighter criteria have been reinforced by the SCR national panel, whose advisory role permits it to challenge decisions by LSCBs not to initiate a review. In their first annual report, the panel were keen to clarify the position in those Boards which had not notified any potential SCRs and "would encourage more LSCBs to consider carrying out a proportionate SCR, even in cases where the statutory criteria are not met" (DfE, 2014a, p.6). This shift could help explain the greater numbers seen in the last year of this analysis, but would not explain any of the earlier fluctuation.

Learning Points

- There has been no statistically-significant change in the number of deaths directly caused by maltreatment, which now number 26-28 per year
- However, there are considerable year-on-year fluctuations in the number of

serious case reviews carried out; these fluctuations relate primarily to reviews which address non-fatal harm

- Working Together 2013 reduced the opportunity for discretion on the part of LSCBs as to whether or not to undertake a serious case review; an SCR should be undertaken in every case where the criteria fit

2.3 The geographical and socio-economic distribution of the cases

2.3.1 Where were the serious case reviews held?

Serious case reviews were notified from all regions of England (Table 2). The serious case review rate per 100,000 child population varied from 0.658 in the South West to 1.143 in the North East. The ratio of fatal to non-fatal serious case reviews varied from 1:1 (equal numbers of both fatal and non-fatal) in the East and the North East, to 3.3:1 in Yorkshire and Humber; the West Midlands region was outlying, with just one non-fatal serious case review compared to 25 fatal cases.

Table 2: Geographical distribution of SCRs

Region	0-17 child population	Number of fatal SCRs	Number of non-fatal SCRs	Ratio of fatal to non-fatal SCRs	Average annual SCR rate per 100,000 child population
East	1,266,602	14	14	1.0	0.737
East Midlands	956,613	23	9	2.6	1.115
London	1,852,927	31	14	2.2	0.810
North East	525,013	9	9	1.0	1.143
North West	1,504,744	33	16	2.1	1.085
South East	1,876,155	24	20	1.2	0.782
South West	1,064,139	15	6	2.5	0.658
West Midlands	1,244,262	25	1	25.0	0.697
Yorkshire & Humber	1,132,855	23	7	3.3	0.883

SCRs were completed by 118 LSCBs, ranging in number from 1 to 8 with an average of 2 per LSCB over the 3-year period. This equated to an average annual SCR rate of 0.97 per 100,000 child population (range 0.00 – 4.88). Twenty-eight LSCBs did not carry out any SCRs. Discounting those LSCBs that did not carry out any SCRs, there was a trend towards fewer SCRs per head of population in the larger local authorities (Table 3). While there was a greater variation in the SCR rates in smaller local authorities, larger authorities tended to carry out fewer SCRs per head of population, and there was a trend towards a greater ratio of fatal to non-fatal SCRs in the larger authorities. This may reflect an overall greater child protection workload in these authorities, perhaps resulting in a higher threshold for undertaking more 'discretionary' SCRs (more discretionary at that time).

Table 3: Local authority annual SCR rate according to child population

Size of child population	Average annual rate of SCRs per 100,000 population*	Ratio of fatal:non-fatal SCRs**
0 - <50,000	1.42	1.59
50,000 - <100,000	1.15	2.24
100,000 - <150,000	0.48	1.90
150,000 - <200,000	0.60	3.60
≥ 200,000	0.33	5.33

* Statistically significant trend: Chi-square 62.9, p<0.0005

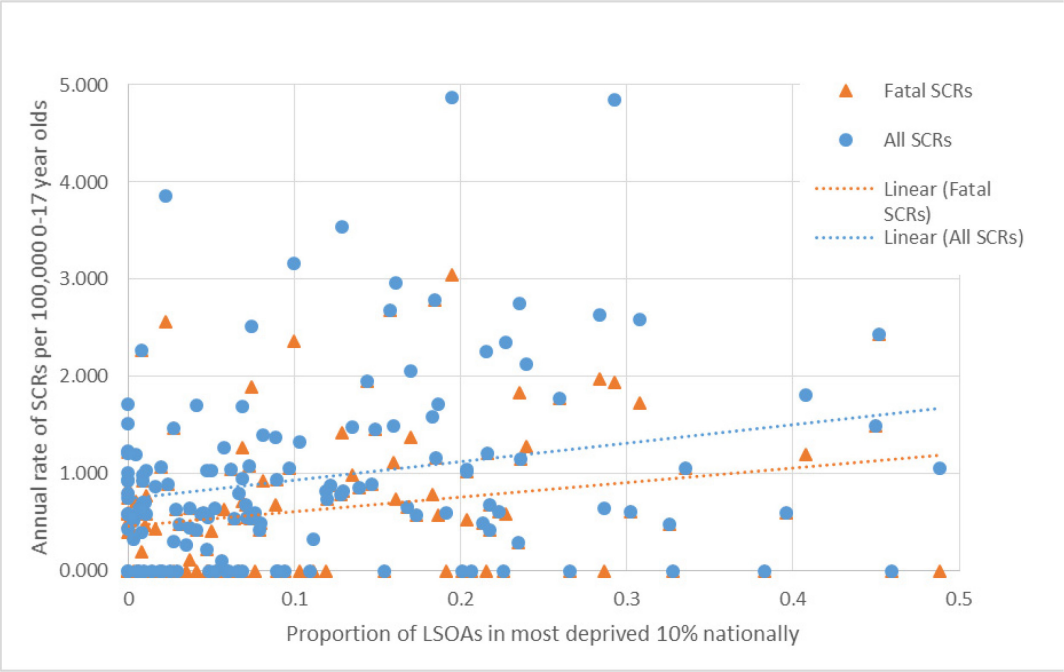
** Not statistically significant

2.3.2 Socio-economic factors

Data on socio-economic deprivation were obtained from the Office for National Statistics English Indices of Deprivation, 2015.[3] These provide various measures of deprivation for local authority areas. We used the proportion of Lower Super Output Areas (LSOAs) within the 10% most deprived nationally to give an indication of the degree of deprivation within each local authority. Figure 7 shows the average annual SCR rate per 100,000 0-17 year olds by this measure of deprivation.

[3] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Figure 7: Annual rate of SCRs by local authority according to level of deprivation



These data show a slight, statistically significant trend towards higher rates of both all SCRs (Spearman Rank Correlation coefficient 0.197, p=0.018) and fatal SCRs (Spearman Rank Correlation coefficient 0.260, p=0.002) in those local authorities with higher levels of deprivation. A similar, significant trend was seen examining just those cases where the death was considered directly due to maltreatment. This is in keeping with research suggesting that child maltreatment is more common in deprived communities (Pelton, 2015). However, it should be noted that the trend is not marked and there is considerable variation between authorities.

Our review of the 175 cases for which we were able to obtain SCR reports highlighted a few issues relating to poverty in some cases, including indicators of poor quality housing, overcrowding, homelessness, financial difficulties and unemployment. However these were entirely dependent on whether the SCR author chose to comment on them. While these issues were mentioned in some cases, this was by no means universal, and, indeed, there were a number where the opposite picture was presented, of reasonably well-off families, with good quality housing and no indication of socio-economic deprivation. Unfortunately data are not collected on the post-code or any other markers of poverty or deprivation for individual SCRs, thus limiting our ability to comment more specifically on whether there is a true socio-economic gradient in serious or fatal maltreatment.

2.4 Characteristics of the children and families in the reviews

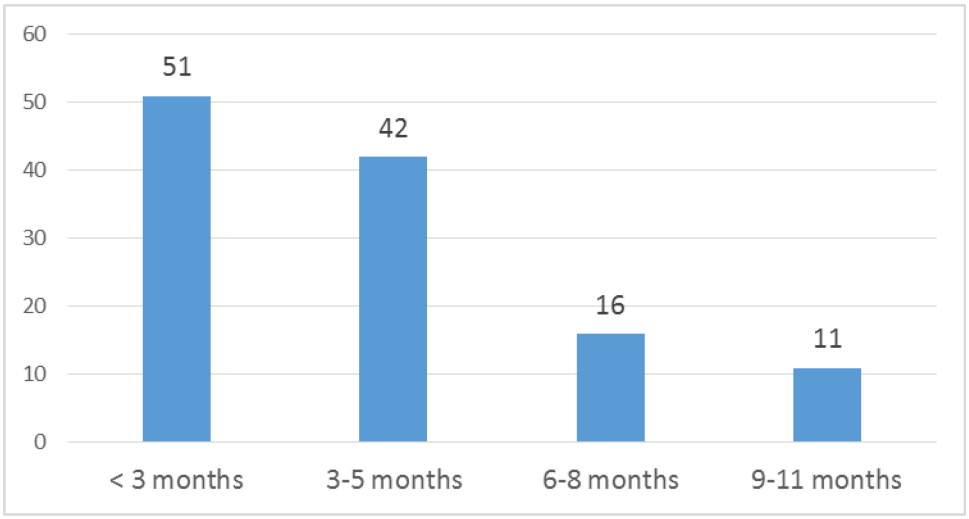
2.4.1 Age and gender of the children

The age of the children at the centre of the serious case reviews

As in previous national analyses, the largest proportion of cases related to the youngest children, who were aged under one year. 120 of the 293 children (41%) were aged under one year at the time of their death, or incident of serious harm; and nearly half of these babies (43%) were under 3 months old (Figure 8)

64 of the children (22%) were aged between 1 and 5 years. Only one in ten (28 or 10%) were in the middle years of schooling, aged between 6 and 10 years. The remaining 81 reviews (28%) concerned young people aged 11 years and over; of whom 41 were aged 11-15 years, and 40 aged 16-18 years

Figure 8: Age (months) at time of death or harm of babies under one year old



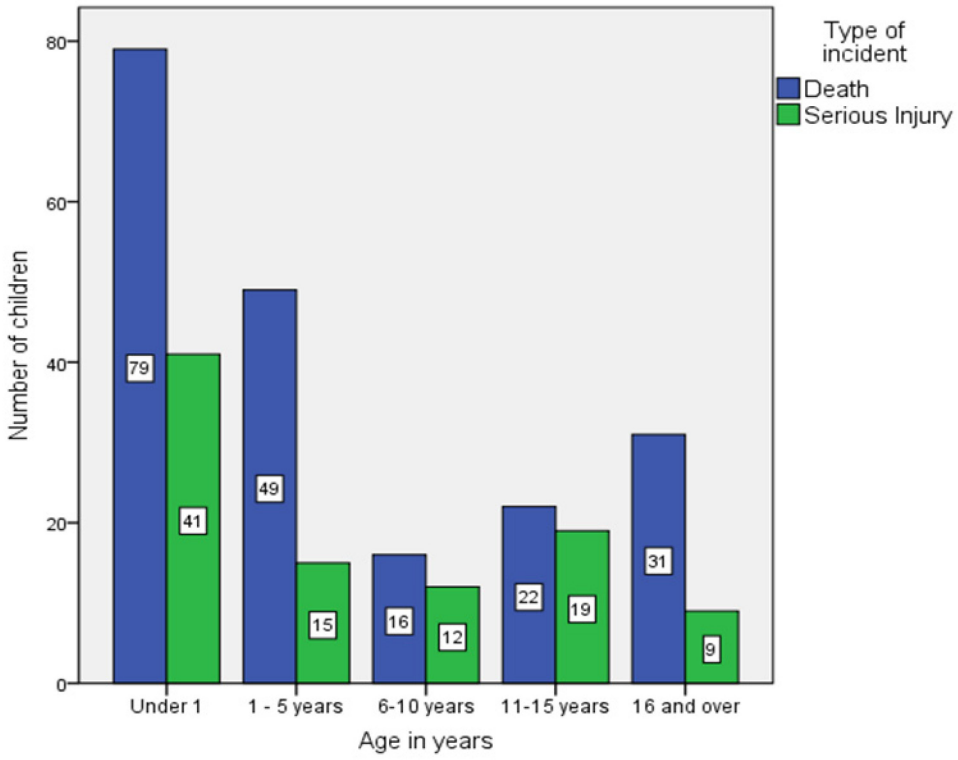
The high number of serious case reviews conducted with regard to babies under one year of age reflects the intrinsic vulnerability of the youngest babies who are dependent on their parents for care and survival. By contrast, children aged 6-10 years, in middle childhood, were in the age group least likely to be the subject of a serious case review, with only 28 of the 293 reviews in 2011-14 relating to a child of this age (Figure 9). Older children are more robust, and less dependent on their parents for their survival. Their school environment offers predictability for the child and the ability to offer some respite from difficult or chaotic home circumstances. It also provides a degree of monitoring of the child's welfare, and adults and/or peers to whom disclosure might be made. For schools to offer this protection, the child needs to be in regular attendance.

Poor or patchy school attendance often becomes an issue for those aged 11-15 years, and risky behaviour and relationships pose different risks of harm for this age group. Of the 22 young people in this age group who died, and about whom reviews were conducted, 14 had taken their own lives. Among the 19 non-fatal incidents reviewed were 14 instances of sexual abuse; four intra-familial, five extra-familial, and five cases with elements of sexual exploitation. Overall, nearly two-thirds (63%) of the young people aged 11-15 at the centre of a review were female.

The 40 reviews concerning the oldest age group, 16 and 17 year-olds, included 19 reviews undertaken in relation to the suicide of a young person. The nine non-fatal incidents which led to a review included one incident of sexual abuse, and five of risk-taking behaviour on the part of the young person, including use of knives, drug use, self-harm and instances where the young person was the perpetrator of a violent incident. Twenty of the forty reviews concerned a young woman.

Figure 9 shows the age distribution according to the type of incident. The fatal cases, as in previous biennial reviews, showed a clear inverted J-shaped curve, with the highest numbers in infancy, dropping to lower levels in the middle childhood years, before rising again in adolescence. The serious harm cases again showed the highest numbers in infancy, though with a less-marked gradient, and no clear rise in adolescence.

Figure 9: Age distribution by type of incident



The noticeably young age of the children at the centre of reviews has been a constant feature over time (Table 4). Children aged five and under represent 69%, 66%, 65% and

63% over the four time periods from 2005-07 to 2011-14. The proportion of children in the other age bands is also broadly similar over time.

Table 4: Age of child at time of incident

	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)	Frequency 2011-14 (n=293)
Under 1 year	86 (46%)	123 (44%)	64 (36%)	120 (41%)
1-5 years	44 (23%)	60 (22%)	51 (29%)	64 (22%)
6-10 years	18 (10%)	26 (9%)	21 (12%)	28 (10%)
11-15 years	20 (11%)	40 (14%)	27 (15%)	41 (14%)
16-17 years	21 (11%)	31 (11%)	15 (8%)	40 (14%)

The one age band of young people about whom a higher proportion of reviews were being undertaken in the latest time period, 2011-14, were those aged 16 years and over (although this increase is not statistically significant). Serious case reviews concerning adolescent suicide and child sexual exploitation will be discussed in Chapter 5.

The average annual rates for all serious case reviews and fatal SCRs were calculated by age group using mid-2012 population estimates for England from the Office for National Statistics.[4] The overall rate of serious case reviews was 0.85 per 100,000 and that for fatal cases 0.57 per 100,000.These data[5] were compared to those for 2009-10, which were presented in the last biennial review (Table 5). This suggests that, for all but the 15-17 year age group, there has been a reduction in the rates of serious case reviews (both fatal and non-fatal). Some caution must be exercised in interpreting these data in light of the data presented above on the overall fluctuations in the numbers of serious case reviews undertaken.

[4] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-319259

[5] Note that for Table 5 the age bands given by the ONS are different from those used elsewhere in this triennial review

Table 5: Average annual rates of SCRs per 100,000 population, by age group

Age group	2009-10 All SCRs (n=114)	2009-10 Fatal SCRs (n=73)	2011-14 All SCRs (n=293)	2011-14 Fatal SCRs (n=197)
	Number (rate per 100,000)	Number (rate per 100,000)	Average annual number (rate per 100,000)	Average annual number (rate per 100,000)
Under 1 year	44 (6.63)	31 (4.67)	40 (5.74)	26 (3.78)
1-4 years	28 (1.11)	19 (0.75)	19 (0.72)	15 (0.56)
5-9 years	13 (0.45)	7 (0.24)	9 (0.30)	6 (0.19)
10-14 years	16 (0.53)	10 (0.33)	11 (0.35)	6 (0.19)
15-17 years	13 (0.67)	6 (0.31)	18 (0.95)	13 (0.65)

In contrast to our previous studies, a higher proportion of reviews in this latest three year period concerned girls (55%) rather than boys (45%). This represents a statistically significant shift (Chi Square 6.93, $p<0.01$) compared to previous years in which there was a male predominance (Table 6).

Table 6: Gender of child

	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=177)	Frequency 2011-14 (n=293)
Male	106 (56%)	142 (51%)	100 (56%)	132 (45%)
Female	83 (44%)	138 (49%)	77 (44%)	161 (55%)

Figure 10 illustrates the girl/boy ratio for each year of age, for the 293 children, and Table 7 gives the gender proportion in each age band. It can be seen that, in 2011-14, girls were over-represented in all age groups except the 1-5 year band (final column). Table 7 also provides comparative data for 2007-09 and 2009-11 from the two previous biennial reviews.

Figure 10: Gender and age of the children at the centre of the SCR

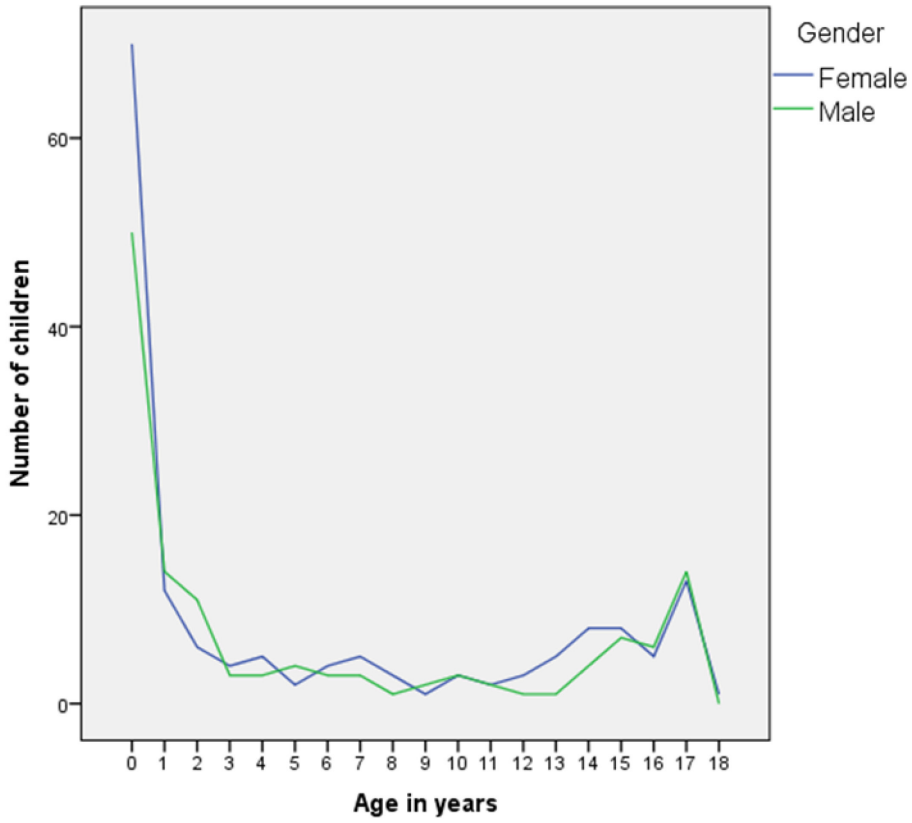


Table 7: Age at time of incident by gender

Age group	Gender 2007-09 (n=280)		Gender 2009-11 (n=177)		Gender 2011-14 (n=293)	
	Female (n=138)	Male (n=142)	Female (n=77)	Male (n=100)	Female (n=161)	Male (n=132)
Under 1 year	55 (45%)	68 (55%)	25 (39%)	39 (61%)	70 (58%)	50 (42%)
1-5 years	23 (38%)	37 (62%)	24 (48%)	26 (52%)	29 (45%)	35 (55%)
6-10 years	14 (54%)	12 (46%)	11 (52%)	10 (48%)	16 (57%)	12 (43%)
11-15 years	26 (65%)	14 (35%)	10 (37%)	17 (63%)	26 (63%)	15 (37%)
16 + years	20 (65%)	11 (35%)	7 (47%)	8 (53%)	20 (50%)	20 (50%)

In 2007-09 and 2009-11 more serious case reviews were undertaken for baby boys than for baby girls, and our previous biennial studies, in line with international findings, had indicated that baby boys were particularly vulnerable. The shift in 2011-14 to a higher percentage of reviews relating to baby girls is significant (Chi Square 4.50, $p<0.05$), and this female preponderance related to more fatal cases (rather than non-fatal cases), a finding that is difficult to explain in relation to previous research.

The high proportion of reviews relating to 11-15 year old girls, as compared with 11-15 year old boys, is similar to the pattern in 2007-09. There was a lower proportion of adolescent females in the intervening 2009-11 cohort. In the 2011-14 cohort, the greater proportion of females in the 11-15 year olds related primarily to serious harm cases. This may reflect the impact of cases of child sexual exploitation being included in this cohort, a topic that will be covered in detail in Chapter 5.

Learning Points

- Infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy
- There are further risks to young people during adolescence, including risks associated with child sexual exploitation and risks of suicide
- In contrast to our previous studies, a higher proportion of reviews in this latest three year period concerned girls (55%) rather than boys (45%).

2.4.2 Ethnicity of the families

79% of the children at the centre of the reviews were White (and 76% White British); 6% were Black/Black British and 5% Asian/Asian British. Children with a mixed ethnicity background accounted for 8% of the total number

Data for ethnicity are given in Table 8, and in only eleven notifications (4%) was ethnicity not stated in the 2011-14 notifications. From 2003 onwards, the families at the centre of the reviews have predominantly been white (between 72% and 80%). This is similar to the overall proportion in the child population. In the 2011 census, 79% of all children aged 0-17 in England were of white ethnicity.[6]

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

Table 8: Ethnicity

	Frequency 2005-07 (n=173)	Frequency 2007-09 (n=267)	Frequency 2009-11 (n=172)	Frequency 2011-14 (n=282)
White	125 (72%)	204 (76%)	137 (80%)	222 (79%)
Mixed	23 (13%)	25 (9%)	11 (6%)	21 (8%)
Black/Black British	13 (8%)	24 (9%)	14 (8%)	17 (6%)
Asian/Asian British	8 (5%)	12 (4%)	7 (4%)	15 (5%)
Other Ethnic Group	4 (2%)	2 (1%)	3 (2%)	7 (2%)

Over time, families with mixed ethnicity have accounted for between 6% and 8% of the families in the serious case reviews, apart from 2005-07 when the percentage was higher at 13%. In the latest set of reviews from 2011-14, eight of the families were mixed White and Black Caribbean, six were mixed White and Asian, and four were mixed White and Black African. In 2011-14 all except eight of the 222 white families were White British. There was diversity in the white non-British families; two were from Ireland, three were from other areas of Europe, and the other three were from various parts of the world beyond Europe.

While the data did not show any increased risk among ethnic minority families, our thematic analysis did identify some learning points and opportunities for protection emerging from some of the reviews where ethnicity and/or culture was an issue. These points will be considered in later chapters of this report.

Learning Point

- These data do not suggest any increased risk of serious or fatal child maltreatment within ethnic minority families

2.4.3 Family size

Full information on siblings was not always available. In particular it was difficult, in some instances, to determine whether there were no siblings or whether this information was simply missing.

In 2011-14 over a quarter of reviews (27%) related to an only child

One in five reviews (22%) related to a child with at least three siblings

Since 2005 approximately a quarter of reviews have related to an only child, and this proportion has been fairly consistent over time (Table 9).

Table 9: Number of siblings

Number of siblings	Frequency 2005-07 (n=177)	Frequency 2007-09 (n=250)	Frequency 2009-11 (n=175)	Frequency 2011-14 (n=292)
0	42 (24%)	52 (21%)	53 (30%)	78 (27%)
1	54 (31%)	90 (36%)	52 (30%)	89 (30%)
2	42 (24%)	59 (24%)	32 (18%)	62 (21%)
3	20 (11%)	30 (12%)	21 (12%)	33 (11%)
4	11 (6%)	9 (4%)	9 (5%)	17 (6%)
5	4 (2%)	7 (3%)	4 (2%)	5 (2%)
6 and over	4 (2%)	3 (1%)	4 (2%)	8 (3%)

In 2011-14 just over one in five reviews (22%) related to families with four or more children (i.e. three siblings and the index child), and this pattern has remained constant throughout the eleven year period of our reports. The Office for National Statistics (2015a) reported that one in seven families (14.5%) in 2011-14 in the UK had three or more dependent children; in the 2011-14 families at the centre of the review 125 (or 43% of the 292) were composed of three of more children (the index child and two siblings). It is clear that larger families are over-represented in serious case reviews, although there may well be problems of definition; for example how half-siblings and step-siblings, and older siblings not living at home, are counted. Larger family size may bring with it added stress, not least financial, and as previously noted in biennial reviews the potential for professionals to overlook the needs of an individual child within a large group of siblings.

Learning Point

- Larger families are over-represented in SCRs when compared to the proportion of larger-sized families nationally

2.4.4 Extent of neglect in the children's lives

A key and recurring theme throughout the previous biennial reviews has been the extent and significance of neglect in the children's lives. This is evidenced yet again in this latest

review for 2011-2014. From detailed work on the available 175 SCR final reports, neglect was apparent in the lives of nearly two thirds (62%) of the children who suffered non-fatal harm, and in the lives of over half (52%) of the children who died (Table 10). Evidence of neglect was taken to be (a) a child protection plan under the category of neglect (b) 'neglect' given as the primary category of harm on the CPD notification or as a case characteristic on the form, or (c) noted in the final report as an important, and often long-standing feature of the child's life.

Table 10: Presence of neglect

	No of children 2009-11 All cases (n=139)	No of children 2011-14 Fatal cases (n=123)	No of children 2011-14 Non-fatal cases (n=52)	No of children 2011-14 All cases (n=175)
Evidence of neglect	83 (60%)	64 (52%)	32 (62%)	96 (55%)

There was a very similar incidence of neglect (60%) in the previous biennial study of serious case reviews (Brandon et al, 2012), which analysed data from SCR final reports relating to incidents in 2009-11.

The previous biennial review and subsequent research (Brandon et al, 2012; 2013) illustrated the way that neglect manifested itself through a number of pathways to harm or death, including severe deprivation, neglect of medical conditions and necessary medication, accidents which occur in a context of chronic long-term neglect and an unsafe environment, unexplained infant deaths within a context of neglectful care and a hazardous home environment, and physical abuse occurring in a context of chronic, neglectful care, where the assumptions about the case being 'simply neglect' masked the danger to the life of the child through physical injury.

Neglect is considered in greater detail, both in relation to the death of six children through extreme neglect and deprivation, and in relation to 14 non-fatal cases (see Chapter 3).

2.4.5 Where were the children living at the time of their death or harm?

Most of the children (245, 84%) were living at home, with at least one parent, at the time of their death or serious harm. A further ten children were living with relatives at the time

For the majority (82%), the incident(s) occurred in a family context, but for 52 (18%) the death or harm occurred in a setting outside of the home and/or involved non-family members

Although most of the children (87%) were living at home or with relatives, as in earlier years death and serious harm could also occur to children living in foster care or in supervised settings. However, it is not possible to identify any trends in the children's placement, given the small number of children living outside of the parental home (Table 11).

Table 11: Where living at time of incident

	Frequency 2005-07 (n=187)	Frequency 2007-09 (n=278)	Frequency 2009-11 (n=177)	Frequency 2011-14 (n=293)
Living at home	148 (79%)	229 (82%)	145 (82%)	245 (84%)
Living with relatives	10 (5%)	11 (4%)	8 (5%)	10 (3%)
With foster carers (short term, long term or short break)	7 (4%)	8 (3%)	4 (2%)	8 (3%)
Hospital, mother and baby unit and residential children's home	7 (4%)	15 (5%)	8 (5%)	10 (3%)
Semi-independence unit	5 (3%)	3 (1%)	1 (1%)	3 (1%)
Other, including YOI	10 (5%)	12 (4%)	11 (6%)	17 (6%)

2.4.6 Family or community context to the incidents

In addition to the information contained in the notifications on where the child or family were living, the researchers were able to make a judgement for each review as to whether the death or harm had occurred within a family or a community context. This categorisation had been developed as part of a previous biennial report (Brandon et al, 2010). Incidents within a household or family setting involved the mother, father/father figure or another member of the household (including separated parents) as the probable or known perpetrator of harm to the child. The suicide of a young person within a family setting was also included.

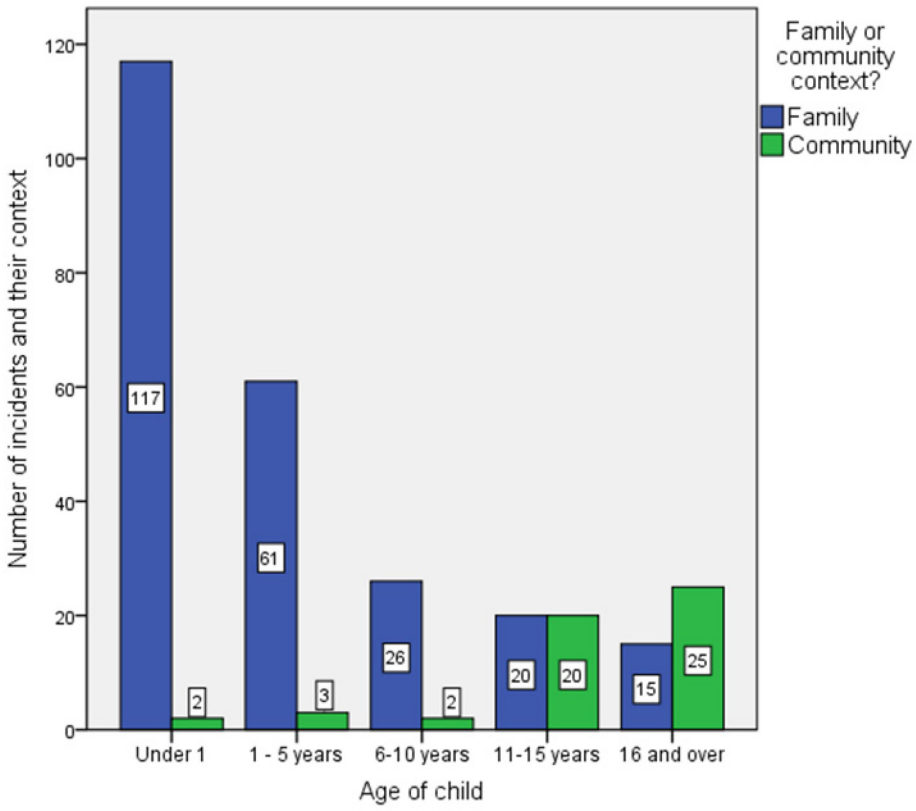
Incidents which occurred within a community context (non-birth family) included those perpetrated by non-household members, for example childminders, foster carers, and in supervised settings such as hospitals, schools or residential care, gang or street related violence, and harm from strangers. The suicide of a young person living outside of a family setting was included in this 'community' category. Table 12 explores the context of the incidents which led to review, for all cases where this judgement could be made.

Table 12: Family or community context of the incidents which led to review

	Frequency 2007-09 (n=268)	Frequency 2009-11 (n=139)	Frequency 2011-14 (n=291)
Family context	213 (79%)	117 (84%)	239 (82%)
Community context	55 (21%)	22 (16%)	52 (18%)

As in previous studies, the majority of cases in 2011-14 (82%) related to incidents occurring within a 'family setting', and this pattern held whether the case was fatal or non-fatal. Just under a fifth of reviews (18%) related to an incident which occurred within a 'community context'. Figure 11 explores the extent to which the family or community context of the harm changed according to the age of the child or young person.

Figure 11: Family/community context of the harm according to the child's age



As might be expected, among younger children the incidents occurred almost exclusively within a family setting, whether these were fatal or non-fatal. In later adolescence, however, the pattern is reversed, with the majority of incidents (both fatal and non-fatal) occurring outside of the family.

2.5 Children's social care involvement

The notification data give only minimal information on children's social care involvement with the child and the family, the mandatory information required being the child protection status of the child concerned, alongside that of his/her siblings, together with the legal status of the child. Involvement of other agencies was not requested[7], although the narrative section on the notification form often provided some background information as to their involvement, particularly about acute health interventions at the time of the death or harm to the child.

2.5.1 Child protection plans

At the time of the death or harm, in 2011-14, 36 (12%) of the children were the subject of a child protection plan (Table 13). A further 36 children (12%) had been the subject of a plan in the past

Over the period 2005-14, the numbers of children with a child protection plan (and where an SCR has been undertaken) have fluctuated over time, and are on average 13% of all children at the centre of a review. This is at a time when nationally numbers of children with a child protection plan have been rising

While children may be named in more than one category, neglect remains the most frequent category recorded on the plan, as it is nationally

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

	Frequency 2005-07 (n=175)	Frequency 2007-09 (n=276)	Frequency 2009-11 (n=177)	Frequency 2011-14 (n=293)
Never on plan	127 (73%)	198 (72%)	136 (77%)	221 (76%)
Current plan*	29 (17%)	43 (16%)	18 (10%)	36 (12%)
Past plan	19 (11%)	35 (13%)	23 (13%)	36 (12%)

* A small number of cases were removed where the plan was highly likely to be post incident. This applied to 4 cases in 2005-07 and 4 cases in 2007-09.

The category of child abuse or neglect noted on the child protection plan is explored in Table 14. Children may be named in more than one category, and the columns therefore

[7] The Ofsted online notification form, introduced in 2014, now requests information on involvement from social care and other agencies, along with education and early years provision for the child. This will lead to fuller information being available in any future analysis of notifications to the child protection database.

sum to more than the total number of children. Neglect remains the most frequent category recorded, as it is nationally.[8] A smaller proportion were recorded under the category of physical abuse than in the earlier biennial review periods.

Table 14: Index child with a child protection plan - category of plan

	Frequency 2005-07 (n=46*)	Frequency 2007-09 (n=78)	Frequency 2009-11 (n=41)	Frequency 2011-14 (n=72)
Neglect	30 (65%)	46 (59%)	21 (51%)	45 (63%)
Physical abuse	11 (24%)	27 (35%)	17 (41%)	12 (17%)
Emotional abuse	7 (15%)	21 (27%)	10 (24%)	13 (18%)
Sexual abuse	7 (15%)	10 (13%)	5 (12%)	10 (14%)

*Category of plan missing for two children.

It is often the case that if the index child has a child protection plan then his/her sibling(s) do too. For the 36 index children with a current plan at the time of the incident, a sibling was also currently on a plan in 22 instances, in a further five the sibling had had a CP plan in the past. For only six children did the sibling(s) not have, or have in the past, a plan. (The remaining three children were only children, without a sibling.)

2.5.2 Legal status of the child

The highest levels of children's social care involvement, where children may be removed from home, require court proceedings, and the granting of a legal order by a judge. However there could be lack of clarity on the CPD notification as to the legal status of the child, when serious harm rather than death had been the outcome. On occasions it is clear from the narrative on the form that an order was made following the incident, in order to remove the child from the parent(s) or to ensure a degree of supervision in the ensuing months or years. On other occasions the order was clearly in force prior to the serious harm which occurred, but on some notification forms it is not apparent whether the order pre-dated or post-dated the injury or harm suffered. (The problem of interpretation obviously does not arise when the child died, since there would be no post-incident order made.)

[8] Of the 48,300 children in England who were the subject of a child protection plan at 31 March 2014, the category was recorded as neglect for 43%, physical abuse for 8%, sexual abuse for 4%, emotional abuse for 36%, and 9% were recorded in multiple categories. Department for Education (2014) Characteristics of children in need in England, 2014-14, final. Table D4.

Reading the narratives on the forms, and where available the final reports for those cases, eight orders or placements were judged by the researchers as highly likely to be post-incident; these comprised three instances of Section 20 accommodation, three interim care orders and two care orders. These orders have therefore been omitted from Table 15, and the lower estimated figures given.

Table 15: Legal status of the child prior to the fatal or non-fatal incident

	Death (n=197)	Serious harm (n=95)	All children (n=292)
Section 20 accommodation	9	4	13
Care order	7	7	14
Interim care order	3	2	5
Supervision order	3	2	5
Residence order	2	1	3
Adopted	1	1	2
Other order	10	6	16
No order in force	162 (82%)	72 (76%)	234 (80%)
Total	197 (100%)	95 (100%)	292 (100%)

There was no Section 20 accommodation or court order in force for the child in 162 of the 197 fatal cases (82%) which were subject to a serious case review. For the children and young people who suffered serious harm, but not death, an order was slightly more likely to be in place, but 76% were not subject to any legal order.

2.5.3 Social care Involvement – a wider analysis

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

The subset of 175 SCRs from the 2011-14 period, for which we had the final reports, allowed us to explore the child's pathway through services, from universal to tier 4. All 175 children at the centre of the reviews were eligible to receive at least universal services, although for some this was at a minimal, or non-existent, level; for example if he or she were of pre-school/nursery age, and had not been seen by a health visitor or GP since the immediate post-birth period, and had not been taken to routine age-related check-ups and immunisations.

The following analysis looks in particular at whether the child's case was open or closed to children's social care at the time of the incident, what level of assessment or involvement had taken place, and whether the child had been 'on the radar' of children's social care, without reaching the threshold for an assessment, or service.

For the 175 cases from the 2011-14 cohort:

79 (45%) of the children's cases were open to children's social care at the time of the incident (Table 16);

- 57 (46%) of the 123 fatal cases were open at the time of death, and
- 22 (42%) of the 52 non-fatal cases were open at the time of the serious harm

33 (19%) of the children's cases were closed cases, at the time of the incident;

- 17 (14%) of the 123 fatal cases were closed cases at the time of death, and
- 16 (31%) of the 52 non-fatal cases were closed cases at the time of the serious harm

Table 16: Whether child's case was open to children's social care at time of incident

	Number of cases 2009-11 (n=138)	Number of cases 2011-14 (n=175)	*Number of Fatal cases 2011-14 (n=123)*	*Non-fatal cases 2011-14 (n=52)*
Open case to CSC	58 (42%)	79 (45%)	*57 (46%)*	*22 (42%)*
Closed case to CSC	32 (23%)	33 (19%)	*17 (14%)*	*16 (31%)*
Enquiry or request for information, unaccepted referral, worked with under CAF or by family worker. Case below the threshold of CSC	19 (14%)	25 (14%)	*20 (16%)*	*5 (10%)*
Never known to CSC	29 (21%)	38 (22%)	*29 (24%)*	*9 (17%)*
Total	138 (100%)	175 (100%)	*123 (100%)*	*52 (100%)*

The final two columns of Table 16 consider the fatal and non-fatal cases separately for the three year period 2011-14. Although a higher proportion of those who were seriously harmed were either current or past CSC cases (73%) as compared with 60% of those who died, this is not a statistically significant difference. For comparison Table 16 also provides data from 2009-11; a similar percentage of cases (42% in 2009-11 and 46% in 2011-14) were open cases at the time of the incident.

For 20 (16%) of the fatal 123 cases in 2011-14 there had been contact with CSC, possibly including a referral which had not been accepted, but the concern had not reached the level for opening the case. The remaining 29 (24%) had never been known to, referred to, or discussed with children's social care. Likewise for the 52 serious harm cases in 2011-14, five (10%) had not reached the level for opening, and the remaining 9 (17%) had never been known to, referred to or discussed with children's social care.

Table 17 illustrates clearly that the older children at the centre of reviews were also more likely to be known, or to have been known in the past, to children's services than were the younger children. Thus nearly two-thirds of the young people aged 11 or over were open cases to CSC and a further 15% had been worked with by CSC in the past, compared with 39% of babies under one year being open cases, and 11% having been an open case previously. In part this is an indication of the fact that the older the child, the longer the period of time that agencies have had to be involved. It is also an indication of the impact of cumulative harm to the child over the years. This observed pattern is statistically significant.

Table 17: Whether child was known to CSC (currently or in the past) by age of child

	Number of children aged under 1 (n=70)	Number of children aged 1-5 years (n=45)	Number of children aged 6-10 years (n=14)	Number of children aged 11 and over (n=46)
Open	27 (39%)	17 (38%)	6 (43%)	29 (63%)
Closed	8 (11%)	14 (31%)	4 (29%)	7 (15%)
'On radar' but below threshold	10 (14%)	8 (18%)	3 (21%)	4 (9%)
Never known to CSC	25 (36%)	6 (13 %)	1 (7%)	6 (13%)
Total	70 (100%)	45 (100%)	14 (100%)	46 (100%)

($\chi^2 = 24.59$, df=9, $p = .005$)

While the two tables above consider the child's present or past service from children's social care, the level at which services were being, or had been provided, can be looked at in greater detail. Children living with a parent(s) under a court supervision order, or being looked after by the local authority constituted the highest levels of service provision, followed by the child being the subject of a child protection plan, or being worked with as a 'child in need'. However, assessments could be undertaken which led to no service, and referrals could be made which resulted in no further action being required (apart maybe from offering advice, or referral on to another provider).

In addition there was low-level contact with social work staff by other professionals, for example requests for information about a child and his/her family, or checks by other professionals (e.g. hospital staff suspecting a non-accidental injury), and working at a pre-threshold level, for example under a CAF arrangement, or with a family worker in a children's centre setting, where children's social care may be aware of this provision, particularly when they are in a shared setting, for example a children's centre.

For the 137 cases where there had been at least some contact with children's social care the following pattern emerges as regards the 'highest' level of help received, with 112 children getting at least as far as an initial assessment. (First five rows of Table 18).

Table 18: Highest level of social care input received

Highest level of input received	Number of cases
Looked After Child (including voluntary S20)	15 children
With parent(s) on supervision order post care proceedings	4 children
Child Protection plan for child	35 children
Services as 'child in need'	21 children
Initial assessment but no service deemed necessary	37 children
Referral but no further action required by CSC	9 children
Enquiry to CSC re child, for information or clarification	13 children
Worked with as CAF, family support worker, below threshold	3 children

The emphasis in this analysis is on the child at the centre of the review. Thus the category 'not known to CSC' (at the time of the incident) does include some children whose sibling, or half-sibling, had received a service in the past, or some cases where the mother had been looked-after by the local authority, and received a leaving care service, but was no longer 'on the radar' of children's services.

2.5.4 Setting SCR data in the context of wider child protection activity

It is worth setting these data in the context of other child protection activity taking place over recent years, as we did in the previous biennial review (Brandon, 2012). During the years 2011-14, a total of 1,856,400 referrals were received by children's social care services in England, an average of 619,000 per year; in 2009-11 this figure was 609,000 per year.

Table 19 compares the number and rates of serious case reviews with the numbers of children subject to section 47 child protection enquiries and the number who were the subject of a child protection plan. This shows that, while there has been a rise in the

number of serious case reviews carried out since a trough between 2010-12, this has been on the background of a steady year-on-year increase in child protection activity, and, as highlighted in section 2.2 above, there has been no change in the number of direct maltreatment deaths, and, if anything, a reduction in the fatality rates in all but the late adolescent group.

Compared to the number of serious case reviews undertaken in relation to a child fatality, there are many thousands of children subject to a child protection plan, and an even larger number assessed by children's social care via s.47. To put these numbers into context, it can be seen that the number of children with a child protection plan between 2011 and 2014 (line C in Table 19) was over 800 times the number of fatal SCRs (line E), and the number of section 47 enquiries (line A) was over 2,000 times the number of fatal SCRs.

Table 19: Numbers and rates of children subject to child protection activity 2009-14

	2009-10	2010-11	2011-12	2012-13	2013-14
Section 47 enquiries and initial child protection conferences					
A) Number of children subject to s.47 enquiries which started during the year ending 31 March	89,300	111,700	124,600	127,100	142,500
Rate per 100,000 children aged under 18 years	795.0	990.0	1,099.0	1,115.0	1,241.0
Children who were the subject of a child protection plan					
B) Children who were the subject of a plan at 31 March	39,100	42,700	42,900	43,100	48,300
Rate per 100,000 children aged under 18 years	348.0	379.0	378.0	379.0	421.0
C) Children who became the subject of a plan during the year	44,300	49,000	52,100	52,700	59,800
Rate per 100,000 children aged under 18 years	394.0	434.0	460.0	462.0	521.0
Children who were the subject of a serious case review					
D) All serious case reviews	116	62	63	95	135
Rate per 100,000 children aged under 18 years	1.03	0.55	0.55	0.81	1.17
E) Fatal serious case reviews	73	45	51	64	82
Rate per 100,000 children aged under 18 years	0.65	0.40	0.44	0.54	0.71

In the same time period, 52,700 children were taken off child protection plans each year. These were children who had been deemed to be suffering or at risk of suffering significant harm and who, through the implementation of a plan, were deemed to be no longer at risk, either because they had reached the age of 18, had been placed in local authority care, the suspected perpetrator was no longer deemed a risk, or other measures had been put in place to support the family and protect the child from harm. There may be many more children for whom earlier prevention strategies prevent an escalation of vulnerability or risk, whether through CAF, or child in need services, or wider health and welfare services.

Learning Points

- A minority of children (12%) who suffer serious or fatal child maltreatment were on a child protection plan at the time of the incident. A further 12% had previously been on a plan
- Almost two-thirds (64%) of children who suffered serious or fatal child maltreatment, and were the subject of a serious case review, were or had previously been 'known to children's social care' and an open case to CSC
- A further 14% of children were below the threshold for a service; their referral had not been accepted, or an assessment had not led to a service, but they were 'on the radar'. Thus in 78% of the cases children's services were or had been aware of the child. In the remaining 22% of the cases children's services had never been alerted or involved
- Fluctuations in the numbers of serious case reviews need to be interpreted in the context of a steady increase in child protection activity since 2009. During the years 2011-14, a total of 1,856,400 referrals were received by children's social care services in England, an average of 619,000 per year

Chapter 3: The nature of the death or serious harm

This chapter analyses in detail the nature of the incident or harm which led to the serious case review. Of the 293 SCRs undertaken, 197 related to fatalities. Of these, four cases involved more than one child in the family being killed; one further case was notified as serious harm rather than a death, but involved a case of arson in which one child died and one survived. For the purposes of these further analyses, only a single index child is included.

3.1 Child maltreatment fatalities

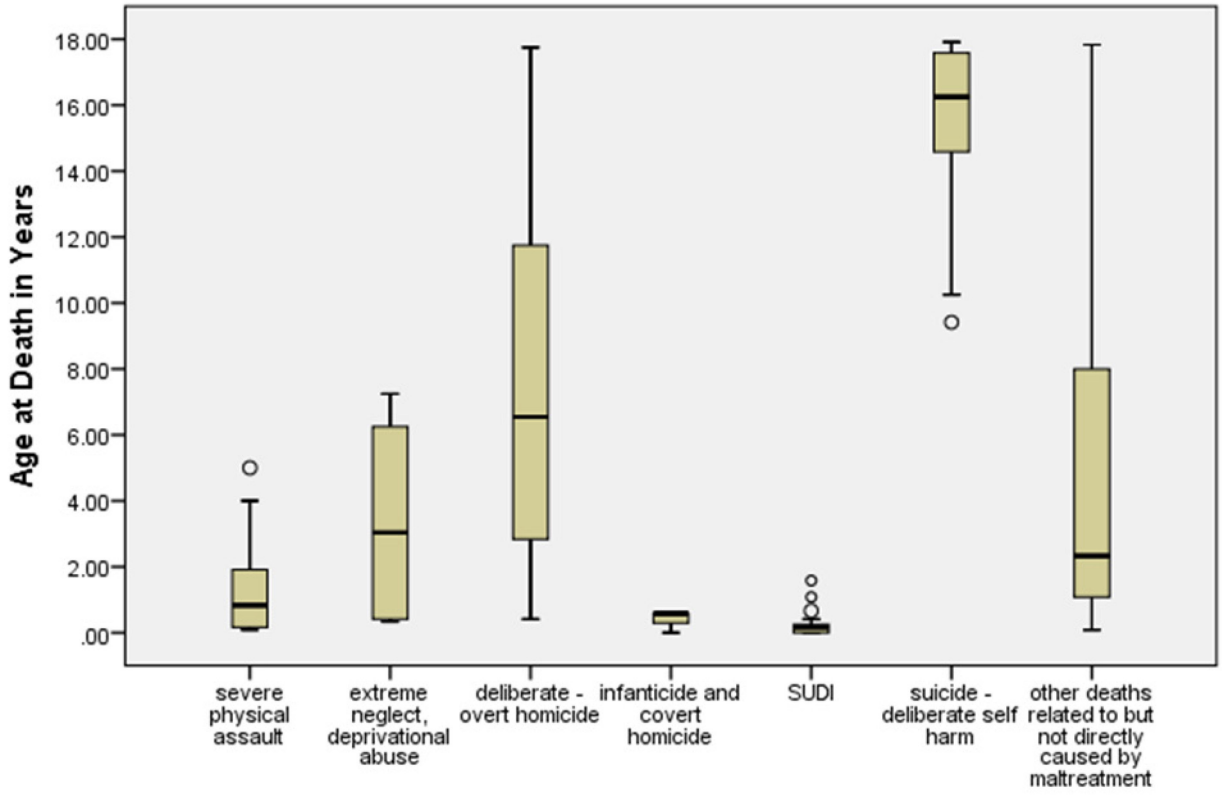
The fatal cases were categorised according to the classification system used in previous biennial analyses (Table 20). Of the 197 fatal cases, we were able to categorise the death in 178 cases (90%). There were 19 deaths for which there was insufficient information available from the CP database or the final reports to enable us to classify the death. Each of these fatal categories will be explored in turn, drawing on learning from the 9 years where the fuller information was available.

Table 20: Categories of death in fatal cases

	Frequency 2005-07 (n=123)	Frequency 2007-09 (n=158)	Frequency 2009-11 (n=118)	Frequency 2011-14 (n=197)
Fatal physical abuse	27 (22%)	33 (21%)	30 (25%)	48 (24%)
Deliberate/ overt homicide	9 (7%)	22 (14%)	20 (17%)	28 (14%)
Familial	*8*	*16*	*19*	*22*
Extra-familial	*1*	*6*	*1*	*6*
Infanticide/ covert homicide	7 (6%)	6 (4%)	7 (6%)	3 (2%)
Extreme neglect/ deprivational abuse	2 (2%)	2 (1%)	2 (2%)	6 (3%)
Deaths related to maltreatment	57 (46%)	81 (51%)	50 (42%)	93 (47%)
Sudden unexpected death in infancy	*20*	*28*	*15*	*31*
Suicide	*20*	*21*	*17*	*37*
Other death related to but not directly caused by maltreatment	*17*	*32*	*18*	*25*
Other death, category not clear	21 (17%)	14 (9%)	9 (8%)	19 (10%)

The ages of the children at death ranged from birth to 17 years 11 months. The age spread varied according to the category of death. Figure 12 demonstrates that the majority of fatal physical assaults occur in infancy and the early pre-school years; extreme neglect occurs across early childhood; while deliberate, overt homicide occurs across the age spectrum. Covert homicide cases occurred exclusively in infancy. The sudden unexpected deaths in infancy (SUDI) were, by definition, limited to infancy, while the suicides were mostly in late adolescence, though with outliers as young as nine years. Other deaths related to, but not directly caused by, maltreatment occurred across the age spectrum.

Figure 12: Ages of the children at death*



* This box-plot shows the range of age at death for children in different categories. The solid line in each box gives the median age at death for that category, the olive box gives the inter-quartile range, within which 50% of deaths will be found, and the bars above and below the box give the 95th centiles. Significant outliers are identified by circles.

3.1.1 Fatal physical abuse

There were 48 children who died from fatal physical abuse in this cohort, accounting for the largest single category of fatal SCR cases (24%). The ages in this category ranged from 1-60 months (median, 10 months); 73% were aged under two years. Forty-six percent were male and 24% were non-white ethnicity. The suspected perpetrator was the biological father in 29%, a non-biological father figure/mother's partner in 23%, and the mother with or without her partner was suspected in 4%. In approximately 40% of the final reports it was not clear who the perpetrator was. Fifty-one percent of families were

known to children's social care prior to the incident, but only two of the children were or had been on a child protection plan.

The fatal physical abuse cases shared many features in common with the non-fatal serious harm cases. In the majority of cases, where specified, the cause of death was a severe non-accidental head injury, including intracranial bleeds from suspected shaking or shaking-impact injuries. In many cases, there were other injuries, including fractures to the head, chest and limbs.

Many of these cases of fatal physical abuse appear, on first inspection, as arising 'out of the blue' in otherwise normal, unremarkable children living in families known (at the time) only to universal services. As such, it would appear that none of these events was predictable. However, a closer inspection of the cases reveals that there are often pointers toward some parent or carer risks arising within a vulnerable social context. Most notable are the risks presented through situations of domestic abuse, particularly when this is in a context of a young or immature mother, or one who has ambivalent feelings to her child, and perhaps exacerbated through a transient or chaotic lifestyle with multiple partners, frequent house moves or overall social isolation. It is the combination of multiple risks coming together in a family with a young infant that puts that infant at risk of harm, and therefore provides opportunities for recognition of this risk and for preventive interventions. These issues are explored further in Chapter 4.

By way of contrast, cases of fatal physical assaults involving older children seem to present a very different pattern, with an ongoing pattern of child vulnerability, and persistent harm involving physical and emotional abuse and neglect. These cases differ in their underlying characteristics and could therefore be considered as a separate category of severe and persistent child cruelty. Two cases, that shared features of extreme neglect and physical abuse, are considered separately later in this chapter.

3.1.2 Deliberate or overt homicide

There were 28 cases of deliberate or overt homicide, accounting for 14% of all fatal SCR cases. The children in these cases spanned the entire age range from 5 months to 17 years 9 months (median, 6 years 6 months). Forty-three percent were male, and 29% were non-white ethnicity. The suspected perpetrator was the biological father in 36%, and the mother in 36%. Eighty-five per cent of families were known to children's social care prior to the incident, and 20% of the children were or had been on a child protection plan. In six cases (21%) the perpetrator was known to the child, but not a primary carer; these extra-familial cases will be considered separately.

Six cases involved the death of more than one family member: either more than one child, or the mother along with one or more children. In 12 cases, the perpetrator took or attempted to take their own life.

In none of these cases were there any significant health, developmental or behavioural concerns identified in the children. The children came across as healthy, happy and well-adjusted, often in spite of disrupted family environments. With the exception of two infants, these cases mostly involved older children, typically of school age, and therefore beyond the age of perceived vulnerability to abuse. Although only 20% of these children were, or had been, the subject of a child protection plan, the majority of families were known to social services, most notably around issues of domestic abuse, which was prominent in nearly all the cases, or mental health problems in one or both parents.

In contrast to the cases of fatal physical assault, in which the perpetrator was often a non-biological father figure/new partner of the mother, in these cases, the perpetrator was usually a biological parent – either the mother herself, or the biological father. In several cases, there appears to have been a trigger event, often a court case around residence or contact, which preceded, or was preceded by, the murder.

While such cases are fortunately rare (around 10 cases per year in England), they are particularly disturbing as in these cases there often appears to have been some calculated premeditation and planning suggesting a clear intent to kill the child or children. Previous work has highlighted the distinction between male-perpetrated overt filicide, in which the motivation often seems to stem from domestic abuse and a desire to exert control or inflict revenge, and mother-perpetrated filicide where the motives appear more to stem from 'altruism' and an apparent desire to save their child from further suffering (Bourget, Grace et al, 2007). This distinction again was found in this cohort.

3.1.3 Extra-familial child homicide

There were six cases of child homicide perpetrated by persons known to the child, but not a primary carer. These were all of older children, ranging from 12 to 17 years (median 17 years 1 month). All but one were female. The male victim was a 14 year old immigrant, with a troubled background, who was killed in a drug-related gang incident.

Two of the female victims were killed by a partner or ex-partner. Their deaths carried similarities with many domestic homicides. Both had been victims of domestic abuse, and both perpetrators had histories of violent offending. Two other girls were killed by wider family members; both had difficult backgrounds with evidence of child abuse or neglect. The final case involved a 16 year old girl who was killed in a sexually-motivated attack by an older man whom she had met via social media. This girl had previously suffered a sexual assault and was known to be at risk of sexual exploitation.

While there was some heterogeneity in these cases, all of these young people were known to have troubled backgrounds, with multiple known risks of harm. Most of the perpetrators were known as violent offenders or had previously displayed disturbing violent behaviours.

3.1.4 Covert filicide

There were three cases of covert filicide (2% of all fatal SCR cases). In these cases there appeared to have been some intent to kill the child, but using less overtly violent means than in the cases of overt filicide, and often with some attempt to conceal the death or the manner of death. One child died shortly after birth as an apparent infanticide and the other two were aged seven months. These two children had been referred to children's social care prior to their death, but neither was on a child protection plan. All three children were killed by their mothers.

In the two older cases, the mothers both had significant mental health problems and had displayed signs of not coping with their own needs and their parenting responsibilities. In one case there was clear evidence of domestic abuse and controlling behaviour. In the other case, although there was no clear evidence of domestic abuse, the father had severe, chronic ill-health requiring full-time care by the mother, and there were some indications of manipulative and controlling behaviour towards the mother.

The third case involved a teenage mother who had denied and concealed her pregnancy, and then suffocated her child immediately after the birth. This case was unusual in that there were no obvious indicators of concern around the mother or the wider family, other than parental separation (mother's parents). The mother had not demonstrated any significant mental health problems, and, indeed, had presented as an intelligent and articulate young woman who was doing well at school.

3.1.5 Extreme neglect and deprivational abuse

There were six children who died directly as a result of extreme neglect, accounting for 3% of all fatal SCR cases. These children ranged in age from 4 months to 7 years 3 months. Four were male, and three were of non-white ethnicity. All six children were known to children's social care, but only two were on a child protection plan. In one case, responsibility for the child's death was placed on the father figure; in all other cases, responsibility rested with the mother alone or both parents.

Four of these children died directly of the consequences of extreme neglect, either as a result of cardiac arrest or multi-organ failure arising from malnutrition, or, in one case, as a possible consequence of hypothermia. In one case, where both parents were implicated, extreme parental beliefs had led them to refuse appropriate medical care. In all of these cases, there were multiple concerns about the welfare of the children over a period of time, particularly with evidence of poor growth. In all cases, there was evidence that the family was isolated, or that this was a particularly vulnerable mother, perhaps through teenage pregnancy, the impact of domestic abuse, or mental health problems. One SCR described how the mother had become 'so overwhelmed with own problems and needs that she was incapable of adequately caring for herself let alone any dependent children.'

3.1.6 Severe and persistent child cruelty

In the remaining two cases the children, aged 4 and 7 years, had died as a result of physical injuries on a background of severe, persistent physical and emotional abuse and neglect. Although in both cases there was ongoing involvement of professionals from multiple agencies, this did not appear to have resulted in any meaningful appraisal of the children's vulnerability. In both of these cases, the child in question appeared to have been scapegoated.

The distinct nature of these cases suggests that they should be considered separately either from extreme neglect per se, or from severe and fatal physical abuse, but rather as a new category of 'severe and persistent child cruelty'**.** While rare in comparison to the apparently impulsive assaults of younger children, these cases are extremely troubling, and tend to garner a lot of media attention. In these cases, the abuse inflicted on these children shares similarities with current understanding of most domestic abuse as 'a very deliberate choice to hurt, damage and control the other' (Storkey, 2015, p.83). In the words of Stark, such behaviour is 'rational, instrumental, and intentional behaviour rather than impulse driven or the byproduct of a dysfunctional personality or up-bringing' (Stark, 2007, p.202).

3.1.7 Deaths related to but not directly caused by maltreatment

There were a total of 93 cases where a child had died of other causes (natural, external or self-perpetrated) but where maltreatment, while not directly causing the death, may have contributed to the death or was identified as being present in the background of the child's life. This group therefore accounted for 47% of all fatal cases. Thirty-one of these cases were infants who presented as sudden unexpected deaths in infancy; and 37 were young people who died as a result of suicide or self-harm; the remaining 25 represented a mixed group of causes.

The 31 cases of SUDI were aged 0-19 months at the time of their death (median 2 months). 29% were boys, and 17% were from non-white ethnicity. The majority of these infants (81%) were known to children's social care, and 27% were the subject of a child protection plan at the time of their death. In many of these families, long-standing issues of neglect and other risks, relating to the child or the siblings had been identified. Most of these children died while co-sleeping with a parent or in other dangerous sleeping arrangements, such as on a sofa, on soft bedding, or in make-shift bedding. Many of these families appear to have led chaotic lives, with frequent house moves, periods of homelessness, or inappropriate housing. Substance and alcohol misuse was common, as were parental mental health concerns. Some of these infants were found to have previously unrecognised injuries or evidence of malnutrition at autopsy (though not sufficient to have caused the death).

The Office for National Statistics reported a total of 249 unexplained infant deaths in England and Wales in 2013, a rate of 0.36 deaths per 1,000 live births (Office for

National Statistics, 2015b). These deaths are typically classified by coroners as either sudden infant death syndrome (SIDS) or 'unascertained'. Previous epidemiological research has identified that these deaths share many background factors in common with child maltreatment, so it is perhaps not surprising that a proportion of these deaths will have some concerns and so result in a serious case review (Blair, Sidebotham et al, 2006). While it is possible that some of these deaths may have been covert homicides, there was little in the SCR reports that we examined to suggest that this was a likely explanation. Much more plausible is the consideration that these were vulnerable infants, living in chaotic environments, within which they ended up being exposed to recognised SIDS risks.

The 37 young people who died as a result of suicide or self-harm were aged 9 years 5 months to 17 years 11 months (median 16 years 3 months). Just over half (51%) were boys, and 14% were from non-white ethnicities. The majority of these young people (84%) were known to children's social care, with 12.5% being on child protection plans, and 25% in local authority care as looked after children. The characteristics and needs of this group of young people is considered in detail in Chapter 5.

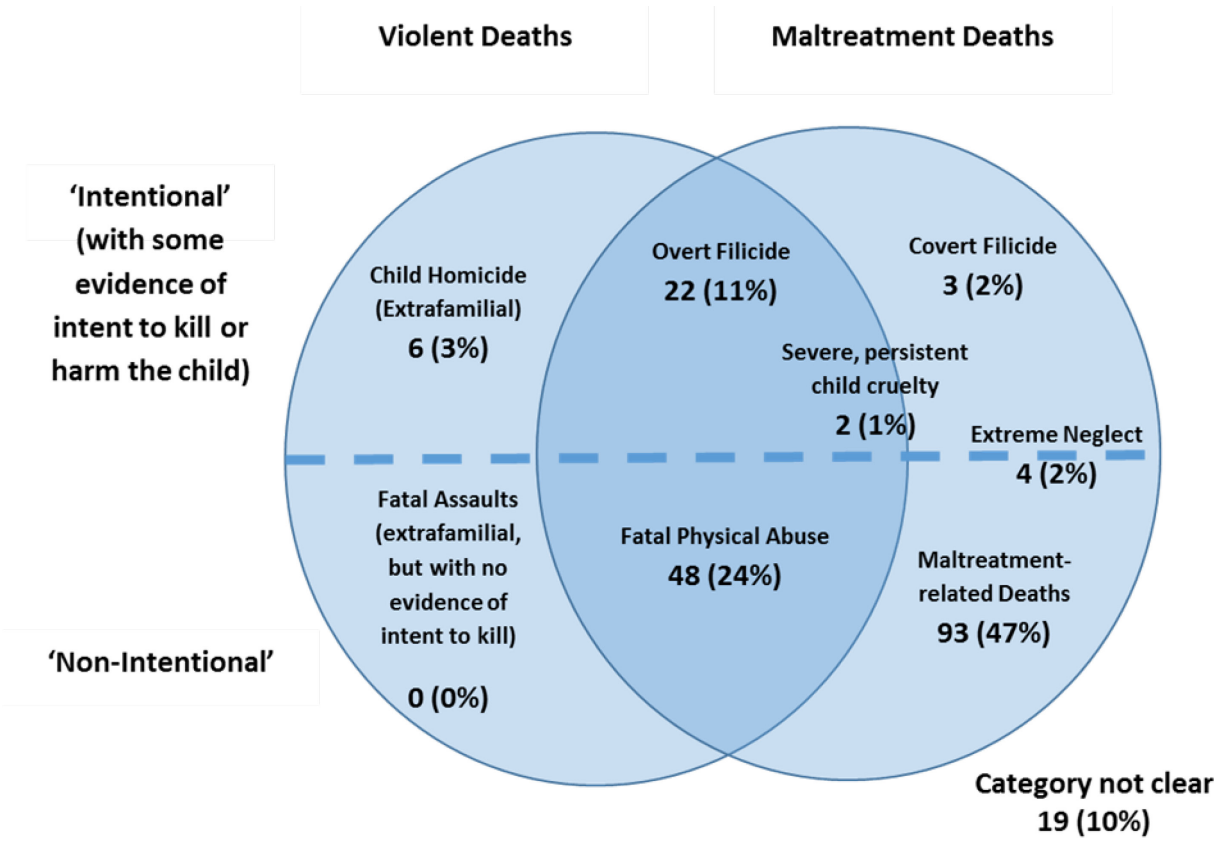
There were 25 other deaths related to but not directly caused by maltreatment. These included children and young people who died of natural causes, typically long-standing medical conditions, but in whom parental neglect may have played a part in the progress of their condition, or their final demise; children who died as a result of accidents or injuries, where neglect or lack of supervision may have played a part; and a number of other causes of death. The median age of these children was 28 months, ranging from 1 month to 17 years 10 months. 64% were boys, and 17% were of non-white ethnicity. As with the SUDI and suicide cases, the majority (85%) of these cases were known to children's social care, with 42% being on a child protection plan and 21% looked after.

Within this group of cases there were six cases of methadone or heroin poisoning and four children who died from drowning, either in a bath (3 children) or in a garden pond. Other children died as a result of falls (2 children), or from furniture falling on them (1 child). Many of the children who died of medical causes had long-standing underlying chronic health needs or disabilities. In some cases, the cause of death was an acute illness, or an acute exacerbation of their underlying illness, for which medical help had not been sought promptly. The older young people in this group typically had significant difficulties, with troubled backgrounds and often with dangerous or non-compliant behaviour which may have contributed to their deaths. In nearly all the cases within this category, there were multiple issues in the parents' backgrounds, including drug and alcohol misuse, criminal behaviour, mental health problems and domestic abuse. A large number of the cases where the child died of a medical cause had evidence of poor engagement, on the part of the parents, with health and social care services. These issues are explored in detail in Chapter 4.

3.1.8 Reframing violent and child maltreatment deaths

In our previous biennial reviews (Sidebotham, Brandon et al, 2011; Brandon, Sidebotham et al, 2012) we have developed a framework for categorising violent and child maltreatment deaths. We and others have built on and further developed this model (Sidebotham, Bailey et al, 2011; Sidebotham, 2013a; Brown and Tyson, 2014). In reviewing the fatal cases in this triennial review, the model has proved a viable framework for understanding the nature of these cases, and from the information available, we were able to categorise the majority of cases. However, our analysis has suggested the need for further modification, in particular, separating out those cases of severe, persistent child cruelty into a distinct category. This revised model is illustrated in Figure 13 below, along with the numbers of cases within each category.

Figure 13: Violent and maltreatment deaths



3.2 Non-fatal harm

Of the 293 serious case reviews included in this triennial study, 96 related to non-fatal cases. The median age of these 96 children was two and a half years, with a range from new-born to 18 years. Just under half (43%) were aged under one year at the time of the serious injury or harm. Over half (58%) of the children were female, and 23% were of non-white ethnicity. The majority of the reviews (81%) related to harm within the family context, the other fifth to harm in the wider community, and from people not in the immediate family circle.

Twenty-nine of the children were, or had been, on a child protection plan (30% of the 96) and, where children's social care involvement was known from the available final reports, 42% were open cases prior to the incident, 31% had been closed, 10% had been referred but not reached the level for opening, and 17% had never been known.

The non-fatal cases were categorised according to the classification system used in our previous biennial analyses (Brandon et al, 2010, 2012). A new category has been added to capture the cases of child sexual exploitation (CSE), which have been a relatively new area of concern in serious case reviews (Table 21), although there were two cases involving CSE, where young women in care went missing, in our first biennial review of cases from 2003-05.

Table 21: Categories of serious harm in non-fatal cases

	Number of incidents 2007-09 (n=116)	Number of incidents 2009-11 (n=60)	Number of incidents 2011-14 (n=96)
Non-fatal physical assault	66 (57%)	31 (52%)	50 (52%)
Neglect	14 (12%)	6 (10%)	14 (15%)
Sexual abuse intra-familial	8 (7%)	6 (10%)	13 (14%)
Sexual abuse extra-familial	12 (10%)	6 (10%)	5 (5%)
Sexual exploitation			5 (5%)
Risk-taking / violent behaviour by YP	9 (8%)	8 (13%)	8 (8%)
Other / not known	7 (6%)	3 (5%)	1 (1%)

Each category is explored in turn, relying on data from the CPD notification for all cases, and on final reports, where available, for details of children's social care involvement and the likely perpetrator of the harm.

3.2.1 Non-fatal physical harm

There were 50 cases of non-fatal physical abuse, accounting for 52% of non-fatal cases. The ages of these children ranged from new-born to 17 and a half years (median 3 months) at the time of their injury; three quarters (74%) were aged under one year. Half of the children were boys and 21% were non-white ethnicity. All the incidents took place within a family context.

Of the 50 children in these serious cases reviews, six had a current child protection plan at the time of the assault, and five had had a plan in the past; the majority (39) had never had a plan. In the sub-set of 27 reviews, where the final reports were available, 20 of the children (74%) were known to children's social care. Of these, 11 (41%) were open cases, six (22%) were closed cases, and three (11%) had not reached the level for opening when referred. The other seven children had never been referred to CSC.

From the sub-set of final reports relating to non-fatal physical assault it appeared that the perpetrator was the mother (37% of the cases), the father (22%), mother's partner (7%), or both parents (19% of cases), with 15% of reports being unclear as to the source of harm to the child.

There was evidence in the final reports that domestic abuse was a characteristic in half (50%) of the families. Physical assaults often occur in a context of chronic, neglectful care, and in these fifty serious case reviews (where a serious physical assault was the main focus) there was evidence of neglect in 43% of the cases. It is important to remember that for many children and young people multiple types of abuse may co-exist.

3.2.2 Neglect

Neglect was given as the primary incident cause in 14 non-fatal serious case reviews. The median age of these 14 children was six years, with a range in age from new-born (no medical assistance at birth at home, and the baby testing positive for heroin) to 17 years of age. Nine of the 14 children (60%) were boys, and all incidents took place within a family context.

Two of the children were on a CP plan at the time of the incident, and a further four had been in the past. For eight children where information on their children's social care history could be determined from the final report, seven (87%) were known to children's social care; two being open cases and five being closed cases. In the case of the eighth child, a sibling was in receipt of a service from children's social care.

However the extent of neglect is likely to be underestimated by looking solely at the notified primary cause of harm. Instead, a detailed examination of all non-fatal final reports found evidence that neglect was apparent in the lives of nearly two thirds (62%) of the children and young people. This was evidenced by there being a child protection plan under the category of neglect; neglect being given as the primary category of the incident or a case characteristic on the notification form; or neglect being discussed in the final report as an important, and often long-standing feature of the child's life. Similar findings regarding the extent of neglect in previous biennial reviews were discussed in section 2.4.4 above.

Neglect may have been apparent to professionals often through a combination of poor growth, non-attendance at health appointments, including routine surveillance, or poor school attendance. Further issues identified in some of the reports included children

coming to school inadequately dressed, or with poor hygiene, and through food-seeking behaviour. In some cases, indicators such as these were known to professionals, but not necessarily identified as indicative of neglect.

3.2.3 Sexual abuse

There were 23 serious case reviews undertaken which related to sexual abuse or sexual exploitation, of which just one review related to a young man, who was in his mid-teens at the time. While the median age was 14 when the incident(s) occurred, or came to light, there were four victims aged five or younger.

The 13 children who were subjected to intra-familial abuse had a median age of 10 years, and four were aged five or under. All were female. The perpetrator, where known from the final report, was the mother's partner (38% of cases), the father (25%), a male relative (one instance), the mother (one instance) or both parents (one instance). Two of the children were on a child protection plan at the time, and five had been previously. In the eight instances where the detailed child's social care history was available, all had been known to children's social care; three were open cases at the time of the incident, four were closed cases at the time, and one had not reached the level for assessment at the time of referral.

The five children abused by someone outside the family had a median age of 15 years, and all were aged 13 or over. One child was on a CP plan at the time, and one further child had been in the past. Both these cases were open to children's social care at the time of the incident(s); a further child's case had not reached the level for opening at the time of referral. In the five cases of extra-familial sexual abuse the perpetrator was known, but not related.

The young people involved in sexual exploitation were all aged 13 or over, with a median age of 15. However these SCRs related to groups of teenagers, who themselves were often representative of much larger numbers of young people, so that the background and characteristics of the 'index child' is not necessarily a helpful way to consider these much larger groups of young people. Child sexual exploitation is considered in some detail in Chapter 5.

Sexual abuse will also be a factor in the lives of some of the children and young people where the focus of the serious case review was primarily on neglect, or a physical assault. The extent of sexual abuse being suffered by the children and young people is therefore under-estimated by focussing solely on the children where the primary category of harm was sexual abuse. A closer analysis of all 96 non-fatal serious case reviews indicates sexual abuse occurred in 32 (33%) of the cases. In addition a further two reviews related to the perpetrators of sexual assault. An even starker picture emerges if babies under one year are excluded from this calculation. In the remaining 55 cases, relating to children of one year and over, there was evidence of sexual abuse in 29 (53%) of the cases.

In addition to these non-fatal cases, sexual abuse was also noted as a background factor in ten of the 37 cases (27%) of suicide, while two other deaths in adolescents appeared to have occurred in the context of sexual exploitation or a sexual assault.

3.2.4 Risky behaviour

Eight serious case reviews were held where the focus of the review was risky behaviour by the child or young person, including substance misuse, self-harm and three instances where the young person was the perpetrator of harm to another child or adult. Six of these young people were aged 15 years or over at the time of the incident(s) which led to the review, although two were under the age of ten. There were five young men and three young women, and most of the incidents (six out of the eight) took place within a community context.

Two of the young people had been on a child protection plan, although none were at the time of the incident(s) which led to the review. In the sub-set of five reviews, where the final reports were available, all five young people were known to children's social care; four being open cases, and one a closed case.

Learning Points

- Non-fatal physical harm took place in a family setting, and three-quarters of the children assaulted were aged under one year. Such assaults often took place in a context of domestic abuse, and chronic, neglectful care of the child
- Where neglect was the primary reason for the SCR it occurred within a family context, with the child ranging in age from new-born to 17 years. The child was likely to have already been known to children's social care at the time of the harm which prompted the review
- For many children and young people multiple types of abuse co-existed; two thirds suffered neglectful care, irrespective of the primary category of abuse identified by the SCR
- Victims of sexual abuse, all but one of whom were girls, ranged in age from under one year to 17 years. Those abused by a family member were generally younger than those abused by someone, or a group of people, outside the family
- Sexual abuse often co-existed with other types of harm; there was evidence of sexual abuse in 53% of cases relating to children who were at least one year of age
- The eight young people engaged in risky or violent behaviour ranged in age from 7 to 17 years, although six of them were aged 15 or above. They were

likely to be male rather than female, and most incidents took place in a community rather than family setting

3.3 The source of harm to the child / young person

The 175 final reports were examined in order to determine who in the child's family, or in the wider community, had been the source of the harm to the child or young person (Table 22).

Table 22: Source of the harm to the child /young person

	Person posing a risk (number of SCRs where pertinent)	% of all 175 SCRs
Mother	41	23%
Father	29	17%
Mother's partner / father figure	18	10%
Both parents	21	12%
Other relation or carer	6	3%
Known, but unrelated	8	5%
Stranger	3	2%
Young person him or herself	27	15%
Not clear, not applicable (e.g. natural causes)	22	13%

The person causing the harm varied according to the type of harm suffered; if it were a physical assault which proved fatal or seriously injured the child, the perpetrator was most likely to be the father (in 24 SCRs), or father figure/mother's new partner (12 SCRs). In SUDI cases, if co-sleeping contributed to the death, then the mother was the more likely parent to be present at the incident (5 SCRs); reflecting the fact that she is more likely to be the parent who attends a baby in the night. In all nine SCRs where neglect was the key issue the mother was noted as the prime source of harm; this related to six non-fatal neglect reviews, but also to the three SCRs relating to extreme fatal neglect, involving deprivational abuse. Again this in part reflects the fact that the mother is likely to be the sole or main carer. The 11 reviews relating to sexual abuse concerned the father (2 reviews), the mother's partner/father figure (4 reviews), both parents (1 review) or another family member (1 review), and in three instances a known, but unrelated, male.

Learning Points

- Most serious and fatal child maltreatment occurs within the family home, involving parents or other close family members
- In later adolescence there are increasing risks outside the family home, although young people may still be seriously harmed within the family home
- Very little serious or fatal maltreatment involves strangers unknown to the child or young person

Chapter 4: Pathways to harm: Child and parent characteristics and vulnerabilities

The majority of the 11.4 million children and young people living in England grow up in 'good enough' families, enjoy safety and security, and live healthy lives. However, for many children, this is far from true, a point that was raised in the Children's Society report, *The Good Childhood Report 2014*, which found that children in England ranked ninth out of 11 countries surveyed for subjective wellbeing (The Children's Society, 2014). It is certainly abundantly clear that the children in these 293 serious case reviews did not experience the positive outcomes envisaged in *Every Child Matters* (HM Government, 2003). This raises a number of key questions if we are to effectively protect these children, or prevent their maltreatment. Firstly, is there anything about the children, their families, or their wider social environment, which sets them apart? Secondly, are there factors that help us to better understand the context of their maltreatment? And thirdly are there particular risks or vulnerabilities which, through professional intervention, we could ameliorate?

4.1 The child's characteristics and vulnerabilities

One of the key challenges for professionals in the child welfare field is the apparent normality of most abused children. These children rarely stand out from their peers, and in many cases can remain effectively invisible to those who might seek to help them. In the words of Lord Laming, *'Cases involving vulnerable children do not come with convenient labels attached'* (Laming, 2003, p.103). This has been highlighted in previous biennial reviews, and was again a common theme in the 175 final reports we examined in detail. In many cases the thematic analysis conveyed a picture of predominantly healthy infants with no particular vulnerabilities, who are known only to universal services:

> *"The family was largely known to routine, universal services and as a result little was known by professionals about the lived experience of the child, their relationship with Mother, Father, Mother's partner and extended family… [This child] therefore had little direct contact with professionals, and when seen for routine health appointments and the Initial Assessment… the available evidence was that the child was well looked after, had a good relationship with their Mother and engaged with professionals."*

However, there is a danger in assuming that simply because children appear to be healthy and adapted, and don't stand out from their peers, they are necessarily free of any maltreatment. This is particularly so when there are known parental risks, or disrupted home circumstances.

4.1.1 The child's age and vulnerability

Two age groups stand out as being particularly vulnerable to suffering serious harm as a result of child maltreatment: young infants and pre-school children; and adolescents. The specific vulnerabilities differ between the two groups, but as highlighted in previous biennial reviews, both deserve particular attention to address their vulnerability and minimise the risks of serious harm.

We know from our past biennial reviews that the very young are particularly vulnerable, and that premature babies, babies with a low birth weight and/or requiring initial (or in some cases lengthy) special care baby unit nursing, and babies born with neonatal abstinence syndrome potentially pose challenges to their parent(s) over and above the considerable demands of any new-born infant:

> *"[The child] was born 12 weeks early… diagnosed with several medical conditions associated with prematurity… kept in hospital for a further 12 weeks before being discharged home. During this period parents visited or rang the hospital but there were several consecutive days when [baby] had no contact with mum or family, the longest being a period of 11 days."*

Adolescent vulnerability

By adolescence the child's problems may have escalated and resulted in behaviours which place him or her at extra risk of harm (a topic developed in depth in Chapter 5). From the final reports we mapped the frequency with which problems or behaviours were occurring in the relevant older age groups. The 175 reports for 2011-14 included 22 relating to children aged 11-15, and 24 relating to young people aged 16 and above (Table 23).

Table 23: Characteristics of the young people aged 11 and above

	Number of children aged 11-15 (n=22)	Number of young people aged 16 and over (n=24)
Young person – mental health problems	14 (64%)	21 (88%)
Young person - using drugs	6 (27%)	14 (58%)
Young person –alcohol misuse	4 (18%)	12 (50%)
Young person – intimate partner violence in own relationships with boyfriend/ girlfriend	1 (5%)	4 (17%)

The extent of mental health problems in the young people was particularly marked, with attendance, or appointments booked, at CAMHS a frequent aspect of these young people's lives.

Some young people engaged in anti-social and criminal behaviour, and this could include gang membership, carrying of knives, drug dealing, robberies and shop-lifting. Many of the young people who took their own lives had involvement with youth offending teams. Three serious case reviews related to young males who were the 'perpetrators' of crime; in one case sexual crimes against other young people, and in the other two cases violence involving knives:

> *"Both young men were alleged to have undertaken criminal activities using weapons and had been convicted of having offensive weapons on their person"*

Learning Points

- The cumulative effect of abuse and/or neglect in childhood can lead to mental health problems and other difficulties in adolescence
- The young person may respond to adversity by engaging in risk-taking behaviours, including drug and alcohol misuse and offending

4.1.2 Disability and additional health needs

In contrast to those cases only accessing universal services, some children were noted to have additional health needs requiring secondary or tertiary health services. For example, a young child referred to a paediatrician and speech therapist because of unusual, repetitive behaviours and language delay; and an older child with significant and complex health needs. With these children, it is possible that their additional health needs may have contributed to additional stresses on the parents, but there was nothing in the recorded histories to suggest this might contribute to risk of harm. This possibility was picked up in the review of one older child with complex needs:

> *"There is no evidence of an assessment of the emotional impact on father and mother of caring for a baby with the complex health needs which [this child] had. A referral to the children with disability team would have been appropriate at the point that [the child] came home from hospital… rather than the transfer request that was made by Social Worker [two months later]*."

A child's disability can present challenges to the parents and carers, and can place great demands practically, emotionally, and potentially financially on the parent or parents, and other family members. Similarly, disability and chronic health needs present significant challenges to young people:

"Specific input from a Child Psychologist may have helped [the young person] come to terms with a chronic life threatening disease which in turn may have influenced decision making. Psychological services for children and young people with chronic health needs is intrinsic to helping children/young people and their families deal with such enormous health issues and is often part of an in house service provision aligned with specialist health services. It will remain unknown if this would have helped in the case of [this young person] as such services were not available as part of the tertiary health service provision."

Drawing on available information from the child protection database (CPD) and from SCR final reports, one in ten children (29) were identified as being disabled (see Table 24). Similar proportions have been noted in previous reviews. This is likely to represent an underestimate, in part because we cannot be sure this is always recorded comprehensively in the CPD and also because of the young age of many of the children, where disability may not yet have been recognised.

Table 24: Disability (prior to the incident)

	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)	Frequency 2011-14 (n=293)
Number (%) of children with disability identified	14 (7%)	24 (9%)	21 (12%)	29 (10%)

The children who were identified as disabled ranged in age from under six months to 17 years. The broad categories of disability, as ascertained from the child protection database, were:

- Physical disability (8) (including cerebral palsy, congenital syndromes).
- Intellectual disability (19) (including severe ADHD and autism)
- Chronic disabling disease (2) (e.g. type 1 diabetes)

There are a number of themes within SCRs which highlight the additional vulnerabilities of disabled children, which recur in these most recent cases.

Potential signs of abuse/neglect attributed to disability

While the primary focus for intervention remains the child's disability or health needs, indicators of abuse may be misinterpreted and the risk of significant harm go unrecognised. Signs such as physical injuries, challenging behaviours, developmental delays, poor growth, and unhygienic living conditions can all be left unchallenged or attributed to the child's disability rather than identified as symptomatic of abuse or chronic

neglect. In some cases, this may be compounded by parents actively deflecting attention from safeguarding concerns:

> *"[The mother's] insistence on a specific medical diagnosis for the children's difficulties seems to have served in many ways to dissipate any consideration of other family and environmental features of their lives – in particular the quality of the parenting they received."*

Health, education and children's social care staff working with disabled children need to remain alert to the possibility of maltreatment, and consider this possibility when a child presents with signs or symptoms which, in a non-disabled child, might be considered indicators of abuse or neglect.

Child not heard, less able to communicate or disclose abuse

Communication difficulties mean that some children were limited in their ability to articulate or verbalise what was happening to them:

> *"Given [the child's] learning difficulties and her difficult early childhood experiences, it was always going to be complex for [the child] to provide a clear picture of what had actually taken place, and this was indeed so."*

Recognising behavioural cues, which might indicate distress or underlying concerns in the child's care, is particularly important when the child cannot communicate clearly. We noted in the last biennial review that there is an obligation on professionals to try to understand disabled children rather than putting the responsibility for communication on the child.

Overestimation of the parent's ability to cope with caring for a disabled child

Caring for the disabled child could pose great demands practically, emotionally and financially on the parents. There may be a lack of consideration given to the impact of the disability on how the family functions:

> *"No assessment took account of her developmental progress and the ecological relationship that her development had with [parents'] capacity to care for her; in the light of their own limitations and difficulties*."

Some of the key opportunities presented to professionals working with disabled children and their families lie in their recognition of the heightened vulnerability of these children and the potential interaction with other risks or vulnerabilities in the family. This requires a comprehensive assessment of the child and family's needs, remaining alert to the child's particular vulnerability, as highlighted by the case of a seven year old child who presented with multiple behavioural and health concerns, within a context of domestic abuse and wider family vulnerability. Although there was ongoing involvement with professionals from multiple agencies, this did not appear to have resulted in any

meaningful appraisal of this child's vulnerability, and he was erroneously seen as resilient, an assessment that ultimately proved to be tragically false:

> *"[The child] was physically, emotionally and sexually abused, and was neglected, physically and emotionally. From infancy he repeatedly witnessed the domestic abuse of his mother, in assaults which were increasingly violent. It is a mark of his resilience that he continued to present much of the time as lively and cheerful, but the failure to see that this presentation masked a lifetime of abuse is alarming."*

Learning Points

- Disabled children are particularly vulnerable to abuse and neglect
- A number of factors may contribute to this vulnerability, including:
  - Signs of abuse or neglect may be masked by or misinterpreted as due to the underlying impairments
  - Professionals are less skilled in communicating with disabled children
  - Disabled children may be less able to communicate their concerns
  - Caring for a disabled child places additional stresses on parents
- Professionals caring for disabled children and their families should consider the possibility of maltreatment in their assessments of the child

4.2 Parent/Carer Risk

In this section we explore a number of parental attitudes and behaviours which impacted on the mother's and father or father figure's ability to keep their children safe, and posed a risk of harm to their child, particularly where adverse factors co-existed.

4.2.1 Young parenthood

There was some evidence of the additional pressures that young parenthood, particularly young motherhood, brought to the task of caring for a baby or young child. In the sub-set of 24 reviews where a family had only one child, and where the age of the mother was known, the mother was aged nineteen or under at the time of that birth in 54% of the

cases. By way of comparison the average age of first time mothers in England and Wales was 28.5 years in 2014, and 28.3 years in 2013[9].

Issues raised regarding young motherhood in serious case reviews from 2011-14 included: denial of pregnancy and/or concealed birth of the baby; estrangement from the new mother's own parents; temporary housing or supported accommodation; lack of support from the baby's father and/or an unstable relationship with the father:

> *"A very young single mother, with a history of unstable accommodation, who appears to have been receiving very little support from either family or professionals midwives were informed by Mother that [baby's] father was not involved. There is no record that the father was present at the time of the birth."*

Good practice was often identified in the work that the teenage pregnancy midwifery teams could provide to first time teenage mothers, offering them a targeted level of support during their pregnancy.

Learning Point

- Young, unsupported parent(s) can face additional pressures and challenges in their caring role

4.2.2 Maternal ambivalence

One potential indicator of parental risk identified in this triennial review was a sense, in a few cases, of maternal ambivalence towards her child. This could present as an unwanted pregnancy, or ambivalent feelings about being pregnant; and result in late antenatal booking, or non-engagement with antenatal services. Later presentations included an apparent lack of joy or warmth in relation to their baby:

> *"[The mother's first child] was cared for by the maternal grandmother, it would appear as a result of concerns about [the mother's] lack of consistent parenting and, possibly, ambivalent attachment to [the child]. [This child] had some health problems at birth, which may have had an impact on the relationship between mother and child. There is information that suggests [the mother] may have had mixed feelings about all of her pregnancies."*

This concept of maternal ambivalence is seen at its most extreme in the rare cases of covert filicide involving a concealed or denied pregnancy. There was just one such case

[9] http://www.ons.gov.uk/ons/rel/vsob1/births-by-parents--characteristics-in-england-and-wales/2014/stb-parents-characteristics-2014.html

in this cohort, involving a teenage mother who effectively denied that she was pregnant and managed to convince others of this, in spite of evidence that she was.

> *"[The young woman] explained that she first became aware of her pregnancy in April/May, but did not take a pregnancy test … and did not voice this belief to anyone. She described that she "went into denial" with regards to being pregnant and "carried on with life". In addition, she is adamant that no further thought was given to her pregnancy even when her mother and GP asked her directly if she was pregnant. [She] describes that she did not experience the 'normal' signs and symptoms of pregnancy."*

Learning Point

- A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaging with parenthood provides an opportunity to explore with that parent, their feelings towards the child and any risks that this might pose

4.2.3 Family size

As in previous biennial reviews, family size was again noted to be a factor in some cases, with a higher proportion of large families in the serious case reviews than in the general population, as outlined in Chapter 2. There may be many reasons for this, not least the interaction between the strain of looking after several children and wider socio-economic considerations and stresses, as emphasised in the following case:

> *"Though neither the views of [the child or her sister] could, by virtue of their age have been sought directly, the community midwife should have been more alert to the additional pressure on the existing children (and parents) consequent upon a third child being cared for in a one bedroom flat."*

4.2.4 Cumulative risk of harm

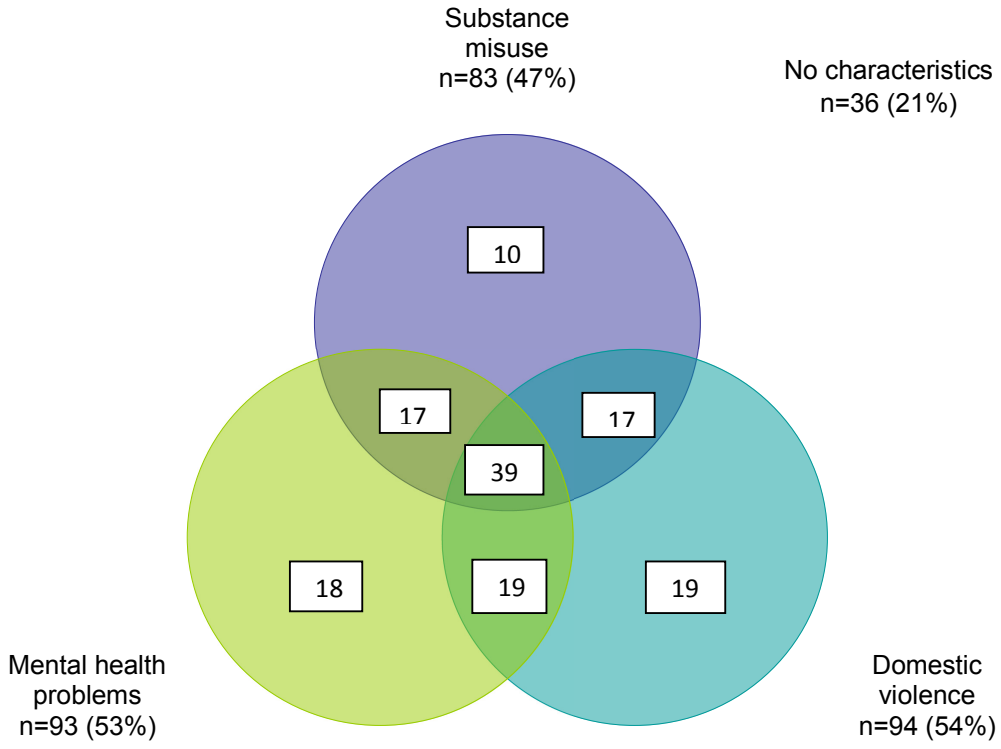
The 175 SCR final reports provided detailed evidence of parental problems and behaviour, and in particular indicated the cumulative risk of harm to the child which is present when domestic abuse co-exists with substance misuse, and with mental health problems (Cleaver et al, 1999).

Parental alcohol and drug misuse were both recorded as present in over a third of reviews (37% and 38% respectively), with at least one of these in 47% of cases. In 48 cases (27%) both factors were present. Parental mental health problems were found in 53% of cases, and domestic abuse in 54%.

The Venn diagram (Figure 14) indicates pictorially the overlap of these three factors within the group of 175 families, with each circle representing a different problem, and containing the set of families with that problem. It is worth noting that there were 36 families (21% of the 175) where none of the three problems were recorded as being present.

By contrast the central overlapping section of all three circles represents the 39 families (22%) where all three factors were recorded as present. Two of the three factors were noted for 53 families (30%). Finally there were 47 families (27%) where only one of the factors was noted.

Figure 14: Number of families experiencing multiple problems



The Venn diagram has been used in previous biennial reviews, and is a useful way to conceptualise the frequency with which these factors are present, and inter-link. Over time we have found that domestic abuse is the most common factor mentioned, followed by parental mental health problems and, thirdly, substance misuse.

Both in this triennial review and in previous biennial reviews, it has become clear that these three issues of domestic abuse, parental mental ill-health, and alcohol or substance misuse are not the only parental risk factors that may contribute to cumulative risk of harm. Other parental risk factors often co-existed with these factors, and potentially interacted with them to create harmful environments for the children. These included issues such as adverse experiences in the parents' own childhoods; a history of

criminality, particularly violent crime; a pattern of multiple consecutive partners; and acrimonious separation:

> *"Drug abuse was a factor in the Child's life with the mother associating with persons convicted of drug offences. In addition the perpetrator abused substances, displayed erratic violent behaviour and there was concern about his mental health albeit there was no diagnosis of mental ill health."*

Learning Points

- A wide range of factors in the parents' backgrounds may raise potential risks to the child. These include:
  - Domestic abuse
  - Parental mental health problems
  - Drug and alcohol misuse
  - Adverse childhood experiences
  - A history of criminality, particularly violent crime
  - Patterns of multiple, consecutive partners
  - Acrimonious separation
- These factors appear to interact with each other, creating cumulative levels of risk the more factors are present

4.2.5 Domestic abuse

Of the many risk factors identified in the parents' backgrounds, the most prominent in these reviews is the ongoing risk posed by situations of domestic abuse. This was seen as a factor in cases from all categories of serious and fatal maltreatment. It is now abundantly clear from research that living with domestic abuse is always harmful to children, and it is rightly seen as a form of child maltreatment in its own right (Humphreys and Bradbury-Jones, 2015). Many of the SCRs are populated by multiple reports of domestic abuse incidents or allegations; often in the context of vulnerable mothers with multiple, abusive partners:

> *"The mother described the child's father as controlling, jealous and unpredictable and reported instances of domestic abuse and harassment by him. Some of the incidents related to the father's denial of access to the Child… it is known that both of the mother's later partners had previously been convicted of domestic abuse related offences against their respective previous partners."*

Domestic abuse was a feature in nearly all the cases of overt filicide. In some cases this was overt violence, with multiple, often severe episodes of physical violence recorded. However, this was not always present, nor always of a degree sufficient to raise the level of concern attributed by professionals. The cases do, however, demonstrate the concept of coercive control (Stark, 2007). A picture emerged of women living with aggressively controlling men, who would isolate these women, impose restrictions on them, and control many aspects of their lives. The women would behave in ways that highlighted the fear within which they lived, but often would not disclose the abuse they were experiencing from their partners:

> *"In her contribution to this SCR, the Mother confirmed that it was the Father who accompanied her to the Hospital and that she did not disclose any abuse to the hospital staff. She said that she felt she was a long way from home, felt very vulnerable at this time, the children were not with her in the hospital and she was concerned about how she would get home if she told anyone about the truth of how she received her injuries. She said that the Father was being very controlling at the time and would not leave her on her own."*

The context of coercion and control may present significant barriers to women disclosing either their own or their children's suffering, particularly in situations where the offending partner is present:

> *"She could not understand why the hospital staff thought that she and the Father were comfortable in each other's company, as she felt that there was evidence in their behaviours in the hospital of the tension that existed between them. The Mother confirmed that she was not seen alone apart from a very brief time when having x-rays undertaken."*

This highlights the need for sensitivity in providing opportunities for women to disclose, the need for repeated opportunities and a safe, trusted environment within which women can voice their concerns:

> *"[The Midwife] asked Mother about domestic abuse and she reported that this was not an issue. Mother has said during this Review process that she does not recall being asked. It is important to continue to ask women who may be wary of telling professionals, for fear of the repercussions for themselves and any children. They may be under scrutiny from a controlling and volatile partner which causes such stress that women are not clear they have been asked. In this case there is no evidence that Mother was ever asked again."*

This control typically continued following separation, often extending to issues around contact with the children. Indeed, in some cases it was restrictions placed on the father's contact, or the fear of that, that appeared to be the trigger for the fatal incident. In some reviews there was evidence of a lack of recognition of the ongoing vulnerability of abused

women to coercive behaviour by their partners, ex-partners, or other controlling men, even after separation:

> *"As a result of Father's arrest, as far as professionals working with the family were concerned, any concerns regarding risk of domestic violence were therefore effectively eliminated."*

> *"There was significant evidence, despite [the mother's] assertions that the relationship had ended, that [the father] remained in contact with her and the children. The daily difficulties that [the mother] faced as an abused and coerced woman and the impact that this would have on her decision making, her self-identity and her ability to protect herself and the children was not understood within a framework of research informed knowledge."*

Domestic abuse was not just an issue in the cases where the perpetrator was the father, but also in at least two of the filicide cases perpetrated by mothers, in both of which the mother also committed suicide. In these cases, it is possible that the isolation, control and fear built up through the ongoing domestic abuse may have contributed to a vulnerable mother taking her own life and those of her children as the only conceivable escape from her situation.

In accepting the reality of coercive control as the dominant issue in domestic abuse, we have to recognise that it is usually women in a relationship who are the victims of men's controlling behaviour. However, coercive behaviour may also be exhibited by women on their partners, or, to different extents by both partners in a relationship. An uncritical attribution of control to a male partner may lead to gender bias and a failure to appreciate the full complexity of a relationship. In the following example, a psychiatrist recognised the coercive behaviour of the mother in the context of significant ongoing mental health needs:

> *"It is significant that this psychiatrist who knew mother better than most identified her as being the aggressor as opposed to her partner."*

There has been considerable progress over recent years in recognising the harm caused to children through all domestic abuse, with systems put in place to enable women to disclose domestic abuse, to identify the risks to children, and to refer and assess cases where there are children in the family. This was evidenced in much of the good practice observed in many of these SCRs, for example in the assessment of the detective constable in one case who undertook a further risk assessment following a mother's decision to retract her statement:

> *"[The officer's] assessment is robust and shows a good understanding of the risk factors associated with domestic abuse cases… The officer notes [the mother's] statement that she did not intend to reconcile with [her partner] but is clear that he doubts this represents the reality. It concludes with a strong recommendation to*

proceed to charging, via the CPS, irrespective of [the mother's] retraction and the officer also identifies that there are safeguarding implications."

One of the limitations observed in several serious case reviews, however, was the impact of an incident-focused approach to domestic abuse. Police officers would respond to specific domestic incidents, assess any risks to the children as a consequence of that specific incidence, and act in accordance with that assessment. While relevant to that incident, this approach does not recognise the ongoing controlling nature of domestic abuse, nor the daily reality with which women and children are often living and the harm caused even in the absence of any physical violence, as in the following case:

"The Police in their investigations of the domestic abuse incidents did however give attention to the part that the male partners played in each incident, sometimes resulting in his arrest for related offences. The purpose of Police involvement was to resolve the particular incidents as they arose and to ensure no immediate recurrence of violence, (which they generally effectively undertook), rather than to develop a longer term view about the role of the father/male partner in the family."

Working within an incident-focused model carries the risk of harm to children continuing unabated for long periods of time, and ignores the huge damage that will already have been done to the victims by the time any action is taken. As Stark (2007, p.218) comments, 'A growing consensus favours intervention in relationships where there is extreme violence, stalking, or an injury to a child. But by the time abuse reaches this point, coercive control is likely to have severely eroded a woman's personhood from the inside out, the way carpenter ants devour a house.' This was demonstrated in the following case, in which a child, who subsequently died of natural causes, had lived, with his siblings for many years in an environment of ongoing harm:

"However, there were five referrals to children's social care due to domestic abuse and parental alcohol misuse between 2007 and 2012. The referrals do not appear to have been recognised or responded to as a significant pattern of risk and harm. [The mother] and the children continued to live with the impacts of domestic abuse and [the father's] alcohol dependency for a further 5 years before the children were made subjects of a child protection plan."

One of the real difficulties experienced when confronted with situations of possible domestic abuse is how to respond when a woman retracts or refuses to pursue an allegation of abuse. In such situations, the police may have little to proceed with in bringing charges, but may still have serious concerns about the welfare of the woman and any children. The recent introduction of a new offence of controlling or coercive behaviour in intimate or familial relationships in the Serious Crime Act, 2015, should help to move things forward, and needs to become embedded in the thinking and action of professionals in response to domestic abuse.

Similarly, professionals need to recognise the extreme difficulty for any woman living in a situation of domestic abuse to effect any change, including the difficulties of moving out of a controlling relationship:

> *"Potentially the health visitor could have given stronger advice about how difficult it is for women to extricate themselves from abusive relationships, and perhaps directed her to receive further advice and support from a more specialist service, such as a Women's Aid service."*

Often in such situations women may seem to act in ways which, to professionals, may appear inconsistent and potentially harmful, but could be understood very differently when appraised in the light of coercive control. When, for example, a pregnant mother discharged herself from hospital against medical advice and appeared to be acting against the best interests of her unborn baby, she may actually have been doing her best to protect her older children who were at home in the care of her controlling partner.

Given these difficulties, professionals should always be cautious in accepting assurances from a mother that a known violent partner does not present any risks to her children, or that circumstances have changed. While individuals may indeed change, such change is probably the exception rather than the rule, takes time, and may be difficult to have complete assurance about. Women may minimise the risks experienced by themselves and their children in response to threats and coercion from their partner, or as a means of minimising the harm their children may suffer. Furthermore, while a mother may be correct in believing that her partner would not physically harm her child, this does not acknowledge the severe emotional harm suffered by the children from living in a household where controlling behaviour is the norm, or the potential risks where a controlling partner does not get his own way. This was highlighted in the following SCR in which there was copious evidence of ongoing domestic abuse:

> *"[The mother] contacted the community midwife and did disclose domestic abuse in her relationship but claimed that [her partner] was never violent to the children. A referral should have been made to [children's services] and [the mother's] assurances that the children were safe should not have been taken at face value. This reflected an inappropriate professional view that domestic abuse was not a child protection issue."*

There was evidence in some of the reviews that professionals continue to attribute blame to mothers for the harm their children suffer, and to place the responsibility for protection on the mother herself, rather than recognising the responsibility of the offending partner:

> *"[The mother] was reluctant to take out an injunction against [the father] and although [the mother] had attended the Domestic Abuse Freedom Project, her understanding of the impact of domestic abuse on the children's overall development and emotional wellbeing was felt to be still questionable as she had continued to allow [the father] to have contact with the children."*

Learning from these serious case reviews, it is our view that a step-change is required in how we as professionals and as a society understand and respond to domestic abuse. We need to move away from incident-based models of intervention to a deeper understanding of the ongoing nature of coercive control and its impact on women and children. There is now substantial research to back up such a shift (see for example Holt, 2015; Humphreys and Bradbury-Jones, 2015; Katz, 2015).

As part of this shift, we need to acknowledge that change is hard to achieve in these contexts, and it is likely that ongoing monitoring and support will be needed. In light of this, it is important that professionals take seriously any disclosed abuse, and take responsibility for acting on any disclosures, not leaving it to potentially vulnerable victims to act for their own or their children's protection.

Similarly, when working with cases in which domestic abuse is a feature, it is essential that the abusive partner is included in the assessment and planning, not leaving the responsibility for protection solely in the hands of the mother. This requires a robust level of challenge to abusive partners to take responsibility for their actions, and where they are not doing so, the recognition that the child will remain at risk.

Learning Points

- Domestic abuse is always harmful to children
- Any evidence of domestic abuse in a relationship in which there are children should prompt a careful consideration of the harms those children are suffering and how they can be effectively protected
- Domestic abuse should not be seen solely in terms of violent incidents, but consideration should be given to the ongoing contexts of coercive control and the impact of these on the parent and children
- Professionals should not rely on victims of domestic abuse to act for their own or their children's protection
- Controlling behaviour may continue to pose risks to mothers and children, even following separation

4.2.6 Acrimonious separation

Violence to the child, or children, following an acrimonious separation of the parents was apparent in 25 (15%) of the 175 SCR final reports; and was particularly pronounced (36%) in the group of children aged 6-10 years. Such acrimonious separations may be a reflection of the underlying coercive control present in situations of domestic abuse and which may continue following separation. In many cases there were ongoing issues

around contact and residence. Often this came to light through private family law proceedings, and in some cases it was a court case, or pending court case, that appeared to have been a trigger for parental filicide.

Even when the parental separation was not noted in the final report as being particularly acrimonious, it was clear from a number of reports that the effect of separation on the child could be hugely damaging, and lead to emotional and behavioural problems for the child subsequent to the separation:

> *"Whilst mother, father and the then three children might have appeared to be a traditional nuclear family, the impact of innumerable parental separations on the children's sense of security and identity, remained largely unexplored. Given mother's impulsivity, hostility and aggression, it can reasonably be assumed that each such separation would have been accompanied by a good deal of noisy and probably aggressive argument."*

The impact of parental separation may be even more marked where a mother has multiple partners over time, offering little stability in the child's life. This may be particularly so where the impact of separation is compounded by violence, aggression or control on the part of either parent, or where the mother herself is a victim of repeated domestic abuse.

Learning Points

- Any parental separation carries the potential for harm to the children involved; this is particularly the case where there is acrimony in the separation
- Family law courts should consider the impact on the child of any contested proceedings, contact arrangements, or parental allegations and counter-allegations: the children will always be victims in such battles, and their rights and needs should always come before those of either parent
- Acrimonious separation and contested proceedings may be warning indicators of possible future serious or fatal harm to the children

4.2.7 Parental mental health problems

Many of the cases, in all categories of serious and fatal maltreatment, specifically indicated mental health problems in the mother, father, or both. However, it is important to note that, in contrast to situations of domestic abuse, which are always harmful to children, the presence of parental mental health problems does not, in and of itself, necessarily indicate any risk of harm to the children. Thus, in these cases, there were always other factors that indicated that the child may be at risk, whether it was the

extreme nature of the parental mental health problems, expressed suicidal intent, or intent to harm the child; the co-existence of mental health problems with domestic abuse or substance misuse; or wider family and environmental factors such as social isolation.

In some cases of overt filicide, this included specific indication of suicidal intent, including previous suicide attempts, or threats to take their own life; or one partner expressing concerns that the other might take his/her own life or that of the child(ren). In one case in which a mother took her own life and that of her child, there was evidence of maternal mental health problems and substance misuse, but no indication of any domestic abuse or other concerns in relation to the father; in the other cases involving mothers as perpetrators, domestic abuse featured strongly. In most of the cases involving fathers as perpetrators, there were indications of paternal mental health problems interacting with known violent behaviour or a previous criminal record:

> *"The father took an over-dose … and attended [the emergency department] and was noted to have family problems … mother attended [the emergency department] following an overdose. A clear intention to die was evidenced in three suicide letters."*

> *"The Father was formerly a soldier, who during his time in the Army had received injuries…Both the Father and the Mother had previous marriages which had ended in divorce, with the Father needing to be prescribed anti-depressants by his GP at that time in order to help him manage any associated stress. He was again treated with anti-depressants…during a period of marital difficulties."*

Learning Points

- Parental mental health problems should not be seen, in and of themselves, as necessarily harmful to children
- Where there are indicators of an escalation in the severity of mental health problems, any indicators of delusional thought patterns towards the children, or where a parent expresses thoughts of self-harm, or of harming her or his children, these should be taken seriously and should prompt an urgent consideration of the safety of the child
- Where parental mental health problems co-exist with other risk indicators, particularly domestic abuse, but also including drug or alcohol misuse, or social isolation, this should prompt a further assessment of the child's safety

4.2.8 Bereavement and loss

Bereavement, separation, loss or fear of loss in the family was a feature in some of the cases reviewed. In one case, it was the death of [the mother's] father that appeared to tip the balance for her, and she took her own life and those of her two children:

> *"[The mother's] father died of a heart attack. [The father] described this tragedy as unsurprisingly having a huge impact on his wife, telling the Police Officers that interviewed him after her death, that from this point she changed, "bottling up her emotions" and becoming withdrawn."*

Another maternal filicide-suicide had taken place in the context of a recent child protection investigation in which the mother clearly had fears that her children might be taken from her:

> *"Several of those we spoke with indicated that while [the mother] was able to display this positive aspect, because of early interactions with children's services, she was in fear that if she did not do what was expected of her, her children might be taken back into the care of the local authority."*

Learning Points

- Any bereavement, loss, or threat of loss may lead to increased parental vulnerability and stress, which may be a trigger point for harm to a child

4.2.9 Parental criminal involvement

Entrenched criminal activity by one or both parents was a feature in a number of serious case reviews, and such activity was a risk factor for serious or fatal maltreatment. Among offences, those relating to drugs were most commonly cited, including possession and intent to supply:

> *"Father was serving a sentence for possession of class A drug … the address was well known to Police because a number of [father's] associates were known drug dealers."*

Drug dealing could be taking place in the house where the child was living, putting the child in danger. One final report mentioned that:

> *"A large quantity of drugs was found in [mother's] bedroom, a bathroom and in a drawer in the bedroom where [four year old child] was sleeping."*

A typical pattern of crime included drug offences, burglary, criminal damage, assault including domestic abuse, wounding with intent and, on occasions, firearm possession:

> *"[The father was sentenced to an extended sentence for public protection, which took account of robberies committed during the period of his relationship with [child's mother]. He asked for 256 other offences to be taken into account."*

> *"Between February 2006 and May 2010 there are 30 entries on the police national database [for mother] relating to robberies, shoplifting and theft."*

A custodial sentence removes the parent from the family, which may be a temporary protective factor for the child(ren). For other children it might remove that parent's care and financial contribution to the family, as well as any meaningful presence in the child's day-to-day life. A child in one of the SCRs had, according to her mother:

> *"Affection for her birth father. She has described visiting him 'in a castle' (possibly a reference to the Prison where he spent time on remand)."*

Wider family members could also pose a risk of harm to the child through their criminal activity. One final report noted that several family members, including an uncle and maternal grandfather had a violent criminal history, while another report cited a paternal grandfather who had:

> *"Been arrested on 7 occasions, 5 in relation to drug offences of possession and intending to supply and also for burglary and criminal damage."*

4.3 The wider family and environmental context

As has been identified in previous biennial analyses and other research, there are a number of wider issues in the social and physical environment within which the child is growing that contribute to a context within which the child may suffer harm. Most notable in these are issues around housing and transient living conditions, social isolation of the family, social deprivation, and disrupted engagement with education.

4.3.1 Housing issues

When families present with housing needs, whether as homeless or through inadequate or poor housing, there are additional stresses, which are likely to adversely impact on the health and wellbeing of any children.

There were issues identified in one SCR around GP registration for families experiencing multiple moves. This meant that one mother had not been seen by a GP, a factor that may have increased the vulnerability of her baby. In this case, the mother's move also led to a breakdown in information sharing, such that pertinent information was not shared with the midwifery team in the new area:

"Mother reported when interviewed as part of this Review that she was unable to register with a General Practitioner (GP) because she lived in temporary/holiday accommodation."

"[Mother] informed the Midwives that she would be moving to [the new area] where she would access antenatal care. There is no evidence that information was shared with the Midwives in [the new area] as would be expected."

Housing can also present challenges to young people who either choose or are forced to move out of home. It is essential that young people are supported through this, and that there are good systems for communication between the housing providers and other services:

"The move from the supported lodgings placement to the unit in another town was not managed as well as it should have been. This was for a number of reasons. Firstly the move was an 'emergency' and had to happen earlier than had been planned. The placement broke down because the supported lodgings carer had a number of personal issues which meant [the young person] could not stay. This meant there was no handover meeting between the previous carer and the unit, as would have been expected practice. This meant that the useful information held by the carer, in regards to [the young person's] diabetes, was not passed on."

In the above case, the young person was in supported accommodation, but there was a gap in engagement, which meant that no staff had seen him for the six days before he died. There was a lack of clarity over who carried responsibility for responding to the young person's needs, a feature in other SCRs we have looked at.

Additional housing challenges may arise for immigrant families, creating stresses, adding to poverty and undermining the health and safety of the children. It is important therefore that the housing needs of these families are not overlooked:

"Due to both adults' immigrant status … the family were not entitled to key state benefits ... It was therefore clear that the family were going to struggle to maintain a basic level of existence although professionals seemed not to appreciate the pressures that this could bring upon a family. When the family were about to be evicted, which was not the first occasion, the only advice given by the social worker was to contact Citizens Advice Bureau."

4.3.2 Transient lifestyles

Several serious case reviews involved families who appeared to live a very transient lifestyle, with frequent moves and little sense of attachment to any geographical location or community. This has the potential effect of creating an environment in which the child experiences little stability and can, as a result, have few ongoing relationships with potentially caring family members or others:

"The Child experienced a transient lifestyle residing at numerous addresses… predominantly with maternal grandparents but also with extended family members and alone with mother. Hence there was very little stability in the life of the Child with the only consistency seeming to be the relationship with the mother and maternal grandparents."

Numerous moves and a transient lifestyle often overlap with a context of multiple, often violent, partners, who may also be caregivers, to create a damaging environment for the children, as seen in the following case:

"Clearly one of the main experiences of the children… was in relation to a chaotic lifestyle, with many house moves, and numerous incidents of serious domestic abuse and violence within the home. The domestic abuse also related primarily to three different men, although to what extent the children formed any meaningful attachments to them was not known."

Learning Points

- Insecure and inappropriate housing causes additional stress to families, and can adversely impact on the health and wellbeing of any children
- Young people require stable housing, where they can feel adequately supported
- Families who appear to have a transient lifestyle or families from abroad, with few geographical or social connections, may be particularly vulnerable

4.3.3 Social isolation

Some families in these reviews appeared to be somewhat isolated from their wider family and community, and as a consequence, little was known about the children's lives in these families:

"As well as the social disadvantage associated with the family's relative poverty and limited accommodation, alleged anti-social behaviours alienated them from what might otherwise have been sources of support such as good neighbours. Whilst practitioners at times raised questions about the allegations of anti-social conduct, denials seemed to have been accepted at face value rather than pursued on the basis that local tensions would impact on the children's welfare."

While family, including the extended family, are usually a supportive and protective element in a child's life, for others the wider family context can instead present additional

risks. It is important that professionals work with the extended family where they can, but that they are alert to the fact that not all family networks will be supportive:

> *"Mother has family living nearby: her own mother, father, and maternal grandparents. There is a history of alcohol misuse and violence in this family, including towards Mother as a young adult. Thus, although family members have offered practical help to her and the children, including in the critical post-natal period, their input has not always been positive and supportive."*

What is essential in working with any extended family is not to make assumptions about their presence or how supportive they may or may not be, but to test those assumptions through appropriate evidence gathering and assessment.

Social isolation was a particular issue in relation to a number of immigrant families in these reviews, where mothers in particular appeared to be relatively cut off from the community and sources of support:

> *"There was only partial recognition of [the mother's] vulnerabilities in relation to a number of circumstances: her arranged marriage; her suggestion that the pregnancy was not wanted by her; her husband's learning difficulties; her abusive and controlling father-in-law; her isolation after leaving Area 4; financial issues; her immigration status and her need for support from her own family in Area 3."*

Working with immigrant families can present particular challenges in connecting with services and the wider community, often due to the lack of a shared language and/or culture:

> *"On occasion the children were used as interpreters when professionals needed to speak to Mother. On a number of occasions however interpreters were used by health and children's social care staff, and this helped in the understanding of the issues for the children in this family. The Police have used [language]-speaking police community support officers. Mother was also aware that she could telephone the police and speak to a person who was fluent in [her language]."*

Providing interpreters to enable the 'voice' of family members to be heard and understood is a necessary requirement in order to fully assess the needs of the family and to identify explicit and implicit safeguarding issues. It is also important to enable information sharing between families and agencies and to build relationships that can further enable and encourage social inclusion. Other issues identified from analysis of the final reports included cultural expectations of children and parenting, discipline, disrupted attachment and isolation:

> *"When the family moved to England, [the child] remained in the family's country of origin in the care of grandparents and joined the family in England in early 2013 [when he was two and a half years]. Through the support of an interpreter, [the*

mother] advised that her mood was low because of the separation from [her son] and that she was finding being a parent lonely and difficult without family support and a husband who worked long hours."

It is clear from a number of SCRs that cultural issues can present barriers to adults accessing appropriate services. It is therefore crucial that front-line services are aware of which services are available in their area and are able to appropriately signpost these to families:

"The IMR suggests that cultural issues could potentially have prevented [the mother] from seeking further help or advice. It is known that the GP gave [the mother] a Children's Services telephone number to ring for advice. It would have been more appropriate if details had been given of culturally appropriate services which are available in the local community."

Learning Points

- Professionals should be alert to the social networks available to parents with whom they are working
- Where a family appears to be socially isolated, this should prompt an appraisal of the safety and wellbeing of the children in that family
- Where extended family is available it is essential not to make assumptions about how supportive they may or may not be
- Immigrant families may find themselves particularly isolated due to the lack of shared language and/or culture

4.3.4 Challenges posed by social media and virtual relationships

Social media now present a way for young people to connect with peers and feel socially included. While being an integral part of life for the older children at the centre of the reviews, the use of social media does pose a number of challenges, which can increase their general vulnerability. Various issues are apparent in the set of SCR reports for 2011-14 which were not evident in our earlier biennial reviews, dating back to 2003. The internet provided opportunities for grooming, for bullying and the exchange of inappropriate photographs, and for access to information and items to purchase. Agencies, schools, organisations and parents could find it difficult to keep up to date with social media developments, and know how to respond to these new challenges.

Reviews indicated that social media provided a (relatively hidden) opportunity for adults to communicate inappropriately with children, for example between a teacher and a pupil. Schools were unprepared as to how to deal with this effectively:

"School had previous similar incident (using social media to groom pupils) but this had not resulted in heightened awareness or lessons learnt."

One young person who was subjected to bullying through the internet and social media had:

"*Made allegations to the police of being coerced to pose naked on a social media website."*

For young people with few friendship groups or close friends, social media could provide a network of on-line contacts and acquaintances, but rather than being supportive these contacts could instead pose a threat:

"The police had intelligence to suggest that in the two or three weeks before his death, [the young person] was receiving threats via social media."

One teenager was lured via social media to an isolated location with the promise of a job, and was subsequently murdered; social media had provided the opportunity for the perpetrator to make initial contact a few days before he murdered her. She had on prior occasions made contact with older males in a similar manner.

A further review concerned a young person who had used the internet to browse websites about explosives, and had made online purchases of explosives:

"[The mother] rang the school to say that she was concerned about [the young person] who was buying chemicals over the internet … Intelligence was received by the police that [the young person] was expressing a desire to kill people and was researching this online."

Learning Points

- The internet can allow inappropriate relationships to develop which are harmful to the young person
- Such interactions are hidden, and difficult for parents, teachers and other agencies to understand and monitor

4.3.5 The role of education in safeguarding children

One of the striking findings in this review was a relative paucity of comment on the role of schools in the safeguarding process. Far more emphasis seems to have been given to the role of health and social services as key agencies in children's welfare. In part this may reflect the age distribution of the cases outlined in Chapter 2: 63% of children in these reviews were aged five years or less; a further 14% were over 15 years, many of

whom were likely, due to their adverse circumstances, to no longer be in school. Thus only a minority of the children in these reviews were actually of school age.

Nevertheless, schools and early years education services do play a crucial role in children's welfare and have important responsibilities in relation to safeguarding. All children have a right to an education (Article 28 of the UN Convention on the Rights of the Child); thus those children who are denied an education, whether through parental actions, or through various forms of exclusion, are being denied a fundamental right. As a universal service accessed by nearly all children of school age, schools can provide a setting within which children can be safe and nurtured, and where indicators of maltreatment may come to light.

In these SCRs we did see evidence of good practice on the part of many schools in relation both to the index children and to siblings. There were, however, a number of issues which highlighted children's vulnerability and opportunities for education staff to intervene to protect children or prevent harm.

4.3.6 Non-engagement with the education system

Poor School Attendance

Factors which may increase a child's vulnerability to harm are poor school attendance, exclusion from school, and unmonitored home education in inappropriate circumstances. Attending school has the potential to decrease the child's social isolation, and to increase opportunities for development, as well as providing respite from everyday difficulties at home.

Erratic school attendance was observed in several of the cases, including the following instances:

> *"The school attendance service began making inquiries with the police about four of the children; this included [the index child] who had never been enrolled for education… [The school's] pastoral manager reported her concerns to the school's named person for child protection when [one of the sibling's] attendance had dropped to 51 per cent and despite letters and phone calls from school they had been unable to make contact with home."*

> *"The IMR challenges the fact that the school attendance for all four of the children other than Child C never increased over 50%. [The] Local Authority have introduced new procedures to include Local Authority investigations when school attendance falls below 80% irrespective of the provider of the education welfare function. This would appear to be an appropriate and robust response to the issue raised in this IMR in relation to the overarching role of the local authority."*

In the latter case, the findings of the serious case review had led the local authority to review and revise its procedures around poor school attendance, recognising this as an opportunity for intervention to protect children.

Home education

One area where parental beliefs and practices may potentially put children at risk is in relation to their education. This may arise both within mainstream education, where, for example, a parent has very different views of a child's needs from those of the school staff or other professionals. It may also arise when a parent chooses to home educate their child. While in most situations such home education is a legitimate parental choice and will be effective and nurturing, there are situations where the level of education provided within the home setting does not meet the child's needs, or where the choice to home educate is in fact a guise to remove a child from public scrutiny, or a further component of neglect or emotional abuse of the child. This was seen in one SCR, where there was no evidence that the child was receiving any effective education:

> *"On two occasions (one of which was prior to the period covered by this review) [the father] chose to home educate one of the children. On both occasions, the elective home education officer determined that the standard of education being provided was ineffective and recommended a return to school."*

We looked in detail at four cases where the child or children were home educated. In three of the cases the children had attended school at some point but were home educated at the time of the death or harm. In one case, the children appeared to have been home educated since reaching school age. Three cases involved serious harm and one case was fatal. The ages of the children ranged from 7 to 16 years old.

There were many similarities between the cases which included:

- social isolation
- parental deception /concealment from professionals
- combinations of neglect and abuse
- professional uncertainty
- awareness within the community of the child's situation

Social isolation was sometimes a consequence of a deliberate attempt to keep the child out of view. In one case a mother ensured that the father of her child did not have contact by changing the child's name by deed poll and moving around her local area. Moving between local authorities, deliberately or otherwise, could make it difficult for agencies to monitor the child's wellbeing. In another case, a group of siblings who lived in a traveller community were socially isolated as there was little integration with the wider community.

Parents at times were untruthful, or intentionally withheld information from professionals. An example was when a father did not inform the education officers that his children had

actually been attending mainstream school until their move to a new authority when he consequently decided to start home educating them. This meant that the education officers were under the impression that it was an ongoing, not a new, arrangement.

In all of the four cases there had been referrals to children's social care due to concerns about abuse and neglect, but the cases did not always reach the level of child in need and none of the cases reached the level of child protection. The abuse experienced by the children included longstanding sexual and physical abuse which might have been noticed had the children been within a school setting. Neglect had resulted in some children appearing underweight and generally unkempt, again a sign which could have alerted teachers, had they attended school. School staff would have been in a good position to challenge decisions made by children's social care not to intervene.

It is not home education per se that is the issue here but the isolation from peers, teachers and agencies who could provide a protective function, and if any abuse or neglect is present this may continue undetected for prolonged periods. When parents of home educated children cooperate and demonstrate the progress of their child, the involvement of education officers may provide enough monitoring of the child. If there is no requirement for any professional to see a child who is being home educated, or to scrutinise the quality of their education and welfare in the same way as would be expected in a school, any deficits will not be picked up. This can be compounded if the parents also choose to opt out of universal health services for their child.

In these four cases parents appeared determined to disengage with agencies. Therefore the disengagement is the issue rather than home education which was providing a potential avenue to hide children from safeguarding agencies. On the other hand, there were opportunities for those staff supporting home education to be alert to possible vulnerabilities or risks within the home, as was demonstrated by the home education officer in the case below:

> *"The elective home education officer visited the family home regarding one child's education and subsequently contacted [children's social care] to express concern about the condition of the home, especially with a baby due. This included a report that the house contained a pigeon, hamsters, a rat and two dogs."*

Managed moves and exclusions

It was surprising to find that some reviews did not specifically explore the education experiences of the adolescent group, perhaps because they were no longer of compulsory school age or as a reflection of the way education was viewed by many of the professionals who were struggling to manage the behaviour of the adolescents which often placed educational experiences and needs as secondary. For young people looked after by the local authority, who experienced a series of different placements, educational aspirations were sometimes low and not a priority:

"The many placement moves did not help and although it was formally recognised that education was an important contributor to long term outcomes, it was always a secondary consideration in any placement change decision."

Children who did not move geographically, at times experienced 'managed moves' between schools when their behaviour became too difficult to manage, in an attempt to disrupt behaviour patterns and some potentially damaging relationships with their peer groups. Given that the purpose of a managed move is to reduce the chances of exclusion and give children a fresh start, the strategy did not always appear to serve that purpose.

One review pointed out that government guidance *Exclusion from Maintained Schools, Academies and Pupil Referral Units* (DfE, 2012, p.6) advises school leaders that: *'A pupil can transfer to another school as part of a 'managed move' where this occurs with the consent of the parties involved, including the parents.'* Managed moves should be viewed as a piece of preventative work to support pupils at risk of exclusion and a strategy to promote the reduction in numbers of pupils being excluded in mainstream schools. Instead, managed moves could paradoxically be *"unstructured, not conducive to effective transition, not child centred"* and also ineffective. When 'managed moves' were not successful, or did not take place, exclusion became the alternative to coping with disruptive behaviour and one report makes it clear that not enough emphasis was placed on exploring the possible causes of the behaviour and subsequent need for exclusion:

"The focus of the advice was on whether the exclusion was compliant with legislation and procedural guidance. A more child centred approach would have explored the underlying circumstances and reasons and created opportunity for the views of [young person] and family being included."

Some schools were more pro-active in seeking advice from other agencies and exploring their options in light of more detailed information about the child and events. In one example the school decided that the support and protection that school could provide for the young person was better than the isolation that exclusion would cause. This was helped by the assessment that the young person presented a low risk at school. The school was able to raise the young person's attendance by carefully listening to and respecting his wishes:

"School 2 were excellent in their handling of the young person; taking a child who had refused to go to a previous school for a number of months and helping him to achieve nearly 100% attendance and 9 GCSEs (in under two years) was a remarkable achievement. This appears to have been achieved by finding out what he wanted and respecting that."

The effect of an exclusion, especially a permanent exclusion, can be devastating for young people who are already struggling with complex difficulties as in the case below when a young man is excluded from his place at a training centre:

"This staff member was aware from earlier contact with [young person] that he was very anxious about being excluded from the training centre and that he felt he was being treated unfairly. It was upon return to the unit that he was discovered hanging from the staircase."

For young people with challenging behaviour there is evidence of little attention to support in planning their future, including career planning, which left the future perceived as uncertain and insecure by the young people:

"Agencies were reacting to the immediate challenges that [young person] presented rather than taking a longer-term approach based on a full assessment, in the context of his personal history, or his current and future needs."

Learning Points

- Children who are not regularly in school, due to poor attendance, home schooling or exclusion, can be vulnerable due to their 'invisibility' and social isolation
- Where neglect or maltreatment is already occurring, absence from school increases the child's vulnerability
- 'Managed moves' have the potential to damage supportive and established relationships with peers and teachers

4.3.7 Social deprivation

As highlighted in Chapter 2, there was some indication of a slight correlation between markers of deprivation and the number of SCRs carried out by individual local authorities. This relationship was, however, weak, and we have not been able to test it at an individual level.

Nevertheless, in some of the reviews, issues around social deprivation and financial needs were raised, suggesting ongoing stresses for the parents:

"Several of the agencies recognised that the family, which was reliant on state benefits, were living under financial pressure in a community where financial and social disadvantage was widespread."

The impact of poverty may particularly be manifest through inadequate housing and the additional stresses this places on families. This was identified by workers in the following case, and led to a positive, though unfortunately limited, response to try and support the family:

"The provision of a [temporary] flat was fortunate: the assessment officer commented this is often not available and families are then placed initially into Bed and Breakfast accommodation. The fact it was on the 4th floor without a lift is recognised to be far from ideal, but reflects the scarcity of temporary accommodation."

The stresses for parents in trying to care for children with inadequate resources should not be ignored, and there is substantial evidence that poverty adversely impacts on children's health and wellbeing, including child death (Pickett and Wilkinson, 2007; Spencer, 2000; Wolfe et al, 2014). Children and families are among those most affected by the recent economic downturn, and this looks set to continue. There is a clear policy imperative here: in the words of the Social Mobility and Child Poverty Commission,

> *'The impact of welfare cuts and entrenched low pay will bite between now and 2020. Poverty is set to rise, not fall. We share the view of those experts who predict that 2020 will mark not the eradication of child poverty but the end of the first decade in recent history in which absolute child poverty increased.'* (Social Mobility and Child Poverty Commission, 2014 [10])

However, the fact that in some cases socio-economic disadvantage was highlighted as an issue does not, by any means, imply that it is only families living in poverty or deprived circumstances that are at risk of serious or fatal maltreatment. In a number of the serious case reviews we examined, there were suggestions that these were well-off families, often professional parents, with good social circumstances.

Learning Points

- There is substantial evidence that poverty impacts adversely on children's health and wellbeing
- Child maltreatment, including serious and fatal maltreatment, occurs across the social spectrum and is far from limited to those families living in poverty or social deprivation

[10] Transcript of speech 14.11.2015 https://www.gov.uk/government/speeches/state-of-the-nation-2014

Chapter 5: Adolescent suicides and child sexual exploitation

Although the majority of adolescents navigate the transition to adulthood successfully, they mostly do so in a supportive environment which is conducive to building resilience. For some adolescents, that support is not available. In the serious case review population, adolescence, as a specific stage of development, presents particular risks of death and serious harm. In this triennial review suicide and child sexual exploitation have most prominence as they represent two growing areas of concern but within these two types of death and harm it is important to remember that polyvictimisation is a common experience for all adolescents where a serious case review has been undertaken (Finkelhor, 2008; Radford et al, 2013). In this respect adolescents are a vulnerable population with 50-60% estimated in community surveys to be exposed to violence, drug and/or alcohol misuse, or self-harm (Herbert et al, 2015). These adverse experiences are associated with underlying psychosocial difficulties and often remain unresolved.

Young people's early experiences influence their development over time and abuse and neglect in the early years presents an increased risk that they will go on to develop more complex, challenging and often entrenched problems. This has been apparent in earlier serious case reviews (Brandon et al, 2012).

This chapter is structured into a summary of adolescent cases within the 11-18 age range with a particular focus on, and discussion of, suicide and child sexual exploitation. The ecological-transactional approach employed in the previous biennial reviews (Brandon et al, 2009) was used to develop emerging issues by considering the impact of the young person's experiences on their development and relationships with family and professionals as well as the impact of wider system issues on professional responses and the young people.

5.1 Case characteristics of the 11-18 year olds

The cases studied in greater depth here are taken from the available 175 final SCR reports from 2011-14. There were 46 reports concerning young people aged eleven and over. A further three reports discussed in this chapter related to historic sexual exploitation[11]. There were 32 deaths and 17 cases of serious harm. The nature of the death and harm suffered is set out in Table 25 below.

[11] The three 'historic' cases were strictly outside of the timeframe, and are therefore not in the statistical analysis. They were notified in 2011-14 but related to events prior to that. The cases had not been included in our earlier biennial reviews (since they had not been notified at that stage). It was, however, important to capture the learning from these events.

Table 25: The nature of death and serious harm in the 49 adolescent cases

Fatal cases (32)
Seventeen cases of suicide or suspected suicide
Three cases where the death followed risk-taking behaviour
Four cases involving young people killed by someone outside the family (two of these cases were associated with child sexual exploitation)
Two cases involving young people killed by their fathers
One case involving a young person killed by the partner of a family member
Four cases where neglect of chronic health conditions was a factor
One case where neglect was considered the primary factor (many of the other cases also had neglect as a factor)
Non-fatal cases (17)
Four cases involving sexual abuse (two intra-familial and two extra-familial)
Five cases with elements of child sexual exploitation – three of which related to historic sexual abuse
Four cases which are attributed to neglect
Three cases where the young person is a perpetrator
One case where serious harm was as a result of risk-taking behaviour

Thirty (65%) of the 46 young people[12] from the 2011-14 SCRs were currently receiving services from children's social care as 'open cases', and a further nine (20%) had received services in the past but were now 'closed cases'. As we reported in Chapter 4, approximately three quarters of this group of 46 young people had experienced mental health problems, and over 40% were using drugs – a proportion which rose to 60% among those who were aged 16 or older.

We decided to explore in more detail all the seventeen final reports relating to young suicide within the 11-18 age group, as this was the largest single cause of death. Six of the young people were aged 13-15, eleven were 16 or 17 years old, and twelve were male.

[12] The three historic cases could not be included in the statistical analysis of the incidents from 2011-14

We also chose to look in detail at seven final reports relating to, or having elements of, child sexual exploitation as the subject had previously received limited attention in biennial SCR analyses, and the issues raised by child sexual exploitation are of growing concern in policy and practice. Two SCRs concerned a death and the other five were cases of non-fatal serious harm. All those mentioned in the final reports, and selected for the purpose of the SCRs were girls; it may be that boys were also part of the large numbers being sexually exploited, but none of the SCRs addressed the sexual exploitation of boys or young men. The majority of the young people at the centre of this set of final reports were under the age of sixteen. A number of other high profile serious case reviews into sexual exploitation had not been completed by the late autumn of 2015, and were therefore not available for inclusion here.

While there are many parallels between the suicide and CSE cases and the young people's experiences and vulnerabilities, including their experiences of practice responses, the following two sections will address each group in turn.

5.2 Adolescent suicides

Adolescent suicide is influenced by the intersection of biological, psycho-social, environmental and cultural factors. Suicide has an associative but non-causal link with self-harm, and those who deliberately self-harm have a risk of suicide some 30 times greater than the general population (Cooper et al, 2005). Antecedents to self-harm and suicide in adults have been found to include early loss or separation from parents, difficult relationships with parents (including rejection) and abuse in early life (sexual, emotional and physical) (Horrocks and House, 2002). A suicide becomes a notifiable incident when a young person dies through suicide and abuse or neglect is known or suspected, the young person is looked after or in a regulated setting or service (HM Government, 2015).

Suicide is a tragic outcome for any young person and clearly few adolescents who have experienced adversity will end their lives. Some adolescents may convey their distress in other ways such as through risky behaviour, self-harm, drug and alcohol misuse and mental health problems, ultimately leading to early death (Devaney et al, 2012). Therefore, the life trajectories and histories of adolescents who commit suicide are likely to be similar to those of adolescents who express their unhappiness through other types of high-risk behaviour.

In this section we explore the context of the young people who took their own lives. Table 26 below sets out some of the common characteristics of the seventeen young people's circumstances and paints a picture of complex issues both during early childhood and teenage years. The characteristics include: parental substance misuse and domestic abuse; parental conflict and separation; time spent in care of the local authority or detained in secure units, including Tier 4 metal health services; going missing and becoming homeless; involvement (at the time of death) with children's social care (CSC);

mental health problems including self-harm; involvement with children and adolescent mental health services (CAMHS); substance misuse by the young person; experiences of being a young carer and involvement with the Youth Offending Team (YOT). Despite the many difficulties encountered the table also demonstrates that at the time of death, only just over half of the young people were actively involved with children's services whereas the vast majority had involvement with CAMHS.

Table 26: The circumstances of the adolescents who died through suicide

Parental DV, substance misuse	Parental conflict/ separation	In care/ detained	At home	Going missing/ homeless	Case open to CSC at time of incident	MH, self-harm, suicide attempts	CAMHS	Substance misuse YP	Young carer	YOT/crime
*	*	*		*	*	*	*	*		*
*	*	*		*	*	*	*	*		*
	*	*		*	*	*	*			*
	*	*		*	*	*		*		*
*	*	*				*	*	*	*	*
	*	*				*	*		*	
	*			* ♦		*	*	*		*
	*		*			*	*			
*	*		*	*		*	*	*		*
	*		*	*	*	*	*			
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*	*		*		*	*	*	*	*	
	*		*		*	*	*			
*	*		*	*		*	*			*
	*		*							
*	*		*		*	*	*		*	*
*	*		*		*	*	*			*

♦ This young person was in temporary housing due to homelessness (i.e. not in care or living at home)

5.2.1 Pathways to harm

The pathways to harm for these young people were complex and often difficulties were enduring. Each young person had their own personal history but there were many experiences that the young people shared as indicated above. In this section we explore some of the features of the lives of vulnerable young people who died through suicide.

Vulnerabilities of young people

Vulnerabilities often appeared to stem from experiences much earlier in life that manifested themselves during adolescence. In some SCRs there was little about the young person's early experiences at home although it was at times alluded to, for example, a parental separation due to domestic abuse or parental substance misuse.

Experiences, and at times early life histories, were sometimes lost over time in professional records which could be due to multiple family moves. For the young people who took their own lives, mental health problems combined with substance misuse was a common scenario. Although some mental health problems had developed relatively quickly (over months), most young people had displayed behaviour indicative of underlying mental health issues over a much longer period of time, as the case study below demonstrates. It indicates how important it is to take seriously changes in behaviour and expressions of suicidal ideation which cannot be considered usual adolescent behaviour. In this case the young person was not seen by professionals and his parents as behaving very differently to the general adolescent population.

Case study 1: *'He was like many other boys of his age'* – adversity over several years

This 16 year old boy took his own life after a long period of unhappiness and CAMHS involvement over five years. He lived in a family where his parents had a difficult relationship and witnessed several years of disharmony and arguments as well as parental alcohol misuse. His parents' relationship became the focus of interventions as the young person became increasingly unhappy and felt that things would never change. He began to miss school as he found it difficult to leave his home. When he was 12 years old he told a social worker that he was depressed and had tried to kill himself. His suicidal thoughts continued but his overall wellbeing was perceived to increase as his parents finally separated. At this time a decision was made that he no longer needed a child protection plan. His school attendance was 100%. One parent continued to have issues with alcohol misuse and the young person started spending weekends with his other parent. At this point he was feeling very unhappy again and the case was re-opened to children's social care but closed again soon after as the young person did not want social work support, stating that things never changed. There was an incident where the police became involved briefly. He was again expressing suicidal thoughts and re-engaged with CAMHS and CSC. One of his parents remarried and he started college. Soon after, his body was found.

What can be learnt?

- The effect of parental conflict and separation can have a significant impact on young people, even older adolescents
- It is essential to support the young person as well as the parents when there is family conflict, and not focus on the parents to the exclusion of the young person
- The improved school attendance was not a true indication of any improvement in his circumstances or his psychological wellbeing

- The young person indicated over and over again that nothing had changed for him, but this was not heard by professionals who only worked with him intermittently since they assumed things were actually changing for him

Loss, rejection and isolation

Almost all of the adolescents came from homes where parents had either separated or divorced, sometimes acrimoniously. In the other cases, where parents had remained together, the young people experienced ongoing parental conflict. Six of the suicide cases involved young people who had spent time in care, young offender institutions or as in-patients in Tier 4 mental health units. Separation from parents and family through becoming looked after or as a result of parental separation, or both, made young people feel a sense of loss and rejection and often isolation. This was compounded by frequent changes of placement, making it difficult for a young person to establish relationships with peers and professionals. In one case the young person had experienced 21 placements over six years, some in residential care units outside his home county. Multiple moves, especially when they are out of the home area, highlight the disruption to continuity of contact with one person who can build a significant relationship with the young person. The substitute parent role is hard for social workers and other professionals to fill as demonstrated by the example below:

> *"It is clear that [young person] lacked a pivotal and stable carer who would provide boundaries to give him some sense of security but, who he also knew, would 'look out for him' and 'fight his corner': in other words be a surrogate parent to him. At this stage, all the evidence indicates that he had little reason to care about himself or the effects of his behaviour on others. Staff from the various agencies involved with [young person], and the YOS staff in particular, made considerable efforts to assist him but their input is necessarily professional and impartial. He had no one person with whom his relationship was special for him alone."*

Young people not in the care system who were living at home with a parent could also feel a sense of loss and rejection when parents formed new relationships:

> *"[Young person's] insistence that he would kill himself if [mother] moved in with her new partner."*

The final reports rarely explore the significance of the changes and upheaval that young people experienced at the time when parents separated. Furthermore they give little indication that the young people were supported to both manage and accept such changes, yet parental separation and/or conflict is a feature in all of the cases where a young person had committed suicide.

Exclusions from school further exacerbated a sense of loss and isolation. In some cases young people had experienced a series of short exclusions and in other cases education

seemed to have become less important as professionals struggled with problematic behaviour and reacted to one crisis after another. Frequent school moves and exclusions were not conducive to maintaining a peer network and resulted in increased feelings of social exclusion. General education issues are discussed in Chapter 4.

Self-harm and risk-taking behaviour

Self-harm and risk-taking behaviour were common themes in the SCRs. Most of the young people had histories of self-harm, sometimes very serious harm, which needed hospitalisation or other medical attention:

> *"The issue of self-harm is a significant issue for all services. The absence of curiosity and rigour in how the YOT and CSC received information appears to reflect an institutionalised or normalised response to behaviour that is not seen to be extreme or unusual. This may reflect the volume of young people with significant problems associated with self-harm and substance misuse as much as the complexity of need presented by [young person]."*

ChildLine studies and other research have found that young people often self-harm instead of talking to others about their feelings and as a way to distract themselves from suicidal thoughts (NSPCC, 2014; McLean et al, 2008). This was a clear pattern in the SCRs of suicide cases and many of the young people went on to attempt suicide, sometimes several times, before they finally succeeded. The isolation and exclusion that so many of the young people experienced was likely to result in reduced or even absent supportive networks, leaving them with few people to confide in about their feelings and thoughts. Despite this pattern of self-harm, its significance was not always recognised by professionals:

> *"[Young person] was never diagnosed with a mental illness when assessed after self-harming incidents, and such assessments generally did not view him as having suicidal ideation."*

Self-harm was displayed in various ways and was not always viewed as easy to spot or label:

> *"[Young person's] mother referred in interview to the forms that accompanied [young person] from court to the YOI that included reference to the incident in the police cell where he was held after arrest before appearing at court the next day: he banged his head and fists on the cell door but refused to see the nurse; the custody sergeant and nurse then formulated a care plan to ensure his safety. She considered that this incident indicated his vulnerability to self-harm and should have led to him being monitored accordingly."*

Self-harm also manifested itself through other risk-taking behaviour by the adolescents. This included substance misuse, risky sexual behaviour, gang membership and suicide

attempts. Cocktails of drugs and alcohol, combined with psychological frailty, led to behaviour which was at times extremely dangerous:

> *"[Young person] was threatening to jump from a motorway bridge. The Police had returned him to the family home and armed with two knives he attempted to stab [step parent]. The Police had to use a Taser gun in order to subdue him. [Young person] was seen by the duty Psychiatrist at A&E and discharged from hospital to Police custody as there was no evidence of affective disorder or psychosis."*

Episodes of emotional instability and impulsive self-harm were at times thought to have been exacerbated by substance misuse. For some young people, the use of drugs and alcohol helped them numb the pain of abuse and neglect. For the first young person below, there were many of the risk factors associated with suicidal behaviour in adolescents. During his life he had been neglected and abused by his parents. He had spent time in long-term care where he had been sexually abused. He felt hopeless and angry – states which he felt were improved by the use of substances, albeit a short term solution to his problems:

> *"A psychology report in respect of [young person] in July 2011 identified "how the alcohol and drugs helped him to forget" his traumatic life experiences."*
>
> *"He admitted what records describe as 'deliberate self-harm in the form of cutting arms and chest as an act of release rather than intent to end his life'. He told staff that he 'absconds when things get on top of him and he feels sad and then he uses drugs'."*

Going missing

Almost half of the final reports recounted episodes of young people going missing. In one case the young person was regularly going missing from residential care and then returned to the same situation. The pattern of going missing was ongoing over several years and in one six-month period he was reported missing at least thirteen times:

> *"He went missing twice during May, on one occasion was found intoxicated, and on the other had participated in anti-social behaviour. These were both for short periods of less than a day, but on each occasion he was with another young person. He absconded from school and was reported missing again in September. On each occasion the Police were involved and returned him back to the residential unit."*

Going missing often indicated a sense of hopelessness and lack of control and was evident in one final report when a young person had breached his YOT order:

> *"…it was only after the decision to breach him that he went missing for three days. He had broken his curfew and gone missing for shorter periods before but this was completely unprecedented. He also committed a string of further offences."*

It was often during times of going missing that young people were most vulnerable with increased use of drugs and alcohol, anti-social behaviour, offending and sleeping rough or staying with un-known adults which increased their vulnerability to being sexually exploited:

> *"[Young person] was reported missing from father's home and the subsequent contacts involving much older adult males should have been an opportunity to recognise their vulnerability and to make referrals to specialist police officers and for further enquiries to be made."*

The final reports rarely portrayed good relationships with parents which have been suggested as a protective factor against suicide risk. The young people in the reports were not consistently in school and had diminished social support networks, both considered factors which could mitigate against suicide (McLean et al, 2008).

Young carers

In four cases the young person had at some time taken on a caring role for the parent because of parental mental or physical ill health but the strain of such a role on the young person was not always adequately recognised. One young carer described himself as *"angry, stressed and fed up all the time"* but never attended the young carers' group activities. Another young carer was discharged from CAMHS in spite of clear vulnerabilities including being a young carer and with no resolution of the problems he experienced:

> *"The young person was identified as vulnerable because of self-harming behaviour and their role as a young carer. Nevertheless, the young person was discharged from CAMHS after three further appointments."*

Parental behaviour

The risks young people faced from parents and carers were cumulative and had sometimes extended over a long period of time. They included witnessing domestic abuse or other trauma during their childhood, which have been common themes in other studies (Cleaver et al, 2011). Risks included parental suicides, parents who misused alcohol and drugs (some with their own experiences of sexual abuse) and having recently arrived from countries with political conflict. In eight cases it was clear that parents had experienced violent and abusive relationships and/or were misusing substances but in some final reports there was little information about parents as the focus was on the teenager and, in some cases, a teenager living out of the home. Parents may not have disclosed to professionals potentially damaging experiences which had taken place in a young person's early life, perhaps because they themselves were managing the trauma they had experienced:

"[Young person] also disclosed some distress about father's use of alcohol and violent behaviour; the inference is that this relates to early childhood before the separation of [young person's] parents."

Thus, parental misuse of alcohol and drugs was a recurring theme. Sometimes it was a parent who no longer lived in the household and at other times it was a new partner introduced to the household. The risk could remain hidden, even during an initial assessment undertaken by children's social care. Some men stood out as being particularly aggressive, intimidating and violent towards the young person. In most cases these were new partners or stepfathers.

Acrimonious parental relationships could impact on the parenting capacity of the adults. While parents had their own problems, the young person was often ignored or stuck in the middle of the disharmony and tension within the home:

"When seen during the Serious Case Review process, the young person's mother and adopted sister spoke of the young person as always wanting the family to get along and tending to take the role of 'go-between' and 'peacemaker'."

"[He] experienced his parents' relationship difficulties as abuse despite the fact that neither of them meant him any harm. Whilst neither parent intended to be harmful to their children…clearly their arguments were having a harmful effect on him."

Parental behaviour influenced the wellbeing of the adolescent. In some cases parents were unable to set boundaries to manage behaviour and appeared to have given up, at times requesting that the young person enters care. One mother demonstrated consistent rejection:

"Mother has consistently recalled saying to consultant psychiatrist 2 'I can't be responsible for that thing' [a reference to her self-harming daughter and the plan that she return home]. If that was indeed the expression used, the choice of words and its meaning required thorough exploration."

Some adolescents lived in middle-class families and were well supported by parents and other family members but that did not necessarily lead to increased wellbeing and appeared not to provide the resilience required to manage major changes in their lives. In many ways, apparently well supported young people were less likely to be helped by professionals outside of the family and could be on the margins of mainstream services as professionals could make assumptions about parents' ability to manage without their support:

"After a long period of being left to manage on their own…when professionals did engage, the parents did not feel assured and sought solutions from other sources including a private psychiatric consultation and homeopathic remedies."

We have shown that all of the young people and their families were living in contexts of changing and unstable relationships. Complex family dynamics included some large extended, chaotic families with intergenerational abuse and neglect. Thus the young people often lived with uncertainty and fear both at home and outside the home.

Community influence

An ecological transactional understanding emphasises the way that the lives of the young people and their development are placed within the immediate context of the family and the wider context of their environment, including the community. It has been suggested that many of the cases share similarities, for example, the presence of mental health problems, parental separation and feelings of isolation. When exploring the circumstances of the cases in more detail it is clear that the local community might influence the trajectory a case takes. There are instances of watchful neighbours who alert agencies to the plight of the young person and opportunities for sports and leisure within the local community. There are also more negative community factors such as dangerous liaisons which include gangs and adults who prey on young people and their loneliness.

In one final report, it was clear that on at least two occasions someone from the local community alerted children's social care about the young person's behaviour and appearance, making allegations of physical abuse and neglect and concerns about sexualised behaviour but the allegations were not investigated. In another case a neighbour raised concerns about a young person after he had seen a suicide note. In that case, there was a quick response from children's social care and a safety plan was put in place but that did not involve a visit to the young person as the mother claimed that he was *"attention seeking and didn't want to see a social worker"*.

Two serious case reviews described how the young people had become interested in religion, resulting in a decision to be baptised, yet professionals did not appear to develop that particular resource with those young people. The opportunity to connect with the wider community through worship could, perhaps, have acted as a protective factor for the young people. Coincidentally, both of the young people had been in long term care:

> *"No other agency was aware of the religious aspects of his personality and needs, which was surprising considering the commitment he put into these whilst at the Secure Training Centre and the secure children's home. This issue was clearly important to [young person] at these times, and whilst the fact that on both occasions he was in a secure environment may have been coincidental, it may have been that this somehow freed him up to pursue religion."*

To summarise, although suicide is clearly a multi-faceted phenomenon, these cases of suicide appeared to follow a pattern of poor family relationships, often with parental separation followed by unhappiness, behavioural and/or mental health problems, which

included self-harm and suicidal ideation. The accompanying isolation, due to school absence and exclusions, further exacerbated the feelings of hopelessness and social isolation. These young people suffered from mental health problems which were enduring, usually preceded by episodes of serious self-harm. Although it may not always have been possible to foresee that the young people's lives would end in suicide, there were many indicators of the high risk of serious harm to themselves and therefore a clear need for more sustained support.

5.2.2 Opportunities for prevention

Opportunities for prevention arose at different times for various agencies, including schools, health professionals, children's services, housing and police. However, negative perceptions of young people could lead to misinterpretations of their behaviour as troublesome and anti-social, rather than as a consequence of their previous or current difficulties (Halsey and White, 2009). Like previous researchers, and as in our previous biennial analyses, we found that in some cases practitioners linked the age of the young person to vulnerability and resilience, expecting older young people to be less vulnerable and more resilient (Gorin and Jobe, 2013).

Recognition

In order to support young people, their difficulties need to be recognised and understood by professionals. The common assessment framework (CAF) was rarely used by practitioners, sometimes because the family would not agree to participate. In one case there was an unfounded presumption of resilience because the young person was articulate and troublesome and they were thought of as an adult rather than a vulnerable young person. In addition, fixed thinking stopped the school from considering using the CAF because the young person was from a middle class family and their experience of using the framework was with more disadvantaged young people:

> *"The inability of all services to see Child as a vulnerable child rather than a troubled or troublesome young adult was a common and recurring theme. People made assumptions that Child was adult and because of their greater intelligence and verbal ability had greater resilience than a child who had come from more disadvantaged or compromised circumstances."*

At times the CAF was used inappropriately for problems like neglect and sexual abuse which were much more serious and needed assessment from children's social care:

> *"An informed appraisal of her circumstances at this time against the authority's guidance would have indicated that her experience required the need for the direct involvement of CSC, through child protection, or, at least initially, child in need arrangements."*

Disagreement about mental health diagnosis and thresholds

In all but two of the suicide cases the young people were involved with Child and Adolescent Mental Health Services (CAMHS). Their problems included delusions, psychosis, depression, anxiety, anger, ADHD and other behavioural difficulties, personality disorder and conduct disorder. In many cases the reports pointed out that no specific diagnosis had been made but rather the diagnoses were changing. In one case a young person was said by his GP to show signs of psychosis and was referred to a specialist team for early psychosis but the referral had not been accepted as it was *"unlikely that he was suffering from psychosis"*. In another case the disagreement among Tier 4 clinicians about an emotionally unstable personality disorder was not discussed with the young person's mother and step-father.

Living with undiagnosed illness or medically unexplained symptoms can be difficult and confusing for young people and their family or professionals who try to support them:

> *"[Young person] was located by the police and maternal grandmother. The police sought advice from the mental health crisis team who felt that she might have a personality disorder but was not mentally ill; she was never diagnosed with a personality disorder according to the information given to the review."*

In the case above, the lack of a diagnosis meant that the response to the young person was that she was seen as 'naughty' rather than doing more to understand the underlying cause of the behaviour which had become very out of character and at times described as 'bizarre'.

Progression to child protection

The disagreement about classifying the mental health condition perhaps contributed to these cases of abuse and neglect not progressing to child protection, in spite of the young people's vulnerability and high risks of harm to themselves. At times there was little urgency in trying to protect and prevent further deterioration:

> *"The referral described [young person] as being at high risk with little or no agency support and that she was at immediate risk without access to a service. The referral from [other local authority] was triaged by the duty manager and allocated to the work tray of a support worker to pick up the following week."*

In these suicide cases, the roots of the young people's problems (e.g. relationship with family, rejection, feeling unloved) were never addressed in a meaningful way. Opportunities to further explore the lived experiences and underlying problems of the young people sometimes presented themselves but were not always taken up. In many of the cases it was evident that the voice of the young person was not always heard, and when a young person articulated distress (verbally or through their behaviour) it was often not understood or responded to appropriately. This issue was addressed in a study for the Office of the Children's Commissioner (Cossar et al, 2013) which suggested that

professionals need to be mindful of young people's behaviour and understand the emotional aspect of talking about abuse. Young people will therefore *'weigh up the advantages and disadvantages of telling'* (Cossar et al, 2013: p.ii) and during the process of deciding whether or how to tell, the young person's behaviour may be labelled as a problem when it is often a sign of distress which may include abuse or neglect.

However, as in our other studies of SCRs, there had been pockets of good practice where the young person had been heard, often by foster carers or trusted staff at school, although insufficient action had been taken in the long term:

> *"The only direct examples are from the x period where his voice is directly heard three times, and each time he is saying that someone has hurt him, that his home is a scary place or that he wants to leave it. The courage that it took him and [sibling] to confide these things to an adult cannot be underestimated. Each time [young person] said these things it was to a trusted, friendly and familiar adult at school. Each time there was an immediate response and steps were taken to keep him and his brother safe in the short term. In the longer term, little changed in a house where people sometimes hit him, hit each other, harmed his mother, and came into and left his life in a bewildering way. A child inevitably becomes dispirited when the supreme and frightening effort he has made to get adults to change something he cannot, ultimately makes no difference."*

Housing and premature adult responsibilities

These young people had housing issues similar to many of the parents in the other SCRs considered in this triennial review, including homelessness, unsuitable living arrangements, insecure housing (and placements) and transient lifestyles which emphasised their pre-mature entry into the responsibilities of adult life.

Disagreements with parents, other family members or carers in some cases led to young people becoming homeless and unwilling or unable to return to the family home. This sometimes meant that young people 'sofa-surfed' short term in relative safety in the homes of friends or friends' families but in some cases it could place them in risky situations as they found other places to sleep:

> *"…the police were alerted to a broken window at a community property in [town]. Child had broken in and had been sleeping at the property."*

Young people who had been looked after had in some cases moved into more independent accommodation. Such moves appeared to increase their sense of isolation and loneliness already experienced after a life of changing placements and instability:

> *"At the time of his death, [young person] was residing in a semi-independent placement, after a three month period of living back with his family. It was apparent that whilst residing in the semi-independent placement, he was experiencing difficulties in adjusting to life outside of the care system."*

One SCR suggested that there was not enough consideration of the impact of such a significant change in the life of a young person and the emotional and practical support required for that transition. In this case, after a short period of reunification, a violent assault on his mother's partner by the young person resulted in the move which had to happen quickly to remove him from the home – he was 17 years old at this point. Shortly before his death, he went missing for the first time (whilst at the semi-independent unit) and he was found at his sibling's home the next day:

> *"When he moved into his final semi-independent placement, workers who knew him well recognised that this was a very different experience for him in that he no longer had peer relationships with other young people in care, who had similar needs and issues to him. In the more independent environment and at the training centre, he for the first time experienced the challenge of making and maintaining friendships which were not based on the shared experiences of being in care. Adapting to a world outside of the residential and secure care environment was an unforeseen consequence of living in residential care for a long period of time and a substantial challenge for him."*

Housing uncertainties could put a big strain on the young person and further reduce their wellbeing:

> *"Earlier in the day [young person] had been seen by his Connexions Personal Advisor who reported that he was very angry and low, as his housing situation was not sorted. He reported that he was not sleeping or eating and was hearing voices. The Connexions Advisor contacted Children's Social Care by telephone to confirm her actions had been appropriate. At this stage it appeared that [young person] was on a waiting list for a housing provider for accommodation."*

In the above case the young person was unhappy with living at home as his 'brother' was dealing drugs and his mother's partner regularly came home on release from prison at the weekends. He presented at Connexions as homeless but could not be accommodated as his mother was willing to have him at home. This did not take into account the wishes of the young person to remove himself from the tensions and dangers at home:

> *"This same debate continued the following day, with the same outcome, although there was seemingly a total family relationship breakdown, the Housing Department would not offer anything because [parent] was willing to have him back home."*

He was eventually accommodated in 'the Crash Pad' which was an unsuitable environment for the young person and intended for emergency placement only, although he stayed there for 4 months. Despite this, children's social care closed the case:

"The rationale being that [young person] was settled at the Crash Pad and had support to ensure that his independence needs were met. This approach by Children's Social Care was clearly wrong."

Children's social care *'seemed unaware of the increased risk of self-harm because of homelessness'* and it was not until he committed an offence that he was remanded to local authority care.

The outcome of homelessness for some young people who were older (17 and over) was to place them in accommodation with adults (as in the case above) which was unsuitable for their needs and increased their vulnerabilities. Due to their age they were often seen less as vulnerable children and more as adults:

"The police had previous contact with [young person] earlier in November. On one occasion father had reported [young person] as missing from his home. The police also responded to a report of a domestic argument involving [young person] and [older adult male]. They had also received information on another occasion about [young person] being in a relationship with another adult male. In all of those contacts, their age and vulnerability in regard to use of drugs and the age difference between the males and [young person] were not recognised and therefore reported to the specialist officers in Public Protection Investigation Unit."

Below is an example of a young person who experienced insecure and transient housing over a period of time which left him more vulnerable, isolated and lonely.

Case study 2: A young person who experienced housing problems

This young person had been in LA care since he was a young child. He had a relatively stable period in the same foster placement until his early teens when it broke down. At the same time offending and challenging behaviour led to several exclusions from school. He went missing, offended and was arrested. He lived with relatives for a short time until an incident occurred and he was no longer able to live with them.

Accommodation was secured for him in a hostel for single homeless males over 16 years old. He was now 17 years old. He reported to the social worker that he was being *'hassled'* by other residents in the hostel. He was subsequently evicted from the hostel and seven moves between different hostels followed as he continued to report intimidation from other adult offenders. He was finally offered a tenancy in new-build council accommodation: '*[He] signed up for his tenancy with his social worker acting as trustee and an agreement that the Pathway Planning team would pay his rent until he was 18. He began buying items for the flat'.* Unfortunately he was arrested before he could move into his new accommodation and it was whilst in custody that he took his own life.

What can be learnt?

- There was insufficient planning for the young person and therefore no coherence or consistency in housing choices. All placements became responses to crises and a result of other options not working out
- As this young person's behaviour became increasingly out of control, the risk to others became the focus of intervention, overlooking the underlying vulnerability. This, again, resulted in reacting to his behaviour rather than exploring the cause of the behaviour
- In this case, there was no evidence of re-assessments of the young person's needs. The care plans were *'prepared in a formulaic manner to fulfil the requirements of statute, rather than being the vehicle whereby actions to support and sustain a young person - who was highly vulnerable and in considerable need - could be formulated and agreed'*
- There was much to indicate the need for multi-agency planning via a professionals' meeting but even when suggested by other professionals, the social worker did not take action. Agencies need to challenge such decisions and be aware of processes to escalate the case through involvement with senior managers

5.2.3 Opportunities for protection

We explored the way that opportunities for protection presented themselves whilst recognising that adolescents who have been maltreated may have particular difficulties with disclosing their feelings and past histories. Reluctance to engage with practitioners can make this age group challenging to work with under the current child protection system.

Recording and sharing history and information

For many of the young people in the SCRs, previous life experiences and adversity were mostly recognised, but not necessarily addressed, as professionals struggled to react to crises in the lives of the young people. For example, witnessing domestic abuse as a child was not considered in relation to later behaviour, partly because it was not documented and shared. In one example, the young person shared information about her father's violent behaviour with a nurse during custody but the disclosure did not trigger concerns for her safety and welfare and there was no referral to children's social care:

> *"The nurse began talking to [young person] and taking a history. Although she continued to be erratic in her speech and movement the nurse was told something of her recent circumstances and that she was living with father in [town]. [Young*

person] was very disparaging about father and made allegations of being hit by him and alleged that he was a drug user."

It is interesting that being in custody was a point when the young person was able to confide something about her childhood which did not appear to be widely shared amongst the professionals nor identified by the parents.

In another case, where there was documented domestic abuse, a move between local authorities resulted in loss of some of the information although some concerns about domestic abuse were raised again with a new professional:

"This information should have been shared with the school nurse and the family GP and could have established an early common information base for further collaborative action."

Sharing information may have offered some insight into the behaviour that the young person was exhibiting at the time which included angry outbursts, cruelty to animals and setting a fire. This indicates the importance of historic knowledge for professionals. Sometimes young people have only spent part of their childhood in the UK and practitioners therefore will not always have the full story of events that occurred before arrival in the UK.

The lack of sharing can have devastating consequences for young people who express suicidal ideation. If a young person is still attending school, teachers clearly need to be aware as they will often see the young person on a daily basis and have the ability to monitor changes. In effect, they could be the 'eyes' for other professionals working with the young person:

"Poor sharing of information with school which was not aware of his suicidal ideation and had not seen any reduction in attainment therefore they had not put any strategies in place to raise alert if he came to a teacher's attention or was absent from school."

The behaviour of many of these adolescents, for example going missing from home, involvement in criminal activity and anti-social behaviour, could bring them into contact with the police as in the case below:

"Police were involved on several occasions when there were allegations of assault by adult 'friends' and missing from home. They were aware of her relationship with an older male (30 years old) and her vulnerability with regards to drugs but did not report to specialist officers in PPIU (public protection investigation unit)."

Although the protocols for 'going missing' may have been followed, any information gathered from contact with the young person and the 'safe and well check' (DfE, 2014b) which indeed suggested increased risk and vulnerability, in addition to going missing, should have been shared.

Working together

Sharing information is not enough when supporting these vulnerable adolescents. Professionals need to have clarity about their own role and an understanding of other professionals' roles to work together effectively. At times agencies were not clear what other agencies were doing, or could do, which missed opportunities for intervention and resulted in agencies working in isolation with young people:

> *"Young Offender Service (YOS) did not enact a Vulnerability Management Plan despite [young person] being 'high vulnerability' as they thought that aspect of safeguarding was being undertaken by CSC."*

> *"YOS worked well with [young person] but did not secure full involvement of other agencies – the service worked in isolation."*

One agency sometimes became more involved with a young person, for example CAMHS where there were mental health problems or YOS for young people who had offended. Giving the young person an opportunity to work closely with one professional is sensible but at times other agencies stood back and that could cause the case to drift:

> *"YOS staff had more involvement with [young person] than any other agency, particularly in the 12-month period leading up to his remand in custody, and were, therefore, in the best position to build up a relationship with him. It is easy to see how the CYPSC social worker might, therefore, leave management of the case to YOS in these circumstances and only respond when a crisis occurred."*

One case in particular demonstrated good practice by children's social care in ensuring continuity of professionals without compromising oversight of the case by thinking ahead:

> *"…the Manager decided to allocate a different social worker so that [young person] could form a relationship with a social worker who would not be going on maternity leave in the coming months."*

Multi-agency meetings with professionals involved in a case can encourage information to be shared and roles to be clarified, improving multi-agency working and allowing professionals to gain a holistic view of the case. However, it is important that outcomes of meetings and any plans made are shared with all the professionals involved with the young person:

> *"There appeared to be a lack of a thread from one meeting to the other, at the first strategy discussion… the summary of CSC involvement…..was of good quality. However in the reconvened Strategy Discussion… the summary was not shared with people who had not attended the initial discussion."*

Although SCRs often show that professionals lack confidence to challenge the work undertaken by other agencies there was an example in one case of sustained and

effective challenge. One agency repeatedly challenged the view that the young person did not meet the threshold for intervention as a child in need and eventually children's social care agreed to reassess. Such challenges from professionals who have a clearer view of the case are important but require persistence and rigorous follow up.

Structural and systemic issues

Risk-taking behaviour such as self-harm may manifest itself in adolescence but for many of the adolescents there were clear indications of their unhappiness through their behaviour at home and at school. In order to adequately protect and prevent suicides multi-agency work is required but with an emphasis on relationship based practice to engage young people over a period of time.

The difficulties in engaging young people at the point when they feel particularly hopeless requires that all agencies involved with the young person communicate their knowledge clearly and accurately to other professionals so that at all times there is a clear picture of the case as it progresses. Structural and systemic factors influence the ability for professionals to talk to each other. This might be due to recording systems (e.g. lack of shared access to the case notes), resource issues such as lack of time or unfilled job vacancies within services or the culture and organisation of certain services:

> *"There were a number of instances of delay and lack of purpose which may have been linked to major problems of high vacancy levels across the organisation."*

Some final reports demonstrated the difficulties for GPs in attending strategy meetings as they were often at short notice or during times when they were required to run surgeries. The cancellation of a complete surgery was rarely an option.

At times it was also difficult within the same organisation to gather the information required to get an overview of a young person's history, often due to the transient lifestyle of the families and the young people. In one case, the young person had experienced a large number of placements and had attended numerous A&E departments in different parts of the country because of self-harming behaviours but there was no IT mechanism for the LAC health staff to know the details.

Leadership issues were also present in the cases, particularly for the looked after adolescents. The lack of oversight could cause drift and poor management of the cases as the focus for intervention was lost:

> *"Because [young person] had such a range of problems which must at times have felt overwhelming to the professionals working with him, and no doubt to him as well, perhaps a priority for intervention should have been the substance misuse issue – to achieve success in this may well have impacted on other aspects of his behaviours. Instead one gets the sense that attempts were made to tackle his problems on all fronts, when perhaps a more measured and focussed approach with fewer practitioners could have achieved better success..."*

Learning Points

- These adolescents' vulnerabilities were compounded by the cumulative effect of abuse and neglect and the challenges of adolescent development
- Loss and rejection in early life can influence psychological wellbeing in adolescence and lead to behavioural and mental health issues and therefore it is important to have knowledge of their early life experiences
- Self-harm and/or suicide attempts preceded all but one of the suicides and should be taken seriously whenever they occur
- The best chance of adolescents responding to relationship-based practice is when it is consistent, holistic and available over a long period of time on their own terms if possible
- Insecure housing and premature adult responsibilities can put young people at risk and increase their vulnerability to exploitation
- Behaviour should be viewed as symptomatic of other underlying problems and difficulties. The cause of the behaviour should be explored and addressed through multi-agency support

5.3 Child Sexual Exploitation

In this section we present an analysis of the subset of SCRs which addressed child sexual exploitation. All serious case reviews are the tip of the iceberg in terms of representing children and young people who are abused and neglected but in two of the child sexual exploitation (CSE) SCRs a small number of young people were featured as a way of reflecting and representing the circumstances of a much larger number who had also been sexually exploited within the same geographical area. The broad features of the seven SCRs relating to child sexual exploitation explored here are listed below.

Table 27: The nature of death and serious harm in the seven CSE cases

Fatal cases (2)
A young person was murdered after being contacted and lured to the murder site via social media contact with the perpetrator. The young person who had a history of risk taking behaviour and vulnerability to CSE had been known to numerous different agencies over many years.
A young person with a history CSE who was killed by the boyfriend of a family member.

Non-fatal cases (5)

Serious and prolonged CSE of 6 adolescent girls (who were representative of a much larger number) several of whom had some degree of learning difficulty.

Serious and repeated CSE of a young person with severe learning difficulties who was known to the key agencies and had a care history.

Serious, repeated and prolonged CSE of many young people, the SCR focused on 6 young women aged 12-16 years who were targeted and groomed using coercion and drugs.

14 year old sexually exploited by her mother's partner who had a previous history of child abduction.

15 year old fostered young woman, with a history of risky behaviour including going missing, raped by an older predatory man in a hotel after mobile phone contact.

There are parallels with many of the other SCRs featuring adolescents in that the risk factors increasing the young people's vulnerability to CSE are often similar to those experienced by young people who are at serious risk of harm through substance misuse, self-harm and suicide. Experience of neglect, parental failure to protect, and time spent in care feature strongly, as do emotional and behavioural difficulties, school disruption, going missing from home, school and care, substance misuse, low levels of self-esteem and seeking affection and approval often in risky places:

> *"[Young person] was undoubtedly affected by her troubled personal history, contributing to her lack of secure attachments, mistrust of those in authority, and weak sense of her own worth. All these underlie her vulnerability, which heightened when she was missing from care, and her whereabouts and her activities were not known."*

> *"It is likely that their low self- esteem and experience of domestic abuse, parental drugs and alcohol use and physical and sexual abuse will have desensitised the girls to the grooming and CSE model making them very vulnerable victims."*

Across the seven SCRs the young people's experiences of childhood were largely ones which seem not to have nurtured a sense of self-worth or self-efficacy. This in turn appeared to increase the young people's propensity to involvement in risk-taking behaviour, perhaps in a search for the security, affection and approval they needed. Arguably therefore, it is a lack of a sense of security or self-worth which results in the downward spiral into risk-taking behaviour which negates a child's safety and wellbeing and sadly feeds into their already low sense of self-worth:

"If a young person is to become resilient, they must have a secure base. There was an issue for [young person] about her resilience and high level of risk taking."

"[Young person] was also seen by many people as resilient with a positive personality that may have masked underlying needs and emotional feelings of low self-image."

The characteristics of the seven CSE-related SCRs are summarised below (Table 28) and they have much in common with other adolescent SCRs in that there are similar themes of childhood experiences of neglect, physical, sexual and emotional abuse, domestic abuse, proximity to criminality including gangs, violence and drug-related activities. Many of the young people had experience of the care system as a consequence of their early childhood experiences and many frequently went missing from home or from care.

Table 28: The sample of young people who had been sexually exploited

Parental D&A, DV/ neglect/abuse issues	Parental conflict/ separation/illness/ mental health issues	In care/detained	At home	Subject of CPP &/or known to agencies at some point	Going missing/ homeless	MH, self-harm, Suicide attempts	CAMHS	Criminal activity/ YOT	Substance misuse YP	Truanting/Disrupted schooling
*	*	*		*	*	*	*	*	*	*
*	*		*	*	*	*	*	*	*	*
*	*	*		*	*					*
*	*		*	*						
*	*	*		*	*	*	*	*	*	*
*+	*+	*+	*+	*+	*+	*+	*+	*+	*+	*+
*+	*+	*+		*+	*+		*+	*+	*+	*+

*+ represent the characteristics of the majority, where the information is known. These two SCRs featured 6 young women in each review.

5.3.1 The family and the environment

In terms of family and environmental factors, wider structural factors, often of poverty, homelessness, transience, as a result of homelessness and related economic factors, had a bearing on many of the cases examined. Such factors clearly had a hindering impact on the safety of the young people concerned. Several of the young people grew up in areas where CSE had, to an alarming extent, 'become the norm'. This had an impact on them and on peers often resulting in additional pressure to become involved in risky behaviour and abuse. The 'abnormal being seen as normal' affected the thinking and responses of the young people, their parents and the professionals involved often with negative and tragic consequences:

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

Parental abandonment, rejection, either physically or by virtue of substance misuse or mental ill health, featured strongly in the young people's case histories as did family breakdown, and many of the parenting difficulties identified in the wider sample prevented parents from protecting their children from serious harm. For some families or carers the risk to their children of CSE went unnoticed, for others it was interpreted as difficult or out of control behaviour or they believed the agency saying that their child was a prostitute. However, there was also a strong sense from families that they felt unheard, when they voiced concerns for their children, by the professionals and agencies involved:

> *"Given the difficulties experienced by professionals working with disengaged young people the challenge for parents is equally an issue. [Young person's] mother's perspective is that she was not provided with the help she needed to protect two girls who were exhibiting challenging and risky behaviour."*

> *"The police were too slow (to act) that made us feel like paranoid parents."*

> *"[Young person's] father described being told by social workers that his daughter was a child prostitute and was angry that he accepted this because he did not know that it was wrong and feels that social workers gave him bad information."*

5.3.2 Opportunities for prevention

New themes emerging from these serious case reviews included: the impact of CSE being missed or misunderstood by professionals, perceptions of young people's agency, and the consequences of victim blaming. These themes showed an overall lack of understanding by professionals of the dynamics and prevalence of CSE more than a decade after the publication of *Safeguarding Children Involved in Prostitution* (DH, 2000). Although the guidance, at that stage, still used the terminology 'child prostitution' it was a clear attempt to raise awareness and offer guidance to local authorities on recognising and dealing with CSE. Despite the language used, the guidance required services to *"treat such children as children in need, who may be suffering, or may be likely to suffer, significant harm"* (DH, 2000: p.9).

In 2009 new guidance was published *Safeguarding Children and Young People from Sexual Exploitation* (DCSF, 2009) and reflected a shift in perception and use of language. It also gave clearer guidance on safeguarding those at risk of CSE.

However, it appears from the SCRs examined to be an issue not recognised by many local authorities as having a significant impact on children in their area:

> *"The SCR concluded that there had been significant weakness in the strategic leadership provided within [the local authority] regarding CSE. In summary, there was a lack of effective prioritisation or focus at strategic level which had a consequent impact on the response at the operational level, both in terms of agency recognition of CSE and of effective intervention."*

This is an issue also identified in the Drew report (2016), an independent review of South Yorkshire Police's handling of child sexual exploitation 1997-2016, which noted that between 2000-2009 senior command in the police lacked interest or professional curiosity about child sexual exploitation, and that in 2000:

> '*a majority of professionals simply did not understand child sexual exploitation, either the scale of exploitation or the way in which it influences the conduct of those who are being exploited as a social problem.'* (Drew, 2016, p.45)

Whilst there have been many recent positive changes in terms of recognition and intervention amongst safeguarding agencies there is, as the SCRs examined indicate, arguably still much to do.

Recognition

> *If a perpetrator can spot a vulnerable child why can't professionals?*

There was a dilemma about how those being sexually exploited were perceived and treated by professionals. This related to an ability to work with young people's perceptions of their own agency and choices which might conflict with what the professionals thought was in their best interests (Dodsworth, 2015; Pearce, 2013).

In the case of a 16 year old Asian young person professionals appear to have had limited knowledge of her early childhood history and little understanding of the cultural issues which may have impacted on her ability to disclose being abused:

> *"There appears to be a degree of disbelief amongst agencies that made it easier to accept [young person's] retractions. It was not until the allegations of CSE that all agencies started listening to her and even then some had doubts."*

A common theme emerging from the SCRs is the young people, perhaps unsurprisingly, demonstrating disruptive, sometimes sexualised, often challenging and occasionally intimidating behaviour. This could be misunderstood or misinterpreted by family, carers and professionals, resulting in the vulnerability of the young person to the risk of CSE being missed or misconstrued:

> *"The practitioners first known to have 'named' what was happening were the sexual health workers who stated explicitly that the young people were being exploited …CSC concluded that no strategy meeting or assessment was*

necessary nor was any action required other than offering support……The response by CSC was wholly inadequate given the nature of the referral."

In the case outlined below, the signs of this young person's vulnerability to CSE were largely missed as her full history was not known. This meant that many of the early warning signs were not 'seen' or if seen not woven into a wider picture of concerns about CSE. Although there was some evidence of recognition by one agency of the possible risks of her exposure to CSE it was not acted upon in a coordinated way so she remained vulnerable:

Case study 3: Misinterpreting the behaviour of a vulnerable young person

This 15 year old girl living in foster care was allegedly raped by an older predatory man she did not know following mobile phone contact. During early childhood in her mother's care she experienced neglect, homelessness, emotional rejection, physical assaults and proximity to drug dealing and adults who may have posed a risk to her. At age 10 she was made the subject of a care order and had more than eight placements and ten social workers in four years. Placement breakdowns were attributed to her behaviour which was described by professionals as rude, disrespectful and at times intimidating. By the age of 12 she was frequently going missing from her foster carers and her school noted sexualised and gang-related behaviour giving rise to concern about sexual exploitation. The school complained about the persistent lack of response by children's social care (CSC) to their concerns. Children's social care did not access the relevant records which provided an account of her history. Staff shortages, sickness and high turnover exacerbated the difficulties. The wider understanding about why this young woman may be demonstrating these risky and challenging behaviours appears to have been missed and her needs were therefore never fully assessed.

What can be learnt?

- Young people with damaging early histories coupled with the impact of these experiences on their self-esteem have little reason to trust those in authority and may present challenging and disruptive behaviours
- Practitioners from all agencies need to recognise and act upon the signs of vulnerability to risk taking behaviours including sexual exploitation. Signs of vulnerability should trigger a full assessment of the young person's history and what is informing their current behaviour
- Equally, it is important that concerns expressed by single agencies, including unqualified workers, who may have been able to develop a position of trust with the young person, are taken seriously and fully explored in order to develop a holistic plan to safeguard the young person

Trafficking within the UK

As professionals become increasingly aware of the complexities of CSE it is apparent that the issue of modern day slavery and trafficking of young people from abroad, and also the trafficking of young people within the UK, is one of growing concern. In one SCR there is evidence of children being trafficked within the UK:

> *"In addition to being abused in various locations in [town], some of the girls were taken to other towns and cities such as London and Bournemouth for the same purpose."*

However, as the final report noted:

> "*If* [the term] '*trafficking' was used, it meant trafficking from abroad. The notion of sexual exploitation of young teenagers by groups in local towns was not something many people saw, or something of which they were even aware."*

This appears to have led to CSE being missed. One young person explained:

> *"I made a complaint about a man who trafficked me from a children's home. He was arrested, released and trafficked me again."*

The Working Together to Safeguard Children Guidance current at that time states:

> *Children do not have to be trafficked across international borders to be exploited in this way. There is evidence that some UK resident children, mainly young girls, are being groomed, coerced and moved around between towns and cities within the UK for the purposes of sexual exploitation. Relevant agencies should remain alert to the possibility that this can happen, and work together to address it.* (DCSF, 2009, p.116)

Growing levels of awareness of the issue of trafficking in this case eventually led to the conviction of five men for trafficking for sexual exploitation. In 2011 the Department for Education published *Safeguarding children who may have been trafficked: practice guidance* (DfE, 2011) which is signposted in the latest *Working together to safeguard children* (HM Government, 2015). It is an issue about which professionals need to remain constantly alert.

Victim blaming

Young people were often perceived as responsible for their difficult behaviour and their vulnerabilities. Victim blaming by agencies was thus a frequently identified issue across many final reports and was at times evident in the language used and recorded by practitioners:

"The language used by professionals was one which saw the girls as the source not the victims of their extreme behaviour, and they received much less sympathy as a result."

"[The missing person] is believed to be prostituting herself to pay for drugs…putting themselves at risk. She is a street wise girl who is wilful."

Losing sight of young people's vulnerabilities and making assumptions about their agency and opportunities to remove themselves from harm was evidenced within the final reports:

"A further common theme amongst agency responses which demonstrated the lack of understanding as to the nature of CSE was a focus not on their vulnerability but their 'high risk' behaviour. There are repeated comments made to and about the young people based on a view that it was within their power to 'keep themselves safe'. A similar frequently made comment was in relation to the young people 'engaging in risky behaviour', suggesting that this was something they could chose not to do."

In other cases the evidence of vulnerability and exposure to CSE was not so much missed as misconstrued, misinterpreted and occasionally ignored:

"Although there was recognition that aspects of [young person's] behaviour and lifestyle represented risk, it was not escalated or formalised through any of the multi-agency assessment and intervention in relation to CSE or missing from home frameworks. Some of this is reflected in her apparent reluctance to engage with some people and services but it also indicates a mind-set in terms of how older children who present with challenging or complex behaviours are helped."

"The author has seen little that has not been replicated in other SCRs on CSE, or in national reviews which have identified over and again the slow progress in responding to guidance, and a poor understanding of CSE and its wide geographical spread. That slow progress was often related to three things – thinking group based CSE happened somewhere else, an inability to grasp that something as horrible could really be happening, and seeing the victims as placing themselves at risk rather than understanding the grooming process."

Not hearing or understanding the young person or their family

Although the importance of seeing and listening to the child is a key lesson identified in previous biennial reviews (Brandon et al, 2008; 2009), there still remains a worrying sense of professionals not seeing and not speaking directly to the young person. More importantly, professionals are not always hearing or recognising what these young people are saying in terms of the wider picture of their potential vulnerability. This was a theme evident across the sample:

> *"This case was referred for an SCR partly because of the concern that the child's voice had been lost. Despite considerable input from the multi-agency network, she continued to be at risk of abuse and suffered significant harm."*

A young person succinctly expressed her feelings of not being heard or understood saying '*no one believes me, no one cares'.*

The lack of assessment of the whole family could result in a reduced understanding both of the lived experiences of the young people and the parents' ability to keep them safe:

> *"The absence of assessment of the young people's family dynamics led to failure to understand their current problems in any context; a failure to recognise their needs were not being met in the home including the existence of neglect; and also the failure to properly understand the families' ability or commitment to protecting their children outside the home."*

Themes emerging about practice, professionals and agency issues therefore again parallel those in serious case reviews generally in that there was, in many cases, evidence that the child had not been listened to, and in many cases the family had also felt unheard suggesting that there was on occasion a lack of 'thinking family' in order to better understand and increase support for the young person:

> *"[Practitioner] viewed the older sister in isolation, without taking a 'think family' approach… This was in the context of a number of significant safeguarding events occurring in relation to both [young person] and [the perpetrator]…There were several missed opportunities to share information that could have helped identify the risk to [young person]."*

5.3.3 Opportunities for protection

The serious case reviews relating to child sexual exploitation revealed issues similar to many found in other SCRs, including the need for professional curiosity and information sharing, but also highlighted the critical importance of relationship-based practice with young people.

Professional curiosity

There were examples of a lack of professional curiosity in several of the cases:

> *"The police response lacked curiosity- they would pick the child up, give them a telling off and drop them back at the children's home."*

In one case an extremely vulnerable young person had to be found a secure placement but children's social care refused to consider legal proceedings to protect her and she was returned to live with her mother with no assessment made of her needs or the risks. This is described in the SCR as a decision "*almost impossible to believe.'* Within three

months the young woman had gone missing from her mother's house having been assaulted by the mother, and was being sexually exploited again. No re-assessment was undertaken. The view expressed about the 15 year old at the time was that *"whilst she needs support to protect herself, she is of an age where she carries some responsibility".*

This, as the SCR noted:

> *"…fails to recognise not only the dynamics of child sexual exploitation but also the young person's developmental age and her capacity to manage her life without the support and protection of anyone taking parental responsibility."*

For many of these young people, their age and behaviour led to professionals viewing them more as adults rather than vulnerable young people with little possibility of changing their behaviour and circumstances:

> *"There was an underlying sense that something tangible can be done to protect the babies whereas the solutions and options available to protect the young people in what was becoming a deeply entrenched pattern of exploitation and abuse was far more challenging and uncertain."*

Recording and sharing information

Lack of inter- and intra-agency communication and an assumption that other agencies knew, or were doing things, were cited frequently as reasons why the wider picture of the risks posed to the young person were not identified, either at all or sooner:

> *"Every agency assumed that they did not need to raise safeguarding concerns about [young person] because CAMHS was involved. Unsurprisingly, her CAMHS workers focussed on her mental health needs, unaware of safeguarding responsibility being afforded them."*

In one SCR it was noted that *"all staff appeared concerned about her safety and were aware of her vulnerabilities in respect of the concerns about sexual exploitation"*. But "*because she was 16 and over the age of consent to sexual activity, she was seen by some professionals as being less vulnerable"* and as having "*the mental capacity to make her own decisions".* Furthermore the young person *"did not accept and was not concerned that she was being sexually exploited. To address her care needs a multi-agency approach was required".*

Unfortunately, whilst individual workers discussed issues with their own line managers, in this case there was not a culture of formal meetings where information could be shared and evaluations of interventions and services undertaken. This led to an incomplete picture of the young person's circumstances:

> *"The constant anxiety that she would withdraw from services led to a lack of confrontation…. If an opportunity had been taken to get professionals together to*

discuss the concerns, and to pull together a chronology looking at all the evidence, it should have made a difference in the care of [young person]… There was a lack of good interagency working. This is not just about sharing information but about shared analysis, planning and interagency practice."

Good practice was also evident, and in one SCR it was noted that an Ofsted inspection had concluded that work undertaken by a multi-agency specialist CSE team was holistic and had a focus on meeting the needs of young people:

"Their work focuses both on reducing risks and meeting wider needs for young people, as well as providing good consideration of the young person's holistic needs. Additionally*, large numbers of professionals have been effectively trained to identify potential indicators of CSE."*

The importance of relationships with practitioners

"If someone had taken the trouble to ask me I would have told them."

Catching young people at a pivotal or critical moment in their life can help them to think differently about their circumstances. This is a step towards their being better able to protect themselves. However, there is evidence from these final reports that the professionals charged with safeguarding young people miss these critical moments. Examination of the SCRs indicates that it is often an unqualified, voluntary or specialist worker who spots and works with a young person at a potentially pivotal moment in her life, but that this work was often unacknowledged or discontinued in wider agency planning. When asked what it was about some voluntary workers that a young person liked she said "*it was because they stuck by her."*

Another final report suggested that:

"Better engagement by CSC with [the voluntary agency], where there was early on a very strong attachment from [young person], might have allowed the LA to build on her positive relationship with the workers there in order to facilitate her agreement to therapeutic help."

There are examples of workers, often unqualified staff, getting alongside young people and trying to make sense, with them, of what they were saying and experiencing:

"The girls' comments on how they trusted and felt most at ease with unqualified staff, finding some professionals hard to relate to and cool/distant/boundaried is food for thought for those involved with professional training and practitioners."

"The support worker was great. She was an adult. She was firm and there for me…She talked about 'we' i.e. me and her…The only person who was any good was [the support worker] …I wasn't confident enough to tell her …but she was talking to me and listening."

One young person spoke of her experience of the specialist team in very positive terms:

> *"I feel like they are my family and they like me .I just get on with everyone, it's a nice environment and everyone is nice and stuff. … Then I got closer to my social worker and I started telling her more on a 1-1 sort of thing."*

It is clear that the good practice inherent in listening to, and getting alongside, a child or young person is key to developing a relationship with them which may dissipate some of their resistance to engagement. This may then begin the process of enabling them to recognise the dangers they may think they are 'making choices' about.

This may in turn begin to resolve some of the dilemmas inherent in working with some young people who feel they are making choices and refute that they are being abused. Self-worth is built from a sense of being loved and lovable. Professionals in all the relevant agencies have these skills and are using them with these young people, despite the challenges of their behaviour. This may begin the upward spiral of building resilience and a sense for them that they deserve better.

Unfortunately, there were many more examples of young people feeling unheard and unsupported by the professionals across the agencies whose jobs were to protect them:

> *"I thought that they [the men] cared about me. They [the professionals] go home at night to their families. I had no-one, I was in a kid's home."*

Structural and systemic issues

Lack of staff, high staff turnover, over use of unqualified staff, inadequate supervision, a lack of professional curiosity and a sense of helplessness and low morale were often identified as reasons for a lack of timely and holistic assessments and appropriate planning. These were often issues for all professional groups:

> *"Severe difficulties in the LAC Team, during the time frame for this review, meant, that their work was not carried out as it should have been. Sickness levels were high and this included one of the two main social workers for [young person]…supervision was irregular…as a 'knock-on' effect of absences in the team [young person's] next allocated social worker was assigned an unrealistically high caseload –and given insufficient guidance."*

We found evidence at a senior level of professional reluctance to accept that CSE was taking place in their area:

> *"A senior safeguarding nurse told the review that it was not that there was no consideration of CSE but that it was 'simply not thought to be a local issue'."*

Perhaps with a mind-set of CSE unlikely to be a local issue, professionals at all levels sometimes appeared to lack curiosity when supporting the young people:

"A lack of professional curiosity was described as 'a theme' which ran through the CSC internal management review. There were unanswered questions in relation to several of the girls, for example, them associating with unknown adults…Team Managers needed to be challenging this in supervision but rarely did so."

Whilst there was some good practice at an individual practitioner level, there was widespread and systemic misunderstanding about young people's vulnerability to CSE. A lack of professional curiosity at all levels might have contributed to the young people's predicament becoming so entrenched. As time went on the abnormal became seen as normal and young people's vulnerability to the risk of CSE was missed or reframed. This affected professionals' response to ostensibly unacceptable situations:

"One does not need training in CSE to know that a 12 year old sleeping with a 25 year old is not right, or that you don't come back drunk, bruised, half-naked and bleeding from seeing your friends."

In addition, what stands out as a key feature is not seeing CSE as the sexual abuse and exploitation of children and young people but rather as a *"lifestyle choice".* There was a view amongst some professionals and within organisations that it was "*difficult girls making bad choices":*

"If this sense of helplessness in the face of young people living with brutal and traumatising experiences is to change it will need an absolutely clear and consistent message from the highest level of the agencies that if this experience is not acceptable for our own children, it will not be acceptable for any children."

In summary, looking across the serious case reviews, particularly those spanning a number of years, there is evidence in more recent years of the emergence of an increased awareness of CSE and better recognition of the early warning signs of young people's vulnerability. This is a positive sign, but one which needs to continue to be built upon.

Learning Points

- Parents need to be given advice and support where they have concerns that their child is being sexually exploited
- Although awareness of CSE is improving, there is still a lack of professional confidence about recognising the early warning signs
- CSE needs to be understood within the wider context of the needs of the young person so that appropriate action can be taken
- Because of, and in spite of, their challenging behaviours, vulnerable young people must feel that someone is 'there for them' and that they are heard and understood.

Chapter 6: Pathways to protection: managing individual cases

Chapters 2 and 3 highlighted that (a) most serious and fatal child maltreatment takes place within the family among children living at home or with relatives; (b) most children were not involved with the child protection 'system' through a child protection plan or a court order, although many were receiving services as 'children in need'; and (c) many of these children and families had been known to children's services in the past, and as such should be considered by agencies as having recognised vulnerability or risk. These findings are in keeping with previous national analyses and the wider research. It is clear that significant opportunities for protecting children lie in preventive interventions within the community and by universal services. Such opportunities arise through recognising and managing risk and vulnerability, and through promoting resilience in children and families.

This chapter outlines opportunities for protection and prevention in relation to managing individual cases and decisions.

6.1 Focussing on the needs and voice of the child

One of the key themes arising in the SCRs was on ensuring a focus on children's needs and identifying vulnerable families. Specific recommendations have related to domestic abuse; disguised compliance; working with fathers; and specific groups of children such as those who are looked after or with chronic health needs. Many recommendations focused on ensuring children's needs and views are central to investigations, child protection plans, and early intervention work.

'Hearing the voice of the child' requires safe and trusting environments for children to be seen individually, speak freely, and be listened to. This is particularly important when children display early signs of neglect or emotional abuse, but are unable to express their concerns. In a case involving a six month old, premature baby, who died as a SUDI within a family context of substance misuse, domestic abuse and neglect, engaging with the older sibling may have led to a better understanding of the family context:

> *"[The sibling] was anxious about explaining why there were absences and why they were often tired when they did come to school. [The sibling] was so anxious and embarrassed when arriving late at school and having to give an explanation, that staff had decided not to question the children as it caused them too much distress."*

Professionals must consider how to enable children to express their views while taking account of the child's age, development, and language. This will be compounded if the child is in any way threatened or coerced by an abusive parent, or if the child has other underlying developmental or communication needs. Previous research emphasises how children have extreme difficulty in expressing their concerns and that professionals

should not *expect* children to disclose abuse (Cossar et al, 2013; Allnock and Miller, 2013).

The onus falls to the professionals and requires an interest in how children express themselves through their behaviour and what they say rather than seeing them as 'difficult' or 'demanding'. This requires skill, creativity and resources such as play, to enable them to express themselves and to be able to interpret their behaviour appropriately. Considerations must be made for children who do not communicate in English:

> *"Especially on occasions when [the child] was the particular focus of concern, there appeared to be an assumption that he was unable to express his wishes and feelings and that the use of interpreters would be ineffective, when this should have been tried. Potentially greater opportunities on other occasions with different professionals could have been taken to communicate through play or other mediums."*

An active effort must be made to actually see children in their families. This is a lesson 'so important that [it must] be re-emphasised and potentially relearnt as people, organisations and cultures change' (Sidebotham 2012, p.190):

> *"The feelings and wishes of the child and his siblings are not clearly captured and recorded in any agency chronology and it appears very little focused and specific direct work took place with the children to address the impact of domestic abuse and parental alcohol misuse. The feelings and wishes of the child and his siblings in respect of contact with their father are also not clearly captured."*

The following case demonstrates how police, while responding to domestic abuse, did not consider its impact upon the children concerned:

> *"Whilst the Police IMR confirmed that it was an expectation via the relevant domestic abuse policy that "children living in the location are physically seen and their welfare checked", this was not always apparent. On some occasions there was no reference to the whereabouts of the children, and when they were seen, there were generalised comments such as the children being "none the wiser", "safe and well" or "fine"."*

Supporting parents without losing sight of the children is particularly important for professionals whose primary focus is caring for adults:

> *"Whilst they did not observe any interaction that caused them to assess that the children were unsafe, they nevertheless focused on mother's mental state rather than her reported aggression towards the children."*

6.1.1 Recognising adolescent vulnerability

Voices of adolescents are of equal importance to those of younger children. Many may struggle to express their needs of feelings, or to engage effectively with services. There are dangers, particularly within health, of falling between child and adult services, as in this case of a 17 year old young man who died as a consequence of his underlying medical condition:

> *"Had [the young person] been under children's paediatric services at this stage, the DNA (Did Not Attend or Was Not Brought) policy would have been triggered. The fact that he was being treated as an adult rather than a child therefore had an impact on the expectation of him to manage his own appointments and treatment. As the agency report for the [Health Trust] states 'during the author's meeting with the adult diabetic team, it was clear that the team had not considered [the young person] to be a child in terms of safeguarding. This appears to have arisen due to the practice that, within health, young people generally receive services from adult teams from the age of 17 years. Safeguarding Children policies were therefore not considered to be relevant by the adult diabetic team, essentially because [the young person] was within an adult service he was seen as an adult and not as a child'."*

The difficulties surrounding engaging effectively with young people are outlined in the following cases of two young people with chronic health needs:

> *"[The young person] displayed challenging behaviour towards professionals and was also challenging for parents. Examples of this were…refusing to attend for health treatment being verbally abusive towards staff and other patients and causing disruption in health settings. Despite attempts from family to support sensible decision making [the young person] continued to make poor decisions about access to both health and education provision which was being offered."*

> *"It was agreed by all those involved that [the young person] was competent and had sufficient capacity to make decisions about his health. What was also clear however was that he showed a degree of disguised compliance, as is common with teenagers in respect of their health needs and treatments. This means he agreed to cooperate with his testing and insulin regime, but in reality did not comply."*

Achieving a balance between respecting the autonomy and wishes of adolescents while recognising their vulnerability is not an easy task for professionals to achieve:

> *"A real and difficult ethical dilemma arises for professionals when a young person, who is informed and understands about health care treatment and the consequences of not accepting treatment, continues to refuse. Professionals can only continue to guide and advise the young person in question and need to be supported by their managers in so doing."*

Learning Points

- Be aware of 'silent' ways of telling through verbal and non-verbal emotional and behavioural changes in children
- Explore creative ways of engaging with children with regards to their age, communication skills and personal history to enable them to share their experiences
- Follow up concerns within families by ensuring each child is given an appropriate opportunity to talk
- Professionals need to recognise young people aged 16-17 years as still being vulnerable and to use appropriate children's services and follow safeguarding procedures

6.2 Identifying and responding to parents' needs

Chapter 4 highlighted the many situations in which a parent's background may present risks to their children. While retaining focus on the child, it is important that professionals working with parents can assess and respond appropriately to their needs. Often, it is in doing so that children's needs are best met.

6.2.1 Assessment of adults with mental health problems

Parental mental ill health has been recognised as a potential risk factor for child maltreatment. The presentation of an adult with mental health problems who has contact with, or caring responsibilities for, children provides opportunities for further assessment and intervention to mitigate risk.

The issue of mental health and child safeguarding, however, presents significant challenges to professionals. Cleaver et al (2011) cited a 2001 study stating one in six adults had a neurotic disorder and presented rates of up to 6.6% for depression, 13.4% for personality disorder, and 27% for post-natal depression. Nevertheless, despite the high prevalence of mental health issues, the incidence of serious and fatal child maltreatment remains low. Mental illness, in contrast to domestic abuse and substance misuse, is not in itself harmful to children and needs to be approached in that light.

Nevertheless, parental mental health issues were prevalent in these serious case reviews, and the wider child maltreatment literature emphasises how adult mental health problems can and do present risks to some children. It is crucially important that professionals consider the risks and implications of any mental health problems for children in the family. This is illustrated in the following case:

"[The mother] attended the GP surgery with [the sibling], with depression and suicidal ideation. She was clearly not coping and this made her very vulnerable. There is no evidence that the GP asked about the welfare of [the sibling] and there was no information sharing with any other professionals at this point. [The sibling] remained a child in need but critical information held by the GP did not influence any planning and the GP appears to be entirely disconnected from any system of support around this child and family. The Primary Care (GP Service) IMR acknowledges that:

'The author did get the impression that the GP agreed that the children were vulnerable, but that the mother's vulnerability stood out more because the GP was dealing with her on a daily basis. The children were effectively hidden because they were not seen often'."

A number of SCRs involving younger children had evidence of parental self-harm. This behaviour should always be considered a risk to children and presents an opportunity for professionals to intervene:

"Although the assessments at all the subsequent attendances / admissions note each prior attendance for self-harm, practitioners' responses do not indicate an awareness that repeated self-harm could be a potential indicator of abuse or neglect… Each single admission represents a missed opportunity to consider child protection and provide an opportunity for additional child and family support via Children's Social Care and joint inter-agency plans of care."

To grasp prevention opportunities, those working in adult mental health including GPs, midwives, and mental health workers, need to be aware of the risks posed; associated risk factors (such as domestic abuse, substance misuse, criminality, and parental history of childhood abuse); or warning signs in the adult's presentation (including escalation of symptoms or suicidal intent). They must inquire about whether the person has contact with or care for children. Difficulties arise when such adults later have access to or responsibilities for children, for example as a new partner, or where individuals choose not to disclose information to those working with them. A number of serious case reviews emphasised the importance of thorough assessments in relation to those presenting with acute mental health problems, as illustrated in the following case in which a young infant was stabbed by her father a few days after this A&E attendance:

"That evening the father presented at A&E, initially with his mother and joined shortly afterwards by his partner… [the father was first seen by a triage nurse… She noted that he had not slept and that he had been very anxious for two days and she noted the medication prescribed by the GP… 30 minutes later [the father] was seen by an A&E doctor who noted that he had been exhibiting paranoid, angry and erratic behaviour; he was also noted to be tearful and suffering from insomnia, based on the history given by his mother. The A&E doctor noted that Mr B had suffered from 'induced psychosis in 2004' and that he had been treated with

medication for two years… the risk assessment recorded was that he was 'no risk to others', 'no risk to self – not suicidal' and 'no risk from others but paranoid'…

For their part family members have expressed frustration and disappointment to the SCR about this assessment. They have expressed concerns about some remarks made by the doctor and the mental health worker which they feel conveyed a negative attitude towards the family. Mr B's partner did not think that there was sufficient probing in depth of his mental and emotional state and how he was feeling."

There are particular opportunities for prevention in relation to pregnant women with mental health needs, as in the following case. Adequate provision of perinatal mental health services could go a long way to ensuring that appropriate assessment and support for such mothers is available:

"At the first 'early pregnancy assessment unit' attendance in 2006 when she was seventeen years old, the casualty card indicated that she had a history of schizophrenia but there is no evidence that this was further explored by the nursing and obstetric and gynaecology staff. This represents a missed opportunity to explore mother's mental health and any medication she may have been taking. The limited assessment also precluded referral to other agencies, such as mental health, who could have supported a positive outcome to the pregnancy and the parenting of the baby once born."

Learning Points

- Mental illness is not, in and of itself, harmful to children; it may, however, present risks in some situations, for example, through delusional thoughts or self-harming thoughts or behaviour, or when combined with other parental risks
- The presentation of an adult with mental health problems who has contact with, or caring responsibilities for, children provides an opportunity for further assessment and intervention
- Professionals working with adults with mental health difficulties should be alert to additional factors or warning signs in the adult's presentation, and must inquire about whether the person has contact with or care for any children

6.2.2 Managing domestic abuse

Domestic abuse is now taken more seriously by all professionals than it had been in the past. Extensive training is now available, along with tools for assessing risk. Possible domestic abuse must be handled sensitively and this can prove difficult, particularly in community settings where mothers may see professionals in the presence of their partners. This may have been a factor leading to a failure to consider domestic abuse in the following case and is an issue that could be addressed through supervision and training:

> *"An antenatal referral was completed. The information regarding her low mood was included but the information regarding allegations of domestic abuse was not. This runs contrary to the requirements to address early vulnerabilities of parents and to consider the implications for the unborn child… There is no evidence that Mother was asked follow up questions about domestic abuse as would be expected, and Mother said when interviewed as part of the Review that she could not recall being asked. During some visits Father was in another area of the family home and in these circumstances asking about domestic abuse would not have been appropriate. However, it would be expected that this would have been clearly recorded in the notes and a plan of action for future routine asking about domestic abuse formulated."*

At the serious case review recommendation stage many recommendations were aimed at improving the management of domestic abuse. These included efforts to improve background knowledge; ensuring that all staff recognised domestic abuse as a safeguarding issue; asking mothers specifically about domestic abuse during contacts; and responding appropriately to disclosures with clear thresholds for taking action:

> *"The Board should request that there be a review of the grading system used by MASH* [Multi-Agency Safeguarding Hub] *with a view of eliminating the ambiguity apparent in the current use of the "amber" grade. This review should explore the degree to which there are shared understanding of thresholds with regard to domestic violence. It should also clarify expectations in terms of responding to each grade."*

6.2.3 Early support and intervention for drug and alcohol misuse

As highlighted in Chapter 4, nearly half of the families in these SCRs had identified alcohol or substance misuse. This is a common feature in many child protection cases. Professionals working with adults who misuse substances, including those in primary care teams and alcohol and substance misuse services, must remain vigilant to the possibility that these adults may have parenting responsibilities, and consider the potential impact of substance use on their children.

On the other side, those professionals working with families, while keeping an appropriate focus on the children's needs, should be alert to the possibility that a parent may have issues with alcohol or substance use, and to refer on for appropriate supportive services, as in the following case of a child who died following methadone ingestion:

> *"Nor is there indication that [the mother] was offered any support which may have been related to her increased use of alcohol and heroin. This may have been a missed opportunity more fully to engage her in drug reducing strategies."*

6.2.4 Criminal behaviour – assessment of potential risks to children

As noted in our first biennial analysis (Brandon et al, 2008), a prior record of criminality has been frequently found among parents and family members. This was found in the current cohort particularly, though not exclusively, in relation to violent crime. This should, perhaps, be seen as a risk factor for serious or fatal maltreatment, especially when combined with other parent/carer risks such as domestic abuse, substance misuse or mental health issues.

One of the difficulties in identifying and acting on these risks is that information about the criminal history may be known to a different set of professionals than those working with mothers and children. Probation services do not typically engage with other agencies unless specific child protection concerns, or risks to vulnerable people have been identified such as through the multi-agency public protection arrangements (MAPPA) process.

Identifying and acting on protective opportunities requires professionals working with these individuals to consider whether they may have access to children and whether this could pose any risks. Those working with children and families must consider whether the adults in contact with those children have criminal records and be prepared to seek out relevant information.

In the following case a three year old died following a violent assault by his mother's new partner - a young man with a criminal record for domestic abuse:

> *"During contact with the probation trust, the perpetrator repeatedly stated his intention to move into independent accommodation with the mother and the Child. However this did not prompt any enquiry or referral to Children's Social Care to ensure that the child was safeguarded. The mother was to move to independent accommodation and the perpetrator was to breach his curfew to move in with her. Within two days he had violently assaulted both the Child and the mother."*
>
> *[One month before the fatal incident,] the mother and the Child were present when the perpetrator was assessed by a Community Psychiatric Nurse. The mother stated that she knew of the past history of the perpetrator, including his criminal*

conviction and that she had known him prior to the break up with his previous girlfriend. The mother was asked in the presence of the perpetrator whether she felt afraid of him to which she said "No", and stated that they had a loving relationship. The perpetrator was described as being open and willing to talk about his history. The perpetrator described himself as a "Jekyll and Hyde" character stating how he was fine at one moment and then agitated and anxious the next. He maintained that his ex-girlfriend had lied to have him convicted and denied using substances or drinking alcohol to excess. The assessment identified that the perpetrator's mood was variable, could change quickly but he denied any thoughts of suicide, self - harm or planned intent. He disclosed that he had twice weekly contact with his Probation Officer. There is no evidence of any contact being made or efforts made to obtain or verify information and there is no indication of awareness of child safeguarding and any risk that the behaviour and lifestyle of the perpetrator might pose to the Child."

Learning Points

- The presence of a criminal record should be seen as a risk factor for serious or fatal maltreatment, particularly when combined with other parent/carer risks such as domestic abuse, substance misuse or mental health problems
- Probation workers and others working with individuals with a criminal record need to enquire as to whether the individual may have access to children
- Professionals working with children and families should consider whether any adults who are in contact with those children may have a criminal record

6.3 Exploring vulnerability and risk

When a child presents with indicators of possible maltreatment and vulnerability, or a parent or carer presents with recognised risks, professionals have an opportunity to explore that vulnerability and risk and take steps to intervene and protect the child. This requires a stance of professional curiosity and awareness of possible maltreatment and cumulative risk. Professionals must challenge parents and explore the issues while maintaining an objective and supportive manner. This is not an easy balance but there were several examples of education and health staff being alert to concerns and acting appropriately, making detailed and well-reasoned referrals, as in this case:

"[The sibling's] school report a deterioration in attendance and lateness and that the Education Welfare Officer and school attendance staff were refused entry to the home by [the father] and subject to 'a lot of abuse by him'. School also report

that [the sibling] presents as unkempt, uncared for, is frequently hungry and often does not want to talk. They have also struggled to contact [the mother] when they have needed to."

6.3.1 The role of universal services: awareness of risk and vulnerability

Families with identifiable vulnerability or risk, who are accessing universal services such as health, early years services and education, present professionals with early intervention opportunities. This can prevent risks from escalating and causing significant harm to the children. Previous research indicates that most children living in vulnerable or risky environments are unlikely to be abused. This could be because of inherent resilience within children and families, through the presence of ameliorating or protective factors in the family or community, or through professionals providing appropriate support and intervention.

While there were some isolated examples where professionals had not identified or responded appropriately to recognisable vulnerability or risk factors, there was little to suggest from our review that there is any widespread lack of awareness of or systemic failure to address risk factors within universal services. Indeed, there was evidence in a number of reviews of good practice in identifying and responding to early concerns:

"Community Midwife 1 made a referral to the Specialist Midwife because of Mother had told her she occasionally used cannabis and the Community Midwife considered that Mother was potentially vulnerable because of her lack of engagement with antenatal care." [This referral led to enhanced support by midwives and health visitor in the post-natal period.]

"The Forced Marriage Unit Specialist Caseworker referred the family to [Children's Social Care]… due to awareness of mother's general vulnerability: aged under 18 years old, having endured a forced marriage, given birth at a very young age in difficult circumstances and whose children may have witnessed violence. Although there were no specific concerns about the welfare of the children the FMU worker made the referral as 'I wanted to check that her and her children were ok and felt they needed a professional (social services) assessment in case additional support was required'."

"Throughout the period of the scoping, the records show health visitors have identified concerns relating to this family and the care of the children and have escalated those concerns appropriately. These concerns have been in relation to missed health appointments, developmental concerns regarding Sibling 2, behavioural concerns regarding Sibling 1, the mother's lack of insight regarding the impact of domestic violence on the children, and the family's housing situation."

However, in many cases, professionals were unaware of underlying risks or vulnerability because parents did not disclose information, as highlighted in this case of a 19 month

old who died following an unexplained non-accidental head injury:

> *"The child's half sibling was born, and Mother and her partner were visited as would be expected by health professionals. There were no concerns raised as a result of these visits, which were described as routine with evidence that Mother was coping well with the new baby. The child was seen and described as "lovely" and "thriving". Mother did not share that there was continued conflict with Father, or the threat of further costly legal action by Father."*

The existing literature identifies a range of risk factors and early indicators of abuse and neglect (e.g. Black, Heyman et al, 2001; Schumacher, Smith Slep et al, 2001; Schnitzer and Ewigman, 2005; Sidebotham and Heron, 2006; National Collaborating Centre for Women's and Children's Health, 2009); many of which are set out in tabular form below.

Risk/vulnerability factor	**Examples and comment**
Poor engagement with services	Particularly when this may reflect an element of maternal ambivalence towards her child or her child's needs. *Following [the baby's] discharge from hospital there was a joint home visit by the social worker and health visitor and subsequently he was seen by the health visiting service, however his parents did not take him to two follow up hospital appointments, his 8 week check or commence his immunisations. He was not seen again by any agency… until his death four months later.*
Repeated 999 calls	This may be combined with a lack of engagement with routine or follow-up health services: In one case of a young infant fatally assaulted by the mother's partner, in the space of six months there were a total of five 999 calls from the property. One instance involved an older sibling presenting with sunburn; another involved the child suffering smoke inhalation from a house fire which occurred when the child was inappropriately left in the care of two teenage babysitters. The latter episode was appropriately referred by the fire service to children's social care on grounds of possible neglect.
Adults with learning difficulties which may impair their ability to parent appropriately	*[The father's] learning difficulties were not understood or fully explored. Agencies provided services based on their expectation that [the father] was the head of the household, in a traditional cultural model when in fact [the mother] was in control. If staff had employed a more challenging assessment of family functioning, these elements may have been known earlier. Some under-standing of [father's] limitations caused by his learning difficulties*

	would have completed the picture of [mother's] situation.
Parental mental health problems and their impact on the parenting	Particular recognition needs to be given to the interaction between parental mental health problems and other risk factors, including domestic abuse, alcohol and substance misuse, criminality, and a parental history of childhood abuse.
Criminal behaviour	Criminal behaviour, particularly violent crime, is a significant risk factor for child harm. This poses challenges to professionals, as those professionals working with perpetrators of crime are often outside the child protection system and may have little engagement with professionals whose primary responsibility is to the child.
Domestic abuse	The issues around domestic abuse and coercive controlling behaviour have been explored in depth in Chapter 4. Police officers and others responding to issues of domestic abuse need to recognise the ongoing vulnerability of any child living in a context of domestic abuse, regardless of whether there are specific incidents of violence directly impacting on the child.
Housing issues	With the increased shortage of housing across many areas it is likely that overcrowding may become more of an issue and local authorities need to be aware of the impact on safeguarding. Increasing numbers of homeless people coupled with aging housing adds to these issues: *Unfortunately, the first flat was on the fourth floor of a building without a lift; this was a potential risk to a heavily pregnant woman and her two young children. However, given a steep rise in homeless applications and the portfolio of aging accommodation without lifts in the borough, this was the only available provision at the time. This lack of suitable resources is a continual problem both in the borough and elsewhere in London*.
Parental beliefs and practices	The issues around parental beliefs were highlighted in one case involving a young infant who died of rickets caused by severe vitamin D deficiency. The parents, strict vegans with strong religious beliefs, had refused any medical intervention for their child, including routine immunisations and health surveillance and recommended vitamin D supplements. When the child became unwell with an infection, the parents did not seek any healthcare, stating that they were awaiting a 'sign from God'.

6.3.2 Dealing with non-engagement

Parents who do not engage with services for themselves or their children present a challenge to professionals, but this challenge also provides an opportunity for protection. It has been pointed out that the term 'did not attend' or 'DNA' in relation to children's appointments is meaningless and potentially damaging. Replacing DNA with 'was not brought' (WNB) could lead to positive interventions to safeguard and promote child welfare (Roe, 2010; Roe et al, 2015).

Failure to engage with universal health and education services was noted in a number of the serious case reviews, along with a number of barriers to proactive working in response to parental non-engagement, as seen in the examples given below:

Barrier to effective intervention	**Examples**	**Opportunities for more effective intervention**
No immediate evidence of harm to the children	*The report from… Children's Social Care identifies their first involvement with the family in 2008. Further referrals were received in 2009 and 2010 identifying that the children were out of school and concern was expressed about a number of risk factors - parental substance and alcohol abuse; mental health, housing and children not attending school. The parents refused to engage and the case was closed, as the Section 47 threshold was not felt to be met.*	Any non-engagement with services that are central to a child's welfare should be seen as carrying potential harm for the child. This should prompt an assessment of the child's needs and how they are being met. Even if the threshold for child protection interventions is not met, steps should be taken to address the non-engagement and ensure the child receives appropriate services.
Perceived to be legitimate parental choice	*The second review conference… failed to grasp the opportunity for the network to form an overview of the likely long term impact of the ongoing parental behaviour. Possibly by then acclimatised to the family norms, the social worker (and others) mistook non-compliance or 'disguised compliance' as legitimate parental choice.*	Recognise that non-compliance may be a parent's choice, but that does not mean it is the child's choice. Changing the terminology used from 'did not attend' to 'was not brought' is a simple measure that promotes a changed mind set around non-engagement.

Disguised compliance or apparently legitimate excuses for non-engagement being accepted at face value	*In mid-May mother spoke with her allocated social worker and indicated that she would be unable to attend the finally scheduled family group conference because it clashed with her follow up appointment with a psychiatrist and because her mother and sister in law would be away. Comment: In analysing mother's excuses for non-compliance it becomes apparent that she usually uses more than one excuse for any given event.*	Professionals need to be prepared to challenge excuses for non-compliance and where appropriate to carry out relevant lateral checks. Being clear in labelling non-compliance as harmful to children could help with engaging parents, or clarifying the need for intervention if non-compliance continues.
Cancellation and rescheduling of appointments not recognised as potential disguised compliance	*The teams within [maternity and specialist child health services] worked well with mother & children, but were falsely reassured by her contact with the team (not recognising a pattern in the rebooking of appointments).*	Repeated cancellation and rescheduling of appointments should be treated with the same degree of concern as repeated non-attendance.

When dealing with non-engagement, families can be seen as 'hard to reach' or 'difficult to engage'. This places the responsibility on parents without considering the underlying causes, such as domestic abuse. Recognising families' vulnerabilities and flexibly accommodating their needs is good practice and facilitates engagement opportunities as in the following example:

> *"Mother's GP saw her as a young single parent who was vulnerable in many ways, including the threat of violence from her ex-partner and the difficulties presented by her housing. The GP was supportive to Mother, and ensured that the practice generally made efforts to ensure she would be seen, even when she was late or failed appointments; this approach was signified by a flag on the system to give her 'priority appointments' whenever she did manage to attend."*

Once families are in the child protection or child in need 'system', their engagement with plans can be difficult for professionals to manage. Professionals may be tempted to ignore aspects of the plan or close the case when there is poor engagement, further compromising child safety. Making clear plans from the outset; engaging professionals and families; and reviewing concerns if non-engagement arises could lead to more effective working. In this SCR, closure of the case left a seven year old girl vulnerable to the effects of ongoing neglect of her medical needs.

> *"The team manager at the time who sanctioned case closure has explained that families do not always feel the need to engage with a child in need plan and in this*

case the lack of focussed planning at the start of the plan had meant that engagement was problematic. Care was taken to ask other professionals whether there were any concerns before the decision to close the case was made. Closing a case due to non-engagement is not good practice and the current more proactive approach within [the local area] to child in need planning needs to ensure that if cases are closed due to non-engagement there is a thorough review of any risks associated with this decision."

In order to employ appropriate support and challenge to parents in the face of non-engagement or disguised compliance, professionals need to be supported through adequate supervision, training and management oversight:

"Professionals working with families need to ensure they do not become over reliant on parental self-reporting. Agencies need to ensure that the current mechanisms in place to support effective professional practice such as supervision, management oversight, training and audit recognise the issue of parental self-report and the risks associated with professionals being over-reliant on it."

Learning Points

- Any non-engagement with services that are central to a child's welfare should be seen as carrying potential harm for the child
- Professionals need to recognise that non-compliance may be a parent's choice, but that does not mean it is the child's choice
- A shift in terminology from DNA ('Did Not Attend') to WNB ('Was Not Brought') can help maintain a focus on the child's ongoing vulnerability and dependence, and the carers' responsibilities to prioritise the child's needs
- Professionals need to be prepared to challenge excuses for non-compliance and where appropriate to carry out relevant lateral checks
- Repeated cancellation and rescheduling of appointments should be treated with the same degree of concern as repeated non-attendance

6.3.3 Recognition of maternal ambivalence as a risk

Maternal ambivalence towards her child (both during and after pregnancy) was highlighted in many SCRs as a potential indicator of a child's vulnerability. At its extreme, this may present with a concealed or denied pregnancy. While such cases are rare, other presentations including delayed antenatal booking or uncertainty about keeping the pregnancy are far more common. Such presentations provide midwives and GPs with

opportunities to explore mothers' concerns; possible medical issues such as depression or anxiety; past experiences; and potential external pressures such as from controlling partners or relatives.

Post-birth, ongoing maternal ambivalence may present with a lack of expressed warmth towards the child; feeding and bonding difficulties; or poor engagement with services such as routine child health surveillance or post-natal classes.

When identified, maternal ambivalence warrants a fuller assessment focusing on children's needs; potential risks; existing support structures; and additional support needs. Extreme maternal ambivalence or its combination with other risks would warrant case escalation to children's social care:

> *"When [the mother] tested positive for pregnancy it might have been expected that consideration would have been given to updating the previous CAF. [The mother] had shown ambivalence about her pregnancies, including a possible pattern of concealment; she was a single parent and was already identified as experiencing some difficulties in parenting her two existing children. This was a time at which she could be anticipated to experience increased stress and a multi-agency review would have been justified."*

Learning Points

- Presentations such as delayed antenatal booking, or uncertainty about keeping the pregnancy may reveal underlying maternal ambivalence about her child
- Professionals should explore with the mother the reasons underlying such ambivalence, to consider whether there may be underlying medical issues, previous experiences which may have contributed to the mother's feelings, or whether there are external pressures such as a controlling partner or family member
- Where true ambivalent feelings towards the child are detected, these warrant a fuller assessment and potential escalation as a child protection issue

6.3.4 Persistence in following through on identified risk/vulnerability

As well as being alert to potential risk factors when dealing with children and families, professionals need to take any identified risks seriously; appraise their potential impact on children; and act decisively and consistently to follow through on such risks. The persistent nature of child maltreatment means that it often cannot be managed as

isolated incidents, through episodes of support with an expectation of case closure. Professionals in all agencies working with vulnerable families must be persistent in their practice, maintaining consistent support for the family and vigilance towards meeting children's needs. This includes pursuing non-engagement, seeking advice, and escalating concerns where appropriate, as in the following case:

> *"The school nursing support worker did try hard to chase up [the mother] in respect of the paediatric appointments and after the second failed appointment did inform the school nurse (her manager) although it is not clear whether this action heightened the identified risk to [the child] or generated greater urgency.*"

Although there was evidence of good practice by individual practitioners, opportunities are lost if actions are not matched by families and other professionals, as illustrated in the following cases:

> *"Throughout the autumn [the Family Worker] continued to undertake home visits and attempted to engage [the mother], but had little success, with [the mother] rarely being available. Eventually after three months the Family Worker closed the case due to the lack of engagement.*"

> *"The Midwife who saw her had concerns that she smelt of alcohol, and made a referral to Children's Social Care. They carried out an Initial Assessment which led to no further action, because the concerns were not substantiated and there was no evidence that Mother needed further support. Mother and her partner had routine contact with health professionals, and there was no reason for any other professional contact with [the child] or their half-sibling in the weeks before the critical incident."*

Where child welfare concerns are identified, poor engagement by families should heighten concern and should not prompt case closure unless there has been a thorough risk appraisal. Identifying unsubstantiated concerns as in the second case does not, in itself, invalidate the original concerns, but should lead to risk appraisal and alternative forms of support. In the following case of a five month old who died as a result of extreme neglect, many vulnerabilities were identified but were insufficient to warrant a child protection investigation. Responsibility fell to the primary care team to follow-through with the family, offering support and monitoring. However, new concerns relating to non-attendance did not result in escalation:

> *"The basis of co-operation and engagement upon which the core assessment was founded was no longer present but it does not appear that these collective factors were recognised therefore no further action or escalation was taken. This lack of concern continued when the family did not attend any further clinic appointments, given the vulnerability of the baby it would seem appropriate that this family had a low threshold for proactive contact. The health visitor does not appear to have*

reassessed the baby's needs or vulnerability at any time in the process in particular when contact dropped off."

In another case, a mother disclosed domestic abuse to the GP. This information was not pursued, leaving the mother feeling isolated and unclear of how to proceed:

"Whilst the GP had no doubt been a helpful "sounding board" for the Mother on these occasions, the GP did not follow up with any further advice or make enquiries with any other agency about what more specialist help could be offered to the family, and especially to address any needs that the children might have in the situation… The Mother explained in her contribution to the SCR that the GP had been supportive but that she nevertheless felt very isolated at this time and didn't know how to resolve the situation or whether to leave her husband. Greater information and advice at this time from the GP therefore may have been helpful."

Learning Points

- Be aware of the presence and nature of risk and vulnerability in relation to child maltreatment
- Take any identified risks seriously, appraise the potential impact on the children, and show persistence in following through on such risks
- Where there are identified concerns, a lack of engagement by the family should not prompt closure of a case without a thorough appraisal of any ongoing risks to children in the family
- Where concerns are identified but not substantiated, that should lead to an appraisal of any ongoing risks and alternative avenues of support for the child and family
- New concerns (such as non-attendance or a new partner entering the household) offer an opportunity for re-appraisal and escalation

6.3.5 Cultural normalisation and professional desensitisation

The sheer volume of needy families in an area was a frequent feature in reviews, as were specific community risks such as crime and street violence. This can mean that there is little to distinguish at-risk families from other families in the area, as expressed by several of the professionals in this case:

> *"The overall belief expressed by several professionals that this was a Mother affected by domestic abuse, aiming to do her best but like many mothers in the same area… struggling to meet all the needs of her children. She was not the only mother whose children were late for school or did not read with them in the evening or who missed out patient appointments."*

A danger that can arise in such situations is that of cultural normalisation and professional desensitisation. This may be a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task, but can result in vulnerable children being left without adequate assessment of their needs.

6.3.6 Exploring personal relationships

Exploring personal relationships within families raises important ethical dilemmas. Practitioners must balance their safeguarding duties with respect for confidentiality and for an individual's personal autonomy. Practitioners depend on what individuals choose to disclose and this is shaped by the awareness, perception, and candour of the individual. This may be a particular issue for vulnerable mothers who may be unaware of a partner's background, deny its significance, or be unable or unwilling to share information with a professional. In the following case, a three year old child was killed in a violent assault by his mother's partner. The mother knew of his violent past, but apparently did not perceive this as a risk:

> *"They met via mutual friends and indeed she knew his previous girlfriend and did not fully believe her version of the violence between them believing that she was 'a bitter ex'. The mother attended and listened to court proceedings relating to the assault by the perpetrator on his ex- girlfriend and she felt that the sentence reflected the fact that he had absconded… rather than as a consequence of the assault. The mother did not believe that the perpetrator posed a risk to the child or to herself. When she moved to live with the perpetrator and his family it was quite amicable and there were just the 'normal domestic tiffs'."*

The complexity of these issues was thoughtfully considered in the following review of a child who was killed in a violent assault by his mother's new partner, a young man with a concerning background including criminal convictions from age 13, drug and alcohol misuse, mental health problems, and evidence of previous domestic abuse against the mother. As this report highlighted:

> *"What this has raised is a complex issue about the role of safeguarding agencies in making judgements about the significance, or otherwise, of decisions made by parents about their personal and sexual relationships. It is however legitimate to consider this issue for two reasons:*
>
> i. *the potential risks involved when men in relationships which offer little commitment are involved in the children's lives*

ii. *the particular impact for the children's emotional development on their understanding about who are the significant parental figures in their lives"*

Such information provides opportunities for intervention:

> *"Professionals need to make careful judgements when seeking sensitive information regarding the personal relationships of adults with whom they are in contact. However, [the child's] experience highlights that it is legitimate to make such enquiries in the context of the impact that such relationships or behaviour may have on the adult's parenting capacity or the child's safety. [The mother] was asked on a number of occasions about whether she had a boyfriend or partner, but she chose not to share this information. Pursuing this line of enquiry without clear reason to do so, would have been highly intrusive. However, had there been a comprehensive assessment of the family dynamics, the significance of [the mother's] relationships and their relevance to her parenting might reasonably have been recognised as a legitimate area for assessment."*

Learning Point

- Professionals working with parents should not shy away from discussing the parental personal relationships and the potential impact of these on the children

6.3.7 Managing complexity

In his inquiry into the death of Victoria Climbié in 2003, Lord Laming criticised workers for not doing simple tasks well:

> *"Although the front-line staff who came to deal with Victoria's case were not helped in their task by the structure within which they operated they were, in many cases, guilty of inexcusable failures to carry out basic elements of their roles competently. In Brent, as elsewhere, the social workers involved would have needed only to do the simple things properly in order to have greatly increased the chances of Victoria being properly protected."* (Laming, 2003)

While justified to an extent, this downplays the complexity of child protection work. Child protection is rarely simple. Indeed, drawing on complexity theory, decision making in child protection has been described as a 'complex' problem: while we may know many of the risk factors that contribute to child protection and have some understanding of how those risks interact, *'even the most in-depth analysis of the factors will not tell us when or where or how serious the next occurrence of child abuse will be'* (Stevens and Hassett, 2007, p.129). Most of the cases examined in this triennial analysis demonstrated multiple

interacting factors within the lives of these children and families, as in the following case of a seven year old who died of an acute illness in which the mother failed to seek medical care:

> *"The case brings to the fore the question of how well our systems support work with complex families where there may be more than one cause for concern. It was interesting that some practitioners described the main issue as neglect whereas others saw it as a situation of domestic abuse which was no longer a problem if Mother was living alone. A smaller number thought the main issue was drugs. In fact to a greater or lesser extent all were issues at different points in time."*

The complex needs of some children and families inevitably mean that multiple professionals are involved in their care and support, requiring a balance of their competing priorities. This emphasises again the importance of good multi-agency working whereby professionals contribute knowledge and expertise, acknowledging their own priorities, while respecting the knowledge, expertise and priorities of other team members. An overall coordinating lead is required to manage the different perspectives and prioritise the child's welfare. This was highlighted in the case of a looked after child with diabetes:

> *"The processes and expectations of single and multi-agency working in place at the time of his death were not always followed, and while this did not directly cause his death it meant that this child with complex health needs did not receive the focus and persistent oversight he required to avoid the crisis in his health which led to his death.*"

6.4 Working with families

Effective safeguarding of children relies on good collaborative working between professionals and families. The reviews contained evidence of good practice as well as scope for improvement. Many issues were identified including hearing the voice of the family; over-reliance on families to act on advice; respecting parental beliefs and practices; and balancing support and challenge.

6.4.1 Collaborative working with parents

Just as hearing the voice of the child is central to effective assessment, working with families is central to effective child safeguarding intervention. Effective partnership working with parents requires their full understanding and engagement with what is expected. Language and literacy can be barriers to this, as illustrated in the following cases:

"There was contradictory information about the degree to which [the mother] could speak and understand English ... It was an additional failure of the assessments undertaken that they did not explore or give a definitive view about her linguistic ability. On the vast number of occasions that professionals had contact, on only a small number of occasions was an interpreter used, and letters that were sent to [the mother] were generally sent in English."

"An issue that stands out is the perceived value within Children's Social Care of a 'working agreement'. The potential value of clarity and reciprocity in a child protection or child in need plan between service users and agencies is a 'given'. However, putting aside the relevance in this case of mother's illiteracy, there was no logic to the decision in early August 2010 after the social worker signed the latest of several such agreements, of immediate case closure."

The latter case highlights the limitations of 'working agreements' in child protection practice. Working agreements can lack rigour and clarity, leaving parents and professionals uncertain of expectations and plans, and raising concerns about truly informed consent:

"Later on the day after the birth of [the sister], what was to be the first of several 'working agreements' was discussed and read to the parents. Mother was at first agitated, and walked away stating no-one would take her baby from her. Father remained calm. Both parents signed the document…

Comment: One suspects that parents in these circumstances might sign anything; in addition being barely literate; they may have had little understanding of that to which they had 'agreed'."

Effective work with parents requires professional curiosity and challenge, without which analysis may lack rigour and depth. Prioritising keeping families together must be tempered by remaining alert to situations where this may not be in the child's best interest. Failure to do so results in children remaining unsafe as in the following case of a mother who, in response to ongoing domestic abuse had attempted suicide, and subsequently went on to kill her two children and take her own life. In this case the children had been placed in emergency foster care, and the mother's priority was perceived to be for her children's welfare:

"The focus of children's services appears to have been to ensure the children returned to the care of their mother as swiftly as was safely possible. The result was that no in-depth analysis was undertaken of the mother's parenting capacity. The significance of mother's attempted overdose and potential risks to the children were overlooked as the focus centred on reuniting the children (who were in emergency foster care) to the care of their mother."

6.4.2 Hearing the voice of the family

As identified in previous national analyses, SCRs repeatedly mention the 'voice of the child'. This concept is central to effective safeguarding. Another less explored element is the concept of hearing the voice of the family. Children live and grow within a family environment, and it is within those contexts that children can both thrive and suffer harm. In most situations, the child's immediate family is the most significant. These vary considerably and include traditional two-parent families; dual households with separated parents; reconstituted families; and those containing new additions of varying permanence. There are often wider family networks with which the child may interact.

Members of both the immediate and the wider family may be aware of concerns before professionals and may choose to disclose this information at different times. This was highlighted in a number of serious case reviews:

> *"The perpetrator's mother was critical of the mother and of her parenting of the child but she never raised any concerns with any agency or professional at the time*."

> *"When there is no evidence of risk to children or additional needs there is no system that enables all professionals who are working with children to know everything about the involvement of other professionals with the family. This depends entirely on parents sharing this information, which they may not choose to do. In this case the mother had some knowledge of her partner's history of mental health problems and drug misuse but did not consider that it was relevant to discuss them with professionals because she did not feel that he presented any possible risk to the children. From the professional perspective this means that there are cases - such as this one - when professionals will not know some information that later turns out to be significant."*

Hearing the voice of the family offers significant prevention opportunities. However, it is incumbent on professionals and agencies to create environments in which families' voices are heard. A number of actual and potential barriers to this are detailed below:

Barrier	**Notes and Examples**
The family themselves may be unaware of the risks/ vulnerability	As with professionals, family members themselves may be kept in the dark and unaware, or unable to recognise potential risks. *In the absence of babies and young children being seen regularly at community settings, we rely on family and neighbours to alert services if there are concerns. This did not happen in this case, partly because extended family, like professionals, thought mother was coping well and had themselves decreased contact and partly because of the family's general social isolation.*

The family do not know where to go with their concerns	Family members may have concerns but be unclear where to take those concerns; confused by the range of different services; or baffled by previous experiences.
The family see their role as support rather than scrutiny	Family members may see their role as being there to support the mother/child and not want to damage that relationship by being seen in a role of scrutiny or criticism; they may see that as the role of professionals.
Fear of the consequences of reporting concerns	Family members may be worried about the possible consequences of reporting concerns, including potential removal of the children, breakdown of relationships, and the stigma of being involved with social services. *In this case the Father felt unable to share his concerns about Mother's parenting and the potential impact on [the child] because he was worried about being involved with 'social services'. If this information had been shared early on it may have influenced the professional view of this family.*
Family members themselves may be covering up abuse, or may fear being judged for their care	*Although most reasonable parents would have informed the school of the admission to hospital children for whom there have been safeguarding concerns might be cared for by parents who are wary of sharing too much information for a multitude of reasons ranging from a fear of being judged through to covering up abuse.*
Family members may experience intimidation by the perpetrator(s)	In this sample, this was primarily seen in relation to the mothers, particularly in contexts of domestic abuse and coercive control where the perpetrator may have threatened the mother with serious consequences for herself or her child(ren) if she were to express her concerns. Such coercion and intimidation may also extend to other family members.
Mistrust of services	Families may be highly mistrustful of child protection services, particularly if they have had previous negative experiences. They may be worried that there could be an over-reaction by professionals, or equally that their concerns will not be taken seriously.
Expressed concerns are not heard or acted on	Family members may be expressing concerns, but these are not taken seriously by professionals, treated as low-level concerns, or given less weight than concerns expressed by other professionals. There are particular issues in relation to how the father's voice is heard, particularly in situations of separation.

Responsibility is deflected back to the family or elsewhere	When a family voices concerns, professionals may, rather than assuming responsibility and acting on those concerns, pass the responsibility back to the family, or on to other professionals or services, leaving the family confused and unsupported.
The family's voice is not sought	Professionals may not actively seek the voice of family members, or provide opportunities for them to speak out. *Father was not aware that the assessment of [the child] had been undertaken. His views were never sought, despite him having parental responsibility, and at this point he had made allegations to court about his concerns regarding Mother's drinking, mental health and her potential aggression.*

There are particular issues arising in hearing the voice of the family in the context of parental separation and private law proceedings. In these settings, allegations made by parents can be misinterpreted, and can be seen as malicious allegations or evidence of controlling behaviour. In one case, both parents had made allegations against the other about drug and alcohol abuse and unsafe care of the child:

> *"During these proceedings Mother told the CAFCASS worker that Father was a cannabis user, and Father said that Mother misused alcohol… The shared residency order application could not be completed because of the allegations of Father's drug use, and counter allegations of Mother's alcohol use… [The child's] Father was at times viewed as abusive and controlling in his contact with professionals. For example, in the Private Law application to the Courts for a Residence Order Father provided a large amount of information to the court about his concerns about Mother's drinking, mental health and aggression. This was viewed as evidence by the Court of his controlling behaviour, and not taken account of.*"

A difficult balance must be achieved that allows professionals to recognise where there are elements of truth, even within otherwise malicious allegations. The implications for the child should the allegations prove to be true must be considered along with the harmful impact of ongoing parental acrimony.

These issues highlight a number of opportunities for protection and prevention of harm including opportunities for LSCBs to increase public awareness of the risks of child maltreatment, of the whole community's responsibility for safeguarding, and to highlight the positive work that is going on to safeguard children; for clear signposting and streamlining of services for children and families; and for individual professionals to take the concerns of family members seriously, and, while avoiding adopting judgemental attitudes, nevertheless remain alert to the possibility that family members may withhold or distort information.

Learning Points

- It is the responsibility of professionals and agencies to create the contexts within which the family's voice can be heard
- Where family members are expressing concerns, these concerns should be taken seriously, acted on, and feedback provided to the family
- Local Safeguarding Children Boards should ensure there is transparency in the safeguarding work being undertaken in their area
- Local Safeguarding Children Boards should take opportunities to showcase the positive aspects of safeguarding work
- There are opportunities for improving public awareness of the nature and consequences of child maltreatment, and everybody's responsibility for safeguarding

6.4.3 Relying on individual family members to follow through on advice

A number of SCRs identified situations where professionals recognised concerns and means of support and intervention, and then relied on parents to act. This can be good practice, promoting parents' autonomy and responsibility for their own and their child's welfare. However, there are inherent risks:

1. The individual may be unwilling to follow through on the advice – perhaps because they do not recognise or acknowledge the concerns or see value in the intervention:

   "The family were correctly assessed as needing both an enhanced health visiting service and the midwifery service, in recognition of mother's vulnerability... In this case a universal service was provided, with the added proviso that mother was able to request additional help. Given mother's underlying vulnerability, such reliance on her to be able to understand she could request and then ask for help should her circumstances change may be over optimistic."

2. The individual may be unable to follow through on the advice – because of financial or other constraints, or through the presence of a controlling partner:

   "The only significant record for [the mother] was a record made… where she had told the GP that [her partner] had hit her and she did not want another pregnancy. She was given advice and a telephone number to ring if she wanted support."

3. While an individual may follow through on the advice, information may be missed or concerns may not be recognised or may be minimised by the individual:

   "With regards to the Improving Access to Psychological Therapies (IAPT) service, a self-referral from [the mother] was received by and responded to in an appropriate and timely manner. When no response was achieved via telephone contact, [the mother] was contacted in writing. [The mother] was assessed via a telephone appointment at a mutually agreed date and time. In terms of appropriateness, IAPT was the correct service for an adolescent who was no longer in education and experiencing feelings of low mood in relation to her father leaving. A referral directly from the GP would have provided more appropriate information regarding [the mother's] psychological and social history and the relevance of prescription of anti-depressant medication."

4. The recommendation itself may not be appropriate:

   "[The mother] gave a history of having separated from her partner and disclosed being physically and emotionally abused by him, that he had been charged with assault and that her children were in foster care. The mother also disclosed a history that included difficulties in her childhood and unresolved grief following the death of her mother. The GP did not observe any evidence of mental illness or any indication of suicide risk and following a discussion about the support available through the Depression and Anxiety Service (DAS), the children's mother agreed to self refer and was provided with a leaflet… Although the children's mother presented as a person who was progressing well, her situation was complex, involving a recent incident of self harm and an ongoing court process regarding domestic abuse amongst other factors. The referral to DAS merited more detail than the self-referral process allowed for. A written referral or telephone contact with the service may have revealed that DAS were not able to deal with this case and referral to another agency may have been achieved."

Learning Points

- Professionals need to carefully consider the implications of relying on individual parents to follow through on advice or recommendations, bearing in mind that they may be unwilling or unable to do so
- Where a professional does pass responsibility for following advice or a recommendation to a parent, he or she should consider what steps could be taken to ensure that appropriate action is taken and relevant information is shared
- Professionals should consider whether the failure of an individual to follow through on a recommended course of action constitutes an additional level of concern

6.4.4 Parental beliefs and practices

Parental beliefs can be a force for good in a child's life and development but may also cause harm (Gilligan, 2009; Sidebotham and Appleton, 2012; Sidebotham, 2015).

In one case where a child died of florid rickets caused by severe vitamin D deficiency, the parents felt their religious beliefs precluded the necessary medical treatment. The professionals were sensitive to these beliefs but their actions did not result in effective child safeguarding. The final report recognised the dilemmas inherent in maintaining respectful challenge and acting on preventative responsibilities:

> *"It is unusual for mothers to decline screening tests in pregnancy especially ultra sound scans as these are usually an eagerly anticipated event. Pregnant women do have the right to decline treatments and screening during pregnancy and it is good practice to recognise individual choice and cultural diversity. This also applies to the decisions made in relation to diet however in this instance it would appear that the voice and rights of the parents outweighed the obvious risk that these choices could have on the child. The midwives respected the parents' expressed religious beliefs which is good practice however there was no professional challenge in relation to the extreme nature of the facts that were presented by the parents of this particular belief system."*

Learning Points

- Professionals need to show sensitivity and respect when dealing with parents' beliefs and practices
- This should not preclude a critical appraisal of the potential impact of any particular beliefs or practices on the child's wellbeing

6.4.5 Balancing support and challenge

Balancing parental support, building on resilience and progress, while still maintaining an attitude of respectful uncertainty is a challenge. In the following case, parental progress was appropriately acknowledged, however this resulted in a lack of focus on the children, and ultimately contributed to their being exposed to further risk of harm. The five year old in this family was killed by his mother in an extended filicide-suicide. The mother was seen as cooperative and *'showing all signs of putting her life back together'*:

> *"The mother's cooperation, which was always considered to be genuine, contributed to a lack of focus on the children. For example; having taken an overdose and going missing overnight she was admitted to hospital... Whilst in hospital she was assessed by a mental health worker and spoken to by the police and children's services. As set out in [the findings] she was seen to be 'seeking*

help' and the incident of self-harm was perceived to be a response to a difficult period which she had now removed herself from."

In another SCR, school staff were commended for maintaining a child-centred focus, while supporting the mother, attending meetings, and sharing information:

> *"The first primary school was in a position to know about the struggles Mother had had in her own upbringing and in her relationship with Father. They were child-centred in their concerns, as well as sympathetic towards Mother. The school staff were consistently involved in attending and sharing information at Child in Need, and later CP, meetings."*

Without professional curiosity professionals fail to recognise risks, downplay them, or focus on parents' needs to the detriment of the child's:

> *"[The child] was seen… by a community paediatrician, but his behaviours regarding food and low weight were linked to a likely medical condition. The potential for emotional abuse or neglect as possible causes was not considered when the circumstances required it."*

Professional curiosity requires professionals to think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically. In the following example, health professionals appeared to be trapped within a narrow medical model of care, and failed to consider the risks to the child:

> *"The IMR recognises that the mother's presentation at the fracture clinic was a missed opportunity to understand the dynamics of the family relationships and risks, with the focus being on the medical model in relation to reviewing and repairing the injuries but little attention to aspects of her situation and the domestic abuse disclosure."*

Social workers must also challenge and verify reassurances provided by parents:

> *"'Respectful uncertainty' identified as necessary in Lord Laming's inquiry into the death of Victoria* Climbié *would have prompted social workers to seek confirmation of matters claimed to be 'facts' or to check on whether promises had been honoured. Had they (social workers) done so, the level of confabulation or perhaps at times plain deceit would have been more obvious."*

This balance presents challenges to professionals but is integral to effective child protection. An authoritative approach, explored further in Chapter 8 emphasises treating parents and carers with respect while keeping child-focused (Sidebotham, 2013b; Tuck, 2013). Treating parents with openness and respect allows professionals to build a trusting relationship within which challenges can be made.

Learning Points

- Professionals face particular challenges in balancing support and challenge
- This approach to exploring vulnerability and risk requires professionals to think 'outside the box', beyond the usual remit of their own professional role, and to consider holistically the circumstances of the child and family

6.4.6 Avoiding drift and drop-off in supportive services

One of the difficulties in working with vulnerable families on a supportive level is the danger of case drift, and of a drop-off in support and scrutiny as time goes on. In the following case, the mother was identified as vulnerable because of poor engagement with maternity care and a history of substance misuse. This led to enhanced midwifery support extending into the post-natal period, but reducing substantially when midwifery input ceased:

> *"It was good practice that Mother was assessed as needing additional Midwifery support promptly after [the baby] was born and the high level of home visits offered reflected the additional support needed. This increased provision was prompted by parental anxiety and awareness by the Community Midwifery team that Mother had not engaged fully in antenatal care."*
>
> *"Overall, given the concerns regarding poor engagement with antenatal care and some vulnerability which led to the Initial Assessment, it would have been appropriate to have a planned approach to Mother's postnatal care and support.*"

A similar drop-off in services was seen in another case involving a very vulnerable young, single mother, with a history of a forced marriage, immigration to this country, and relative social isolation. As this mother appeared to be coping well, services were withdrawn, isolating the mother further and leaving her unable to cope with her three pre-school children:

> *"Professional contact decreased after the birth of [the baby] as the mother was assessed to be coping well and (according to the midwife) chose not to attend the last midwifery post-natal appointments (Mother though understood that the midwife would visit her). Mother ceased attending a Young Parents Group at the Children's Centre: she had attended this regularly until the birth of [her baby] and subsequently on a few occasions. There was no health visitor or GP contact after [the baby was 2 months]."*

Low-level risks that do not meet child protection thresholds present certain challenges. The resulting support provision may lack the rigour of thorough risk assessment, making subsequent plans unclear.

This was an issue in the following case, which did not meet child protection thresholds and was managed through multi-professional 'Child Action Meetings'. These, however, did not have the structure to establish clear outcomes and professional accountability. Professionals recognised the families' vulnerabilities and considered how they may be addressed but there was limited monitoring of outcomes. The findings from parenting assessments were not clearly recorded and there is no information as to what form these assessments took:

> *"The response to the concerns raised in the months prior to [the younger child's] birth however requires a more critical analysis. The lack of information recorded by Children's Social Work regarding the CAMs in this period is of significant concern. There is no evidence that either an Initial Assessment, or a parenting assessment, took place at this point, neither is there information about what decisions were, or were not, taken in relation to Children's Social Work involvement. An action for the review Child Action meeting… was that [the mother] should contact Children's Social Work directly about her concerns. There is no explanation as to why the Health Visitor did not take responsibility for this action, or contact the Social Worker directly to ensure that [the mother] had done so... Given the concerns being raised about the care for [the older child] and [the mother's] failure to properly engage with agencies, this approach is difficult to understand and raises concerns about the effectiveness of the Child Action Meeting process in practice."*

There is scope for improving multi-professional meetings, including Child Action Meetings and Common Assessment Framework (CAF) meetings, which operate outside the formality of strategy meetings or child protection conferences. They would require a clear structure and format; an assigned chair; full and frank information sharing; risk appraisal; and plan formulation with assigned accountability and measurable outcome. Meetings must be minuted and these should appropriately circulated.

Learning Point

- Strengthening the rigour of multi-professional meetings that operate below the child protection threshold can lead to greater awareness of risk and more appropriate plans for support

Chapter 7: Pathways to protection: Working together dynamics

> *"Professionals in this case have been appraised by their agency IMRs as working well. They have followed procedures, generally communicated effectively with multi-agency colleagues, and tried hard to offer support to Mother as the protective parent and to remain alert to the risk from Father."*

When a child is identified as being vulnerable, opportunities arise for professionals to work together to protect that child from harm. Interventions may involve a focus on parenting skills; engaging professionals, relatives and the wider community to provide practical and emotional support to the family; setting action plans and monitoring targets; removing perpetrators or minimising risky contact; or, in extreme cases, removing the child. In many of these cases, as highlighted by the quote above, we found evidence of good inter-agency working to support families and manage risk.

Effective intervention requires careful assessment of the child's vulnerability and ensuring the child's rights and feelings remain central. The child's circumstances and environment, the resilience of the child and family, and any inherent risks, all work together to inform actions by the multi-agency team. Effective safeguarding work depends on collaborative multi-agency working: no single professional retains all of the required knowledge or skills. Good communication is essential for collaboration. Serious case reviews, and, by extension, child welfare professionals, are often criticised for repeatedly identifying the same failings in communication and information sharing. Given the centrality of effective communication to safeguarding work, it is inevitable that this remains one of the key points of break-down. Such communication requires practitioner skills, effective facilitative systems, and a culture that promotes information sharing for the protection of children. This must fit into a wider information-handling process whereby information is critically appraised and used to guide decision making and planning.

Throughout our review, we encountered examples of creative and effective child safeguarding. Examples of poor practice were also identified, involving failure to follow guidelines; an absence of safeguarding systems; barriers to effective co-working; or failure to recognise or act upon safeguarding opportunities. These apparent failures, however, need to be seen in the light of the effective safeguarding work that takes place across the country on a daily basis.

Learning Point

- For many of these children, the harms they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them

7.1 Information sharing

The centrality of information sharing to effective child safeguarding cannot be stressed enough. Of the 66 serious case review reports reviewed in depth, there was only one where information sharing was not specifically mentioned. All others identified issues ranging from direct failure to identify risk or protect the child to simply identifying information sharing as an area for improvement. In contrast, in over ten years of analysing serious case reviews, we have not come across a single case where a child has been killed or harmed because a professional has shared information.

It is vital that professionals for whom safeguarding is not a core responsibility, or rests within a wider range of responsibilities, are aware of the need to share information early. In the following examples, professionals were party to information relevant to safeguarding but did not share it with those who could have assessed it from the perspective of child safety:

> *"The perpetrator repeatedly stated [to the Probation Trust] his intention to move into independent accommodation with the mother and the Child. However this did not prompt any enquiry or referral to Children's Social Care to ensure that the child was safeguarded. The mother was to move to independent accommodation and the perpetrator was to breach his curfew to move in with her. Within two days he had violently assaulted both the Child and the mother… [the] Probation Trust only had information gleaned directly from the perpetrator who clearly minimised the extent of his mental health issues, substance abuse and violence, whilst the Mental Health service was aware of the extent and volatility of his behaviour."*

> *"Mother spoke to her General Practitioner (GP) before pregnancy about domestic abuse, but this information was not included in the antenatal referral and no other professionals were aware of this as a potential concern."*

Failure to share relevant information precludes effective assessment of parental capacity and child vulnerability, as in the following case:

> *"The IMR Author identifies that the impact of not sharing information in a timely manner was that the information about [the mother's] medical history was not shared and did not therefore inform assessments of her ability to care for initially two and then four additional children. [The mother] had a history of Post-Traumatic Stress Disorder since the sudden death of her husband 13 years previously and dependence on diazepam."*

7.1.1 When to share information

It is difficult to decide when to share relatives' personal information, such as a sexual history, finances, or personal views. Nevertheless, it seems that often the default position is to not share such information unless a practitioner actively decides to do so. This

means that no professional would have a comprehensive overview that would enable appropriate risk assessment. This was highlighted in the following case involving a 19-month-old who died following an unexplained non-accidental head injury:

> *"Mother shared with her GP that she wanted a termination, but she found that her pregnancy was too far advanced… An antenatal referral was made, which did not include the information regarding Mother planning a termination… consequently no other professional knew about this start to the child's life or had an opportunity to consider its meaning for the child or Mother. Although this was an intensely personal issue, the GP should have made an assessment of whether sharing this information as part of the health response to antenatal care would be appropriate in the context of Mother and the unborn child's wellbeing."*

An alternative position, suggested at by the quote above, would be to presume that any information that has a bearing on child welfare should be shared with other professionals unless there is reason not to. As such, the onus would be on the professional to make an active decision not to share information and to document their reasoning.

Despite the frequent issues in communication, several serious case reviews highlighted very good information sharing practice, particularly where this may be outside the usual remit of particular professionals:

> *"The following week, the Neighbourhood Safety Officer spoke to the Health Visitor and made another referral to Children's Social Work, concerned that:*
>
> - *The child had no cot and was sleeping with [the mother]*
> - *Anti-social behaviour was continuing and [the mother] was at risk of eviction*
> - *There were complaints of parties and drug taking whilst [the child] was present*
> - *[The maternal grandmother] was reporting ongoing concerns about [the mother's] lack of money."*

The persistence of findings relating to communication and information sharing suggests a deep, systemic issue. That information sharing is highlighted repeatedly in reports and training suggests neither a lack of professional awareness nor a failure to appreciate the importance of information sharing that is at fault. Nor can the issues be blamed on lack of guidance or systems for sharing information. All national guidance and legislation on confidentiality and data protection supports sharing information to safeguard children and vulnerable people (Appendix B).

Our reviews of serious case reviews spanning more than ten years suggest that, despite national guidance and legislation, there are deep cultural barriers to effective information sharing among professionals. The following excerpt, from a case of a two and a half year old killed by his mother who had significant mental health needs and

issues around domestic abuse, illustrates anxiety and confusion among professionals, creating barriers to effective information sharing. Data protection legislation is viewed as a set of constraints limiting information sharing rather than a facilitative tool:

> *"In the absence of a system to continually assess the risk to children, universal services are best placed to raise concerns. This case has illustrated that in order to perform a child protection role effectively universal services need to be fully informed of the family 'history'. However, data protection legislation and concerns about information sharing is leading to anxiety and confusion about when information can be shared, and with whom, with or without consent. The culture of patient confidentiality in some organisations, such as those working within 'health', means that the focus tends to be on protecting this right rather than on the safety of children."*

This serious case review identified a 'culture of patient confidentiality' prioritising the right to confidentiality over child safety. It appears that, in spite of outrage at children's deaths, abuse and sexual exploitation, our professional, legal and political cultures continue to emphasise the right to privacy, fuelled by public fears of a 'nanny state', and excessive surveillance and scrutiny.

It is our view that, unless and until this culture is challenged and society accepts that children's safety deserves a higher priority than individual privacy, information sharing will continue to be an issue whenever children die or are seriously harmed as a result of abuse or neglect.

7.1.2 Gaps in information sharing

The centrality of communication and information sharing to effective safeguarding practice was again identified in the later stages of child protection where information was missing, not sought, or withheld, compromising the effectiveness of assessments and planning, as in the following cases:

> *"It is clear that there were weak communications and information sharing, particularly between health and the other agencies involved. This contributed to the lack of effectiveness in the overall response to [the child's] needs. Examples of agencies not being aware of the situation for [the child] include the police dealing with the criminal matters who were not aware of the Child in Need status or placement being funded and supported by children's social care, the college being unaware of the involvement of children's social care, and the hospital diabetes team not being aware of the Child in Need/Looked After Child status or children's social care support."*

> *"The review of this case has shown that there were serious gaps in information sharing both within and out with the health service which meant that the whole picture of the family's functioning, dynamics and lifestyle remained unknown. This*

applied when the children were Children in Need and when they were subject to child protection plans."

In contrast to those cases where there were issues around information sharing, other cases highlight how agencies can take steps to overcome these and ensure that relevant information is shared with those who know the child and are potentially in a place to offer support and care, as highlighted in relation to domestic abuse notifications in the following case:

> *"There are… two initiatives… that make the numbers more manageable. The first is a pilot project… whereby DV1s [the police notification of domestic violence form] were sent by Police to the normal partner agencies but also to secondary schools via [the] County Council. This appears to be sensible in as much as teachers are in an excellent position to help children and young people discuss their situation as well as giving the teachers background knowledge that may help to explain a child's absence, poor attainment or bad behaviour."*

Effective information sharing is facilitated by clarity over the reasons for requesting information and the basis on which any request is made. This was emphasised in the following SCR:

> *"From discussion with the GP practice, such requests for information from the safeguarding team at the regional hospital are not uncommon and a generalised question regarding "safeguarding concerns" without knowing specifically why the question is being asked does not promote effective sharing of information particularly if information is needed from an adult's records. There is now an information sharing form that should be filled in and faxed to the GP surgery when information is needed."*

A key element of communication is that it must be two way. Where front-line workers express concerns or share information with child protection agencies but receive no feedback, their confidence in the process may be undermined, potentially compromising their ability to contribute to safeguarding, and inhibiting future information sharing. Thus there is a clear imperative for prompt feedback to referrers and others participating in safeguarding.

While many serious case reviews highlighted information sharing issues, few went beyond individual failings to consider deeper systemic issues underlying such failings. Some issues that were identified included fragmentation of services; delays in sending information; bureaucracy; and limited specificity in requests.

Where services are identified as fragmented, or operating from different settings or management structures, setting up clear pathways and agreements to allow effective information sharing is crucial. Delays are addressed by installing systems that ensure discharge forms are processed promptly, letters dictated and typed without delay, and,

where there are safeguarding concerns, direct information sharing that circumvents routine processes. In sharing safeguarding concerns, including in staff-to-staff handovers, best practice should be to combine direct verbal communication with clear documentation of the concerns. Staff need to be clear in their requests for information in terms of what is being sought and their reasoning. This can be facilitated by clear procedures or pro-formas for information sharing.

7.1.3 Triangulating information

In addition to gathering and sharing information, information must be triangulated and verified. This involves seeking independent confirmation of parents' accounts and triangulating information between professionals.

This concept was explored in the following accounts:

> *"In this case, the parents' own version of events was often accepted by professionals without triangulating with other sources such as professional information or records. Mother was able to tell maternity services that she had accessed care and had been denied a booking in process because the Midwife did not turn up, an inconsistency that was not challenged. During the initial assessment Mother and Father's view about why they had not accessed midwifery care were reported without challenge, despite there being discrepant evidence regarding this."*

> *"[The mother] disputed information that the midwife had provided, asserting that it was the midwife that was mistaken; she gave untrue information about [the child's] contact with their Father, saying she had organised it because she believed that it was important they developed an effective relationship and she denied having drunk any alcohol, despite smelling slightly of alcohol being the reason for the assessment. This information was recorded in the assessment without comment, or a professional view being provided."*

One approach to improving inter-agency communication, identified in a couple of SCRs, was through 'practitioner forums', offering support to isolated professionals and creating an arena where disagreements could be raised without families present:

> *"[The SCR recommends that] a forum is established by the Strategic Substance Misuse Manager to enable General Practitioners involved in delivery of shared care arrangements to come together and identify areas of concern or barriers to effective joint working and also to share current best practice."*

> *"The LSCB should support a framework of meetings which allow professionals involved in particular cases to meet and reflect on professional dynamics and disagreements without the presence of children and families."*

Learning Points

- As highlighted throughout this report, effective communication is central to all safeguarding practice
- All national guidance and legislation on confidentiality and data protection supports sharing information to safeguard children and vulnerable people
- The Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately
- Child protection agencies must feedback promptly to referrers and others participating in safeguarding
- Information must be triangulated and verified. This involves seeking independent confirmation of parents' accounts and triangulating information between professionals
- Practitioner forums may provide opportunities for professionals to discuss cases and share information in a safe environment

7.2 Clarity of referrals

The starting point for child safeguarding is typically a child protection referral from a professional to children's services or the police. It is crucial that this initial referral is managed well to ensure an appropriate response. It is essential that professionals express their concerns in terms of a child protection referral, and outline clearly what the concerns are. Where this does not happen, there is the potential for a referral to be treated differently by social services, and as a result, proper child protection processes are not initiated, as seen in the following case, where both health and education staff had clear concerns, but did not formulate these into a clear referral:

> *"The hospital midwife wished to make a referral to [children's services] following the birth of [the younger child]. There were considerable concerns ... Despite a detailed discussion with the social worker, the midwife was advised not to make a formal referral but was told that the information would be logged for future reference… The lack of a formal referral meant that the concerns were able to be downgraded by [children's services] which would not procedurally require a response from them."*

Many serious case reviews indicated that information received by children's services was treated in one of two ways: as "information only", which is logged but not acted on; or as a formal referral. There is an inherent danger in information that suggests potential child protection concerns being treated solely as information and logged without any further action.

Learning Point

- Clearly identifying referrals as child protection referrals, and documenting the concerns and identified risks can help facilitate an appropriate response by child protection agencies

7.3 Strategy Discussions

Strategy discussions, described in Working Together (HM Government, 2015), are an important starting point for inter-agency child safeguarding. Despite their significance in statutory guidance, strategy discussions do not feature highly in the serious case reviews examined. The relative absence of any consideration of the purpose, nature, or effectiveness of strategy discussions suggests these are a neglected component of safeguarding practice, and their role in collating and appraising information, risks to children, and assessment and action is not widely appreciated by professionals.

Delays in holding strategy discussions, confusion over the status of meetings, attendance, availability of appropriate information, a lack of clear minutes, and failure to disseminate minutes appropriately were all identified in these reviews.

Strategy discussions provide opportunities for information and opinions to be clarified. Appropriate attendance or representation of all relevant professionals is essential so that effective challenge and clarity can take place when ambiguity is identified. This may particularly apply where medical opinions are provided where it is not possible to be certain about the cause of any particular injury or presentation, as in this case:

> *"What was missing from the Strategy Meeting was recognition that the medical view was not necessarily the most significant contribution to whether physical abuse had taken place … There should have been the opportunity for the hospital staff to have challenged this at the time which in turn may have affected [children's services'] understanding that some concerns re the existence of non-accidental injury still remained."*

Learning Points

- Strategy discussions are a central part of the safeguarding process and should be accorded due weight
- The effectiveness of strategy discussions depends on the right professionals being present and engaged in the discussion, with the relevant information available

7.4 Assessments

A difficulty identified in previous biennial analyses is that of thresholds for intervention. Perceptions of these vary between agencies and fluctuate depending on workloads, professional backgrounds, new or emerging understanding, or political or cultural expectations. Differences in perceived thresholds can lead to frustration or breakdown in effective working, resulting in children falling through the gaps or their needs not being met.

Where different thresholds are being applied, concerned professionals have a duty to escalate their concerns through the appropriate agency or LSCB channels. One SCR identified this lack of escalation as a common difficulty for schools, making cases more likely to drift:

> *"The social worker did later indicate to the school the agency's commitment that if health appointments and school attendance continued to be a problem, a strategy meeting 'would be considered'. The suggestion of decisive action if ... was by then a familiar response. The promised decisive action was brought no nearer by a new allegation from the paternal aunt of an attack by mother on father whilst he had care of [the sister]."*

This may well be a more widespread problem, where professionals continue to work with families in a supportive manner, or cases are allowed to drift, agreeing to escalate if a particular threshold is crossed, but failing to recognise where continued low-level problems, or other new concerns are exposing the child to ongoing harm.

Many cases subject to SCR had not been identified as child protection cases prior to the event leading to the SCR. In these situations, the Common Assessment Framework can provide a suitable multi-agency context for exploring risks and thresholds and for embedding a holistic approach to the family. In order for such processes to work effectively, however, it is essential that there are clear thresholds and clear pathways for escalation and de-escalation, as emphasised in the following recommendation:

> *"Children's Social Care should review and the Safeguarding Board disseminate to agencies a clear step up/step down pathway that is cognisant of all current procedures and developments to ensure that all agencies are clear on the status of cases and what support is available and ensure that this is embedded into agencies."*

Learning Points

- Processes such as the Common Assessment Framework can provide a multi-agency context for exploring risks and thresholds and for embedding a holistic approach to the family
- Such processes need clear pathways for escalation and de-escalation

7.4.1 Rigour in assessment and analysis

It has long been recognised that thorough, comprehensive assessments contribute to effective decision making and action to protect children. The positive role of assessments in the process, and how they can be used effectively was highlighted in this report:

> *"The core assessment completed by children's social care was a key document that defined and guided the work of children's services. As a tool it provides a structured framework for children's social care to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning."*

Assessments need to be planned, comprehensive and timely. Children's social care takes the lead but all professionals working with the family must be involved. Assessment must involve critical analysis rather than simply gathering information or completing a pro-forma. Opportunities for improvement were identified in gathering or adequately appraising relevant information, delays, and a lack of clarity in the assessment processes:

> *"The lack of a comprehensive core assessment involving other agencies when [the young person's] circumstances changed was however a missed opportunity to fully consider his health needs and ensure that all professionals involved with [the young person] shared the responsibility for his on-going care."*

It is important to move beyond identifying failings to consider the deeper systemic issues which may provide opportunities for improvement and a number of possible barriers to effective assessment and analysis were identified.

Professionals saw assessment as a one-off event rather than an ongoing process and relied on single visits and single sources of information, as in this case:

> *"A practice approach relying on one visit to the family and minimal historical information must risk being ineffective given the complex family dynamics that usually exist in situations of domestic abuse, and the decision to close the case at this point has been acknowledged by Children's Services as premature."*

Opportunities exist throughout case working such as in supervision sessions, strategy discussions, child protection conferences or core-group meetings. Practitioners must remain mindful of the ongoing nature of assessment, constantly updating them and identifying where new assessments are required. Holistic assessments can be supported by initial scoping and regular review of different aspects of children's lives and noting which professionals are able to contribute throughout. Focus on a single issue rather than other relevant factors highlights the importance of good quality and continuous information gathering and analysis that incorporates all relevant information:

> *"The assessment did not take into account the information held by partner agencies arising from their assessment processes. Based solely on information obtained from the children's mother the police and the school there was no contact with mental health services, the GP in respect of mother's health, health visiting or school nursing resulting in an incomplete assessment of the situation and did not lead to an overall judgment of risk."*

Where fixed thinking becomes an issue, whereby other possibilities are eschewed once one opinion has been formed, professionals must actively strive to keep an open mind to different explanations for any presenting feature. Even where a possible non-abusive explanation is found for a concerning presentation, this should not be taken as confirming that the child has not suffered or will not suffer significant harm. In the following case of a four year old child, professionals appeared to have focused on the likely accidental nature of an injury, ignoring other possibilities and concerns:

> *"The second and final Core Assessment … was linked to the injury (fractured arm) to [the child] rather than to mounting concerns about domestic abuse. However, because the collective professional view that had been taken that the injury was on balance likely to have been accidentally caused, then there was little evidence of this being further probed to any significant extent."*

One further issue identified was that of relying on other avenues in lieu of proper assessment. This SCR noted a practice of relying on a parenting programme to fulfil the assessment role, when it was clearly outside the remit of the programme. This had apparently become an embedded practice in spite of clear policy directives to the contrary:

> *"These programmes (Triple P) focus on parenting skills and were not designed to deliver an analysis of Mother's history, emotional vulnerability and psychological capacity to parent. An understanding of this capacity was therefore lacking in the reports to the child protection conference.... The clear expectation from children's social care is that social workers will be responsible for detailed analytical assessments that look at all aspects of parenting but within this team at that time this did not always happen."*

One serious case review, drawing on published research (Barlow et al, 2012), emphasised how challenging the process of analysing complex information can be. This was also highlighted in the Munro Review and suggests that more effort is required to train professionals in analysis and decision making and develop appropriate supportive tools.

Learning Points

- To be effective, assessments must incorporate both information gathering and appropriate appraisal of that information to understand risk and formulate appropriate plans
- Professionals need training and support in analysis and decision making

7.4.2 Working with unsubstantiated concerns

The nature of child maltreatment is such that often professionals are presented with concerns which are impossible to substantiate. There may be a lack of supportive symptoms; alternative, plausible explanations; those involved may withdraw disclosures or allegations, perhaps because of underlying threats or coercion, or out of fear for their own or others' safety, or of the consequences of disclosure. In such situations, there is a temptation to discount concerns that cannot be proved. In keeping with a child-focused approach to practice, however, it is important to be mindful of the original concerns. Even if they cannot be substantiated, potential risks to the child must be considered, addressed and monitored.

The following case summed up well the dangers of relying on formal disclosure of abuse for substantiating concerns:

- *"Following the incident… when the children's mother went missing the children were placed with foster carers. [The child] disclosed to the foster carer details of both domestic abuse and neglect that had occurred within the family home. [The child] was able to recount specific details. The foster carer appropriately referred this into children's services.*
- *Children's services shared this information with the police and the child was seen at school later that day by a police officer and social worker. [The child] was video interviewed two days later. [The child] did not confirm the allegations neither when seen at school nor in the interview. As there was no formal disclosure no further criminal action was taken.*
- *At the time of the disclosure and police interview the [child protection] Investigation was ongoing; despite this consideration was not given to the concerns about abuse and neglect of the children and the potential risk to them was given no further consideration in the core assessment and was*

not subsequently used in care planning.

- *All disclosures of abuse and neglect by children need to be taken seriously. The fact that the disclosure was not repeated in the video interview did not mean that the abuse and neglect had not happened. This information should have been taken into account in the assessments that followed in order to assess risk and to help inform future assessments."*

Local teams need clear procedures that respond to the needs of children and families when the threshold for child protection is not met or concerns are not substantiated. In situations where concerns have been raised it is likely that the family will have ongoing needs. Further multi-agency work with families may still be possible through child in need meetings, or other forums. Such an approach may identify further needs or lead to re-evaluation of the threshold, as highlighted in the following case, involving a 'Child Action Meeting' at a lower threshold than a child protection plan:

> *"Whilst the threshold for a Strategy Meeting had not been reached on this occasion, what should have been given serious consideration was the convening of a further Child Action Meeting. Such a meeting if working effectively should have identified the historical concerns and could then have indicated the need for a more active degree of involvement by Children's Social Work."*

The possibility of professionals safeguarding children is particularly compromised when court hearings have concluded that a child has not suffered significant harm, as in the following case. Tragically, in this case, the seven month old infant was killed in a violent assault by the father two months after the court case:

> *"Following the hearing, some professionals still believed that the injury was non-accidental and that the judgement of the magistrates was wrong; as a result there were considerable informal discussions about the court's decision. At the same time there appears to be no sense of urgency in regard to moving the care plan forward as a "child in need" (as agreed by the professionals, magistrates, mother and father after the court proceedings) nor was there any planning on the basis that suspicions remained. In short they could have offered child in need services and maintained a respectful scepticism with regard to the court's decision."*

In such situations, professionals may well have ongoing concerns and need to be able to act accordingly. This may be achieved through a child in need process, however plans must be in place for ongoing monitoring and care. Also, professionals working with the child must be clear about any ongoing risks. In the SCR referred to above it was highlighted that there was no consistent narrative among the professionals:

> *"[There were three] sets of professionals… the professionals who had been involved in the court case had the belief "that the court had come to an incorrect conclusion and that [the child] therefore remained at risk of harm from one of his carers" … the professionals who had not been involved in the court case had the*

belief that [the child] "had been admitted with some bruising … and that he had been discharged back to his parents' care when it was concluded that this bruising was accidental," … [and] a third set of professionals who became involved with the family later who were unaware that the court case had even happened. These professionals were working with the belief that [the child] was simply a child with complex medical needs. The agreed narrative should have been that concerns remained that [the child] was a child at risk from significant harm because his injuries were still believed by children's social care and medical professionals to be non-accidental, even though the court had deemed them, on the balance of probability, to be accidental. All professionals involved with [the child] should have been aware of this."

Learning Point

- Even where concerns cannot be substantiated, potential risks to the child must be considered, addressed and monitored

7.5 Development and implementation of child protection plans

"The centre made an early assessment that if [the child] did not access appropriate treatment this would lead to deterioration in health and subsequent death. This coupled with concerns that [the child] was resisting medical intervention and parental inability to endorse attendance resulted in an appropriate safeguarding referral from the tertiary centre to Social Services Child Care Team... The health care providers recognised that [the child] and family required additional support to meet health needs. This resulted in [the child] being subject to a Child Protection Plan, the category of which was neglect, with intensive multi agency support. Successful compliance with the Child Protection Plan resulted in both [the child's] health and welfare needs being met more consistently and a Child in Need Plan was then implemented which maintained the same level of support from practitioners."

In spite of the apparent effectiveness of planning in the above case, and the ongoing support offered by professionals, this young person's overall needs were ultimately not met and he died as a result of his underlying chronic health condition. In all child protection cases, the planning that takes place in a child protection conference is a crucial part of effective multi-agency working, but it is only one part and needs to be supported by and seen within the context of professionals working in conjunction with children and families on an ongoing basis, often over a prolonged period.

The child protection conference can be a crucial, pivotal point in the overall child protection process, facilitating analysis of information, appraisal of risks, decision making

and planning for intervention. As with any pivot, its effectiveness is dependent not just on the structure and function of the conference itself, but on the processes on either side: those of gathering and analysing information and working with families to protect children (Figure 15).

Figure 15: The pivotal nature of the child protection conference

To function effectively, the conference must balance assessment and intervention. An incomplete or inadequate assessment process undermines subsequent intervention and conversely, excessive emphasis on assessment can lead to drift or failure to proactively work with families. Similarly, rushed, uninformed interventions can be counterproductive or misdirected. Central to all this is a well-structured, informed conference with a capable chair and the relevant people (professionals and family) attending.

In our review we identified good examples of effective planning within and outside conferences, as well as issues where there were opportunities for improvements**.**

It is essential to the effectiveness of any plan, that all relevant people (both professionals and family members/young people) are involved in its development. Their ownership ensures that it is relevant to the child's needs, achievable, and they are enabled to implement the plan:

> *"Not having a health professional actively involved in the (child in need) plan led to staff who were not medically qualified giving [the young person] advice. This continued when [the young person] became a Looked After Child, with the family support worker who saw [the young person]… discussing about his diet with him as they noted that he seemed quite sleepy. This was a missed opportunity to ensure that a medical professional assessed [the young person] and his compliance with his treatment."*

This case, of a 17 year old looked after young person, whose family had not been supportive, highlights the crucial importance of involving young people in any planning around how to meet their needs, along with the challenges inherent within seeking such engagement:

"However [the young person] did not attend the conference and the Chair did not ascertain his wishes and feelings prior to the meeting, as he was away. His level of commitment to the child in need plan was therefore not confirmed with him, and he did not hear first-hand the concerns (and the fact that people cared and worried about him) that were shared at the meeting.

There had been a lot of discussion about how to engage both boys with a plan, as it was accepted that they were keen to be better cared for at home, but that they were not motivated beyond that to cooperate with professionals. This was not felt to be unusual with young people of their age, and it was agreed that any engagement with them would need to be creative."

One further implication of the pivot model of the child protection conference is the recognition that, like a see-saw, there will be movement between the two sides. Intervention doesn't need to wait until the conference but can start once needs are identified; similarly, once an intervention is in place, further assessments, appraisals, and modification may be required.

The need for rigour in evaluating plans and monitoring their effectiveness was highlighted in the following case where there appeared to have been insufficient rigour in identifying a lack of progress, and a tendency to keep going with more of the same:

"Child protection and child in need plans were formulated and implemented as one might have expected, albeit there was a significant degree of repetition of approaches e.g. 'working agreements' , trusting mother's promises to attend mental health appointments, which records show had failed."

Learning Points

- The child protection conference is a pivotal part of effective multi-agency working, but it is only one part and needs to be supported by and seen within the context of professionals working in conjunction with children and families on an ongoing basis
- It is essential to the effectiveness of any plan, that all relevant people (both professionals and family members/young people) are involved in its development

7.6 Taking responsibility

Professionals' recognition of their safeguarding responsibilities is crucial to child protection. When professionals instead expect others to act, there is a chance cases will slip through the net, leaving children at risk of harm. This is illustrated in the following

case where two different agencies effectively bounced a case between each other, leaving the school in a dilemma as to how to proceed:

> *"School staff were concerned that the parents and [the child] were very dirty. The school teacher initially spoke to the social worker about this concern and was told that the case was closed to [children's services] and that contact should be made with the health visitor. The school did phone the health visitor whose response was that concerns must be referred to CSWS as they have a statutory duty to investigate concerns about neglect."*

A general failure to take responsibility manifests itself through professionals making assumptions about the actions or views of other professionals, as demonstrated in the following case:

> *"There were also occasions when assumptions were made by some professionals about the actions or views of others without checking them out. For example when the health professional was told on an occasion when she was expressing concern, that [children's services] had closed the case, the assumption was made that there were no child protection concerns, and no purposeful action followed from her. Similarly the school nurse made a false assumption that [the child's] weight and growth had been taken by a colleague.*
>
> *The school staff recognised that [the child] was not growing, and… felt that he was losing weight, with one teaching assistant stating in the later criminal proceedings that "he was wasting away", although with the apparent view that the medical aspects of his presentation were being investigated, no school staff member chose to request the school to make a referral to [children's services] about possible neglect."*

7.6.1 Silo working

Issues of silo practice have been highlighted in previous biennial reviews, and again were identified in several of these serious case reviews. No single profession has a monopoly of knowledge or skills for protecting children. By working in isolation, professionals miss opportunities to effectively support families and safeguard children.

Silo working does not always mean professionals are working in isolation. It can equally arise in the midst of multi-agency working, when individual professionals see the case within a narrow frame of their own professional background:

> *"Although there were good examples of communication between professionals, practice in this area was not consistently good and some professionals did not actively look to seek or share information to assist assessment processes. There was a tendency for professionals to work in 'silos' i.e. to view aspects of need narrowly, solely from the perspective of their own discipline. This was*

compounded in part by a lack of awareness of other agencies and how they operate."

Sometimes professionals choose not to involve other professionals, believing this to be the best option for working with a family as in the following case. However, the simple step of informing other professionals of the intended plan could go a long way to ensuring needs aren't missed:

> *"[The GP] was the first to be made aware… of mother's latter pregnancy. On examination, mother appeared to have no thought disorders or depressive features… she was at that stage, refusing Children's Social Care or Mental Health Service involvement. The fact these options were recorded indicates the doctor was properly considering and discussing with his patient, their possibility… The GP's records indicate that he evaluated the risks and benefits of involving other agencies. His judgment was that 'there does not appear to be significant risk at present to self / others; plan is for follow up appointment with myself in few weeks –note – dysfunctional relationship when previously referred to Children's Social Care without consent'."*

Learning Points

- Effective joint-agency working depends on ensuring all relevant parties are involved in safeguarding practice, that professionals take seriously their own safeguarding responsibilities, and that they are enabled to effectively challenge and escalate concerns
- A silo mentality can arise in the midst of multi-agency working, when individual professionals see the case within a narrow frame of their own professional background

7.7 Ending child protection plans

Over the past decade there has been a very welcome shift whereby child protection plans are focused and time-bound, counteracting a dangerous tendency for cases to drift. This is aided by the requirement for LSCBs to review cases subject to child protection plans for over two years. Building in an expectation that cases will be closed once it is demonstrated that plans have been appropriately implemented and that the children are safe, or that they will be escalated if this is not achieved is appropriate and leads to much greater clarity in inter-agency working. However, this carries the risk that cases may be closed prematurely, or without sufficient safeguards in place for the ongoing monitoring of and support for the family.

Typically, when a child protection plans ends, the level of scrutiny and support reduces. This is appropriate and necessary but carries with it the potential for families to be left relatively unsupported or with inadequate monitoring:

> *"During the year following the discontinuation of the child protection plan the family were offered an enhanced health visiting service which involved two home visits [in an 18 month period]. Members of the review team have questioned whether two visits a year is sufficiently "enhanced" for this family and there is no indication that supervision systems facilitated further discussion of whether the health visiting service was adequate to meet the children's needs."*

It is essential, as emphasised in a number of the reviews, that the final child protection conference involves a clear and comprehensive appraisal of the family's circumstances and ongoing risks. Mere acknowledgement of the previous plan being finalised is insufficient. Similarly, there must be agreement between the professionals and the family about ongoing plans for support and monitoring and how they will be met. In the following case a lack of clarity over the plan left professionals in doubt over their responsibilities and aims:

> *"Children's Social Work closed the case three months later concluding that outcomes were improved and referring to a 'very clear plan of action as to how progress should be monitored'. However, it is not apparent … which action plan is referred to. Action for Children had put together a plan, but by this time [the mother] was already disengaging from the Family Intervention Project… There is no evidence what the progress which was to be monitored was, who was monitoring it and what would be considered a successful outcome or otherwise."*

A difficulty faced after ending a child protection plan is that the formal, independent mechanisms for scrutiny are removed. It is therefore essential that those professionals continuing to work with the child and family take ongoing responsibility for such scrutiny, and that this is reflected in their supervision.

In one SCR, in response to a clear gap in effective inter-agency working, a change in practice was identified in relation to final child protection conferences which now include the formulation of a clear child in need plan, agreed by all those present:

> *"However the details of the plan were left to the social worker to develop and no plan was put in place which focused on Mother's ability to maintaining this positive change. Practice in [the county] has now changed and child in need plans are written at the end of any child protection conference where the child protection plan is being discontinued. All attending the conference are therefore aware of their role."*

While it is important to keep child protection plans focused and time-bound, this must be done with a note of caution, recognising the long-term, often cyclical or recurrent nature of risks within some families, as highlighted in the following case:

> *"The review conference which agrees the end of the child protection plans notes that [the mother] has 'engaged extremely well' with the social worker, she is insightful into her own issues and difficulties, is engaging with substance misuse services and receives support from [the father]. Sibling One's school attendance is much improved and Sibling Two is 'thriving'. The relationship and strong bond between [the mother] and the children is noted throughout the records at this time and home conditions are consistently clean and tidy... It was acknowledged by the Independent Reviewing Officer that although [the mother] is working positively and has made significant progress, it is still early days and the situation needs to be monitored… The multi-agency conference decision was to remove [the children's] names from the child protection register.*
>
> *Given the chronic, long lasting nature of concerns the question must arise as to whether this was the correct judgment and that only 7 months after registration the risks to both children had demonstrably reduced sufficiently to remove their names from the child protection register?"*

Learning Points

- The fact that a decision has been made to end a child protection plan does not necessarily mean that all risks to the child have ceased
- Consideration should be given on ending a child protection plan to following this with a child in need plan agreed between the family and professionals and with processes for appropriate ongoing monitoring and scrutiny

Chapter 8: Pathways to protection: Agency structures, processes, and cultures

The last two chapters have explored how individual practitioners can work on their own and in collaboration with others to support families, identify risk and vulnerability, and respond appropriately in partnership with families. We now turn to the underlying agency structures, processes, and cultures that may support effective working to prevent harm to children.

While the move to embracing systems approaches to review appears to have led to a greater depth of analysis, identifying many of the systems issues which led to mistakes on the part of professionals, in most cases this has still maintained an emphasis on professional failings. In this chapter therefore, we will highlight some of the systems issues that were identified, and pick up on some of the creative thinking that is emerging on ways to promote good practice and improve opportunities for prevention and protection.

In our analysis, we identified four broad themes in relation to underlying systems improvements:

- Building effective structures
- Coping with limited resources
- Establishing workable processes
- Embedding responsive cultures

8.1 Building effective structures

The changing shape of agencies, with new commissioner-provider structures in health; and the broadening scope of children's safeguarding, bringing in new agencies and organisations have brought with them the need to expand and develop new policies and procedures. In light of this, a number of recommendations referred to the need for agencies to develop, update or review safeguarding and child protection procedures. These recommendations applied to education, social care, healthcare, housing agencies, and armed forces welfare agencies.

The configuration of services was a key issue both in social care and in health; in some SCRs, recommendations looked towards the possibility for reconfiguration, ensuring that any review or redesign should effectively meet the needs of children and families. This includes ensuring that the staffing structure reflects appropriate knowledge, skills and experience. This applied to social work teams and also to third sector staff.

This may be particularly pertinent in relation to transition and change in the configuration of services. Public services in our country seem to regularly undergo what are, at times, quite fundamental structural changes. This can have substantial knock-on effects on

individual professionals within those agencies. It is crucial that effective systems are maintained through periods of change, and that arrangements are made to ensure continuity and coherence.

8.1.1 Primary care integration

A number of reviews pointed out the complexity of primary care services, which rely on a mixture of independent, public and private contractors, with a multitude of different professionals, often working in relative isolation. There was a lot of evidence that this fragmentation has got worse over time, and has been adversely affected by changes in the health service, and the contracting out of some segments of health care:

> *"The GPs later explained, as part of this review, that they no longer have the same contact or alignment with Health Visitors as in previous years, where they would have regularly met with Health Visitors assigned to the practice."*

The fragmented nature of primary care, with GPs working as independent practitioners, but nevertheless as part of a multi-disciplinary team including practice staff, health visitors, midwives and school nurses, many of whom would be located elsewhere and under different employment structures, brings substantial challenges to effective safeguarding practice. This has the potential for both duplication of and gaps in service provision. This was reflected, for example in a recommendation in one SCR to review the provision of midwifery support to pregnant teenagers:

> *"Currently there is only one part time Specialist midwife providing tailored support to a proportion of these clients in one half of the Trust's catchment area. Alongside this and on both sides of the district there is an increasing development of the Family Nurse Partnership. There is significant overlap of the responsibilities of each role and the services they offer. This introduces a risk of both duplication of, and gaps in, provision*."

Recognising that there are inevitable transitions inherent within primary care services, such as those between midwifery and health visiting, and between health visiting and school nursing, local teams need to ensure that there are appropriate structures in place for smooth transition, ensuring that information is recorded and passed on, and that any transition, particularly for a vulnerable family, is planned so that appropriate support is maintained:

> *"The midwifery service continued to support the family appropriately until the health visitor had taken on the care of the family and this is good practice although there is no evidence of earlier communication between the two services which would have been expected in a high risk family. This is presumably due to the lateness of the booking although this should have increased the need for communication between the two services."*

The fact that general practitioners are essentially autonomous independent practitioners causes a lot of concern among safeguarding professionals. This, combined with the huge remit of general practice, means that there are inevitably wide variations in the degree of engagement by GPs in safeguarding processes. As highlighted in this SCR, this places responsibility on the commissioners of GP services to be clear how they will support GPs in their safeguarding role and ensure that expectations may be met:

> *"GPs have no 'senior managers' and are essentially autonomous. Wide variations in levels of awareness of and involvement in safeguarding seen within this serious case review pose issues for commissioners of GP services about how expectations may be defined, monitored and (if unfulfilled) responded to."*

General Practitioners play a crucial central role in relation to early services for children and families, given that all children are, or should be, registered with a GP. They potentially provide a central repository of information, and a bridge between community services and secondary/tertiary care. This responsibility was identified in a case involving a 17-year-old who died as a result of his underlying chronic health problems, and was related to Care Quality Commission findings in relation to the Peter Connelly Inquiry:

> *"The GP was not as effective as would be expected in ensuring that children's social care were aware of those involved with [the young person], or at informing staff from the hospital that children's social care were involved. As stated by the GP agency author 'following the death of Peter Connelly in 2008 the Care Quality Commission clarified that GPs are seen as the central medical record holder and should be able to identify trends in patients' care. I don't believe that in this case the GP practice saw itself as the service that was pulling all the information regarding [the young person] together in order to consider what extra support this young man needed to manage his diabetes'. The reviewer agrees that the GP was essential in this case in ensuring that [the young person] received the health care he needed, but they were not adequately aware of, and therefore were not undertaking, this important role."*

However, it is important that this role isn't accorded undue weight, or that unrealistic expectations are placed on GPs in this regard. In the following case, the impossibility of a GP being able to keep tabs on all vulnerable children was highlighted in relation to those children who are not brought to appointments:

> *"Although there are procedures in place… relating to children not taken to appointments these did not make a difference in this case. Volume may be an issue as in relation to the follow up appointment made by the regional hospital this was an error made within the context of approximately 8-12% (2000) appointments a year not being kept… Discussions with hospital practitioners suggested that there can be a reliance on GPs to identify where follow up has not taken place although it is hard to know how the GP would realise that this had*

happened, particularly in the case of the second episode of vomiting when the GP was not informed of the failed appointment until four months later."

This would suggest there is a need for a deeper consultation at local levels between GPs, their commissioners, secondary health services and other agencies as to what expectations can realistically be placed on GPs as central repositories and coordinators of care, and how any expectations can be effectively supported by robust structures and processes. This is something that LSCBs could usefully take a lead on, in partnership with their local health commissioners and providers.

Learning Points

- The increasing fragmentation of primary care services requires creative discussion at a local level to identify processes and structures to enable effective sharing of information and transition between different providers of care
- LSCBs could work with GPs, their commissioners and other stakeholders to realistically review what can reasonably be expected of GPs as repositories and coordinators of care, and how such expectations can be supported

8.1.2 Complexity of services

If complexity of services and fragmentation is an issue within primary care services, it is potentially even more so in relation to secondary care health services and in the interplay between primary and secondary care. Navigating between complex agency structures can prove difficult for both professionals and families. Professional misunderstandings take place, families are misdirected, and information-transfer is disrupted, all of which can impact on the effectiveness of overall safeguarding processes. These issues were graphically illustrated in a number of SCRs, such as the following involving a mother with severe mental health and alcohol problems who went on to kill her young son in an extended filicide-suicide:

"The children's mother was a woman who was well able to engage with professionals and explain her situation. She did not give evidence of critical need, rather as was recorded in a variety of assessments, she presented as a person who had been through a difficult time and was finding a way out of it. If her need had appeared more critical or if she had presented as a person at real risk of taking her own life, there were referral routes available. In the mother's case, the range of options, including DAS [Depression and Anxiety Service], DASS [Drug and Alcohol Support Service] and IDVA [Independent Domestic Violence Advisor] support had different exclusion factors and scoring regimes that together left her in a complex maze of service offers, which did not in the end lead to the service

provision she was seeking."

Complexity in services arises where individual organisations, such as health trusts, GP practices, or individual schools provide related services under different umbrellas or management systems. In such situations it is essential that professionals recognise this fragmentation and don't assume that one organisation can speak for all organisations within a particular agency, as highlighted in the following SCR in relation to education:

> *"There were examples within the case of a lack of appreciation of the fact that the infant and junior school were separate organisations working with different siblings. Where this is the case the opportunity to gain all relevant information may be lost if there is an overreliance on communication with one school."*

This complexity can be at least partially mitigated by developing clear care pathways for particular circumstances of vulnerability. Such pathways can go a long way towards ensuring that parents, children and families receive the care and support they need in appropriate ways and in a timely fashion. However, care pathways need to be coordinated and clear, and need to have built in systems for review and updating, particularly when underlying structures change.

Opportunities exist within all health and welfare services for clear signposting towards appropriate services. This again can be facilitated by clear care pathways, by ensuring professionals have access to information about services in their area, and by individual services making clear their referral and acceptance criteria. In the case of the mother with mental health and alcohol misuse problems highlighted above, the SCR identified the importance of clear signposting and referral guidelines:

> *"The mother was advised during this call that there was an exclusion criteria for clients experiencing domestic abuse and she was therefore not appropriate for Depression and Anxiety Services at that time, although she could access the service once the pending court case had concluded. The mother was signposted to the Domestic Abuse Support Service for further advice and support. This occurred some eight weeks after she first contacted the Depression and Anxiety Service for support. It would have been helpful for the children's mother to have been signposted or referred to the correct service at the outset."*

Learning Points

- Clear coordinated care pathways for families with particular vulnerabilities can help ensure parents and children receive the help and support they need in a timely and accessible manner
- Local services need clear signposting, and clear criteria for referral and acceptance/rejection of cases

8.1.3 Cross-boundary issues

Working across regional borders within England can present hurdles for agency operation and information transfer between area centres is potentially problematic. Work between geographical areas can cause logistical issues as well as differences in professional opinion with regards to how to proceed with cases:

> *"According to the social workers involved at this time, it was at the point that the structure of the child protection process was no longer in place that the implications of the case being held by a social work team out of area became more apparent. Social workers describe the problems of working out of area (albeit only twenty minutes away), in relation to knowing the services and professional networks. Once the child protection plan had ceased they recall that the focus was on getting the case back to area 1 although that area were reluctant to receive the case back."*

In light of this, it is important that LSCBs and their constituent agencies, including local authorities recognise they have a collective responsibility that crosses local area boundaries. One SCR involving a sudden unexpected death of an infant from a travelling family recognised the need for local authorities to work together to develop a collective response to sharing information in relation to families who move frequently:

> *"This Serious Case Review should make recommendations to the pan London Safeguarding Children Board to commission further work on developing a collective response to sharing information on children within families who move frequently."*

8.1.4 The role of the courts

The last biennial review of SCRs highlighted significant difficulties raised by the interaction between court processes and inter-agency working to safeguard children (Brandon et al, 2012, p.84). This again was identified in a number of the serious case reviews in this cohort. It is clear that the courts are well-positioned to identify and flag pertinent information relating to families and children. However, the way in which courts function and their independence from the wider safeguarding arena can present challenges to professionals working to protect children.

In the court arena, the manner in which information is presented and interpreted has implications not only for the immediate outcome but the way in which individual actors are portrayed and perceived by agencies for the remainder of their interaction. In the following case in which the small child in question ultimately died due to the actions of his mother and her partner, the child's father was seen as controlling and abusive in court and thus his contributions were not taken into account:

> *"Father made a number of allegations about Mother to the court. This information included allegations of Mother's misuse of alcohol, her lying about when she discovered that she was pregnant and that she had attacked Father physically and self-harmed with the intention of telling the Police that Father had hurt her. He also provided a large quantity of texts from her… Father was told by his solicitor that the evidence that he had provided was viewed within the court proceedings as further evidence of his controlling behaviour in the context of domestic abuse. It is of concern to the Review Team that the court did not ask for an assessment… to be undertaken, given the concerns raised about both parents."*

Throughout the course of a case, the wealth of information amassed within legal and forensic records places courts in a position to be a vital resource to other agencies. However, access to such information by other professionals is not guaranteed despite its potential use in informing how cases would best be handled, as in this case involving a father with known issues in relation to his mental health and violent behaviour:

> *"The most significant aspect of the history that remained inaccessible to any professional who was working with [Mr X] or the children were the court and prison psychiatric reports prepared in 2006 and prison health records from 2006-2008. These were only used within the court and in the prison service and never made available to local professionals. It is not possible to know what effect it would have had if the GP, mental health trust and probation service had had these records. They showed what [Mr X] was like in a different setting at a particularly stressful time in his life and they offered a different opinion as to the nature of his mental health problem."*

This can result in incorrect assessments of risk and the individuals in question may be placed in a position where harm can take place. In the above case, although the perpetrator was referred to a multi-agency risk assessment panel (MAPPA), the absence of relevant information may have led to a downgrading of the potential risks posed. This man went on to stab his eight month old baby, who suffered serious injuries as a result.

In addition to the issues around sharing of information within and beyond the court arena, the manner of court investigations can have implications for the subsequent management and ultimate outcomes of a case. In the following case, in determining the nature of an injury to a child and the means of doing so, interpretation of information from the available sources was clouded by a lack of clarity in the interpretation of findings presented to the court; this in turn led to an apparently inappropriate judgement being made in the court, which ultimately appeared to limit avenues for future work, and disempower staff working with the family. In this case, a seven month old infant was killed in a violent assault by the father two months after the court case:

> *"The key event in this situation is the court case, and the key event within the court case is the finding of fact. The reason that this is fundamental is that it limited the*

avenues for future work and appeared to disempower the health, legal and social work staff who had been present throughout the court case.

The outcome of the case hinged upon the medical evidence presented by the doctors and it appears that they left enough doubt for the magistrates to refuse to make the order. "It is unusual for medical evidence to be completely diagnostic in child abuse cases…In family proceedings the level of proof is on the balance of probabilities… It is unfortunate that neither of the doctors giving evidence articulated clearly and unequivocally that on the balance of probabilities they felt the injuries to be non-accidental".

The complex issues surrounding the interface between inter-agency safeguarding and the role of the courts were explored in our last biennial review (Brandon et al, 2012). The persistence of these issues reinforces the need for further research and consultation:

> *This highlights some of the difficulties inherent in the interaction between court processes to protect children and wider inter-agency working to safeguard and promote their welfare. The principles of judicial independence and due process of law are inherent to a just system and provide important safeguards to all involved. This can, however, lead to frustrations among practitioners in the multi-agency arena. Misunderstandings of these processes and breakdowns in communication may at times lead to children being put at further risk of harm. These cases highlight the need for further research and consultation into how the courts and other agencies work together to effectively safeguard and promote the welfare of children, while maintaining these important principles.* (Brandon, Sidebotham et al, 2012, p.86)

Learning Points

- Consideration needs to be given, at both a local and national level, of how local safeguarding agencies can more effectively work with the courts to ensure the appropriate sharing of information both ways; how the quality of evidence provided to the courts can be improved; how any assessments carried out in the court arena can be made more robust; and how judicial decisions could be made in ways that support ongoing inter-agency work to support families and safeguard children
- Such discussions could be facilitated by the Family Justice Council, whose remit is to promote an inter-disciplinary approach to family justice and to monitor the system

8.2 Coping with limited resources

In contrast to previous biennial reviews, resource issues were flagged up in quite a number of the SCRs we looked at. This may partly reflect an ongoing impact of the economic climate; it may, in part, reflect the difficult balance between rising public expectations of services and finite resources; it may also reflect a shift towards more rigorously exploring the systems issues underlying individual failings.

8.2.1 Managing increased workloads

Chapter 2 highlighted the steady increase in child protection activity year-on-year since 2009. This increase is matched by an equal increase in child in need activity, and extends back now over several years. All this has occurred during a time when many services have remained static or been cut, thus leading to increased workloads for individual practitioners and teams. The impact of this was pointed out in three different agencies in the following SCRs:

> *"All of those we spoke to in the course of this review from children's services talked of high workloads, with evening and weekend working routine and necessary. In the 12 months leading up to the period under review children's services had seen a 30% increase in the number of contacts received by the Safeguarding Hub. As a result caseloads had risen significantly, especially in the initial response team."*

> *"However, the Police are clear that with 15 children going missing every day in the … area, they would not have had the resources to go out to the College. They were particularly under resourced at this time, because the Olympics were taking place and several Police Officers had been taken off normal duties."*

> *"Concerns were however identified in respect of the size of the caseload of the school nurse and the lack of clarity about expectations upon them when in receipt of domestic abuse notifications. The issue about the caseload was subsequently addressed by extra support being put into that particular school nurse team."*

While some services may be able to provide additional staff to cope with increased workloads as in the case above, this is not always possible within limited resources. Therefore, organisations need to look to other ways of managing workload stresses. This requires creative thinking on the part of managers and leaders. On the whole we did not find a lot of evidence of strong recommendations in this regard in the SCRs studied. However, some highlighted opportunities to address workload issues through effective scheduling and configuration of services; through strengthening systems for staff support and supervision; or for ensuring adequate administrative support.

High and unmanageable workloads can result in delays in provision of services, higher thresholds for accepting referrals, or a lower level of service being provided. In particular,

agencies often adopt short-term pragmatic solutions, rather than considering the ongoing needs of families, as in the following case:

> *"Short term solutions are more likely to be the focus of help to families in situations where there is a high volume of work, there are a number of apparently similar children and/or systems are under pressure due to structural changes."*

This can also lead to a lower quality of working, with practitioners not having sufficient time to complete tasks appropriately, or taking short-cuts in order to manage their workload:

> *"This assessment was written up as a case summary. Senior managers had agreed that for all non-child protection cases that this was an appropriate course of action due to a backlog of assessments which had come about as a result of workload pressures as well as the impact of the reclaiming social work pilot."*

While these approaches may provide some short-term pragmatic solutions, ultimately they can prove highly damaging to effective working, leading to the quality of assessments being jeopardised, delays appearing, and bureaucratic processes adding additional obstacles. It is essential that managers recognise these dangers and take steps to ensure that staff can work effectively within protocols and that any delays are recognised and addressed before they build up further.

The reality, however, is that expectations of practitioners and the workload they are likely to have to carry are not going to get any less, and resources are finite. It is therefore important that systems are in place that recognise the impact of these pressures and seek ways to support professionals in working effectively within such constraints. As the following cases emphasised, in such situations, it is even more important that professionals adopt practices of critical reflection, and that appropriate supervision is provided to facilitate this:

> *"During the period under review and indeed subsequently staff across various agencies… worked under considerable pressure, dealing not only with their case load but the challenge of reducing resources. Professionals can develop an over committed approach to their work and it is at these times that effective supervision to maintain safe practice is even more important. If managers have to adopt the same over committed approach systems can become stretched, unreliable and potentially unsafe."*

> *"This family were one of many coming to the attention of professionals and would not have raised as many alarm bells as other similar situations were being confronted on a day to day basis. The opportunity for critical reflection on practice is crucial particularly in situations which are "bumping along the bottom." However, it is often just these situations which are not discussed within supervision sessions*

particularly within heath environments where practitioners are also providing a universal service and caseloads are high."

Effective working within the constraints of limited resources can be facilitated by good administrative support to professionals. Unfortunately, it is often administrative support that is cut when resources are tight. Within many organisations, administrative support may be contracted out, or slimmed down, leading to delays in appropriate communication. This was highlighted in one SCR relating to an eight year old who had died of a medical cause in the context of ongoing neglect. The SCR documented several instances of delays of between five and seven weeks in letters being typed and sent within health services.

Allocating cases to junior/trainee workers

One common response to inadequate staff numbers appears to be to allocate cases to junior or trainee workers. This was observed in several SCRs in health, social care, and, as in the following case, probation services. While there may be benefits for allocating cases to junior or trainee workers, this needs to be handled appropriately, with good levels of support and supervision, and shouldn't be seen as a means to filling gaps in service provision:

"The allocation of a Child in Need case to such an inexperienced officer was unusual, but she did handle to (sic) case well. However, her inexperience was evident in three instances, none of which were picked up by her Team Manager or mentor. The failure of registering the case as medium risk to children, the lack of a formal letter to the County Council Children's Services at termination of the Order and, despite the concerns raised with the Team Manager, no Child Protection referral was made."

Learning Points

- The impact of increasing workloads in the face of limited resources places an imperative on leaders and managers within all agencies to think creatively about how their systems and structures can effectively support front-line workers
- This may require restructuring of services; scheduling systems; and ensuring adequate administrative support for teams
- Effective supervision becomes increasingly important as workloads rise

8.3 Establishing workable processes

The centrality of effective processes for safeguarding has been embedded in UK child protection practice since the 1970s. The various iterations of *Working Together* guidance have formed the basis for inter-agency working to safeguard children and are reflected in local protocols and procedures. Where local protocols are clear, they can support effective inter-agency working, however, they also have the potential to be ambiguous or contradictory, or to present barriers to professional working. It is essential therefore that any guidelines or protocols are coordinated, kept up to date and based on the best available evidence, and are developed and made available in ways that support professionals in their role.

8.3.1 Being bound by structures or processes

Bureaucratic processes are implemented with the intention of forming a robust and replicable mechanism around professionals and families to ensure best practices are upheld, as in the following case:

> *"The assessment carried out by the probation service was necessarily determined by the focus of the service on reducing the risk of reoffending. Assessments took place shortly after Mr B was released on licence and identified the factors that the probation officer believed to be likely to influence possible reoffending. Mr B was assessed as a high risk of reoffending and referred to the local multi-agency risk assessment panel (MAPPA). The probation supervisor commissioned additional assessments in relation to risks associated with mental health and substance misuse. All of these assessments were within the framework of probation responsibilities and correctly carried out."*

However, the rigidity of these processes may at times be incompatible with the realities of how services operate and are accessed, as demonstrated by the following case where the constraints on a mother registering with a GP surgery led to her antenatal support being compromised:

> *"When Mother was interviewed as part of this review she said she thought that the [Area 1] Midwives would contact [Area 2] Midwives and they would contact her in due course. Mother told the Review that she had not known how to contact the [Area 2] Community Midwives because when she had tried to register with a number of Doctor's surgeries she said she had been told she could not do so because she did not have a permanent address."*

To a degree, rigid procedures, combined with high workloads and limited resources can sometimes create a disincentive for acting outside of the usual processes. This was seen in the case of a six year old child who died as a result of neglect in which a lack of response to appointments led to a mother and her children being removed from a GP's list, contributing to even greater invisibility and vulnerability of the children:

"The GP practice had removed [the mother] and the children from the register… due to her persistent lack of response to appointments to have the children seen and to have the opportunity for routine care such as immunisations. If [the child] had for example been seen by a GP prior to being removed from the register it would of course have been an opportunity for evidence about the extent of malnourishment that contributed to the death... It is not a requirement for a GP to see a child before they are removed from the register."

Over-reliance on these systems with the additional factor of human error can lead to the needs of families remaining unmet:

"Mother was only 17 years of age a referral should have been made to the Teenage Midwifery service as part of routine ante natal care. A referral form was completed but was not sent because the midwife forgot to obtain the mother's signature and hence the mother did not receive the benefit of this service."

Use of Assessment tools

In the context of assessment various tools are used as a means of standardising information gathering, the interpretation of cases, and informing subsequent practice. However, variation in the effectiveness, value, and types of assessment tools available can be detrimental to their overall use. Rather than being led by the benefit and learning to be gained from using assessment tools, professionals can instead be led by the need to complete the task at hand. The following case illustrates how the execution of the assessment was considered to be the goal in itself:

"The majority of agencies involved in the review relied on some form of assessment tool in their day to day work with clients. It was clear from conversations with the Case Group that issues regarding capacity mean people often complete these tools hastily and use them as a recording tool as opposed to an aid to understanding and analysing risk."

Learning Points

- Guidelines and procedures can be useful tools for supporting professionals in working effectively. However, they need to be seen as tools to facilitate good working, and not as constraints or barriers to professional practice.
- This may require flexibility on the part of professionals responding appropriately to the needs of children and families: professionals need to consider how they can best support the family and protect the child, not just how to follow the rules.

8.3.2 Lack of clarity of processes

The efficacy of guidelines and procedures relies upon their integration into the target setting, the education and awareness of those involved, and the speedy identification of any unforeseen gaps.

Professionals' familiarity and comfort using processes is integral to their effectiveness. In the following case, the issues arising from failing to use the correct reporting system were compounded by limited supervision and oversight:

> *"To compound this the junior member of staff appeared not to have fully understood the request for a social services referral and instead completed a concern and vulnerability form. Within the hospital this form has been amalgamated with the CAF [Common Assessment Framework] for ease of completion and to avoid duplication, in this instance it is unclear why this form was used and what happened to the form itself… This may have been a result of confusion in relation to the current hospital processes that had recently changed and a lack of knowledge of processes for flagging concerns to senior staff. Senior midwifery overview of practice appears to have been absent and if present is likely to have identified the confusion and flagged the need to escalate concerns."*

Additionally, constant evaluation of whether procedures are used effectively and remain fit for purpose is required. In the following case, the procedures failed to meet the required need, were used inconsistently, and betrayed large and systemic gaps in function, both in relation to recording information, and policies around missed appointments:

> *"The health agency chronologies and narratives highlighted the problems of health professionals not having common policies or systems of patient recording; this is a national problem. There was no sense of a shared view that could identify patterns of missed appointments, inconsistencies and risk.*
>
> *The Child missed appointments with the GP, the Orthoptist, the Paediatric Consultant [Trust 1] and the Paediatric Respiratory Consultant [Trust 2]. Each of these component parts of the health service have their own policy and practice covering missed appointments. The missed appointment policies were not consistently applied sometimes as a result of clinical judgement and sometimes as a result of error."*

The following case demonstrates the failure to abide by accepted clinical guidelines. In this case, a pregnant mother and her baby were at high risk of vitamin D deficiency. The infant subsequently died as a consequence of rickets in a context of extreme neglect. While guidance on vitamin D supplementation in pregnancy has been in place for a long time, in this case it appeared not to have been followed. This may have been due to lack

of professional awareness or professional error. There was no deeper consideration in the SCR as to why the guidance wasn't followed, but it raises issues around the effectiveness, clarity and accessibility of national guidance:

> *"The GP practice failed to address [the mother's] vegan diet and its impact on either her or her child's health… NICE guidance in 2008 noted the increasing prevalence of rickets and the need for vitamin D supplements in certain cases and recommends routine assessment within antenatal care for vitamin D supplements. The government issued guidance in relation to Vitamin D supplements in pregnancy in 2012 and it can only be assumed that this practice were unaware of this guidance. However this is a common feature in this SCR as no other health practitioners appeared to proactively follow this guidance/recommendations."*

One further issue in relation to clarity relates to the fragmentation caused by having multiple steps within any one pathway. This was highlighted in one SCR in which potentially unhelpful stages were built into a referral pathway within an ambulance trust:

> *"Given that [the Ambulance Service] is a regional service, the process for making referrals at the time involved any referral from an ambulance crew being faxed to a central Emergency Control Centre, who would then fax it on to the relevant Children's Services department … the service … recognised that there was a potential weakness in their systems for managing referrals."*

Learning Points

- Simplicity and clarity in published guidelines can help ensure that professionals are enabled to work effectively to safeguard children.
- Consideration needs to be given as to why, where national guidance is available, it is not regularly followed. This may require further research into professional behaviours.

8.3.3 Access to records

One of the major issues faced by professionals working within complex organisations or agencies is that of having access to appropriate information. This issue was flagged up within a number of different agencies in the SCRs. It is perhaps particularly marked within health, where many different organisations go to make up the local health economy. In such situations, different teams within an organisation may hold different records, let alone different organisations within the same agency.

In many areas, steps have been taken to overcome these barriers by unifying case records, moving to electronic recording systems, or establishing protocols for sharing information. In one SCR, the issue was particularly pertinent in relation to the armed forces, in which the SCR identified that there was no automatic system for medical

records to be shared with civilian primary care services once a soldier leaves the army. In this case, in which an ex-soldier killed his two children in an extended filicide-suicide, the information about his mental health history could have had an impact on the GP's management of the case:

> *"It was confirmed that when a soldier leaves the service for whatever reason, he gets a final medical and at that medical he is provided with a full print off of his service medical records that he can take to a civilian GP in order to register. He is also provided with the address and details of who the civilian GP needs to write to (Army Personnel Centre) in order to obtain the actual medical records. The service person himself must give consent for the Medical records to be released to the GP for data protection reasons. The Civilian GP has no automatic right to that information."*

8.4 Embedding responsive cultures

In his Founder's lecture at the 2015 BASPCAN congress in Edinburgh, Professor Nigel Parton argued that we are undergoing a shift in the culture of child protection in this country (Parton, 2016). He highlighted how the Children Act 1989 and subsequent *Working Together* guidance was rooted in a number of high profile cases, and primarily related to physical and sexual abuse within the family:

> *'The Children Act 1989 was thus centrally concerned with trying to establish a new set of balances between the state and the family in the care and protection of children. I argued (Parton, 1992) that the idea of child protection at that time, in the early 1990s, was essentially concerned with both the protection of children from 'significant harm' in the family and also the protection of the family from unwarrantable and inappropriate state interventions. Crucially the focus of law, policy and practice was how we could best address the abuse of children within the family and the primary concerns were physical and sexual abuse.'* (Parton, 2016, p.10)

While the necessity of balancing support and scrutiny remains, and perhaps in many ways has become even more critical, many other aspects of our child protection culture have shifted. Professor Parton identified four particularly significant developments:

- *An increasing focus on the full range of the life-course from pre-birth to young adulthood, particularly as the dangers of child neglect in the early months of life and its impact on the brain and child development have received considerable attention;*
- *The recognition that young people themselves, as well as adults, can perpetrate abuse;*
- *The growth of new dangers including those related to the internet and a range of forms of social media and, most recently, the dangers of 'radicalisation';*

- *The identification of new forms of abuse which include female genital mutilation, forced marriage and child sexual exploitation.* (Parton, 2016, p.11)

Some of these developments have been identified in this triennial review, in particular issues around child sexual exploitation and wider aspects of adolescent vulnerability. However, the first of his points highlights an important issue which was identified in our review and potentially has quite far-reaching implications for our culture of child protection, suggesting the need for a shift in emphasis from incident-based or episodic models of care to a more ongoing culture of long-term and continuous support and protection.

8.4.1 Moving from episodic to long-term models of support and intervention

The interaction of child vulnerability with parent/carer risk identified in the 'pathways to harm' model in Chapter 1 is not a linear process which results in single episodes of harm to the child; rather it represents an ongoing, fluctuating and at times cyclical interplay of vulnerability and risk within which a child may suffer multiple and ongoing harms, even without any specific, serious incident. For many of the cases we examined, it was clear that the final serious or fatal harm represented just one episode in that child's life, by which time it was too late for professionals to intervene to prevent the harm. A child protection system based on responding to identifiable incidents can end up with professionals working on a 'firefighting' basis rather than considering longer term impacts of risk and vulnerability, as in the following case in which the police responded to specific incidents of domestic abuse, but did not address wider issues of ongoing concern:

> *"Most incidents were dealt with in isolation and the cumulative effect of domestic abuse was not sufficiently recognised by any of the involved agencies. The interventions which did take place appeared to do nothing to cease the pattern of alcohol abuse and domestic abuse continuing."*

In cases such as these, the nuances of long-term vulnerability and risk are incompatible with an episodic approach. They instead require coordinated and holistic planning and intervention, particularly when dealing with underlying emotional abuse and neglect:

> *"There was no recognition of the chronic nature of the emotional abuse and neglect experienced by the children and the need for an ongoing well-coordinated multi agency plan. Chronic neglect does not generally respond to short term approaches and requires medium to long term work to achieve the best outcomes. The challenge for multi-agency partnerships is how best to deliver this help and engage with often hard to reach families."*

The use of chronologies and systematic review of the history and development of a case can facilitate recognition of the accumulation of concerns. In the following case, in which

a young child was killed in a violent assault by the mother's partner, this was identified as an opportunity which might have made a difference to the outcome:

> *"However, other identified improvements, such as a reduction in anti-social behaviour and inappropriate visitors, could not be assumed to be long term given [the partner's] previous history. Children's Services have recognised that this case … suffered from a lack of a chronology. Had there been a systematic review of history relating to both children, the development of a pattern of predominantly low level concerns should have been visible and a more cautious assessment adopted towards [the partner's] ability to maintain improvements."*

Long-term planning

With many underlying parental risks, including substance misuse and domestic abuse, the nature of these issues are such that the risks extend over long periods of time and cannot be confined to specific, identifiable incidents. When dealing with such issues, there is a need to move away from incident-based models of intervention to consider the ongoing lived experience of the child and parent, how resilience can be promoted, and what ongoing support and monitoring is required.

Thinking within these terms allows professionals to view safeguarding events cumulatively and permits a view of a case from which a long-standing issues can be ascertained. This also facilitates a measure of improvement, where the impact of interventions can be considered and sustained. In the following two cases a more proactive approach was identified, illustrating how acknowledging the long-standing nature of an issue permits work that encompasses monitoring, review, and revision, and provides a context for escalation at appropriate times, not just relying on individual incidents of harm:

> *"The social worker emailed the Drug Agency worker requesting regular updates on [the father's] engagement with the service and results of drug screens. The social worker attached details about the Public Law Outline process and a copy of the partnership agreement made with the parents. This ensured that the Drug Agency worker was aware of the plans for monitoring the family situation and their part in it."*

> *"The learning mentor outlined concerns about the children being poorly dressed and having poor hygiene and recorded that the social worker said the case was going to be "stepped up as the parents are not improving" and that there would probably be a Child Protection Plan due to long-term neglect."*

Such an approach does not lend itself to well-defined episodes of care, nor to the constraints of our current child protection systems. There have been welcome moves over recent years to improve the rigour of child protection plans, and to ensure that cases are not left to drift for months or years with no tangible improvement in the lives of the

children. However, this can have the unintended consequence of brief intensive interventions leading to improved short-term outcomes yet without ever fully addressing the underlying issues and leading to sustained change. In many of these vulnerable families, such interventions need to be maintained in order to effect sustained change, as in the following case of a 15-year-old who died of a chronic health condition in the context of years of long-standing neglect:

> *"There were periods when brief but intensive interventions from specialist services within children's social care were mobilised for time limited periods which resulted in improved outcomes for the Child. There may have been an opportunity to maintain these interventions and thus sustain this change over a longer period of time."*

Learning Point

- Professionals working with children and families need to recognise the long-term, ongoing nature of vulnerability and risk; the nature of child maltreatment, particularly neglect and emotional abuse is such that long-term approaches to supporting families are needed

8.4.2 Authoritative Practice: dealing with complexity and ambiguity

As highlighted in Chapters 4-7, the cases in these serious case reviews were often highly complex cases, with multiple risks and vulnerabilities, often extending over considerable periods of time. This complexity could be further exacerbated by the interactions between multiple professionals and providers of services working with the family in different settings, and often in isolation from one another. As identified in previous serious case reviews, the complexity and dynamics within the family could be mirrored in the involvement and responses of professionals. In many ways it is not surprising that the more complex a case, the more complex the inter-agency working becomes.

A further complication arises due to the often ambiguous and opaque nature of child maltreatment. As emphasised by Lord Laming in his report into the death of Victoria Climbié, *'Child protection cases do not always come labelled as such'* (Laming, 2003, p.365). Where children are living with ongoing maltreatment, the adverse effects of that maltreatment may not be apparent until much later. Furthermore, we need to recognise that for many (perhaps most) parents, child protection agencies are perceived as a threat, and so they may be reluctant to work with professionals, hide or cover up information, or take steps to appear to be complying. These issues of resistance and disguised compliance have been identified in previous biennial reviews, as well as in much of the literature and again were identified in many of the SCRs in this cohort (Tuck, 2013).

This places an imperative on core agencies to develop models and cultures of working that mitigate the complexity and ambiguity. It requires professionals to approach their practice in an authoritative manner, combining authority, empathy and humility (Sidebotham, 2013b).

Authority

Professional authority involves both confidence and competence; it 'requires the application of appropriate evidence, combined with the experience of the practitioner and their responsiveness to the current context' (Sidebotham, 2013b, p.1); authoritative practice will enable professionals to be curious and exercise their professional judgement in light of the circumstances of particular cases, as in the following case where a midwife acted appropriately in referring a case even though it didn't meet the strict criteria for referral:

> *"The midwifery service liaised with Health Visitor 4 and it was agreed that Midwife 2 would complete the MARAC assessment, which she commenced at Adult R's home. The assessment was completed on four days later and achieved a score of 13. A score of 14 marks the standard threshold for a referral to MARAC, but the midwife referred the case to MARAC in any event on the basis of her professional judgement. The risk assessment was classified as High."*

Professional authority enables professionals to adopt a stance of professional curiosity and challenge from a supportive base, rather than relying on undue optimism. These issues, identified in previous biennial reviews, were again prominent in many of these cases:

> *"[The] assessments took an unrealistic and naïve stance that domestic abuse would not continue and would not pose risks to the children. [The mother's] assertions that circumstances had changed and improved were taken without sufficient challenge and her alcohol misuse was not fully addressed."*

> *"A fundamental issue in this case is that work with the family was based on an optimistic view of Mother's psychological strength and capacity to meet the practical and emotional needs of the children… This family might be described as "bumping along the bottom" with care that at times dipped below acceptable and then with help appeared to improve enough for the case to be closed to children's social care."*

One important component of authoritative practice is that each professional takes responsibility for their role in the safeguarding process. Although a lot has been said about this in the past, it would appear that there continues to be a culture of effectively 'passing the buck' in some cases. Professionals continue to make assumptions about the actions of other professionals, or to presume that when they have passed on a request, the accountability for follow-through then lies elsewhere. This was seen dramatically in

the following case where several professionals passed on responsibility to other members of the health community:

> *"This lack of identification of risk and inter-professional communication was also highlighted when the GP was informed by the hospital of the missed out patient appointments. The paediatrician specifically requested that the GP reviewed the child, this should have raised an alert within the practice and a proactive response initiated. The GP advises that this was passed to the HV although no evidence for this is available, however even if the responsibility was delegated the accountability remains the GP responsibility and this should have been followed up. This was a significant missed opportunity and it is difficult to ascertain the reason for this lack of response by any of the health professionals."*

Empathy

The quality of empathy embraces considering both the voice of the child and the needs of the family. It must be grounded in the centrality of the rights and needs of the child, while being sensitive but not colluding with the needs and views of the parents; to maintain high expectations of parents, provide the support to enable them to try and meet those expectations, and to challenge and act when they are unable to do so. The centrality of the child's voice has been emphasised in Chapter 6, and it was clear in many of the SCRs how this priority seemed to be missing. In the following case, a very different picture emerged of positive authoritative practice on the part of practitioners from a number of agencies working with a young person with chronic health needs:

> *"There was excellent communication between all practitioners involved in supporting [the child] including social workers, social work support workers, education workers, Consultant and Specialist Nurse from the tertiary centre and the Police. Staff worked well together and shared information appropriately. Staff should be commended on their tenacity in seeking to develop and maintain communication and a relationship with [the child] who was displaying very challenging behaviour towards staff visiting at home and when accessing health care provision. Their passion to work together to secure positive outcomes for [the child] was undeterred."*

It is important that appropriate empathy towards the parents does not cloud professional judgement or challenge. Again, in the following case, professionals acted in an authoritative manner, combining empathy and challenge in a supportive but proactive manner:

> *"The two health visitors who visited the mother at home recognised the stresses and risks posed to the mother and the children by the domestic abuse, alcohol dependency and associated poverty. They were empathetic to the mother but did not allow their empathy to influence their judgement, making appropriate referrals and at the same time offering consistent support and challenge."*

This raises one of the most challenging aspects of child protection practice, that of balancing support and scrutiny. In Chapter 6, we explored some of the barriers to professionals hearing the voice of the family and effectively working in partnership with parents and families. Perhaps the greatest opportunity for countering these and building effective partnerships lies in establishing and maintaining relationships of trust between parents and professionals. Maintenance of these relationships can mean that professionals are positioned to be sensitive to the changing circumstances of families and meet their needs accordingly:

> *"The … Women's Housing Action Group workers were able to establish a trusted relationship with the mother at the most challenging times in her family's life. Mother felt able to confide in them the truer extent and nature of the domestic abuse she and the children were experiencing."*

In contrast, in the absence of such relationships, parents can feel isolated from the agencies involved:

> *"Mother explained to the review author, that without a consistent relationship with any one professional she was unable to develop a trusting relationship and feel able to speak openly. An identified lead professional may have made a consistent relationship more likely."*

Professionals need to actively work to create and nurture these relationships. However, changes in the way services are structured and delivered mean that new ways of fostering trusting relationship need to be explored. The following case illustrates how changes in the way perinatal care is delivered has meant that these relationships have become less easy to foster:

> *"Contact normally takes place outside of the home, at clinics, children's centres and schools. This contrasts with a generation ago when the universal health provision involved home visits by health visitors to households with pre-school children and midwives visiting the home for 10 consecutive days post birth. This change to service delivery via clinics and children's centres is more efficient and has the advantage of encouraging parental links with community resources and other parents. The disadvantage of this change may though be the ability to develop a trusting relationship with practitioners: this can impact on the quality of assessments undertaken as well as the chances that further help is requested."*

Establishing relationships of trust that balance support and scrutiny is challenging. Nevertheless, if we are to move to a position of effective safeguarding in partnership with parents, it is essential that we prioritise this approach. Managers and supervisors in all agencies need to consider how they can facilitate such working relationships between their staff and clients and build in structures of support and supervision which allow staff to work in such a manner.

Humility

A final characteristic of authoritative practice is that of humility, a term used here *'not in a derogatory or self-deprecating way, but as a positive quality that enables practitioners to recognise their own limitations, to acknowledge and use their skills and strengths, and to seek to improve their practice'* (Sidebotham, 2013b, p.2). This promotes inter-agency working and respect for all members of the inter-agency team, as well as respect for established multi-agency procedures, recognising that they are there to support both professionals and children. In the following SCR, a failure by social care to follow established procedures was interpreted as showing either ignorance or a lack of respect for the arrangements. This places a responsibility on the LSCB to ensure that procedures are appropriately disseminated and accessible to professionals; it also implies a need to consider how relevant and achievable such procedures are:

> *"Worse, in that it suggests ignorance of or lack of respect for, established multi agency arrangements, was the failure in the last week of Xmas term to provide a formal response to the concerns expressed in a letter sent to Children's Social Care by the head teacher."*

The characteristic of humility also requires that all staff recognise their role in the safeguarding process, and recognise and value the roles of others.

National guidance emphasises that 'safeguarding is everybody's business' and that effective safeguarding requires the input of all professionals in collaborative multi-agency working. However, evidence of subtle hierarchies within the systems was identified. There were examples of information provided by some professionals, such as health visitors or social workers, being weighted differently than information from others, such as nursery nurses or family support workers. Medical opinions appeared to be held in high esteem and professionals were wary of challenging their seniors. Roles could be viewed rigidly and professionals would often defer safeguarding responsibilities to social workers. Decision making in conferences was seen as within social workers' remit or that of the conference chair and non-social work professionals viewed social workers as ultimately responsible for child protection, as in the following case of a four year old child with ongoing issues of neglect:

> *"What then followed over the next five months was the health visitor seeking liaison with the social worker whom she knew was conducting an assessment, making numerous attempts to contact the social worker during this time. The purpose was not only to understand what the assessment was indicating but the health visitor wanted to be made aware of this before deciding on her own input – this was something agreed upon in her supervision a month after the injury… The health visitor's efforts seem to have all been in relation to liaison with the social worker when she should have made contact with the family, seen [the child] and undertaken her own assessment of his situation and developmental progress. It appeared as though the health visitor was in effect deferring her responsibilities to*

that of the social worker in not making independent contact with the family because the social worker was."

A number of SCRs emphasised the importance of valuing different professionals' roles, respecting their opinions and the information they hold irrespective of their place in any professional hierarchy. It is important in challenging any such hierarchies, that professionals themselves recognise and value their own role within the wider safeguarding arena, for example nursery staff or the school nurse who may know the child well.

Learning Points

- Principles of authoritative practice can be encouraged across all agencies. These include:
    - Allowing professionals to exercise their professional judgement in light of the circumstances of particular cases
    - Encouraging a stance of professional curiosity and challenge from a supportive base
    - Each professional taking responsibility for their role in the safeguarding process, while respecting and valuing the roles of others
    - Developing and maintaining relationships of trust with young people and parents
    - Ensuring that procedures are relevant and achievable, and that they are appropriately disseminated and accessible
- Managers and service leads have a responsibility to foster such cultures and to model authoritative practice in their own leadership

8.4.3 Building cultures of support and empowerment

The professionalism and authoritative practice described above does not emerge automatically within our services. It needs to be embedded in education and training of professionals, and undergirded by cultures of supportive supervision. Building cultures of support and empowerment needs strong organisational leadership within Local Safeguarding Children Boards and in their constituent agencies.

Effective supervision is a theme that emerges frequently in these serious case reviews. When functioning well it is seen as a positive and empowering system by practitioners and managers alike; it facilitates reflective practice and continuous improvement, along

with a more proactive approach to case management. Often, however, supervision was either absent or inadequate, preventing opportunities for more positive intervention, as in the following case of a young child with issues around possible neglect:

> *"Whilst one of the health visitors discussed the family with her team leader on one occasion, there were other situations when the circumstances would have benefited by consultation or guidance from a manager. This may have prevented some of the missed opportunities for intervening more proactively from occurring."*

Effective supervision needs to balance support and challenge for the professional. It must include appropriate scrutiny and accountability in a way that is not demeaning. In the following case, involving an infant who died at the age of three weeks, a lack of appropriate challenge meant that concerns were not escalated at an early stage:

> *"The supervision of practitioners working with the family does not appear to have allowed for challenge and any error correction in thinking, analysis or planning. Although supervision with the School Health Advisor did log child protection concerns, it was only following the pregnancy… that a S.47 investigation was undertaken. Escalation should have raised these concerns at a more senior level in the County Council Children's Services."*

A number of systems and processes to promote more effective supervision were highlighted in these reviews. These included processes for clearly recording concerns in one place so that all information would be available to supervisors; for compiling and using chronologies in individual cases; and for ensuring that incidents are not just recorded but reviewed as well. Even simple systems such as keeping a 'page per pupil' rather than simply documenting incidents in date order in a diary can enable patterns to emerge and individual cases to be viewed in their entirety.

In the following case, a number of injuries were noted in a school age child; however, these were recorded individually in two separate places and were not always notified to the designated school safeguarding lead. The SCR identified the potential for improving the systems for recording and supervision within the school:

> *"The reasons why they did not do so appeared to have reflected a disorganised response to injuries witnessed, meaning that no records were made, incidents were viewed individually, and there was no person who was coordinating the concerns and identifying that a clear pattern of risk was potentially emerging. The system within the school to respond to safeguarding concerns was therefore dysfunctional at this time. The schools own safeguarding and child protection policy does not make it clear what the internal arrangements were for reporting and recording concerns."*

In another SCR, good practice was noted in two schools which had developed systems for good record keeping and regular review of the records of vulnerable children. The

SCR suggested that other schools and the LSCB could learn from this good practice:

> *"Both the primary school and the junior school attended by the child were examples of good practice in record keeping. Both schools did not simply keep records but also had in place mechanisms for regularly reviewing the records of vulnerable children with key staff members in order to pick up early on whether there were emerging patterns that could indicate a cause for concern."*

In the same case, the infant and junior schools had effective systems in place for transfer of information between the schools at transition:

> *"The infant's school has a "page per pupil" record keeping system where all significant issues/contacts with parents etc. for individual children are recorded. Both schools are on the same site and work closely together and there was a good handover with "page per pupil" and child protection records being passed over and a meeting between the junior school's inclusion manager and the infant's schools special educational needs coordinator. The junior school were therefore aware of the previous child protection concerns, domestic violence and death threats, as well as the infant school's perception that the child helped out a lot with her siblings and needed additional help due to under achievement."*

Cultures of support and empowerment extend beyond supervision to supported practice. Several of the SCRs recognised the challenging nature of the work undertaken by professionals in child protection, particularly when confronted with aggressive or non-compliant parents. Staff in such situations can feel threatened and disempowered:

> *"There is no evidence that [the father's] manner affected the services provided by practitioners and agencies took appropriate steps to ensure this by supporting and protecting their staff, for example by ensuring that senior practitioners or managers either accompanied more junior staff or dealt directly with him."*

The approach taken in this case of ensuring that junior staff could be accompanied by senior practitioners or managers ensures that the work with a resistant or hostile family remains effective and child-focused, and supports and empowers the staff member, enabling them to learn and develop.

Learning Points

- Effective supervision needs to balance support and challenge for the professional
- Good supervision is facilitated by systems for clearly recording and reviewing concerns relating to individual children
- Effective supervision and support should extend beyond formal supervision sessions to consider what support staff require in their day-to-day practice,

particularly in settings of resistance or aggression

8.4.4 Developing the base for evidence-informed practice

The need for a strong evidence base to inform practice is well established. This in turn means that research should be informed by practice and that research questions are developed in response to perceived needs and gaps. While there was much potential learning from these SCRs, there were only a minority of recommendations that suggested actions beyond the immediate confines of the LSCB with proposals for service development, research or public health campaigns.

One SCR included a number of recommendations around improving outcomes for teenagers at risk of criminal behaviour, including lack of access to employment and exploring the use of volunteers:

> *"[The LSCB] to require all agencies to work in partnership with Learning and Children's Services to develop a system of multi-agency risk assessment and management for adolescents who are at risk of involvement in: Emergent criminality, serious youth violence perpetrated by their peers in gangs, or increasing anti-social behaviour; and Serious youth violence perpetrated by children acting on their own."*

There were a few recommendations suggesting commissioning research to fill evidence gaps and create evidence-based practice guidelines to improve practice. These involved both rare events such as concealed pregnancy as well as more common issues such as the lack of involvement of fathers and the reason for this.

One recommendation however suggested the development of 'an evidence based 'mood' assessment tool for the postnatal period'. This was both an unusual and an unrealistic recommendation in that there are well known tools such as the Edinburgh Post-Natal Depression Scale already in widespread use in clinical practice by health visitors so it is unclear what benefit another tool would be. Nor does it demonstrate any awareness of the scale of research and development required to produce an evidence-based tool such as this.

Some recommendations focussed on service improvements nationally considering issues such as the difficulty in detecting non-accidental injury in infants during routine clinical encounters and GP involvement in the safeguarding process, or reviewing the current definition of neglect.

> *"The LSCB Chair should write to the Department of Health and suggest they invite the relevant professional bodies, such as the Royal College of General Practitioners, to examine the case which triggered this serious case review and consider whether there are further reasonable tests or steps which could be could*

be taken at the 6 week stage to determine whether a baby has suffered from gross injuries of the nature described in this report."

It would appear from our review that most SCRs focus, appropriately, on learning lessons and implementing change at a local level. However, it would also appear that there are further opportunities for learning lessons nationally and for informing further research, service development and wider public health initiatives which could have a wider impact on children's safety and wellbeing. Embedding responsive cultures that are grounded in strong evidence, and facilitate authoritative professional practice is crucial for this.

Learning Points

- Child protection practice should be grounded in an evidence-informed approach
- Good evidence-informed practice is dependent on practice-informed research
- There are many opportunities for wider learning and developing arising from serious case reviews

Chapter 9: The quality of serious case reviews

This chapter considers the quality of serious case reviews in the light of changes to the way that many reviews have been undertaken including the structuring of the final report. A crucial aspect of the SCR is the recommendations or learning points that stem from the review. We have therefore followed up our earlier analysis of recommendations (Brandon, Sidebotham et al, 2011) to study any changes in the way in which recommendations are made and followed through.

9.1 Policy Context

The variable quality of serious case reviews was recognised as a potential barrier to learning by Ofsted (2008; 2009; 2011) and continues to be expressed as a concern in both annual reports from the national panel of independent experts (DfE 2014a; 2015). Since June 2010, there has been a requirement to publish the serious case review which has brought both challenges and changes to the production of the review's final report with issues like redaction to preserve confidential information, evident in the early experiences of publication, potentially impinging on the clarity of this document.

The period under study, 2011-2014, straddles two sets of guidance for completing SCRs; Working Together 2010 which had 22 pages of prescriptive guidance about conducting the review and compiling the final report and the much slimmed down Working Together 2013 which has seven pages of guidance based on principles rather than prescription. Although the precise format of the final report in Working Together 2010 was said to depend on the features of the case, the structure and specific headings were laid out and used as the template for the final report (HM Government, 2010, p.247).

The most recent editions of Working Together (HM Government, 2013; 2015) are much less prescriptive demanding three things of final reports, namely that they should:

- *"Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;*
- *Be written in plain English and in a way that can be easily understood by professionals and the public alike; and*
- *Be suitable for publication without need to be amended or redacted"* (HM Government, 2015, p.79).

The specific criticisms of the quality of final SCR reports, by the first report from the national panel of independent experts, were published in July 2014 (DfE, 2014a). This was after most of the SCRs studied here were completed, or at least initiated, since our triennial study concerns children who died or were seriously harmed between March 31 2011 and 1 April 2014. The panel identified a number of key problems in the quality of reports including: too much detail making it hard to read and hard to understand what

happened; too much listing of what happened without asking why; a failure to look at human motivation and the impact of fear, overwork, timidity, wilful blindness and over optimism; reports that fail to centre on the child; and unclear, unfocussed recommendations. Instead the panel provided a list of features they would expect to see in an effective review:

- *"A sharp focus on what caused something to happen and how it can be prevented from happening again.*
- *A concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events).*
- *A detailed analysis of what went wrong and why, including individual errors and system failures.*
- *Clear learning points and recommendations addressed to named people or organisations locally and nationally, including adult services where appropriate. Measures should be included to follow up and see whether these recommendations have been accepted and implemented.*
- *A focus on what the lessons should be for the services concerned, rather than a blow-by-blow account of what happened to a child.*
- *Proportionate to the case being considered when applying the points above. This is far more important than a blind adherence to a specific methodology. LSCBs should be looking at a 'sliding scale' of SCRs, from those which result in very quick outcomes and a short report, to those which by the nature of the incident require a greater level of investigation.*
- *Prepared to highlight relevant failings and good practice and policy at all levels, not just those at lower levels"* (DfE, 2014a, p.8).

In their second report the panel was still concerned about the inability of some reports to '*capture clearly and succinctly what went wrong and why'* and found there was sometimes still too much detail, a lack of clear findings and too much emphasis on the methodology rather than the production of a good quality report (DfE, 2015). The panel also noted delays in completing and publishing the review and suggested that briefer, more proportionate SCRs might reduce the long wait for the learning. It is important to note that these comments about quality have not been incorporated into Working Together 2015 as guidance.

9.1.2 Models of serious case review

It was not until the publication of the Munro Review of Child Protection, (Munro, 2011b) that alternative review methods, beyond the approach set out in Working Together 2010,

were seriously considered. Some LSCBs started to think about carrying out SCRs using a systemic methodology as recommended by Munro. The revisions to Working Together published in 2013 indicated for the first time in clear guidance that LSCBs were free to decide how best to conduct SCRs, and could use any learning model for these reviews 'which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro (HM Government, 2013, p.67). This paved the way for a plethora of types of review and final report but also some confusion among reviewers about whether systems methodology was indeed required (Brandon et al, 2014). This perhaps prompted the widespread use of 'hybrid' models.

A description of three different review methods are included in Appendix B adapted from material from a small scale evaluation of a Department for Education funded national training programme for SCR authors and commissioners (Brandon et al, 2014). This study identified confusion among authors and LSCBs about what constituted a quality SCR report and their wish for clear exemplars of quality from the Department for Education. A parallel study has also been commissioned as part of the Department for Education Innovation Programme, *Serious Case Reviews: Learning into Practice Project,* which considers quality in serious case reviews in some depth.

9.2 Examining the quality of the SCR final report

Our study of quality in reports and recommendations pays attention to the wide range of approaches adopted in the review and how this might contribute to the final report and to the ongoing learning. The period 2011-2014 provides a set of diverse SCRs, with the published final report offering good opportunities to glean what might constitute a high quality written report.

Understanding quality primarily as fitness for purpose, our aim here is not to evaluate the reports, but rather to compare and contrast how the final reports are constructed. To provide some consistency in examining the SCR final reports a quality review template was developed and then tested against 5 reports which used four different review methodologies. It was then refined further (see Appendix D). The template takes into account key findings from a range of sources including Working Together guidance (HM Government, 2015); the first and second annual reports of the national panel of independent experts (DfE, 2014a; 2015) as well as findings from other studies of SCR processes (Rawlings et al, 2014; Brandon et al, 2014; Sidebotham et al, 2010). These sources highlighted issues such as the need for proportionate reviews fit for publication, analysis of why things went wrong rather than focusing on descriptions of events, and the need to establish clear learning points. Our study of final reports comprises:

a) A brief analysis of page length, review type and structure of 175 available final reports.

b) In-depth learning from a sub-sample of 40 final reports, selected to represent a wide range of review styles and a good regional spread, set against a template of quality features.

9.2.1 Length and structure of 175 final reports and types of review undertaken

On the whole, reports are considerably shorter and more succinct than those scrutinised for previous biennial reviews which often exceeded 100 pages. The average (mean) length of reports over the three year period under scrutiny was 48 pages. The shortest report was 3 pages long while the longest report was 188 pages. Just under half of the reports (84) came in under 50 pages long and only twelve reports went beyond 100 pages in total. The longest reports tended to concern the most complex cases, for example the sexual exploitation of numerous young people.

Although most reports had at least some information in an appendix, just under one in five (31 reports) did not. Most appendices were reasonably brief (on average 5 pages) although the lengthiest were 44 pages long. There was little consistency about which material was relegated to the appendix and some reports were kept very short by shifting material to the appendix. For example the shortest report (at 3 pages) had an additional 8 pages of appendix material. Appendices often included details of the methodology or process, the lead reviewers and the review panel. This enabled the reader to get to the nub of the report promptly rather than reading extensive details of the methodology at the beginning.

There was a wide range of review methods with evidence of at least nine potentially different review types among the 175 reports. The type of review undertaken was not always clear however and 103 of the 175 reports either did not state a particular method, said it was a 'blended approach' or a 'hybrid' or appeared to be conducting these reviews using the 'traditional' model gathering information from Independent Management Reviews (IMRs) and a composite multi-agency chronology. The latter approach was taken from guidance in Working Together 2010. The Social Care Institute for Excellence (SCIE) Learning Together approach was used in 25 reviews and a further 19 reviews specifically claimed to use either a systems methodology or a combination of systems and the SCIE approach. Ten reviews followed the Significant Incident Learning Process (SILP) and four conducted a Partnership Learning Review. Two used what was described as a 'thematic approach' and two followed the Welsh Practice Review guidance. The Welsh Practice Review appears to be the only model to specify that the final report should be very short.

Learning Points

- Reports are much shorter and more succinct than those scrutinised for previous biennial analyses

- There were at least nine different review types not including blended approaches and hybrid reviews

The remainder of this section offers more in-depth findings from the qualitative analysis of the 40 final reports

9.2.2 Preparations and timescales

Preparations for the review, including the approach taken to the SCR, how to involve family members, as well as delays along the way, all had implications for the final report.

Timescales and delay

Working Together has always expected the SCR to be completed within six months. Where this is not possible there is an expectation that any improvements needed will be noted and corrective action taken while the review is still in progress (HM Government, 2015, p.79). There were numerous hold-ups apparent in the SCR process culminating in delays in getting the learning and findings into the practitioner and public domain and potentially affecting the quality of the final report. These delays appeared to take place for particular reasons and sometimes at particular points in the review process.

Delay points in the SCR process

- *The decision of the LSCB chair to hold the review* - including debates about whether the case meets the criteria to initiate an SCR or a different type of review; waiting for results (e.g. post mortem, parental toxicology) and late notification of the incident because of late discovery of maltreatment information
- *The decision to hold a parallel review alongside the SCR* - for example a domestic homicide review
- *What kind of SCR to hold* - there could be a prolonged debate about what methodology or combination of methodologies to adopt
- *Delay once the review has started affecting timely completion* - progress was halted by a change of lead reviewer/author, by performance and disciplinary proceedings, by court proceedings being initiated, or by concerns about the quality of the report or the IMRs causing reports to be sent back to be re-done or re-commissioned
- *The release of the report by the LSCB for publication* – this included managing concerns about the impact on family members

The reasons for delay at any of the stages are not always given in the report. Precise reporting on timescales was not possible because of gaps in information and because dates were sometimes omitted to preserve anonymity. Where there had been delays it was not uncommon for reviews to take two or more years from the date of the child's death or harm to the date of publication.

Proportionality

One of the principles for learning and improvement in SCRs is that the approach taken should be proportionate according to the scale and level of complexity of issues being examined (HM Government, 2013; 2015). A number of the 40 reports mention the principle of being proportionate in conducting the review (often quoting Working Together) but none explained how or why the approach taken to this particular SCR and report was proportionate to the particular case. These issues may have been part of the debate about whether the case met the criteria for an SCR, but this was not evident in the published final report.

The nearest thing to a discussion about proportionality was the decision about the scope of the review and the time frame set for enquiry. Most often, particularly in the more recent cases, the time frame set was no more than two years prior to the child's death or serious harm. This timescale was often determined by the LSCB's commissioning SCR panel. The LSCB scoping for the review could include specific questions for examination and reporting, for example in one case there were 15 detailed questions with further sub-sections which were addressed in turn in the final report. Pre-set questions could in some cases dictate the shape of the review and structure of the final report. One report, however, stated that pre-set terms of reference were not in the spirit of systems methodology and that routes of enquiry would emerge as part of the independent review process and should not be pre-determined. Other reviews balanced initial LSCB direction with separate routes of enquiry also emerging:

> *"Whilst specific terms of reference were established to help structure agency reports, the practitioners group and review panel followed the nose of the Review as information emerged."*

Family Involvement

Guidance since Working Together 2006 has included the need to invite family members, including surviving children, to be involved in the SCR process. Family involvement continues to be a principle for learning and improvement in Working Together 2013 and 2015 which state further that family members should understand how they going to be involved in the review and that their expectations should be managed appropriately and sensitively. Ways of managing the process sensitively and the importance of family involvement for the review's learning was underlined in a four UK nations study by Morris and colleagues (2012).

There is consistent evidence of serious endeavours to involve family members. In all but one of the 40 reviews family members were invited to participate and in all but a very small number of reviews family members did indeed take part. The range of family members included parents, step-parents, former partners, extended family for example grandparents, aunts and uncles. Older siblings were also involved for example one sibling who was said to have left home and another who was married. In two instances the surviving teenaged child was spoken with. Family members included both those not involved or implicated and those who were known to be the perpetrators of the harm or death. In more than one case efforts to involve family extended to interviewing a convicted parent in prison. Some parents were also interviewed after the conclusion of criminal proceedings. Some reviews indicated how family contributions were used and the perceived benefits to the process and the learning, as in the example below:

> *"The contribution by (mother) helped significantly in understanding this family's story and significantly filled in the gaps of information that was known to agencies. (Mother) expressed a lot of anxiety about the impact of publication on her family relationships and the Board will need to give consideration to the issues raised by (mother) when considering the format and date of publication."*

Learning Points

- No reports examined explained why the approach to the SCR taken was proportionate to the case
- There is much better engagement of family members in the review process than in previous biennial reviews

9.2.3 The final report

Sources of information used

Depending on the methodology chosen for the SCR, the 40 final reports were based on a variety and range of information gleaned from a combination of sources, for example, written reports, interviews or structured conversations with practitioners, managers and family members, learning events with practitioners present and comparisons with local prior serious case reviews and /or from wider research.

Accessibility and Structure

Accessibility relates not only to ease of reading the final report but also to ways of locating it. Finding the report has been made simpler by the establishment of the NSPCC

repository of national serious case reviews[13]. Working Together (HM Government 2013; 2015) notes that the final report should be published and readily accessible on the LSCB website for a minimum 12 months and thereafter available on request. This is important *"to support national sharing of lessons learnt and good practice in writing and publishing SCRs"* (HM Government, 2013, p.71; 2015, p.79). Tracking down serious case reviews on LSCB web sites is not always a reliable or straightforward route. Finding the serious case reviews can be very complicated and is easiest when there is a specific SCR tab or hyper link.

The structure of the reports was very varied and although the review type sometimes influenced how the report was compiled there was very little consistency of report format even between review types. A clear structure which includes 'signposting' so the reader knows what to expect and where, made it easier for us to read and understand the report and its key learning points. Navigating a way through the final report, particularly electronically, could be perplexing but was generally helped by a contents page. At a basic level, a contents page shows where to find different sections, although in a significant minority of reports there was no contents page. One report using the SCIE Learning Together model also used the contents page to summarise key learning points at the outset making clear where each key learning point was further elaborated and justified in the report.

A glossary can be helpful as a check for unfamiliar terms and acronyms, although not when a wide range of acronyms beyond the familiar are used repeatedly and liberally. Acronyms for local organisations make little sense to those reading the report beyond the local area.

Fit for publication

Early distracting redaction, where pieces of text are obliterated, is a feature of earlier reports and was not evident in any of the later reports. Most reports are written without disclosing identifiable family information but nevertheless showing that it is possible to provide a sense of the child/children as a person and giving a narrative of the child's and the family's experience. This suggests a shift in confidence in report writing. A minority of reports provided potentially identifiable family information or conversely were anonymised to the extent that sense can be lost. For example in one review where cultural context was said to be crucial the specifics of what this meant are left vague and non-specific, potentially limiting the learning.

- SCRs are readily available on the NSPCC repository
- LSCBs can make SCRs easier to find on their website by adding a specific SCR tab or hyper link

[13] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/england/serious-case-reviews/

How analytical - moving from description to analysis - the 'what' the 'why' and the 'how'

It was clear from scrutinising the reviews that there was no single best approach to constructing a quality report including moving from description to analysis. Although there were examples of over-long unfocused reports, there were also good examples of reports which offered a clear analytical overview, and this could be achieved through a range of review types.

The context

Many of the final reports were able to provide a succinct account of relevant family history and past agency contact (sometimes less than a page) which helped to provide a context for understanding how the past affected the present and aided the understanding of why and how the child died or was seriously harmed. Providing a brief summary of significant features of family life and of the child and parents' history and prior agency involvement appeared possible regardless of the particular review style.

The what and the how?

The account of agency involvement with the family was a lengthy section in many reports, often making up between a quarter and a half of the final report. In the majority of reports there continues to be an emphasis on chronological detail, and this can be the case in even the shorter reports. The emphasis on chronological accuracy and specificity could encourage extraneous detail. However reports which summarised agency involvement more succinctly, for example in a table, seemed more able to identify patterns of involvement and highlight key episodes more clearly. In one SCIE model review, agency involvement in a complex neglect case involving four children was summarised in a table in fewer than three pages.

Why?

An examination of why the child died, or was harmed, normally formed part of the analysis section of the report. Repetition of events often got in the way of analysis for example when the detailed accounts of agency involvement (the what) were revisited in detail as part of the analysis. In two 'traditional' reviews the IMRs were said by the author not to have focused sufficiently on why the baby died and had for this and other reasons been returned for redrafting.

One report that offered clear analysis of why the child died outlined the analysis as a clear four stage process. Attention to both individual errors and system failures were considered as part of the report structure and process as was human motivation issues for workers (for example fear, overwork, timidity, over-optimism, wilful blindness). Some other reports were able to consider human motivation issues for individual members of families very skilfully, but did not consider the human impact on workers and agencies interacting with the family.

While the stated approach to analysis was followed through and successfully achieved in a number of reports this was not always the case. Some methodological claims did not deliver what had been promised and examination of human motivation, for example, might have been promised in the methodology, but this was not evident in the report. This could sometimes be the case where reports claimed to follow, adapt or have elements of a systems approach. In some of these reports a systems approach appeared to be interpreted, primarily, as being concerned with procedures and processes.

Learning from local and national SCRs

Only a small minority of reports referenced national or other regional serious case reviews. Similar, local SCRs were most often referred to in relation to neglect and to reviews concerning adolescents. In one report, concerning a concealed pregnancy, it was noted that eight of the twelve local serious case reviews over the last ten years had involved a concealed pregnancy. Another review considered other national SCRs involving child deaths from a fire.

Conveying a sense of the child as a person

Some reports that provided an otherwise carefully thought through analysis that led on to well-argued learning points and recommendations did not, however, manage to reflect the child clearly as a person. In one example the report devoted a section to the parents but not to the child although a later paragraph lamented that no one had made efforts to listen to the voice of the child. Having a specific section about the child tended to prompt a distillation of information to give the child an identity. Reports that conveyed a strong sense of the child usually also demonstrated a good understanding of that child or young person's development in the context of their experiences over time.

Knowledge gaps and analysis

The credentials and knowledge base of lead reviewers is usually listed in the report, often in the appendix, and the LSCB are requested to submit the names of these reviewers to the national panel of independent experts. In some instances specific knowledge pertinent to the review and choice of lead reviewer(s) was highlighted.

The knowledge base of authors might be apparent in the way the report is written for example a familiarity with practice with adolescents and adolescent development. There was an example in one report where apparent lack of knowledge about child development may have hampered the author's interpretation and analysis and the translation into findings and recommendations. In this instance there was an expectation that a non-English speaking, but scarcely vocal, four year old child might have disclosed abuse if an interpreter had been made available. This would not be borne out from

knowledge of child development or disclosure of abuse research (Cossar et al, 2013; Allnock et al, 2013).

From a quality perspective it is a tall order to expect lead reviewers to have comprehensive knowledge about topics that may not be apparent at the outset of the commissioning stage. However, the SCR panel or other body, should be on the alert to ensure that the knowledge base that informs findings and recommendations is sound. The LSCB serious case review panel will also have wide ranging knowledge and should have a role in carrying out a rigorous check of the final report.

In many final reports research findings are integrated into the analysis and used to help justify the SCR's findings and recommendations.

Learning Points

- Where there was a focus on the chronological accuracy and detail of agency involvement this did not aid the later analysis
- Some reports did not reflect the child as a person but were more likely to do so where there was a dedicated section about the child
- Serious case review panels have a quality assurance role in checking that the knowledge base that informs findings and recommendations is sound.

9.2.3 The review process

Good practice and defensiveness

Balanced reporting is essential, including noting examples of good practice (as required by *Working Together*). It was not unusual to find examples of practitioner commitment and tenacity:

> *" ..there had been much time and energy invested in child x's family by local agencies, indeed some practitioners had gone the extra mile to try to engage Mother in services that would promote her daughter's safety and welfare."*

However, the efforts to maintain balance can tip into defensiveness and it was startling that the majority of the 40 reports indicated specifically that the child's death or harm could not have been predicted or prevented:

> *"A clear conclusion has been reached by the SCR Panel and the independent author of this Review that [Child's] death could not have been predicted and as such could not have been prevented by the agencies involved"*

This included cases where the learning highlighted increased family stresses and missed opportunities to assess the person believed or known to have been responsible for the child's death or harm. The preoccupation with this statement in the final report underlines the professional anxiety that accompanies serious case review work and the fear of the consequences of blame. Nowhere does *Working Together* require serious case reviews to show that the child's death or harm could have been predicted or prevented, although one report did claim that reviews should address these issues. Working Together requires that learning be acted on as soon as possible, including during the review process and indeed, where reviews are held up, this is imperative. This might mean that there are no outstanding recommendations or follow up actions:

> *"The recommendations made were acted on during the process of the review in order to ensure delay was not incurred in using learning as it occurred."*

If the LSCB considers that the learning has been achieved by the time the report is completed, it is arguable that there needs to be some form of check to see whether the learning has been sustained, and what if any changes have been achieved. This was not evident in most of the cases where learning was said to have been achieved already. By contrast, in one report where the author could find no satisfactory explanation for why a situation had been allowed to continue for years it was said that although changes had been made, there was no guarantee that the same problem would not recur:

> *"Nevertheless, it cannot be assumed that the reorganisation of services will improve poor decision making and inadequate management oversight."*

The professional curiosity demanded of practitioners should, arguably, be apparent in the Board's response to the final report where there could be curiosity about whether and how early improvements will be sustained.

Learning Points

- Where learning and recommendations have already been achieved, LSCBs need to find out whether the learning has been sustained and what, if any, changes have been achieved

Independence and the final report

Serious case reviews are commissioned by the LSCB. Although not the end of the learning process, the final report is the written legacy of the review and is intended to promote the learning and to share findings both locally and nationally. The report also serves to demonstrate transparency and accountability. The final report becomes, effectively, a joint product emerging from the work of the review lead(s) or author(s) and the LSCB (usually the serious case review panel).

Working Together (2013; 2015) and predecessor editions, emphasise the importance of the lead reviewer(s) being independent of the LSCB and organisations involved in the case at the time. Some reviews commented on the importance of independent lead reviewers who were able to stand back and consider the impact on staff thinking and action and issues like overwork, reorganisation and hostility from the family. The lead reviewers are commissioned by the LSCB and the Board is closely involved through most of the stages of the review. This means that independence has limitations since the LSCB scrutinise the findings, learning points or recommendations and will be overseeing the implementation of actions resulting from the review. In a minority of cases the LSCB designed a bespoke method for the review alongside the lead reviewers. One review set out the parameters of independence of the final report but did not specify how the LSCB would comment on the report or make any contributions.

> *"In the event that the (LSCB) does not ratify the final overview report it will specify the rationale for this decision. (LSCB) will only take this position in exceptional circumstances and it is expected that only two factors would give rise to this situation: a) Failure of the overview author to meet the requirements of terms of reference b) Failure of the overview author to provide a report of an acceptable quality."*

It is arguable that the whole SCR is a joint product and is not wholly independent since the LSCB has a quality assurance role and is responsible for actions and learning resulting from the review. The lead reviewers can maintain independence in relation to carrying out the review and elements of the final report but not necessarily the whole report including recommendations. Tensions can arise in maintaining the focus on learning rather than what could be perceived as a deflection of blame.

Learning from the process and model of review

Most models, including some adaptations of the 'traditional' Working Together 2010 approach based on Independent Management Reports, included at least one 'learning event' intended to both gather information and to get shared learning into practice quickly. This potentially transfers the emphasis on learning from the final written report to the shared face-to-face event. Although most reports described the process of the review, usually in relation to the methodology adopted (and sometimes in great detail), it was rarer to find explanations about how or why the process contributed to the learning.

Particular models of review had set questions or areas of enquiry which potentially encourage analytical thinking and a learning culture, but follow through is not always obviously facilitated. It is potentially helpful when the model requires consideration of how the learning from this particular case and review compares with previous SCRs undertaken with similar themes (for example is the case typical? Does it reflect everyday practice in the various agencies or 'provide a window on the system'?). The SCIE systems model appears to always ask and respond to these questions rigorously.

Partnership Learning Model (PLM) reviews and bespoke and hybrid models usually claimed to consider similar questions but these types of review were all very different and sometimes the questions were posed but not answered.

Moving from analysis to learning points and recommendations

The more analytical reports were able to build up to the learning points, or recommendations, clearly and methodically, answering the what? why? and how? questions clearly and distilling description into patterns and common features. In other reports there appeared to be flaws in the analysis, which were likely to have an impact on the recommendations and learning for example when there is no attempt to understand or even consider how and why the actions of the family-based perpetrator in a case of sexual abuse were not detected.

Learning Points

- There may be tensions in the independence of the final report since the LSCB is responsible for embedding the learning that results from the SCR
- Not all reports identified the learning that had come from the process of the review rather than from the final report

The clearest reports tended to have the following features:

- A succinct summary of key learning which is explained in more detail in the report. Key learning might be different from specific recommendations.
- Learning is concerned with wider systemic issues as well the professionals' responses to the family and each other and the understanding of the child and the family
- Demonstration of the way that the past was used to understand the present vulnerabilities without needing excessive descriptive detail about the past.
- All models of review appeared to be potentially able to achieve these

9.3 Recommendations

In our 2009-10 review of recommendations (Brandon, Sidebotham et al, 2011; 2012) we highlighted the large number of recommendations in most reviews, many of which, in spite of improvements, remained unfocused.

Of the 175 SCR final reports examined in this current analysis, 143 (82%) made recommendations, with a median of 7 recommendations per review (range 0-53). 69% of

SCRs had fewer than 10 recommendations and 90% fewer than 20. This compares to an average of 47 recommendations per review (range 10-94) in the 2009-10 analysis.

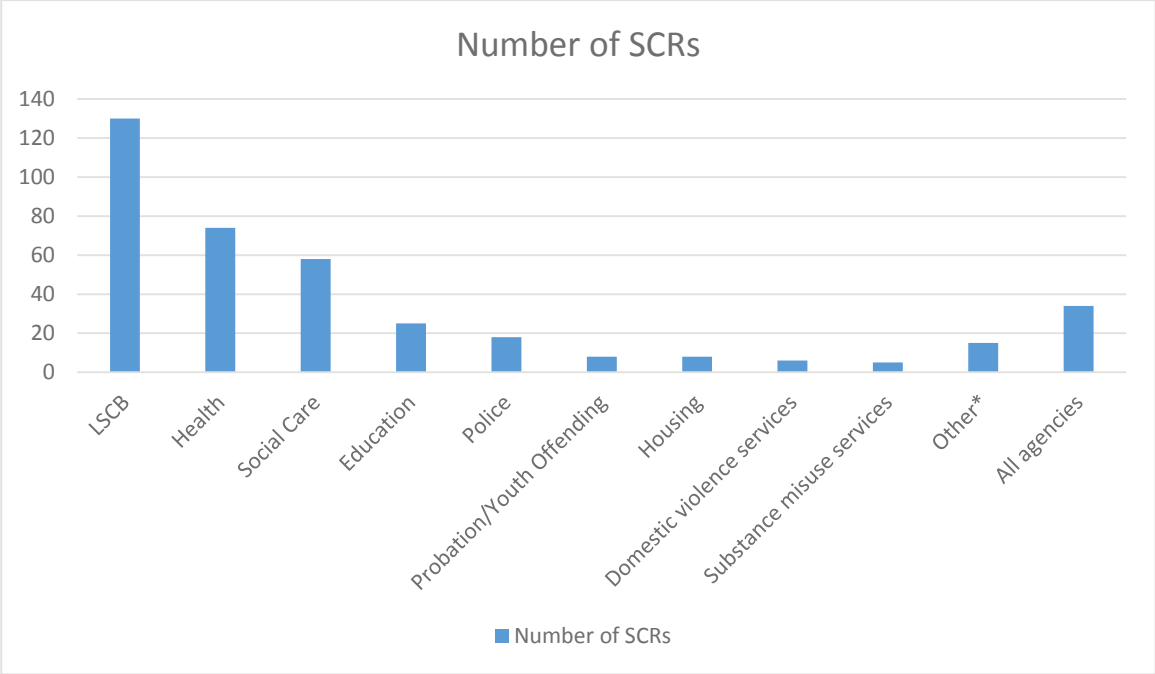
32 (18%) SCRs did not include any recommendations. In some, this was stated as inherent to the methods used. For example, those SCRs employing the SCIE *Learning Together* methods presented findings, along with questions for the safeguarding board to consider, rather than specific recommendations; a review using the Welsh *Child Practice Review* approach presented learning points; others used the old-style approach with IMRs and recommendations, but adapted 'systems' principles to the review which sometimes altered the way recommendations were presented. One review explained this in relation to the previous review of recommendations:

> *"The Learning Together model for case reviews has three core principles which must be adhered to for it to be considered a Learning Together review… to gather data whilst avoiding hindsight bias; to appraise and explain practice; and finally to move away from the case specifics identifying system wide learning. These systems issues are not presented as recommendations but as findings. This last part is a fundamental shift from previous review styles and the associated recommendations. However, a study of recommendations arising from Serious Case Reviews (Brandon et al, 2012) calls for a curbing of 'self-perpetuating and proliferation' of recommendations. Therefore the findings are accompanied with a series of questions and considerations for the LSCB rather than a pre written action plan."*

While the SCR is independently conducted and the final report written by lead reviewers, the recommendations and ensuing implementation of actions are the responsibility of the LSCB. The shared responsibility of the SCR between the review authors and the Board is evident here and it was not clear whether recommendations had been written by the lead reviewers or the Board. The difference in style between some recommendations and the rest of the report suggested that recommendations may have been written by the Board.

Most recommendations were targeted at the LSCB (130/175 SCRs). Health was most likely to be mentioned in specific agency recommendations, followed by social care, education and the police (Figure 16). All other agencies had agency-specific recommendations in fewer than 10% of SCRs.

Figure 16: Number of serious case reviews making recommendations per agency



* There were specific recommendations for CAFCASS, the armed forces, charities, legal services, youth organisations, fire services, and the forced marriage unit, each included in fewer than 5 SCRs.

40 cases were selected for detailed analysis, of these 30 made recommendations with a mean of 12.8 recommendations per SCR (95% fell within the range of 8.5-17.1). The 384 recommendations in these 30 SCRs were reviewed and coded using a thematic approach to analysis. Further details of the qualitative methods are provided in Appendix A.

Learning Points

- Different methodological approaches, particularly systems models, result in different approaches to the number and nature of recommendations. Not all SCRs will have recommendations. Some will, instead, offer learning points or findings and questions for the LSCB to consider
- Where recommendations are made, there are fewer in number since our last biennial review

9.3.1 The content and type of the recommendations

The overriding concern reflected in the majority of recommendations was of improving the overall management of cases from the individual practitioner through to entire systems. In that respect, the recommendations displayed a move towards deeper

systems thinking in these reviews. Many of the recommendations demonstrated a move away from recommendations targeted at individual practitioners or groups of practitioners, to exploring deeper issues that required addressing by managers or at an organisational level. These included structural changes to facilitate better individual or inter-agency working; training and supervision to improve practitioners' knowledge and effective working; protocol development; and audits of practice to highlight areas for further improvement.

Recommendations around safeguarding policies related to general policies and procedures as well as those relating to specific situations such as escalation of concerns, missed appointments, and looked after children. At a systems level, some recommendations referred to organisational restructuring, managing caseloads, and enhancing staff skills. The content of the recommendations will be explored below at the different levels of managing individual cases; inter-agency working; and agency structures and cultures.

9.3.2 Promoting Good Case Management

Effective case management is supported by a number of systemic processes which were identified in many of the recommendations. These included the importance of good documentation, supervision and reflection. In turn these and the specific issues raised above can be promoted through appropriate training, ensuring that protocols and guidelines are up-to-date, relevant and reflect good practice, and their implementation monitored through audit and governance arrangements. All of these aspects were reflected in the recommendations reviewed.

Good documentation

These recommendations were mostly procedural and had the overall intention of ensuring that clear and accurate documentation allowed children's needs to be kept at the forefront of investigations. Recommendations included having a robust system in education settings for recording injuries or welfare concerns, ensuring family members were correctly recorded, chronologies were used to help manage complex cases by maintaining a clear focus and leading analysis, and caution over the use of different names:

> *"The LSCB should implement local procedural change to ensure that integrated multi-agency chronologies are available to core group meetings, initial child protection conferences and review conferences. Chronologies should be proportionate and focus on improving the quality of analysis in individual cases. Procedural guidance should place the responsibility for maintenance of an up-to-date chronology with the core group."*

Supervision and reflection

There were several recommendations relating to supervision of cases including those that were not managed as child protection cases. General supervision of child safeguarding concerns was recommended specifically for health professionals. The social work model of reflective practice was highlighted for difficult cases and there were recommendations for supervision in specific situations such as with disguised compliance and substance abuse:

> *"The role of conference chairs and safeguarding nurses are critical in developing criteria for the need for additional reflection in specific cases. The LSCB should establish ways in which their challenge and reflection role can be strengthened in order to provide a fresh pair of eyes, identify and prevent drift and focus on the effectiveness of multi-agency working."*

> *"That [the LSCB] review its model of reflective supervision, to ensure that it is fit for purpose in assisting professionals to gain confidence in working with parents who are manipulative and show disguised compliance. Consideration is to be given to using this model with more complex Child in Need cases, as well as those subject to a Child Protection plan."*

Training

There were many recommendations concerning training of professionals; these all reflected the previously identified main themes for example workshops to promote a culture of respectful uncertainty, training for social workers to develop their skills in direct work and relationships with children and families and quality assurance of existing training:

> *"That [the LSCBs] commission or undertake quality assurance measures to satisfy themselves that: existing training programmes adequately emphasise the importance of canvassing the views and feelings of all children, and taking account of that information in safeguarding assessments; and that practitioners across all partner agencies have accessed relevant training in this area and can demonstrate their awareness of its significance."*

Reviewing and updating protocols and guidelines

While it is clear that individual agency and multi-agency guidelines and protocols around safeguarding are in place in all areas, several recommendations focused on reviewing or updating existing guidance to embrace some of the learning raised through the SCR; to ensure that the guidance is evidence-informed and relevant; to develop new guidelines or protocols where gaps are identified; or to ensure that awareness of existing guidance is improved and their implementation monitored:

"That [the LSCBs] review existing guidance to ensure that assessments of families who persistently avoid contact with professionals give appropriate weight to that non-compliance. Evidence that guidance is widely known and understood by practitioners should also form part of this Review."

Less helpful were recommendations which appeared solely to reiterate already-existing guidance, to develop unnecessary protocols (for example for dealing with rare situations, or around practice which should be standard for all professionals), or which did not appear to be realistic or evidence-based.

Audit

There were numerous recommendations for audits to be carried out; these related to every theme already described for example concerning safeguarding policies and procedures, monitoring numbers of section 47 enquiries, addressing children's needs, and case management:

"[The LSCB] to undertake an audit of assessments and of child in need and child protection plans to ensure that the child's voice has been heard and is taken into account in the conclusion of the assessment and throughout the plan."

"That [the LSCB] carry out a multi-agency audit of young people with serious long-term and life-threatening conditions to identify where agencies are working well together and where improvements can be made. The audit should ensure that any safeguarding concerns have been identified and that responses follow procedures. This learning should be disseminated to all managers and staff across agencies working with this age and client group."

Learning Points

- Good case management can be promoted through selective, evidence-informed and up-to-date guidelines
- Good documentation, reflective practice and supervision are all important to effective individual case management and decision making
- Effective case management can be promoted through appropriate training and audit
- There is still, at times, an over-reliance on creating new procedures to improve practice and decision making

Challenging cultures

A number of SCRs identified professional cultures within some of the agencies which potentially mitigated against effective safeguarding. Challenging and changing cultures is far from straightforward, and requires deep understanding of the issues, creative thinking, and engagement with practitioners and management to identify ways of moving forward. This complexity was reflected in the recommendation in relation to barriers to engaging fathers:

> *"The LSCB should convene a working party to explore the barriers to midwives and health visitors gathering information about fathers within families and supporting them. Through imaginative and mature multi agency discussion, the working party should actively look at ways in which any culture not to engage with fathers can be challenged*."

Another SCR identified the culture of repeated assessments, but sought assurance in its recommendation that a move to a single assessment process would be effective for children:

> *"The LSCB should seek assurance from CFSC and partners that the introduction of the single assessment process achieves its objective of moving away from repeated assessments and, as a result, improves outcomes for children*."

There is a danger, however, in SCRs, of the reviewing team not fully understanding the cultures and structures of individual agencies, and of recommendations therefore being potentially unrealistic, such as the following recommendation which places the onus on GPs to be proactive around their involvement in child protection conferences in a way that may not be achievable given the nature of general practice:

> *"That [NHS England local team] advise all GPs in [the local area] that when the GP hears of a child protection conference being scheduled, they ensure that they have been invited and if they are unable to attend they send a report and also advise GPs that the GP contacts the social worker if they do not receive a report after the conference."*

9.3.3 Recommendations as a means of achieving change

There was considerable variation in the quality of recommendations and the way they were likely to promote change. Our previous study of SCR recommendations outlined the tensions in producing recommendations that were SMART (specific, measurable, achievable, realistic and timely) since this could often result in a proliferation of prescriptive activities and tasks (Brandon, Sidebotham et al, 2011; 2012). We commented that relying on procedures and adding new layers of prescriptive activity will leave little room for professional judgement (p.135). Where there were recommendations, rather than questions for the Board or learning points, a majority demonstrated some

elements of being SMART. However very few of the recommendations set specific time frames for completion, and only a minority identified specific measurable outcomes. For example, the following recommendations are both specific in identifying what should be done and what person or body should be responsible, but do not set any time frame or demonstrate how this will be measured:

> *"The School and Nursery should both amalgamate and update their current Safeguarding and Child Protection Procedures."*

> *"The Chair of the LSCB should ensure that the conflict resolution process (also known as 'dispute resolution process' and 'concerns resolution process') is updated, published on the LSCB website and widely disseminated to staff in agencies working with Children and Families in x*."

In other instances, recommendations combined both specific, relevant and achievable elements along with more vague suggestions with no clarity as to how that might be achieved. In the following example, there is a recommendation that the Board seek assurance from member agencies as to their procedures, but with no clarity as to how that would be carried out, or within what timeframe. The second element, that GPs should follow LSCB procedures is particularly unhelpful, as there is no indication how that could be achieved, or even whether it is possible, given that the procedures are already in place, so presumably not being followed:

> *"The Board should seek assurance that member agencies have procedures which emphasise the need to ensure follow up appointments in the safeguarding context. GPs should follow LSCB procedures in relation to making referrals to Children's Social Care and the Police, and ensure that missed appointments where there are safeguarding concerns are followed up and escalated as appropriate."*

Some recommendations seemed merely to reflect and emphasise what was already present in published procedures; as such, it was not clear why the recommendation was necessary or what it hoped to achieve: simply stating that professionals should follow the procedures is unlikely to effect any change in practice.

> *"All professionals involved with the family or who may have had recent contact must be consulted and asked for information particularly prior to or as a Section 47 investigation commences as specified in the London Child Protection Procedures*."

Our appraisal suggested that the most helpful recommendations were those directed at the LSCB, or a specific agency member of the Board, with clarity over what should be done and why, linking the recommendation to learning from the review, and with an indication of how the Board would know that it had been implemented. For example, the following recommendation, does target the recommendation at the Board and its member agencies, and provides scope for agencies to report back:

> *"That the LSCB request all agencies examine their supervision of professionals who work with children in need. Agencies to report on whether supervision arrangements are sufficiently robust and capable of challenging and sceptical review*."

And in this review, where failings in individual practice were identified, the recommendation, rather than putting the onus on individual practitioners, places the responsibility on the LSCB's members to provide evidence of action to address shortcomings, along with an expectation for an audit to measure its implementation:

> *"That the Board adopt and implement a consistent recording format for Strategy Meetings. A thematic audit should be undertaken within four months of implementation to ensure this practice becomes embedded*."

The least helpful were recommendations that were generally aimed at a range of professionals, with no indication as to how those professionals were to be informed of the expectations, nor how their response would be measured. Often such recommendations simply reflected expected good practice and came across as aspirational, as in cases where professionals are advised to follow LSCB procedures, including the following example:

> *"All staff to whom a pregnant woman might disclose domestic abuse need to be aware that LSCB safeguarding procedures require them to follow Local Safeguarding policies*."

Learning Points

- Recommendations must be specific and appropriate, however an over emphasis on making recommendations SMART may reduce professional judgement and add layers of prescriptive activity
- For recommendations to be most effective, they need to be targeted at the LSCB or its constituent members
- Action plans are the place for auditing and checking, where appropriate, that selected recommendations have been achieved within a specific time frame

9.3.4 Action plans and LSCB response to the serious case review

Acton plans are not required by the NSPCC repository and were only available with the published report in six of the 40 SCRs subject to detailed analysis. However many other SCRs made reference to action plans. All six action plans were appropriately detailed and the actions reflected the recommendations and intended outcomes.

There was evidence of a formal response by the LSCB to the SCR in four of the 40 reviews scrutinised in depth; three out of the four made no recommendations as they used the SCIE methodology and kept to learning points. In all cases the LSCB responses agreed with the findings and detailed new procedures, training and audits underway to improve practices.

9.3.5 Learning Lessons

Throughout all the SCRs we looked at, a wide range of lessons were identified, highlighting aspects of good practice, areas for improvement, or key learning for professionals. Many of these emphasised good practice that was already embedded in national or local procedures, or in relevant professional training. Many of these lessons repeated issues that have been flagged up in previous serious case reviews, and in the earlier biennial analyses, particularly around good communication and information sharing; multi-agency working; keeping child-focused; working in partnership with families; and dealing with resistance or hostility. For many of these, the serious case review served to lend weight to the importance of these issues, providing local impetus to a broader problem. As such, these could be seen as lessons to be learnt, rather than necessarily issues to be addressed through further recommendations.

In our review of recommendations, we found that this distinction wasn't always present, and that some SCRs appeared to treat learning and recommendations as synonymous. The following recommendation, for example, focuses on learning from the review, rather than being specific recommendations that can be implemented:

> *"[The] Safeguarding Children Board should share the learning from this serious case review with the Midwifery Service and in particular ensure that midwives are able to identify, assess and respond to risks to unborn and newly born babies. These responses would include pre-birth assessments, multi-agency risk assessment conference, and referral to children's social care.*"

Some of the more innovative SCRs, however, did distinguish between them, and particularly emphasised learning that had already taken place in the process of the SCR through practitioner learning events, or that had been or would be disseminated through training and distribution of the SCR report, or appropriate briefing sheets.

It seems clear, from looking at some of the recurrent themes in recommendations over several years of SCRs, that recommendations can be made without necessarily achieving any effective learning. Conversely, learning can take place, at a local or national level, without there necessarily having to be any recommendations.

9.3.6 Findings and Recommendations

As highlighted earlier, many of the SCRs, most notably those that adopted a SCIE Learning Together approach, chose to present a set of findings and questions to the

Board, rather than a set of recommendations. As such, this captures more of a learning approach and carries the potential for the Board itself to develop an action plan that is more specific, relevant and achievable.

Many of the issues identified in these 'Findings and Questions' mirror those encapsulated in recommendations in other SCRs, for example, the need to consider parenting responsibilities in adults with mental health problems; dealing with domestic abuse; professional curiosity and challenge; information sharing; and engagement of fathers:

> *"A tendency for professionals not to consider mental health issues in the context of parenting capacity, means that a full understanding is not reached, and potential risks to children not identified."*
>
> *"The message about the importance of routine enquiries to be made about domestic abuse in the pre and post-natal period may have got lost where there are no other obvious risk factors*."
>
> *"The acceptance of parental explanation has prevented professional curiosity and challenge*."
>
> *"Preconceived ideas about fathers as either "good" or "bad" influences potentially whether they are involved in assessments regarding their children. This means that important information about risks may be lost*."

However, in addition, some new findings were identified, such as a tendency to rely on personal knowledge, rather than having robust systems and structures in place; or services for children with mental health problems, both at an early stage, and at a more complex Tier 4 level; and on the way CAF functions:

> *"There was a reliance on personal relationships and knowledge to obtain services of partner agencies which creates a weakness within the safeguarding system…"*
>
> *"For our multi-agency protection system to be reliable, and work in all cases, arrangements for obtaining advice and input from other services need to be embedded within procedures and routine practice. Agencies need to have in place robust systems of communicating details of on-call specialist practitioners to front-line practitioners."*
>
> *"There is no written Early Help pathway to support children and young people's psychological and emotional wellbeing when they do not meet the threshold for CAMHS or whilst awaiting a CAMHS threshold decision."*
>
> *"Despite the expectation… that the CAF should operate as a formal 'early help' process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in*

Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift."

9.4 Is there a place for recommendations in a systems approach to reviews?

Some of the findings reflected very specific issues around effective practice that potentially could have led to specific recommendations in order to address these. In these situations, it seemed that presenting the issue as a finding with questions to the board had the potential to become a cumbersome process, which could have been replaced by a specific recommendation. The following examples illustrate the finding and questions, and suggest how they could more appropriately have been presented as recommendations:

Finding	**Questions to the Board**	**Possible recommendations**
The process of strategy meeting conduct, minute taking and appropriate information sharing was not as robust as it should be and fell below the standards of "Working Together 2010"	• Is the LSCB confident that statutory guidance and local policy is being complied with? • How are minutes checked for accuracy and progress of actions monitored? • Has the Multi-Agency Safeguarding Hub (MASH) addressed the issues identified? • Did the LSCB agree to this procedural deviation? • Are there systems in place so that if a local variation of guidance seems to be suitable it is considered and agreed by the LSCB? • Is key information being consistently and accurately shared with partners?	• The LSCB carry out a review of its processes for strategy meetings, to include an audit of strategy meeting minutes to identify the extent to which statutory guidance and local policy is being complied with, and a review of processes for checking accuracy and progress of actions
[The Hospital's] Quality Assurance framework was ineffective which allowed	▪ How can the Board ensure risk assessments are informed by known past	• The NHS Trust carries out a review of practice and documentation in

poor practice to develop, specifically: ▪ [The] Consultant Psychiatrist had not kept written records following his consultations. ▪ application of the risk assessment tool varied and did not reflect accounts in the nursing records. ▪ the hand-written risk assessment completed… had been incorrectly recorded on the electronic version. ▪ there was not an assessment process in place to assess any risk in the home environment or the parenting capacity to manage [the young person] whilst on home leave	history, clinical assessments, the views of the parents and views of the child? ▪ How would the Board know if the poor practice identified in [the Hospital] is an isolated example? ▪ Would the Board want to have assurances from [the NHS Trust] about any learning from their investigation into the practice of their employee? ▪ Should the learning about poor practice from this case be disseminated across other CAMHS units and consultants? ▪ Is the Board assured that children and young people receiving tier 4 in-patient services are safe when having home leave?	mental health assessments, reporting back to the Board within 6 months in order to provide the board with assurances that practice in this area is safe, and effectively assesses the risks to young people within their home environment.
There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.	Is there a piece of work to be done on how agencies can track and share information about missed appointments and DNAs across a multi-agency network when working together – including in FSPs, as well as Child in Need and CP cases?	• The LSCB commissions a working group to explore how agencies can track and share information about missed appointments and to develop an action plan to address the current shortfall.

9.5 Summary

Our review of findings and recommendations in these SCRs identified a number of common themes, as well as some very specific issues. Overall, there appears to have been an improvement in the number of recommendations, with fewer, more focused

recommendations overall. However, there is still great variation in the quality of recommendations.

The adoption of systems approaches to reviews appears to have led to a greater focus on learning lessons, and of separating out lessons to be learned from specific recommendations. Several of the different systems methods present findings in an easily accessible way, which relates the findings clearly to the case, and appear to promote much deeper analysis and thinking by practitioners, managers, and by Board members. However, even within these, there was variation in how the findings are presented and how relevant they were. Furthermore, there were some circumstances where the findings identified specific issues for which it would have been appropriate for the SCR to make recommendations to the Board.

Both with those SCRs that produced recommendations, and those that presented findings and questions, the SCRs came across as incomplete in the absence of a response from the Board, with a clear action plan, including clarity over ownership and responsibility for specific actions, where possible measurable outcomes and a clear time frame for completion and reporting back.

Given that the SCRs are commissioned by the LSCB and presented to it, it is our view that any recommendations made in a serious case review should be directed to the LSCB or its agency representatives, specifying clearly what the recommendation is intended to achieve, and how the Board can know that it has been implemented. Any such recommendations, if accepted by the Board, should be accompanied by an action plan, detailing who will take responsibility for its implementation, and a time frame for implementing and reporting back to the Board.

While we are not advocating a return to SMART principles for all learning, it is our view that a good quality SCR would incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies.

Chapter 10: Pathways to Protection: Learning Over Ten Years

This is our fifth consecutive study of serious case reviews in England spanning the period 2003-2014, where we have examined a total of 1100 cases, each representing the death or serious harm of at least one child. We have built up a database of information about all serious case reviews in England which has allowed us to track themes and trends over time. In parallel, we have been undertaking in-depth studies of smaller numbers of SCRs which can provide different learning. Since we have been examining serious case reviews for a period of more than ten years, this is an opportune time to take stock of the cumulative learning and use it as the context for the findings from the recent SCRs studied here from 2011-14.

10.1 Introduction

Looking at the totality of SCRs since 2003 has allowed us to capture broad patterns over time. Chapter 2 showed the themes and trends across the years and, allowing for some important exceptions, gave an overall picture of a steady pattern rather than dramatic changes over time. However, examining SCRs statistically in this way fails to show the overwhelming extent of individual differences between each case. For this triennial review (2011-14) we studied a larger number of cases in depth than previously (more than 66) to try to achieve 'theoretical saturation' whereby no new themes emerged (Charmaz, 2006). Even with this large number, new differences and new themes kept occurring.

The complexity and difference of each child's circumstances has been an abiding and powerful theme running through each of our five reviews. Yet the extent of this complexity and difference is only known with the accumulation of information from the review in hindsight, so for practitioners, the danger to the child in this type of case at the time would not have been so clear. This apparent contradiction where the risks in cases with similar features can play out very differently is a considerable challenge. We noted this in our study of cases from 2007-09:

> *"It is the individual differences in each child's case that pose the most challenges for understanding and hence for practice and decision making. Although each child's circumstances are unique, children and families at the centre of most serious case reviews look very much like the children and families who practitioners encounter in their day to day work."* (Brandon et al, 2010, p.56)

This lack of certainty and the constant professional concern about whether the child is safe enough is at the heart of child protection and wider safeguarding practice. Since more than half of serious case reviews occur for children who are below the threshold for children's social care, all those working with children and families need to be alert to children's need for protection in their every-day work. The consideration about whether

and how urgently children need protection is a challenge for all who work with children and their families. Social work is probably the professional discipline most familiar with dealing with risk and uncertainty but for all professional groups, dealing with complexity and uncertainty is uncomfortable and stressful (Howe, 2014).

Numerous other dilemmas for child protection practice have been brought to the fore in serious case reviews over the years and are considered throughout this chapter. There are rarely clear solutions to dealing with practice dilemmas and uncertainties beyond using carefully considered professional judgement on a case by case basis, working alongside the young person and their family, and acting with compassion. A means of handling uncertainty and complexity was highlighted in our summary of learning in 2010:

> *"Our argument throughout our three studies has been for the need for practitioners and managers to be curious, to be sceptical, to think critically and systematically but to act compassionately."* (Brandon et al, 2010, p.56).

A criticism of serious case reviews has been that they create distance; distance because of the lengthy time taken to conduct the review; distance because they are conducted by individuals who may lack local knowledge and distance because of limited involvement from the family and the practitioners who knew the child best (Sidebotham et al, 2010). Our role in standing back and analysing SCRs adds yet another layer of distance from the child at the centre of the review. A significant challenge for the research team has been to try to get close to the practice at the time and to understand the context of the child's experiences.

> *"There are clear indications that [the child] was vulnerable from early childhood, and stark evidence that, in the 12-month period leading to his death, there was an acceleration in his personal difficulties and social exclusion. Staff focused their attention on the individual crises with which [the child] regularly presented them and did not stand back and consider the underlying causes of his behaviour."*

For the rest of the chapter findings from 2011-2014 will be set against the learning from the five studies using the model of pathways to harm and protection from Chapter 1.

10.2 Predisposing risk and vulnerability

10.2.1 Accumulating parental risks

Throughout the ten years domestic abuse has featured as one of a set of harmful parental behaviours that increases the risk of significant harm to a child. In the current review we have used evidence from recent SCRs to illustrate the ways in which domestic abuse is itself a form of abuse to a child, and the importance of understanding patterns of coercive control in domestic abuse. We have also followed up our work on the accumulating risks posed to the child where there is a combination of parental substance misuse, violence and mental health problems. Other frequently co-existing risks in the

recent SCRs include adverse childhood experiences, a history of criminality (especially violence), acrimonious separation, and a pattern of consecutive partners. These factors are often compounded by poverty, frequent house moves and /or eviction. These cumulative problems and adversities are widespread and present significant risk factors for children; however in individual cases, they do not act as 'predictors' for serious harm or death.

10.2.2 Understanding the child

A recurring theme across the years has been the way that the child is sometimes side-lined by or missing from the SCR itself as well as by the practitioners at the time and by the parents or carers who could not keep the child safe. Not keeping the child in mind poses a problem for parents, professionals and LSCBs commissioning SCRs.

Children's age, development and resilience

There is a consistent pattern across the ten or so years of the prominence of two recurring age-groups revealing potentially life-threatening vulnerability to abuse and neglect; firstly young infants and pre-schoolers, and secondly adolescents. This cluster of ages may reflect the specific vulnerabilities that children bring to and take from their physical and caregiving environments. Although there is emphasis on the deleterious effects of neglect on the youngest children and their developing brains, the age group where neglect is most prominent in serious case reviews is among young people aged 11-15, where the impact of neglect over many years becomes apparent (Brandon et al, 2012).

The impact of maltreatment over time is not always acknowledged and there were a number of examples in the current SCRs of children being erroneously seen as resilient. This included a disabled child's presentation as "lively and cheerful" which was said in the SCR to mask a lifetime of abuse but was, however, misinterpreted by practitioners as resilience. In other instances adolescents were presumed to be resilient because they were articulate and troublesome. There was also presumed resilience among young people in recent SCRs for child sexual exploitation. Similar findings were apparent in our earliest biennial review where adolescents who were aggressive or feisty were thought of as "challenging and robust" and able to seek help and advice when needed rather than as vulnerable young people (Brandon et al, 2008, p.86). Rees and colleagues also noted the tendency to see adolescents as resilient in their study of neglect (Rees et al, 2010).

10.3 Preventive and protective actions

10.3.1 Think family and keeping the child in sight and at the centre

> *"An unsurprising wish to be with her mother* and *yet to be safe is illustrated by [child's] recent touching proposal that her mother moves to the [foster] carer's house and they all live together."*

A dilemma in professional practice seen played out repeatedly in SCRs is understanding the family while not losing sight of the child. There can be a tendency for professionals to make allowances for struggling parents, at the expense of recognising and acting on harmful behaviour towards the child. Parents can wittingly and unwittingly be a source of danger rather than comfort to their child (Crittenden, 2008). But often professionals do not know the child or family well enough to see this. There were some examples where professionals did not intervene to ensure children were seen and some instances over the years where home education, for example, effectively isolated the child from any outside contact. In a recent SCR, when a mother quoted the Education Act 1996, professionals stepped back and took no action for a year. In other cases, children were also unable to speak about their abusive experiences because of disability, trauma, and fear, although it is important to note that children are generally reluctant to tell or disclose about maltreatment (Cossar et al, 2013).

There are simple questions that practitioners can ask themselves to help them to understand children's experiences better. Our study of child development knowledge highlighted the importance of thinking explicitly '*What does the child mean to the parent(s) or carer(s)*?' and '*What do the parent(s) or carer(s) mean to the child?'* This opens up thinking about relationships within the family and also provides simple questions to frame impromptu observations of children with their family and with others (Brandon, Sidebotham et al, 2011; 2012). While every effort should be made to intervene early to prevent a parent-child relationship deteriorating, once the relationship is severely damaged urgent action needs to be taken. Action is stalled when this danger is hidden, and when children, adolescents and families disappear from view.

10.3.2 Learning about Abuse and Neglect

The need to understand more about neglect, which we have shown is present in more than 60% of serious case reviews, has been a constant theme across all the SCR studies. From the study of cases from 2009 -2011 we learnt that where a child died from physical assault with a child protection plan in place, the child protection plan was much more often for neglect than for physical injury. This underlines the importance of neglect as a marker not only for long term damage to a child's development and wellbeing but also as a marker of potential physical danger to the child. This means that neglect should be treated with as much urgency as any other category of maltreatment.

Elements of neglect were also evident in the new category from this triennial review of severe and persistent cruelty. These rare but extremely troubling cases have been evident in most of our five national reviews of SCRs, and have often attracted a substantial amount of media attention. In these cases the child had been particularly scapegoated and died as a result of physical injuries against a background of severe, persistent physical and emotional abuse and neglect. Practitioners in such reviews over the years missed the life-threatening risks that arose when relationships were so poor that care and nurture were almost non-existent and had tipped into cruelty. The abuse inflicted on these children shares similarities with current understanding of most domestic abuse as a 'very deliberate choice to hurt, damage and control' (Storkey, 2015, p.83).

10.4 Services and processes to support prevention and protection

10.4.1 What do serious case reviews tell us about the child protection system?

The pattern of SCRs over time shows that once a child is known to be in need of protection the system is working well, on the whole. Over time only a small minority (on average 13%) of children at the centre of an SCR had a current child protection plan at the time of their death or serious harm. This has occurred while nationally numbers of children with such a plan have been rising in recent years. When set against the current numbers of children in need (390,000) and in need of protection nationally (49,000) the maltreatment-related death of up to 85 children annually shows that the very substantial majority are protected from the most serious harm.

When looking in detail at the service history of children and their families over time, the outcomes are less straightforwardly positive. Almost two thirds of the children or their families had been previously known to children's social care, at least to the level of 'in need'. This suggests that only a small minority of SCRs come wholly 'out of the blue' and more needs to be done to support children and families with these known vulnerabilities and especially to be on the alert for vulnerability slipping into the need for child protection. This raises issues about long term planning and support and how known vulnerabilities are responded to at a strategic as well as an individual case level. If these cases do not reach the threshold for children's social care or are 'stepped down' the children's needs, including their need for protection, might be missed by early help services, or the child may disappear from view.

The consistent pattern, over time, that in more than half of SCRs, professional contact around the time of the death or harm is outwith child in need or child protection services shows that more general universal and specialist services play an important role in the child protection system. This means that practitioners from these services need to be

alert to the opportunities to work to prevent serious maltreatment and also to pass on information and refer on concerns about abuse or neglect.

Some of these issues are picked up in findings in the recent and earlier SCRs about thresholds.

10.4.2 Thresholds

Although the child protection system appears to be working well overall, SCRs over the years have highlighted pressure points. Many SCRs in 2011-2014, as during earlier periods, clustered in early help services just below the threshold for services from children's social care, or at the borders of child in need and child protection.

The current study (2011-14) gave examples of the way that the Common Assessment Framework (CAF), an early help process used for 'below the threshold' cases, was not always managed robustly or tenaciously enough to pick up increasing risks of harm and prompt a child protection enquiry. SCRs also noted that this framework could not be used when the family would not agree to participate. Sometimes there was a presumption that CAF was for disadvantaged families and that it would therefore tend not to be used for more affluent families.

While recent SCRs suggest a good awareness of risk factors across universal, early help and specialist services, practitioners are not always rigorous in assessing and following through on all identified risks including domestic abuse. Where risks are identified which do not appear to meet the threshold for children's social care involvement, there may be little analysis of risks of harm. Support plans may be unclear and can easily drift.

Across the ten or so years, there has been evidence that protection for children can be blocked at the entry point to children's social care because referrals lack clarity in the way concerns about risks of harm are presented. Practitioners need to be mindful that their referral is more likely to be logged for 'information only' unless the risks of harm to the child are made clear and specific. Similarly, our earlier SCR child development study noted that any concerns about the child's development at any stage of the safeguarding process need to be made explicit (Brandon et al, 2011).

In the recent SCRs, as in our past reviews, there were examples of differences in perceived thresholds between referring practitioners and children's social care. Where a practitioner continues to have concerns, and feels that their concerns have not been understood or acted upon, they have a professional duty to escalate those concerns through their agency or LSCB channels.

Lack of follow through can occur not just into but also through and out of the child protection system. A perennial problem across SCRs at all levels of intervention has been cases closed prematurely without a full assessment of vulnerabilities or risks of harm because of a lack of engagement by parents and older children. Instead, lack of

engagement should prompt a robust follow up. Within children's social care, earlier and recent SCRs revealed problems with parental cooperation and cases being closed before assessments had been completed or because parents had not engaged with the child in need plan. Sometimes cases were being closed in the recent SCRs because of a lack of change rather than because of improvements. These examples demonstrate a lack a proper appraisal of any risks associated with the decision to close the case. The closer attention to systemic factors in the recent SCRs provided better explanations for professional lapses which were sometimes linked to capacity, workload and inadequate staff support. In earlier SCRs there was little discussion of the impact of organisational factors on practice and decision making.

Throughout the ten years there has been a preoccupation, often linked to thresholds and eligibility, about which practitioner or professional group is 'responsible' for the child. Particular vigilance is needed at the borders into and out of children's social care and especially when children's cases are closed to children's social care. Children's cases need to be 'stepped down' in a planned way so that the child and family are linked to specialist or universal services. Attention to children where decision making about their welfare is at the boundaries between services is important to stop them slipping from view. Although there was much more clarity in child protection plans than in earlier reviews, in a number of recent cases we identified issues around decisions to end the plan. These decisions came across as particularly unsafe when there was no clear alternative plan for support or monitoring, or a lack of clarity over who would follow these through, illustrating yet again the importance of shoring up longer term planning where cases are at the borders.

The appraisal of pressure points and thresholds through the child protection system give an indication of where and how blocks can occur.

10.4.3 Working with the complexity of abuse and neglect

Professional contact with abuse and neglect can influence practitioner thinking and behaviour. This was exemplified in our concept of the 'start again syndrome' (Brandon et al, 2008) where SCRs illustrated the way that practitioners put knowledge of the past and particularly past patterns of parental behaviour and functioning aside to focus on the present. There could, especially in neglect cases, be an untested and unfounded assumption that struggling families 'starting again' with a new baby or a different partner would be able to parent more successfully. There is a problem when such a view is reached without professional reflection about whether the capacity to care for and nurture the child, or a new baby, is any different and whether patterns of damaging or dangerous care have changed.

This way of thinking and behaving happens most commonly when workers are overwhelmed. Starting again is a way of dealing not only with overwhelming amounts of information, especially in long term neglect cases, but also the feelings of helplessness in

the workers. This can prevent workers from having a clear and systematic understanding of the family and the child's experiences in that family.

There were also some unfounded assumptions of change in relation to adult-led services particularly for domestic abuse, substance misuse and mental health services, and offending, where practitioners may be keen to acknowledge the successes of the often disadvantaged, socially excluded parents using their services. On occasion practitioners were reluctant or felt unskilled in also seeing their adult clients as parents and judging their behaviour as harmful to the child. In cases where adult-focused workers perceived their primary role as working within their own sector, failure to take account of children in the household persists as a problem in a small number of recent SCRs.

Overwhelmed practitioners

The impact of being overwhelmed as a practitioner has been apparent throughout the five studies. Overwhelmed practitioners formed a theme in the second 2005-07 study where the chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response. The muddle in the family was reflected in practitioners' thinking and actions so that both families and workers failed to see or fully take account of the harm to the child. In recent SCRs as in earlier cases practitioners lack confidence and are confused about guidance about confidentiality. This could form a backdrop to not passing on information. Another recurring reason for not sharing or passing on information was because workers felt that another professional was more responsible or that others would already be aware of what they had discovered. Practitioners who are overwhelmed not only with the *volume* of work but also by the *nature* of the work struggle to think, understand, make good decisions and do even the simple things well (Laming, 2003).

Supervision and training

To prevent feeling overwhelmed and out of control, practitioners, and particularly social workers, need challenging and reflective supervision to help them recognise the emotional impact of the work and to think more clearly and systematically. Supervision can be used to check rigid thinking about families and fixed views about the source of harm or potential harm to children. For example believing that the source of the harm was neglect might preclude the thought that the child might also be physically or sexually harmed.

There is evidence over the years of much better structures for supervision across a wide range of agencies (for example health) than in earlier years when supervision was primarily for social workers. In the recent SCRs however child protection risks could be missed (in health visiting and probation) when it was left wholly to the supervisee to choose which cases to bring to supervision. While, traditionally, reflective supervision has been seen as the preserve of social workers, some recent SCRs recommended that reflective supervision be offered to all professionals working in child protection.

10.4.4 Balancing partnership and challenge

Safety for children and protection from abuse are ultimately produced by good, warm, trusting relationships that offer care, nurture and conditions that provide solid foundations for good development. Practitioners have an important role in helping children and their parents to establish better relationships and improvements are encouraged when a good relationship can be forged between workers and the family (Wilson et al, 2008). However when needy, suspicious, frightened or desperate families and children are faced by overwhelmed practitioners, building a strong relationship is a challenge. Parents and young people may be reluctant to open up to professionals if they are constantly changing or if they had negative experiences of previous services, and especially if parents fear their children will be removed if problems are admitted.

In this triennial review as in our earlier analyses we noted that the already stressful day to day demands of front-line practice were intensified by repeated organisational change, staff turnover and staff sickness. In these circumstances professionals sometimes kept a distance from children and their problems taking on a restricted, minimal professional role. At other times practitioner fearfulness or anxiety could foster a reluctance to either support or challenge parents or truculent or reticent teenagers. We have argued in this and earlier reviews that the ways in which children are at risk of harm is complex and requires clear thinking from practitioners. Clear thinking is a foundation for professional curiosity.

Findings from some SCRs in this triennial review have shown that workers can be too ready accept parental explanations without showing any curiosity about whether these explanations are right. Building strong relationships with children and families is crucial to reducing maltreatment. However, trust needs to be placed with care and Lord Laming's term 'respectful uncertainty' is important alongside an interest in families' narratives. (Laming, 2009). Approaching families with respect and an open and questioning approach is often referred to within the SCRs as professional curiosity.

Central to effective partnership working with parents is the need to ensure that they have fully understood and engaged with what is expected of them. In recent SCRs language and literacy problems sometimes proved a barrier to clarity of expectations. 'Working agreements' could also create uncertainty for both parents and professionals when they lacked rigour and clarity about what was expected or how it could be achieved.

This approach requires regular challenging supervision. The emotional and intellectual demands on social workers are substantial; this and their need for high quality supervision and support was acknowledged by the Munro Review and within these recent SCRs.

10.4.5 Working together dynamics

Professional challenge and a positive practice cycle

Each of our SCR reviews has highlighted the importance of sustained and dogged professional challenge and the ability to question, with confidence and authority, professional colleagues within one's own agency and in other disciplines. Lord Laming's term 'respectful uncertainty' can be usefully applied to working together with other professionals as well as to direct work with children and families. In the 2007-2009 SCR study, interviews with practitioners about the impact of being involved in a case where a child had died or been seriously harmed illustrated that challenging other professionals, especially when they were more senior or of higher status, was more likely when practitioners had strong professional confidence. This confidence came from good support and trust within teams and colleagues and good reflective and challenging supervision. In turn this prompted clear lines of communication with other agencies. Similar aspects of a positive working together practice cycle also emerged in the most recent SCRs. Confident, well supported workers who communicated well with colleagues from other agencies were also better placed to create good working relationships with children and their families. In these circumstances it appeared to be easier not only to see children, but to also keep them in mind and understand them (Brandon et al, 2009, p.102).

10.5 Moving from a culture of failure and blame to one of progress and hope

In his Founder's lecture at the 2015 BASPCAN congress in Edinburgh, Professor Nigel Parton highlighted some of the shifts that have occurred in child protection work over the years (Parton, 2016). We have identified many of these changes reflected in the SCRs we have examined over the past ten years, along with many continuities and recurrent themes. Recent years in particular, have seen a huge increase in the volume of child protection work, as evidenced by the increasing number of referrals and of child protection plans. Nevertheless, there is no evidence that the numbers of children suffering serious or fatal harm have either increased or decreased. Professionals across the country are working extremely hard with heavy and emotionally-charged caseloads. In spite of this, Parton argues that 'debates about child protection have become increasingly emotionally charged and politicised' with what he calls 'a politicised narrative of blame and failure'. Rather than being seen as motivated professionals who are committed to working for children's safety and wellbeing, child protection workers are blamed both for failing to protect children and for disrupting families.

This 'narrative of blame and failure' finds its way all too readily into SCRs, particularly when the fundamental aim is seen as being '*to find out what went wrong in the care of a child, when and why it did so, and what can be done to minimise the chance of the same mistakes being repeated'* (DfE, 2014a, p.7). It seems to be particularly reflected in the

emphasis, in many of the SCRs, on determining whether or not the incident could have been predicted or prevented.

Having reviewed SCRs now for over 10 years and identified in nearly all of them clear lessons and opportunities for improvement in our child protection systems and practice, it seems inappropriate to focus on a narrow understanding of whether or not the death could be predicted or prevented. In many SCRs this comes across as an attempt to try and reassure practitioners that they are not to blame for the child's death. The SCRs typically do so in a very unconvincing way. It is our perception that practitioners often feel very vulnerable in relation to SCRs, and often feel blamed for mistakes made, regardless of any attempt to reassure otherwise.

The SCR process could well take a leaf out of the child death review process instituted in 2007. In the child death overview panels (CDOPs) each child's death is reviewed by a panel and a judgement formed on whether the death was preventable. This judgement takes a forward-looking, public health approach to consider what can be done to prevent future deaths:

> *"For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced."* (Working Together, 2015, p.85)

In most SCRs, even when the author specifically commented that a child's death could not have been predicted or prevented, they nevertheless were able to identify learning points, and often areas for improvement in the structures or processes of the organisations and individuals working in child welfare and protection. That would imply that for those cases, there were actions which "*could be taken through national or local interventions*" to reduce the risk of future child deaths or of harm to other children.

Thus, we would suggest an approach that steers away from trying to pronounce on whether a death or serious harm could have been predicted or prevented, to acknowledging that there is always room for learning and improvement in our systems, and therefore we owe it to children and their families to identify those lessons, disseminate the learning, and implement appropriate actions for improvement.

Such an approach was summed up in one SCR:

> *"It is important to state that none of the practice issues identified in this Serious Case Review contributed to the tragic death of the child. However undertaking this Serious Case Review process has clearly highlighted learning for all agencies and areas of practice which could be improved."*

Such an approach embraces the model of pathways to harm and protection outlined in Chapter 1 of this report. It recognises that children are harmed within contexts of risk and vulnerability and that there are many opportunities for prevention and protection, even without being able to predict which children may be harmed, when or in what manner. It affirms the very positive work being done by professionals working with families to support and challenge, and acknowledges the need for an authoritative approach, combining authority, empathy and humility. Most of all, it challenges the culture of blame and failure, and helps us move instead to a narrative of ‘progress and hope’ (Parton, 2016) affirming what has been achieved, and taking hold of the opportunities to learn and improve.

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Glossary

ADHD	Attention Deficit Hyperactivity Disorder
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAM	Child Action Meeting
CAMHS	Child and Adolescent Mental Health Services
CIN	Child in Need
CP	Child Protection
CPD	Child Protection Database
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CYPSC	Children and Young People's Social Care
DAS	Depression and Anxiety Service
DASS	Drug and Alcohol Support Service
DfE	Department for Education
DNA	Did not attend
FGC	Family Group Conference
FMU	Forced Marriage Unit
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LA	Local Authority

LAC	Looked after Child
LSCB	Local safeguarding children board
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi-agency safeguarding hub
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
PLM	Partnership Learning Model
PPIU	Public Protection Investigation Unit
SCIE	Social Care Institute for Excellence
SCR	Serious case review
SIDS	Sudden Infant Death Syndrome
SILP	Significant Incident Learning Process
SMART	Specific Measurable Achievable Realistic Timely
SUDI	Sudden Unexpected Death in Infancy
WNB	Was not brought
YOI	Young Offender Institution
YOS	Youth Offending Service
YOT	Youth Offending Team
YP	young person

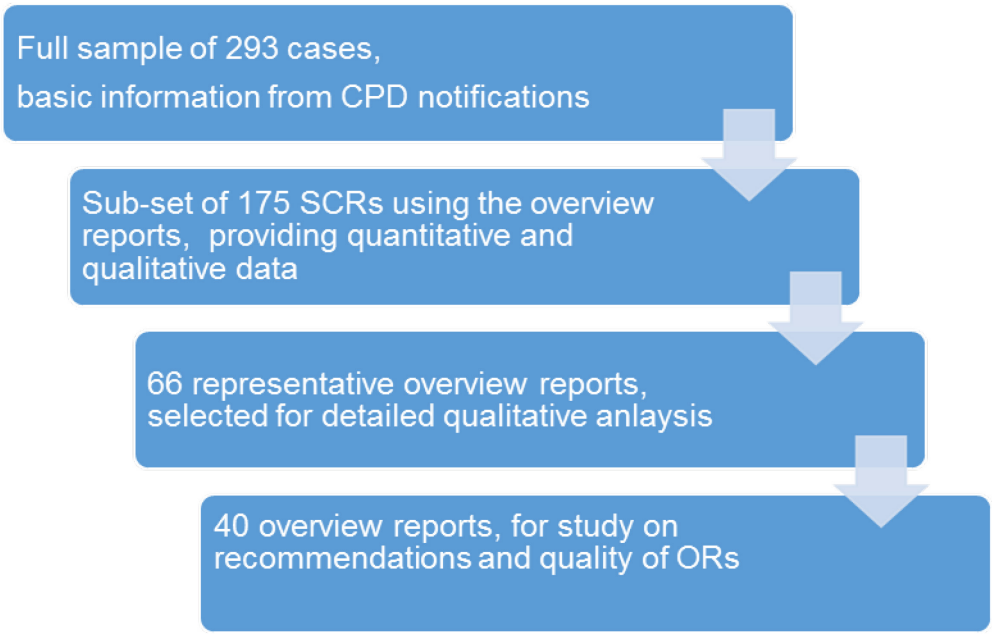
Appendix A: Methodology

Introduction

A mixed-methods approach was used for the project. This involved a quantitative analysis of those child protection notifications which led to a serious case review within the specified period, and further quantitative analysis of the sub-sample where final reports were available. These final reports allowed the researchers to add further details to the database, sometimes based on researcher judgement, which enabled more comprehensive quantitative analysis of the sub-sample of cases.

In addition to this, a layered reading approach, developed in earlier studies (Brandon et al, 2008), was adopted for the qualitative aspect of the study. This involved brief reading of the SCR final report and completing a colour coded front sheet for each report (Appendix E). More in-depth reading was undertaken for the smaller representative sample of final reports (66) which allowed for completion of researcher summaries (Appendix F). This layered approach is demonstrated by the diagram below, followed by more methodological detail.

Figure A.1



Child Protection Database (CPD) notifications

Child Protection Database (CPD) data were provided by the DfE, and were checked for accuracy and completeness, cleaned and formatted on an SPSS (statistical package for the social sciences) database. The research team were provided with an Excel spreadsheet with 808 incidents and notifications to Ofsted from January 2010 through May 2015 (along with two notified in 2009). From this, all those with an incident date

between 1st April 2011 and 31 March 2014, which proceeded to a SCR were included (293 cases). Those with an incident date prior to 1st April 2011, or after 31 March 2014, those which did not proceed to a SCR, and those for which a decision on whether to proceed had not been made were excluded.

The research team were provided with a series of Word documents with incident details of all notified cases by region. The cases on the Excel spreadsheet were matched with those on the Word documents, by case number and date of incident. Demographic and incident data on the Excel spreadsheet were manually checked for all 293 included cases, and supplemented where additional information was available on the Word files.

A SPSS database was created from the included cases on the Excel spreadsheet, and information from the CPD notification transferred to this database, and included incident date, details of the incident, child and family characteristics, child protection plan history and legal status of the child. Additional variable fields were constructed from the information given on each case and certain variables, for example age, were banded. Analysis was then undertaken on the completed database of 293 cases, and this forms the core of Chapter 2, allowing the team to tabulate the findings in a manner comparable to that of previous biennial studies. Thus some information can be produced continuously for a nine-year period from 2005 to 2014.

Analysis of 175 published final reports

For each included case, a search was made of the NSPCC national case review repository and on individual LSCB websites for published final reports. These were matched by at least three of the following variables: responsible LSCB; child's initials or case reference; incident date; child's age or date of birth; name of reviewer/author; incident details. A total of 175 final reports were obtained through this route by mid-October 2015 – reports which became available after that date were not added to the subset. A list of the 175 reports is given in Appendix G.

Fifty-two reviews (30%) related to serious harm to the child at the centre of the review, and 123 (70%) to a death. Ninety-one reviews concerned a girl or young woman (52%), and 84 a boy or young man (48%). The subset thus matched the full set of 293 notifications in these two respects (for fatal/non-fatal cases chi-square=0.4714 and p =.4923; as regards gender chi-square=0.383 and p =.536 ; there was thus no significant difference between the two sets). The age bands of the full set and the subset were very similar, with no statistically significant difference between the two (chi-square=1.09 and p =.777).

Additional quantitative information from the 175 final reports

Each final report was read to ascertain further details of the child and family, the background to the case, and information about the incident. A brief summary front sheet was compiled for all 175 cases. These details were then added as additional information

to the SPSS database created from the child protection notifications. The additional information comprised whether substance use, mental health problems and domestic violence were mentioned in these reports (either for the parents or for the young person at the centre of the review), and whether there was evidence of an acrimonious separation of the parents. Agency involvement was noted for health, education, police, housing and children's social care, and in the latter instance the level of service accessed and whether an open, closed, or never opened case was noted. Evidence of neglect as a factor in the case was noted, as was mention of a disability for the child, or learning disability of a parent. Maternal age and paternal age at the time of the incident was noted when mentioned in the final report, and the relationship of the perpetrator of the fatal/non-fatal injury or harm to the child was added to the database, where known.

Each case was further classified according to the nature of serious or fatal harm, according to the previously developed categories by the research team in earlier biennial reviews (Brandon et al, 2009; 2010).

Detailed qualitative analysis of 66 SCR final reports

Sixty-six final reports were sampled from the 175 available reports, to provide a sub-set for intensive qualitative analysis. The cases in the sub-sample were purposively selected to reflect, as far as possible, the full set of CPD notifications in terms of the age/gender/fatal or non-fatal nature of the incident; whether the incident occurred within the home or in the community or a non-family residential setting, and cases where children may be the perpetrators of harm. Cases were also selected where they seemed to raise particular issues of concern and interest across the spectrum, and include both those cases which have received public attention as well as less well known cases.

The sub-sample of 66 reports related to 43 deaths and 23 cases of serious harm. Although no attempt was made to represent the numbers of reviews produced by individual LSCBs, the sub-sample includes cases from all nine government office regions. Of the reports included in the sub-sample, 5 were published in 2012, 20 in 2013, 32 in 2014 and 9 in 2015.The low number of reviews available in 2012 may be a reflection on the change in guidance to publish serious case reviews which came into effect for SCRs initiated on or after June 2010, as well as the inherent delay in completing SCRs for those notified during 2011-12.

A researcher summary was written for all the non-fatal cases by the UEA team. This summarised the key features of the case, and noted factors relating to the child, the family background, the mother's and the father's history and parenting capacity, the wider environment around the family, professional involvement, an analysis of interacting risk and protective factors and some notes as to what the research team judged could have been done differently.

For the larger group of fatal cases, the Warwick team developed an analytic framework and created NVivo files for each death category and imported the final reports to be

included for each. A coding framework (Appendix H) was used to create nodes and sub-nodes representing:

1) Preventative and protective actions and omissions for the agencies, parents/carer, and the child,

2) Child vulnerabilities that were either inherent or via the parent/carer

3) Carer risk relating either to current behaviours/circumstances, or their childhoods

Adolescent suicide and child sexual exploitation chapter

All 17 final reports from the 175 available, relating to the suicide of a young person in this age group, contributed to the section on suicides. A further seven reports were chosen which related to young people who had experienced serious and often prolonged child sexual exploitation; all available reports which fitted this category were included for detailed qualitative analysis. Three of the CSE cases had an historic element to them. Strictly these reviews were outside the timeframe; they were notified in the 2011-14 period but the incidents had occurred prior to that. These cases had not been included in earlier biennial reviews, due to their late notification. It was, however, important to capture the learning from these events, and to acknowledge the intense interest from all sides which these cases had generated.

The method used by the UEA team for the non-fatal cases, outlined above, was again employed for the analysis of suicide and child sexual exploration cases.

Quality and recommendations chapter

Quality study:

The study of quality of reports involved a two-step process

a. Brief analysis of page length, review type and structure of 175 available final reports recorded in Excel

b. In depth learning from a sub sample of 40 final reports set against a template of quality features

For the purposes of examining the final reports in-depth, a quality review template was developed. The template takes into account key findings from a range of sources including the first and second annual reports of the national panel of independent experts as well as findings from other studies of SCR processes. The template was tested against 5 reports which used four different review methodologies and then refined further (see Appendix D).

Recommendations study:

Forty final reports were analysed thematically (Braun and Clarke, 2006), assisted by NVivo software package. This involved an initial reading of each final report to develop a coding framework and a subsequent re-reading and coding of the recommendation section of each report. Themes were developed from the codes.

Appendix B: Information sharing – national guidance and legislation

Source	What the guidance says about information sharing
Caldicott Guidelines, 1997, updated 2013 (Caldicott 2013)	The original six Caldicott Principles were updated in 2013 to include a seventh principle, particularly recognising the importance of information sharing for safeguarding: ***The duty to share information can be as important as the duty to protect patient confidentiality.*** *Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.* The original six principles remain: that the use of personal confidential data must be justified; necessary; proportionate, using the minimum necessary data; used on a need-to-know basis; lawful; and that those handling personal confidential data are aware of their responsibilities.
Information sharing: Advice for practitioners providing safeguarding services (Department for Education, 2015)	Outlines seven golden rules to sharing information, including: *The Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.* *Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case.*
Data Protection Act, 1998 (HM Government 1998)	Defines personal and sensitive data and outlines legal requirements for the safe and secure handling of such data. Allows for the disclosure of personal and sensitive information for the prevention or detection of crime; where the disclosure is required by or under any enactment, by any rule of law or by the order of a court; and where the disclosure is necessary for the exercise of any other functions of a public nature exercised in the public interest by any person.
Confidentiality: NHS code of practice, 2003 (Department of	The NHS Code of Practice outlines guidance that must be followed by all NHS staff. It emphasises the duty of confidentiality, and stresses that information may be shared if it is done with the individual's explicit consent; if there is a statutory requirement or court order to do so; or if it is the public interest. This latter clause allows for staff to share

Health 2003)	information in order to prevent and support the detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others: *Information that can identify individual patients, must not be used or disclosed for purposes other than healthcare without the individual's explicit consent, some other legal basis, or where there is a robust public interest or legal justification to do so.* *Any disclosure that has either a statutory requirement or court order must be complied with.* *Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.*
General Medical Council, 2009 (GMC, 2009)	Sets out principles for patient confidentiality and allows for the legitimate sharing of information where the patient has given consent; where it is required by law; and where it is justified in the public interest. In this latter regard, the guidance specifies: *Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential.* The guidance advises seeking consent before sharing information deemed to be in the public interest, but outlines situations where this would not be appropriate, including when to seek such consent might put the doctor or others at risk of serious harm, or where to do so might undermine the purpose of the disclosure, for example by prejudicing the prevention or detection of serious crime. It stresses that *When you are satisfied that information should be disclosed, you should act promptly to disclose all relevant information*.

Appendix C: Information about selected models of review

SCIE Learning Together

SCIE's Learning Together model adapts for SCR use an established systems methodology for improving safety in fields marked by 'low probability, high impact' incidents and accidents e.g. aviation, nuclear power as well as health. It offers a core set of principles and tools for analysis to unify all learning and improvement activities including SCRs. By 2014 there was not a specific SCIE format for the SCR but rather a range of possible applications including 'reflective audits'; 'focused' and 'speed' versions. Review leads are specifically trained and accredited in the model and are provided with methodological supervision to assure rigour and reliability of analysis.

Child Practice Reviews

Child Practice Reviews replaced the previous SCR system in Wales from 1st January 2013. The reviews are underpinned by a set of principles and bring together agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is said to be on accountability and not culpability and about learning and not about blame. A Review Panel is established to both guide and steer the process and is integral to the learning. At the heart of the review is the learning event, facilitated by the reviewer(s), which brings together the practitioners who were involved in the situation to reflect on what happened and to identify learning for future practice. After the event a short, anonymised report is prepared, together with an outline action plan and these are presented to the LSCB for discussion and approval. There is also feedback to the family.

Significant Incident Learning Process (SILP)

The key principles of SILP are that alongside members of LSCB Serious Case Review Panels and agency Safeguarding Leads, frontline practitioners and first line managers have access to all the agency reports prepared for the review, and fully participate in analysis and debates of all the material, including early drafts of the Overview Report.

Analysis, reflection and learning on a multi-agency basis takes place at one or more learning event where practitioners involved in the case at the time share their experiences and perspectives on what aspects of the whole system influenced them and comment on drafts of the final review report.

Appendix D: Quality template for serious case review final report

SCR process type:

Date of incident: **Date of decision carry out SCR:** **Date of publication:**

How long from date of incident to publication?

- ***Accessibility***

Contents page with clear headings?

How long? How long appendices?

Plain English/easy to read?

Is the report repetitive and, if so, is this purposeful?

SCR process:

Is there an explanation for the choice of review method and why this method is proportionate to the case?

Is the learning from the SCR ***process*** distilled?

Were family members involved in the review, if so is it clear how they contributed to the learning?

- ***Analysis***

Is there a concise account of critical points in the management of the case (rather than lengthy chronology of undifferentiated events?)

Is there too much focus on descriptions of events?

Is there enough information about the past to understand the present?

Is there a detailed analysis of **what** went wrong and **why?**

Is **why**? Include individual errors and system failures

Is human motivation examined (e.g. fear, overwork, timidity, over-optimism, wilful blindness etc.?)

Is research-based evidence used? (And how?)

- ***The child as a person***

Does the report reflect the child as a person?

Is the child understood within the context of his/her family (background, culture and history) and viewed independently from siblings/other children in SCR?

Is the child's development/wellbeing reflected (in the context of his/her age)?

Learning

Are the key themes from SCR reported?

Is there a focus on what the lessons should be for the services?

Is there a focus on what caused something to happen and how it can be being prevented?

Are implications for local and/or national practice/policy identified?

Is the way the learning from this SCR fits with others, regionally, stated?

- ***Fit for publication?***

Appropriately anonymised (confidentiality)?

Redacted?

- ***Recommendations and Follow up:***

Number of recommendations?

Are recommendations, clear and specific and addressed to named people/ organisations?

Are there clear next steps for learning (e.g. Action plan?)

Are next steps tracked and measured?

Is impact audited?

Are root causes monitored system wide?

Is the response ***after*** the report publication proportionate? (Sensitive to the scale, locality and context of the case?)

Overall

Is the report well/structured?

Is the report well balanced e.g. description v analysis

Are there accuracy discrepancies? - If so specify

What were the particularly good things about the report?

Were there flaws?

Appendix E: Researcher brief overview sheet of SCR

SCR 2011-2014 **Code ……..**

LSCB…… Date of incident……

Age at time of incident …… d.o.b……

Key words:

Gender: Male ❑ Female ❑

Ethnicity ……

Death ❑ Serious injury ❑

Death classification / serious injury classification

Overt filicide ❑

Covert filicide/deprivational abuse ❑

Fatal physical abuse ❑

Child homicide ❑

Fatal assaults ❑

Death related to but not directly caused by maltreatment

SUDI ❑

Suicide ❑

Other ❑

Category not clear ❑

Serious injury

Physical assault ❑

Sexual abuse (intrafamilial) ❑

Sexual abuse (extrafamilial) ❑

Sexual exploitation ❑ Historic ❑

Neglect ❑

Risk taking / violent behaviour by YP ❑

Other (specify) ❑

Family involved in review Yes ❑ No ❑

Subject to child protection plan? Yes ❑ No ❑

Mother known to CSC in her childhood Yes ❑ No ❑

Father known to CSC in his childhood Yes ❑ No ❑

Mother's partner known to CSC in his childhood Yes ❑ No ❑

Family context of incident ❑ Community context of incident ❑

Key aspects of case, child, family etc.: (e.g. DV; learning/disability; mental health issues for parents; substance use; prematurity; multiple birth etc.)

Birth father living in household? …… Other male in household? ……..

Perpetrator (of the incident) …….

DV Yes ❑ No ❑

Mental health issues Yes ❑ No ❑

Alcohol/drug misuse Yes ❑ No ❑

Involvement with agencies:

Education (school/nursery) Yes ❑ No ❑ Not applicable ❑

CSC Yes ❑ No ❑ Not applicable ❑

Health (midwife/HV/GP/hospital) Yes ❑ No ❑ Not applicable ❑

Police (YOT/SARC) Yes ❑ No ❑ Not applicable ❑

Housing Yes ❑ No ❑ Not applicable ❑

Appendix F: Researcher summary of SCR final reports

The purpose of the summary is to produce notes which help us to understand the story of the case and how professionals worked with/responded to the family. It should help us with the ongoing analysis and the final report.

The summary of each final report should include the following:

- A summary of the story using some standard 'systemic' headings e.g. features of the case, the family and professional involvement using the 'Case Summary Template'
- Useful quotes

CASE SUMMARY TEMPLATE

Key features of the case

Child and Family background

Child's needs/characteristics/behaviour

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

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

Wider family and environment

Professional involvement

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

What efforts did professionals make to engage with child/family members? e.g. response to missed appointments etc.

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

How did professionals work together/share information?

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

[How have failings/deficits in inter-agency working been addressed – robust follow up investigation or not? (Leave this for recommendations study)]

Analysis of interacting risk and protective factors to include:

Summary of risk and protective factors and supports

Analysis of family/professional cooperation

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

What could have been done differently?

Quality of the SCR

- Thoughts on the structure and quality of the final report
  - Ready for publication (e.g. redacted or not)
  - Length (page numbers)
  - Easy to understand? (jargon, acronyms)
  - Number of recommendations

Appendix G: List of 175 serious case review final reports used in the analysis

Reviews concerning a child under 1 year of age

Fatal case			Non-fatal case		
LSCB	Child reference	Year	LSCB	Child reference	Year
Barnsley	Child K	2012	Blackpool	Baby Q	2015
Bexley	Baby F	2014	Brent	Child F&G	2014
Bolton	Child 1	2013	Buckinghamshire	Baby D	2012
Bournemouth	Baby J	2013	Bury	Baby I	2015
Bristol	Child T	2015	Gateshead	Baby T	2014
Bromley	Child E	2015	Haringey	Child D	2015
Buckinghamshire	Baby C	2013	Harrow	Child D	2014
Coventry	Child T	2015	Isle of Wight	Baby T	2013
Coventry	Child W	2012	Leicester	Baby Z	2014
Croydon	Child X	2013	Lewisham	Child S	2015
Derby	DD12	2014	Lewisham	Child O	2015
East Sussex	Child K	2015	Lincolnshire	Family T/S	2013
Hammersmith &	Child M	2013	N E Lincs	R Family	2014
Fulham	Baby V	2014	N.E. Lincs	Baby H	2014
Hampshire	Child I	2014	Nottinghamshire	EN12	2014
Hampshire	Child L	2014	Oldham	Child B&C	2012
Hull	Baby Z	2014	Peterborough	Child J	2014
Isle of Wight	Baby J	2012	South Tyneside	Child X	2014
Lancashire	Baby E	2013	Surrey	Child S	2014
Lancashire	Child Y	2015	Surrey	Child Y	2014
Leeds	Child R	2012	Surrey	Child X	2013
Leicester	Baby L	2012	Wiltshire	Child H	2012
Leicester	Baby W	2015			
Lincolnshire	Child M	2015			
Liverpool	Maisie	2015			
Liverpool	Child A	2012			
N E Lincolnshire	Child I	2014			
Northamptonshire	Leah B	2014			
Northamptonshire	Baby E	2015			
Northumberland	Child G	2015			
Nottingham	Child H	2015			
Nottingham	Child D	2015			
Oldham	Child A	2014			
Peterborough	Baby F	2013			
Rochdale	Child C	2014			
South Gloucestershire	Child W	2014			
St Helens	Baby L	2015			
Sunderland	BabyA&Child C	2014			
Sunderland	Child B	2013			
Telford Wrekin	C40	2014			
Torbay	Jamilla	2014			
Tower Hamlets	Abigail	2012			
Wakefield	Emma	2013			
Wakefield	Child B	2012			
Waltham Forest	Amber	2015			
Warwickshire	Child G	2013			
West Sussex	Child C	2015			
Wigan	Child GW	2013			

Reviews concerning a child aged 1 – 5 years

Fatal case			Non-fatal case		
LSCB	Child reference	Year	LSCB	Child reference	Year
Bedford	Child A1301	2014	Anonymous	Child C	2014
Birmingham	2011/12-02	2013	Cambridgeshire	Child J	2014

Blackpool	Child BT	2015	Durham	Child J	2015
Bolton	Child J	2014	East Sussex	Child H	2014
Brent	Children I&J	2014	Gloucestershire	Abigail & sibs	2014
Bristol	Child K	2012	Nottinghamshire	GN13	2014
Cambridgeshire	Child H	2014	Oxfordshire	Child H	2014
Cambridgeshire	Child K	2015	Tameside	Child H	2014
Coventry	Child D	2014	Trafford	Child K&L	2012
Coventry	Daniel P	2013	Wandsworth	Zara	2014
Croydon	Josh	2015	West Berkshire	Child G	2014
Derbyshire	Child BDS12	2013			
Devon	CN08	2014			
Dudley	Child C	2013			
Essex	Olivia	2013			
Hampshire	Child X	2015			
Hull	Child T	2014			
Kirklees	Child	2013			
Lambeth	Child H	2014			
Lambeth	Child I	2015			
Lancashire	Child K	2013			
Lincolnshire	Family V	2014			
Manchester	Child C1	2014			
Manchester	Child U	2013			
Oxfordshire	Child N	2014			
Sheffield	Child H	2014			
Stoke on Trent	SOT12(1)	2013			
Suffolk	Anderson fam	2014			
Surrey	Child Q	2012			
Tameside	Child F	2013			
Torbay	C42	2014			
Warwickshire	a Child	2012			
Warwickshire	Child A	2013			
Wolverhampton	Daniel	2013			

Reviews concerning a child aged 6 – 10 years

Fatal case			Non-fatal case		
LSCB	Child reference	Year	LSCB	Child reference	Year
Bradford	Hamzah K	2013	Norfolk	Family L	2014
Bury	Child H	2014	Nottinghamshire	Child 1,2,3	2014
Derby	ED12	2014	Southampton	Family A	2014
Hampshire	Child U&V	2013	Southampton	Child L	2014
Hampshire	Child E	2015	Walsall	Child W3	2014
Kent	Amy	2012			
Lancashire	Child L	2015			
Southampton	Child K	2015			
Stockton on Tees	Gavin	2014			

Reviews concerning a child/young person (or group of young people) aged 11 years and over

Fatal case			Non-fatal case		
LSCB	Child reference	Y	LSCB	Child reference	year
Bath/NE Somerset	David A	2013	Anonymous	Family W	2013
Bexley	Child E	2012	Dorset	Family S15	2015
Blackpool	Child BR	2014	East Sussex	Child G	2013
Buckinghamshire	Child F	2013	Haringey	Child CH	2015
Buckinghamshire	YP G	2014	Havering	Child Y,X &W	2015
Bury	Child F	2013	Hillingdon	Jasmine	2015
Cornwall	YP	-	Kingston	Tom & Vic	2013
Cornwall	Female child	2013	Kirklees	A YP	2014
Croydon	Child M	2014	Salford	Child N	2015
Derbyshire	ADS	2014	South Tyneside	Edward	2014
Devon	George	2015	Southwark	Child R	2015
Dorset	Family S11	2014	Stockton on Tees	Child H	2015

East Riding	YP	2013	Thurrock	Julia	2014
Hampshire	Child S&R	2013	West Sussex	John	2014
Harrow	Child R	2015			
Herefordshire	HH	2014			
Hertfordshire	Child X	2014	***Historic CSE***		
Hertfordshire	YP B	2015	***SCRs***	YP A, B, C	2015
Lancashire	Child R	2014	Oxfordshire	YP 1 2 3 4 5 6	2013
Leeds	Ryan C	2015	Rochdale	YP 7	2013
Liverpool	Child D	2012	Rochdale		
Medway	Callum	2013			
Merton	Child A	2013			
Newham	Michael	2012			
St Helens	Child JSH	2015			
Surrey	Hiers	2014			
Sutton	Child B	2013			
Tameside	Child M	2015			
Tower Hamlets	Child F	2013			
Wakefield	Christine	2013			
Walsall	W4	2015			
Wirral	Child G	2013			

Appendix H: Coding framework used for analysing the SCR final reports

Main theme	Sub-nodes	
Preventative	Health	Action
		Omission
	Police	Action
		Omission
	Social care	Action
		Omission
	Education	Action
		Omission
	3rd Sector	Action
		Omission
	Legal	Action
		Omission
	Inter-agency	Action
		Omission
	Parents/carers	Action
		Omission
	Child	Action
		Omission
	Communities/Extended family	Action
		Omission
	Housing	Action
		Omission
Protective	Health	Action
		Omission
	Police	Action
		Omission
	Social care	Action
		Omission
	Education	Action
		Omission
	3rd Sector	Action
		Omission
	Legal	Action
		Omission
	Inter-agency	Action
		Omission
	Parents/carers	Action
		Omission
	Child	Action
		Omission
	Communities/Extended family	Action
		Omission
	Housing	Action
		Omission
Incidents (all incidents)	Fatal incident	
	Serious injury incident	
Child's vulnerabilities	Inherent	
	Via parent	
Carers'/ Perpetrator risk	Childhood	
	Current	

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