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

Messages for education and early/family help from SCRs conducted 2017–19

December 2022

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Part 1: Introduction and key data

About this briefing

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

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

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

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

Who this briefing is for

This briefing[1] is for:

- All staff working directly with children and young people in education settings, including early years settings, schools (including maintained, independent, academy, free and non-maintained special schools – alternative provision and after-school settings) and further education colleges.
- Designated safeguarding leads.
- Governors, management committees and proprietors and local authorities in their education functions.

The briefing also presents learning relevant for practitioners working in early help (family help) services. However, this was not a specific focus for the 2017-19 analysis and so does not feature extensively in this briefing.

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

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

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

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

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

What is a serious case review?

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

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

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

The new system

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

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

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

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

The 2017-19 analysis report

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

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

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

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

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

Themes and trends across SCRs 1998-2019

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

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

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

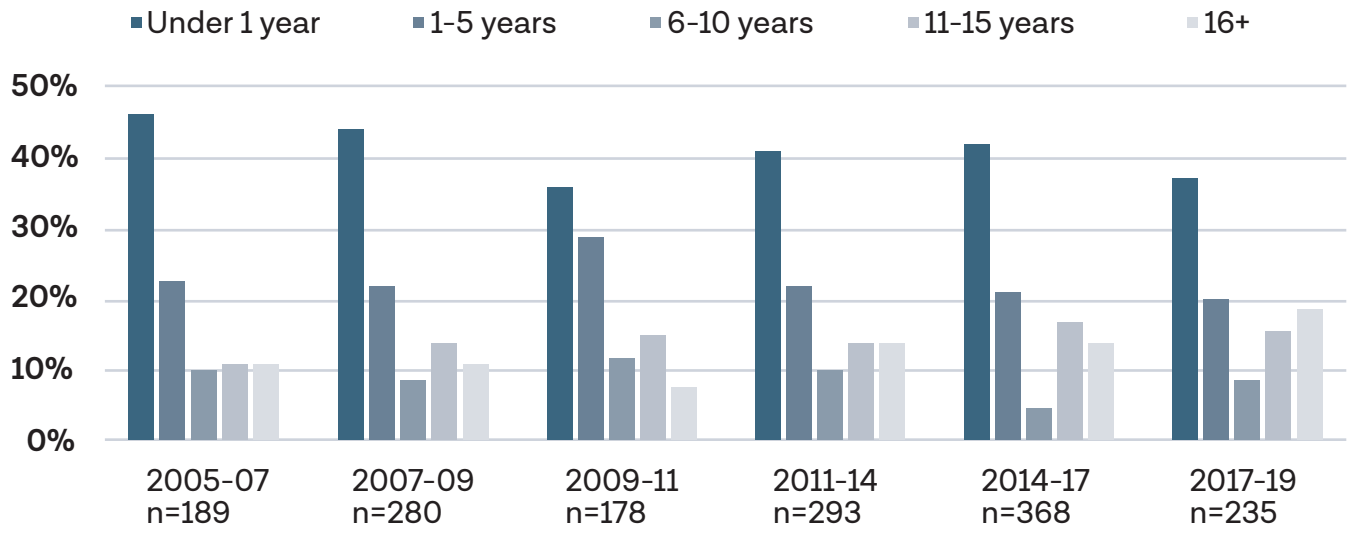
In their analysis of trends since 1998, the research team reflect on why periodic analyses of SCRs have so often identified repeat messages (Dickens et al., 2022b). They note that safeguarding practice is not only inherently complex, challenging and often ambiguous, it is also directly affected by a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

Key data from the 2017-19 SCRs

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

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

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



> **Fatal cases:**

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

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

Table 1: Categories of death 2014-19 SCRs

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

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

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

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

> **Non-fatal cases:**

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

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

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

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

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

> **Neglect:**

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

> **Ethnicity:**

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

> **Disability:**

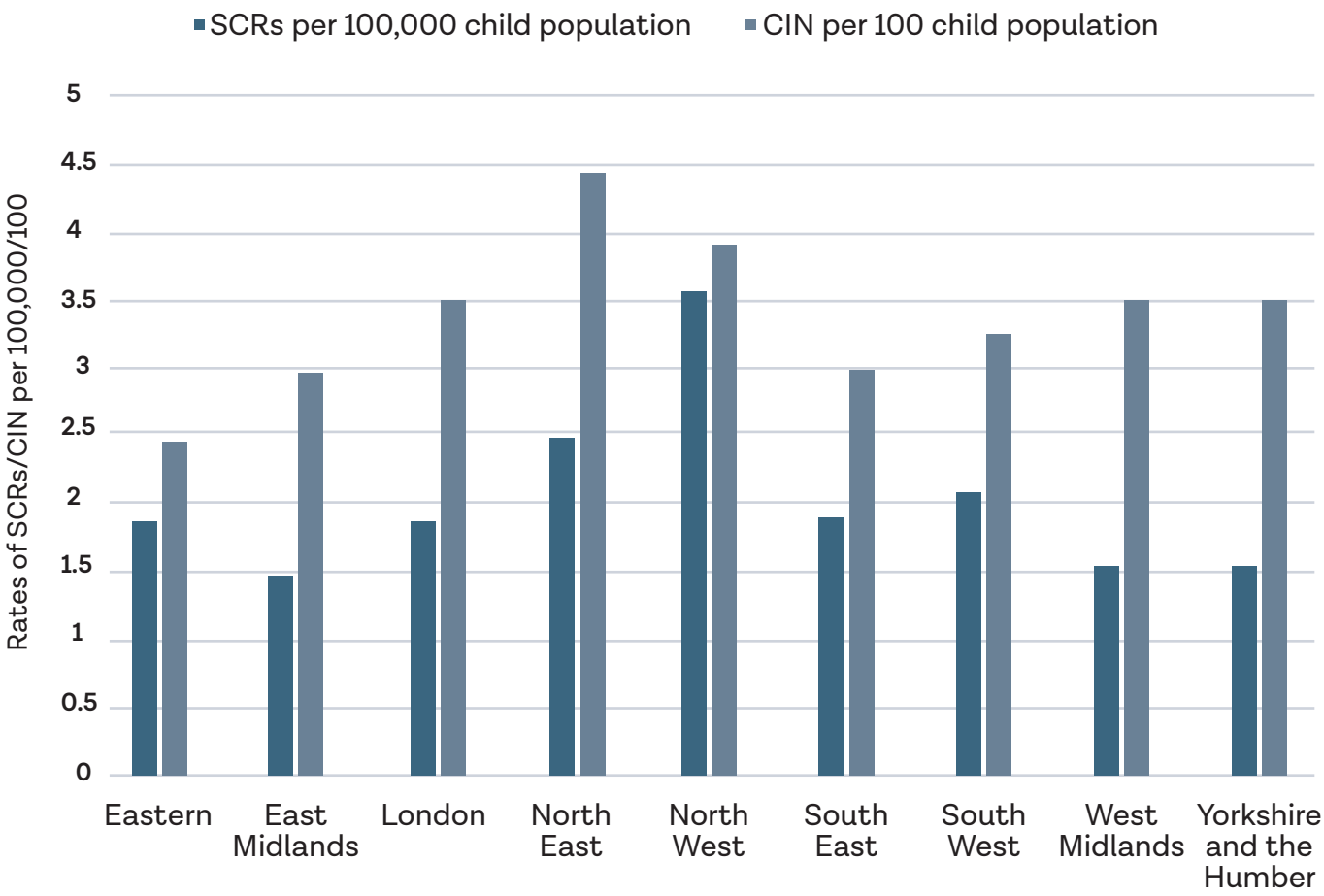
- One in four (25%) children at the centre of the SCRs analysed in depth were reported to have an impairment or disability at the time of the incident – up from 14% in 2014-17.
- In particular, there was an increase in the numbers of children with a social/communication disability or complex/combined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

> **Where children were living:**

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

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

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



Parental and family characteristics

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

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

Table 4: Parental characteristics: 2017-19 SCRs

Parental characteristic	Mother	Father*	Father figure/ mother's partner*	Both parents	Total number of SCRs in which the characteristic was reported (n=166)
Mental health problems	58	11	1	22	92 (55%)
Adverse childhood experiences	27	8	0	22	57 (34%)
Alcohol misuse	24	10	1	22	57 (34%)
Drug misuse	19	13	0	25	57 (34%)
Criminal record	7 (4)**	34 (19)**	6 (6)**	6 (2)**	53 (32%)
Known to children's social care as a child	19	7	1	11	38 (23%)
Intellectual disability	9	5	0	11	25 (15%)

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

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

Table 5: Family characteristics: 2017-19 SCRs

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

Child characteristics

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

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

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

Table 6: Child characteristics: 2017-19 SCRs

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

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

Part 2: Learning for education and early/family help

Recognising and responding to neglect

As in earlier periodic analyses, neglect featured prominently in the lives of most children who became the subject of an SCR. While neglect is rarely a direct cause of death or primary cause of non-fatal harm, it is consistently a contributory factor to both. As one review author put it:

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

Despite its potentially deep and long-lasting effects, identifying and responding to neglect and recognising its severity remain a challenge for practitioners across all sectors, including education and early/family help. Unlike physical abuse, neglect 'does not usually produce an immediate and noticeable crisis'.

Sometimes, children who were 'visible' to services were left in conditions of long-term neglect because practitioners did not see the wider picture. For example, when children had multiple or complex needs, practitioners' focus on managing their needs and/or disabilities sometimes meant safeguarding was overlooked. Similarly, failure to meet developmental milestones was not necessarily understood as part of a broader picture of the child's life at home.

Normalisation of neglect in areas of high deprivation and poverty

As with earlier periodic analyses, loss of focus on neglect in the context of poverty was a key feature of the 2017-19 SCRs. This was most often observed among those working with families in areas of high social and economic deprivation, where professionals could become de-sensitised to endemic levels of poverty or feel powerless to do anything in the face of poverty; in these circumstances, neglect could in effect become 'normalised'. One review author visited the child's local area before writing the SCR; they noted that '***poverty in the area is palpable***' and one child in seven had a special educational need or disability. SCRs described practitioners who appeared to be struggling to distinguish signs of neglect or abuse from the effects of poverty.

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

Neglect and its impact could be inadvertently downplayed when there were concerns associated with poverty, such as poor housing or debt, or if practitioners had developed low parenting expectations. This sometimes led to practitioners misinterpreting neglect for poverty and focusing exclusively on parents' need for practical support, rather than also assessing and responding to neglectful parenting. Some practitioners may also have wanted to avoid appearing judgmental by identifying neglect, or been unwilling to stigmatise parents.

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

Providing practical support is important, not only because it meets families' needs, but also because it helps to build the trust and relationships with families that provide the essential foundation for relationship-based practice and support. However, practical help should never be at the expense of looking at other issues and risks within the family. This was also a concern when parents were being supported by adults' services, such as drug and alcohol or mental health services. In such cases, workers' focus on parents' own needs and behaviours did not always include consideration of their ability to adequately parent their child.

Learning points

- Neglect rarely occurs on its own (Daniel et al., 2010). It is commonly accompanied by emotional or physical abuse, and it is often a factor in child sexual abuse or exploitation.
- Neglect can sometimes come to mask other forms of harm. In 8 of the 10 SCRs (examined in depth by the research team) in which intrafamilial child sexual abuse was a feature, neglect had 'dominated' interactions with professionals – and the abuse had continued.
- Complex parental needs – including chronic health conditions, drug or alcohol use, poor mental health, and learning disabilities – were common aspects of family life in cases of children who experienced neglect. SCRs found that the risk to children was not always considered by practitioners working to meet parents' needs.
- Assessment tools for neglect can be helpful, but these need to be used consistently across all sectors and services, including education, and by professionals who have been trained in their use.
- The use of neglect assessment tools is likely to be more effective when sector and service leaders work together to develop a local culture of collaborative working. Some local areas are implementing a local neglect strategy (at partnership level), which includes the use of recognised neglect assessment tools by all practitioners.

Understanding the child's daily life

A persistent theme across the 2017-19 SCRs was that the lived reality of the child's day-to-day life was not sufficiently understood or explored; practitioners either lacked or lost focus on the child's lived experience.

Lived experience can be understood in a number of (related) ways, including:

- Considering the child's life in different contexts (e.g. in the community as well as at home and at school).
- Thinking about all aspects of the child's health and wellbeing (not just one in isolation).
- Reflecting on the impact of past experiences (including their cumulative impact).
- Exploring and reflecting on how the child may be experiencing professional decisions and interventions.

SCRs suggest that insight was especially likely to be compromised when children were:

- not being seen on their own
- not attending school
- not being taken to health appointments.

Thinking about all aspects of the child's wellbeing

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

When practitioners did not adopt a holistic perspective of wellbeing, the maltreatment of disabled children sometimes became 'hidden in plain sight' (Franklin et al., 2022), with disability seen first and the possibility of abuse not considered.

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

In the following example of a large family of Traveller heritage with complex needs and children of varying ages, the older children came to be seen 'as part of the problem', and their safeguarding was compromised. The children's non-attendance at school was viewed 'as a compliance issue' and other potential factors were disregarded.

The family were well-known among local agencies due to their perceived challenging and intimidating behaviour. The mother had mental health needs, the father was known to be aggressive, neighbours had been attacked by the parents, and practitioners reported being afraid of the father. Team Around the Family meetings focused on housing and antisocial and criminal behaviour, in which the children were seen as complicit, and there was a lack of focus on understanding the lived experiences of the children. ***'Other risks around education, health and emotional wellbeing, domestic abuse, suspected sexual abuse and neglect did not feature.'*** Non-attendance at school was seen as a compliance issue rather than a symptom of the ongoing neglect, and sexualised behaviour and genital injuries among the children were not flagged as indicators of sexual abuse.

Some SCRs reported that practitioners had used assessment tools, but they had considered the results only in isolation, rather than in the broader context of other known information that would have given a fuller and more realistic picture of the child's day-to-day life. In the following example, a boy's emotional difficulties were assessed by a school nurse but not considered alongside other relevant information.

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

As mentioned (see page 15), some SCRs found that when children did not reach development milestones, this was seen as an 'individual issue' that required support 'rather than being understood as part of a wider picture of parenting and the child's circumstances'.

Rosie was admitted to hospital at 3½ years old, having suffered long-term neglect which left her with a life-threatening illness. She was severely malnourished, socially isolated and developmentally delayed. Both parents had a history of substance use, and the father had a history of domestic abuse; the parents had resisted offers of parenting interventions. As a result of the neglect, Rosie will need specialist care for the rest of her life.

Rosie had been seen by a number of health professionals during her first two years, but all the appointments were focused on discrete tasks (e.g. weight, infection, hip dysplasia) rather than on the reality of her daily life. Rosie was not weight-bearing at 12 months, not walking at 20 months and had not met most of her developmental milestones. The SCR found that professionals had shown little curiosity at missed appointments at the Children's Centre and with the paediatrician, nor at her lack of attendance at any kind of educational or out-of-home provision.

In one case (Billy – discussed on page 20), the mother of a two-year-old boy (the youngest of six children) was sent a developmental progress questionnaire but did not return it; there was no follow-up by the health visiting service.

Learning points

- Practitioners should aim to develop a holistic sense of each child's lived experience; as well as engaging with the child directly, this means integrating information from different sources, including from other agencies.
- It is important that practitioners are supported to work holistically to view children's lives and experiences in the round and not exclusively through one lens. SCRs suggest that this is a risk in particular for children who have special educational needs and/or disabilities.
- Practitioners should not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting; it may be, but a holistic approach also means considering other potential causes.

Adolescents – children's lives in multiple contexts

It is important to consider the different contexts to every child's life, but SCRs suggest this was challenging in relation to older children in particular. Professionals often had a limited understanding of adolescents' daily lives. Adolescents were often at the centre of extensive professional activity, but this had not always provided significant insight into what their lives were like. A number of SCRs described multiple, longstanding and cumulative difficulties in young people's lives, but those issues had been considered only in isolation – which meant that practitioners lost sight of the cumulative impact.

Thinking about the child's past may also help address the issue of 'adultification', where children are treated as though they are older than they are.[5] In a number of the SCRs, young people were viewed as 'streetwise', 'resilient' or 'mature' and their true vulnerability was hidden:

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

Many adolescents who died by suicide or who were at risk of child criminal exploitation or child sexual exploitation had experienced cumulative harm over many years. A key message to emerge from those SCRs was the number of relationships that young people were sometimes expected to sustain as risks increased and professionals worked reactively to crisis situations; this could leave the young person feeling overwhelmed. It may be helpful for local agencies to work with the young person to establish which relationships are most supportive and, where possible, help them to maintain those relationships.

Learning points

- It is important that practitioners seek to develop a sense of a child's life over time. Not only will this help practitioners to make a judgment about risk, but it will also help them to understand the cumulative impact of the child's experiences.
- All professionals who have contact with children living in areas where violence and antisocial behaviour are significant factors within the community should consider those children vulnerable to serious harm. This includes young people who may themselves perpetrate some of the violence or antisocial behaviour.
- Where multiple agencies are involved in a young person's life, it may be necessary to liaise to ensure that the young person is not overwhelmed by having too many professionals involved at the same time. It may be necessary to prioritise different elements of support for the young person.

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

Children not in school

The 2017-19 SCRs highlight that a continuing safeguarding concern is children becoming 'hidden' or 'invisible' by not being brought to health appointments or not attending school or other education provision (as in the case of Rosie discussed on page 18). Sometimes, as in the second example below, irregular school attendance was one of a number of concerns that had led to the involvement of services, yet the children remained effectively 'hidden in plain sight'.

In one family, the children were removed from the family home after an investigation had been instigated following a report from an older sibling who was no longer resident in the country. The sibling was particularly concerned about Billy (the youngest child) and had contacted ChildLine, which he remembered from his own minimal time in school. In this case, the children's GP was not aware that the children were being home schooled – there is no necessity to inform GPs under typical circumstances. The parents did not engage with professionals and had effectively withdrawn from services. There was a reliance on parental reporting of any issues; for example, housing services were in regular contact about maintenance but contact was mostly by telephone. The Education Welfare Officer took at face value the parents' claims that children were taking part in leisure activities outside the home. The children were not spoken to without the parents being present, and Billy in particular was kept quiet and hidden by older siblings whenever 'sporadic visits' did occur.

Another SCR, which describes long-standing concerns around neglect, non-attendance at school and antisocial behaviour, offers 'a clear demonstration of the phenomenon of the invisible child'. Later, it emerged that these issues had masked intrafamilial sexual abuse, which prompted the SCR. The children were rarely seen alone and practitioners had been reluctant to explore the reasons for the children's sometimes obvious distress. Practitioners' accounts of their interactions with the family were 'suffused with a sense of threat' and 'a palpable sense of anxiety'.

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

Learning points

- Professionals' curiosity and concern should always be aroused by children missing school and non-attendance at early education and other settings. Practitioners should also maintain a sense of curiosity about parental explanations.
- Local leaders should ensure that systems are in place to identify children who may be not attending school and missing health appointments (see the section on information sharing on page 24) and to respond appropriately.
- There is no proven correlation between home education and safeguarding risk. Nevertheless, as some SCRs over the years have shown, parents can sometimes use home education as a means of reducing or avoiding professional contact and oversight. Local authorities should ensure they follow the guidance on safeguarding and elective home education (Department for Education, 2019).

Recognising the meaning of behaviour

As in earlier periodic reviews, SCRs highlighted the voice of the child frequently going unheard. Crucially, 'hearing' involves not only listening but also observing, as children usually find it hard to disclose abuse directly and often communicate their distress through their behaviour rather than what they say. A recurring theme in the SCRs was the need for practitioners to be alert to what a child or young person's behaviour might be signalling.

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

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

One young person who was invited to take part in the SCR described what had happened after her sexual abuse began:

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

Some SCRs found that practitioners had not considered sexual abuse despite children displaying overtly sexualised behaviour.

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

In another case, two children in a kinship care placement were both sexually abused.

> ***Despite agency involvement her behaviour within school continued to raise concerns. She was continually aggressive and violent to both staff and other pupils and used sexualised behaviour and language that was inappropriate for her age.***
>
> ***The youngest child had shown signs of sexually reactive behaviour and had possibly re-enacted their own experiences of being abused. Although they did not make a disclosure, they attempted to engage in sexual activity and initiated sexual contact with other adults and children.***

Because of her 'extreme' behaviour, one of the girls was eventually placed in a special school for children with emotional and behavioural difficulties. She spoke to the SCR author about her experiences and said that no one had asked her about the changes in her behaviour or spoken to her alone.

> ***'We used to have to be so careful as the family were in the room. We never got offered to be seen alone .... Social workers could have taken us out, they just used to sit us down at home. ... Everything you said to the social worker got repeated back to the carers anyway.'***

Learning points

- Where there are safeguarding concerns, practitioners should not rely only on verbal disclosure. They should be attuned to what children and young people's behaviour may be signalling, particularly if there is a change in behaviour or if children behave differently in different contexts.
- Inappropriate sexualised behaviour should always be recognised as a red flag for possible sexual abuse and considered in a multi-agency forum. Practitioners should not wait for a verbal disclosure
- Young people with learning disabilities are at greater risk of abuse and might only display their distress through their behaviour. Disabled children are around three times more likely than their non-disabled peers to be abused; they are also more likely to receive a poor response from professionals (Ofsted et al., 2020).
- When young people are known to have experienced early harm or are living in care, education and other practitioners may be tempted to assume that difficulties in adolescence are a consequence of early childhood trauma or subsequent placement moves. However, changes in behaviour may indicate current harm; professionals need to be alert to this.

Perpetrators' 'targeting' of children with disabilities/other vulnerabilities

Some children's vulnerabilities may have made them an 'easy target'. For example, one young person with a learning disability did not recognise that she was being abused by her mother's partner despite having received relationship and sex education. SCRs described a number of families in which older children had previously been abused – and then younger children were abused by different perpetrators. One interpretation is that perpetrators had targeted families who they perceived as particularly vulnerable and who had not been adequately supported to recognise risks. The Child Sex Offender Disclosure Scheme, or 'Sarah's Law', allows parents to ask police if someone with access to their child has been convicted or suspected of child abuse, but no requests had been made under the scheme in the 2017-19 SCR cases.

Learning points

- Schools, including special schools, and family support services may be particularly well placed to promote the Child Sex Offender Disclosure Scheme, or 'Sarah's Law', to vulnerable families. Local leaders should consider how the scheme can be better promoted to protect children and families.

Supportive and trusting relationships

The importance of engaging children and building supportive and trusting relationships is a recurring theme across all the periodic analyses, including the 2017-19 SCRs. Periodic analyses over the years have also shown that a wide range of practitioners, not just social workers, can provide such relationships, including teachers, youth workers, family support workers, housing officers, police officers, mental health workers, and adult social care workers. As the 2011-14 review noted:

> *... 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.*
> (Sidebotham et al., 2016, pp. 241-242)

One 2017-19 SCR described how a young person's highly valued relationship with a support worker was brought to an end because he was no longer thought to be on the edge of care.

An adolescent support worker had been commissioned by an 'edge of care' team, but when the young person was no longer considered to be on the edge of care, the service was withdrawn and the case was closed – even though the young person remained at risk. Over time, the boy's offending behaviour worsened; he was signposted to an array of specialist services, but an intervention that had been working was lost.

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

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

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

Older children in particular may be strategic about who they talk to based on their previous experiences of professionals. They may also be particularly adept at concealing the impact of neglect. Education settings should bear in mind that a number of factors may be at play, which may not be immediately obvious to the school, as in this case:

> ***The elder sibling carried the heavy burden about what was happening within the family over a period of many years. This included time when they were enrolled at a faith school. Loyalty to parents and not knowing how to share concerns within the school community was a factor that prevented earlier help-seeking. Teaching staff at the school were perceived as friends of the parents.***

Learning points

- Supportive and trusting relationships are key to effective safeguarding and can be forged by a wide range of practitioners who work with children and young people; all these relationships matter.
- Service leaders should work together and make every effort not to allow resource pressures or commissioning restrictions to undermine opportunities for sustaining established and effective relationships.
- Seeing children alone can optimise the chances of children feeling safe enough to talk. Education practitioners, including school nurses, counsellors and other pastoral staff, are more likely than some other professionals to see children alone and should be sensitive to the possibility that children may want to talk.
- Where there are safeguarding concerns, practitioners should not over-rely on verbal disclosure, nor on children's denials or minimisation. When children do talk about abuse and maltreatment, they must be listened to.

Information sharing and effective communication

Difficulties around information sharing have long been recognised as a feature of interagency and interprofessional working. They have been persistently highlighted in the SCR periodic analyses. A recurring theme in the 2017-19 SCRs was the crucial distinction between sharing information and communicating effectively.

In many cases, important information had been shared but had not been fully understood by practitioners in other agencies. This was part of a pattern around medical diagnoses, in particular: sometimes, health services had shared important information about a child's diagnosis, but that information or its implications were not fully understood by practitioners in other sectors who were also working with the child. This left those practitioners unable to assess risk adequately.

One SCR was prompted when a young person, who had been supported by mental health services for several years, severely injured a younger child. The SCR found that the significance of his diagnosis of conduct disorder had not been fully understood by those outside mental health services. ***'Without clarity across the professional network of the ... diagnosis and its significance, the level of concern reduced ... There was no overt articulation by mental health professionals of the implications of this diagnosis.'***

In another SCR, a recent health diagnosis was found to have been a factor in a young person taking her own life. Although the diagnosis had been shared between agencies, its far-reaching social implications – the diagnosis precluded the young person from participating in sports and activities that she valued highly – were not obvious to non-health specialists.

Where there was evidence of local good practice, this typically involved some form of regular interprofessional dialogue. For example, meetings and telephone conversations enabled professionals to explain or 'translate' information for those in other disciplines and provided opportunities for generating alternative hypotheses. However, practitioners' heavy workloads meant such opportunities were increasingly restricted.

Learning points

- Information sharing is necessary but not sufficient for effective communication between professionals. Practitioners should remain ever mindful of how other professionals may interpret any information they provide.
- On receiving new information – for example, from health services – all professionals in the child's network should reflect individually and collectively on the question: 'What does this mean for the child?'
- Phone conversations and meetings are opportunities for professionals to explain the significance of information to others outside their discipline. Dialogue between professionals is also an important opportunity for asking questions and generating alternative hypotheses about the meaning of information.
- One SCR found that local policies had inhibited routine information sharing between education and health services. Given the implications for safeguarding, the SCR author recommended implementing a more effective system that would identify any children who are missing education and not using health services and would facilitate inter-agency communication and response.

Professional disagreements and escalation of concerns

Effective multi-agency working is integral to supporting families and safeguarding children. However, multi-agency working does not always entail agreement. Discussion and respectful challenge are a key part of collaborative working and robust decision-making, but unresolved professional disagreements were a frequent issue within SCRs – especially insufficient 'escalation' of concerns between professionals in response to increasing risk.

SCRs highlight that practitioners were not always clear about local procedures for challenge or escalating their concerns. This was a problem for school staff in particular, who often found it difficult to make their voice heard.

A key area of disagreement was around the threshold for children's social care. Education practitioners found it difficult to initiate social care involvement, and referrals were often rejected on the grounds that they did not reach the threshold – but with no explanation and no suggestion of alternative action. SCRs identified a sense among some education professionals that they were powerless and that their professional judgment was not valued by social care, as is implied by these two examples.

One SCR found that teachers who had tried to escalate their concerns about a child were told that their concerns would be discussed at the next CAF (Common Assessment Framework) meeting. But subsequent meetings were either cancelled or no social care representative attended. The teachers were left frustrated and anxious for the child's safety.

In the case of the two children who were abused by their kinship foster carer (discussed earlier - see pages 21 and 23), regular looked after child reviews did take place. But despite the worsening behavioural issues and other evident problems, including overcrowding and poor home conditions, no one challenged the view that the children were in a positive placement. The reviews were held at the family home and, due to lack of space, school staff were excluded – despite the fact that they were the professionals who had most contact with the children.

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

In one case, a school had used pupil exclusion to force the involvement of children's social care because school staff were increasingly concerned about the safety of a child.

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

One SCR author spoke to children's social care to get their perspective on local disagreements. The social care view was that schools' expectation of support was often misplaced or premature, as ***'other avenues'*** were available that may be ***'more suitable such as psychology and behaviour specialists'***. Schools also needed to be more 'specific' about what support they were requesting. The review team conclude:

> ***'The rejection of referrals on the basis of the school not being 'specific' about the support required can act as form of gatekeeping and place schools and CSC [children's social care] in a kind of stalemate. The stalemate is compounded where referrals are rejected without explanation or advice, or further information about other available services.'***

In many SCRs, prevailing professional hierarchies appear to have acted as a barrier to constructive interprofessional challenge. This could be a problem within health services, in particular. Professionals may be reluctant to use 'escalation' processes if it means challenging senior leaders. The 2014-17 periodic review found that the terms 'escalation' and 'dispute' can feel adversarial, but reframing the issue as 'resolving professional differences' created a sense of professional empowerment, with staff saying: 'We didn't feel that we were empowered enough to escalate but we do feel that we are empowered enough to share a professional difference' (Brandon et al., 2020, p. 201).

Learning points

- Discussion and respectful challenge is integral to collaborative working. Crucially, this means all professionals being open to challenge and willing to answer questions about their judgments and decisions; senior managers in all sectors should make clear that this is an expectation.
- Staff should be supported to ask questions about the decisions or actions of others. Agencies should work together to create a local culture, supported by clear and widely understood guidelines, that makes it easy for professionals to raise any concerns as a way of resolving professional differences.
- Escalation policies should be formalised. If disagreements are dealt with informally rather than through formal channels, evidence from the SCRs suggests this can lead to potentially constructive dialogue between agencies being shut down.
- Reframing escalation processes as 'resolving professional differences' may help to make them more effective.

A system-wide response

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

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

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

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

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

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

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

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