research in practice

University of East Anglia

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WARWICK THE UNIVERSITY OF WARWICK

2019 Triennial Analysis of Serious Case Reviews:

Education sector

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Contents

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

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

This briefing is for staff working directly with children and young people in:

- Early years provision
- Schools and colleges (including maintained, independent, academy, free and non-maintained special schools) and Pupil Referral Units
- After-school settings.

It is also for:

- Governors, management committees and proprietors and local authorities in their education functions
- Designated safeguarding leads.

Introduction

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

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

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

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

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

What is a serious case review?

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

A new system – child safeguarding practice reviews

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

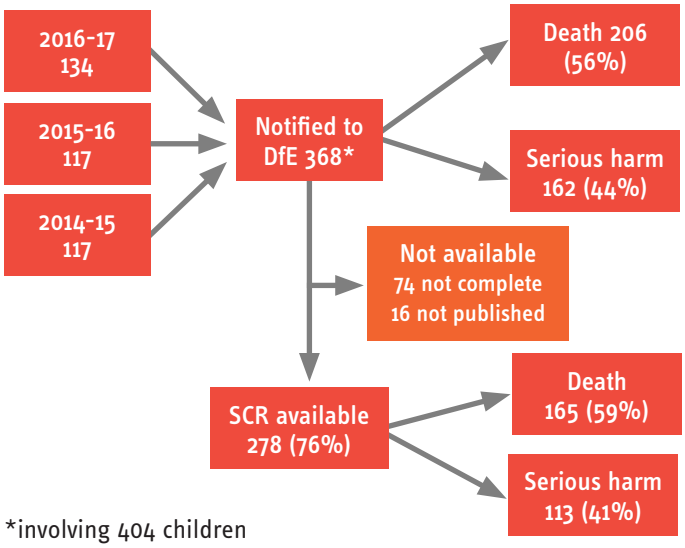
Under the new arrangements SCRs will no longer be commissioned. When a serious incident becomes known safeguarding partners must decide whether to commission a local child safeguarding practice review (LCSPR). The main purpose of an LCSPR is to identify improvements in practice. This means partners must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

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

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

The triennial analysis report

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



*involving 404 children

Figure 1: Numbers of SCRs examined

Key themes

- **Complexity:** Complexity and challenge

  form the underlying theme to the report. Researchers were struck by the complexity of the lives of children and their families, and the challenges faced by practitioners seeking to support them.

- **Service landscape:** The evident challenges for practitioners of working with limited resources, including high caseloads, high levels of staff turnover and fragmented services.

- **Poverty:** One issue that came through more strongly than in earlier analyses was the impact of poverty, which created additional complexity, stress and anxiety in families as well as being an important factor alongside other cumulative harms. Evidence of its impact in neglect cases was particularly prominent.

- **Child protection:** As identified in the previous triennial analysis, once a child is known to be in need of protection, for example with a child protection plan in place, the system generally works well, with positive examples of creative and effective child safeguarding.

Key data

- **Gender:** More than half (54 per cent) of the SCRs involved boys. The predominance of boys is seen in younger age groups (up to age 10); more girls are the focus of SCRs for children aged 11 and older, which reflects the increasing number about girls affected by child sexual abuse and exploitation.

- **Fatal cases:** 78 of the 206 deaths were a direct result of the maltreatment – equivalent to 26 cases a year; this number has not increased in recent years, averaging 26-28 cases per year.

- **Increase in non-fatal cases reviewed:** The number of SCRs relating to non-fatal serious harm has increased from 30-32 per year across 2009-14 to 54 per year across 2014-17. The increase is associated with physical abuse, child sexual exploitation (CSE) and neglect.

- **Neglect:** Neglect was a feature in three-quarters (74.8 per cent) of all SCR reports examined.

- **Children's ages:** As in earlier analyses, the largest proportion of incidents relate to the youngest children: 42 per cent were under 12 months old; 21 per cent were aged one to five; 5 per cent were aged six to ten; 17 per cent were between 11 and 15 years old; and 14 per cent were aged 16 or above.

- **Ethnicity:** From 2005 onwards, families at the centre of SCRs are predominantly (between 72 and 80 per cent) white, broadly reflecting the overall child population.

- **Disability:** Fourteen per cent of children in these SCRs were reported to have a disability prior to the incidents reported in the SCR.

- **Where children were living:** At the time of the incident most (83 per cent) children were living at home, two per cent were living with relatives, four per cent with foster carers and four per cent were in a residential setting (eg, children's home, mother and baby unit).

- **Who was involved:** Most serious and fatal maltreatment took place within the family home, involving parents or other close family members. Child death and serious harm also occurred in supervised settings. Very little serious maltreatment involved strangers unknown to the child.

- **Social care involvement:** Most children were known to children's social care: 55 per cent had current involvement; 22 per cent were previously known but their case was closed; 16 per cent had never been known to social care.

- **Child protection plans:** In only 54 of the 368 SCRs (15 per cent) was the child on a child protection plan at the time of the incident; 56 (15 per cent) had been the subject of a plan in the past.

- **Categorisation of harm:** Many of the children and adolescents experienced multiple forms of harm (although the categorisation system highlights a *primary* cause of harm for each SCR).

Family characteristics – parents

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

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

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

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

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

Table 2: Family characteristics noted in final SCR report

Family characteristics – children

Table 3 sets out a number of child experiences 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.)

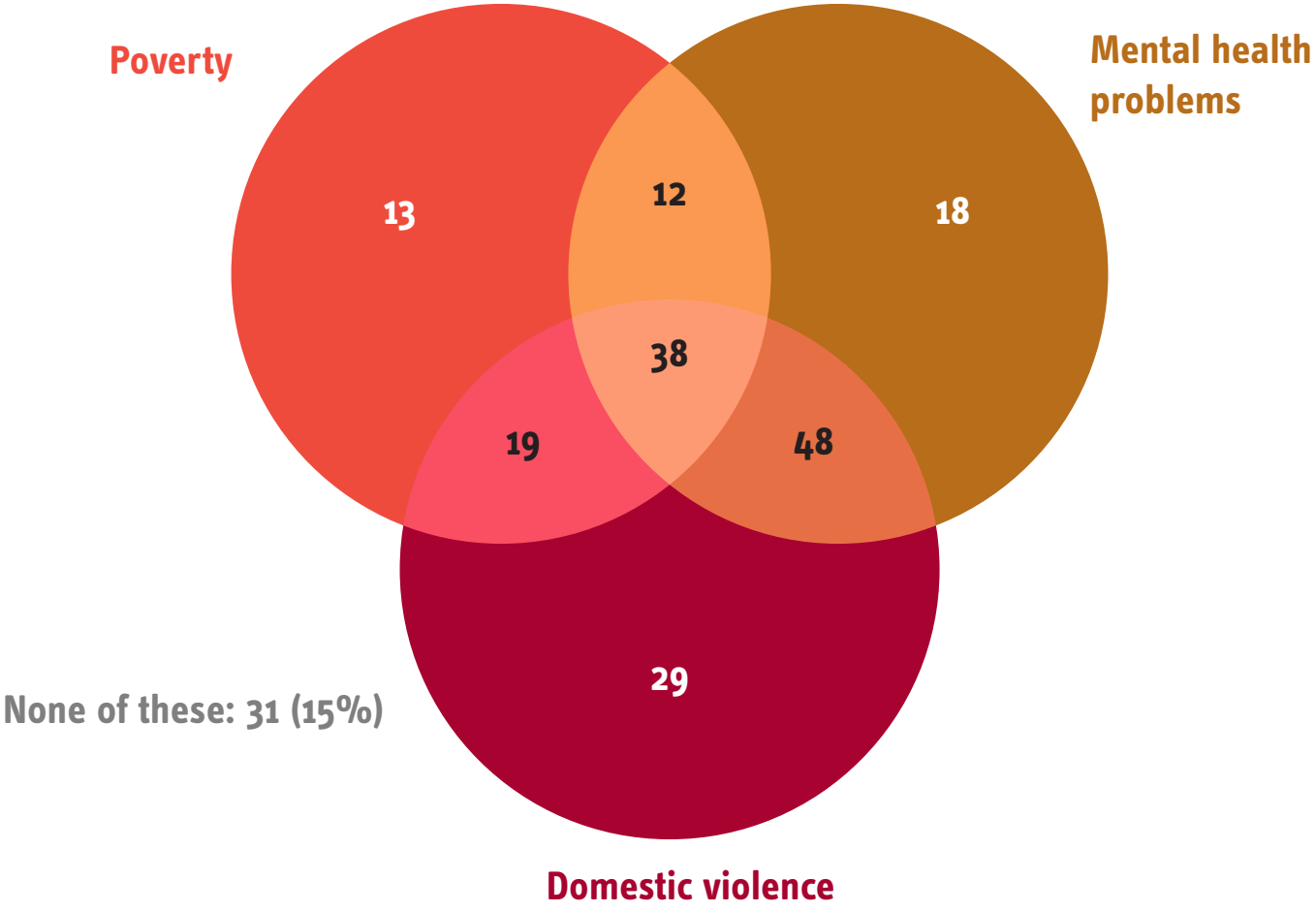


Figure 2: Adverse family circumstances in cases of neglect (n=208)

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It is also for:

- Governors, management committees and proprietors and local authorities in their education functions
- Designated safeguarding leads (DSLs). DSLs take lead responsibility for child protection issues in a school or college so this briefing will be of particular interest to them. (The DSL should be a senior member of the school's leadership team and the role should be set out in their job description – Department for Education, 2018.)

Neglect and poverty

'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.'

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.

Evidence from a range of studies from across developed countries shows a strong association between families' socio-economic circumstances and children's chances of experiencing abuse and neglect. Most children living in poverty do not experience neglect, but where poverty and neglect co-exist, adverse outcomes for children will be escalated.

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

Neglectful parenting is almost inevitably a sign of complex and long-standing problems, and adverse parental and family issues were a common feature of neglect cases in this triennial analysis. Table 4 shows frequently occurring adversities in these families' lives; Figure 2 shows the intersections between poverty, mental health difficulties and domestic abuse. Parental separation was also common (reported in 54 per cent of SCRs, of which over a quarter were felt to be 'acrimonious' separations).

The impact of these adversities appears to be cumulative – many families at the centre of the SCRs had evidence of multiple adversities. Only 11 per cent of cases did not have any of these adversities recorded; 42 per cent documented at least three.

Learning points

- A common feature in neglect cases was a period of low-level concerns followed by a sudden escalation in risk in response to unexpected life events or a change of circumstances triggering a series of events that swiftly became unpredictable.
- Parents living in poverty have fewer social, emotional and physical resources to call on, and shame, hopelessness and previous negative experiences of social work intervention may hinder their seeking or accepting help.
- Education staff need training in recognising and responding to signs of neglect, poverty and risks of harm to children and young people. Some professionals become accustomed to working in areas of high deprivation and may become desensitised to the warning signs of neglect such as poor physical care, smelly and dirty clothes or poor dental care.
- Providing immediate support for children in poverty – such as breakfast clubs and meals at school holiday clubs – is important. But rectifying the physical manifestations of poverty does not equate with children being safe (see the example of Cara below).

Example Cara was a two-year-old white British girl who died from ingesting 20ml of her mother's methadone. She was the youngest of five, all of whom had some degree of developmental needs. Cara's mother struggled with long-term drug addiction and domestic abuse and had a long history of contact with services. Concerns over poverty had been identified five years before Cara's birth. All the children shared a single bed and there was very little food in the house. Cara's mother sometimes borrowed money to buy food or relied on charity food parcels. The younger children had sometimes failed to attend nursery because of unpaid fees.

Agencies' primary focus was on improving physical conditions in the home and ensuring the parents continued to attend their drug treatment programme. Failure to assess the ways in which poverty was affecting the children led to short-term bursts of activity to clean up the home or provide cash or food for the children. Signs of improvement then led to the case being closed to children's social care. The underlying causes of the family's poverty, and its relationship with parental drug addiction, were not explored. Most significant of all, perhaps, was the lack of any exploration of the children's experiences and how poverty impacted on their safety, health and overall development.

Learning points

- How does your education setting ensure teachers and other staff do not become desensitised to children's experiences of poverty and signs of neglect?
- In early years settings, what action would your DSL take if a child you were worried about was not brought to nursery because the parents had not paid the fees?

Enabling children to have a voice

Listening to what children may be telling us – through their behaviour, as well as what they do or do not say – about their experiences is integral to effective safeguarding practice.

Hearing a child express their concerns requires a safe and trusting environment where they can speak freely and be listened to. Children in school (or nursery) have the advantage of regular contact with responsible adults – not only teachers but also support staff and school nurses; these adults are well placed to notice a child's distress and any worrying behavioural changes.

Assessments by the school nurse can enable children's voices to be heard. In one example, the school nurse observed that an eight-year-old boy, who had previously been subject to a child protection plan and a short period in foster care, was *'very tired and wearing a dirty ill-fitting school uniform; his face was unwashed and nose dirty'*. The boy said the children were given biscuits or crisps with tea instead of an evening meal, which he contrasted with the cooked dinners (meat and pasta) he received while fostered.

Listening to adolescents is also important, as in the following example.

Example One SCR describes the neglect and subsequent suicide of an adolescent who took a fatal dose of opiates aged 15. Her family had 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. After asking about the cuts on her arms, the teacher reported being told: 'When I am feeling this pain, I am not feeling anything else.' Her self-harm escalated to the extent that prior to the fatal overdose, 32 episodes had been recorded. All professionals working with the child were aware of her extreme vulnerability, but little was recorded of her perspective, views and wishes or what life was actually like for her.

Learning points

- Teachers and other school staff are in a unique position to notice a child's appearance, signs of distress or worrying behavioural changes. Careful recording and sharing of these observations over time is essential to building the full picture of a child's needs.
- Developing a trusting relationship is key to enabling children to talk about what is happening to them. After-school activities and clubs offer opportunities for adults to form trusting relationships with children and for children to be heard and concerns acted upon.
- Particular attention should be paid to those children who, through communication or learning difficulties, or their home circumstances, may find it especially difficult to express their experiences.
- It is important all school staff have a good understanding of the impact of trauma, loss and separation on children's behaviour, at the time and as children grow into adolescence. The harm children have suffered in the past can affect their later behaviour; earlier neglect may leave adolescents particularly vulnerable through the impact on their behaviour or mental health.

Reflective questions

- How do you help children who, through communication or learning difficulties, or home circumstances, may find it hard to express their experiences? Do you involve the SENDCO or educational psychologist in a timely manner?
- How does your education setting build children and adolescents' efficacy in expressing their experiences? Are there sufficient opportunities for staff to build the trusting relationships that enable these conversations?

Early help assessments

Early help assessments and services can play a vital role in identifying what help a child and family require to prevent needs escalating to a point where intervention is needed via a statutory assessment.

Many young people whose cases were examined in the sample of SCRs involving adolescents (see next section) had displayed behaviour that indicated something was wrong long before they reached adolescence, but the underlying cause was not always explored and incidents were dealt with in isolation as they happened.

Several SCRs describe circumstances in which an early help assessment would have generated protective opportunities much sooner in the child's life.

The following example underlines the importance of capturing low-level concerns, recording issues that come to light on a day-to-day basis in order to be able to demonstrate the potential for an early help assessment.

Example The definition of neglect set out in statutory guidance clearly states that neglect includes a 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 related to whether her physical and emotional needs were being met (these included concerns about her weight and apparent malnourishment). However, Child J was not identified at any stage as a child who may benefit from an early help assessment; the lack of a formal assessment meant the potential for identifying neglect was lost. The SCR report also emphasises the importance of a trauma-informed understanding and approach by professionals in order to help the children and those caring for them.

There was little support for another child 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 multiagency support or intervention. The child's risk taking behaviours began to escalate, placing Child S at risk of harm and CSE.'

Learning point

> In making referrals to early help or children's social care, it is important always to use language that describes issues clearly and accurately and provides evidence of the lived reality of life for the child.

Reflective questions

> What tools and processes are in place to enable staff in your education setting to capture and share low-level concerns in order to demonstrate the potential need for an early help assessment?

> What systems are in place to ensure you follow up referrals to see what action has been taken?

Wider family and community resources

A child's wider family and community are valuable partners in safeguarding and important sources of support and intervention.

Through their extensive contact and relationship with children and families, schools and other education settings are well placed to draw on the knowledge and insight of their local community.

The commitment of relatives was evident in a number of SCRs. In one case, a school supported a grandmother to make a referral to the children and families service about the state of the home and the difficulty the mother was likely to face in coping when she left hospital. The mother was given support and the home was cleaned up.

But although wider family can be an important source of information and support for children, SCRs suggest their voice often goes unheard.

Learning points

> Schools and education settings should ensure any concerns about a child reported by wider family, neighbours or anonymously are always accurately recorded and taken seriously by those receiving the information, and that appropriate action is taken.

> School staff may be better placed than other professionals to understand family networks and relationships and feed that information into local safeguarding networks.

Adolescents

Nearly one in three SCRs (115 of 368) involved children aged 11 and over. The two most common causes of serious harm in these cases were (i) risk-taking or violent behaviour by the young person, and (ii) child sexual exploitation.

Teenagers spend less time at home and more with their peers. While harm can continue to come from within the family during adolescence, there is increased potential for extra-familial risk and harm. Both virtual and local communities provide spaces for exploitation.

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

Adolescents about whom there are safeguarding concerns often have early experiences of abuse and neglect, separation or loss and time spent in care. They may have witnessed parental domestic abuse, substance misuse and mental illness. These early experiences can contribute to feelings of worthlessness and lack of self-efficacy in adolescence. Adolescents living with neglectful parents are particularly vulnerable to having their needs overlooked.

Chapter 4 of the report looks at the vulnerability of adolescents using an in-depth qualitative analysis of a sample of 25 cases. It looks at findings in relation to going missing, exploitation, harmful sexual behaviour and social media/online behaviour (see below).

Gaining a holistic understanding

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. Understanding a child's emotional world requires a holistic approach that takes into account past experiences, not only the here and now.

Practitioners can become reactive when working with adolescents who have a history of disturbed or disturbing behaviour. SCRs commonly revealed a focus on isolated incidents (eg, self-harm, violence, going missing) while underlying causes and the lived experience of the child went unexplored.

If schools and other agencies do not share information appropriately, then no one is seeing the full picture of multiple difficulties. Understanding an adolescent's early years, current and changing family situation and wider social networks is vital for understanding their lived experience and risk of harm. (Information sharing is discussed later in the briefing – see page 17.)

Going missing

Children missing from education, or who go missing from home or care, are at increased risk of harm. Episodes of going missing increase the risk of exploitation in the community.

Children missing from education

Poor school attendance is relatively common among the general population (around 8 per cent of children are regularly absent from primary school and 13 per cent from secondary school) but it was also a common SCR finding in neglect cases.

There is statutory guidance in place to safeguard children missing from home or care, and schools have to put in place procedures and policies for when a child goes missing from education. However, although schools should have developed robust procedures, the report noted SCRs in which schools did not take appropriate action.

In one case, a ten-year-old year went missing from education. The school reported the episode to the police and the girl was found, but a decision was made to take minimal action and log the incident 'for information only', even though it was known she had a much older (adult) 'boyfriend'. The event was perceived as an isolated incident, even though the school was aware of the girl's learning difficulties and previous disclosure of violence, which indicated the need for a multi-agency response.

Children missing from home or care

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 response is required. This should not depend on where a child goes missing from or to (eg, abroad).

The local authority has a duty to offer an independent return interview within 72 hours of any child who goes missing 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.)

Return interviews should be undertaken by a trained independent worker who is able to take forward actions that emerge. Interviews are an opportunity for the child's voice to be heard and to find out what prompted going missing.

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).

Learning points

- Schools and local authorities need to follow unauthorised absence and children missing from education procedures, as set out in *Keeping children safe in education* (Department for Education, 2018).
- Evidence gathered in a return home interview should be shared with other agencies, including schools, to facilitate a holistic safeguarding response.
- When children return after having gone missing from home or care, the DSL should be proactive in working with partner agencies and be mindful of any needs identified in the return interviews. They should identify what support they can provide within the school.
- School staff and other practitioners will need ongoing training and support in relation to radicalisation. Partnership working is essential, as specified in Prevent duty guidance and *Working Together* (HM Government, 2015; 2018).

Child sexual exploitation

Child sexual exploitation 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 following is an example of good practice in building trusting relationships with two adolescent females who were sexually exploited:

'Both Y and X's parents described the involvement of one particular member of school staff who communicated well with the children, their carers and agencies on a regular basis and whom Y reported as being only one of two individuals that she could trust.'

As well as supporting the two young people, the school also shared important information with other agencies.

One school was described in an SCR as a 'beacon of good practice' for the support it provided to a male adolescent who was sexually exploited over several years. The school *'worked closely with parents and pupils, put in place practical measures and ensured other agencies were kept informed'.*

Learning points

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

Criminal exploitation

Exploitation can occur in a range of circumstances but when adolescents are missing from care, home or education, or go missing abroad, vulnerability to different forms of exploitation may be heightened.

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

Adolescents sometimes went missing to get away from those exploiting them or because the criminal activity they were being exploited into took them out of their local area.

Schools sometimes sought to manage incidents (eg, minor assault) in-house for fear of criminalising a young person, but this could leave other professionals less able to safeguard the adolescent.

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

Learning point

> Working with adolescents who have experienced or are vulnerable to exploitation requires time to build relationships and trust. Schools and youth charities are often best placed to sustain that work over a number of years.

Harmful sexual behaviour (HSB)

Harmful sexual behaviour (HSB) has been defined as:

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

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

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

Learning points

> Children with HSB are likely to have experienced polyvictimisation and their actions need to be seen within the context of their own maltreatment. There must always be a therapeutic and/or safeguarding response in addition to any criminal justice response.

> Being a victim and a perpetrator can be very closely related, particularly when offences are committed as part of a group; support and safeguarding are required for both aspects.

> HSB can be assisted by use of the internet, via phone or other devices, and can occur in group settings. Shared sexual images can be used for bullying and blackmail to continue abuse.

> Guidance for practitioners in educational settings on responding to HSB, including technology-assisted HSB, can be found on the **NSPCC website**. The National Institute for Health and Care Excellence (2016) has also published **guidance for practitioners working with children and young people who display HSB**.

Social media and technology-assisted harm

Adolescents increasingly use technology and social media to communicate, explore friendships and find information. Those who feel disconnected from family and society, including at school, may turn to social media and online activity in an effort to find a sense of identity and belonging.

However, social media provides fast-changing spaces within which children may be bullied by peers and groomed or exploited by adults.

One SCR describes 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.

Professionals who have built a trusting relationship with a young person are a potential source of help. In one case, a girl who felt too worried to talk to her family about 'sexting' (a male peer was threatening to post images online) and did not want to go to the police because she feared repercussions from the abuser, did feel able to talk to staff at her hospital education service.

Learning points

- As with criminal exploitation (see page 13) some SCRs indicated schools may seek to deal with incidents of 'sexting' in-house to avoid criminalising young people. Staff need to be mindful of the wider dangers; if images are shared further they can be used for bullying or blackmail.
- Online video material can exacerbate existing vulnerabilities, especially if there is little to counter messages relating to extremism, pornography, gaming and criminal and sexual exploitation.
- It is important that teachers and school staff receive ongoing education and support on how to keep children safe online – for example, by making use of advice and resources produced by organisations such as **UK Safer Internet Centre**. Online sexual images of under-18s should be reported to the **Internet Watch Foundation**.
- Guidance about online safety, including specific guidance on sexting and bullying connected with race or faith, is also available from the **UK Council for Internet Safety**.

Loneliness

Experience of loss and separation due to family or social disruption can leave young people feeling lonely and at increased risk of depression and low self-esteem.

Early childhood trauma can also leave adolescents poorly equipped to recognise and nurture healthy relationships, which can lead to loneliness and isolation.

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

Although their use of social media means adolescents are generally more connected than other age groups, social media can also increase feelings of loneliness – through seeing images of the lives of others or by being bullied online.

Learning points

- Building long-term, trusting relationships with young people who are isolated and lonely is key to helping them express their feelings and wishes.
- Signs of loneliness can manifest as withdrawal and lack of engagement at school. Schools may see this as 'troublesome' behaviour and so focus on the presenting behaviour rather than explore what is driving it.
- Loneliness is a subjective but common feeling among young people. Where it appears a young person may be caring for a parent, they should be referred to Children's Services for a young carer's assessment. Loneliness should be considered as part of the assessment.

Suicide and self-harm

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

Learning point

> Non-fatal self-harm is strongly associated with completed suicide and should be referred to health services for a thorough specialist assessment.

Reflective questions

> How confident are you that all education settings understand and follow the correct procedures when children are missing from education?

> What training have teachers and other school staff received around different forms of exploitation and how to respond?

> How are staff made aware of issues relating to adolescent neglect and the links between behavioural issues in adolescence and earlier childhood experiences? (See related resources from Research in Practice **here**.)

> How does your school manage disruptive behaviour? Do your policies take account of young people's vulnerabilities – specifically, how those vulnerabilities may present through behaviour that is perceived as troublesome or disruptive?

> When responding to disruptive behaviour or other concerns, do you involve all relevant professionals (eg, pastoral staff, SENDCO, educational psychologist, virtual school head) at an early stage?

> What are the processes for referring – and following up – concerns about a young person to relevant agencies before they escalate?

> Are staff alert to the difficulty that boys in particular may have in disclosing CSE?

> How well prepared are staff for working with adolescents who may be vulnerable to radicalisation?

> How do senior staff ensure practitioners have the skills and knowledge to support adolescents who are vulnerable because they are being exploited, or are involved in 'risk-taking' behaviours?

> How does your school or setting support children and young people to stay safe online and to understand the potential risks involved when using social media?

> What training have staff received about online safety? Are clear procedures in place for dealing with any issues that arise?

> What training have staff received to make them aware of mental health issues, self-harm and suicide in adolescence? Are there clear procedures for dealing with any issues that arise?

Information sharing and multi-agency working

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

The importance of effective information sharing and communication (between practitioners and agencies) was the most frequently cited category when LSCB survey respondents were asked to identify the main learning topics to emerge from SCRs.

The report finds many examples of schools and other education settings, such as PRUs or hospital education services, supporting children, sharing information with other agencies and making referrals appropriately.

For example, one SCR provided evidence of good information sharing and communication between a school and the youth offending service. Team Around the Family meetings set up by the school ensured appropriate practitioners were engaged in supporting the boy and his parents. (Some other examples are highlighted earlier in the briefing – in the section on child sexual exploitation, for example.)

The report also contains examples were practice fell short of what was needed, however. As highlighted earlier, it appears some schools try to manage some types of incident (eg, minor assault, sexting) in-house to avoid criminalising young people. However, that leaves other professionals without the full picture and less able to safeguard the adolescent.

Delays in sharing information can also hamper effective safeguarding, particularly if incidents are happening frequently in a young person's life. In one case, police notification of a stabbing was sent to a school 15 months after the adolescent had left, but the school do not appear to have responded by informing the police he was now attending a neighbouring college.

Poor liaison between schools and others can also lead to misunderstandings. One 15-year-old girl had a history of poor school attendance (said at times to be as low as 50 per cent) dating back ten years, which the school mistakenly believed was attributable to various illnesses. This was not the case but there was no effective school-GP liaison.

Language

The use of clear and descriptive language is integral to effective information sharing. It can paint a vivid and detailed picture that accurately describes concerns and the context of the child's life; conversely, the use of vague or stock phrases or professional jargon can obscure concerns.

In one case, both school and ambulance staff had made referrals using clear and descriptive language that accurately conveyed a picture of the conditions in which the child was living. However, when the home environment was described in assessments or meetings, the language used diluted the level of concern. A description of the home as *'unsanitary with a foul smell and a fire hazard'* was translated in the minutes of the strategy meeting as *'poor home conditions'*.

Schools and the safeguarding system

Schools and other education settings are an integral part of the multi-agency safeguarding system and it is vital that no setting or service, including those that provide a specialist support role, perceives itself as being outside of that system, as in the example below taken from one SCR:

'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 team 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.'

Learning points

- It is crucial education staff are alert to issues affecting individual children's safety, health and wellbeing and that their knowledge informs multi-agency planning.
- Good quality record keeping and communication of relevant issues with other agencies helps to identify patterns of events, concerns, strengths and unmet needs and to ensure a clear and comprehensive picture of all significant aspects in a child's life.
- If information is not recorded and shared, identifying links between past and current concerns can be missed.
- Records should be maintained – and information shared with relevant partners – for children and families who:
  - Are currently involved with statutory children's services
  - Have been referred to early help services (whether or not support has been accepted)
  - Are eliciting lower-level concerns. Such concerns need to be monitored regularly (at times daily), recorded and addressed; records should be kept up to date and shared so concerns can be triangulated.
- Records and referrals should be written in clear, descriptive and jargon-free language that accurately expresses concerns and captures the lived experience of the child.
- Maintaining and sharing chronologies is useful for evidencing changes and alerting staff to the possibility of cumulative vulnerability and spiralling risks. When multiple agencies are working to support needs and risks over time, cross-service (combined) chronologies are especially valuable.

Reflective question

- How does your school or setting support children who are on a multi-agency plan?

Professional challenge and escalating concerns

While the report finds many examples of schools being instrumental in noticing, alerting and managing potential harm, they were also often aware they could not act as the sole agency. However, if referrals did not meet the threshold for children's social care, for example, it seems schools often failed to challenge the decision or escalate their concern.

Working Together (HM Government, 2018) clearly sets out the need for the three safeguarding partners (local authority, police and health) and other relevant agencies, including educational settings, to *'challenge appropriately and hold one another to account effectively'*.

In one local area, the LSCB realised practitioners were reluctant to 'escalate' a case if they disagreed with a decision by the lead agency (eg, a decision by children's social care to 'step down' or close a case). Practitioners disliked the word 'escalate'; they felt 'escalating' a concern would make future partnership working more difficult. The LSCB overcame this anxiety by reframing the process as 'resolving professional differences' and making clear that differences of opinion are healthy and to be expected.

Learning points

- Disagreements are to be expected and are not unhealthy; they are part of a process of appropriate challenge in reaching the right decision for a child. Local escalation policies should set out clearly how disagreements will be handled and resolved.
- If, after referral, a child's situation does not appear to be improving, the DSL (or whoever made the referral) should press for reconsideration to ensure concerns have been addressed – and, most importantly, that the child's situation improves (*Keeping children safe in education* – Department for Education, 2018: paragraph 34).
- Challenging decisions made by professionals from other agencies requires confidence and the support of senior leaders to enable escalation.
- Leaders should foster a culture of professional curiosity and challenge to support staff development in this aspect of practice.

Supervision and authoritative practice
Supervision is widely used to support children and family practitioners to enable authoritative practice, support reflective practice, critical thinking and analysis. It also provides valuable space to support staff with the often overwhelming feelings that safeguarding concerns may evoke.

Supervision does not feature widely in education settings, however, although there are pilot initiatives for supervision with DSLs (see **here**).

Reflective question

> What supervisory support can the DSL in your education setting access?

Learning points

> Education settings are in a unique position to notice how children are because they have contact with the same child on an almost daily basis.

> A trusting relationship with a member of school staff can offer children support and means they are more likely to confide, including about abuse and neglect.

> Education staff should use the reflective questions in this briefing to review safeguarding activity, information sharing and working together in response to safeguarding concerns.

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