Quality of reviews of serious cases[1]

Introduction

This briefing considers statutory safeguarding reviews of death and serious harm and the quality of information about police practice compiled within them. The Vulnerability Knowledge and Practice Programme (VKPP) have been conducting a secondary analysis of child, vulnerable adult and domestic homicide reviews to understand how police feature in them and investigate the key gaps in practice within these types of cases. In the first 18 months of operation, the VKPP team analysed **126 child and adult statutory reviews of death and harm:** 69 Serious Case Reviews (SCRs) or Child Practice Reviews (CPRs), 45 Safeguarding Adult Reviews (SARs) or Adult Practice Reviews (APRs), 10 Domestic Homicide Reviews (DHRs) and 2 joint reviews (one SCR/DHR and one SCR/ SAR). We encountered a number of issues relating to quality of information through our research, and suggest improvements should be considered in order to maximise the learning.

This briefing will be of interest to:

- national policy makers responsible for overseeing review processes
- public protection leadership with responsibility for overseeing internal force review processes
- safeguarding leads with direct engagement with the commissioning of review processes
- learning and development leads with responsibilities for collating and disseminating the learning in reviews.
- internal governance and quality service leads with responsibilities for ensuring quality services
- voluntary, advocacy and policy non-government organisations with an interest in creating responses to evidenced gaps affecting children, young people and vulnerable adults

Rationale for this VKPP workstream

The VKPP recognised early on that there are gaps in drawing together the learning about police practice from statutory reviews. These different review types are siloed by different areas of vulnerability and we hypothesised that examining practice across different types of

[1] This briefing was written by Dr. Debra Allnock, a senior research fellow with the Vulnerability Knowledge and Practice Programme (debra.allnock@norfolk.pnn.police.uk)

reviews would allow us to synthesise the commonalities from these disparate systems of learning. In addition, we anticipated learning about the different ways that police practice featured in relation to different types of vulnerabilities and across age groups. Streamlining the learning in this way could help to reduce siloed thinking about police responses to vulnerability, maximise the value of the reviews and identify where there are differences that require emphasis. This workstream is fully integrated with other VKPP workstreams, providing, for example, a supportive evidence-base for the National Vulnerability Action Plan and will inform our peer review workstream. The learning is also being used to inform and influence practice and policy at the national level.

Research questions

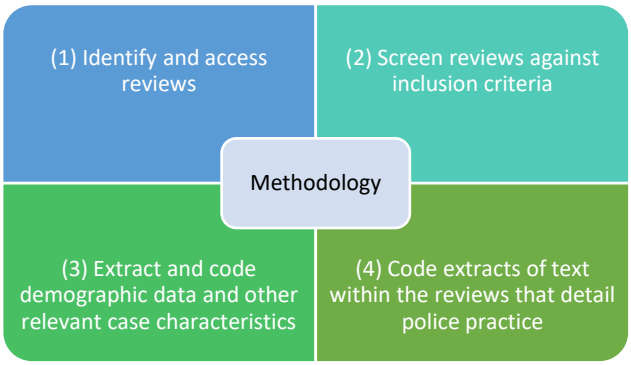
Four key research questions guided the research:

1) How does police practice feature in review of death and significant harm?
2) What explains missed opportunities in police practice to safeguarding children and adults?
3) What are the most common gaps in practice?
4) Where are the commonalities and differences in police practice across review and vulnerability types?

Overview of methodology

The methodology consisted of four steps, as seen in Figure 1. Detailed methodologies for each of the three statutory reviews can be found in the appendices of their separate briefings published on the College of Policing *Vulnerability and Violent Crime Programme* website.

Figure 1: Four-step methodology



(1) Approaches to identifying and accessing reviews differed for each review type.
(2) The primary requirements for inclusion were police involvement with child/vulnerable adult and/or their families prior to (but within the timeframe of the reviews) the death or harm that triggered the review

Limitations of statutory reviews for police practice

Statutory safeguarding reviews of death and significant harm provide important insight into practice, and what agencies with safeguarding responsibilities can do better to support and protect children and vulnerable adults. The VKPP experience of conducting analysis into 126

different types of reviews revealed a number of limitations which prevented a full and comprehensive understanding of policing practice as it features in these reviews. These limitations are likely to extend to other sector-specific learning also, but this project has focussed explicitly on the role of the police. The key limitations identified are summarised below.

Deficit model

Statutory reviews are designed to investigate what relevant agencies and individuals involved could have done differently to prevent death or significant harm. This means that the focus is typically on 'what went wrong' rather than 'what went right'. Reviewers do occasionally praise professionals when they get things right but 'good practice' – or ways in which forces positively respond to the review findings – are not consistently shared. Where they are shared, the description of such practice tends to be weak, making it difficult to interpret and articulate specific practice that is useful to sectors.

Varied methodologies and quality of reviews

Statutory guidance gives latitude to responsible bodies commissioning reviews (for example, Safeguarding Adult Boards, Local Children Safeguarding Boards[2]) to administer review processes they feel are most likely to promote effective learning and improvements[3]. Our research noted the adoption of a range of methodologies in use in both SCRs and SARs, supporting findings of other research into these reviews[4]. Additionally, other experts have commented on the variable quality of reviews, seen as too long and detailed and lacking in clarity[5], although length of reports appears to be shortening and streamlining over time[6]. The Child Safeguarding Practice Review Panel have produced guidance[7] advising what they believe a 'good' review looks like, but it is too early to see if this guidance is informing the production of new local Child Practice Reviews. The variation in methods applied and quality of reviews can make the consistent collation of practice difficult for those in practice development or research roles, limiting possibilities for comparison. It also results in a postcode lottery for local areas in terms of the quality of learning they gain from the review process.

Missing data on protected characteristics

[2] Under previous child safeguarding arrangements, these bodies were known as Local Children Safeguarding Boards. They are now called Safeguarding Partnerships and the system for learning from reviews is overseen by the National Panel.

[3] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationary Office.

[4] Braye, S. & Preston-Shoot, M. (2017) *Learning from SARs: A report for the London Safeguarding Adults Board*. London: LSAB; Preston-Shoot et al. (2020) *Analysis of Adult Safeguarding Reviews April 2017-March 2019: Findings for sector-led improvement*. LGA and ADASS.

[5] Wood, A. (2016) *Wood Report: Review of the role and functions of Local Safeguarding Children Boards*; Rawlings, et al. (2014) *A study to investigate the barriers to learning from Serious Case Reviews and identify ways of overcoming these barriers*. London: Department of Education; Preston-Shoot et al. (2020) *Analysis of safeguarding adult reviews April 2017-March 2019*. LGA and ADASS.

[6] Brandon et al. (2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017*. London: Department for education.

[7] Department for Education (2019) *Child Safeguarding Practice Review Panel: practice guidance*. London: DfE.

The process of anonymisation of reviews often means that key protected characteristics are not included in reviews in order to protect the identity of children and vulnerable adults. We acknowledge this is an important process, but also are concerned that this means that it is not always possible to explore the lived experiences of children and vulnerable adults and how this intersects with their engagements with the police. Importantly, it obscures learning about communities which might face disproportionate levels of harm, leading to gaps in learning about practice and engagement with communities which are marginalised.

Social care/ health focus

Statutory reviews have historically been social care- and health- focussed given the statutory roles of these agencies. Often these sectors have greater involvement in the lives of the children and vulnerable adults they are supporting given their responsibilities in care and service provision. As a result, the space in reviews taken up by these sectors tends to outweigh that given to the police. This might be partially explained by the background and expertise of the reviewer, few of whom, in our sample, had policing backgrounds. Reviewers without policing expertise may miss important processes, or give more weight to the sectors they are more familiar with. However, the police are a key statutory partner in the new child safeguarding arrangements, having a duty to make arrangements to work together and with other partners to safeguard and promote the welfare of all children in their locality[8]. They have a wider duty under human rights legislation to safeguard the human rights of all victims of crime, and are noted as a key partner in adult safeguarding arrangements as detailed within the Care Act 2014 guidance[9]. These reviews would benefit from ensuring policing practice is given equal consideration to understand where improvements to their responses to children and vulnerable adults can be made.

Length of time between review and publication

As other experts have commented, time between review and publication is lengthy, sometimes over a matter of years which delays the timely dissemination of learning. In terms of policing practice, we noticed that by the time the reviews were available, practice may have developed or new guidance and training implemented. This can make the learning feel dated to some forces, and a significant amount of work must be done to identify new practice in order to contextualise the findings. We do know, however, that new directions in or guidance on police practice may not be absorbed and implemented equally across forces, particularly where vulnerability is complex and police responses are entrenched[10]. Therefore, despite this limitation, we believe that much of the learning we are seeing continues to be relevant – even if some forces have successfully addressed some of the issues.

[8] Department for Education (2018) *Working together to safeguard children*. London: DfE.
[9] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationary Office; ACPO (2012) *Guidance on safeguarding and investigating the abuse of vulnerable adults: First edition*. London: The College of Policing; Department of Health & Social Care (2020) *Care and support statutory guidance*. London: DHSC.
[10] HMICFRS (2019) State of policing: The Annual assessment of policing in England and Wales. London: HMICFRS. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/state-of-policing-2019.pdf

Police input/analysis

Several reviews noted that the information provided by police through their Internal Management Reviews (IMRs) did not contain sufficient analysis for reviewers to fully understand the underpinning reasons for practice considered within the review, as this quote articulates: "*Learning from the IMR process. The [force] IMR submitted regarding Ms H does not use the template but lists events in a separate document, largely without reflection or analysis. Some IMRs contain reflective analysis; others much less so"* (Safeguarding Adults Review). This raises a need to improve the IMR process to ensure the learning fed into the review process is maximised.

Focus on multi-agency working

The focus of these reviews on ways in which agencies could have worked better together to support children and vulnerable adults means that other thematic areas relating to single agency practice are not necessarily prioritised within reviews. This is why the majority of our findings related to collaborative working and some early aspects of policing work around identification and management of risk, which often rely on multi-agency relationships.

Systems analysis

The VKPP noticed that not all missed opportunities or poor practice identified within the reviews were explored with sufficient detail to provide an understanding of why the practice occurred (or did not). In some cases, it is likely that reviewers lacked the relevant context or explanations; or it may be that reviewers simply did not approach the reviews which effectively unpicked the broader contextual, organisational and environmental issues which may have impacted on individual officer practice. The absence of clarity about what underpins missed opportunities or poor practice means that targeted recommendations for practice or intervention are difficult to make.

Formal recommendations not often for police

Formal recommendations made at the end of reviews are often aimed at the multi-agency network (formerly Local Children Safeguarding Boards, for example). Only occasionally did reviews highlight single-agency recommendations. It may be likely that busy public protection professionals only look at the recommendations rather than the additional qualitative learning within the body of reviews that offers deeper insights and context into practice and are often not threaded through to the formal recommendations at the end of reports. The multi-agency focus of recommendations can also obscure single-agency responsibilities within those recommendations.

Future steps: Quality rating system

The VKPP have devised a simple quality rating system to apply to reviews in order to comment on the overall quality of police information included. The team are currently working to pilot this rating system with our current library of reviews. The findings from this pilot will be shared in early 2021.