Learning for the police from reviews of death or serious harm or injury as a result of child abuse or neglect: November 2019

This briefing contains learning for strategic and operational police practice in England and Wales

Introduction

This briefing is the third in a series of briefings produced by the Vulnerability Knowledge and Practice Programme (VKPP)[1]. Between July 1st and September 30th, 36 unique published Serious Case Reviews were identified and examined, with 11 fitting the inclusion criteria for analysis (see Appendix B for methodology). The briefing uniquely focuses on operational and/ or strategic police practice as it features within Serious Case Reviews (SCRs, in England) and Child Practice Reviews (CPRs, in Wales). The system for learning from reviews is changing in line with the new safeguarding arrangements. Please see the Q1 briefing and Working Together to Safeguard Children 2018 for more detail.

This third briefing features information sharing as a special theme. Information sharing continues to emerge as an area for development. We have tried to identify, using information in the SCRs, why information sharing continues to be problematic. We also, as in previous briefings, have identified cross-cutting learning for forces. We would welcome any feedback or suggestions in relation to the briefing at vkpp@norfolk.pnn.police.uk. We would also encourage forces to engage with us by highlighting any new reviews as they become available by contacting us at the same address. Please consider filling out a very brief, anonymous survey about the briefing by clicking on this link so that we can continue to improve its usefulness and relevance to you: VKPP police briefing - short survey

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[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

Snap shot of cases

Police forces

- Five police regions, and 7 police forces, are represented in these 11 SCRs

Police involvement

- Police initially became involved with the child and/or family in the following ways:
  - 4 reports of a missing child
  - 3 incidents at family home (domestic violence)
  - 2 crimes committed by a parent(s)
  - 1 child left unsupervised outdoors
  - 1 unknown reason for initial involvement

Categories

- The 11 SCRs relate to: **6 deaths (55%)** and **5 (45%) cases of significant harm**

Deaths

- ***The 6 deaths related to:***
- *2 cases of 'covert filicide'*
- *2 cases of suicide*
- *1 case of 'overt filicide'*
- *1 case of child homicide*

Significant harm

- ***The 5 cases of significant harm*** *related to:*
- *2 'Physical assault'*
- *2 neglect (1 of these cases was undertaken as a joint serious case review and adult safeguarding review)*
- *1 other (child was hit by a car whilst unsupervised)*

SPECIAL THEME: INFORMATION SHARING

The Home Office guidance for practitioners on information sharing states: *"Sharing information is an intrinsic part of any frontline practitioners' job when working with children and young people. The decisions about how much information to share, with whom and when, can have a profound impact on individuals' lives. Information sharing helps to ensure that an individual receives the right services at the right time and prevents a need from becoming more acute and difficult to meet"* (Home Office[2], 2018; p. 6).

Research finds that breakdowns in communication can happen where there is an absence of local safeguarding systems, barriers to effective co-working or failure to recognise or act upon safeguarding opportunities (Sidebotham[3] et al., 2016). Guidance on information sharing assumes that poor information sharing is a result of uncertainty among professionals about how and when to share information (Home Office, 2018).

In the 68 SCRs reviewed for this special theme, we did not find evidence that police were unwilling to share information, or uncertain about how and when to do so. This is not to say that this does not happen, but the examples relevant to policing found within SCRs show a more complex story. Examples found within SCRs are highly specific to their individual contexts, but provide insights into the types of barriers that exist to effective information sharing by the police – with police or with partners.

Information sharing deficits: summary

Across the 68 Serious Case Reviews in our analysis, information sharing by police was notable in 37 cases (just over 50% of the sample).

Information sharing problems were evident in a number of ways. Most commonly, information was not shared with police or partners that would have been warranted.

Sometimes, however, the quality of information shared was poor, or the amount of information shared was minimal. There were also examples of delays to information sharing that meant safeguarding opportunities were also delayed. In a smaller number of cases, police did not act on information that was shared with them, even though it would have warranted action.

[2] Home Office (2018) *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers*. London: HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

[3] See report at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

Table 1 focuses on the 23 instances in which police did not share information that would have been warranted in the circumstances. Sometimes, information was not shared because police were unable to recognise vulnerabilities present, so they were unable to generate relevant information to share. In other cases, police were hampered by ineffective, or absent, systems for sharing information either internally (within policing) or with partners.

Table 1: Barriers to sharing information

Information about vulnerability must be recognised as such in order for it to be shared in the first place. The following examples show how information sharing has been prevented because of a lack of awareness of indicators, signs and patterns of vulnerability.

- Information not shared because the **safeguarding needs of a young person** - alleged to have committed a sexual offence against another young person - **were not recognised**.
- Police responding to a young person **with escalating offending patterns did not recognise signs of criminal exploitation**, leading to failures to refer the young person to the National Referral Mechanism.
- Officers' consideration of domestic abuse incidents **in isolation** from the broader DA history meant escalating concerns were not shared with MARAC.

Even where vulnerabilities are recognised by officers, processes or systems may be absent, or ineffective, for sharing information in a timely way. The following examples demonstrate how processes or systems can prevent information sharing by the police.

- **Multiple police teams/ officer involvement** in an investigation has led to **lack of clarity about the progress of investigations**, frustrating effective approaches to sharing information with partner agencies. The more officers/ teams involved, the greater the information sharing challenges. Effective information sharing within each agency is first necessary to support effective information sharing with partners.
- **Multiple police force** involvement in investigations similarly frustrates effective information sharing. This can lead to an inaccurate picture of police interactions with children and families across borders. Where police systems do not link together, information logged across borders may not match up.
- **Multiple IT systems** in use can frustrate information sharing because information is held in different locations. This can be particularly problematic for partner agencies working with the police, for instance where a voluntary sector or social care practitioner may be co-located with the police.
- **Ineffective systems for sharing information from multi-agency meetings** has prevented the sharing of information with partners by the police. Minutes of meetings, in one case, were stored solely on police systems. Centrally produced records of these meetings should be distributed to all to ensure accuracy is checked and actions noted.
- An **absence of a system in place for communicating information between police and partners** prevents good information sharing. Good systems need to be in place for police to share information with clinical

staff at hospitals, for example, when thresholds for s136 of the Mental Health Act are not met.

- **Information sharing by specialist police teams in the early stages of development** may be ineffective where systems for doing so are not fully embedded. In one example, a newly established CSE perpetrator scheme did not refer a young person displaying sexually harmful behaviour on to the operational group for multi-agency tasking. This was a missed opportunity to have developed a multi-agency risk management plan for the young person.
- Information sharing within force can be hampered where adequate processes are not in place. For example, **good systems should be in place for neighbourhood policing teams** to be aware of families where child protection plans are in place. Their knowledge of their local community can help build a picture of emerging vulnerabilities.
- Sometimes SCR reviewers note that national guidance on safeguarding may not be effectively customised for local use by police. One example concerned Safeguarding Children Who May be Trafficked and was incorporated into local policies and procedures, but the reviewer felt responsibilities would have been clearer if they had been **customised as local documents setting out steps to be taken** (for example, procedures outlining timescales and agency responsibilities).

In a number of cases, there was not enough information included in the SCR review to determine why missed opportunities occurred. We found missed opportunities for:

- talking to young people who have been missing about wider vulnerabilities or crimes within safe and well checks, because officers did not thoroughly review all relevant reports about a young person prior to undertaking the check;
- accurate and robust background checks, because those checks were based on inaccurately completed paperwork;
- sharing accurate information, due to failures to thoroughly check all police IT systems;
- referring a child involved in a DA incident to Children's Social Care;
- sharing information or concerns with partners despite holding relevant intelligence. In one case of domestic abuse, the mother was living at home with her children and a new partner, while the father of the children was in prison. He was due for release, and the police had reason to be concerned about potential violence on his release, yet did not submit a Public Protection Notice

CROSS CUTTING THEMES

The themes presented below offer universal messages for police practice across a range of case types. The messages below are drawn directly from SCRs where Police practice either did not meet standard expected practice or missed important opportunities for intervention. It is structured roughly according to the flow of an investigation for ease of reflection, and the themes within each section are classified by the likely explanations for the missed opportunities. In some reviews, it is not possible to glean information about why missed opportunities occurred. A matrix listing the 11 SCRs and the themes associated with each can be found in Appendix A, where interested readers can go directly to the SCR by clicking on the title link.

Multi-agency working and decision-making

Knowledge, awareness or attitudes as barriers to effective multi-agency working

Importance of multi-agency working to address repeat missing episodes

In complex cases, such as those involving repeat missing episodes, it can be a challenge for all agencies involved to find effective solutions for keeping children safe. In one SCR, the Police – **feeling frustrated in their responses to a young person with many repeat missing episodes** – used Police Powers of Protection to move them to safety; this was taken in the absence of a multi-agency discussion. The Police, and partner agencies, were all taking single-agency actions, resulting in a highly uncoordinated response. **Had a multi-agency forum been convened, a more effective and meaningful plan of safety** could have been developed and ensured that the actions of one agency did not contradict those of another.

Working with partners to engage parents in safeguarding

One reviewer identified good practice by the Police and School, when early concerns about a child's behaviour emerged. The SCR was triggered when a child of 6 was hit by a car on a dual carriageway. He was on a Child Protection Plan for neglect due to inadequate care and supervision and mother's drug use. The two agencies provided positive behaviour mentoring, information on safety and educational support. The child's mother, however, disengaged from this support. The reviewer advised it would have been **beneficial to bring in support for the mother**, to enable continued support of the child, alongside continued safeguarding responsibilities and relevant escalation to a multi-agency forum where necessary. Police, alongside their partners, should be alive to the **needs of parents**, which may be preventing effective safeguarding support for their child.

Resourcing barriers to effective multi-agency working	In one SCR in this sample, a social worker requested the police carry out a safe and well check following difficulties in gaining access to a home where there were concerns about a child (the child told the social worker that their mother was drinking heavily). At the time, no officers were available to carry out the safe and well check and, by the time an officer was able to make contact with the social worker about this, the child and their siblings had already moved out of the property.
Unknown barriers to multi-agency working	SCRs do not always uncover – or provide detail about – why multi-agency working was not effective. Some examples show that: • police sometimes assume that partner agencies will do something, but fail to follow up or escalate their concerns; • police state in their records they will do something (for example, refer to MARAC), but evidence suggests a lack of action.

Information sharing	
Knowledge, awareness or attitudes as barriers to information sharing	*Awareness of wider safeguarding issues* SCRs demonstrate that appropriate and expected information sharing can be hampered when officers are not alive to **wider safeguarding issues beyond those which are of immediate concern**. In one example of child death, officers responded to a domestic abuse incident at the home of young, vulnerable parents (both were 18 years old). Although the police identified that a 'new' male (a friend of the father, with a criminal record and not from the local area), was living with the family, they did not submit relevant intelligence about this. While in this case, the father's friend was not implicated in the death of the child, it highlights the need for police to be professionally curious about new adults residing with young, vulnerable families. While the new male was not later implicated in the death of the child, the case highlights a missed opportunity for using professional curiosity about a new person living in the family home of a young, vulnerable family.
Procedural or systemic barriers to information sharing	*Single point of contact across police boundaries* In one SCR, the reviewer praised police for effective information sharing across three different police forces, and with partners in multiple locales. However, to strengthen these processes, one of the forces has now established a **'single point of contact'** to receive intelligence information when several other counties are involved in a case. This single point of contact can then share information as needed. *Processes for information sharing between police and hospital staff* When responding to mental health needs where the threshold for s136 of the Mental Health Act is not reached, it is crucial for police and health professionals to have a **process in place for effective sharing of information**. In one case, police responded to a family dispute where a mother (with mental health needs) was arguing with, and had assaulted, her adult children. The police escorted her to the hospital to be checked out, but did not hand over information about the incident to clinical staff in the absence of a process for doing so. In the learning event, the police noted that because the threhold for s136 had not been met, there was no need for the police to stay with her. While this is not unusual, police need to ensure they safely and confidentially share all relevant information with clinical staff who need a full picture of events in order to provide the best service. In this case, hospital staff treated the mother in the absence of knowledge about her mental health needs and domestic abuse against her children.
Unknown barriers to information sharing	In one case, a DASH completed on a domestic incident involving the subject of the SCR was not shared with relevant partners, even though this would have been of use to partners in providing a full picture of a young person's circumstances.

Risk assessment	
Knowledge, awareness or attitudes as barriers to effective risk assessment	*Awareness of vulnerabilities and risks for young parents* One SCR highlights the importance of **giving full consideration to the vulnerabilities and risks present for a young parent**. One young mother was experiencing domestic abuse by their child's father. Police responded to DA the first time when the mother was under the age of 18, and again when she was 18. The reviewer noted that the risk levels applied during the child risk notification process and subsequent MASH analysis **did not fully consider all vulnerabilities and risks faced by the mother as an older child (in the first DA incident) or as a very young adult (in the second DA incident). The child of the DA victim also did not appear to have been considered in the risk analysis.** The reviewer hypothesised that the focus of the Police was on her as a mother with her own child, obscuring her wider needs as a young, vulnerable person herself. This meant that opportunities for professionals to engage with the family were missed and no support was offered to the mother.
Unknown barriers to effective risk assessment	Sometimes, a number of errors come together to prevent effective risk assessments. It is not always possible to know why such errors occurred, from the information provided in the SCRs. In one SCR reviewed in this sample, an officer attended a family home following an anonymous report about a possible domestic abuse incident. The parents were uncooperative and denied anything had occurred. The officer was, in fact, concerned about the children in light of the parents' attitudes, and had intended to complete a DASH. Unfortunately **the officer forgot to do so**. This was coupled with **a call handling error**, in which the incident was logged as a 'concern for welfare' rather than as domestic abuse and this, along with the failure to complete the DASH, meant that **no referral was made to Children's Social Care**. Here, some individual errors resulted in a failure to conduct a risk assessment that would have provided the opportunity to share information with CSC.

Investigation and charging

Knowledge, awareness and attitudes as barriers to effective investigation and/or charging

Lack of knowledge or awareness can impact the shape of investigation as well as the way in which young people are charged with crime.

Criminalisation of young people in care

The *National protocol on reducing unnecessary criminalization of looked-after children and care leavers* (Home Office, 2018[4]) highlights that looked-after children and care leavers are over represented in the criminal justice system[5]. The report states "*Coming into contact with the criminal justice system tends to increase the likelihood of offending, and children and young people, especially the most vulnerable, such as looked after children, should be diverted from it wherever possible".* In one SCR, the young person (subject of the SCR) was found in his foster home in possession of a knife while under the influence of 'legal highs' (as they were designated at the time) which resulted in his conviction for a criminal offence. The SCR reviewer referred to the Howard League for Penal Reform briefing (2017) which said *"In some cases children in care are at risk of being criminalised. Challenging behaviour must be recognised for what it is. Children's homes and police ought to respond sensitively so that children do not have their life chances blighted by an unnecessary criminal record."* The reviewer advised that the Police, as well as the Crown Prosecution Service and judiciary must be aware of the impact of criminalisation of looked after children and take this into account in their decision-making.

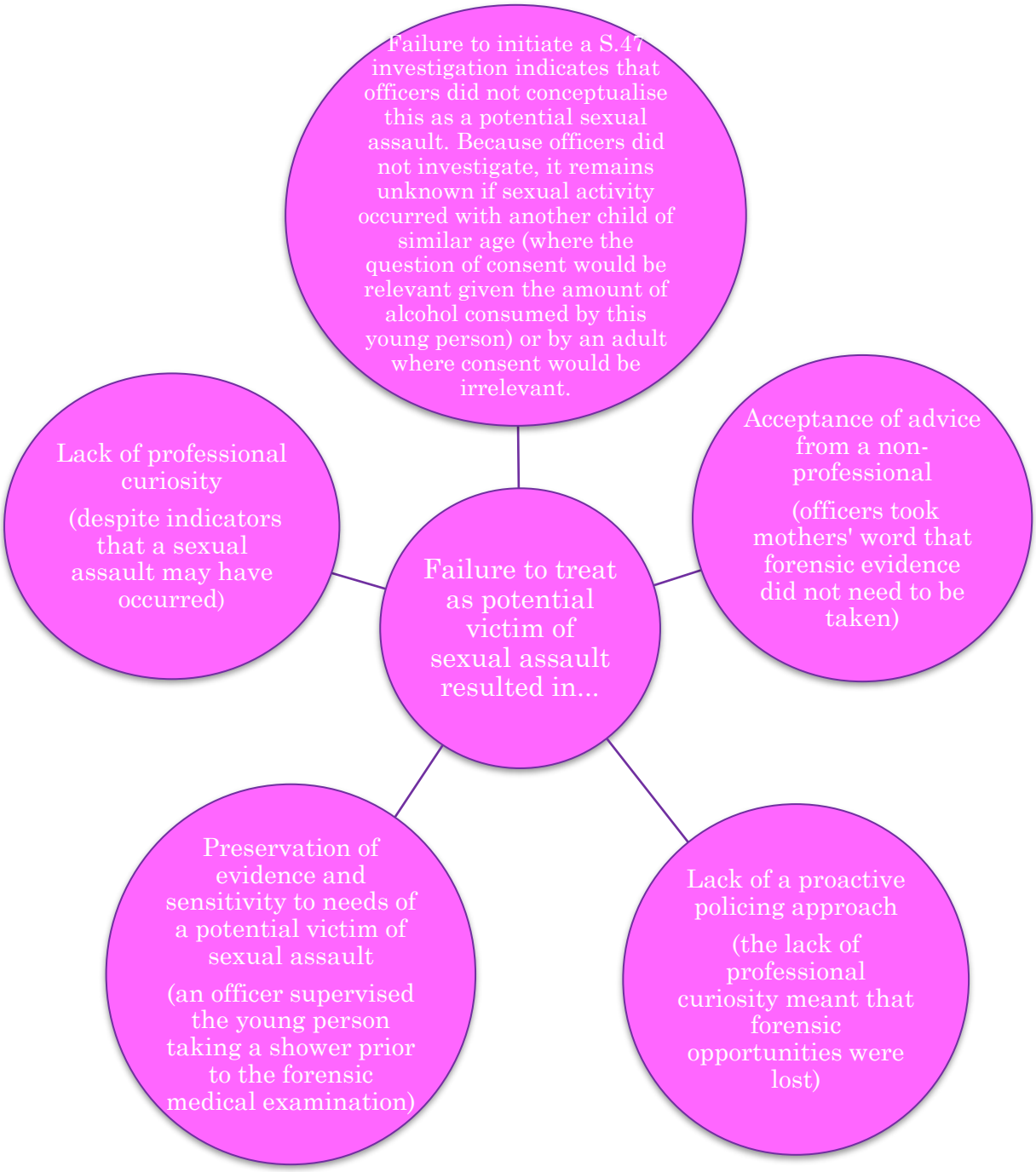
Failure to recognise the potential sexual assault of a young person

One particular SCR highlights a multitude of missed investigative opportunities by the police. The case concerned a young female whose body was found decomposed in the wardrobe of a flat. A man was charged with and found guilty of her murder. The police had come into contact with the young person prior to her murder when she was 14 years old. She was brought to the hospital in a dishevelled state, was incomprehensible due to her consumption of a significant amount of alcohol and she presented with indicators that sexual activity had taken place. No disclosure was made, but there were clear indicators that sexual activity had occurred. The reviewer's primary concern was that officers and partner agencies failed to treat this young person as a victim of a potential crime and did not treat the incident as a potential serious sexual assault. Figure 1 the following page details the series of failures that followed.

[4] The National Protocol can be found at this website: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765082/The_national_protocol_on_reducing_unnecessary_criminalisation_of_looked-after_children_and_care_.pdf

[5] In the year to 31 March 2018, 4% of LAC aged 10 or over looked after for at least 12 months were convicted or subject to youth cautions or youth conditional cautions during the year. Looked after children (who have been looked after for at least 12 months) are five times more likely to offend than all children. (Children-looked-after-in-england-including-adoption-2017-to-2018).

Figure 1: Missed opportunities arising from initial failure of officers to treat a young person as a potential victim of sexual assault



Engagement with children and families

Knowledge, awareness or attitudes

SCRs continue to demonstrate that **the 'voice of the child' is not always being sought by the police.** This was highlighted in two SCRs in this sample, particularly in relation to accommodating young people who go missing, and in responses to the needs of young carers.

Placing young people in places of safety
When young people go missing repeatedly, it can be challenging to make decisions to keep them safe. It is essential that police work with multiagency partners to establish an effective safety plan, and within this, ensure the young person themselves is asked about their views about where they should be placed.

Responding to young carers' needs
A joint Serious Case Review and Adult Safeguarding Review was undertaken in respect of a mother and her 16 year old son. The mother was diagnosed with cancer, was a heavy drinker, and her 16 year old son assumed an important caring role in this context. On one occasion when his mother was displaying psychotic behaviour, Police attended, describing her son as 'independent' and 'not distressed'. The Police did not speak directly to the child about how he was feeling and their assumptions meant they did not grasp the impact of this episode on her son. He later described the incident to the SCR reviewer in a way that demonstrated he had been traumatised by it.

Conclusions

Improving multi-agency working and decision making

- Multi-agency decision-making is essential in challenging and complex cases such as those involving young people who are repeatedly missing, and single-agency actions are rarely effective because they can confuse and contradict actions taken by other agencies. Front line staff and supervising officers should always seek multi-agency perspectives in their attempts to safeguard children who go missing.
- Where parents may be hindering their child's safeguarding because they themselves are not supporting or engaging with multi-agency provision, officers, with their partners, should look for ways to re-engage the parent. This might be through referral or support by another agency.
- Officers, when sharing concerns as a matter of safeguarding, should have agreed processes for escalation when the response received needs to be challenged or is perceived to be inadequate by the officer. This could be underpinned by local agreed escalation protocols. Officers should also always obtain feedback on the concerns they have raised to ensure they are satisfied with the action taken by other agencies.

Improving information sharing

- Officers must be able to recognise vulnerability in order to generate information that is pertinent for sharing. In particular, officers should be 'professionally curious' about wider safeguarding issues that may present themselves. This means being alive to potential safeguarding issues when responding to calls about a domestic abuse incident, for example.
- In cases which involve multiple Police teams, forces or officers, effective information sharing between Police staff is necessary to support effective information sharing with partners.
- The absence of effective communication systems limit the possibility of good information sharing. Systems should be developed with effective multi-agency working in mind.
- Officers should ensure that they provide all appropriate information to other agencies before handing over responsibility of the case.

Improving risk assessment

- Awareness of the range of vulnerabilities present for young parents is essential for an effective risk assessment. While the focus may be on the young adult as a parent, their needs as vulnerable young people are relevant in considering the wider risk for the family.

Improving investigation

- Frontline and senior officers should be aware of the impact of criminalisation on young people in care, and consider this in decision-making.
- Initial conceptualisation of a crime can clearly dictate the actions that follow, as shown in the case presented in this briefing. Officers' awareness of when an incident may be a sexual assault is critical in gathering evidence and making decision about the safeguarding needs of a young person. It is important to be open to reviewing assumptions that have been made, through reflective practice and supervision so that alternative explanations are explored and discounted.
- It is important that officers consider an individual's capacity to consent to sexual activity when deciding whether to investigate a potential sexual offence. Consent is irrelevant where

sexual activity occurred between an adult and a child, but it may be relevant where it has taken place between two young people of a similar age (and who are over the age of 12).

Improving engagement with children and families

- Forces need to continue to improve how they seek the voice of the child. There should be genuine attempts to talk to children and young people, in developmentally appropriate ways, to understand what they are thinking and how they are feeling.
- Officers should not make assumptions about how a child or young person is feeling based on how they 'appear'. Talking directly to a child or young person who may 'appear' to be 'ok' may provide a different picture when asked directly, providing an opportunity to identify additional support for them.

Next steps

This was the final briefing on Serious Case reviews produced for 2019. We will be conducting a wider meta-analysis of all reviews collated over the last year, due to be published in March 2020. If you have any additional SCRs you think we should consider, we encourage you to alert us to these by the end of December, 2019. **We would also encourage forces to share any practice that tackle the issues raised in this briefing or which meet recommendations made in the conclusions. This would help us share good practice in these areas.** Please click on the link in the introduction to complete a brief survey where you can provide your feedback, or, if you would like to be in touch, please contact debra.allnock@norfolk.pnn.police.uk.

APPENDIX A: SAMPLE OF SERIOUS CASE REVIEWS AND RELATED THEMES

Case review title and link	Review focus	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Responding to vulnerability	Investigation	Disruption, diversion, pursuit of perpetrators	Engagement with children and/or their families
Blackpool: Child CB	Death of a 17 year old by suicide					■			
Cumbria: Child BE	Significant harm to an infant, non-accidental injuries		■						
Dorset: Child T	Death of a 16 year old male, drug overdose					■			
Dudley: Child N	Significant harm to a 17 year old, who sustained life changing injuries from a stabbing	■							■
Dudley: Young Person P	Death of 16 year old by murder						■		
Gloucestershire: James	Death of 4 month old child			■	■	■			
Kent: Child H	Death of a 5 year old child by overt filicide		■						
Lancashire: Child LL[6]	Death of a 20 month old child, child homicide		■		■				
Middlesbrough: Daisy[7]	Significant harm to 3 year old from ingesting methadone			■		■			
Stockport: KW and KG	Concerns about agency support of a 16 year old young carer	■							■
Middlesbrough: Billy		■							

[6] Report no longer available
[7] Report no longer available

APPENDIX B: OVERVIEW OF METHODOLOGY

Identifying Serious Case Reviews for inclusion

The NSPCC repository was searched for any new SCRs added following June 2019 (any published in the repository before this time would have been included in the previous briefing). Two reviews were identified by this method, but neither were included for analysis.

Additionally, emails were sent to Single Point of Contacts across the forces to request any recent SCRs they may hold, but which may not have yet made it onto the repository. None were provided.

An additional search of LSCB websites for any SCRs fitting the inclusion criteria as detailed below yielded a number of SCRs not yet on the repository or shared by forces. All 11 of the SCRs included here were identified by this method.

Inclusion criteria

Cases were included where they fit the following criteria:

1. The incident that triggered the 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

SCRs were excluded from this analysis where:

1. the incident that triggered the 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 SCRs included in the analysis

A total of 36 SCRs were reviewed, 11 of which fit the criteria for inclusion for analysis. Table 1 details the number and percentage included, or excluded and the reasons for this. The second column details the number in each category identified from the repository, from forces or from LSCB websites.

Table 1: Number of SCRs considered for this review, and their inclusion status

Inclusion status	Number (%)	Number from NSPCC	Number from forces	From LSCB websites
Included	11 (30%)	0	0	11
Excluded: Post incident involvement only[8]	6 (17%)	1	0	5
Excluded: Date unclear	5 (14%)	0	0	5
Excluded: Out of date[9]	4 (11%)	0	0	4
Excluded: No learning relevant to policing practice[10]	6 (17%)	1	0	5
Too brief to extract any useful learning about police practice	3 (8%)	0	0	3
Excluded: No police involvement in the case[11]	1 (3%)	0	0	1
	36 (100%)	**2**	**0**	**34**

Timeframe of reviews

Of the 11 cases included for analysis, all were published in 2018 (n=5) and 2019 (n=6). The month/year of incident that triggered the SCR spanned from July 2016 to July 2018.

[8] In these cases, the police were only involved with the child subject to the SCR (or their family) post-incident usually through an investigation; but no learning was provided about the quality or detail of police involvement post-incident.

[9] In these cases, the review was published between 2017 and 2019, but the incident that triggered the SCR occurred prior to January 1st, 2016 and was thus excluded from the analysis.

[10] In these cases, police were involved with the case prior to the incident that triggered the SCR, but the reviewer identified no messages for practice for the police within the body of the review or within the recommendations.

[11] In these cases, there was no involvement by the police with the child/family prior to the incident that triggered the SCR, and the result of the incident did not include a crime that the police would investigate – therefore there is no specific police practice identified in the SCR.