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

Messages for child and family social care from SCRs conducted 2017–19

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Part 1: Introduction and key data

About this briefing

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

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

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

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

Who this briefing is for

This briefing[1] is for:

- All practitioners working in child and family social care, and their frontline managers
- Senior managers and strategic leaders
- Child protection conference chairs
- Family court advisers.

It will also be relevant for many practitioners working in family help and wider early help services.

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

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

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

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

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

What is a serious case review?

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

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

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

The new system

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

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

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

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

The 2017-19 analysis report

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

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

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

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

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

Themes and trends across SCRs 1998-2019

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

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

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

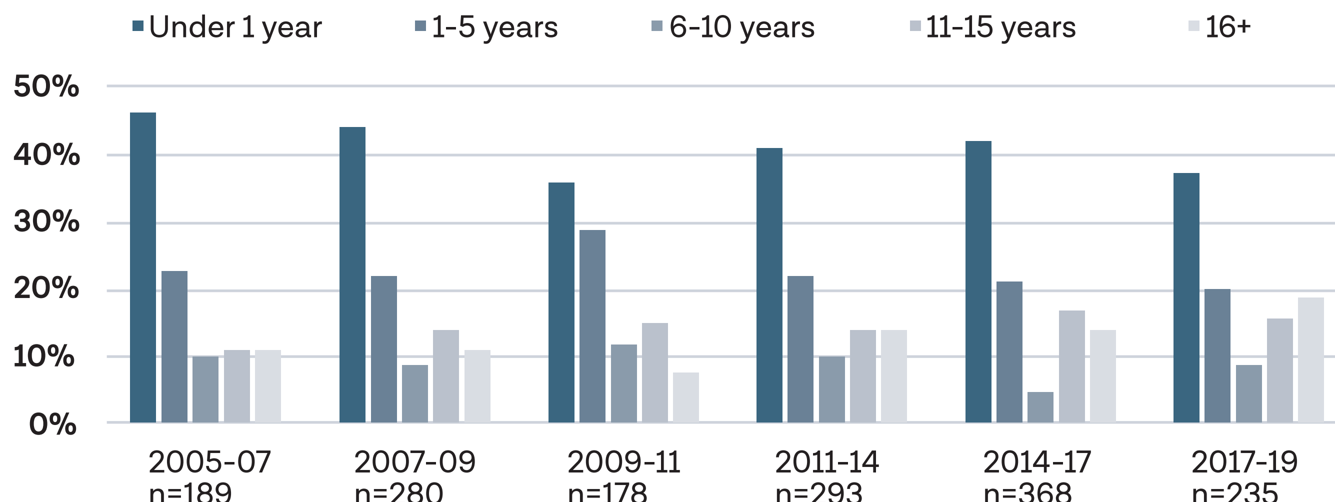
In their analysis of trends since 1998, the research team reflect on why periodic analyses of SCRs have so often identified repeat messages (Dickens et al., 2022b). They note that safeguarding practice is not only inherently complex, challenging and often ambiguous, it is also directly affected by a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

Key data from the 2017-19 SCRs

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

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

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



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

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

Table 1: Categories of death 2014-19 SCRs

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

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

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

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

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

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

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

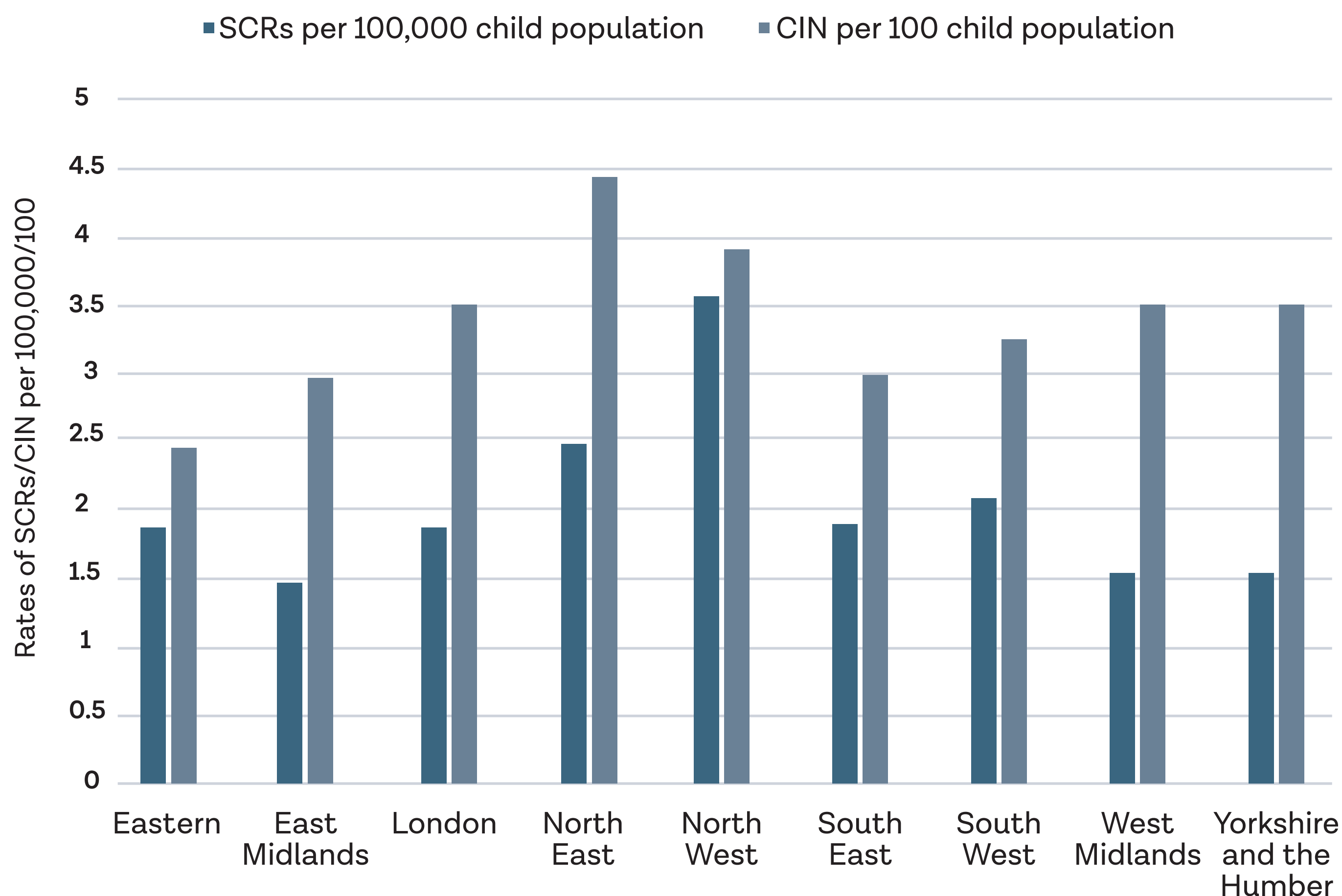
Category of serious harm*	2009-11 (%) n=60	2011-14 (%) n=96	2014-17 (%) n=162	2017-19** (%) n=98***
Non-fatal physical abuse	31 (52%)	50 (52%)	83 (51%)	44 (45%)
Neglect	6 (10%)	14 (15%)	30 (19%)	22 (23%)
Child sexual abuse – intrafamilial	6 (10%)	13 (14%)	16 (10%)	13 (13%)
Child sexual abuse – extrafamilial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

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

- **Neglect:**
  - There was evidence of neglect in three-quarters (124 of 166) of all SCR reports examined; features of neglect were apparent in two-thirds (66%) of fatal cases and nine in ten (90%) non-fatal cases.
  - Neglect was the primary cause of harm in 21% of non-fatal cases in 2017-19, more than twice as high as in 2009-11 (10% of cases).
- **Ethnicity:**
  - Where known, ethnicity of the children involved in SCRs was broadly consistent with earlier review periods: 73% of children were white/white British, 10% black/black British, 9% mixed race, and 6% Asian/Asian British. (In 18 (8%) of the 235 SCRs, ethnicity was not stated anywhere.)
- **Disability:**
  - One in four (25%) children at the centre of the SCRs analysed in depth were reported to have an impairment or disability at the time of the incident – up from 14% in 2014-17.
  - In particular, there was an increase in the numbers of children with a social/communication disability or complex/combined disability.
- **Where children were living:**
  - At the time of the incident, most children were living in the parental home (81%) or with relatives (3%), and 5% were living with foster carers.
  - Although overall numbers are small, death and serious harm also occurred when children were living in a supervised setting; for example, 4% of children were in hospital, a children's residential home, or a mother and baby unit.

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

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



Parental and family characteristics

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

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

Table 4: Parental characteristics: 2017-19 SCRs

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

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

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

Table 5: Family characteristics: 2017-19 SCRs

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

Child characteristics

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

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

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

Table 6: Child characteristics: 2017-19 SCRs

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

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

Normalisation of neglect in areas of high deprivation and poverty

As with earlier periodic analyses, loss of focus on neglect in the context of poverty was a key feature of the 2017-19 SCRs. This was most often observed among those working with families in areas of high social and economic deprivation, where professionals could become de-sensitised to endemic levels of poverty or feel powerless to do anything in the face of poverty; in these circumstances, neglect could in effect become 'normalised'. As one SCR where neglect was a feature highlighted:

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

When there were concerns associated with poverty (e.g. poor housing, debt), or when practitioners had developed low levels of parenting expectations, neglect and its impact were sometimes inadvertently downplayed, leading to practitioners focusing on the provision of practical support and failing to follow through with attention to neglectful parenting itself. Practitioners may also have been unwilling to stigmatise parents or appear judgmental by identifying neglect in families.

> ***[There are] a number of reviews underway […] where there has been a delayed response to aspects of neglectful parenting, and in many of these cases the families have experienced significant poverty which appears to inhibit professionals from being assertive in their interactions with parents, meaning they do not respond to clear risks presented to children.***
>
> ***Professionals lost sight of the domestic abuse and violence that had been reported and became focused on the housing situation; the view being that if the family had secure and appropriate housing then "everything would be alright".***

The relationships between poverty and neglect and abuse are complex and have been debated over many years (Bywaters et al., 2016, 2022). Of course, not all poor children are neglected and not all neglected children are poor, but poverty is widely accepted to be a 'contributory causal factor' for abuse and neglect (Bywaters et al., 2016, p. 33). The 2015-17 periodic analysis observed:

> *Where good practice in neglect cases was noted, the quality of relationships with families was apparent as the primary vehicle for supportive and protective practice. This is particularly so when it is rooted in a sound grasp of the family context and roles and relationships, as an effective way of managing the complexity of compound and cumulative risks of harm over time.*
> (Brandon et al., 2020, p. 219)

Providing practical support is important not only for meeting families' needs but also because it helps to build the trust and relationships with families that are the essential foundation for relationship-based practice; but this should never be at the expense of looking at other underlying risk factors within the family. This was also an issue when parents were being supported by adults' services, such as drug and alcohol or mental health services; workers' focus on parents' own needs and behaviours did not always include consideration of their ability to adequately parent their child.

Learning points

- Neglect rarely occurs on its own (Daniel et al., 2010b). It is commonly accompanied by physical or emotional abuse and is often a factor in child sexual abuse or exploitation.
- Neglect can sometimes mask other forms of harm. In 8 of the 10 SCRs (examined in depth by the research team) in which intrafamilial child sexual abuse was a feature, neglect had 'dominated' interactions with professionals; sexual abuse then continued despite ongoing social care investigations or support.
- Older children in particular can become adept at hiding the impact of neglect (Ofsted et al., 2018), and their presenting behaviours should be considered as possible masking or surviving strategies.
- Practitioners need to have a clear understanding of the interaction between neglect and deprivation and be able to address both in their work with children and families.
- Assessment needs to tease out where inadequate parenting relates to social, environmental or parental risk factors (e.g. parental depression, substance use, homelessness, mental ill health). Addressing such practical and contextual problems may be an essential element in tackling entrenched difficulties – such as lack of parenting skills, inappropriate expectations of children or a breakdown in parent-child relationship – that are a barrier to effective care-giving and a key feature of neglect (Glaser, 2002).
- Assessment tools for neglect can be helpful, but these need to be used consistently across all services and by professionals who have been trained in their use. Their use is likely to be more effective when sector and service leaders work together to develop a local culture of collaborative working. Some local areas are implementing a local neglect strategy (at partnership level), which includes the use of recognised neglect assessment tools by all professionals.

Understanding the child's daily life

A number of SCRs found that professionals had paid insufficient attention to the lived experience of the child's daily life. This sometimes included inadequate safety planning before the birth of a child. Children who were the subject of SCRs were often viewed through a single lens. For example, practitioners focused on a child's disability or health condition, or there was insufficient focus on the lived reality of the child's life even though the family was known to services and seen regularly.

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

- considering the child's life in different contexts (in the community as well as at home, for instance)
- thinking about all aspects of the child's health and wellbeing (not just one in isolation)
- reflecting on the impact of past experiences (including their cumulative impact)
- exploring and reflecting on how the child may be experiencing decision-making, planning and professional intervention.

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

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

> ***[A child] who has significant developmental and communication needs, was effectively 'hidden' from view, having apparently not been seen by any professional since the age of 14 months [to 9 years]. The effect of the toxic stress and maltreatment that all the children suffered has been recognised to have compounded Billy's learning difficulties and his confirmed diagnosis of autism.***

'Hidden in plain sight'

Maltreatment of children who are disabled or have a chronic illness can sometimes be 'hidden in plain sight' (Franklin et al., 2022, p. 77), with the disability seen first and the possibility of abuse not considered. This was a problem across all services, including health services (this is discussed more fully under 'Being alert to behavioural indicators'). In the following example, there were longstanding concerns around neglect, antisocial behaviour and non-attendance at school, but practitioners' focus on the parents meant that attention was deflected from the children. Later, it emerged that these issues had masked intrafamilial sexual abuse, which prompted the SCR.

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

Sometimes, when children did disclose abuse or neglect, a parent's explanation of what had happened was taken at face value. For example, one child said that his mother's partner was responsible for his facial bruising, but the partner's explanation that it was a result of 'rough play' was accepted. Another SCR reported that two children placed in kinship care told the social worker that their carer was hitting them, but nothing was done. This inaction can act as a barrier to disclosures about other aspects of children's lives, in this case sexual abuse.

Trusting relationships

The quality and meaning of a child's relationship with their social worker is key in helping to understand their daily life. Children's trust can be compromised by their previous experiences with professionals, particularly if they feel that their views have not been considered during decision-making or, ultimately, have not influenced decisions. One SCR in relation to a young adolescent who had died by suicide found evidence of workers having explored her views, hopes and worries, ***'but it is not evident how these influenced the analysis or planning or decision-making'.***

Trusting relationships are not necessarily established simply by the duration of the practitioners' involvement, as illustrated in the following SCR where the child had social work involvement for a number of years. For the child, what matters is the quality and meaning of the relationship.

> ***'I didn't feel the social worker was relevant to me. I was asked the same questions and gave the same answers. They wouldn't show up for another six months….There were too many social workers to know what was happening.'***

Children's experience of decision-making

In another SCR where a child died by suicide, the social worker understood that the young person did not agree with a planned placement move that was judged to be in her best interests. The review found that the decision was justifiable and that the social worker had worked hard to help the girl understand the decision. Nevertheless, she became more reluctant to work with her social worker and other professionals before then taking her own life.

Although there was some discussion in SCRs about whether professionals had been able to gauge children's wishes and feelings and how they had been documented, there was far less discussion of how children's views had informed decision-making. Discussion was more evident in SCRs involving adolescents than those involving younger children, but even so 'it often seemed as though the young person was being consulted and informed of a decision, but it was not always clear how their views had influenced the decision-making process.'

The wider family network

The periodic analysis highlights the lack of consideration and involvement of children's family networks; this includes older siblings and grandparents, as well as fathers who were not living with the child. One SCR found that 'insufficient consideration' had been given to information provided by former partners of the child's mother, all of whom were said to be 'fearful' of the mother. In another SCR, the maternal grandmother was not told about the father's history of sexual abuse and harmful behaviours and was not involved in the team around the child meetings.

Learning points

- A trusting relationship between a child and their social worker is key to effective safeguarding practice, as is seeing children on their own; this can help the child feel secure enough to share their concerns and feelings.
- Practitioners need the time and skills to build relationships and get a sense of each child's daily life. Senior managers and leaders should make every effort not to allow resource and other constraints to undermine opportunities for building and maintaining relationships.
- The wider family network can be a protective resource for children; where appropriate, practitioners need to seek out family members and listen to what they say, as they are often in a position to share information and 'speak up for the child'. Practitioners need to be mindful that:

  It can be difficult for family members, e.g. grandparents, aunts and uncles, to 'report' family members to agencies and they need to be approached by practitioners.

- Where children do talk about abuse, it is vital that professionals act on the disclosure.
- Practitioners should remain alert to how children are experiencing professional interventions, actions and decisions.

Being alert to behavioural indicators

Because of the difficulties children face in disclosing abuse and neglect to adults, their behaviour may be the key indication that something is amiss; this is true for both younger and older children. Children may be reluctant to disclose abuse (particularly sexual abuse) through fear of not being believed or because they fear family breakdown, as in the following example:

> ***'I felt I had no privacy and couldn't tell anyone, but at the same time I didn't want to move from my family. I used to put on a happy face to hide my problems. I didn't want people to know. I told Mum about the sexual abuse, but I didn't make it clear what had happened. I told Sibling 1, but he didn't believe me cos I'd told so many lies.'***

Some children displayed behaviours that may be indicative of abuse (e.g. aggressive, challenging and sexualised behaviour), but these non-verbal signs were often missed or attributed to other causes. For example, an adolescent was sexually abused over a long period by her mother's partner. Her challenging behaviour was attributed to ADHD, neurodevelopmental disorder and learning disability, and 'there was a lack of curiosity about an alternative narrative even when her behaviour changed'.

One SCR concerned two children in a kinship care placement who had been sexually abused. The behaviour of one of them became 'so extreme' that she required placement in a special school for children with emotional and behavioural difficulties. The girl spoke to the SCR author about her experiences. She said no one had asked her about the changes in her behaviour or spoken to her alone:

> ***'We used to have to be so careful as the family were in the room. We never got offered to be seen alone – maybe we should just have been taken. Social workers could have taken us out, they just used to sit us down at home. I would have loved to have gone out without my siblings. Everything you said to the social worker got repeated back to the carers anyway.'***

The siblings were in local authority care and had regular contact with social workers, but they were torn between wishing they had a chance to tell the social worker and fear of doing so.

> ***Despite agency involvement her behaviour within school continued to raise concerns. She was continually aggressive and violent to both staff and other pupils and used sexualised behaviour and language that was inappropriate for her age.***

> ***The youngest child had shown signs of sexually reactive behaviour and had possibly re-enacted their own experiences of being abused. Although they did not make a disclosure, they attempted to engage in sexual activity and initiated sexual contact with other adults and children.***

Research shows that neglected children rarely ask for help on their own behalf. The experience of neglect is likely to erode the capacity to seek help, and, in addition, children who are neglected may have little experience against which to gauge what more effective parenting would feel like (Daniel et al., 2010a).

> ***The act of reporting the neglect may also be something that is challenging for older children to do. It is crucial to remember that their behaviour, especially changed behaviour, might be a form of communication and an opportunity to open conversations should be noted by professionals in contact with these children.***

Learning points

- Where there are safeguarding concerns, practitioners should not rely only on verbal disclosure. They need to be attuned to what children and young people's behaviour might be signalling, particularly when there is a change in behaviour or if children behave differently in different contexts.
- Professionals should not assume that challenging behaviour in a child with a learning disability is due to their underlying condition or parenting; it may be, but practitioners need to take a holistic approach that considers possible alternative causes.
- Young people with learning disabilities are at greater risk of abuse and may only display their distress through their behaviour. Disabled children are around three times more likely than their non-disabled peers to be abused; they are also more likely to receive a poor response from professionals (Ofsted et al., 2020).

Lack of action following disclosure of sexual abuse

Even when a child did make a disclosure (e.g. of sexual abuse) while living at home, it did not always result in action to safeguard them. One SCR reported that in a family with a history of child sexual abuse, a boy had told his paternal grandparents about a relative 'getting his winky out'. The boy was spoken to by the social worker but said no more about this, except that his relative 'often lied and hurt him every day'. The strategy meeting concluded that

> ***… no child protection enquiries were required as 'no immediate child protection issues were raised' and 'no immediate safeguarding actions' were required….***

In another SCR, professionals from other agencies raised concerns to social care for around nine months about a child's extreme sexualised behaviour. Despite this, a Section 47 enquiry was not instigated, apparently because professionals were waiting for a verbal disclosure from the child before taking action.

> ***The paediatrician stated that she had made it clear to those in the [strategy] meeting that she had a high level of suspicion that [the child] presented with injuries of sexual abuse and was advising that a specialist sexual abuse examination needed to be arranged immediately….the children's services manager said there is 'no disclosure, only suspicion of sexual abuse and therefore insufficient evidence to reach threshold for Section 47 …'***

The child subsequently presented with genital injuries, but again professionals were uncertain about what actions could be taken in the absence of a clear disclosure. Not responding placed her at further risk and potentially jeopardised investigations. The SCR concluded that some professionals had felt the need to have a criminal burden of proof to commence Section 47 enquiries. This was contrary to *Working Together* guidance (HM Government, 2018), prevented effective safeguarding and contributed to the child remaining at home with her abuser for many months.

Learning points

- Professionals need to recognise sexually inappropriate behaviour as a 'red flag' for sexual abuse and consider this fully in a multi-agency forum. They should be prepared to start detailed investigations without waiting for a verbal disclosure.
- The response to a disclosure should not only be investigative, it also needs to be sensitive and supportive to the child and to the non-abusing parent/relatives. This is skilled work and practitioners need to be supported to get the balance right (Ofsted et al., 2020).
- Deception by perpetrators was a key feature of SCRs where there was child sexual abuse. This included deceiving other family members, not just professionals. Practitioners need to be alert to the likelihood of deception and coercion and be ready to investigate this.

Achieving best evidence (ABE) interviews

There was evidence in some SCRs of the police and children's social care taking different approaches to interviews with children when child sexual abuse was alleged, as in this case.

One SCR describes how a strategy meeting about a four-year-old child decided against an ABE interview, but an interview was subsequently agreed when the case was transferred for investigation. Although local protocols were for ABE interviews to be arranged within 24 hours of a strategy discussion, the interview took place four months after the allegation was made. The delay, which is described as 'unavoidable' (although no reason is given), is likely to have had an impact on the child's ability to recall events.

The uncertainty in this case may reflect a difference between police and social care about whether the interview's primary purpose is to enable the child to talk about what has happened so they can be supported (social care perspective) or to gather potential evidence for use in a criminal prosecution (police perspective). ABE good practice guidance emphasises the importance of careful planning for the interview and is clear that the safety and welfare of victims 'takes primacy over the needs of the investigation' (Ministry of Justice & National Police Chiefs Council, 2022). The SCR concluded:

> ***Where there are suspicions that a child has been sexually abused the strategy meeting should ensure that a process for determining the need for Achieving Best Evidence interviews should be in place and that planning for any proposed interviews is consistent with best practice.***

In order to ensure that ABE interviews are conducted promptly and effectively, there has to be a sufficient number of social workers and police officers trained to do them. This was identified as a concern in the 2014-17 periodic analysis (Brandon et al., 2020) and continued to be an issue during 2017-19.

Learning points

> Children's social care leaders should work in collaboration with police leaders to ensure that enough social workers and police officers are trained in ABE. Where possible, this should include joint training, as this provides an opportunity for police and children's social care practitioners to build relationships and better understand each other's role.

The experiences and behaviour of older children

As noted earlier, one in five (19%) SCRs in 2017-19 involved a young person aged 16 or older – a significantly higher proportion (11% of SCRs) than in 2005-07. Many of the SCRs involving adolescents describe multiple, cumulative and longstanding difficulties in those children's lives. Young people were often at the centre of considerable professional activity, but this had not always generated significant insight into what their lives were like.

Although trusting relationships could sometimes be identified in these young people's lives, one issue to emerge from the SCRs concerning adolescents who died by suicide, and some who were at risk from child criminal exploitation, was the number of relationships that young people were expected to sustain as risks increased and professionals worked reactively to crisis situations. Potentially, this could be overwhelming.

It is important that practitioners seek to gain an understanding of a child's past as this can have a major impact on the way they behave as they get older. Many young people subsequently came to the attention of the police for offending behaviours and were seen as criminal rather than victims. Thinking about a child's past may also help to counter the risk of 'adultification', whereby children are treated as though they are older than they are.[5] This was evident in a number of SCRs. Practitioners perceived young people as 'streetwise', 'resilient' or 'mature', and their true vulnerability was hidden.

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

Firmin (2017) has highlighted the importance of thinking about children in the different contexts in which they live (contextual safeguarding). One SCR pointed to the challenge practitioners face in bridging contextual safeguarding approaches with intrafamilial safeguarding, where children are vulnerable in their families and also at risk in and to their communities.

Learning points

- All professionals who have contact with children living in areas where violence and antisocial behaviour are significant factors within the community should consider those children vulnerable to serious harm. This includes young people who may themselves perpetrate some of the violence or antisocial behaviour.
- 'Poly-victimisation' refers to the experience of different types of abuse over time (Finkelhor et al., 2007) and can help practitioners to consider and respond to the impact of cumulative harm that young people have experienced across their childhood and adolescence.
- The behaviour of young people who are known to have experienced early harm or who are living in care may be attributed too readily to their early childhood experiences and placement moves. Practitioners need to be alert to the possibility that a young person's behaviour may be an indication of current harm.
- Where multiple agencies are involved in a young person's life – as with some young people who were at risk from child criminal or sexual exploitation and some young people who died by suicide – it may be necessary to liaise to ensure that the young person is not overwhelmed by having too many practitioners involved in their life at the same time. This means it may be necessary to prioritise different elements of support for the young person.

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

Engaging parents and effective challenge

Relationship-based practice is at the heart of working with families and effective safeguarding practice, but a supportive approach needs to encompass and be balanced with a sufficient level of challenge to parents. The research team note the tensions practitioners can face in adopting a 'curious, challenging and investigative stance' while also maintaining partnership with parents. One SCR found that practitioners had felt compromised between maintaining a relationship with the parents, which allowed them some access to the children, and challenging the parents, which resulted in access being denied. As another SCR notes:

> ***Engagement is a legitimate and important objective but an exclusive reliance on engagement, if accompanied by a reluctance to make use of personal, professional and statutory authority, may not serve young people well.***

Professionals sometimes didn't ask key questions because they found parents 'too difficult' to engage; instead, they accepted parents' accounts of a situation. SCRs also describe examples of parents refusing to acknowledge children's behaviour difficulties, deliberately misleading professionals and sometimes displaying 'outright hostility and physical intimidation'. One family did not allow their children's allegations of child sexual abuse to be investigated, which resulted in 'No Further Action'. In some cases, non-abusing parents 'made strenuous attempts to prevent investigations'. Another SCR notes that the mother held a professional position and that her knowledge of child protection procedures may have led professionals to be falsely reassured, preventing them questioning her account of events.

However, SCRs also highlight some examples of good practice where professionals did persist, challenge and exercise curiosity:

> ***The health visitor and family worker tried on numerous occasions to visit the family. They showed good professional curiosity by speaking with neighbours and the landlord. They left messages, wrote letters in the family language and sought to check social media to try to trace and speak to the family...***

SCRs highlight the anxiety and fear practitioners faced in their interactions with some parents, which sometimes led to practitioners appeasing parents to preserve their own safety. This has implications for practitioners' ability to exercise the authority needed to keep children safe, sometimes meaning that children were not seen alone or their needs were not recognised.

> ***Describing their relationships with the family, one worker was reminded that the door would be locked after she went into the house ... She was only once able to speak to one child alone, the rest of the time they were seen collectively.***

Cultural difference

Some SCRs identified potential gaps in practitioners' cultural competence when challenging parents from diverse backgrounds. As one SCR noted, this can contribute to ***'a lack of curiosity and potentially a reluctance to ask or challenge things in case this may be viewed as offensive'***. One SCR found that biases and assumptions about a Traveller family had led to the children being identified as perpetrators rather than vulnerable in their own right.

> ***Professionals that worked with the family had a varying understanding of how to work with travellers, poor knowledge of cultural beliefs and lifestyle. For some professionals this was the first case that they had worked with traveller families. The visits and interaction with the family became overly focused on recording what they had observed rather than analysing and assessing the impact of the situation in relation to the safety of the children.***

Learning points

- Engagement with families is key to effective support and investigation. If families do not engage, practitioners need to consider the possible underlying reasons and the likely outcomes for the child, while maintaining a sufficient level of challenge.
- There are many reasons why parents may not engage or may respond in a hostile or argumentative manner – for example, shame, embarrassment, fear or stigma (Forrester et al., 2012; Turney, 2012) or because their experience of professionals is that they are 'uncaring, unsupportive and judgemental' (Smithson & Gibson, 2017).
- Practitioners need to be alert to the fact that deception was a key feature of SCRs, particularly where there was intrafamilial child sexual abuse.
- In order to maintain a stance of professional curiosity and child focus, all practitioners need to feel physically and psychologically safe. Organisations should have robust policies in place, including joint-visiting protocols and lone-working procedures.
- Staff also need space and support to discuss and process the powerful emotions evoked by challenging encounters. Supervision and organisational cultures which allow this are important, yet research points to a lack of support for professionals in response to 'stressful and frightening circumstances' (Hunt et al., 2016).
- Practitioners should be supported to develop the confidence and skills to work with families from culturally diverse backgrounds.

Information sharing and effective communication

Effective multi-agency working and communication are crucial for supporting families and safeguarding children. This is especially important when a family is being supported by multiple services, as inadequate information sharing may mean that 'there is no coherent overview of the daily lived experience of children'. One SCR author noted that they had:

> ***…concerns as to the way in which professionals have worked together in terms of the identification of safeguarding needs and the lack of escalation of these to provide Child […] with an appropriate level of help and protection.***

A key theme identified in the 2017-19 analysis was a crucial distinction between exchanging information and communicating effectively. There were a number of examples of one agency having information that indicated risk to the child, but this was either not accepted or not understood by the wider professional network:

> ***… lots of information was exchanged, but was not shared, interrogated or its importance properly understood… Multi-agency work requires staff to be alert to their own "professional cultures, languages and knowledge base" and to be ready to "translate" this to other professionals.***

Reporting and recording systems

Inadequate reporting and recording systems were noted in some SCRs. One SCR noted that 'two separate systems' for working with a family were operating within the same local authority children's services department:

> ***… one focussed on managing a family in the community who disrupted life for their neighbours and a separate process focused on the child protection system that protected and safeguarded children. Although both came under the remit of children's social care to those outside the system, within children's social care the processes were quite distinct and information shared in one forum was not automatically available to another.***

Risk assessment

Inadequate (or missing) risk assessments of the potential risks posed by perpetrators, and the sharing of these, was a recurrent feature of SCRs where there was child sexual abuse.

> ***The assessment was never updated or reconsidered in light of new information, such as when an adult female made allegations of sexual abuse against the children's father. This led to the risk of sexual harm to the children being unassessed.***

Another example relates to a girl in a family where her siblings had been removed due to sexual abuse by her father.

Following assessment within care proceedings, the girl was returned to her mother's care under a supervision order. The mother then started a new relationship with a man who subsequently abused the child. There was minimal acknowledgement by children's social care of the risks faced by this child, given the significant abuse that had occurred previously in the family.

> ***Given the concerns about [mother], her past history and research about how perpetrators target children and groom families, this information, contained in [Forensic Psychologist's] report did not lead, as it should have done, to a risk assessment on [mother's partner]…***

This minimal acknowledgement was further illustrated when the girl retracted an allegation. Despite pre-existing concerns that this might happen and uncertainty about the mother's ability to protect her, the retraction was not considered in a multi-agency forum. This resulted in the child remaining at home with her abuser and suffering further abuse.

> ***… what was missing was any evidence that the content, context and circumstances of Jane's retraction had been as carefully and well considered by CSC and agency partners as was her initial allegation.***

Communication with health agencies, including diagnoses

Sometimes, important information was shared by health services, but that information or its implications were not fully understood by other practitioners supporting the child. One SCR was prompted when a young person, supported by mental health services for several years, severely injured a younger child. The review found that the significance of his diagnosis of conduct disorder had not been fully understood by those outside mental health services.

> ***Without clarity across the professional network of the … diagnosis and its significance, the level of concern reduced … There was no overt articulation by mental health professionals of the implications of this diagnosis.***

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

Another SCR highlighted that a health practitioner, in this case a GP, had been treating a child in the absence of crucial information.

A baby's mother reported that there was blood in her child's nappy, but the mother did not attend a follow-up visit with the GP. The father had previously abused other young children, but that information had not been shared with the GP. The bleeding may not have been the result of abuse – but the lack of information at the GP's disposal prevented a holistic understanding of the situation.

Learning points

- Information sharing is necessary but not sufficient for effective communication between professionals. Practitioners should remain mindful of how other professionals may interpret any information they provide.
- On receiving new information all professionals in the child's network should reflect individually and collectively on the question: 'What does this mean for the child?'
- Phone conversations and meetings provide opportunities for professionals to 'translate' the significance of information to others outside their discipline and what it means for the child. Good inter-professional communication involves listening as well as explaining; dialogue between professionals is an important opportunity for asking questions and generating alternative hypotheses about the meaning of information.
- Effective communication is vital when families move between areas. Local authorities should ensure that a handover discussion takes place. A number of SCRs identified cases that were not picked up by the receiving authority, particularly if the transfer was made via email or entry into an electronic system.
- When known perpetrators are living with families, social care should share that information with other professionals working with those families so that they can be alert to any potential signs of abuse. Children's social care should undertake robust up-to-date risk assessments, which should be reviewed regularly – particularly if new information becomes available.
- The Child Sex Offender Disclosure Scheme, or 'Sarah's Law',[6] allows parents to ask police if someone with access to their child has been convicted or suspected of child abuse. Managers and sector leads should consider how the scheme can be better promoted to families.

6 For information about the Child Sex Offender Disclosure Scheme, see **www.gov.uk/guidance/find-out-if-a-person-has-a-record-for-child-sexual-offences**

Professional disagreement and escalation of concerns

The 2017-19 analysis highlights difficulties in the 'escalation' of concerns in response to increasing risk. When they had reason to challenge a decision, practitioners often found it difficult to 'make their views heard'. A key area of professional disagreement was around the threshold for children's social care involvement; referrals from other agencies were often rejected without explanation or suggestions for alternative support. Some education practitioners reported feeling 'powerless' and that their professional judgment 'was not valued' by social care. In one case, a school had used pupil exclusion to force the involvement of children's social care because staff were increasingly concerned about the safety of a child.

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

Other SCRs describe professionals who raised concerns and had evidence of risk being 'overruled' in the decision-making process. Professional power appeared to play a role in cases where professional challenge was shut down. Practitioners can be reluctant to use escalation processes if it means directly challenging senior professionals (within and across agencies). In some cases, formal processes for escalating concerns were not clear.

One SCR describes how, following disclosure of child sexual abuse, a GP appropriately referred the child to the MASH (multi-agency safeguarding hub) to arrange a medical examination. This was deemed unnecessary, and the child remained at home and was further abused. The decision not to go ahead with the examination was made by a senior manager, although she was not aware at the time of advice that had been given by the designated doctor. The SCR reports that this decision was 'accepted by practitioners of all disciplines without further challenge'.

Another reason for lack of professional challenge was a 'shared acknowledgement' among professionals of the pressures facing local services 'in terms of workforce capacity, caseloads and reduced funding'. Not only did this mean that practitioners were sometimes reluctant to challenge decisions, in some cases it led to a decision not to refer at all.

Learning points

- Discussion and respectful challenge is integral to collaborative working. Effective interprofessional working means staff being supported and having the confidence to ask questions and pursue concerns if they are unhappy with the decisions or actions of colleagues. Crucially, it means all professionals being open to challenge and ready and willing to answer questions about their decisions or judgments.
- Professionals may be reluctant to use 'escalation' processes if it means challenging senior workers. The 2014-17 periodic analysis found that the terms 'escalation' and 'dispute' can feel adversarial, but reframing the issue as 'resolving professional differences' rather than 'escalation' may help in creating opportunities for constructive inter-professional dialogue (Brandon et al., 2020).
- Organisations should work together to create an inter-agency culture, supported by clear and widely understood guidelines, that makes it easy for professionals to raise any concerns around decision-making as a way of resolving professional differences.
- All professionals need to have the skills and confidence to challenge decisions and escalate concerns where there is tangible evidence of a safeguarding risk.
- Local authorities need to have clear policies and procedures to inform other professionals of their decisions and how they can formally challenge the decisions.
- Escalation policies need to be formalised; where disagreements are dealt with informally rather than through formal channels, this can result in potentially constructive dialogue between agencies being shut down.

A system-wide response

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

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

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

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

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

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

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

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