Serious Case Reviews 2016-2020 Briefing Paper

Surrey Safeguarding Children Partnership

Contents

1 Introduction

Serious Case Reviews (Working Together 2015) and Local Child Safegarding Practice Reviews (Working Together 2018) are commissioned in cases where abuse is known or suspected and a child has died or been seriously harmed.[1] The purpose of a Serious Case Review (SCR) or a local child safeguarding practice review (LCSPR) is to ensure that the local safeguarding system is able to learn from these cases, identifying issues/potentially modifiable factors as well as learning from good practice and that demonstrable improvements are made in the quality of safeguarding practice. Learning reviews are not about apportioning blame or making hindsight judgements but are about improving the quality of practice.

This briefing report has analysed 13 case reviews[2] over the last 5 years in Surrey. This review has identified the features of the cases, the nature of harm experienced by the children who were the subject of each Serious Case Review or internal case review and the key themes. When reading the case reviews, we identified the very complex lives lived by these children and their families in our County and the challenges faced by agencies in supporting these children and keeping them safe from harm.

The purpose of this briefing report is to share the learning from local SCRs and other local reviews across all agencies in Surrey so that the quality of our practice with children and families improves. We have a responsibility to demonstrate that we are learning and taking action to improve practice from the experiences of children and families who have died or experienced serious harm whilst subject to our support and intervention. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.

In this briefing report of Surrey SCRs we aim to

- understand the key issues, themes, challenges and highlight the implications for practice.
- draw upon the learning from both academic research and practice guidance.
- Ensure opportunities for improvement are shared with all agencies who work with children and their families in Surrey.
- include a series of reflective questions that can be used to guide and promote learning with individuals or groups of practitioners.

[1] Working Together 2015, defines serious harm as, "Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following: • a potentially life-threatening injury; • serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development., Chapter 4, paragraph 17, p. 76

[2] Sally and Simon SCR, (2016), HH, II, JJ SCR (2016), KK SCR (2016) and LL SCR (2016) , Child A SCR (2017), Family Cape SCR (2017),Child G SCR (2018), Child D SCR (2018), Child F Partnership review (2018), Family Blue SCR (2018), Child Z (Hampshire) SCR (2019), Rapid Review Report 2020

2 Identified child vulnerabilities and risks

The findings of the recently published DfE report, *Complexity and Challenge: a trienniel analysis of SCRs 2014-2017 (*March 2020) [3] found the following:

- The most prevalent parental characteristic reported in these SCRs was mental health problems, particularly in the mother (noted in 47% of SCRs) but also in the father or father figure.
- Parental alcohol or substance misuse were each noted in 36% of SCRs. In 37% of SCRs parental adverse childhood experiences were noted. Of particular note was the number of SCRs reporting parental criminal records (30% of SCRs, of which half reported [4]violent crime).
- Nearly half of SCRs involving children over 6 years of age reported mental health problems in the child; 24% reported alcohol misuse; and 29% drug misuse.
- Fourteen percent of children in these SCRs were reported to have a disability prior to the incident.
- In terms of practice nationally, they also found persistent and recurring themes relating to case management in the sample included: the recognition and identification of risk; the use of risk assessment and planning to provide a structured framework for intervening to protect children; and the provision of appropriate oversight to ensure that assessments and plans are purposeful and outcomes-focussed.[5]

Within Surrey the cases reviewed in this report included children subject to a range of safeguarding risks and the cases identified that there were a number of risks present including;

1. Chronic neglect
2. Domestic abuse including coercive control
3. Emotional abuse
4. Physical abuse
5. Sexual abuse
6. Adolescent Vulnerability and Safeguarding
7. Parental mental health
8. Parental substance misuse

Along with a range of practice issues including;

1. Listening to the voice and experience of children

[3] DfE report, *Complexity and Challenge: a triennial analysis of SCRs 2014-2017 (*March 2020)
[4] Ibid
[5] ibid

2. Asesssment planning and intervention
3. Special guardianship orders
4. Effective multi-agency working
5. Information sharing
6. The need to 'Think-family'
7. Issues of escalation and professional disagreement including stepping down (de-escalating concerns)

2.1 Chronic neglect

National and local evidence shows that neglect is more likely to be identified in 0-4-year olds followed by the 10-14-year olds. Nationally, 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.

According to the NSPCC there are four types of neglect[6]:

- **Physical neglect**
  A child's basic needs, such as food, clothing or shelter, are not met or they aren't properly supervised or kept safe.
- **Educational neglect**
  A parent doesn't ensure their child is given an education.
- **Emotional neglect**
  A child doesn't get the nurture and stimulation they need. This could be through ignoring, humiliating, intimidating or isolating them.
- **Medical neglect**
  A child isn't given proper health care. This includes dental care and refusing or ignoring medical recommendations.

2.1.1 Identifying neglect:

Within this briefing report different issues and missed opportunities around these types of neglect were identified, these included;

Appropriate investigations and assessments must be conducted when babies and infants have faltering weight. Findings will clarify the causal factors and inform the provision of support in order to improve weight gain and promote the well-being of babies and infants.

One review identified that it is challenging for professionals to evidence significant harm where there is neglectful parenting, and this may cause delay in the progress of legal proceedings. The review also highlighted that closer working between hospital professionals and social workers could assist in identifying significant harm earlier and improve safeguarding of children in these situations.

[6] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/

In another review, it was identified that specialist services did not take into account the child's high level of distress, or work in a coordinated way with universal services to address identified risks associated with the reports of parental neglect and the impact this was having on the child. The review identified that too much reliance was placed on onward referrals, without checking that agencies were able to support or ensure compliance.

If cumulative long-term neglect is not recognised or addressed, babies, infants and children can experience significant harm. Evidence from case reviews showed that there was a history of professional concerns about the state of the home prior to the birth of the child. However, this understanding was not related to the lived experience of the child and did not form part of the professional intervention to safeguard children.

One case also raised the need for health practitioners, in this instance GPs, to raise concerns regarding the protection and care of children with children's social care.

2.1.2 Neglect and inter-agency working

Cases of chronic neglect highlights the need for effective inter-agency working. It is essential that attention is paid to all agencies who raise concerns regarding the quality of care and that these concerns are fully investigated. Research conducted by Hilary Tompsett et al in 2009 found that half of the GPs consulted expressed a preference for seeking early advice and support from a paediatrician or other health colleague, rather than children's social care. In addition, two thirds of GPs rated the health visitor as highly significant to refer to, where there was concern for a child. GPs on the whole would prefer a model of referral that allows more stages of consideration, discussion and consultation before 'raising concerns'.[7]

Failure to meet milestones can be a significant indicator of abuse. Common to these cases were **home observations.** Some agencies demonstrated greater awareness of home conditions on the emotional and physical well-being of the child than others. In common, were the challenges in understanding the impact of cumulative neglect before coming to a crisis point or an incident of significant harm. Learning from the reviews highlights the need to understand neglect in the context of historical concern and multi-agency interactions – without an holistic view of the risk supported by good information sharing negelct can be hard to identify. The neglect cases reviewed all reflected the uncertainty of whether there was neglect and evidence of health presentations where each incident was seen and treated in isolation. Of the neglect cases reviewed, the authors frequently mentioned delayed development as an indicator of abuse.

[7] Child KK SCR Report

Reflective Questions

What is your understanding of neglect? Do all agencies have access to the right multi-agency tools to help them recognise and respond to neglect?

How would you evidence your concerns regarding neglect? Do agency assessments/referrals accurately describe how poverty is impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their daily lived experience?

What systems are in place to ensure parental failure to bring children to appointments are monitored and shared with safeguarding colleagues?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where neglect is a feature?

2.2 Domestic Abuse, including coercive control

Research is clear that living with domestic abuse is always harmful to children. The Joint Targeted Area Thematic Review into domestic abuse found in cases of domestic abuse, that

> "focusing on the needs and experiences of children is critical. A failure to adequately focus on the experiences and needs of children means there is a high risk that the emotional and mental impact of domestic abuse will go unaddressed. Children and young people who have lived with domestic violence for several years frequently experience intense feelings of responsibility, guilt, anger and a sense of despair and powerlessness over their lives."[8]

A number of the reviews highlighted the complex nature of the children's lives. One case involved a family who had decided to electively home educate their children. It is evident that the father appeared controlling of the professional network and his hostility frustrated the interventions of a range of services across multiple Local Authorities. Professionals found the father to be aggressive and manipulative. In this case, the report notes that, "It is evident that the Local Authority involvement prior to and during the child protection planning was frustrated by the lack of engagement and by the father becoming increasingly hostile."[9]

The review recommended authoritative practice. "Authoritative practice means that professionals are aware of their professional power, use it judiciously and that they also interact with clients and other professionals with sensitivity, empathy, willingness to listen and negotiate and to engage in partnerships. They respect client

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Ofsted (2017) The multi-agency response to children living with domestic abuse Prevent, protect and repair September 2017, p. 14, paragraph 49, The Office for Standards in Education, Children's Services and Skills (Ofsted)

[9] ibid

autonomy and dignity while recognising their primary responsibility is the protection of children from harm and the promotion of their well-being."[10] (See also the section on authoritative practice below).

Seven reviews detailed domestic abuse including coercive control. This manifested as increasing push back on services, obstruction and or refusal to allow services access to children and vulnerable adults. In some cases, this enabled the abusive parent to shift the focus of the intervention toward them and their concerns and away from the needs and safety of the child. This also had an impact on practitioners' ability to challenge and steer the intervention from managing parental behaviours to focussing on professional concerns in relation to the child. Two cases identified incidents of physical assault on the child by the mother that may have been seen as an indicator of domestic abuse.

Common to all the observations of coercive control was the challenge of evidencing significant harm or abuse. Harm to children was often observed and considered but there was not always clear action in response. As a mirror to the aggression displayed by perpetrators using coercive control, there were cases of **disguised compliance,** in which both the aggression and coercive control served to deflect practitioners' attention from further investigations.

The reviews also highlight the ongoing impact on the emotional and mental well-being of children who are subject to or witness domestic abuse. Domestic abuse in the context of the reviews considered also highlights the issue of **'grooming'** of both professionals and other family members including the children. Of the 12 reviews, grooming of professionals and children to support the preferred narrative was explicit in three reviews.

A theme across the cases which involved coercive control was the impact on the emotional and mental well-being of the non-abusive partner. There was one case where the mother was charged and the father retained parenting capacity. Supervision orders were put in place which resulted in supervision being used as another point of control for the coercive partner. In this case there was insufficient attention given to the concerns of the mother over the behaviours of the father; which if investigated further, potentially could have resulted in referrals to MARAC. There was also evidence of a lack of understanding amongst professionals of how coercion can lead to retaliative violence.

2.3 Engaging challenging families

A Research in Practice Briefing, *Prompt Briefing, Engaging Resistant, Challenging and Complex Families*, the organisational barriers to effective engagement include

- A pre-occupation with thresholds
- 'Start stop' service delivery

[10] Essex Safeguarding Children Board (May 2011) *Authoritative Child Protection Practice: Quick reference guide***,** May 2011 Adapted from Jane Gilgun

- Inactive case management and de-sensitisation of staff[11]

In one case, there was 'start stop' to service delivery and periods of inactive case management. In addition, this was a family with a history of moving between a range of local authorities across the United Kingdom.

When working with resistant families, avoidant or challenging families it is important that practitioners are respectfully persistent.

Practice guidance from *the London Child Protection Procedures* 5th Edition 2017 details the following,

When working with uncooperative parents, professionals in all agencies can improve the chances of a favourable outcome for the child/ren by:

- Keeping the relationship formal though warm, giving clear indications that the aim of the work is to achieve the best for their child/ren;
- Clearly stating their professional and/or legal authority;
- Continuously assessing the motivations and capacities of the parent/s to respond co-operatively in the interests of their child/ren;
- Confronting uncooperativeness when it arises, in the context of improving the chances of a favourable outcome for the child/ren;
- Engaging with regular supervision from their manager to ensure that progress with the family is being made and is appropriate;
- Seeking advice from experts (e.g. police, mental health specialists) to ensure progress with the family is appropriate;
- Helping the parent to work through their underlying feelings at the same time as supporting them to engage in the tasks of responsible child care;
- Being alert to underlying complete resistance (possibly masked by superficial compliance) despite every effort being made to understand and engage the parent/s;
- Being willing, in such cases, to take appropriate action to protect the child/ren (despite this action giving rise to a feeling of personal failure by the professional in their task of engaging the parent/s).[12]

Work with families who are aggressive and avoidant requires what, Professor Harry Ferguson describes as, the use of 'Good authority' (Ferguson 2011).

According to Ferguson, good authority requires three things:

- "a model/conceptual framework that clarifies its nature, role, ethical dimensions, appropriateness and methods of application
- An analysis of the relations of authority with the organization and their impact on how frontline staff feel about and exercise authority

[11] Fareena Shaheed, (2012) *Prompt Briefing, Engaging Resistant, Challenging and Complex Families,* p. 5, Darlington

[12] London Child Protection Procedures,(2017) *Managing work with Families where there are obstacles and resistance* https://www.londoncp.co.uk/chapters/manag_fam_obst_resist.html access 17th March 2020

- An understanding of one's own personal relationship to authority."[13]

Ferguson goes on to present a model of what he calls 'authoritative negotiated child protection'. The model consists of the following 8 steps

1. Recognise authority and assume conflict and not cooperation
2. Encourage openness and honest expression of feelings
3. Identify what the resistance is really about and what is working well
4. Identify dangers to the children
5. Identify what is not negotiable
6. Identify what is negotiable
7. Formulate a child protection plan
8. Be clear about criteria for progress[14]

There is a need for clarity and urgency when working with hostile and aggressive parents or carers. Practitioners must quickly understand what is driving the hostility and aggression and formulate a child-centred, protective response. Effective management oversight and supervision is critical to enable this.

Ferguson's work highlights this, and it is important to quote him at length when he notes,

> What is clearly needed are supportive systems that are emotionally aware. This is particularly important if the complex dynamics of pathological communication or danger are to be brought to the surface and combated. Workers' sense of safety or danger must be seen as a key measure of child safety. Organisations, managers and case supervisors need to give attention to all the emotional dynamics and relations of authority… Workers' feelings need to be at the centre of this, not simply so that their concerns for their own well-being can be addressed, but because their emotional experience provides crucial data about what the children are feeling and experiencing. If workers don't feel authoritative and safe, the strong likelihood is that the child is not safe either.[15]

Authoritative practice is not authoritarian, coercive or oppressive to service users, but it is practice which includes

- a clear focus on the desired outcomes,
- sets clear expectations regarding behaviour from parents and other adults in the family network including how breaches should be responded to.

[13] Ferguson, Harry, (2011) *Child Protection Practice,* p. 171, Palgrave Macmillan
[14] Ibid, pp.174-178
[15] Ibid p. 179

- ensures that the child protection (CP) plan is not simply a list of concerns, but the plan clearly identifies risks, the parental responses that are needed to address these risks and the required outcomes for children to be safeguarded and their welfare promoted.
- Authoritative practice follows through when the needed response/required outcome does not happen
- ensures contingency planning occurs through a legal planning meeting in which the thresholds for court action are clearly identified and progressed in a timely way[16]

Authoritative practitioners ask, what are the bottom-line expectations in this case? What are the known, evidence-based risks and harm to the children (including how these are understood by the professional network)? What are the bottom-line expectations of good and safe parenting and what needs to change in the care-giving responses of parents? What are the contingency plans if these expectations are not met?

Reflective Questions

How do you manage feelings of fear, intimidation and agression?

If you are afraid, intimidated, etc. what must it feel like to be a child in that family and their daily lived experience?

Evidence from research and these reviews show that perpetrators groom and intimidate victims and networks around victims, how can we remain focused on the safety of children and vulnerable adults?

What support is needed when working with service users who are aggressive or charming/manipulative and avoidant?

How can management support and trauma informed supervision help you to stay focused on safety for the children as well as keeping yourself safe as a worker?

2.4 Child Sexual Abuse

Cases of child sexual abuse present a range of practice challenges for professionals and those working with children. These challenges include the fact that in cases where sexual abuse is a feature, most interventions are disclosure-led. However, research shows that children and young people who are experiencing sexual abuse are unlikely to disclose. This dilemma is referenced in the Children's Commissioner's 2015 report into familial child sexual abuse, where it is noted that

> "Victims of child sexual abuse in the family environment may tell teachers or other professionals directly, though it is more likely that their suspicions will be

[16] *Authoritative Child Protection Practice Quick reference guide* Essex Safeguarding Children Board 2011

raised by the behaviour or presentation of a child or young person. This is the 'grey area' where concerns reside, and professionals are called upon to act upon their judgement in the best interests of the child. Participants in site visits and oral evidence sessions highlighted the difficulty of initiating safeguarding processes in the absence of a direct disclosure from the young person."[17]

This raises the importance of professional curiosity, the skilled use of questioning and, where necessary, professional authority. In addition, keen attention to the voice and experience of the child is critical to ensure that the child's safety remains the focus and he/she does not become invisible to professionals.

In one case, a father had a history of being sexually abused as a child and a history of sexually abusing children. In this case, as in others, there was a need for robust risk assessments of parents with a history of offences and allegations of direct or indirect harm to children. This case also highlighted the fact that assessments need to be shared with key agencies in the network.

It is important that information about risk is shared and acted upon in order to safeguard children.

There is a need for timeliness of decision-making and specialist risk assessments, for example, in one case there was a delay of two months before a child was seen and assessed by professionals.

Reflective Questions

Effective practice requires us to think the unthinkable. If you were concerned about a child experiencing sexual abuse, how would you raise the issue?

What signs or indicators of sexual abuse do you need to be attuned to?

How would you respond to a disclosure?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where child sexual abuse is a feature?

2.5 Parental mental health

The most prevalent parental characteristic reported in these SCRs was parental mental health difficulties, particularly for the mother (noted in 55% of SCRs) but also for the father or father figure.

Parental mental health problems occur more commonly in the SCR population than the general population, depression and anxiety were found to have a prevalence of 13.7% in adults using the GP patient survey (Public Health England, 2018b)[18]. However, mental health problems occur in similarly high frequencies in families requiring social care support; 52.8% of adult social care users suffer from depression

[17] Children's Commissioner for England (2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action* p. 33

[18] Public Health England (2018b) *Mental Health and Wellbeing JSNA*. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna/data#page/0

or anxiety (Public Health England, 2018b), and parental mental health problems were a factor in 40% of completed children's social care assessments (Department for Education, 2017b)[19].

One review recommended that adult mental health services inform health visitors as well as social workers of parental mental health episodes and the consequent ability of a parent to care for her/his child/ren.

There was some learning suggesting that there were failures to link parental mental health issues with domestic abuse and the link between child(rens) presentations to health with physical violence/neglect. A situation exacerbated by not having access to family histories.

Reflective Questions

What systems are in place to enable women or men to disclose domestic abuse including coercive control, to identify the risks to children, and to refer and assess cases where there are children in the family?

What is your understanding of domestic abuse and the ongoing nature of coercive control and its impact on the parent and children?

Do multi-agency practitioners have access to the right tools to help them recognise and respond to domestic abuse?

How well embedded is trauma informed supervision in all agencies that provide services to children and families where domestic abuse is a feature?

2.6 Cumulative harm

Cumulative harm is where there is the co-existence of multiple forms of risk and harm including parental mental health problems, parental substance misuse, and domestic abuse. Within the triennial review of SCRs, *Pathways to Harm, Pathways to Protection* published in 2016, researchers noted,

> …It has become clear that these three issues of domestic abuse, parental mental ill-health, and alcohol or substance misuse are not the only parental risk factors that may contribute to cumulative risk of harm. Other parental risk factors often co-existed with these factors, and potentially interacted with them to create harmful environments for the children. These included issues such as adverse experiences in the parents' own childhoods; a history of particularly

[19] Department for Education (2017b) *Characteristics of children in need: 2016-17, England*. Available at: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2016-to-2017.

violent crime; a pattern of multiple consecutive partners; and acrimonious separation.[20]

Practitioners need to be clear that when multiple risk factors exist there is a need for clarity in assessment and urgency in action and intervention. It is also important that practitioners are tuned into the lived experience of children and young people.

> When a child presents with indicators of possible maltreatment and vulnerability, or a parent or carer presents with recognised risks, professionals have an opportunity to explore that vulnerability and risk and take steps to intervene and protect the child. This requires a stance of professional curiosity and awareness of possible maltreatment and cumulative risk. Professionals must challenge parents and explore the issues while maintaining an objective and supportive manner.[21]

These reviews all hightlighted the need to understand and share information effectively. One of the features of cases was that a great deal of information was known about the potential risks that perpetrators posed to children. However, there was limited evidence that this information was used effectively to inform assessments and to effectively manage risks.

Pathways to Harm, Pathways to Protection addresses this issue at length,

> Effective intervention requires careful assessment of the child's vulnerability and ensuring the child's rights and feelings remain central. The child's circumstances and environment, the resilience of the child and family, and any inherent risks, all work together to inform actions by the multi-agency team. Effective safeguarding work depends on collaborative multi-agency working: no single professional retains all of the required knowledge or skills. Good communication is essential for collaboration. Serious case reviews, and, by extension, child welfare professionals, are often criticised for repeatedly identifying the same failings in communication and information sharing. Given the centrality of effective communication to safeguarding work, it is inevitable that this remains one of the key points of break-down. Such communication requires practitioner skills, effective facilitative systems, and a culture that promotes information sharing for the protection of children. This must fit into a wider information-handling process whereby information is critically appraised and used to guide decision making and planning.[22]

According to statutory guidance, *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children 2018,* high quality assessments:

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[20] Peter Sidebotham, Marian Brandon, et al, (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*, © University of East Anglia & University of Warwick May 2016 and DfE
[21] Ibid p.139
[22] Ibid, p. 162

- are child-centred. Where there is a conflict of interest, decisions should be made in the child's best interests: be rooted in child development: be age-appropriate; and be informed by evidence
- are focused on action and outcomes for children
- are holistic in approach, addressing the child's needs within their family and any risks the child faces from within the wider community
- ensure equality of opportunity
- involve children, ensuring that their voice is heard and provide appropriate support to enable this where the child has specific communication needs
- involve families
- identify risks to the safety and welfare of children
- build on strengths as well as identifying difficulties
- are integrated in approach
- are multi-agency and multi-disciplinary
- are a continuing process, not an event
- lead to action, including the provision of services
- review services provided on an ongoing basis
- are transparent and open to challenge[23]

Reflective Questions

How can you stay focused in the face of multiple and complex family needs?

What helps practitioners to work effectively together when working with complex families?

What does effective 'Think-family' work look like in high-risk, high harm cases?

What support is needed when working with the complexity of the lives of children and their families?

How can management support and trauma informed supervision help practitioners to stay focused on safety for the children and the challenges faced when seeking to support them?

3 Learning Themes for Practice

A number of themes for practice were identified as part of this review.

- Professional Curiosity
- Disguised Compliance
- Multiple referrals and re-referrals
- Parental Capacity
- Lived experience of the child

[23] *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* chapter 1, pp. 25-26, paragraph 51

3.1 Professional Curiosity.

Professional curiousity is a stance of respectful scepticism where a practitioner remains open and enquiring about the possibility of harm to children. In practice, this means not taking things at face value or making assumptions about what is seen or heard.

A report by the Care Quality Commission notes that

> "The risks to many children are not always obvious and require a continuous professional curiosity about the child and their circumstances. The emphasis must be on both identifying and supporting those in need of early help, as well as those at risk of 'hidden' harms."[24]

In all of the cases reviewed there was a degree to which risk was left unchallenged through lack of professional curiosity, acting as an inhibitor to understanding the full extent of risk faced by the child(ren). The reasons for this were varied but can be summarised as:

- Lack of managerial supervision and reflective practice
- Assumptions about the narrative given by the parents with a lack of **respectful challenge**
- Not responding effectively to coercive and aggressive behaviours
- Cultural bias
- Lack of capacity in the system

The impact of practitioners not consistently being curious and challenging narratives was that at times indicators of abuse, particularly neglect and domestic abuse, were not recognised, recorded or escalated. There were missed opportunities to safeguard children and involve other services which could have provided a more holistic overview of the child(ren)'s history.

In relation to neglect, there was a lack of challenge and curiosity of parental narratives and/or with domestic abuse and neglect / lack of curiosity in relation to coercive control where interventions particularly from health and mental health focused on physical presentations rather than emotional health and well-being. Professionals seemed to become habituated to presentations of neglect.

Professional curiosity is much more likely to flourish when practitioners:

- are supported by good quality training to help them develop
- have access to good management, support and supervision
- 'walk in the shoes' (have empathy) of the child and/or adult to consider the situation from their lived experience

[24] CQC Report (2016) Not Seen, Not Heard: At review of the arrangements for child safeguarding and health care for looked after children in England, p. 5

- remain diligent in working with the family and developing the professional relationships to understand what has happened and its impact on all family members
- always try to see all parties separately.[25]

Reflective Questions

What behaviours or practices promote professional curiosity?

What behaviours or practices limit or inhibit professional curiosity?

How can you consciously tune into what you see, hear, smell and sense in families?

3.2 Disguised Compliance

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993).[26]

To improve practice in relation to disguised compliance, the following is recommended

Recognising disguised compliance

- Local safeguarding agencies should ensure practitioners are trained in recognising and responding to disguised compliance.
- Practitioners need to remain aware that disguised compliance could be occurring.

Establish facts and gather evidence

- Practitioners should display professional curiosity when working with families and not accept information from parents and carers at face value without investigating further.
- Practitioners need to establish the facts and gather evidence about what is actually happening or has been achieved.
- Practitioners should focus on the child's lived experience rather than the parents' and carers' actions.[27]

Reflective Questions

What does authoritative practice look and feel like for your agency and in your role?

[25] Adapted from https://www.manchestersafeguardingpartnership.co.uk/resource/professional-curiosity-resources-practitioners/
[26] Cited in NSPCC (November 2019) *Learning from case reviews briefings Disguised compliance*, NSPCC
[27] ibid

How can you be authoritative without being authoritarian – that is whilst respecting the rights of service users?

What helps to keep workers focused on the needs of the child and not distracted by the needs or behaviours of parents/carers?

3.3 Multiple referrals and re-referrals.

The reviews provide a significant amount of learning about **referrals.** One of the most common themes emerging was multiple and repeat referrals to either children social services or Children And Adolescent Mental Health Services (CAMHS) which resulted in no further action as referrals were assessed as not meeting the threshold despite the referrals coming from more than one agency. Overall, there is a general feeling that this was more prevalent in cases of neglect and domestic abuse.

The impact of a child not meeting thresholds for targetted or specialist support early in the life of the child meant that opportunities were missed to safeguard the child or put in support and services to reduce the risk of harm or abuse. A common thread was the ongoing concern of other professionals.

Conversly, there were missed opportunities to refer where a child would have met the threshold that were not taken – this appears to be mainly in response to personal disclosures either by an adult or a child that would have warranted further investigation, such as disclosure of physical violence.

3.4 Assessments and Planning

The right support at the right time; common themes identified across the reviews include:

- Premature or **poor planning and risk management in step down arrangements** across services
- Poor communication
- Drift and delay in the completion of assessments
- Poor quality assessments including lack of clear outcomes and poor decision making
- Not sharing assessment outcomes with key partners
- Missing critical input from key partners in planning meetings
- Lack of clear risk rating and risk mangagement around assessments
- Poor follow up of assessments
- Assessment being made without face to face contact
- Over-optimistic assessments
- Assessments too heavily reliant on parental narratives
- Poor communication of assessments.
- Lack of child and family history

3.5 Escalation of professional dissent:

Among health and universal services there was some evidence of child protection procedures not being fully followed. This included missed opportunities to refer to children's social care or escalate to the paediatrician in hospital. More common was the **lack of understanding of escalation and dispute resolution procedures** for dissent in decision making over the risk of harm to a child.

There are clear policies for escalating a concern over the professional judgement of risk to a child from another agency – but these seem not to be well understood or followed in at least three cases. In one case, there was evidence of over reliance on expert opinion rather than on professionals with longer term contact with the family. In Child Protection conferences there was evidence that professional opinion was not equally weighted. Professional differences are to be expected and are not unhealthy. Openly embracing and resolving them is an opportunity to strengthen safeguarding.

Reflective Questions

How do you evidence your concerns regarding a child/ren?

Do agency assessments/referrals accurately describe how your concerns are impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their lived experience?

What further action do you take if a referral is not accepted and your concerns remain?

3.6 Parental Capacity

Across the reviews, there were a number of opportunities to reflect on parental capacity and the impact of various parental vulnerabilities from mental health, physical health, and substance misuse to learning difficulties.

There were missed opportunities to listen to professionals with concerns who had longer term contact with the families that would have in a broader context led to a more robust assessment of need and risk. There were also missed opportuhnities to listen to disclosures of one spouse on the other.

Assumptions relating to parental capacity were made based on unchallenged narratives of events or single presentations. This allowed for the explanation of events to be directed by the parent/carer

In all of the neglect and domestic abuse cases considered, one or both parents were involved in the abuse of the child. In the context of child sexual exploitation cases, child vulnerability or abuse did not originate from the family or at home but an external community or social risk. Although the CSE cases have some commonality with the themes of the neglect and domestic abuse cases, in the small number reviewed there seems to have been extensive interventions across agencies, often joined up albeit

with different applications and assessments of risk. The challenges in these cases appear on the surface to be more around the **efficacy of strategies** put in place to manage the risk and the lack of specialist resource accessible both in and out of county. Multiple placements appear to have an ongoing impact on stability for both the child, their personal relationships and education. Movement in placements were often cited in the two reviews as due to the inability or suitability of placement to manage behaviours – behaviours which were oversexualised, self harming or otherwise risky were little understood and required expert assessment to diagnose.

In common with all cases, a subtext to the reviews is the impact of abuse and neglect both current and historical to the parent on the ongoing emotional and mental health of the family. In the two CSE cases there was little evidence that the impact of early trauma on behaviour was understood. In the neglect and domestic violence cases there was evidence that violence in the family had been a factor in both historical and in current work.

Reflective Questions

Do agency assessments/referrals accurately describe the concerns that are impacting on the parent's capacity to parent, the voice of the child, what it feels like to be a child in that family and their lived experience?

How can management support, and trauma informed supervision help practitioners to avoid parental behaviours overshadowing the children's needs and stay focused on safety for the children?

3.7 Lived experience of the child

The voice and lived experience of the child was another common element of all the reviews and most clearly captured by the consultation with children/young people and their families during the review process. Each case identified a missed opportunity to understand the experience of the child(ren) from either their own or a siblings perspective.

In some cases this resulted in actions taken in the best interests of the child that did not fully consider the potential and actual trauma that these actions caused. In other cases it lead to delay in understanding the abuse or negect experienced by the child(ren). Also, this led to disclosures by the child to professionals not prompting referral or other appropriate actions. This is a critical learning for our safeguarding system.

Reflective Questions

How can you ensure that seeing and hearing children is an essential part of your practice with children and families?

How can you reflect the voice of the child in your work with children and families?

What are the barriers to hearing and responding to the voice of the child and how can these be overcome?

4 Adolescent Vulnerability

4.1 History and Family Functioning

The cases in this review highlight the need to take into consideration history and family functioning. The safeguarding adage: the best indicator of present and future harm is past harm.

It is essential that all practitioners working with vulnerable adolescents are fully aware of the history including understanding family functioning and the potential impact of adverse childhood experiences and family trauma.

It is also important that practitioners and agencies have an understanding and evidence-based assessment of the impact of cumulative harm. Neglect and abuse experienced in early childhood can result in vulnerabilities and increased risks that young people experience in adolescence. This issue highlights the need for effective early intervention.

4.2 Child Special Educational Needs

Children with special educational needs and disabilities are overrepresented in the population of children on child protection plans and in children who are at risk of various forms of child exploitation including criminal and sexual exploitation. Practitioners must be alert to the increased risks to children with special educational needs, including learning difficulties and social and emotional disorders such as autistic spectrum disorder and the impact of these additional needs on children's safety and well-being.

4.3 Missing Episodes and Placement Instability

There was evidence in reviews that missing episodes resulted in exposure to additional risk including sexual and criminal exploitation.

The findings of the Ofsted Inspection in relation to CSE and Missing Children found,

> "The response to children who go missing or who are at risk of sexual exploitation is improving, supported by new, stronger operational arrangements with partners. Return home conversations are also improving and are starting to be used to inform plans to reduce risks to children.
>
> Return home conversations are much improved since the recent commencement of new arrangements. Refreshed guidance and the

> appointment of a coordinator for missing children and child sexual exploitation support this progress.[28]

Ofsted Inspectors also found that

> The strategic approach to child sexual exploitation has improved, with some evidence of better partnership working at district borough level. Performance on return home conversations has been poor, and there is only very recent evidence of improvement following recently introduced revised arrangements.[29]

Return home interviews (RHI) practice is still not always being consistently applied. There is evidence from this review that the return home interview (RHI) process needs to be strengthened.

4.4 Adolescent Safeguarding including Issues of Agency (freedom and choice) and Safety (mitigating and managing risks)

Adolescent safeguarding is complex, especially in cases of sexual exploitation and abuse. Complicating factors include the adolescent sociological drives for increasing independence and the need to be with peers, as well as adolescent neurological development in relation to risk taking behaviours (see Hanson and Holmes 2014[30]). This cases in this review highlighted the need to effectively balance issues of agency and choice with the need to safeguard children.

This dynamic is recognised in the work of Carlene Firmin (2018), which notes, that "Choices are made but social conditions have compromised the freedom and/or capacity of a young person to make a safe choice.[31]

There is a need for agencies and professionals to form a view around risk, welfare, choice and consent –this is a key issue arising from our SCR thematic report and the issue of authoritative practice.

Good practice in this review included:

- Attempting to ensure an effective transition between placement by securing continuity of key workers
- Ensuring there was a psychological assessment and the offer of therapeutic support
- Attempts to investigate and disrupt the activity of perpetrators including issuing a Child Abduction Order

The learning from this review includes practice related to

- Risk Management Meetings (RMM) – how effective are the multi-agency risk management meetings in diverting young people who are at risk of CSE and

[28] 2018 SIF, paragraph 37
[29] 2018 SIF paragraph 91
[30] Elly Hanson and Dez Holmes, (2014) *That Difficult Age: Developing a more effective response to risks in adolescence*
[31] Carlene Firmin (2018) *Abuse Between Young People: a contextual account* , p. 159, Routledge

CCE. Members of the Panel heard that Children's Services have since been reorganised; this includes the establishment of targeted youth support teams and safeguarding adolescence teams which have been set up to support vulnerable adolescents. It was noted that there is , increased joint work with the Police who are co-located in these teams. This also includes working with Community Safety in developing the strategic response to CSE and CCE. The Partnership should seek assurance regarding the effectiveness of Risk Management Meetings in supporting children who are at risk of CSE and CCE.

- Absence of a consistent meaningful relationship between social worker and young person
- The Effectiveness of Inter-Agency Working, particularly the effectiveness of information sharing between the Metropolitan Police and Surrey Police.
- The Independent role of the Independent Reviewing Officer (IRO) in preventing drift and delay and ensuring that children are safeguarded from experiencing significant harm. The Safeguarding Partnership should seek assurance from Children's Social Care that the IRO footprint is seen and there is evidence that this is working to reduce risk and safeguard children especially in cases where CSE and CCE is a factor
- Placing vulnerable children in educational provision that is known to be weak. It is acknowledged that this was a failing at the time of the incident. However, the Director responsible for Corporate Parenting has made this issue an area of conspicuous focus in order to ensure that looked after children are placed in appropriate educational provision.
- This case also highlights the need for effective multi-agency practice in relation to understanding adolescent sexuality, especially exploration of sexual harm in the context of unsafe relationships. This would include consideration of consent and issues of agency and choice with the context of adolescent vulnerability.

Other learning includes:

- The heightened risk of CSE for young people with SEND and learning disabilities
- Return home interviews (RHI) – on review of the case file whilst improvement has been noted in respect of offering a RHI, practice is still not always being consistently applied. The Partnership should seek assurance regarding the consistency and quality of return home interviews.
- Risk Management Meetings (RMM) – how effective are the multi-agency risk management meetings in diverting young people who are at risk of CSE and CCE
- The need to promote sex and relationship education, including understanding consent and what constitutes health relationships

- The need to ensure that foster carers are supported to provide care to highly vulnerable children who are at high risk of CSE in order to support permanency
- Absence of a consistent meaningful relationship between social worker and young person
- The Effectiveness of Inter-Agency Working, particularly the effectiveness of information sharing between the Metropolitan Police and Surrey Police.
- The Independent role of the Independent Reviewing Officer (IRO) in preventing drift and delay and ensuring that children are safeguarded from experiencing significant harm.
- Placing vulnerable children in educational provision that is known to be weak.
- Understanding the impact of cumulative harm.
- This case also highlights the need for effective multi-agency practice in relation to understanding adolescent sexuality.

5 Conclusion

Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened, but also why things happened as they did, can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgments about what might need to change at a local or national level.

Recommendations from reviews must be focused on improving outcomes for children. It is the responsibility of all agencies to ensure that relevant recommendations are fully implemented and used to make improvements to the quality of their practice in relation to safeguarding children.

The overall purpose of the serious case review/child safeguarding practice review arrangements is to ensure that practice is improved more generally through changes to the system as a whole. It is only through this kind of extended analysis that we will understand whether or not a systemic change is required, either at a local or national level. Without it, we risk making unnecessary systemic changes or not addressing the root causes of problems.