Vulnerability Knowledge & Practice Programme

Learning for the police from reviews of child death and significant harm: Identification and management of risk

A sixth briefing concerning CSPRs/SCRs/CPRs produced by the VKPP.

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Contents

Introduction

When it began operating in 2018 the Vulnerability Knowledge and Practice Programme (VKPP)[1] established a process for drawing out learning for the police from statutory reviews. This has resulted in the publication to date of a series of briefings which can be located here. The VKPP is continuing to build on this evidence base by identifying practice issues as they emerge in reviews, as well as good policing practice where possible.

This is the sixth briefing produced by the VKPP focusing on Child Safeguarding Practice Reviews (CSPRs) in England [formerly known as Serious Case Reviews; SCRs] and Child Practice Reviews (CPRs) in Wales. It is the second in a series of three briefings resulting from the analysis of 64 unique CSPRs/CPRs/SCRs published between 30th September 2019 and 23rd July 2020 (see Appendix A for an overview of the study methodology). The previous briefing addresses police responses to young parent families. This current briefing focuses on operational and/ or strategic police practice regarding the identification and management of risk as it features within child safeguarding practice reviews. This theme draws on 22 cases from our larger sample of 64 case reviews.

[1]This programme operates under the auspices of the National Police Chiefs' Council Lead for Violence and Public Protection. You can read more about this programme here: https://whatworks.college.police.uk/Research/Pages/Vulnerability.aspx

Snapshot of cases

Police Forces

22 police forces are represented in these reviews, over 8 regions

Case Types

34 of the cases related to the death of child or adolescent and 30 related to incidents of significant harm.

Death

Cases involving the **death** of a child/adolescent (34):

- 11 Sudden Unexpected Death in Infants (SUDI)
- 10 suicide
- 5 fatal assaults
- 2 fatal physical abuse
- 2 'overt filicide'
- 2 child homicide
- 1 other (untreated terminal illness)
- 1 cause of death unclear

Significant Harm

Cases involving **significant harm**[2] to a child/adolescent (30):

- 11 Physical assault)
- 8 child sexual abuse/exploitation
- 6 multiple abuse (neglect; physical; sexual)
- 3 other (2 attempt suicide; 1 abduction)
- 2 neglect

The 64 cases featured a range of contextual elements of note even where the lead reason for harm/death is something different. These included: mental health needs (36 cases); domestic abuse (31 cases); the child or young person going 'missing' (12 cases); child sexual (10 cases); child sexual exploitation (10 cases); child criminal exploitation (7 cases) and financial exploitation (4 cases).

We use case examples in this briefing either to provide context or exemplify issues that have been identified as collective learning over a number of reviews or where the circumstances of a particular review are potentially unusual but where there is learning that could be applied in similar circumstances in the future. Reviews are likely to be the result of an accumulation of complex systemic and multi-agency factors.

[2]The death and harm types here are assigned from the main issue associated with the death or serious harm and the lead reason for the review being conducted. Other harms and circumstances may also have been present in the case.

Cross cutting themes

Identification and management of risk

NVAP Action 2.1.1, 2.2.1

The findings in this area relate to the NVAP actions concerning 2.1.1 Recognition and response and 2.2.1 Appropriate action

Identification of risk was found to be an issue in 39 cases. Some of the learning points have also been identified in our previous reports. Here we identified learning concerning:

- How policing could improve safeguarding by carrying out more comprehensive and informed risk assessments, which in turn would lead to necessary child protection activity and engagement in multi-agency approaches and strategy meetings;
- How particular care needs to be taken in identifying and assessing risks related to CSAE and CCE, domestic abuse and parental capacity to provide adequate care;
- How improved identification and understanding of the risk and impact upon children of witnessing domestic abuse could achieve better safeguarding responses by police;
- How important the careful recording of risk assessment and decisions made in child safeguarding cases is.

Recording rationale for decisions and risk assessment conclusions

While in previous VKPP reports, we found that grading of risk is often inaccurate, in this sample of reviews we identified additional problems with insufficient recording by police, of reasons for conclusions reached in risk assessments and the clear rationale for decisions taken as a result; this was particularly problematic in matters where no further action was taken when concerns arose. Such issues with recording make it difficult to tell whether or not risk factors were actually identified and effectively taken into account, as well as who was involved and accountability for decision making in specific cases. Some evaluations of risk were considered to be overly narrow in focus, not taking sufficient account of the wider family context or children's lived experiences. Careful and detailed recording of the reasons for reaching decisions and risk assessment conclusions are important in safeguarding, not just for justification and accountability reasons but also to help other colleagues or multi-agency partners understand what information has been considered at the point specific decisions are reached.

Cross cutting themes

Identification and management of risk

NVAP Action 2.1.1, 2.2.1

The findings in this area relate to the NVAP actions concerning 2.1.1 Recognition and response and 2.2.1 Appropriate action

Risks related to child sexual abuse/exploitation (CSAE) and child criminal exploitation (CCE)

There were examples of frontline officers not recognising the risk of CSE or not documenting concerns effectively; not considering the risk of CSE where a young person was repeatedly going missing; recognising potential CSE risk but not recognising the associated concerns around CCE and potential gender bias in not recognising the risks of exploitation with adolescent boys. This useful resource by Research in Practice provides an integrated account of the different forms of exploitation experienced by children and young people and may help develop understanding of the overlaps between them. In one example, the reviewer noted the different response by police to a teenage boy and a teenage girl both stopped while in the company of an 18-year-old male. A referral to Children's Social Care was made in relation to the teenage girl but not in relation to the boy, despite the fact he was three years younger than the girl. The reviewer suggested the possibility of agencies not always recognising the risks of exploitation with adolescent boys. The same child had also been found out late at night with a group of older teenagers and adults arrested for robbery. Despite his clear association with others who may involve him in offending, no referral to Children's Social Care was made and there was no recorded evidence his mother was advised about what had happened. The issues related to how stereotypical assumptions regarding masculinity and the vulnerability of young men can be problematic are detailed in this briefing published by the Safeguarding Board of Northern Ireland (Montgomery-Devlin, 2020) and in this briefing entitled 'Immaterial Boys?'.

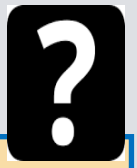
Although these briefings relate to CSE much of the content is equally relevant to CCE. Our VKPP Spotlight Briefing on exploitation, county lines, threats and weapons discusses learning from two CCE cases involving adolescent boys, also highlighting considerations around policing practice in this area. This briefing also discusses race (both boys were Black) and demonstrates how the intersection of race and gender can put children further out of reach of support and be relevant in responses to black adolescent males. The briefing also summarises the key findings and recommendations around safeguarding children at risk of CCE published by the national Child Safeguarding Practice Review Panel in March 2020. It is imperative then, that police consider any concerns regarding CSE and CCE equally regardless of the gender or race of the child or young person involved.

Cross cutting themes

Identification and management of risk

Risks associated with other adults involved with children/families

An issue common to case reviews and found in several cases here, concerned missed opportunities to identify the risk associated with other adults (usually males) involved with the child and their family. Some cases demonstrated a lack of consideration of the relationships between these adults and the child/children in the family and their role in childcare. The NSPCC (2015) *Hidden Men* report highlights common issues around risk assessment in this area and provides some specific pointers for improving practice. Examples were found of appropriate police background checks not being done, appropriate safeguards not being implemented, or relevant information not passed to other agencies. In one example, background information about the father of several children in a family (concerning domestic violence in a previous relationship where children were directly harmed, involvement in another violence incident and his criminal convictions) did not appear to have been checked and shared with other practitioners by police and Children's Social Care in multi-agency safeguarding considerations and care proceedings. Early in care proceedings the father stated he did not want to be considered as an alternative carer if his children could not remain with their mother.



Reflective practice

- Some cases analysed in this research, as well as the findings of the Hidden Men report (NSPCC, 2015), highlight the need for professional curiosity and thorough consideration of potential risks posed by other adults involved with the family, whether, in the case of the above example, they live together or not. In all cases where adult partners are known, do you take care to consider what the nature of that person's relationship with the child/family is and in particular what that might mean for the child/children? Consider the potential risk to any unborn child as well as children already living in a household from any partner of a parent, even if they do not live together in the same home.

- Do your risk assessments and other written case records relating to safeguarding clearly state the reasons for any decisions or conclusions reached and who was involved in making those?

Cross cutting themes

Identification and Management of Risk

NVAP Action 2.1.1, 2.2.1

NVAP ACTIONS: 2.1.1, 2.2.1 The findings in this area relate to the NVAP actions concerning 2.1.1 Recognition and response and 2.2.1 Appropriate action

Management of risk was found to be an issue in 40 cases. Some of the learning points identified have also been discussed in our previous reports. Here we identified learning concerning:

- How safeguarding can be improved by very careful consideration in decisions to reduce the child protection status where evidence of risk is known to police and other professionals;
- How important it is for police to carefully consider of the actual capability of parents and children to effectively manage potential risks themselves. By doing so police can help prevent unrealistic expectations being placed upon them and better safeguard children;
- How awareness of the risks associated with domestic abuse around the time of separation can help safeguarding responses. This is also a relevant risk where adult parties are believed to be separated.

Reduction in child protection status where potential risks known

As part of decision making in multi-agency safeguarding arrangement (MASA) processes in several cases police colleagues were contributing partners in premature decisions to 'step down' the child protection status of children in families even where potential significant risks remained. In one example, this included quickly agreeing for a child protection plan to be reduced to a child in need plan where the police had just become aware, via their checks, of concerns about the mother's current partner. Initial social work observations of him with the child were positive, however, the identified issues in the police checks related to historic concerns about his mental health and convictions for violence and drug-related offences. He had also had a previous allegation of sexual assault against a teenage girl made against him. The review identified that multi-agency discussions focussed on the sexual assault allegation (considered unfounded) and did not include a robust consideration of the other newly available relevant information. Consequently, a unanimous decision to step down was made. These types of cases identify the importance of full consideration being given to *all* relevant information known about individuals in close contact with children. Those needs were the priority and relevant appropriate action by the police should include consideration of their lawful duty to act and make a referral themselves.

Cross cutting themes

Identification and Management of Risk

NVAP Action

NVAP ACTIONS: 2.1.1, 2.2.1 The findings in this area relate to the NVAP actions concerning 2.1.1 Recognition and response and 2.2.1 Appropriate action

Expectations for parents, families and children to manage risk themselves

In several cases the reviewers expressed concerns about the amount of responsibility and expectation placed upon parents, families and even children themselves, to manage potentially serious risks to children. These expectations appeared to reflect a lack of considered assessment of the individual or family's actual ability or capacity to protect the children in question. For example, a parent called police for assistance at home as she was unable to manage her adolescent child's threats to self-harm. This followed a missing episode when the adolescent had left a suicide note and was returned home. The police initially advised the parent to lock the child in the house as they felt her presentation was behavioural, and that if she was taken to hospital, she would be likely to be sent home. The parent was advised by the police to ring children's services out of hours support. The social worker ensured the adolescent was taken to hospital. The case demonstrates the risks of making assumptions regarding a child or adolescent's presenting behaviour and not properly recognising the potential for mental health related risks. The parent's call to the police in itself was an indicator they were unable to respond to the child's needs.

Risk management in cases of separation

Two reviews identified missed opportunities in recognising the continuing risk in domestic abuse cases where couples are said to have separated, but where in reality they continue to be in contact. This meant the children involved continued to be exposed to domestic abuse and violence. These cases showed that risks were considered to be reduced when the partner was not officially living at home, this included within DASH assessments. There is evidence that indicates there is potentially an increased risk of harm and escalation in domestic abuse and homicide cases at times of separation (Hohl & Johnson, 2020; VKPP, 2020). It is not clear how long such increased post separation risk may last, but it is likely to be highly case dependent. A recent report examining women killed by male perpetrators reported that of victims killed by a (current or ex) partner who had separated or made attempts to separate from their partner, 89% had been killed within the first year, with 38% being killed within the first month (Long et al., 2020). Our recent Domestic Homicide Review briefing also highlights the fact that the end of a relationship can be an event that results in the start or escalation of domestic abuse, stalking and harassment. Physical violence is not the only precursor to domestic homicide. Social media has become a method of stalking and harassment, which can result in coercion and control even if the victim and perpetrator do not meet or speak to each other.

Cross cutting themes

Identification and Management of Risk

Recognition of the risks associated with separation and the management of risk has been of particular concern recently as a result of the easing of Covid-19 restrictions. A VKPP rapid learning briefing was sent out to force Domestic Abuse leads in February 2021 emphasising the importance of identifying coercive controlling behaviour and associated risk of harm linking useful resources regarding safety planning during Covid-19 and more generally: College of Policing APP; Women's Aid; Covid-19 safety and support. A report by Hohl & Johnson (2020) suggests there is a possibility that police would see a surge in high-risk and high-harm domestic abuse reports related to separation as Covid restrictions were lifted.

Reflective practice

- College of Policing guidelines for recognising and responding to vulnerability related risks have been updated. Police should familiarise themselves with these guidelines and utilise them to enhance their approach to risk identification and management. APP guidelines on Understanding risk and vulnerability in the context of domestic violence were also published in July 2021.
- Decisions to alter child protection status require full consideration of all available information about adult parents/partners where there are concerns evident in an individual's history. Are your reviews of police information to inform multi-agency risk assessment decisions thorough and systematic? Consider how all information known may or may not indicate a risk to children and families.
- Risk management considerations in domestic abuse cases need to take account of the fact risk of harm can increase around the time couples separate. Safeguarding decisions and risk assessment should consider the potential for increased risk rather than decreased risk in these circumstances and not overly weight partnership separation or moving away from the family home as mitigating risk factors. Consider all information including whether continuing contact is happening and whether this could constitute stalking and/or coercive control. Consider any information on whether Family Courts have ordered post-separation contact between children and parents who have perpetrated domestic abuse and any additional risks this may present regarding access and controlling behavior.
- The College of Policing APP guidance on Victim Safety and Support provides further information on safety planning for victims of domestic abuse.

Relevant reading

Johnson, K., & Hohl, K. (2021) The Impact of Covid-19 on Domestic Abuse Reported to the Police, and Policing Responses. *Written Evidence to the Home Affairs Select Committee Inquiry on Home Office Preparedness for Covid-19 (Coronavirus) Consultation*.

Respect. (2021) Survey of Those Who Use Abusive Behaviour in Relationships (during lockdown).

SafeLives. (2020) Survey of Survivors of Domestic Abuse June 2020.

Next steps

Two further briefings based on this latest sample of CSPR/SCR/CPRs are also being published on the internal police Knowledge Hub and the College of Policing Vulnerability and Violent Crime webpage, here. These will cover specific learning for police from these reviews regarding young parent families and collaborative working, victim engagement and evidence and investigation.

We also encourage feedback about the briefing from forces about both content and style. Please click **here** to complete a brief survey where you can provide your feedback, or, if you would like to be in touch, please e-mail vkpp@norfolk.pnn.police.uk. We'd love to hear from you.

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College of Policing (undated) APP guidance on victim safety and support in domestic abuse cases. https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/victim-safety-and-support/

College of Policing (2021) APP guidance on *Risk and Associated Investigations* Risk and associated investigations (college.police.uk)

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Lloyd, J., Walker, J. & Bradbury, V. (2020) *Beyond Referrals: Harmful sexual behaviour in schools: a briefing on the findings, implications and resources for schools and multi-agency partners* Final-Briefing-final-Beyond-Referrals.pdf (contextualsafeguarding.org.uk)

Long, J., Wertans, E., Harper, K., Brennan, D., Harvey, H., Allen, R., Elliott, K. (2020) *Femicide Census: UK Femicides 2009-2018*, [online] Available at: Femicide-Census-10-year-report.pdf (femicidecensus.org)

Montgomery-Devlin (2021) *Briefing Paper No. 3: The association between youth offending and the recognition of child sexual exploitation in young males*. Safeguarding Board for Northern Ireland. https://www.safeguardingni.org/latest/briefing-paper-number-3-child-sexual-exploitation

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The Child Safeguarding Review Panel (2020) *It was hard to escape: Safeguarding children at risk from criminal exploitation*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870035/Safeguarding_children_at_risk_from_criminal_exploitation_review.pdf

VKPP (2020) *Learning for the Police from Domestic Homicide Reviews* https://whatworks.college.police.uk/Research/Documents/VKPP_Domestic_Homicide_Review.pdf

VKPP (2020) *Spotlight on…Exploitation, county lines, threats and weapons: learning from two serious case reviews*
https://whatworks.college.police.uk/Research/Documents/VKPP_Exploitation_SpotlightBriefing.pdf

Appendix A:

Overview of methodology

Identifying Child Safeguarding Practice Reviews, Child Practice Reviews and Serious Case Reviews for inclusion

The NSPCC repository was searched for any new CSPRs/CPRs/SCRs added between September 2019 and July 2020 (any published in the repository before this time would have been included in the previous briefing). 41 reviews were identified by this method.

An additional search of local safeguarding children boards (LSCBs)/child safeguarding partnership (SCPs) websites for any CSPRs/CPRs/SCRs fitting the inclusion criteria as detailed below yielded a number of reviews not yet on the repository. 118 reviews were identified by this method.

Inclusion criteria

Cases were included where they fit the following criteria:

1. The incident that triggered the CSPR/CPR/SCR occurred on or after January 1st, 2016
2. Police were involved with the child or family in the timeline of the review; if police were only involved post-incident, but learning for police practice was identified during the investigation, this was also included
3. There is explicit reference to police practice within the review; this could be either omissions in practice or good practice identified.

Reviews were excluded from this analysis where:

1. The incident that triggered the CSPR/CPR/SCR occurred prior to January 1st 2016
2. police were not involved in the case at all
3. Police were only involved in investigation after the incident, and no detail about police practice within the investigation was identified
4. No learning was identified by the reviewer in relation to police practice.

Number of CSPRs/CPRs/SCRs included in the analysis

A total of **159** CSPRs/CPRs/SCRs were reviewed, **64** of which fit the criteria for inclusion for analysis.

Timeframe of reviews

Of the 64 cases included for analysis, 1 review was published in 2016, 3 were published in 2017, 9 were published in 2018, 19 in 2019 and the remaining 32 in 2020.

Appendix B:

Overview of Cases

Case review title and link	Review focus
Anonymous: Tracy	Death of a child under one (SUDI)[1]
Anonymous; Case W	Significant harm of a large group of siblings, abuse and neglect.
Anonymous, Child A19	Death of a teenage girl, suicide.
Anonymous; Child Z	Significant harm to an adolescent girl with complex needs
Anonymous; Family D	Significant harm to a sibling group, sexual abuse.
Anonymous; Georgia	Significant harm to a 15-year old female, self-harm.
Anonymous; Harry	Significant harm to a young male, under 16-years old, attempted suicide.
Bury; Dina	Death of a 16-year old female, suicide.
Bury; Isabella	Death of a 14-month old baby girl, (SUDI).
Cambridgeshire and Peterborough; Eleanor	Significant harm to a 19-month old baby girl, assault.
Cambridgeshire and Peterborough; Jack	Significant harm to a 3-month old baby boy.
Cambridgeshire and Peterborough; Sonia	Significant harm to a 13-year old female.
Camden; Child D	Death of a 2.5-year old child.
Cheshire West and Chester; Lauren	Death of a 16-year old female, suicide.
Cornwall and Isles of Scilly; Child C	Death of a 16-year old female, suicide.
Coventry; 2020	Significant harm (extra-familial CSA) to several children in a family
Cumbria; George	Significant harm to a 2-year old boy.
Devon; Baby F CN18	Significant harm to a 12-week old baby.
Dudley; Child A	Significant harm to a 10-week old child, non-accidental injuries.
Dudley; Young Person F	Death of a 17-year old male, stabbing.
Essex; Baby M	Death of a 3.5-month old baby, filicide.

Appendix B:

Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, female.
Gloucestershire; Liam	Death of a 1-month old baby boy (SUDI).
Hertfordshire; Child K	Death of a 16-year old male, suicide.
Hounslow; Sasha	Death of a 17-year old female, suicide.
Kent; Child I Carys	Death of a 16-year old female, suicide.
Kent; Child N	Death of a 9-year old male, filicide.
Kirklees; Child D	Significant harm of a 22-month old male, assault.
Kirklees; Child E	Death of a 4-month old baby boy (SUDI).
Knowsley; Child Y	Death of a 17-year old male, suicide.
Knowsley; Jane	Significant harm to a 4-year old female.
Lewisham & Harrow; Child LH	Significant harm to a 4-year old male.

Manchester; Child U1	Death of a 22-month old child, physical abuse.
Medway; George	Death of a 3-year old child, fatal assault.
Milton Keynes; Child J	Death of a 5-month old baby boy (SUDI).
Newham; Child L	Significant harm to an 8-year old female.
Norfolk; Child V	Death of a 6-month old baby girl, physical abuse.
North Yorkshire; Child C	Death of a 2-month old baby (SUDI).
Nottingham City; Young Person N	Significant harm to a 17-year old male, assault.
Oldham; Child M	Significant harm to a 15-year old male.
Rochdale Borough; Case M	Death of a 9-month old child, non-accidental injuries.
Rochdale Borough; Child X1 and Child X2	Significant harm to two siblings.
Rochdale Borough; Child X1 and Child X2	Significant harm to two siblings.
Salford; Baby MD	Death of a 5-week old baby, maltreatment.
Salford; Child T	Significant harm to a 2-year old female child, parental abduction.
Sandwell; Child HS	Significant harm to a child under one, non-accidental injuries.

Appendix B:

Sefton; Beatrice	Significant harm to an 8-week old baby girl.
Sefton; Mathilda	Significant harm to a female child under 1-year old.
Sheffield; Archie	Death of a 15-year old male, stabbing.
Southampton; Adam and Anna	Significant harm to two siblings (intra-familial CSA)
Southampton; Billy	Death of a 4-month old baby boy
Surrey; Baby LL	Death of a 4-month old baby boy (SUDI).
Surrey; Child D	Significant harm to a 16-year old female, sexual abuse.
Sutton; Child T	Death of a 17-year old, suicide.
Tameside; Child V	Significant non-accidental harm to a 7-week old child, shaking.
Torbay; C66	Death of 17-year old male, suicide
Trafford; Baby X	Death of a 4-month old baby boy, shaking.
Waltham Forest; Child C	Death of a 14-year old male, stabbing.
Waltham Forest; Child D	Death of a 4-month old baby boy (SUDI).
Waltham Forest; Kesandu	Significant harm to a 9-year old female, neglect.
Warwickshire; Child K	Significant harm to a 12-week old female child, skull fracture.
Wiltshire; Child K	Death of a 1-year old child.
Wirral; Liam	Significant harm to a 20-month old male.
Wolverhampton; Child N	Death of a 14-year old female, homicide.
Worcestershire; Isaac	Death of a 12-week old baby boy (SUDI).