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WARWICK THE UNIVERSITY OF WARWICK

2019 Triennial Analysis of Serious Case Reviews:

Health professionals

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This briefing summarises themes emerging from the 2019 Triennial Analysis of Serious Case Reviews 2014-17, presenting messages for health professionals.

A set of PowerPoint slides available at: **seriouscasereviews.rip.org.uk** includes links to related Research in Practice resources which will be useful for learning and development activities based on the findings of this report.

This briefing is for all health professionals, including:

- Designated and named safeguarding leads
- Doctors, including general practitioners (GPs) and paediatricians
- Mental health early help providers and children and young people's mental health services (CYPMHS) teams
- Dentists, pharmacists, physiotherapists, speech and language therapists, occupational therapists
- All nurses, including mental health nurses, practice and community nurses, midwives, public health nurses, health visitors, school and nursery nurses, health support workers
- System leaders and wider stakeholders, including: clinical leads; CCGs; CYPMHS commissioners and leads; Directors of Public Health (local authorities); NHS England safeguarding workforce; Health Education England commissioners; private providers and agencies.

All professionals working in healthcare services have an important role to play in protecting children from harm.

Introduction

This briefing is based on the findings of *Complexity and challenge: A triennial analysis of serious case reviews 2014-2017* ('the report') (September 2019). The report is the eighth national analysis of serious case reviews (SCRs). View previous reports **here**.

Six practice briefings highlight key safeguarding issues, challenges and implications for practice to emerge from the report for practitioners in:

- Children's social care
- Early help
- Education
- Health
- Police
- Local safeguarding partnerships.

Learning from SCRs can be applied in: Continuing Professional Development (CPD) either through self-directed or team-based learning; organisational learning, including team learning; and reflective revalidation activities. The briefing includes questions and points for reflection throughout. View all the briefings **here**.

Unless otherwise attributed, all quotations in this briefing are taken from the report.

What is a serious case review?

- An SCR is a local review commissioned by the Local Safeguarding Children Board (LSCB) where abuse or neglect are known or suspected and:
  - a child has died, or
  - a child has suffered serious harm and there is concern about the way agencies have worked together to protect the child.
- The purpose is to identify what happened and why, so that systems to prevent harm and protect children can be improved.

A new system – child safeguarding practice reviews

The *Children and Social Work Act 2017* replaces LSCBs with flexible local safeguarding arrangements led by three safeguarding partners: local authorities, the police (Chief Officers of Police) and health (Clinical Commissioning Groups).

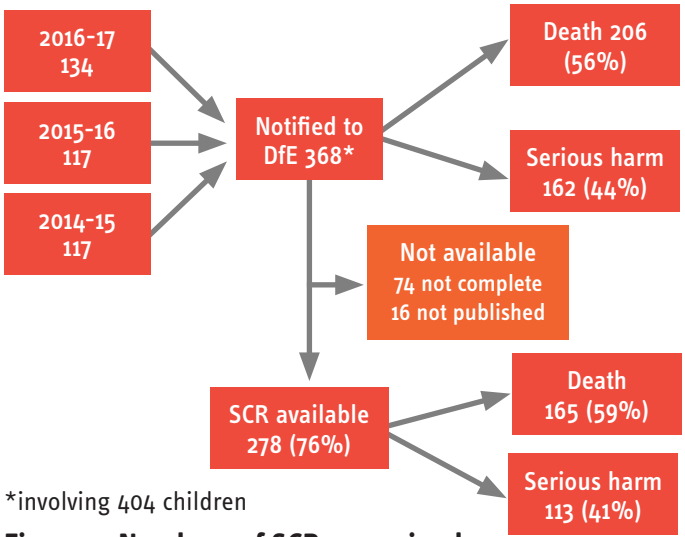
Under the new arrangements SCRs will no longer be commissioned. When a serious incident becomes known safeguarding partners must decide whether to commission a local child safeguarding practice review (LCSPR). The main purpose of an LCSPR is to identify improvements in practice. This means partners must consider whether a case is likely to highlight improvements needed to safeguard children, recurrent safeguarding themes, or concerns about how agencies are working together.

Although the decision to conduct an LCSPR is for local safeguarding partners, they must inform the national Child Safeguarding Practice Review Panel of their decision and rationale.

Part of the Panel's role is to raise issues it considers of complex and national importance. The Panel can decide to commission a national child safeguarding practice review (of a case or cases) – for example, if it considers issues may be raised that require legislative change or changes to current guidance.

The triennial analysis report

Findings are based on a quantitative analysis of all 368 SCRs notified to the Department for Education between 1 April 2014 and 31 March 2017, detailed data analysis of 278 SCR reports that were available for review (74 SCRs had not been completed, 16 had been completed but not published), and qualitative analysis of a sample of 63 SCR reports. The report is also informed by a national survey of LSCBs on the implementation and impact of SCR recommendations.



*involving 404 children

Figure 1: Numbers of SCRs examined

Key themes

- **Complexity:** Complexity and challenge form the underlying theme to the report. Researchers were struck by the complexity of the lives of children and their families, and the challenges faced by practitioners seeking to support them.
- **Service landscape:** The evident challenges for practitioners of working with limited resources, including high caseloads, high levels of staff turnover and fragmented services.
- **Poverty:** One issue that came through more strongly than in earlier analyses was the impact of poverty, which created additional complexity, stress and anxiety in families as well as being an important factor alongside other cumulative harms. Evidence of its impact in neglect cases was particularly prominent.
- **Child protection:** As identified in the previous triennial analysis, once a child is known to be in need of protection, for example with a child protection plan in place, the system generally works well, with positive examples of creative and effective child safeguarding.

Key data

- **Gender:** More than half (54 per cent) of the SCRs involved boys. The predominance of boys is seen in younger age groups (up to age 10); more girls are the focus of SCRs for children aged 11 and older, which reflects the increasing number about girls affected by child sexual abuse and exploitation.
- **Fatal cases:** 78 of the 206 deaths were a direct result of the maltreatment – equivalent to 26 cases a year; this number has not increased in recent years, averaging 26-28 cases per year.
- **Increase in non-fatal cases reviewed:** The number of SCRs relating to non-fatal serious harm has increased from 30-32 per year across 2009-14 to 54 per year across 2014-17. The increase is associated with physical abuse, child sexual exploitation (CSE) and neglect.
- **Neglect:** Neglect was a feature in three-quarters (74.8 per cent) of all SCR reports examined.
- **Children's ages:** As in earlier analyses, the largest proportion of incidents relate to the youngest children: 42 per cent were under 12 months old; 21 per cent were aged one to five; 5 per cent were aged six to ten; 17 per cent were between 11 and 15 years old; and 14 per cent were aged 16 or above.
- **Ethnicity:** From 2005 onwards, families at the centre of SCRs are predominantly (between 72 and 80 per cent) white, broadly reflecting the overall child population.
- **Disability:** Fourteen per cent of children in these SCRs were reported to have a disability prior to the incidents reported in the SCR.
- **Where children were living:** At the time of the incident most (83 per cent) children were living at home, two per cent were living with relatives, four per cent with foster carers and four per cent were in a residential setting (eg, children's home, mother and baby unit).
- **Who was involved:** Most serious and fatal maltreatment took place within the family home, involving parents or other close family members. Child death and serious harm also occurred in supervised settings. Very little serious maltreatment involved strangers unknown to the child.
- **Social care involvement:** Most children were known to children's social care: 55 per cent had current involvement; 22 per cent were previously known but their case was closed; 16 per cent had never been known to social care.
- **Child protection plans:** In only 54 of the 368 SCRs (15 per cent) was the child on a child protection plan at the time of the incident; 56 (15 per cent) had been the subject of a plan in the past.
- **Categorisation of harm:** Many of the children and adolescents experienced multiple forms of harm. The categorisation system highlights a *primary* cause of harm for each SCR.

Family characteristics – parents

Data on family characteristics were limited in earlier analyses. For the latest report, researchers were able to scrutinise the 278 available SCR reports for information on parent, family and child characteristics.

The most prevalent parental characteristic reported was mental health problems, particularly for the mother (see Table 1). The frequency of alcohol and drug misuse was also much higher in SCR cases than in the general population, where only two to three per cent of children are thought to be living with parents who have a significant drug problem. Parental separation and domestic abuse were also prevalent among families where there had been an SCR (see Table 2).

Parental characteristic	Total and percentage where characteristic reported (n=278)
Alcohol misuse	99 (36%)
Drug misuse	99 (36%)
Mental health problems	153 (55%)
Adverse childhood experiences	102 (37%)
Intellectual disability	36 (13%)
Criminal record (of which violent crime, excluding domestic abuse)	83 (30%) 42 (15%)

Table 1: Parental characteristics noted in final SCR reports (Prevalence rates are a minimum for each factor; failure to note a factor in the SCR report may mean it was not present or simply not commented on.)

Family characteristic	Total and percentage where characteristic reported (n=278)
Parental separation (of which, acrimonious)	150 (54%) 41 (15%)
Domestic abuse	164 (59%)
Social isolation	51 (18%)
Transient lifestyle	81 (29%)
Multiple partners	67 (24%)
Poverty	97 (35%)

Table 2: Family characteristics noted in final SCR report

Family characteristics – children

Table 3 sets out a number of child factors noted in the SCRs. Nearly half of SCRs involving children over six years of age reported mental health problems for the child. In around three out of ten cases where the child was aged 11 or over, alcohol misuse (26 of 90) or drug misuse (31 of 90) by the young person was recorded. Children who were the focus of SCRs were often subject to more than one form of maltreatment.

Experience/feature	<1 year N=113	1-5 years N=158	6-10 years N=117	11-15 years N=52	16+ years N=38	Total N=278* (%)
Disability	2	7	5	15	11	40 (14%)
Behaviour problems*	-	3	7	26	26	62 (38%)
Alcohol misuse**	-	-	0	12	14	26 (24%)
Drug misuse**	-	-	0	13	18	31 (29%)
Mental health problems**	-	-	2	26	22	50 (47%)
Bullying**	-	-	0	19	11	30 (28%)
CSE**	-	-	0	17	9	26 (24%)

* For behaviour problems, children aged under 1 year were excluded hence the denominator for this characteristic is 165.

** For alcohol and drug misuse, mental health problems, bullying and CSE, children aged under 6 years were excluded hence the denominator for these characteristics is 107.

Table 3: Child experiences and features

Neglect

Although rarely a primary cause of death, neglect is consistently a major factor in the lives of children who die or are seriously harmed as a result of child maltreatment. Neglect featured in three-quarters (208 of 278) of the SCRs examined and was the primary issue in one in five (19 per cent) serious harm cases.

A high prevalence of adverse parental and family circumstances was documented in the SCRs where neglect was a feature (see Table 4). There is some suggestion these problems can be cumulative: only 11 per cent of cases did not have any of these adversities recorded in the SCR, while 42 per cent documented at least three. Figure 2 shows the overlap of poverty, mental health problems and domestic abuse.

SCR findings in neglect cases typically include poor dental hygiene and untreated dental caries, incomplete vaccinations due to missed routine healthcare appointments, poor school attendance and developmental delays due to lack of stimulation.

Parental/family adversity	Percentage of 'neglect' SCRs in which adversity a feature (n=208)
Domestic abuse	64%
Mental health problems (parent)	56%
Adverse childhood experiences (parent)	40%
Poverty	39%
Alcohol or drug misuse (parent)	39%
Criminal behaviour (parent)	34%
Transient lifestyle	31%
Multiple partners (parent)	27%
Social isolation	17%

Table 4: Parental and family adversity in SCRs where neglect was a feature (Rates are likely to be an underestimate as they depend on whether a factor was recorded in the SCR report; in some cases the question may not have been asked, in others the SCR author may not have felt the factor was relevant.)

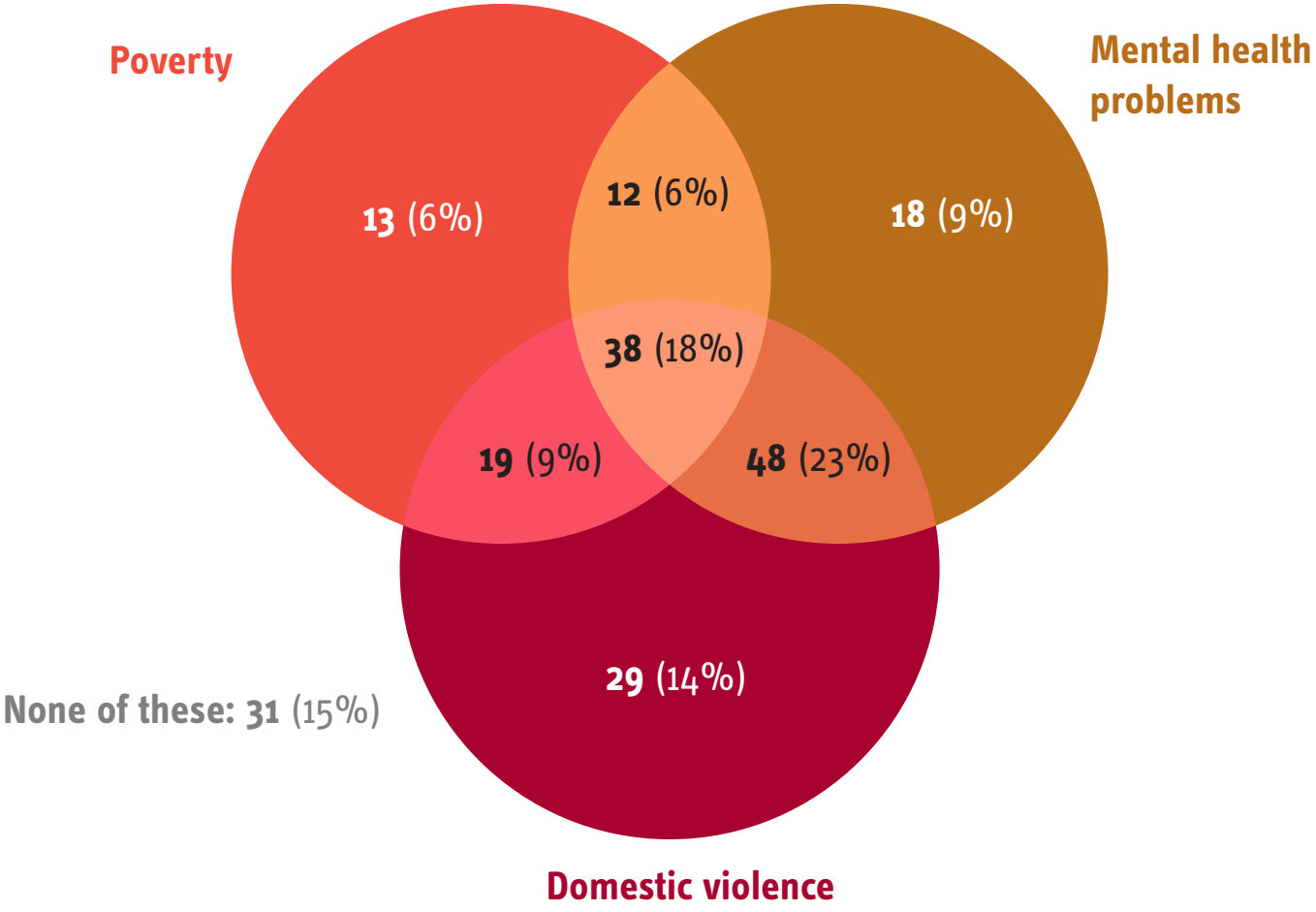


Figure 2: Adverse family circumstances in cases of neglect (n=208)

About this briefing

This briefing should help health professionals to:

- Understand safeguarding issues and priorities that need to be addressed.
- Understand the messages from the report and the implications for the development of local policies and procedures.
- Identify local and national training needs and gaps.

Neglect

'How we respond to and protect children from the harmful effects of neglect is one of the most pressing and challenging aspects of safeguarding work in this country.'

Neglect is consistently the most common initial category of abuse for children on a child protection plan and consistently a factor in the lives of children who die or are seriously harmed as a consequence of child maltreatment.

Categories of neglect – pathways to harm

The report describes eight pathways through which neglect can lead to serious harm or death. Family doctors, health visitors, school nurses and CYPMHS staff should all be alert to early signs of these issues.

1. **Severe deprivational neglect** where the neglect was the primary cause of death or serious harm; neglect of the child's basic needs leads to impairments in health, growth and development; severe illness or death may result from malnutrition, sepsis, or hypothermia among others.
2. **Medical neglect** – failure to respond to a child's medical needs (acute or chronic) and necessary medication; such failure may lead to acute or chronic worsening of a child's health.
3. **Accidents** which occur in a context of neglect and an unsafe environment; hazards in the home environment and poor supervision may contribute.
4. **Sudden unexplained death in infancy (SUDI)** within a context of neglectful care and a hazardous home environment; deaths may occur in dangerous co-sleeping contexts, or where other recognised risk factors are prominent and not addressed.
5. **Physical abuse** occurring in a context of chronic, neglectful care; the primary cause of serious harm or death may be a physical assault, but this occurs within a wider context of neglect.
6. **Suicide and self-harm** in adolescents with mental health problems associated with early or continuing physical and emotional neglect.
7. **Vulnerable adolescents harmed through risk-taking behaviours** associated with early or continuing physical and emotional neglect.
8. **Vulnerable adolescents harmed through exploitation** associated with early or continuing physical and emotional neglect.

Poverty and neglect

Chapter 3 of the report includes an in-depth qualitative analysis of a subsample of 32 SCRs in which neglect was a recognised feature. Three overarching issues stood out:

- Poverty as a feature of families' lives
- The complex and cumulative nature of neglect
- The invisibility of some children and young people to the system.

Poverty leads to additional complexity, stress and anxiety in families, which can in turn heighten the risk of neglect or abuse. The impact of impoverishment is not always fully understood or captured effectively in recording or assessment processes, however.

The majority of children living in poverty do not experience neglect, but where poverty and neglect co-exist, adverse outcomes for children will be escalated.

There are ongoing debates about the links between poverty and maltreatment but we can recognise with certainty that both are damaging to children's health and development, and to the wellbeing of their families.

Recognition of poverty and its impact was often missing in SCRs or referred to only obliquely, with little detail of how it impacted on parenting capacity or the children's lived experience. All too often, poverty was perceived as a co-existing factor among many, or as an outcome not a cause of a family's needs and difficulties.

Health practitioners, in particular those making home visits, play a vital role in identifying and responding directly to address the impact of poverty on children's health and wellbeing, working in partnership with other professionals and signposting families to welfare support. It is vital that their safeguarding practice does not fall into the trap of only responding to the material needs – ie, providing food, clothing or health care – while failing to deal with neglect or abuse when that is present.

Example A lone mother – with three children, all previously subject to care orders because of neglect, and a newborn baby – was struggling with depression, substance misuse and domestic abuse. Social workers and health visitors all had serious concerns about the home conditions, which were described as *'chaotic, untidy and filthy, at times'*. After the birth of the fourth child, a visit by the health visitor identified that the mother had borrowed money from her mother to buy food for the children, but this wouldn't last the weekend. The health visitor approached a charity asking for a food parcel. Practitioners focused on improving home conditions and responding to immediate need, but no further planning to address the causes and consequences of the family's poverty was recorded.

Learning points

- Immediate responses to the physical manifestations of poverty and a chaotic lifestyle do not equate with children being safe; the child should always be the primary focus of any assessment.
- Health visitors, nursery nurses, school nurses and GPs are especially involved in health assessment during a child's early years. All need to be curious and explore children's development through respectful enquiry that includes talking and listening to children and observation of nonverbal infants and children.
- It is important that single issues (eg, a chronic health condition) are seen and responded to in context. How are poverty and poor housing exacerbating the condition? What impact are the health condition *and* deprivation having on a child or young person's mental health and emotional development?
- Parents who are vulnerable or feel overwhelmed may not have the emotional capacity or material resources to be able to attend appointments or take up services. Parents facing poverty often have fewer social, emotional and physical resources to call upon; feelings of shame and hopelessness may also hinder their seeking or accepting help.
- Assessing how poverty may be a factor in reduced parental capacity or child health and development has to be communicated sensitively, in a non-judgmental and respectful manner.

Analysis for this report and other research suggest professionals working in areas of high deprivation can sometimes become desensitised to the warning signs of neglect such as poor physical care, smelly and dirty clothes or poor dental care.

Reflective questions

- The trusted relationship many health professionals have with families, particularly in a child's early years, can mean they are well placed to explore issues of poverty and deprivation in a sensitive manner. How can information about a family's experience be shared with other professionals in a way that does not add to parents' feelings of shame or stigma?
- As highlighted in the introduction, SCR findings in neglect cases typically include untreated dental caries, incomplete vaccinations, missed healthcare appointments, poor school attendance and developmental delays. What systems are in place to ensure parental failure to bring children to appointments are monitored and shared with safeguarding colleagues?
- Reflective supervision (individual or group) can enable practitioners to work proactively with families and support staff wellbeing and self-care. What access do practitioners in your health care setting have to supervision?
- How can health professionals be supported to recognise that perceived 'resistance' on the part of families is not a justification for withdrawing support?

Adverse family circumstances in cases of neglect

A high prevalence of adverse parental and family issues was a common feature of neglect cases. Table 4 shows frequently occurring adversities in these families' lives while Figure 2 shows the intersections between poverty, mental health difficulties and domestic abuse. These risk factors appear to be cumulative – many families in the SCRs had evidence of multiple risks.

A common feature in neglect cases was a period of low-level concerns followed by a sudden escalation in risk in response to unexpected life events or a change of circumstances, which triggered a series of events that swiftly became unpredictable.

Learning points

- The understanding of neglect is a partnership requirement; it must not be seen as only the responsibility of children's social care.
- Health professionals should be aware that children living in these families will need continuing, proactive support to help them with health and social challenges.
- Good relationships with families are the primary vehicle for protective practice. A positive, consistent relationship with a health practitioner (relationship-based practice) may be the most significant and supportive relationship in a parent or child's life.

The SCR extract below describes the return of a young mother, after three weeks in hospital following the birth of her child, to a home situation characterised by multiple and persistent safeguarding concerns. A community midwife provided the lead intervention in the context of relationship-based support.

Example *'The community midwife went out of her way to see the mother at home for her appointments (most appointments are held at GP surgery or hospital). She was very sensitive to the needs of the mother for support but also involved in child protection processes, working closely with the social workers to address the safeguarding concerns. She saw child S on several occasions after her birth and had no specific concerns about her health and wellbeing during this four weeks period. [The review author] commends the community midwife for her exceptional care of the mother, alongside her alertness to child protection concerns, including her potentially lifesaving action to ensure that the mother received urgent medical treatment.'*

Reflective question

> In the example above, the safeguarding midwife was also said to have '*persistently monitored the actions in relation to this family*'. How are practitioners in your service supported to provide this level of support and cross-agency connectivity?

Parental mental and physical health

Poor mental health was the most prevalent parental characteristic reported in neglect cases (see Table 4), noted often for mothers but also for the father or mother's partner. Parental mental health problems occur in similarly high frequencies in families requiring social care support.

However, assessments do not always consider holistically how issues impacting on parental capacity may be leading to neglectful parenting, or consider what support is available from extended family or wider community.

In one case, a mother of three children, all subject to child protection plans for emotional abuse, suffered from HIV/AIDS. There was little evidence that professionals explored fully the impact of her debilitating illness on her capacity to look after the children. The SCR noted:

'... the network did not appear to sufficiently appreciate mother's ongoing and varying physical vulnerability and its consequences for capacity to parent, ie, that the excessive proportion of child G's waking and sleeping time spent unstimulated in his buggy may have been primarily a result of mother's health-related lethargy.'

Reflective question

> In your health-care setting, what attention is given to the experiences, wellbeing and safety of the children of parents who present with mental health concerns in particular and health conditions more generally?

Ethnicity

Ethnicity is often recorded in case files and SCRs, but the report finds the implications for the day-to-day lives and lived experiences of parents or children were rarely explored.

Example Discussions in regional workshops highlighted a failure to learn from numerous local SCRs concerning dual heritage or Black and minority ethnic (BAME) children. Discussions highlighted a tendency in some SCRs to provide minimal detail on ethnicity or culture in order to preserve family anonymity. Workshop participants felt this diluted any specific messages, as well as the child's story, and so limited the power of the learning.

Two SCRs were highlighted in particular: one involved a young South Asian woman; in the other, which involved the murder of a baby, the mother was dual heritage and had been ostracised by her community. Participants noted that in neither case had anyone in the system asked: 'What is life like for this young woman?' Two issues emerged: a 'fear factor' among white workers of being seen as racist; and black workers not feeling sufficiently empowered to challenge that fearful thinking.

Learning points

> Ascertaining and *applying* knowledge about past experiences, culture, religion and beliefs is vital in assessment and planning for all children. Avoiding asking such questions – for example, for fear of being seen as overly intrusive, or with BAME families for fear of being seen as racist – hampers the way children of all ethnicities are safeguarded.

> Practitioners need training and support to develop confidence in exercising professional curiosity about parent or carers' culture and religious beliefs and practices.

Ethnicity and mental health

There are profound and long-standing inequalities for people from ethnic minority communities in accessing treatment for mental health concerns, their experiences of care and the quality of outcomes (IRMHA, 2018: 5).

Mental health need may be particularly acute for refugee and asylum seeing people who have witnessed genocide, lost family members and their home country.

Learning point

> One of the challenges in diagnosing a mental health condition is to take account of the patient's beliefs, background and culture, and to give these due weight. Practitioners need to explore and *apply* that knowledge.

Role of fathers

There was very little information in the SCRs about birth fathers, stepfathers or mothers' partners who were living in the home or part of the family network. This reflects the paucity of such information in case files.

The primary focus of health professionals and social workers continues to be on mothers, even in established relationships in which a man has a major role in the child's life. Practitioners are missing the significance of men in families, both as a potential support and a possible risk to a child's wellbeing or safety.

Learning point

> Healthcare professionals need to be mindful that father figures are often overlooked when assessing a child's circumstances, which means potential risks *and* protective factors can be missed.

Children and young people

Safeguarding infants

As highlighted in the introduction, infants are especially vulnerable to harm and abuse. The largest proportion of SCRs related to the youngest children, and in nine out of ten (93 per cent) SCRs relating to a child less than one year old, the child was no older than eight months.

The most common category of death related to maltreatment was sudden unexpected death in infancy (SUDI) (38 cases) (only around four per cent of SUDI deaths in this period were subject to SCRs). Previous triennial and biennial analyses of SCR cases have shown that (as in SUDI more generally) most deaths involved the combination of co-sleeping with other recognised risks such as parental alcohol or drug misuse.

Health visitors play a significant role in the lives of babies and young children. They have responsibility for the care of babies and and so may continue to provide support to families previously known to Children's Services but who are no longer receiving social care support. They are also in a good position to help ensure the focus is kept on the child when the complex lives of parents may otherwise come to dominate professional interventions.

However, a number of SCRs found health visitor assessments had focused narrowly on weighing and measuring the baby (and in most cases, observing the degree of bonding between mother and baby). Unrealistic caseloads may leave health visitors insufficient time to observe or critically reflect on the interaction between mother and baby, understand the roles of men in the household, talk to siblings to gain a child's perspective, or analyse how the baby might be communicating its lived experience.

Learning points

- Health professionals need to be particularly alert to when the circumstances of a pregnant mother may be putting the baby at risk, and consider how best to safeguard both mother and baby prior to and following delivery.
- Pre-birth child protection conferences and other multi-agency meetings, and inter-agency discharge planning meetings, can help to ensure a positive transfer to home and safe care of a vulnerable baby.
- One example of learning from SCRs in relation to the vulnerabilities of infants was the promotion of awareness among parents and professionals of the 'crying curve' (also known as 'purple crying' – see **www.purplecrying.info**) and the impact on parents of coping with inconsolable crying.
- Collaboration with other organisations is important. There were instances in the analysis where health visitors identified difficulties and made referrals, but over time the focus on the child's lived experience was lost.

Talking and listening with children

Assessments by a school nurse can enable children's voices to be heard, as this case illustrates.

Example An eight-year-old child and his younger siblings had previously been subject to a child protection plan and a period in foster care. This child was observed by the school nurse to be *'very tired and wearing a dirty ill-fitting school uniform; his face was unwashed and nose dirty'*. The boy reported that the children were given biscuits or crisps with tea instead of an evening meal, which he contrasted with the proper cooked dinners (meat and pasta) they had received while fostered.

Even when heard, a child's voice may not be responded to appropriately, as in the following example.

Example A six-year-old girl was part of a family with a multitude of challenges including domestic abuse, substance misuse, poor mental health, poverty and poor housing. While attending the medical practice with her mother, she told the doctor about her sexual abuse at the hands of a family member that had occurred two years previously.

The GP noted that the child recounted this 'slowly and clearly' and presented as 'alert and happy' apart from when recollecting what had happened. The GP made a referral to children's social care but the SCR found *'there was no assessment of Child M's emotional and developmental needs and there was no consideration toward the need of support or counselling despite the request from the GP'*. From the child's perspective, little changed regardless of what she had revealed to responsible adults.

Adolescents

Three out of ten (31 per cent) of all SCRs related to children and young people aged 11 or older. For the majority of adolescents, earlier long-standing neglect had contributed to their vulnerabilities. Many continued to experience neglect throughout their adolescence.

As noted in the introduction (see Table 3), child mental health problems were reported in nearly half of the SCRs involving children over the age of six. Alcohol misuse and drug misuse were also common among children over the age of 11. Neglect of a child's medical needs was the cause of death or serious harm for four adolescents.

Children who experience abuse and neglect carry those experiences with them into adolescence. Their perceived rejection can lead to feelings of worthlessness and lack of agency and leave them particularly vulnerable to mental health and behavioural issues and at increased risk of extra-familial harm and exploitation, gang involvement and sexual exploitation.

Contextual Safeguarding is an approach to safeguarding children and young people which responds to their experience of harm outside the home – for example, online, in parks or at school (see box on page 14).

Complex Safeguarding is a term that has been applied to encompass a range of safeguarding issues related to criminal activity (often organised) involving vulnerable children or adolescents, where there is exploitation and/or a clear or implied safeguarding concern. This might include (but is not limited to) child criminal exploitation, county lines, modern slavery including trafficking and child sexual exploitation (CSE).

Contextual Safeguarding is an approach developed by Dr Carlene Firmin and colleagues at University of Bedfordshire. It provides a framework for local areas to develop an approach that engages with the extra-familial dynamics of risk in adolescence. The primary focus is the need to assess and intervene with extra-familial contexts and relationships in order to safeguard older children and young people.

Further information on Complex and Contextual Safeguarding can be found here: **www.rip.org.uk/safeguarding-briefing**; resources on Contextual Safeguarding are also available from the Contextual Safeguarding Network: **https://contextualsafeguarding.org.uk**.

Learning points

> School nurses and sexual health nurses have a particular role to play in identifying where a young person is at risk of or experiencing harm and in helping the young person to address any health-harming behaviours.

> It is well known that children in care are much more likely than the general population to suffer from mental health problems, learning disabilities, speech and language difficulties and emotional and behavioural issues. The report emphasises the importance of trauma-informed practice across all professions to build appropriate practice responses to presenting issues and behaviours.

Reflective question

> How can health professionals, particularly those working in mental and sexual health and substance misuse services, help to ensure that any health-harming behaviours (exhibited by young people and parents) do not obscure their underlying needs and vulnerabilities?

Criminal exploitation

Criminal exploitation includes young people being exploited into moving drugs (county lines), violence, gangs, trafficking and radicalisation. The report analyses four SCRs that feature criminal exploitation and found it was closely associated with young people being excluded from school, going missing, substance misuse and previous experiences of loss and separation.

The report makes clear the importance of having effective information-sharing procedures in place. When information is not shared, practitioners – including health practitioners – may be less able to safeguard a child, as the following example illustrates; it also illustrates the importance of maintaining curiosity about a young person's life and lived experience.

Example Few questions were asked when an adolescent attended A&E with injuries because hospital staff were unaware of any concerns. However, his escalating difficulties included assaults at school, exclusions from school, going missing and gang involvement. The hospital had a safeguarding team and a youth work project that could have picked up a referral relating to violence or gang membership, so an opportunity for intervening was missed.

Learning points

> Young people involved in criminal exploitation should always be seen as victims and safeguarded accordingly. The report suggests some practitioners may sometimes see children and young people as partly at fault for having 'put themselves at risk' of exploitation.

> Health practitioners should seek to maintain a sense of professional curiosity and look beyond immediate presenting incidents and concerns to consider whether any additional needs may be evident.

Child sexual exploitation

Child sexual exploitation was noted in nearly one in ten (26 of 278) SCRS. However, despite its high profile, professionals were still slow to recognise vulnerability to CSE; this was particularly so for adolescent males being exploited by older males.

One SCR describes how agencies failed to follow safeguarding procedures in the case of an adolescent male who had in the past gone missing in the company of an older man. Even though he was known to be a victim of CSE, when he attended A&E with a genital injury *'there was no involvement of a named doctor for safeguarding children or curiosity about his life'.*

'... staff did not appear to recognise there could have been a current risk of further exploitation and abuse. There is no reference in the documentation to the staff talking to Jack's parents regarding any change in his behaviour or how he was managing. There is a lack of documentation of staff talking to Jack and finding out what his life was like. At no time was it recorded whether Jack was spoken to alone.'

Some practitioners were alert to the risks involving young males, however. The report highlights examples of effective practice involving immediate strategy discussions and multi-agency disruption:

'Child A was looked after in a therapeutic unit. He told staff that he planned to meet a man for sex whose number he had seen on a toilet wall. An immediate strategy meeting was convened, all agencies informed and a criminal investigation initiated.'

Learning points

- Although children who have experienced abuse, neglect or other trauma are more at risk, any child can become a victim of CSE. Multi-agency collaboration is essential for tackling CSE; no agency can address CSE in isolation (Eaton and Holmes, 2017).
- Staff should be mindful that boys may be less likely to disclose abuse and exploitation, but the risks for male victims of CSE are no less serious than for females. Recent guidance suggests staff should always ask themselves if their response would have been different if the victim had been a girl (The Children's Society, 2018a).

Loneliness

Experience of loss and separation due to family or social disruption can leave young people feeling lonely and at increased risk of depression and low self-esteem. Early childhood trauma can also leave adolescents poorly equipped to recognise and nurture healthy relationships, which can lead to loneliness and isolation.

Children with caring responsibilities for a parent are particularly at risk of becoming isolated from their peers.

Learning point

- Loneliness is a subjective but common feeling among young people. Where it appears a young person may be caring for a parent, they should be referred to Children's Services for a young carer's assessment. Loneliness should be considered as part of the assessment.

Suicide and self-harm

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

Example: Neglect and later suicide A 15-year-old girl took her own life with a fatal dose of opiates. She was born with serious narcotic withdrawal symptoms into a family with a long history of substance misuse, sex work and alcohol-fuelled violence and domestic abuse. Signs of distress and self-harm were first identified by a teacher when the child was 12 years old. When the teacher asked about cuts on her arms, she was told: 'When I am feeling this pain, I am not feeling anything else.' Self-harm escalated to the extent that prior to the fatal overdose, 32 episodes had been recorded. If these incidents had been managed as safeguarding concerns there is greater likelihood that professionals would have engaged in a strategy meeting that focused on the nature of risk and supported a much clearer sharing of information.

Learning points

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

Harmful sexual behaviour (HSB)
HSB has been defined as:

'Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult.' (The Children's Society, 2018b)

Seven SCRs were examined where adolescents had displayed HSB towards other children. All seven had experienced neglect, but neglect alone is not a predictor for the development of HSB. Practitioners should not assume HSB is due to a young person's own experience of sexual abuse; research evidence suggests experience of any form of maltreatment can be an indicator for HSB.

The severity of HSB should be understood as being on a continuum; age and stage of development will influence the perceived severity of the behaviour and relevant interventions.

Learning points

- Children with HSB are likely to have experienced polyvictimisation and their actions need to be seen within the context of their own maltreatment. There must always be a therapeutic and/or safeguarding response in addition to any criminal justice response.
- Being a victim and a perpetrator can be very closely related, particularly when offences are committed as part of a group; support and safeguarding are required for both aspects.
- HSB can be assisted by use of the internet, via phone or other devices, and can occur in group settings. Shared sexual images can be used for bullying and blackmail to continue abuse.
- Guidance for responding to HSB can be found on the **NSPCC website**. NICE (2016) has also published **guidance for practitioners**.

Transitions for disabled young people
Inadequate pathways between services can render some children and young people effectively invisible. The need for joint working agreements is prominent in the transfer of young disabled people with complex health needs to Adults' Services.

Example: Transition to Adults' Services

In one case, a local transitions protocol did not contain sufficient detail to identify what should happen if a young disabled person was not in receipt of support from the Children with Disabilities Team. As a result, statutory services were for some years unaware that P, a young person with very complex health needs, was living in the household at all. The transition process was compromised by the fact that the case was not open to Children's Services.

The school was unclear regarding the need to notify the Adult Learning Disabilities Team of P in Year 9 and did not appreciate how this would allow for further planning for P's future. Since P was staying under the umbrella of the school until age 19, school staff did not recognise the need for transition until the summer prior to P's death. The process within the hospital meant all children and young people over age 16, including those who were disabled, were admitted to adult wards unless receiving ongoing acute paediatric care. P was admitted to an adult ward; this distressed him and was inappropriate based on his level of ability.

Learning points

- Health professionals play a vital role in ensuring children with disabilities are seen and heard, and that the multi-agency partners involved are cooperating effectively to ensure a coherent plan is developed and implemented. Thresholds for protection can become invisible unless specific arrangements for their identification across agencies are put into place.
- Increased child and family health needs arise at points of transition (eg, when a child is moving into and out of the child protection system, into and out of kinship care, foster care, adoption and institutional care). Services are challenged by the need to engage with and monitor families or individuals with transient lifestyles, particularly those crossing local authority boundaries.

Multi-agency working: Fractured perspectives and sharing information

'Effective information sharing is one of the most basic tenets of good child protection practice and is one of those lessons that is "so important that [it must] be re-emphasised and potentially relearnt as people, organisations and cultures change" (Sidebotham, 2012: 190).'

The issue of fractured or partial perspectives was prolific within the subsample of SCRs involving neglect. In the majority of cases, incidents were seen and dealt with in isolation. This can be exacerbated when practitioners are operating with high caseloads and unfilled vacancies.

Bringing together large volumes of data and information when multiple agencies are involved is a significant challenge, as illustrated in the three case examples below.

1. Despite information being shared, none of the professionals working with Sam had the complete picture. The nurse practitioner was unaware the mother's partner was not Sam's father, and the GP treating the stepfather for depression was unaware he was in a relationship with the mother of a young baby. There was no evidence professionals had given any consideration to how these risks may be impacting on the parents' ability to meet the needs of baby Sam, who had faltering weight gain and identified health needs of his own. Information shared by the mother with the nurse practitioner was not shared within the practice or with the health visiting team. This was a missed opportunity for staff working in primary care to consider and share the information about the family. Had this happened, the stepfather's GP would have been aware there was a baby living in the household.

2. No health service flagging system was in place for children for whom there had been previous safeguarding concerns or where other children in the family are looked after.

   For example, there was no chronology of D's family history on the community nursing records, the GP was not aware of any previous safeguarding concerns (having not received her records) and D's college had no access to any records about D's family history.

3. A family of four children, with a long history of involvement with Children's Services because of neglect, had seven different health visitors. Poor communication and a failure to read the observations of previous workers resulted in an inconsistency of approach to address home conditions.

Good-quality record keeping and communication of relevant issues and incidents with other agencies provides a clearer picture of a child's life and helps identify patterns of events, concerns, strengths and unmet needs. When this does not occur, identifying the link between past and current concerns can be missed.

Learning points

- An incident-based approach to child protection and the identification of neglect has served children and adolescents poorly. When each involvement with a family is treated as a discrete event, information is not accumulated and professionals fail to develop a comprehensive understanding of the child's life experiences.
- Information solutions need to be identified at systems level. This can involve building flags and triggers into IT systems, or ensuring that regular information-sharing meetings are embedded and made an integral feature of daily or weekly practice.
- These issues highlight the value of routinely undertaking combined or cross-service chronologies when multiple agencies are addressing different support needs and risks over a period of time.
- Fragmentation of services, with different frontline providers within the same agency, can lead to silo working within as well as between agencies. In such situations, it is important to have a clear understanding of the roles and responsibilities of different organisations, and clear pathways for information sharing and shared working.

Assessment and planning tools

Several SCRs identified that assessment tools had not been used appropriately. However, the report also identifies examples where effective tools are making a real difference to practice.

Example The patient registration form used by one GP practice did not include a field to identify whether children were subject to a child protection plan or were looked after. This appeared to be the case for all the standard forms used in primary care, the implication being that GP practices are reliant on parents sharing that information at the point of registration, especially where there are delays in transferring notes and records from a previous practice. This omission is particularly significant in working with families who have a history of mobility and transience, and increases the potential for GPs to receive only selective information.

Example A healthy child programme was devised and developed by staff to promote the use of evidence-based antenatal guides for health visitors. The SCR reports that most of the workforce had been trained to use the guide, which has become embedded in practice and has received excellent feedback from parents. It has also had a marked impact on record keeping including details of action plans, greater depth of analysis and better focus on preparation for parenting.

Learning point

> Assessment and planning tools must be carefully designed to facilitate communication of concerns across agencies. Tools that are not fit for purpose can impede the assessment and identification of risk.

Strategy discussions

Strategy discussions, whether they take place by phone or face to face, are an important vehicle for framing decision-making, determining whether thresholds have been met for a child protection enquiry and delineating the roles of the key statutory agencies.

The report finds strategy discussions too frequently failed to involve all the key agencies. One SCR highlighted a practice of preceding the strategy discussion with a phone call between children's social care and the police, which had the effect of excluding multi-agency involvement. This has now been addressed by introducing telephone conferencing to ensure all agencies are able to participate in strategy discussions.

Learning point

> Clear multi-agency plans, at both child in need and child protection level, are central to effective working. This requires all relevant professionals (including those from specialist agencies and third sector organisations) to be involved in drawing up plans, and a continued focus on the needs of the child as central to any plan. Plans must be child-focused, jargon-free and holistic.

Reflective question

> How are staff in your team or setting enabled to prioritise attending strategy discussions? Do you use teleconferencing to enable strategy discussions?

Strengthening safeguarding through appropriate language, and professional challenge

The language used to talk about children's circumstances can hinder or support effective safeguarding. Appropriate and unambiguous language can paint a vivid and realistic picture of context and risk when making a request for protective interventions; conversely, vague stock phrases can dilute or obscure concerns.

In one example, the ambulance service had graphically and appropriately described a child's home living conditions as *'unsanitary with a foul smell and a fire hazard'*; however, this was changed in the minutes of the section 47 strategy meeting to *'poor home conditions'*, which diluted the specificity of risk.

Semantic choices can also hinder or strengthen effective partnership working. The report features a case study in which one LSCB (Local Safeguarding Children's Board) identified a reluctance among practitioners to 'escalate' concerns because they felt doing so made partnership working more difficult. The LSCB overcame this by reframing the issue as 'resolving professional differences'.

Where previously practitioners had felt uncomfortable in 'escalating' concerns (if social care had rejected a referral, for example), they now felt 'empowered' to share a professional difference because the LSCB had made it clear that professional differences are to be expected and are not unhealthy. A small semantic change had 'altered the sense of professional empowerment'.

Learning points

- Clear and straightforward language that properly and explicitly describes issues and concerns, and does not dilute harm or the reality of life for the child, can lead to more effective safeguarding.
- Professional differences are to be expected and are not unhealthy. Openly embracing and resolving them is an opportunity to strengthen safeguarding.

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