Vulnerability Knowledge & Practice Programme

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

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

## Foreword

*"All police officers, and other police employees such as Police Community Support Officers, are well placed to identify early when a child's welfare is at risk and when a child may need protection from harm. Children have the right to the full protection offered by criminal law. In addition to identifying when a child may be a victim of a crime, police officers should be aware of the effect of other incidents which might pose safeguarding risks to children and where officers should pay particular attention"*
(DfE, Working Together to Safeguard Children, 2018; p. 63).

Safeguarding children is a multi-agency effort and the Police have an important role to play. Police responses to safeguarding have improved significantly in recent years, but there continue to be areas for development. It is important to reflect on where things go wrong and what can be done to improve and strengthen the response to children in order to get it right for them.

This briefing – the first in a series to be produced over the next year by the Vulnerability Knowledge and Practice Programme (VKPP)[1] – uniquely focuses on the Police contribution to the safeguarding effort. It draws together the learning from Serious Case Reviews (SCRs, in England) and Child Practice Reviews (CPRs, in Wales) where these reviews identify messages for strategic or operational police practice.

We acknowledge that the previous system for learning the lessons from SCRs has not been optimal. For many complex reasons, the learning takes a long time to emerge, has not been easily accessible and has not been effectively disseminated across local areas, leaving forces and partners frustrated in their efforts to apply the learning and strengthen practice in a timely manner.

While the system for learning the lessons from these reviews is changing, we hope that this briefing, and those that follow, will begin to fill a gap in learning for the Police. It focuses explicitly on the systems and procedures within policing organisations that may constrain and undermine effective practice in safeguarding children. Furthermore, it provides direct links to relevant published SCRs so that the learning is more accessible to forces. As the year progresses, we will continue to build on the themes that have emerged in this first briefing, identify trends and new, emerging issues. We also anticipate that over time, the briefings will evolve to incorporate new types of learning emerging from the new arrangements.

We encourage those in forces with responsibility to learn the lessons and improve safeguarding responses to reflect on the messages emerging from this briefing and consider how they may apply to systems and procedures in your own force.

[1] This programme operates under the auspices of the National Police Chiefs' Council Lead for Violence and Public Protection

## CONTENTS



Nearly 200 published Serious Case Reviews (SCRs) were initially examined for this first in a series of briefings to be produced by the VKPP. We sought to identify any available SCR where 1) the incident that triggered the SCR took place between the 1st of January 2016 and the 15th of December 2018; 2) the police had been engaged with the child and/or their family pre-incident; and 3) where specific learning for strategic or operational policing was identified within the review. Using this criteria, **17 published case reviews**[2] of death of, or serious harm or injury to, a child or young person as a result of abuse or neglect were selected for inclusion in this briefing (see Appendix B for more detail on the methodology).

In Wales, these reviews are referred to as 'child practice reviews'. In England, these reviews were previously referred to as Serious Case Reviews (SCRs). The system for identifying improvements to be made to safeguard children is, however, transitioning to new arrangements as detailed within Working Together to Safeguard Children 2018. The new national arrangements are overseen by the national Child Safeguarding Practice Review Panel and, at local level, by safeguarding partners. Going forward, these reviews will be called 'child safeguarding practice reviews'.

Five consecutive reviews of SCRs have been undertaken dating back to 2003 by a team of researchers at the Universities of Warwick and East Anglia, with the sixth review due for publication in spring 2019. This briefing will not duplicate, but instead add to the learning derived from these studies. *Research in Practice*, working with the SCR triennial review team, host a website with published reports, briefings and other resources that can be accessed here.

***-The 17 reviews considered here concern 29 children and young people, aged between infancy (under 1) and 17***

***- 9 reviews involved deaths, including suicide, fatal assault, fatal physical abuse and overt filicide***

***-8 reviews involved serious harm or injury, including physical assault, intra-familial CSA, extra-familial CSA and drug ingestion/overdose***

***-Police most often came into contact with children/ families in response to a report of an incident at the family home. Domestic abuse was the most common reason for the call out.***

[2] Not all SCRs have significant police involvement; and not all have specific learning for the police. All in England; none from Wales fit the inclusion criteria for this briefing.

## SPECIAL THEME: THE NEED FOR IMPROVED RESPONSES TO DOMESTIC ABUSE RELATED TO NON-INTIMATE PARTNER FAMILY VIOLENCE

The Bristol Safeguarding Children Board conducted a joint domestic homicide and serious case review following the death of a 17-year-old boy in February 2016. Child D and Brother D had consumed significant amounts of alcohol and illegal drugs before returning home where, after an argument, Child D was fatally stabbed by Brother D. Brother D was charged with murder and sentenced to life imprisonment with a minimum tariff of 11 years and three months. Police were involved with the family on 10 occasions over three years leading up to the homicide, either in relation to family arguments or the brothers' drug use. While Police made referrals to Children's Social Care and the Health Safeguarding Board at relevant stages, no further action was commonly an outcome because offences or injuries could not be identified or the family were unwilling to make statements. The DHR/SCR author could not definitively state that what was occurring in this family home was domestic abuse, but the case raises questions about the ability of services to respond effectively to domestic disputes that do not fit a recognisable form of domestic abuse.

*THE MOTHER FELT THAT POLICE SHOULD HAVE RESPONDED TO VIOLENCE IN THE HOME AS THEY WOULD HAVE IF IT HAD BEEN VIOLENCE FROM ONE ADULT TO ANOTHER. SHE FELT IT IMPOSSIBLE TO MAKE A STATEMENT AGAINST HER OWN SON AND THAT IF THE POLICE HAD TAKEN MORE DECISIVE ACTION WITH BROTHER D EARLIER ON IT COULD HAVE MADE A REAL DIFFERENCE*

**Q** What does research tell us about the prevalence of domestic homicide between siblings?

**A** The majority of domestic homicides involve intimate partner relationships; a small number, however, involve other family members

### STRATEGIC MESSAGES

-Forces should ensure their front line staff are **equipped to assess risk in relation to non-intimate partner family violence**. This includes ensuring they are **well trained to recognise warning signs of domestic abuse, assess coercive control** and **apply professional judgement** alongside the use of any risk **assessment tool.** Such understanding is critical in ensuring crimes/non-crimes and command control logs are accurately flagged for domestic abuse under ADR and Home Office Counting rules.

-Forces should take a **clear view on which team should be investigating** individual cases of non-intimate partner family violence.

**-Risk assessments should be continually reviewed.** Even where incidents appear to be separate, the context and frequency of incidents may be pointing to a pattern.

### OPERATIONAL MESSAGES

**-Professional judgement** is required alongside the use of any risk assessment tool in cases of domestic abuse to ensure assessments reflect the frequency and escalation of violence, even in less common forms of domestic abuse.

**-Even where witness statements are not forthcoming,** frequency of police call outs should alert officers of the need for a plan to be put around this.

-**Partners, such as schools, should be consulted** to ensure a holistic picture of what is occurring can be developed.

**-Injuries** in cases of non-intimate partner family violence **should be documented and photographed** for use in building a charge in the absence of witness statements.

**-Potential witnesses**, including neighbours and members of the community, should be **identified and spoken with as part of an investigation** concerning non-intimate partner family violence.

-Full consideration should be given to **criminal charges** in cases of non-intimate partner family violence.

## CROSS CUTTING THEMES

The themes presented below offer universal messages for police practice across a range of cases. It is structured according to the flow of an investigation for ease of reflection, and identifies, where possible, those systems which hampered effective response. A matrix listing the 17 SCRs and the themes associated with each can be found in Appendix A. Interested readers can go directly to the SCR by clicking on the title link.

### Patterns and dynamics

- **Understanding patterns and dynamics of abuse is essential for an effective response**
- There is still some evidence in recent reviews that patterns of reporting by victims of child sexual exploitation are not fully comprehended. Patterns of volatility in intimate and non-intimate partner family violence also need to be better understood by front line staff to support effective risk assessment and response.

### Crime recording

- **Crime recording should be at the point of reporting to the police and crime should be accurately recorded**
- Crimes were not recorded in a timely fashion in three cases. Lack of ownership over investigation and multiple police IT systems in use were key systemic issues that appeared to underpin this omission. In an additional case, a crime was inaccurately recorded although it is not clear why this occurred.

### Investigating officer

- **Immediate allocation of an investigating officer is necessary to ensure no delays to safeguarding**
- Swift allocation of an investigating officer was hampered by excessive workload of officers and decision-making within the MASH, in one case. Processes for allocation and adequate resourcing should be reviewed to ensure swift allocation for earlier safeguarding activity.

## Ownership

- **Clear ownership of investigations by the most appropriate department should be expedited**
- Where multiple investigative teams (e.g. Custody Investigation Unit/ CID) could be assigned a particular investigation in a single force/ division, inadequate mechanisms for allocating a suitable team and Officer In the Case (OIC) can result in clear lack of investigative ownership. Where this occurred , it had a negative impact on appropriate and swift crime recording and effective information sharing and decision-making.

## Risk assessments

- **Risk assessments for the safety and wellbeing of young people as victims and in cases where they are suspected to have committed an offence are crucial for supporting their safeguarding needs.** Systemic issues identified include:
  - Inadequate understanding of the safeguarding needs of young people suspected of committing sexual abuse; inadequate understanding of the mental health needs of a young person in custody; insufficient understanding of patterns of volatility within a domestic dispute, compounded by a sub-optimal risk assessment tool; and lack of a systematic approach to gathering comprehensive information to support safety and wellbeing needs for handover to partner staff.

## Background checks

- **Accuracy and consistency of completing background checks on all adults involved in domestic disputes are a vital part of safeguarding practice**
- Several SCRs evidenced inconsistent background checks and erroneous recording of adults involved in a domestic dispute. In one case, this resulted in incomplete case information and, in another, led to a missed opportunity to identify an adult that should not be living in the property.

## Proactive policing

- **Proactive policing approaches are essential for effective risk assessments and multi-agency investigations**
- Several SCRs evidenced missed opportunities to implement proactive policing approaches. These missed opportunities appeared to be based on taking information gathered from the children and their parents at 'face value'. Systemic issues underpinning these decisions appeared, in both cases, to rest on failures to understand patterns of child sexual exploitation, compounded in one force by a lack of ownership of a case and inadequate follow-up of information provided in a missing report.

## Information sharing

- **Information sharing with and between partners is necessary for building a full picture for effective responses.** Systemic issues evident in undermining information sharing included:
  - Ownership of investigation not clearly established;
  - Sub-optimal force procedures for sharing notification forms (such as Child Protection Notification and Domesic Abuse Notification forms) with relevant police teams and with relevant partners; and
  - Inadequate procedures for sharing the minutes of multi-agency meetings with attending partners.

## Strategy meetings

- **Local Authority and Police need to share referrals quickly and prioritise strategy meetings to plan a joint response**
- In a number of cases, strategy meetings were not prioritised or deemed not to be necessary by police. A key systemic issue underpinning in at least some cases is the demand of attending strategy meetings and the associated resourcing. Virtual strategy meetings may be a cost-effective alternative to physical meetings that should be considered.

## Examination of electronic devices

- **Forensic examination of electronic devices should be expedited to ensure children are safeguarded**
- Evidence in one force underscores the pressures that forensic teams may face when there are unexpected increases in the volume of sexual abuse cases. Advanced planning and increased resources may be necessary to reduce lengthy waiting lists to ensure swift safeguarding activity.

## Referrals for support

- **Referrals to relevant support agencies should be offered directly to a young person and their primary safe carer**
- Relevant referrals to Independent Sexual Violence Advisors (ISVAs) were not made in two cases. In one of these cases, police were unduly influenced by the involvement of a family member with a strong personality who felt the young person did not need the support. Unless it is contrary to the interests of a young person, and where it is developmentally appropriate to do so, offers of support should be made with their involvement to ensure a child-centred approach.

# Concluding recommendations

### Senior leaders

- Processes for case allocation to an appropriate team should be reviewed to ensure that effective mechanisms are in place for ownership of investigation. This is likely to support appropriate and timely crime recording, the establishment of good proactive policing approaches and improved information sharing within forces and with partners.
- Resourcing and procedures for allocating a case to an investigating officer should be reviewed so that blockages are removed and safeguarding activity can commence immediately.
- Risk assessment tools such as the DASH (which is currently under review) should always be paired with professional judgement to ensure appropriate risk assessment and consideration of referral of cases to MARAC. Front line staff must be equipped with the knowledge to recognise less obvious cases of domestic abuse.

### Front line staff

- Crimes should be recorded at point of reporting to the police. This includes crimes identified within initial missing reports and in safe and well checks.
- It is crucial to ensure accuracy and consistency of background checks on adults who may pose a risk.
- Officers should recognise the safeguarding and wellbeing needs of young people who commit crimes, not just the victim.
- Officers should offer referrals for support, where it is developmentally appropriate to do so, with the involvement of young people who have experienced sexual abuse. This is supportive of a child-centred approach.

### Custody staff

- It is imperative that young people held in custody have needs assessments undertaken to identify any potential risks to their mental health and wellbeing and enable effective early intervention by an appropriate service provider.

### Learning and Development staff

- Safeguarding training should incorporate learning around complex and less obvious forms of abuse and violence to support better recognition and response by frontline and specialist officers.

# Next steps

The next briefing will be produced and disseminated in July 2019. **We encourage forces to alert us to newly published reviews for inclusion in this briefing by June 15th, 2019.** We also encourage feedback about the briefing from forces about both content and style. 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 | Patterns of abuse | Crime recording | Allocation of SOI | Owning investigations | Risk assessments | Background checks | Proactive policing | Information sharing and multi-agency working | Forensics | Supporting referrals |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Blackburn with Darwen: SCR Child G | Death of a 16 year old | ■ | ■ | | | | | | ■ | | |
| Blackburn with Darwen: SCR Child Y | Death (suicide) of a 14 year old girl | | | | ■ | | | | | | ■ |
| Bristol: DHR/ SCR Child D | Homicide of a 17 year old | | ■ | | | ■ | | | | | |
| Croydon: SCR Child L | Death of an 11 month old | ■ | | | | | | | | | |
| Dorset: SCR Child M | Death of a 2 year old | | | | | | ■ | | | | |
| Enfield: SCR 'YT' | Death (suicide) of a 17 year old boy | | | | | ■ | | | | | |
| Isle of Wight: SCR Child G | Death of a 6 year old | | | | | | | | ■ | | |
| Kent: SCR Child D | Death of a 5 month old | | | | | ■ | | | | | |
| Manchester: SCR Child L1 | Death of a 2 month old baby | | | | | | | | ■ | | |
| Manchester: SCR Child M1 and M2 | Non-accidental injury of a child under 1 month | | | | | | | | ■ | | |
| Manchester: Learning | Death of an adolescent | | ■ | | | | | ■ | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **report Child J1**[3] | | | | | | | | | | | |
| **Newham: SCR Child KA** | **Death (suicide) of a 17 year old** | | | | | | | | | | |
| **Norfolk: SCR Child Y** | **Physical & sexual abuse of 6 siblings** | | | | | | | | | | |
| **Norfolk: SCR Child CZ** | **Death of a 6 month old girl** | | | | | | | | | | |
| **Rochdale: SCR Child L** | **Death (suicide) of a 14 year old** | | | | | | | | | | |
| **Wiltshire: SCR five siblings** | **Sexual abuse of siblings** | | | | | | | | | | |
| **Unnamed: SCR Charlie and Sam** | **Sexual abuse and exploitation of two siblings** | | | | | | | | | | |

[3] This learning report is not currently published.

## APPENDIX B: OVERVIEW OF METHODOLOGY

Child practice reviews and child safeguarding practice reviews (and, previously, SCRs) are retrospective accounts of professional involvement with a child / children and their family and are often published several years after the incident under review.

*How did the team identify reviews?*

The NSPCC house a repository of reviews which was used to identify most of the documents included in this briefing. Almost all of these are SCRs because they pre-date the new national arrangements (see introductory context). 168 reviews published on the NSPCC repository between 2016 and 2018 were scanned for relevance.

Relevant SCRs were also requested from English and Welsh forces to identify any reviews not published in the repository. An additional 10 documents were provided which were not already in our library from the repository.

178 review documents were therefore initially scanned for inclusion in this briefing.

*Which reviews were included in this briefing?*

The thematic learning presented in this briefing is based on the following inclusion criteria:

- The incident that triggered the review occurred between January 01, 2016 and December 15, 2018;
- The review concerns an incident in England or Wales;
- Police had some direct involvement with the child and/or their family pre-incident that falls within the recent review timeline; and
- Learning for the police as a single agency was apparent in the review.

17 reviews in total were selected on the basis of this criterion for inclusion in this briefing.