Vulnerability Knowledge & Practice Programme

Learning for the police from reviews of child death and significant harm: Collaborative working, victim engagement & evidence and investigation

A seventh briefing concerning CSPRs/SCRs/CPRs produced by the VKPP

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Dr Andrea J. Darling

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 seventh 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 third 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 the methodology). The other briefings address police responses to young parent families and operational and/ or strategic police practice regarding the identification and management of risk. This current briefing focuses on operational and/ or strategic police practice regarding collaborative working, victim engagement and evidence and investigation as they feature within child safeguarding practice reviews. This theme draws on 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

The cases constituting the full sample involved 22 forces over 8 police 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)

Significant harm

Cases involving **significant harm** 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

Collaborative Working

NVAP Action 2.2.1

The findings in this area relate to the NVAP actions concerning 2.2.1 Appropriate action

Collaborative working was the second most common perennial issue reflected in the sample of reviews. Similar to the findings of our meta-analysis of reviews, information sharing from police to partners and police communication and engagement with partners were key areas of learning.

Here we identified learning concerning:

- How policing could improve safeguarding by ensuring attendance (at the appropriate level of seniority) at multi-agency meetings and proactively escalating concerns internally or via local multi -agency safeguarding processes where there are differences in professional opinion;
- How important clarity and joint understanding around the specific roles and responsibilities of different agencies in child safeguarding processes is in ensuring necessary actions are progressed;
- How important effective information sharing is in cases involving missing young people and CCE;
- How helpful appropriate, professional challenge of medical professionals and consultation with a named doctor for safeguarding can be in cases where medical opinion differs.

Information sharing

In some cases involving missing episodes and child criminal exploitation (CCE), police missed opportunities to share information with a range of partners including youth offending or youth justice colleagues. In two cases police did not appear to fully recognise the significance and extent of the risks of CCE to the young people involved. In another case, on two occasions police did not share information about a young person's potential association with firearms, possibly because this was considered uncorroborated. In a fourth case, police did not reassess the level of risk to a young person despite responding to numerous episodes of them going missing and their involvement in criminal activity. The impact of not sharing the information was that partner agencies were not able to fully understand the extent or immediacy of the young person's vulnerability to CCE and address particular risk factors. Consequently, the risks were not optimally managed.

These cases indicate the need for increased police understanding and awareness of the indicators of potential exploitation. Being able to identify the factors and characteristics of situations, backgrounds and experiences of children and young people which may identify risk (regardless of resultant harm type) leads to improved information sharing and safeguarding. Our VKPP Spotlight Briefing on exploitation highlights indicators and resources to support understanding around CCE.

Cross cutting themes

Collaborative Working

Medical advice and differing opinions

At times police may find themselves in situations where there is partner disagreement or uncertainty about what to do when faced with expert medical opinion. An example of this involved differing views on medical assessment in a complex case of a young child where there were suspicions of non-accidental injury. Medical staff at one of the hospitals where the child was treated discounted non-accidental injury as the cause of the child's presenting problem. Despite their reservations police and social work colleagues felt that as non-accidental cause was being discounted by the most senior medical professional involved, even though more junior medics had a different view, there was little they could do. Consequently, the child was discharged home with no further child protection consideration or monitoring planned. In this case police could have consulted with a named doctor for safeguarding and used this as a sounding board for potential challenge. This lack of use of a named doctor for safeguarding has also featured in other local and national review cases. In cases where there is disagreement in professional opinion police can also escalate concerns both within their own agency and via local MASA processes.

Appropriate Action:

Reviewers commented positively upon the appropriate collaborative working efforts of non-specialist frontline officers in some cases. Officers sought advice and support from specialist teams (both internal colleagues and external partners) in responding to specific issues involving children and young people and demonstrated good leadership, which was not rank specific, in their responses. In one example officers sought specialist help and advice from CAIT (Child Abuse Investigation Team) in a suspected CSE case. In another example, officers took immediate specific advice from medical staff dealing with a young person experiencing a mental health crisis in hospital, so as not to inflame the situation. One of the officers subsequently remained at the hospital until the Mental Health Team arrived to conduct the relevant assessment of the young person. This ensured the young person's safety in the interim. The use of 'champions' on frontline shifts where some officers have enhanced training on particular specialisms (e.g. trafficking, exploitation or mental health) is an area of good practice to ensure there is always someone with specialist knowledge available to support officers in their responses.

Content around information sharing in Working Together to Safeguard Children was updated in December 2020. The changes are a response to the Data Protection Act 2018 and General Data Protection Regulation (GDPR). The revised guidance includes an explicit statement that data protection legislation does not prevent the sharing of information to keep a child safe and that consent is not required when sharing information for safeguarding and protecting the welfare of a child. The guidance also recommends using GDPR lawful bases for sharing when making decisions about appropriate information sharing, i.e. legal obligation (the exercise of official authority) or public task (a task performed in the public interest). A useful myth-busting guide to information sharing is also provided on page 21 of the guidance.

Cross cutting themes

Collaborative Working

Reflective practice

- Where decisions for actions have been made between agency partners ensure to proactively follow up to check progress has been made or agreed meetings have been arranged.

- Where there are differing opinions or concerns in cases of potential non-accidental injury in children is there a process in place to consult with a named doctor for safeguarding and potentially challenge assessments by hospital staff if necessary? In deciding whether to consult further or potentially challenge medical view it is important to also consider all information available in the case (such as the circumstances when police arrived on scene, the history of people involved in the incident, etc.)

- It is important to share information with other agencies following a safe and well check being conducted after a child is returned home after being missing. Is this being consistently done in your force? Do you know how your independent return home interviews are conducted, and by whom? Have you got clear intelligence reporting and an information sharing pathway between police and the commissioned return home interview providers? These actions also relate to NVAP action 2.1.3 'Access to Services'.

Cross cutting themes

Victim Engagement and Supporting Vulnerable People Through the Criminal Justice System (CJS)

NVAP Actions 2.4.1, 2.7.1

The findings in this area relate to the NVAP actions concerning 2.4.1 Voice of the Victim and 2.7.1 Working with Communities

Missed opportunities to obtain and consider the 'voice of the victim' continues to feature as a consistent theme in this sample of cases, as within our previous analyses, and was observed in both child and adolescent cases. Similar themes occurred to those identified in the previous meta-analysis. These included children and young people not being spoken to directly meaning that opportunities to identify the impacts of abuse or neglect, further risk, or support needs were missed. Officers' responses were also found to be too 'adult-focussed', meaning that the risk and needs of the adults who were the subject of police response were prioritised over the wider safeguarding needs of children. Similarly, at times, the dominant voices of parents in interactions with police and other agencies overshadowed consideration of the voice and needs of the children. Here we also highlight issues with not taking account of cultural contexts when engaging with children and young people who are victims of exploitation and abuse. At the end of this section we provide links to resources that can support officers in obtaining and considering the voice of the victim.

Engaging with children and young people

Several reviewers commented on how both single and multi-agency assessments did not take into account the voice of children and young people, nor were they sufficiently focused on the child's daily life experience. There were numerous examples of police not engaging directly with children and adolescents who were at risk of harm.

In one example, following a young person's disclosure of sexual abuse their voice appears to be forgotten throughout subsequent action taken. The young person's mother informed the police the family did not want to support a prosecution but there was no reference to this decision ever being discussed directly with the young person themselves to find out their views. College of Policing APP guidance on working with victims and witnesses has recently been revised to support officers provide reassurance to child victims and witnesses who may be reluctant to engage with the police even when given the direct opportunity to do so. This followed an inquest into the deaths by suicide of siblings after reporting familial sexual abuse. The guidance update advises officers to provide ongoing reassurance that a decision made by a victim or witness not to support police action doesn't have to be final; officers should advise them that the door remains open for them or a nominated representative or professional to re-engage at a later date.

The police were involved in another case where an adolescent experienced several incidents of bullying and harassment by other young people but there was little evidence to suggest that the police and other agencies directly sought the young person's views about their situation and what the most appropriate response for them might be. There was no record of attempts to understand the young person's lived experience or the emotional impact that being subjected to intimidation on a daily basis had upon their wellbeing.

Cross cutting themes

VICTIM ENGAGEMENT AND SUPPORTING VULNERABLE PEOPLE THROUGH THE CRIMINAL JUSTICE SYSTEM (CJS)

Wider research and participatory work with youth victims of crime and abuse highlight their wishes to be consulted with and be informed about matters that affect them within the criminal justice system (see this poster created by young people with researchers from the Safer Young Lives Research Centre). The voice of the victim should always be prioritised. Where victims are unwilling or unable to speak to the police directly efforts should be made to observe and record what is going on for the victim, so as to capture their lived experiences.

The need to keep children and young people directly consulted and informed about progress and outcomes through the criminal justice process was also commented upon in several reviews. This applied both when children were victims or where they were personally facing allegations of criminal behaviour. There were examples of communication about police matters always only being via a parent even when young people were old enough to engage themselves and where they may have wished to do so. In one case substantial delays in undertaking an ABE interview with a young person (and the reasons for these) were not communicated to them which left them feeling uncertain and frustrated. This led to them withdrawing their consent to be interviewed and the matter being closed by police.

Dominant parental voices

In some cases, the responses of parents or carers to agency intervention were overly controlling, aggressive or obstructive. This had the impact of effectively drowning out the voice of the child for practitioners who sometimes failed to challenge what the parent/carer was doing. It could also interfere with police speaking directly to children. In one example, when an officer visited the home of a young child who had made allegations of sexual abuse, the child's mother was behaving quite obstructively and the officer did not speak directly to the child about the allegations made. Despite the mother's behaviour the child should have been given the opportunity to talk about the allegations, in a safe place and without a parent present. Where officers are unable to access a safe space to speak to a child and enable them to share their concerns at a particular time, this should be clearly recorded, stating the reasons why. The matter should also be raised as an action point for further consideration in the referral process.

Cultural barriers

Police officers will often encounter children, young people and families with different backgrounds to themselves and this can prevent full and effective engagement and response, as the following example demonstrates. The case involved a young person and their family who were part of a minoritized cultural and religious community. The family felt that the limited understanding held by professionals, including the police, about what life was like for the young person and the religious and cultural codes and expectations that guided them, was a major barrier for them working effectively with services. The young person was at potential risk of CSE and experiencing a range of issues at school and with their mental health. The reviewer found that while one police force was perceived by the family to have responded sensitively and appropriately, there was no evidence that another police force and CSC considered the cultural context when working with the young person. Insufficient account was taken of the impact of the young person's cultural heritage, their personal and social norms and their daily lived experienced as a member of a specific religious and cultural community. This would have been particularly difficult for the young person as some of the issues of concern related to potential sexual exploitation. The reviewer commented on the need for bridges to be built between agencies and the community the young person came from.

Cross cutting themes

VICTIM ENGAGEMENT AND SUPPORTING VULNERABLE PEOPLE THROUGH THE CRIMINAL JUSTICE SYSTEM (CJS)

The reviewer considered communications and relationships between the community and agencies may have been impacted by the community's lack of trust in mainstream services. This is turn can contribute to placing vulnerable young people at greater risk of exploitation and other harm. By being aware of, and mindful about, the particular cultural and religious sensitivities in responding to the case the police and CSC colleagues might have been able to engage more effectively with the young person and their family to better manage the risks at the time. This report by the Independent Inquiry into Child Sexual Abuse (2020) describes how this type of abuse can have a serious impact on victims and survivors' sense of identity and belonging within their communities. It also refers to a lack of cultural awareness in service responses to CSA in ethnic minority communities.

The VKPP's Domestic Homicide Review briefing also identified the influence of cultural frameworks in cases involving domestic abuse. The briefing highlighted the significance of culture in shaping victims' views of abuse and their engagement with the police and the need for police to fully consider these cultural influences. The NSPCC published a briefing on learning from case reviews about culture and faith and their website provides practical advice on safeguarding in faith communities. Local safeguarding partnerships also publish advice on guidance on 'cultural competence' when working with children and families, for example this guide, published by the Newcastle Safeguarding Board.

Appropriate Action:

There were some examples of good practice in engaging and supporting victims identified in the reviews analysed for this briefing. For example, in one case CID officers established a good rapport with a child's sibling before they took part in an ABE interview as a witness. The officers made drinks and snacks for the child and talked to them about matters of interest to them. Seemingly small relational actions such as this are really important to children and young people, who emphasise that they want police to personalise their interactions with them. The reviewer in the case described how developing such rapport would be expected to improve the likelihood of the child speaking freely in their ABE interview.

Communicating effectively with children can be challenging, particularly when dealing with sensitive issues and in emotional circumstances. A number of resources provide advice and guidance for professionals. This 'Big Up the Bill' campaign report contains ideas and feedback from children and young people on how police effectively communicate and behave when working with them. This NSPCC webpage provides advice about talking to children about difficult subjects. It also includes a list of books to support professionals in having conversations with children and adolescents. In addition, a new interactive training simulation tool, 'Talk to Me' has been developed in collaboration with the NSPCC. It's designed to give adults the confidence to hold difficult conversations with children around abuse and allows professionals to practice talking to children in a simulated environment. The Communication Trust also publishes resources to help communicate effectively with children with speech, language and communication needs, including within the youth justice sector. The Centre for expertise into CSA is also developing a practical resource to support practitioners when engaging with children and young people about child sexual abuse and exploitation which will be published on their website.

Cross cutting themes

VICTIM ENGAGEMENT AND SUPPORTING VULNERABLE PEOPLE THROUGH THE CRIMINAL JUSTICE SYSTEM (CJS)

Reflective practice

- Considering the daily lived experience of a child or young person is important to understanding risks and appropriate responses. Think about what day to day life is like for the child/young person living in the specific circumstances in which they do; what relationships and environments are they exposed to and how they might feel to the child. Where possible, talk to the child to gain their perspective, feelings and wishes.
- Where particular cultural or religious contexts are a feature of the child/young person's life take care to consider the impacts of this. Where appropriate consult with parents, family and other members of the community to understand this or seek specialist advice. The NSPCC website provides practical advice on safeguarding in faith communities and this example guidance provides advice on 'cultural competence'.
- The approach to working with child and adolescent victims of sexual abuse or exploitation also needs to be culturally sensitive and take into account specific aspects of equality and diversity. Consider if any approaches or materials you use in your area are culturally appropriate for direct work with young people from specific religious and cultural communities. Might they present any potential barriers to engagement for children, young people and their families?
- When conducting home visits or engaging with children about potential concerns of abuse or neglect, it is important to ensure children are given opportunities to speak to professionals in a safe place and without a parent present. Is this consistent practice in your force? Do officers have the skills and confidence to engage with children of all ages and abilities or have support to do so when required?
- The newly revised Code of Practice for Victims of Crime (the Victims' Code) came into effect on 1 April 2021. Under the code victims have the right to be provided with information about the investigation and prosecution. Wherever possible and appropriate ensure children/young people are kept personally up to date with what is happening in any case that concerns them. Explain the reason for any delays and ensure they have support. This should provide assurance and keep them engaged in the process. This leaflet explains to under 18s what support they should get as victims of crime.

Cross cutting themes

Evidence and Investigation

NVAP Action 2.4.2; 2.4.3

The findings in this area relate to the NVAP actions concerning 2.4.2 Evidence and Investigation and 2.4.3 Evidence-led prosecutions.

Most missed opportunities around evidence and investigation primarily related to evidence gathering and delays in investigation, having a variety of consequences for children and their families. In a number of cases there were impacts both in relation to the investigation of specific incidents but also with regard to the ongoing safety and welfare of children and young people. In some of these cases where there were delays, resourcing appeared to underpin the problems. Reasons for delays included: victims/alleged perpetrators living in different geographical areas; staff resourcing and shift patterns; the availability of investigators; and a shortage of trained interviewers. There were examples where delays in investigation and evidence gathering resulted in evidence being compromised, the withdrawal of child and family support for police investigation and cases being closed without full investigation and reaching an appropriate conclusion based on all available evidence. In some cases resourcing issues and delays in interviewing victims and alleged perpetrators not only had an evident impact on the quality and sufficiency of evidence, but also resulted in a lack of appropriate risk assessment and protection for children and young people involved.

It is the joint responsibility of partners, including the police, to ensure local child safeguarding systems are working. This includes not only assessing threats and risks to children but also anticipating and responding to barriers across the whole system. Resourcing, capacity and capability are systems issues within local child safeguarding arrangements within which police are joint partners. In order to recognise and respond to issues, it is important that threat diagnosis and management information available to police leaders (both at force level and via local child safeguarding partnerships) is able to highlight areas of pressure or particular risk in the system. This helps the allocation of resources or facilitates the escalation of concerns within partnerships.

Issues in this regard were apparent in one example case where evidence was compromised by the delay in interviewing a very young child following potential harmful sexual behaviour towards them by an older child. As a result of 'process and practical constraints' the interview was delayed by a month after the original concern became known. During that period family members had discussed the alleged incident with the young child and were believed to have encouraged them to expand on their thoughts and feelings about the young person who was the suspect. This then had an impact on the evidence collected at the interview. The reasons for the delay were also not recorded on the child's record or police recording system in accordance with the local police and social joint working protocol.

Cross cutting themes

Evidence and investigation

An example of the impact of early case closure was reflected in a case where a strategy meeting was held 8 days after a young person made an allegation of sexual assault against an adult relative. The police had already closed the investigation before the strategy meeting took place, at a time where the facts of the case remained largely unknown. The reviewer notes that there was a sense of professionals, including the police, considering the reported assault to have been minor and the young person's parents having taken control of the situation. This potentially reflects a lack of understanding about the nature and impact of abuse. There also appeared to be no consideration of the perpetrator's potential ongoing ability to contact the young person without their parents' knowledge.

Consequently, the young person was not offered any support or help to learn how to keep safe, which could have resulted from a referral to the local multi-agency Child Sexual Exploitation Team.

Reflective practice

- It is important to hold ABE interviews as soon as reasonably practicable (dependent on specific interviewing training and guidance), particularly those with young children. However, it is also important to carefully consider the circumstances in each case and the potential impact upon children who may be experiencing trauma of being subject to interview when they are not ready. There can be a negative impact on both the child victim and the evidence obtained if this is done when they are not ready. If there are delays in conducting planned ABEs ensure to fully record clear reasons for such delays. The ABE guidance on interviewing victims and witnesses addresses interviewing very young children and College of Policing APP Guidance on working with victims and witnesses and investigative interviewing is also available.

Next steps

The VKPP are currently planning the Research & Review strategy for the future. A number of different research and review projects are in progress, including studies looking at the 'Voice of the Victim'. Outputs will be published in due course on the Knowledge Hub and the College of Policing Vulnerability and Violent Crime webpage, here.

Please engage with us! If you have comments or feedback please let us know by emailing us. Also, if you have specific topics you would like us to spotlight, let us know. You can contact us at vkpp@norfolk.pnn.police.uk.

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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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:

The incident that triggered the CSPR/CPR/SCR occurred on or after January 1st, 2016

1. 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

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

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).
Cambridge-shire and Pe-terborough; Eleanor	Significant harm to a 19 -month old baby girl, assault.
Cambridge-shire and Pe-terborough; Jack	Significant harm to a 3-month old baby boy.
Cambridge-shire and Pe-terborough; 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).