research in practice

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WARWICK THE UNIVERSITY OF WARWICK

2019 Triennial Analysis of Serious Case Reviews:

Early help

March 2020

Contents

This briefing summarises themes emerging from the 2019 Triennial Analysis of Serious Case Reviews 2014-17, presenting key messages for those working in early help provision.

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 intended for practitioners in targeted early help services, including:

- Family support workers
- Youth workers
- Drug and alcohol services
- Parenting programme providers
- Early mental health support
- Relationships and sexual health services
- Safeguarding leads in housing services and housing associations
- Third sector/voluntary organisations supporting children, young people and families with additional needs.

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 reflections points 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).

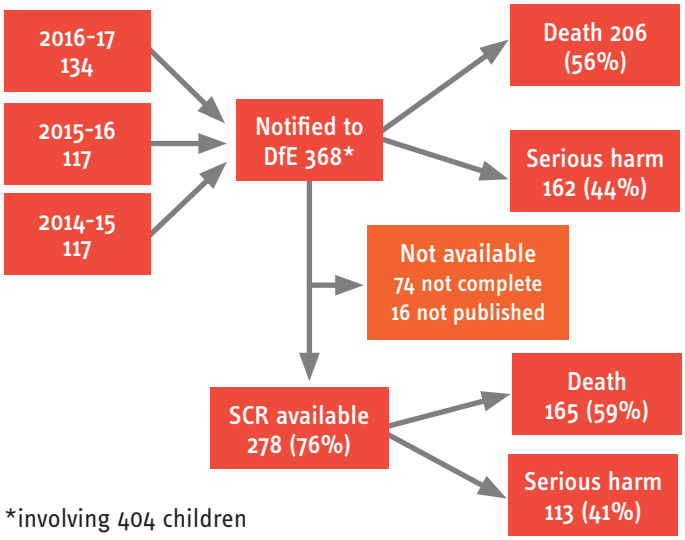
Under the new arrangements SCRs will no longer be commissioned. When a serious incident becomes known safeguarding partners must decide whether to commission a local child safeguarding practice review (LCSPR). The main purpose of an LCSPR is to identify improvements in practice. This means partners must 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

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	83 (30%)
(of which violent crime, excluding domestic abuse)	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	150 (54%)
(of which, acrimonious)	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.)

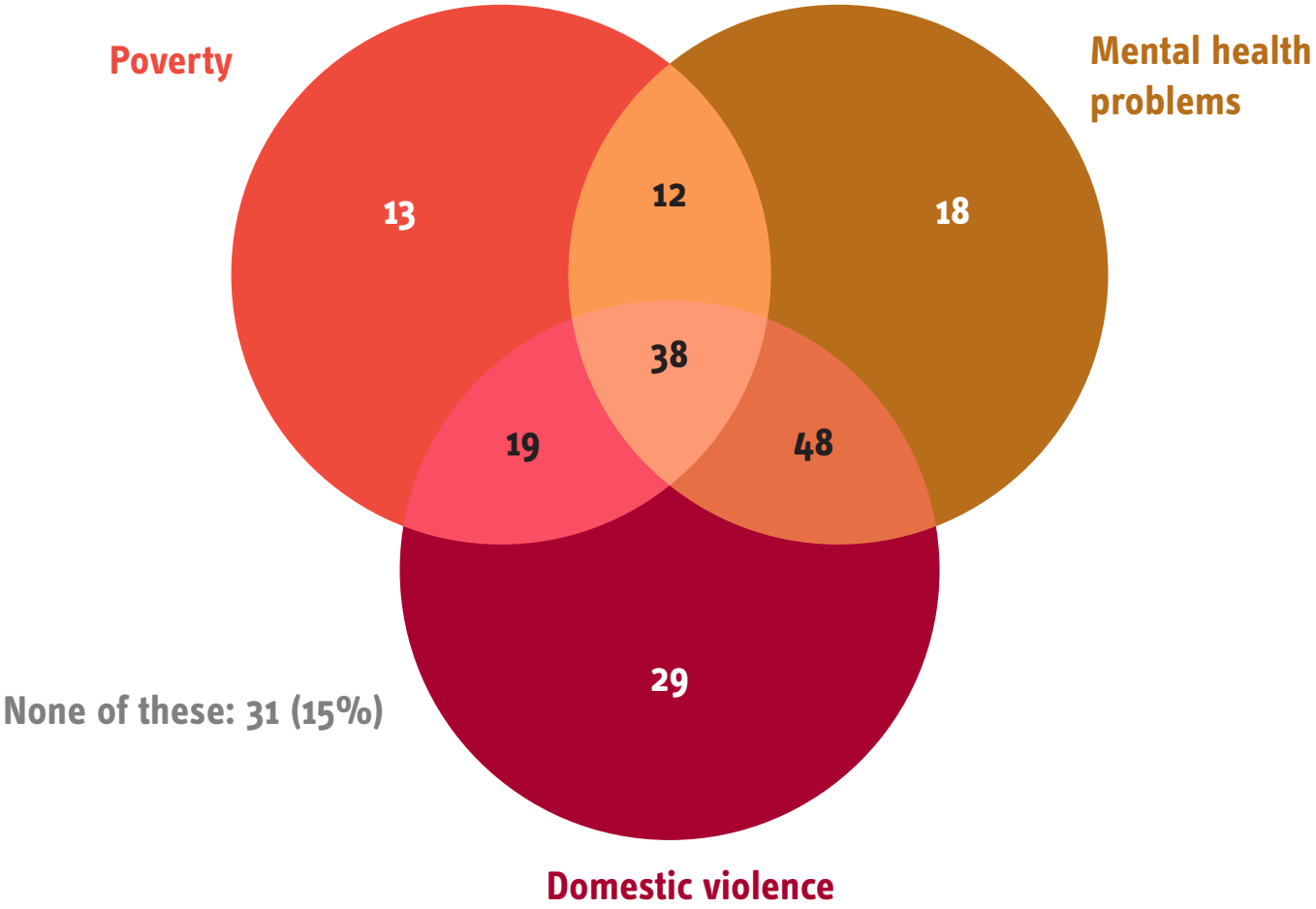


Figure 2: Adverse family circumstances in cases of neglect (n=208)

About this briefing

The briefing highlights findings from the report related to the following key areas and discusses them in the context of early help provision:

- Poverty and neglect
- Vulnerable adolescents
- Multi-agency working.

The five other briefings in this series draw out key messages for different professional groups involved with safeguarding children and supporting families. All have useful messages for partners involved in local early help provision.

Safeguarding and early help

The phrase 'safeguarding is everybody's business' is brought to life in the report by data showing involvement with services at the time of the serious incident for the children and young people who were the focus of the SCRs. While more than half (55 per cent) of cases were 'open' with children's social care at the time of the incident, many others:

- Were previously known to children's social care but the case was closed
- Had been referred but had not met the threshold
- Had never had social work involvement.

Many of these children and their families were involved with targeted early help services of various kinds.

A recurring theme throughout the report is that although individual incidents – for example, of self-harm or going missing – often elicited a response, earlier recognition of the issues underlying the eventual serious harm could have led to a more holistic response much earlier in the child's life.

Early help assessments should seek to:

- Understand issues underlying presenting behaviours
- Look at the complexity of family issues
- Collate information held by partners across universal services to develop a holistic picture of the child's experiences, needs and safeguarding concerns.

However, the impact of austerity on the availability and configuration of local services is evident in the SCRs. Cuts in funding and services, staff shortages and high caseloads all challenge and mitigate against practitioners' capacity to develop and maintain this holistic approach to gathering and reviewing evidence to support practice decision-making.

Changing service landscapes also meant professionals were not always aware when support services – particularly from third sector agencies – had ceased, as illustrated in the following example. The implications for safeguarding and protecting children had not been sufficiently grasped.

Example A young woman with high support needs received intensive and daily support, amounting to several hours a week, from a housing association in a supported accommodation scheme for vulnerable young women – an example of good practice from an agency that did not have a primary safeguarding role. Funding for the service ended prior to her becoming a mother, however – and with it were lost important opportunities for protection. The daily presence of the support worker, who had been involved in multi-agency arrangements for safeguarding/protection, had been a very positive protective factor. The loss of the service was not widely known among other professionals, who may have assumed there was at least some support at close hand, when in reality this was no longer the case.

The local safeguarding system

The coherence and cohesion of protective systems is also reliant on wider services being identified (and self-identifying) as part of the local safeguarding system, as this example illustrates.

Example In one case, a contact centre played a key role in engaging parents, with important implications for information sharing with regard to family dynamics, roles and relationships where domestic abuse was a feature. The SCR found: *'A conversation with the [contact] centre would have elicited a much fuller picture of family relationships and their impact on the child than was contained within an e-mail. The contact centre informed the review that their impression is that they are not always seen as a full member of the professional network yet they have much important and relevant information about children using their service.'*

It is also important that specialist support services do not perceive themselves as outside of that safeguarding network, as in the following case:

'Professionals were unaware of the Access to Education Team (AET) for travellers and refugees and the specialist knowledge and experience that the team has. It became apparent during the review that staff within the AET had acclimatised themselves, or believed that they were uniquely placed to help Travellers without going through the legitimate safeguarding channels. As a consequence there continues to be a risk of the Access to Education service not referring concerns.'

Examples in systems thinking with regard to improving engagement with young people and families included drawing on voluntary sector organisations' skills and expertise in methods of engagement. In one case, a local policy for working with 'non-compliant' families was being tested to see if it might be used to frame the engagement of young people; in another, a local voluntary organisation was contracted to undertake 'return home' interviews when young people go missing.

Poverty and 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. Recognising neglect is a responsibility for all practitioners.

Evidence of the impact of poverty in SCRs in which neglect was a feature was much more prominent in this report than in earlier triennial and biennial analyses. Most children living in poverty do not experience neglect, but where poverty and neglect co-exist, adverse outcomes for children will be escalated.

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

Recognition of poverty and its impact was often missing in SCRs, or it was 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.

It is vital that safeguarding practice does not fall into the trap of responding only to material needs 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

- Recognising and responding to neglect is an issue for all practitioners; it must not be seen as the responsibility of children's social care alone.
- Analysis for this report and other research suggest practitioners working in deprived communities can become desensitised to a family life lived in poverty and come to accept lower standards of care or wellbeing for children and families. This can lead to lack of attention to warning signs of neglect, such as poor physical care, smelly and dirty clothes, or poor dental care.
- Practitioners across multi-agency early help need to be mindful of the link between experience of early and ongoing neglect and behaviours in adolescence that leave young people at risk of harm (see page 13).
- Practitioners who make home visits have a vital role to play in identifying and responding directly to the impact of poverty on children's development and wellbeing, working in partnership with other professionals.

Understanding parents' experiences

Neglectful parenting is almost inevitably a sign of complex and long-standing problems. Table 4 above shows frequently occurring parental and family adversities in the lives of children at the centre of SCRs where neglect was a feature.

These vulnerabilities contribute to social isolation, inconsistent and ineffective parenting and a disorganised lifestyle and affect parents' ability to provide adequate emotional warmth to their children. The impact of adversities also appears to be cumulative with the presence of more than one increasing the likelihood that problems will be more serious.

The report found a common feature in neglect cases was a period of low-level concern followed by a sudden escalation in risk in response to unexpected life events or a change of circumstances, triggering events that swiftly became unpredictable.

Additional challenge occurs when families or individuals frequently move home. Crossing local authority boundaries creates challenges for effective information sharing and for clarifying responsibilities.

When engagement is voluntary, in some cases parents may seek to close down professional engagement by blocking communication, pleading ignorance or trivialising the significance of an action. In one case, the mother of a two-month old baby who died unexpectedly (a sudden unexpected death in infancy – SUDI) denied any drug use, reacted negatively to criticism and then made a complaint against the school CAF (Common Assessment Framework) Coordinator stating she did not want this person to come to her home or to be involved in the CAF process.

However, while identifying parental 'resistance' or 'avoidance' strategies is important, it is equally important practitioners do not resort to labelling such behaviour with jargon such as 'hard to engage' or 'resistant'. Such terminology runs *'counter to relationship-based practice and discourages exploration of individuals' perceptions, historical experiences of services or their anxieties about accepting support'*.

Rather, early help is an opportunity to explore underlying issues leading to such resistance (such as prior negative experiences of professional involvement or parents' own history of maltreatment and/or being in care) and/or to identify any systemic issues that may be making it difficult for practitioners to engage parents.

For instance, the fact that parents under stress and facing adversity may not always 'hear' or fully understand what is said in meetings, or may not remember agreed plans clearly, can leave them feeling out of control and defensive – especially if they experience official agencies' involvement in family life as something to be avoided.

Voluntary engagement with early help requires parents to have both the motivation and ability to work with service providers. Parents who are vulnerable or feeling overwhelmed may not have the emotional capacity or material resources to be able to take up the services offered or to attend appointments. Professionals need to take time both to understand the underlying issues and to build a trusting relationship with parents. When that happens, offers of help are more readily accepted.

Learning points

- Practitioners can feel reluctant to name neglect, especially if they feel this might be a barrier to engagement. They may also be reluctant to name and discuss poverty for fear of stigmatising the family.
- Parents living in poverty have fewer social, emotional and physical resources to call upon. Feelings of shame or hopelessness and previous, negative experiences of social work intervention may 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.

Relationship-based practice

A recurring theme in the SCRs that identify good practice is the quality of relationships. Good relationships with families are the 'primary vehicle for protective practice'. Early help practice offers opportunities for relationship building without the stress and anxiety that often affect families' engagement with statutory services. There may also be the potential for longer-term involvement than would be offered by statutory services.

Early help workers need to be curious and explore context, circumstances, and the roles and relationships of individuals within the family network. Understanding children and young people's experiences at home and young people's experiences online and in their neighbourhood is achieved through respectful enquiry – talking and listening to children. All this is vital in managing the complexity of cumulative risk over time.

Learning points

- A positive, consistent relationship with a practitioner may be the most significant and supportive relationship in a parent or child's life.
- In many cases, the labelling of families or young people as 'not willing to engage' led to opportunities being missed and cases closed inappropriately. Language is key to developing empathic practice, and reflective supervision can support practitioners to recognise the importance of the language they use.
- Managers need to do all they can to support practitioners to build relationships, including allowing time for respectful enquiry. In this light, it is vital that the impact of changes of staff and the reallocation of cases is recognised and planned for.

Wider family, neighbourhood and community

Relatives can also be an important source of information and support for children. They have the potential to be valuable partners in safeguarding children if given appropriate support. When children live with their mother or father and grandparents, or where grandparents or other relatives are frequently present in the home, professionals should explore grandparents' perspectives on what is happening.

Neighbours are often well aware of the difficulties families are experiencing. They may help directly by providing shelter and food to children or they may report suspicions of abuse, neglect or abandonment. Analysis of the SCRs suggests that in some cases insufficient weight was given to concerns expressed by neighbours.

Community or voluntary services can provide practical and emotional support to vulnerable children and families, but their potential supportive role is rarely referred to in SCRs. Housing agencies may have valuable information about a family but they are not generally seen as a safeguarding agency in children's plans and multi-agency meetings. The challenge of how best to involve them increases with the rise of private sector housing with no safeguarding point of contact.

Learning points

- Concerns reported by wider family, neighbours or anonymously should always be accurately recorded and taken seriously by those receiving the information. When nothing is seen to happen future concerns may not be reported.
- It is important to recognise that there is no opportunity to challenge the outcome of such referrals; as such, they should be scrutinised and triangulated with other sources of information.

Early help assessments

Several SCRs describe circumstances in which a holistic early help assessment would have generated timely opportunities for protection much earlier in the history of engagement with a family, as in these examples.

Example Little support was provided for Child S (a young adolescent) as she experienced ongoing neglect with neither early help nor escalation to any child protection process. *'Child S was left for too long, living with neglect, without any effective ongoing multi-agency support or intervention. The child's risk taking behaviours began to escalate, placing Child S at risk of harm and CSE.'*

Example The statutory definition of neglect clearly states that it includes failure to meet a child's basic physical needs, including the provision of adequate food, as well as neglect of emotional needs. In the case of Child J, there were concerns over time relating to whether or not the child's physical and emotional needs were being met, but at no stage was Child J identified as a child who may benefit from an early help assessment. Even when there is clear information outlining concerns, thresholds for a social work assessment may be set too high – as in this case.

'By the time MASH responded to the Education Welfare Officer they would have received a referral from the GP who was very concerned about Child J's weight and apparent malnourishment. The GP asked Mother to take Child J to hospital and the GP also contacted the hospital via telephone to alert them [to] their pending arrival. A referral was also made to children's social care citing concerns about neglect... The [hospital] records state that Child J was admitted with severe malnourishment and a referral was made to MASH. The decision within MASH was that the case did not reach the threshold for child protection enquiries but Child J should be allocated to a social worker for a child in need assessment.'

The case of Child J above also highlights the importance of agencies (in this case a pre-school) capturing and recording low-level concerns over a period of time in order to demonstrate the potential for an early help assessment.

Learning points

- Opportunities for preventive or protective intervention within the family and wider community are often missed, leaving children without some of the most important sources of support.
- Immediate responses to the physical manifestations of poverty and a chaotic lifestyle do not equate with children being safe. The child and their wellbeing should always be the primary focus of any assessment.
- Practitioners can be reluctant to name neglect. This points to the importance of a multi-agency approach to identification and assessment through which differing views and perspectives can be robustly triangulated.
- The links between domestic abuse, substance misuse and poverty are complex. Addressing a single issue will not deal with underlying causes or interdependencies. Children are left at risk when short-term solutions address only immediate issues followed by case closure.

Early help for adolescents

Nearly one in three (31 per cent) of the SCRs involved children aged 11 years and over, but analysis suggests that in many cases the child's behaviour had indicated something was wrong long before they reached their teens. Underlying causes of behaviours were not always explored, however, and incidents were instead dealt with in isolation as they came up.

Understanding adolescents' past and current experiences, including their family lives, local community and wider social networks, is necessary for understanding adolescent harm.

Children who experience abuse and neglect carry those experiences with them into adolescence. Their perceived rejection by family, foster carers and agencies has an effect on their self-efficacy that can lead to feelings of worthlessness and lack of agency.

However, professionals working with adolescents who have a long history of disturbing and disturbed behaviour may become reactive rather than proactive. For instance, when children self-harm or disclose suicidal ideation professionals may focus on each individual incident rather than considering the incident within the context of their past experiences.

Example Child AC developed behavioural problems during primary school and received support focused on managing the behaviour. By the age of ten AC had had his first encounter with the criminal justice system, but there was still no sense of why he was behaving as he did. Despite early help to manage symptoms of maltreatment, there was little support offered to make life better for him. AC was eventually accommodated in a secure centre where the routine and boundaries were said to suit him. He adhered to them. AC attended education daily and was reported to have formed positive relationships with staff and his peers. It took many years (and multiple criminal acts) before AC received support he felt able to engage in. His problems might not have escalated to the extent that they did if he had received more appropriate support earlier on. Children and young people are not always able to express clearly what is happening to them, and practitioners should be alert to changes in behaviour as a sign that all is not well.

Although the family may continue to be a potential source of harm for some adolescents, there is increased potential for harm from adults and other young people as adolescents spend more time outside the family home.Communities and virtual spaces provide hidden opportunities for exploitation but safeguarding measures designed for younger children may well not be suitable for the developmental needs of adolescents.

Criminal exploitation
Criminal exploitation includes young people being exploited into moving drugs (county lines), violence, gangs, trafficking and radicalisation. The report found criminal exploitation was closely linked to school exclusion, going missing, substance misuse and loss and separation.

Although adolescents exploited into crime are victims, there is a suggestion that some professionals may see them as partly at fault. The APPG on Runaway and Missing Children and Adults (2017) believes that in some areas of the UK, such a culture exists around children groomed into criminal exploitation by gangs – in the same way that some professionals in the past saw victims of CSE as at fault due to their 'risky behaviour' (Sidebotham et al, 2016; Children's Commissioner, 2019).

Voluntary agencies are sometimes better placed to encourage engagement through mentoring and mutual experiences. One youth charity supported an adolescent and his family for five years; they provided a mentor for the child during which time he engaged with football and a programme aimed at diversion from offending.

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 below).

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**. Resources on contextual safeguarding are also available from the **Contextual Safeguarding Network**.

Child sexual exploitation
Child sexual exploitation (CSE) was noted in nearly one in ten (26 of 278) SCRS. Despite its high profile, professionals were still slow to recognise vulnerability to CSE, particularly for adolescent males being exploited by older males. The risks for boys who are victims are no less serious than for girls and staff should be alert to the fact that boys may find it difficult to disclose CSE. Recent guidance suggests practitioners should ask themselves if their response would be different had the victim been a girl (The Children's Society, 2018).

Going missing
The pathway to harm for adolescents is often triggered by episodes of going missing. Young people missing from home, education or care are at increased risk of harm.

When a child goes missing from home or care it is a powerful signal all is not well in their life; it is not enough simply to find them and bring them home. A timely multi-agency safeguarding response is required. Communication and information sharing can support practitioners to develop a holistic picture when adolescents repeatedly go missing.

All incidents should be reported and statutory guidelines followed. The local authority has a duty to offer an independent return interview within 72 hours of any child who goes missing from home or care being found or returning. (This is different from the police 'prevention interview' – formerly a 'safe and well check' – which should be conducted in all 'serious' cases, such as a child who goes missing repeatedly.)

Two of the reviews concerned young people who had gone missing abroad. When children who are not subject to child protection processes go missing abroad, the investigation is left to the police and the authorities of the country where the child is suspected of being. This can result in a loss of information and potential strategies to protect the child. In one case of a child missing abroad, the child's mother reported her missing and the following day the police informed children's social care. As she was missing abroad, children's social care did not open the case until some months later as they viewed it as a police investigation.

In another case, two brothers who went missing abroad and were killed whilst fighting in Syria were groomed into radicalisation online. The review in this case suggested that there are different responses, depending on where the child is, which can result in inconsistencies in interventions. The review concludes, that Prevent (part of the UK Government counter-terrorism strategy) should be situated within child safeguarding to prevent the child being drawn into terrorist-related activity (HM Government, 2015).

Loneliness

Separation and loss may leave young people lonely and at increased risk of depression and low self-esteem. Early childhood trauma often leaves adolescents poorly equipped to recognise and nurture healthy relationships, leading to loneliness and isolation. Isolated adolescents with a need to belong can be more vulnerable to grooming, in particular sexual exploitation and radicalisation.

Although their use of social media means adolescents are generally more connected than other age groups, social media can also increase feelings of loneliness. The pathway to harm online may be triggered by feelings of loneliness.

Harmful sexual behaviour

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. Experience of any form of maltreatment can be an indicator for HSB.

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.

The National Institute for Health and Care Excellence guidance for practitioners who work with children and young people who display harmful sexual behaviour recommends an early help assessment to determine whether a statutory or criminal justice response is needed (NICE, 2016). Two SCRs demonstrated that in aiming to avoid criminalisation of young people in cases of HSB, episodes of HSB were effectively 'forgotten'. A criminal justice response was not seen as appropriate in either case; however, child protection services and specialist services should have been offered but were not.

Suicide and self-harm

Practitioners need to understand the strong link between non-fatal self-harm and subsequent suicide. Suicide was the second 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).

Example: Neglect and subsequent suicide

A 15-year-old girl took her own life with a fatal dose of opiates. 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.

Social media and technology-assisted harm

Adolescents use technology to communicate and explore friendships, as well as to find a sense of identity and belonging. This may be especially so for young people who feel disconnected from family and society.

One SCR described the case of a young person who had begun to explore his sexual orientation online, which included contact with older men. He had become isolated from his peers who distanced themselves from him when he disclosed his sexual orientation.

Practitioners should be aware of the link between sexting and exploitation. Shared images can expose adolescents to risks and exploitation if images are shared further, as they can be used for bullying or blackmail. Evidence from SCRs suggests the seriousness of such technology-assisted abuse was not always recognised by practitioners.

Learning points

- Adolescents' early experiences may contribute to feelings of worthlessness and lack of self-efficacy in adolescence. Practice responses to previous harmful experiences can also influence young people's (lack of) confidence in services.
- Children who have had traumatic experiences are likely to require long-term support to keep them safe. Adolescent SCRs demonstrate the need for:
  - Persistent and prolonged engagement
  - A balance of preventative work and crisis management.
- Developing a trusting relationship is key to supporting adolescents. If authentic relationships are not part of the service response to young people and if professionals are not actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people are likely to be ineffective.
- Statutory agencies often struggle to establish long-term work with adolescents due to limited resources and potential lack of engagement by the adolescent. Voluntary agencies may be particularly well placed to encourage engagement, for example through mentoring.
- Practitioners need to look beyond immediate presenting behaviours. Young people involved in criminal exploitation should be seen as victims and safeguarded accordingly.
- Children with HSB are likely to have experienced polyvictimisation. 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.
- Loneliness is a subjective feeling common among young people and should be explored in assessment. Those with caring responsibilities can become particularly isolated from their peers; additional needs should be addressed through a young carer's assessment.
- Non-fatal self-harm is strongly associated with completed suicide and should be referred to health services for thorough assessment and intervention.
- Social media provides fast-changing spaces within which children may be bullied, groomed or exploited. Even practitioners who feel confident about technology use may struggle to support young people in an ever-changing digital world. Ongoing and up-to-date education and training for practitioners on how to keep children safe is therefore essential – for example, by making use of advice and resources produced by organisations such as **UK Safer Internet Centre**.
- Practitioners can feel unprepared for working with adolescents vulnerable to radicalisation and will need ongoing training and support. Partnership working is essential, as specified in Prevent duty guidance and *Working Together* (HM Government, 2015; 2018).

Effective multi-agency working

Systems and services around families can be fragmented and uncoordinated. Professionals who work predominantly with adults do not always consider the impact of risk from the perspective of the children. The report finds there was often a focus on either a child or an adult, with little consideration of the dynamic context of the family.

Joint service responses

A Multi-Agency Safeguarding Hub (MASH) is a co-located, multi-agency team, led by the police or Children's Services, which provides a central referral point and triage. MASHs now operate in many areas. When working well, a MASH will provide opportunities for key agencies to work together to establish appropriate criteria for meeting thresholds for neglect based on a full understanding of the variety of indicators.

- Appropriate threshold criteria are pre-requisite in ensuring proportionate responses to concerns. If they are set too high, the consequences for individual children are likely to be serious.
- IT systems should be reviewed regularly to ensure they do not present barriers to the progress of referrals or to effective information sharing.
- Co-location: there are examples of local authorities reviewing the physical proximity of services in order to increase opportunities for informal liaison (for instance the co-location of midwives and health visitors in adjacent offices in the same building).

Information sharing

'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).'

As in earlier triennial and biennial analyses, poor practice in information sharing, between professionals and between agencies, continues to be a problem.

The report highlights a number of examples where delays in sharing information had impeded work with adolescents. Delays were particularly problematic when incidents were happening frequently in a young person's life.

- There was a delay of 19 days after a young person was arrested for rape before the information was shared with children's social care.
- When a 14-year-old girl was admitted to hospital with an episode of self-harm there was no communication with children's social care at all.
- When a police notification of a stabbing was sent to a school, which the young person had left 15 months previously, there was no indication staff responded by letting the police know he was now at college in a neighbouring borough.

In other cases, information was simply not shared at all.

A useful way of sharing information is through strategy or review meetings although that only works if representatives from relevant agencies are invited. There were plenty of examples of good practice and agencies coming together to share and discuss cases involving vulnerable adolescents, as in the following example.

Example *'Once AC came to the attention of youth offending services (YOS) there was further evidence of good information sharing and communication between YOS professionals and the secondary school. The Team Around the Family meetings that were established by the school ensured that appropriate professionals were engaged in supporting AC and his parents.'*

The report found sharing historical information remained an issue, however. Agencies did not always share information about current and previous circumstances and multiple difficulties (such as substance misuse, special educational needs and school exclusions, antisocial and criminal activity) and therefore a more complete picture of an adolescent was rarely available to practitioners.

Example It was clear that a lot of key information about Child U was known but not shared. Incidents such as assaults at school were not shared with the police and going missing incidents were not always shared with children's social care or the school. For Child U, this meant that when he attended emergency departments with injuries, few questions were asked as staff were not aware of any other concerns. *'Had hospital staff been aware of Child U's escalating difficulties, they could have followed the process within the hospital for advice to be sought from the safeguarding team (named doctor and named nurse). Both hospitals also had youth worker projects that could pick up referrals regarding youth violence or gang membership and offer services on a voluntary basis. Involvement with such services may have prevented escalation of the exploitation of Child U.'*

Effective early help in complex service environments requires a **lead professional** acting as the key contact, co-ordinating service activities and 'holding' the full picture of the child's reality. In many SCRs this lead role was absent and outcomes underline the importance of the role being embedded at a systems level, with checks to ensure it is appropriately allocated and identified to all involved agencies.

Example *'It would have been helpful if one professional had taken time to draw together all information and undertake a critical analysis of professional issues/concerns and decisions made. There was no evidence that at any one time, professionals clearly considered: the impact of the parents' behaviour on the family as a whole; the impact on the children, specifically the emotional impact of drug abuse and domestic incidents; [or] the impact on professionals working with a family with significant vulnerabilities, chaotic lifestyle and parenting capacity/capability.'*

Learning points

- The use of straightforward language that clearly depicts issues can lead to more effective safeguarding. Referral forms, assessment tools and incident-logging tools should all encourage the use of language that describe issues in ways that do not dilute impact and harm, and express the reality of life for the child.
- Careless description or vague, stock phrases and jargon can minimise or obscure the lived reality of a child's life. (In one case highlighted in the report a frontline worker's vivid description of a child's living conditions as *'unsanitary with a foul smell and a fire hazard'* was changed in the section 47 strategy meeting minutes to 'poor home conditions', which impacted on the interpretation of risk and vulnerability.)
- When schools or other universal services try to manage incidents in-house to avoid criminalising young people, this can leave other professionals less able to safeguard the adolescent, as the example of Child U (opposite) illustrates.
- 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 these plans, and a continued focus on the needs of the child(ren) as central to any plan.
- It is important practitioners in early help services have a clear understanding of the roles and responsibilities of different organisations, and that clear pathways for information sharing and shared working are in place.

Reflective questions

- What development activities are available to support practitioners' understanding of parents' 'resistance' or 'failure to engage' with support offered?
- Reflective supervision (individual or group) can enable practitioners to work proactively with families and support staff wellbeing and self-care. What access do family support and other early help practitioners have to multi-agency group supervision?
- How is service mapping kept up to date in your local area? Does this process include communicating on multi-agency safeguarding responsibilities and local child protection thresholds and referral routes?

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2019 Triennial Analysis of Serious Case Reviews:

Early help

Acknowledgements

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With grateful thanks to colleagues who peer reviewed early drafts of these briefings.

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