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

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

Introduction

This briefing is the second in a series of quarterly briefings being produced by the Vulnerability Knowledge and Practice Programme (VKPP)[1]. Between April 1st and June 30th, 76 unique published SCRs were examined and 41 fit 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 second briefing continues to build on the learning from the previous Q1 briefing. Over the coming year, we will be able to build a better understanding of what the entrenched issues are for the Police *as they feature in these reviews*, and identify new learning. The briefing also incorporates references to relevant and current research and policy allowing readers to easily access links to these resources. 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 come 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 Q2 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

- All police regions, and 18 police forces, are represented in these 41 SCRs

Police involvement

- In 40% of the SCRs, initial police involvement was due to **responses/call outs to the family home – most commonly in relation to domestic abuse**

Categories

- The 41 SCRs relate to: **23 deaths** (56%) and **18** (44%) cases of **significant harm**

Deaths

- ***The 23 deaths related to:***
- *6 suicides*
- *6 cases of 'overt filicide'*
- *4 'other'*
- *3 'unclear'*
- *2 child homicides*
- *1 fatal physical assault*
- *1 sudden death in infancy*

Significant harm

- ***The 18 cases of significant harm*** *related to:*
- *8 'Other'*
- *5 'Physical assault'*
- *2 CSE*
- *2 neglect*
- *1 intra-familial child sexual abuse*

SPECIAL THEME: ADOLESCENT SUICIDE

Adolescent suicide was selected as the special theme for this quarter's briefing in part because so many of the 41 SCRs (6) related to it and, notably, all the young people were 16 years old (4 males and 2 females). The many indicators that were present prior to these young people's deaths emphasise the preventable nature of many of these deaths and the online activity preceding these deaths highlights key messages for safeguarding in a wider context.

Key research findings on adolescent suicide

-Suicide is one of the leading causes of death among young people (WHO, 2014), and the rate of suicide among young people is rising (University of Manchester, 2018)

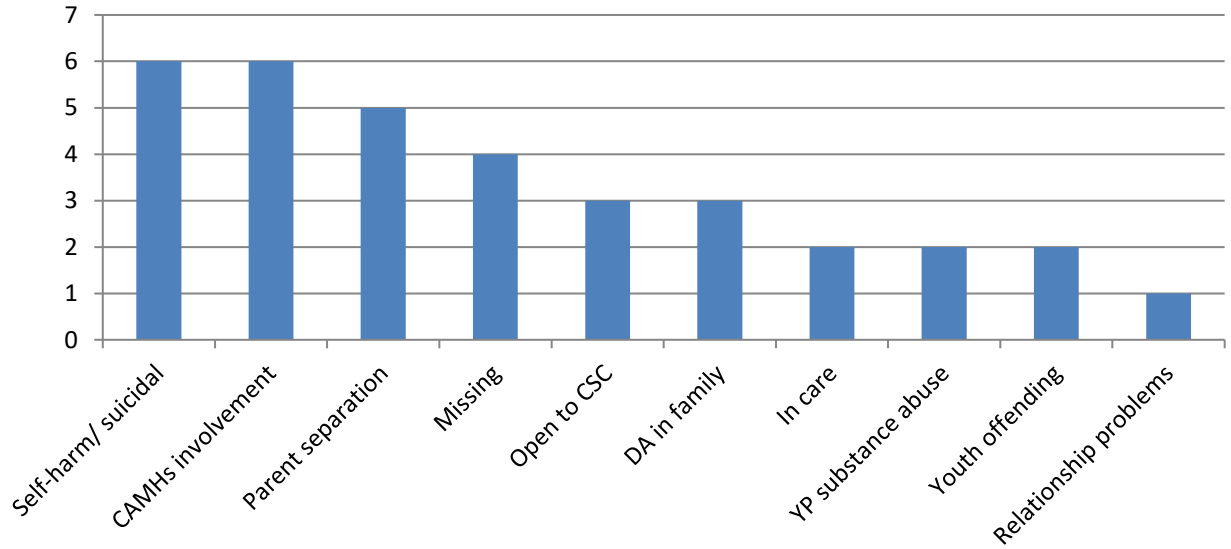
-Suicidal thoughts and behaviours predict future suicide and suicide attempts (Geulayov et al., 2016; Robinson et al., 2018)

-The period immediately following discharge from a psychiatric inpatient treatment is associated with highest risk for suicide (Hawton & Harris, 2007)

-Common antecedents to adolescent suicides are: family problems, bullying, physical health conditions, self-harm, exam stresses and relationship problems (Sidebotham et al., 2016; University of Manchester, 2018)

-Around a quarter of adolescents who commit suicide are using the internet in a way that is suicide-related (searching for suicide methods, suicidal posts on social media) (University of Manchester, 2018)

Circumstances in the lives of these 6 young people



The graph above shows that the six young people featured in this sample of SCRs have much in common with young people examined in other research (Chapter 5 of Pathways to harm, pathways to protection; and National Confidential Inquiry into Suicide and Safety in Mental Health).

Good police practice in SCRs in relation to adolescent suicide

Operational police actions which met expected standards of practice, and in some cases, notable practice by police include:

- Child X: Police **shared information** appropriately with relevant agencies; **responded sensitively and efficiently to missing episodes**, including **sensitive conduct of Safe and Well checks**; and followed appropriate procedures in response to a mental health incident, including **expediting an exam by a mental health nurse**.

- Child R: A Neighbourhood Police Officer **fostered a trusting relationship** with Child R. Even when the officer left his role, he was brought in when required to engage with Child R, who would open up to him. This notable practice demonstrates **sensitivity, the importance of continuity in police-public relationships and development of trust.**

Operation Passkey was a community mobilization programme initiated by police in response to the death of a young person in a fight (one of Child R's closest friends). The operation aimed to mobilise local services and voluntary organisations to support young people following this tragedy. Over 70 young people were identified as affected by this death and each could access a Lead Professional for support. Child R took her own life only some months following the death of her friend. Local police subsequently contacted another police force with expertise in youth suicide for advice. Very quickly, local agencies planned a strategic and operational response to the Child R's death and support any child who was affected by it. Local police reported the operation to be successful.

Missed opportunities for intervention

Consideration of safeguarding needs when identifying harmful sexual behaviours

Prior to Peter's death, the Child Exploitation and Online Protection (CEOP) agency identified sexualised online images posted by Peter. They identified him from his school uniform, and visited Peter to interview him. Peter told them it was a silly mistake and that he would not do it again. There was a missed opportunity for CEOP to refer Peter to Children's Social Care to ensure his safeguarding needs were considered.

Message for the police

Posting sexualised images online signals the need for safeguarding intervention. Police should always make appropriate referrals to support the young person, even where no crime has been identified.

Police learning emerging from adolescent suicide SCRs

Assessments of children not living at the family home

Mario lived with his father but was deeply affected by domestic abuse towards his mother by her new partner. Limitations of the wording in the DASH is likely to have influenced officers' intermittent recording of Mario as an affected child as the DASH refers to the 'presence' of children in the home, whilst additional questions added to the DASH by the local force refer to children who 'live in the household'. Whilst this helps identify immediate risks, it may also divert attention away from children not living in the household. Mario's omission from some referrals meant that no information was sought from Mario's school health practitioner.

Message for police:
When using the DASH or any similar tools in response to a domestic incident, information about any child who the involved adults have on-going contact with, even when they are not living at the same property, should be recorded to ensure they remain 'visible' in further assessments and referrals.

Prioritising intelligence from digital media following a suicide

Three cases [Mario, Child X and 'Rachel'] provide examples of suicide-related internet use. Mario searched for suicide-related material on school computers and played the Doki Doki Literature Club game (though no conclusions were made about the role this game played in his death). Child X purchased Xanax online. Rachel had been part of a social media group of young patients from the Adolescent Unit where she had been an in-patient, and she accessed euthanasia websites.

Message for the police: Swift collection and examination of intelligence from digital devices of young people following suicide should be prioritised even if a crime is not apparent. Not only might a crime be identified in the circumstances of a young person's death by doing so, but wider safeguarding risks may become apparent as a consequence of suicide or self-harm contagion. Public Health England (2015) guidance emphasises that prevention measures should be taken after even a single suicide in a group vulnerable to imitation.

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 roughly structured according to the flow of an investigation for ease of reflection. A matrix listing the 41 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.

Understanding and awareness of patterns, dynamics and impacts of abuse

Recognising indicators of exploitation

Recognising potential indicators of all forms of exploitation is essential for working within effective local strategies to address them, as well as their causes. Policy, practice and research identify similar behaviours that may feature as a symptom or indicator of CSE, CCE and modern slavery

Failure to recognise potential indicators can result in a focus on 'status' (e.g. 'perpetrator' or asylum status) to the exclusion of a young person's safeguarding needs as both potential victim and offender.

(see Firmin et al., 2019 for an overview of commonalities between types of exploitation)

Avoiding use of victim-blaming language

Language is an important tool for communicating and framing appropriate responses to vulnerability

Use of victim-blaming language in Strategy Meeting minutes and intelligence reports was noted in some SCRs. This can reinforce shame and guilt in victims and, in turn, may decrease the likelihood of disclosure. It may also fail to draw attention to the range of proactive policing responses that may be available.

(See NPCC reference for guidance for professionals on appropriate use of terminology in CSE cases)

Multi-agency working and decision making

Adhering to statutory procedures

Working Together to Safeguard Children and Families (2018) clearly sets out responsibilities of all agencies who have responsibilities relating to children.

In some cases, Police, alongside their safeguarding partner agencies, did not comply with this guidance (for example, attend or hold Strategy or Strategy Review Meetings or initiate s47 enquiries).

These failures sometimes occurred because:

-professionals took overly-optimistic views of the risk to children

-police and partners made decisions in the absence of all relevant information

-police and partners treated Strategy Meetings as a 'formality'

Escalation of concerns

Partner agencies sometimes disagree about safeguarding decisions, or may make the wrong decisions. Police should have the confidence, and be supported, to escalate concerns about decisions or actions taken - or not - by their partners. Local policies for escalation should be available to officers.

The SCRs in this sample provide evidence that Police are not always effectively raising or escalating concerns they may have about, or decisions taken by, safeguarding partners. Failure to escalate concerns represent missed opportunities for safeguarding children.

Clarity about roles and understanding of child protection thresholds

Understanding other agencies, their roles and threshold decision making is essential for effective multi-agency working. It is necessary to have an appreciation of the different contexts in which partners work.

In several cases, there appeared to be disconnect between Police and partner agencies in relation to:

(1) Police roles in undertaking welfare checks and

(2) mutual understanding of child protection thresholds.

(See Atkinson et al., 2007 for a comprehensive review of the literature on effective multi-agency working)

Information sharing

Ineffective systems for information sharing, both within and between forces and with partners

Information sharing continues to emerge as a theme from SCRs, contributing to missed opportunities to develop a full picture of the circumstances of incidents. In some cases, information sharing is hampered by ineffective systems. Examples include:

(1) Absence of a good system for sharing names and addresses of families where there are child protection plans in place with Neighbourhood Police.

(2) Two neighbourhing forces, both of whom were involved in a case, did not have Police logs that matched up, which led to incidents being treated in isolation to others. As a result, the overall risk to the child subject to the SCR was not well understood by either force.

(3) Ineffective systems for sharing official minutes of Strategy Meetings and making these accessible to those who need them.

Ineffective information sharing by Police

It is not always possible to know comprehensively from SCRs why information was not shared effectively.

Examples of ineffective information sharing:

-referral to Children's Social Care lacked all relevant details known to the police.

-failure to complete Police Protection Notices (PPNs) when they should have been.

-despite officers recording concerns about neglect and categorising an incident as a low risk domestic abuse, officers made no referral to the Local Authority.

-despite good effort by Police officers to gather information from a domestic abuse victim to corroborate evidence, the victim did not wish to proceed. Police did not, however, share this information with a wider professional audience.

Auditing and recording

Background checks

Background checks are a vital part of safeguarding activity.

Ineffective background checks on all relevant Police IT systems - and international checks - were found to negatively influence Police decisions to attend Strategy Meetings and leave partner agency professionals without a full picture of circumstances on which to base decision-making. In one case, the Police did not undertake background checks that could have been standard procedure, preventing them from making appropriate threshold judgements in the case of domestic abuse.

Record keeping

Good record keeping ensures clarity of events involving children and families, supports good joint decision-making and provides a full and accurate picture of circumstances to support Police action.

Across a number of cases, SCR reviewers noted that records were not always complete: the names of other professionals involved in decision-making were not recorded; records were not updated with new emerging information; and relevant Court Orders were not logged on the PNC. This last example was the most serious, and meant that because Police did not have this information, they did not arrest a perpetrator for breaching the conditions of the Court Order. Had they done so, it may have prevented further violence.

Risk assessments

Limitations to incident-based risk assessments

Domestic abuse risk assessments require attention not only to the current incident but to prior history which may indicate patterns of controlling and coercive behaviours.

There are cases in SCRs that identify incident-based assessments which obscure wider patterns and limit understanding of risk to victims and children.

(See Robinson et al., 2016)

Unconscious bias

Each of us carries attitudes and sterotypes that affect our perceptions and inform our actions. When these are inaccurate or over-generalised, they can result in discriminatory actions and outcomes.

The DASH tool has been found by researchers to be inconsistently applied at the frontline, with officers and staff prioriting physical violence and injury at the current incident. While this attends to the most immediate risk, this may also divert focus toward female victims who are considerably more likely to experience repeated and severe forms of abuse and are much more likely to be seriously injured. While men are less likely to experience the severity of abuse and injury that women do, they can still be victims of domestic abuse and therefore should be subject to the DASH in the same way that women are.

(See Robinson et al., 2016)

Risk assessment accuracy

Risk assessment accuracy is enhanced when it is based on full and relevant information being shared and where there is robust assessment of all information and history.

Research into the use of the DASH reveals that officers sometimes record information in incomplete or partial ways. In some SCRs, only partial domestic abuse history was shared with partners, and, in one case, the alleged perpetrator was not considered and spoken to in a follow up and assessment.

(See Robinson et al., 2016)

Investigation

Managing cross-border investigations

Working across regional borders can present hurdles for agency operation, information transfer and the collation of a full history for appropriate risk assessment.

In one case, Police were managing the offending of a young male who was in foster care. As placements broke down, police transferred his management to police in the local area of his new placements. Frequent placement breakdowns, however, meant that there were gaps in his management and the Police could not get a grip on it.

Evidence-gathering

It is imperative that evidence gathering is complete and Police are satisfied with evidence presented to them before making decisions in the course of an investigation.

Reliance on a verbal transmission of the outcome of a medical report is insufficient, as it may prove to be inaccurate, as occurred in one SCR. This resulted in an unwarranted closing of a s47 enquiry. In other cases, Police did not speak to relevant witnesses or sieze phones and computers for forensic examination where these activities would have been expected.

Maintaining a focus on the child and their safeguarding needs

Children and their safeguarding needs must be a paramount focus in any investigation.

In cases where children were not sufficiently 'seen', this usually resulted from Police focussing on the circumstances of adults which diverted focus away from the wider needs of the children connected to them - this has also been found in previous SCR analyses (Ofsted, 2011).

Responses to missing children

Forces should ensure their response to reports of 'missing' children fully considers the risk to a child, and whether 'absent' is appropriately being applied where the force retains this option for under 18s.

In one case, the missing/ absent distinction was being utilised. Although new procedures following APP guidance are in place in this force, it may be useful for other forces to ensure this guidance is being applied.

Disruption, diversion and pursuit of perpetrators

Disruption

Effective disruption of all forms of abuse and exploitation requires prompt and thorough responses to disclosures and use of legal remedies available.

In one area, an SCR reviewer found that there were missed opportunities for, and significant delays in, implementing relevant disruption activities (for example, the issuing of CAWNs).

Diverting young people from offending

Holistic diversion strategies are needed to safeguard young people affected by county lines drug dealing.

Youth diversion strategies are found to be effective for low-level criminal behaviour of young people (D'Cruz & Estep, 2017). However the evidence is clear that use of scare tactics by Police, as found in one SCR, are not only ineffective, but they can increase risk and be more harmful than doing nothing.

(see Aos et al., 2001)

Bail conditions

It is important to monitor bail conditions to ensure perpetrators are not in breach of them, potentially endangering lives and the safeguarding needs of children.

In one case of domestic abuse, bail conditions were imposed to exclude a perpetrator from his victim's address. These were not monitored, however, and the perpetrator was later found to be living at the home with the victim.

Supporting and communicating with children and families

Keeping children, other victims and families informed

Communicating with families about the status of investigations is important in building trust with the Police and minimising distress and disruption for the child and family.

Ineffective management of cross-boundary investigations left one family under the impression that an investigation had completed. They became aware that it was not only after receiving a call from an officer 'out of the blue'. This left the family feeling uninformed and confused.

Hearing the child's voice

Children's voices should always be sought through direct work with the child or through child-focussed conversations to engage the child throughout agency involvement with the family.

Age and verbal ability of the child were noted to be underlying reasons why Police did not speak to children. An Ofsted (2011) analysis of SCRs identified good practice where professionals recorded observations of parents' interactions with their child where the child was too young to communicate. It may be that the Police are not best placed to do this work, but they can advocate for the child and draw on partners' skills to do this work.

Conclusions

SENIOR LEADERS

- Local policies for escalating concerns should be made accessible and be disseminated to all relevant staff. Staff should be encouraged and supported to escalate, and follow up with, concerns they may have about partner agency decisions or actions.
- Procedures and training around the submission of Police Protection Notices should be reviewed to ensure that officers are completing and logging these effectively on systems.
- Processes for managing cross-border investigations and offender management should be reviewed, in particular in relation to the transfer of care taking arrangements and the status of investigations to ensure timely information sharing takes place and consistent practice is adhered to prior to and during these arrangements.
- Staff must be trained in vulnerability, and its indicators, to improve their ability to recognise it and respond effectively.
- Responses to reports of 'missing' children need to fully consider the risk to a child, and whether 'absent' is appropriately being applied where the force retains this option for under-18s. This should be considered alongside the College of Policing APP guidance on missing.

FRONT LINE STAFF

- When working in multi-agency contexts, Police should be aware of their own responsibilities according to statutory guidance such as *Working Together* 2018 (and comply with these unless exceptional circumstances arise), escalate concerns where appropriate and communicate well with partners to ensure there is a common understanding of thresholds.
- When recording information about children and young people within minutes of meetings and intelligence reports, language should reflect the presence of coercion and lack of control that they experience as part of exploitation to accurately reflect this as a child protection issue.
- Strategy Meeting minutes must be accurately maintained and ensure that detail of any decisions are made available to the investigating officer.
- Officers should ensure they are carrying out relevant background checks and recording all relevant information in IT systems.
- Consideration should be given to current incidents of domestic abuse within wider patterns of relationships to ensure that controlling and coercive behaviours can be recognised. Officers should also be alert to unconscious bias in applying the DASH tool. Risk assessments must be accurate, complete and historical information shared with partner agencies where appropriate.
- Holistic strategies for youth diversion should be considered instead of employing scare tactics with young people, which may do more harm than good.
- Bail conditions must be monitored to ensure perpetrators are not disregarding them without consequence. This also protects victims and attends to the safeguarding needs of children who may be connected with a victim or perpetrator.
- Confidence in the Police can be supported where families are kept informed of the status of investigations.
- Where investigations cross boundaries, Police may want to consider the allocation of a key officer to oversee the safeguarding needs of a child during investigation.
- Police must remain child-centered so that the child is not 'lost' in the investigation. This may mean improving officers' confidence in speaking to children of all ages, or considering how to record observations of parent-child interactions where children's verbal ability is not developed. It may also be prudent to draw on the skills of partner agency staff who may be better placed to do this work.

Next steps

The next briefing will be produced and disseminated in November 2019. **We encourage forces to alert us to newly published reviews for inclusion in this briefing by September 30th 2019.** We also encourage feedback about the briefing from forces about both content and style. 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**	Understanding of abuse	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Investigation	Disruption, diversion, pursuit of perpetrators	Supporting and communicating with children and families
Anonymous: John	Significant harm to 2.5 year old child, multiple unexplained injuries		Procedures & Escalation				Evidence gathering		
Anonymous: Katie	Significant harm to a 14 year old, CSE	Use of language to describe YP	Procedures & escalation				Evidence gathering & staying child-centered & response to missing	Disruption	
Barnet: Child E	Death of a 16 year old male, drug overdose						Response to missing		
Bexley: John	Significant harm to a 13 month old child, fractured skull		Procedures						
Blackpool: Child BZ	Death of 13 week old child, murdered by father		Procedures						
Bournemouth & Poole: Child R	Death of 16 year old female, suicide								Child-centred
Bury: Mario	Death of 16 year old male, suicide					Limitations of the DASH in assessing children connected to the home			
Cardiff & Vale of Glamorgan: 02/2016[2]			Clarity of role						

[2] Link broken

Case review title and link	Review focus	Understanding of abuse	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Investigation	Disruption, diversion, pursuit of perpetrators	Supporting and communicating with children and families
Cardiff & Vale of Glamorgan: 03/2016	Significant harm to 7 year old child, neglect and possible sexual abuse			Ineffective information sharing	Record keeping				
City & Hackney: Child M	Significant harm to a 13 month old child, non-accidental injuries								
City & Hackney: Child X	Death of a 16 year old male, suicide			Ineffective information sharing					
City & Hackney: Rachel	Death of a 16 year old female, suicide						Evidence gathering		
Croydon: Child Q	Death of a 16 year old following a moped crash						Managing cross-border investigations		
Derby: Child FD17	Significant harm to a 9 year old child due to neglect		Lack of understanding between partners	Systems for information sharing			Proactive policing		
Dorset: Child S26	Death of a 3 year old child following traffic collision			Cross-boundary IT issues			Managing cross-border investigations & staying child-centered		
Greenwich: Young person X	Death of 16 year old male, suicide				Auditing and recording				Response to missing (good practice)
Hertfordshire: Child I	Death of child under 1, drowning			Ineffective info sharing with partners					

Case review title and link	Review focus	Understanding of abuse	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Investigation	Disruption, diversion, pursuit of perpetrators	Supporting and communicating with children and families
Lambeth: Child K	Death of 5 year old child, murdered by mother's partner		Lack of understanding between partners & adherence to procedures				Voice of the child		
Lancashire: Child LG	Significant harm to 3 month old baby, non-accidental injuries						Managing cross-border investigations		Keeping victims and families informed
Lancashire: Child LI	Significant harm to 4 month old baby, non-accidental injuries				Record keeping	Risk assessment (good practice)			
Lancashire: Child LK	Death of 8 month old child, murdered by mother						Evidence-gathering (Good practice)		Keeping victims and families informed (Good practice)
Lincolnshire: Child G	Significant harm, neglect of 4 siblings		Procedures						
Manchester: Child N1	Death of a 3 year old child, unknown circumstances	Recognising possible honour based violence (Good practice)			Background checks				
Medway Secure Training Centre	Institutional abuse of children at an STC		Escalation						
Newham: 'Chris'	Death of a 14 year old boy (homicide)	Recognising indicators of exploitation	Escalation					Diversion	

Case review title and link	Review focus	Understanding of abuse	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Investigation	Disruption, diversion, pursuit of perpetrators	Supporting and communicating with children and families
Northants: Child Ak	Death of 2 year old child, murdered by father						Staying child-centered		
Northants: Child Ap	Death of 1 year old child, murdered by mother's partner		Escalation	Ineffective information sharing			Staying child-centered	Bail conditions	
Northumberland: Natalie	Significant harm, non-accidental injuries					Inadequate risk assessment			
Nottinghamshire: Madison	Serious harm, child seeking to be looked after by LA		Procedures						
Nottinghamshire: Peter	Death of 16 year old male, suicide		Procedures	Ineffective information sharing	Background checks				Procedures for communicating with families
Reading: I17	Serious harm, 4 year old child ingested medication					Incident-based risk assessments for domestic abuse			
Shropshire: Child C	Death of a 21 year old man (initially thought to be 17 years old) from drug misuse	Recognising indicators of exploitation	Procedures						
Shropshire: Child E	Death of 7 year old child, murdered by mother		Procedures			Risk assessment accuracy (unconscious bias)			
Somerset: Family A	Significant harm, sexual abuse and neglect of 3 children		Escalation	Ineffective information sharing			Evidence gathering		
St. Helen's: Baby A			Procedures (Good practice)						

Case review title and link	Review focus	Understanding of abuse	Multi-agency working and decision-making	Information sharing	Auditing and recording	Risk assessment	Investigation	Disruption, diversion, pursuit of perpetrators	Supporting and communicating with children and families
Telford & Wrekin: Family Q	Significant harm, neglect of 5 siblings	Recognising neglect	Multi-agency response (Good practice)						
Tower Hamlets: Elias	Death of a 14 week old boy from non-accidental injuries						Evidence gathering		
Wakefield: Madison	Death of baby, murdered by father		Clarity of role	Ineffective information sharing					
Wakefield: Ollie	Significant harm to 5 week old baby, physical assault and neglect	Recognising controlling and coercive behaviours		Ineffective information sharing	Background checks				
Walsall: Child W8	Death of an 8 year old child, murdered by father			Ineffective information sharing			Evidence gathering		
Western Bay: S36 2017	Death of an 8 month old baby (reasons unknown)			Ineffective information sharing					

APPENDIX B: OVERVIEW OF METHODOLOGY

Identifying Serious Case Reviews for inclusion

The NSPCC repository was searched for any new SCRs added following March 2019 (any published in the repository before this time would have been included in the first briefing).

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.

An additional search of LSCB websites for any SCRs fitting the inclusion criteria as detailed below yielded a number of SCRs not on the repository or shared by forces, some of which were included. These varied in the year of publication, but all were published between 2016 and 2019.

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 76 SCRs were reviewed, 41 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	41 (53)	19	6	16
Excluded: No learning relevant to policing practice[3]	18 (25)	4	5	9
Excluded: Out of date[4]	10 (13)	2	4	4
Excluded: Post incident involvement only[5]	4 (5)	2	0	2
Excluded: No police involvement in the case[6]	3 (4)	0	0	3
	76 (100)	**27**	**15**	**34**

Timeframe of reviews

Of the 41 cases included for analysis, just over 90% were published in 2018 and 2019 with the remaining cases published in 2016 or 2017 (these were mainly those SCRs identified in a search of LSCB websites).

The month/year of incident that triggered the SCR spanned from January 2016 and May 2018; 21 incidents having occurred in 2016, 16 in 2017, and 4 in 2018. Therefore a majority of the incidents occurred two or more years ago (and two or more years between incident and publication of SCR). This emphasises the lengthy timeframe for publishing the learning from these reviews.

Limitations of reviews

SCRs do not always go into great detail about the policing role in these types of cases. It may be possible to know, for example, that information sharing was a problem but it is not always possible to know why. Future Serious Case Reviews of this sort would benefit from

[3] 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.
[4] 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.
[5] 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.
[6] 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.

reviewers attention to the reasons why police practice that did not meet expected standards. This would assist in increasing the relevance of learning from these reviews for the Police.

Appendix C: References

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