Vulnerability Knowledge & Practice Programme

The role of police in responding to child and adult vulnerability: A meta-analysis of 126 reviews of death and serious harm

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About the Vulnerability Knowledge and Practice Programme

The Vulnerability Knowledge and Practice Programme (VKPP) is a national policing programme working with all forces in England and Wales. The VKPP has a range of work streams including: the National Vulnerability Action Plan (NVAP, 2020-2022, v 2), of which the VKPP is custodian. It is a holistic strategic plan which is evidence-based and designed to support forces to develop a wide range of work from supporting victims, recruiting the right people to data management and dealing with officer norms. The VKPP also collates emerging promising practice in relation to all vulnerability strands, such as domestic abuse, rape, county lines, modern day slavery, adults at risk, management of sex offenders, early help, child sexual exploitation and honour-based abuse. These are stored on the VKPP site on the Knowledge Hub[1]. Other key work includes academic analysis of police learning in reviews of cases of significant harm and death, presenting the findings in quarterly briefings and producing overall analysis of cases (of which this report is the first). The VKPP also leads the policing response and co-ordination of the new role as key partner in local safeguarding arrangements. There are other work streams including exploring outcomes work within policing and a peer review function. The overall work is varied and aims to build and co-ordinate the evidence base of vulnerability, knowledge and practice across policing.

[1] Readers can click on this link which will direct you to the main page of the Knowledge Hub. Readers may sign up for free if you have a *pnn.police.uk* email address, and then join the '*Vulnerability and Violent Crime Programme',* to view promising practice and all other VKPP resources.

Contents

Executive Summary

This report presents key findings from research into the police role in serious cases of significant harm and death, carried out by the Vulnerability Knowledge and Practice Programme (VKPP). The research aimed to understand the ways in which police, as a statutory partner, feature in reviews of serious cases of significant harm or death in children and adults; key gaps in police practice; and to understand the cumulative learning for police across different review types, involving a range of vulnerabilities. Reviews of serious cases tend to be examined as separate and distinct sources of learning. However, there is potential for considerable cross-over among reviews which can maximise the learning. This inclusive approach has allowed for the consideration of practice that might be common across reviews, but play out differently within the contexts of responses to adults versus children, or in relation to different vulnerabilities, for example.

While the reviews themselves are deficit-based models of learning, the findings, key messages and recommendations presented here are intended to be solution-focussed to inform positive and sustained improvements to police practice. Our approach, much in the same way as other research into serious cases in the child protection arena, does not seek to blame individual officers for mistakes. Instead, it acknowledges that there is always room for learning and improvement in the system to better support police in their safeguarding responsibilities.

The research is based on an analysis of 126 reviews: 69 Serious Case Reviews (in England)/ Child Practice Reviews (in Wales), 45 Safeguarding Adult Reviews (in England)/ Adult Practice Reviews (in Wales), 10 Domestic Homicide Reviews and two joint reviews. Five individual practice briefings have been published on smaller subgroups of these reviews to date and can be found here.

The aims of this report are to:

a) summarise the findings of the research for a police audience and their safeguarding partners;
b) map the key findings against relevant actions in the National Vulnerability Action Plan (NVAP 2020-2022, v2);
c) highlight additional considerations for forces.

The findings here will be important for Chief Officers and safeguarding leads in England and Wales, along with learning and development staff, to support the workforce in practice improvement. The findings will also be useful for Staff Officers responsible for aligning thematic action plans with the NVAP (2020-2022, v2). The VKPP programme will also use the evidence in this report to inform and shape the discussions across all of its workstreams to ensure targeted practice improvement, and will continue to build this evidence base into 2021.

Alignment of key findings to the National Vulnerability Action Plan

There are 8 key findings that closely align to 8 of the 16 actions in the NVAP (2020-2022, v. 2). These findings provide evidence to support the continued need for inclusion of these actions in the plan. No additional recommendations to those within the NVAP are made on the basis of these findings. Table ES1 presents these findings alongside the relevant actions.

Table ES1: Key findings as aligned to the National Vulnerability Action Plan

Identifying & managing risk **NVAP Action 2.1.1** **'Recognition and response'** Ensure that recognising and responding to vulnerability is everyone's business, especially at first point of contact	**Key finding 1:** Identifying vulnerability that may increase a child or vulnerable adult's risk of harm was the most common gap in practice for the police within the reviews examined. Sexual violence including child sexual exploitation, criminal exploitation and stalking and harassment were the most common types of vulnerabilities to be missed. Risks and vulnerabilities were also missed when they related to children or vulnerable adults who were not the main focus of the police response.
Identifying & managing risk **NVAP Action 2.1.2** **'Mental health'** Acknowledging that mental health (MH) can impact across all forms of vulnerability. Forces to consider any links to MH as part of their vulnerability assessment, differentiating from other vulnerabilities where possible and ensuring individuals receive appropriate signposting, guidance and care	**Key finding 2:** Mental health needs featured regularly in reviews of vulnerable adults, often linked to other behaviours such as substance abuse and self-neglect. Within these cases, officers commonly missed opportunities to identify mental health needs which had a range of negative impacts on management of risk, sensitive victim support and investigation. Police and multi-agency partners appeared less likely in vulnerable adult cases to work together to manage risk and support them than in child cases of significant harm and death.
Supporting vulnerable individuals **NVAP Action 2.1.3** **'Access to services'** Ensure all staff know where and how to access service provision for all strands of vulnerability, especially at the local neighbourhood level	**Key finding 3:** The reviews evidenced some cases where officers did not make support referrals to partner agency services, such as to Independent Sexual Violence Advisors, when this may have been helpful to victims. It is not always clear why this did not happen, but may be related to officers lacking knowledge about local service availability and referral pathways.

Collaborative working **NVAP Action 2.2.1** **'Appropriate action'** In response to identified risk, ensure staff understand and utilise appropriate referral pathways including how to access partner provisions and are empowered to challenge or escalate decisions	**Key finding 4:** While the reviews evidenced many appropriate safeguarding referrals to other agencies and processes made by the police in these cases, they also showed that sometimes referrals did not occur when they should have. Referrals to MARAC and MAPPA could be problematic for example, with thresholds and processes unclear to officers. The reviews also evidenced that sometimes officers held concerns about decisions made (or not made) by partner agencies, yet did not escalate their concerns.
Victim engagement and care **NVAP Action 2.4.1** **'Voice of the victim'** Develop clear processes to ensure that 'the voices of vulnerable victims and witnesses' are heard	**Key finding 5:** Police sometimes missed opportunities to talk to children and vulnerable adults to ascertain their views and experiences, their wishes and their support needs. Sometimes police made assumptions about the way a child or adult presented in lieu of speaking directly to them; in other cases, officers lacked the confidence and skill to do so (in cases of very young children).
Evidence and investigation **NVAP Action 2.4.3** **'Evidence-led prosecutions'** Develop and utilise in more effective ways early evidence gathering techniques and the use of 'evidence-led' prosecutions in all appropriate cases (wider than DA & child abuse)	**Key finding 6:** Evidence-led prosecutions appear to have had limited consideration in all types of reviews where domestic abuse was a key part of the context. Evidence-led prosecutions were considered in only a small number of domestic abuse cases, but were discounted and not pursued.
Developing the workforce **NVAP Action 2.6.2** **'Officer norms'** Recognise that officer norms will change from exposure to aspects of criminality/ vulnerability and that these need to be re-set so that thresholds of acceptability are maintained	**Key finding 7:** Preconceptions or negative attitudes prevented some officers from identifying vulnerability that may increase a child or vulnerable adult's risk of harm, delivering appropriate risk management, providing sensitive victim support and carrying out effective investigations. Particularly in the context of repeat incidents, some officers appeared to apply preconceptions of victims which would influence decision-making, rather than taking each incident on its own merit. These police responses were observed across a range of vulnerabilities including child sexual and criminal exploitation

	and missing children; domestic abuse cases; and adult safeguarding cases, particularly involving mental health needs and substance abuse.
Crime prevention and long-term problem solving **NVAP Action 2.7.1 'Working with communities'** To work with communities to build confidence, improve understanding and increase reporting especially with marginalised groups	**Key finding 8:** Within the reviews where domestic abuse is part of the wider context, and particularly in DHRs, there is evidence that victims of domestic abuse and stalking and harassment find it difficult to report crimes to the police. Sometimes this is because victims do not recognise the abuse as a crime or do not feel it is serious enough to report. Some victims in the reviews did not report because they lacked confidence that the police would take them seriously. Family members and friends are often unaware of how and when they should help and support victims of domestic abuse.

Additional considerations

Additional findings not directly aligned to the NVAP (2020-2022, v2) but which have implications for the actions within it is described below in table ES2.

Table ES2: Additional considerations for forces and future NVAP refresh

Researching and recording The reviews evidenced common officer errors in recording and researching that often had impacts on risk identification, management and investigation. Inevitably, some of these errors may also impact on the ability of forces to identify vulnerability and risk. Forces should consider their systems for assessing the quality of information recorded about vulnerability and crimes. This may be done through audits and dip-sampling strategies as well as on-going staff development of skills in recording and researching.
Quality of reviews While the reviews offer rich insight into policing practice in cases of death of and significant harm to children and vulnerable adults, there were some limitations to the overall quality of learning contained within the reviews. Reviews in general vary in length, quality and methodology and the extent to which it is possible to understand the learning from a 'systems' approach. Some reviews are better than others at describing practice clearly and accurately, exploring the reasons underpinning missed opportunities or poor practice, identifying good practice and what this looks like, and determining whether the learning is a localised issue or one that is relevant to police practice more widely. Protected characteristics are not always reported within reviews, which limits

what can be learned about the lived experiences of children and vulnerable adults in their interactions with the police. Recommendations at the end of reviews often highlight multi-agency messages rather than single-agency learning, despite the identification of missed opportunities by specific agencies within the narrative of the reviews themselves; in other words, learning identified within the reviews does not always translate into a direct recommendation for the police. This means police may be missing important learning if their focus is solely on recommendations contained at the end of reports.

These learning points may be something that learning and development staff and police leads may wish to consider when collating the learning consider when collating the learning and that police leads may wish to consider, particularly within their role as potential commissioners of reviews.

Introduction

The VKPP recognised early on in its programme of work, flagged as an NPCC action in the first iteration of the NVAP, that there was a gap in learning for the police from reviews of serious cases. First, the time to publish serious cases is often lengthy, taking years in some cases, which means the learning can be very slow to emerge. Second, access to published cases is varied because not all cases are centrally collated (see Appendix A, Table A2). Third, although reviews of serious cases have been subject to various programmes of research[2], none have focussed exclusively on the policing role in these cases, and only one research study that we know of has cross-analysed different types of adult reviews in Wales only[3].

A programme of work was, therefore, initiated to a) understand how police feature in such cases; and b) analyse multiple types of reviews of vulnerability to understand what cumulative learning might be present. While reviews of serious cases examine the ways in which agencies worked together to protect and respond to children and vulnerable adults, this project focusses specifically on the policing role within this.

During 2019/20, the VKPP published five practice briefings which analysed police practice and areas for learning within a number of different review types. This report summarises the findings across all the reviews included in those briefings, taking a cumulative perspective.

This report covers 126 reviews of serious cases involving children and adults where the police have had a role prior to the incident or concern that triggered a referral for a review to be undertaken. The reviews included in this analysis are:

- 69 *Serious Case Reviews* (SCRs) in England/ *Child Practice Reviews* (CPRs) in Wales[4],
- 45 *Safeguarding Adult Reviews* (SARs) in England/ *Adult Practice Reviews* (APRs) in Wales
- 10 *Domestic Homicide Reviews* (DHRs)
- 2 joint reviews (1 SCR/DHR and 1 SAR/SCR).

In this report, we examine key characteristics of the cases including: the demographics of the children and adults involved; the categories of death and harm; the source of that harm (whether intrafamilial, extrafamilial or self-harm); and the presence of vulnerabilities in these cases such as child sexual exploitation (CSE), child criminal exploitation (CCE), financial

[2] For example, the triennial reviews of serious case reviews, the most recent published in 2020: Brandon, M., et al. (2020) *Complexity and challenge: a triennial analysis of SCRs2014-2017*. London: DfE. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

[3] Robinson, A., Rees, A., & Dehaghani, R. (2018) *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews*. Cardiff: Cardiff University. Available at: https://orca.cf.ac.uk/111010/1/Robinson%20Rees%20and%20Dehaghani%20%282018%29%20Thematic%20Review_english.pdf

[4] The system in England for reflecting on how well the child protection system is working is in transition (see Working Together to Safeguard Children 2018). The responsibility for how the system learns sits nationally with the Child Safeguarding Practice Review Panel. The Panel identifies and oversees the review of serious child safeguarding cases which they believe raise issues of national importance. However, local areas continue to have a duty to review cases locally – now called 'Child Practice Reviews' instead of Serious Case Reviews.

exploitation, missing, domestic abuse and stalking and harassment (whether or not these vulnerabilities were the trigger for the review).

The report also examines the most common gaps, or missed opportunities, in police practice so that areas for improving police responses to vulnerability can be prioritised. We have looked at broad areas of police practice aligned with the 'perennial issues'[5] framework developed by the College of Policing, including the identification and management of risk; evidence and investigation; victim engagement and care; and collaborative working.

Our approach, much in the same way as other research into serious cases in the child protection arena, does not seek to blame individual officers for mistakes. Instead, it acknowledges that there is always room for learning and improvement in the system to better support police in their safeguarding responsibilities. Reviews tend to be examined as separate and distinct sources of learning. However, there is potential for considerable cross-over among reviews which can maximise the learning. This inclusive approach has allowed for the consideration of practice that might be common across reviews, but play out differently within the contexts of responses to adults versus children, or in relation to different vulnerabilities, for example.

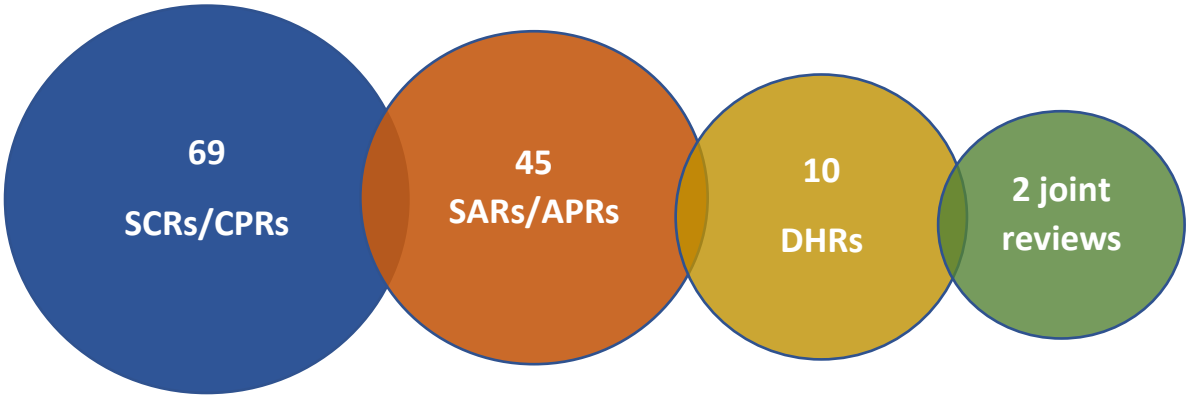
Three original research questions guided this work:

1) How does police practice feature in reviews of death and serious harm?
2) What explains missed opportunities or practice that does not meet expected standards?
3) What are the most common gaps in practice?

A total of 609 reviews were scanned for inclusion, yielding a total of 126 cases which fit our criteria for inclusion. A full account of the terms of reference of these reviews and the methodology of the research can be found in Appendix A. Diagram 1 illustrates the distribution of review types among these 126 cases.

[5] The College has undertaken research to obtain a rounded view of priorities for improvement in, or support to, policing over the short to medium term. The research included analysis of HMICFRS thematic and force PEEL inspections and interviews and focus groups with Chief Officers and frontline staff including constables and sergeants, in order to identify the recurring 'perennial issues' in policing where action is needed to drive improvement for the public across a range of contexts, rather than for a particular crime type or operational area of policing. This approach was aimed at identifying how the College can best work with and support policing practitioners to develop the professional skills which will enable them to respond to current, new and unforeseen challenges.

Diagram 1: The number of reviews included in this meta-analysis, by review type



Excel was used to log key characteristics of cases and a bespoke template and coding framework was developed to extract and analyse qualitative text from reviews related to police practice, using the College of Policing (CoP) 'perennial issues' framework to structure the learning. The nature of serious case reviews means that not all of the ten overarching issues appearing in Figure 1 emerge within the types of reviews analysed in this research (for example, serious case reviews typically do not comment on staff wellbeing). The key themes that emerged as being most relevant in this research were: identifying and managing risk; victim engagement and care/ supporting vulnerable people through the criminal justice system; evidence and investigation; and collaborative working.

Figure 1: The College of Policing 'perennial issues' framework

A 'systems' approach was applied to the analysis to explore not only 'what' happened, but 'why' missed opportunities occurred. However, not all reviews report these explanations in depth. Where it was possible to understand a broader 'systems' explanation for the practice, we have noted this.

Caveats to, and limitations of, the research

While these reviews provide a source of rich data on multi-agency practice and, most relevant to this analysis, an insight into the role of the police in serious cases, there are some limitations that must be acknowledged.

First, these reviews represent *serious cases* of death and harm that are identified as such and accepted by safeguarding boards for review. They do not, therefore, represent *all* cases of death and harm of children and vulnerable adults, nor do they represent the full picture of police practice in response to vulnerability and safeguarding needs.

Second, our analysis was necessarily dictated by the types of cases referred to and selected by commissioning boards for review. Historically, SCRs on balance have reflected abuse in the family home. In contrast, abuse occurring in extrafamilial contexts has been reflected in SCRs to a lesser extent[6]. While this system is changing in England[7] and will, we hope, evolve to expand the focus beyond abuse in the family home, learning about the police role in serious cases involving extrafamilial harm to children within our sample contained here remains limited.

Third, the time it takes between commissioning of a review and publication can be lengthy, by which time police practice may have moved on or been addressed through new guidance or training. However, we also know that new directions in or guidance on police practice may not be absorbed equally across forces, particularly where vulnerability is complex and police responses are entrenched. The current 43-force system means that forces are largely free to operate in the way they consider most suitable to meet local demand. HMICFRS (2019)[8] argue that with this freedom comes a cost, with procedures and practices becoming unacceptably inconsistent. We believe, therefore, that much of the learning we are seeing continues to be relevant – even if some forces have successfully addressed some of the issues. However, in recognition of the 'learning lag', we have worked closely with the College of Policing and other stakeholders to ensure our messaging and recommendations within our briefings remain current and offer links to the most relevant resources.

Fourth, the quality and quantity of information about the role of the police in these cases is variable within reviews. Sometimes reviewers primarily *describe* police responses, with little analysis or reporting of the reasons *why* the practice occurred. In part, we know that

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[6] SCIE (2019) *Analysis of statutory reviews of homicides and violent incidents: A report commissioned by the Mayor of London's Violence Reduction Unit.* London: SCIE. Available at: https://www.london.gov.uk/sites/default/files/vru_homicidesviolentincidents_report.pdf

[7] See *Working Together to Safeguarding Children* 2018 for an account of the changes to child safeguarding arrangements https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[8] 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

reviewers may themselves be limited by the quantity and quality of information they are able to access within police Internal Management Reports (IMRs). Without good detail about the explanations for errors or missed opportunities, we are less able to target messages for practice at the 'right level'. Readers can see Appendix B for a standalone briefing on the methodological learning from the VKPP's work on these reviews.

Fifth, relevant characteristics of cases, like ethnicity and gender, are often missing from reviews which limits our ability to examine the lived experiences of children and vulnerable adults in relation to their contact with the police.

Sixth and finally, reviews take a 'deficit' model approach which means they seek out what went wrong, rather than what went right. Reviewers do praise officers for good practice on occasion, but specific detail about the features of good practice is often weakly described, limiting our ability to articulate what 'good' looks like.

About the cases

The 126 reviews considered in this report cover at least 29 of 43 forces in England and Wales (in three SCRs, location is anonymised). This section features detail about the following characteristics of cases:

(1) demographics of the children and adults
(2) patterns of death and significant harm
(3) sources of harm and contexts of cases
(4) overlapping vulnerabilities.

Demographics of the cases

The demographic characteristics of the children and adults central to the reviews are detailed in Tables 1, 2 and 3. Some characteristics are significantly under-reported in reviews. While under-reporting typically occurs as part of the process of anonymising reviews, it does limit what can be learned about the lived experiences of different groups of children and vulnerable adults who have died or experienced significant harm and the patterns of practice responses by agencies involved with them.

Age

There is a notable age gap in Table 1 below, where the oldest young person subject to an SCR was 17 and the youngest person subject to a SAR was 20. This raises the question of how safeguarding systems are reflecting on practice in relation to young people in transitional stages, moving into the adult safeguarding arena.

Table 1: Age of individual children and adults in reviews

Cases/ review type	Age range (average)
SCRs/CPRs/ combined reviews (n=55)	Under 1 to 17 (7.8)
SARs/APRs (n=37)	Between 20 and 95 (52)
DHRs (n=8)	Between 19 and 51 (31)

Gender

The gender of the 62 individual children was available in only 38 SCRs/CPRs (including the two combined reviews), with a roughly equivalent split between males and females, as detailed in Table 2. The latest triennial review of SCRs found a similar gender split[9]. In the 42 (of 45) adult cases, males and females were evenly split, different to other samples of SARs which tend to include a higher proportion of males[10]. All but one of the DHRs

[9] Brandon, M., et al. (2020)

[10] Braye, S., Orr, D. & Preston-Shoot, M. (2015) 'Learning lessons about self-neglect? An analysis of serious case reviews.' *Journal of Adult Protection*, 17(1), 3-18; Braye S & Preston-Shoot, M. (2017) *Learning from SARs: A report for the London Safeguarding Adults Board*. London: LSAB.

concerned female victims, a slightly higher ratio of females-males than is found in other analyses of DHRs[11], likely explained by the non-representative nature of this sample of DHRs.

Table 2: Gender of individual children and adults in reviews

	Male No. (per cent)	**Female No. (per cent)**
SCRs/CPRs/ combined reviews (n=38)	20 (53)	18 (47)
SARs/APRs (n=42)	21 (50)	21 (50)
DHRs (n=10)	1 (10)	9 (90)

Ethnicity

Ethnicity was particularly under-recorded across all reviews. As in Table 3, of the 62 individual children (including the two combined reviews), ethnicity was reported in only 21 cases. Of these, the majority of children were White British, with a range of other Black and Minority Ethnic (BAME) children represented. In the remaining 9 cases with sibling or other groups, ethnicity was only recorded in four cases and these included: White British, mixed White and Black British, Roma and Asian (Bangladeshi). Ethnicity in SARs/APRs is also under-recorded, as observed by other authors[12]. Of the 17 SARs/APRs with ethnicity reported, almost half were White British, with a range of other BAME adults represented. All of the DHRs where ethnicity was recorded concerned White British victims; and the under-recording of ethnicity in DHRs has also been raised elsewhere[13]. As concluded in other research, the under-recording/ reporting of ethnicity consequently means that the racialised and cultural lived experiences of children and vulnerable adults went largely unexplored in many of these reviews, and, importantly, shed little light on the ways in which the professionals involved considered these lived experiences and interacted with them – and other professionals[14].

[11] Home Office (2016) *Domestic Homicide Reviews: Key findings from an analysis of Domestic Homicide Reviews*. London: Home Office.
[12] Braye & Preston-Shoot (2017) ibid
[13] Home Office (2016) ibid
[14] Bernard, C. & Harris, P. (2019) Serious case reviews: The lived experience of Black children. *Child and Family Social Work,* 24(2), 256-263.

Table 3: Ethnicity of individual children and adults in the reviews

Ethnic group[15]	SCRs/CPRs (n=21) No. (per cent)	SARs/APRs (n=17) No. (per cent)	DHRs (n=6) No. (per cent)
White: White British	6 (28.6)	8 (47)	4 (66)
Black British	3 (14.3)	2 (12)	-
Mixed/ multiple ethnicities: White and Black British	2 (9.5)	2 (12)	-
Other ethnic group: Roma	2 (9.5)	-	-
Black Caribbean	2 (9.5)	-	-
Asian/Asian British: Pakistani	2 (9.5)		-
Asian/Asian British Bangladeshi	1 (4.7)	-	-
Asian/Asian British: Vietnamese	1 (4.7)	-	-
Black African	1 (4.7)	2 (12)	-
Other ethnic group: Lithuanian	1 (4.7)	-	-
Other ethnic group: Kurdish	-	1 (6)	-
Asian/Asian British: Filipino	-	1 (6)	-
Asian/ Asian British: Central Asian Republic	-	1 (6)	1 (17)
Other ethnic group: Hungarian	-	-	1 (17)

Disability

Disability was only explicitly recorded in two (3%) SCRs/CPRs concerning individual children. It is not possible to say whether disability was intentionally left out of the remaining reviews in the process of anonymisation or if the remaining cases did not involve disability. Disability was only referenced in one of the 8 sibling cases. Within the SARs/APRs, disability was clearly recorded in 10 cases. None of the DHRs recorded disability so this was either not a feature of the case or it was unreported.

Patterns of death and significant harm across review types

In child cases (including the two combined reviews), there is a slightly higher percentage of deaths than significant harm, as displayed in Table 4. This roughly equates to the distribution of death and harm in cases analysed in recent, and previous, triennial reviews of SCRs[16]. The majority of cases in the SARs/APRs in the current sample relate to deaths,

[15] Table 3 uses the ethnic groups recommended by the Office for National Statistics for England and Wales, see https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion

[16] Brandon et al. (2020)

although in other studies, rates of death vary between 55 and 95%[17]. While this sample of reviews is not representative of all SARs/APRs because of the specified inclusion criteria of police involvement, it may be that this sample's high rate of deaths relates to the seriousness of the cases, where police would be more likely to be involved. In all DHRs and combined reviews, the cases relate to deaths.

Table 4: Patterns of death and significant harm across review types

	SCRs/CPRs[18] No. (per cent)	**SARs/APRs No. (per cent)**	**DHRs No. (per cent)**
Death	40 (56)	42 (93)	10 (100)
Harm	31 (44)	3 (7)	-

Deaths

Of the 40 child deaths, suicide and overt filicide were the most common categories of child death, together accounting for just over half of the cases. As in Table 5 below, 7 cases were categorised as 'other', including: death likely caused by neglect; death in a road traffic accident, death in a moped crash, death by drug overdose, death by drowning in a bath, death by illness and self-neglect (combined review) and central nervous system and cardio pulmonary depression and morphine use.

Table 5: Categories of child death (n=40)

Categories[19]	**Number (per cent)**
Suicide (linked to maltreatment)	12 (30.0)
Overt filicide	8 (20.0)
Other	7 (17.5)
Child homicide	3 (7.5)
Unclear	3 (7.5)
Covert filicide	2 (5.0)
Fatal physical abuse	3 (5.0)
Fatal assault	1 (2.5)
SUDI (linked to maltreatment)	1 (2.5)

Of the 42 deaths within SARs/APRs, over one-third were due to ill-health, the majority of which were recorded as death by natural causes (see Table 6). In three of these cases, ill-health was connected to substance abuse. In an additional three cases, cause of death was explicitly recorded as self-neglect, however, self-neglect was apparent in the context of many more cases. Nearly a quarter of the SAR/APR deaths were by homicide. A further quarter were 'accidental', and included several cases of house fire, one road traffic accident, one fall and, in one case, a victim died after a door collapsed on them. In 9 of the DHRs, death was a result of homicide. In the tenth case, death was by suicide, but the significance of domestic abuse in this case explains the referral for a DHR review.

[17] Braye & Preston-Shoot (2017) ibid

[18] This includes the two SCR combined reviews

[19] These categories were adopted from those used in the triennial reviews of serious case reviews (Brandon et al., 2020)

Table 6: Categories of adult deaths

Categories	SARs/APRs No. (per cent)	DHRs No. (per cent)
Ill health	15 (35.7)	-
Homicide	10 (23.8)	9 (90%)
Accidental	10 (23.8)	1 (10%)
Suicide	5 (11.9)	-
Overdose	2 (4.8)	-

Harm

In the 31 cases of significant harm to children, physical assault and 'other' comprised the largest categories of significant harm (see Table 7). 'Other' included: suspected drug ingestion by child (2), unexplained injuries (4), child hit by a car (1) and the remainder involved multiple concerns.

Table 7: Categories of significant harm to children (n=31)

Categories of significant harm[20]	No. (per cent)
Other	11 (35.5)
Physical assault	10 (32.3)
Neglect	4 (12.9)
Intrafamilial child sexual abuse	3 (9.7)
Extrafamilial child sexual abuse	2 (6.5)
Child sexual exploitation	1 (3.2)

Only three SAR reviews concerned significant harm involving adults, with the categories of harm listed in Table 8.

Table 8: Categories of significant harm involving adults (n=3)

Categories of significant harm	No. (per cent)
Physical assault	1 (33.3)
Neglect	1 (33.3)
Multiple abuse	1 (33.3)

Contexts of death and harm

While the figures concerning patterns of death and harm detailed above tell us something about the specific incidents or concerns that led to the commissioning of the review, they do not tell us about the wider contexts in which they occurred. Tables 9 and 10 below detail the contexts of death and harm featured in the 126 child and adult reviews.

The child cases are starkly balanced towards intrafamilial violence, abuse or neglect, comprising nearly 65% of the cases. Extrafamilial violence, abuse or neglect, in contrast, makes up only 13% of the sample. Extrafamilial harm is broken down into three categories in Table 9: 6 cases where the perpetrator of the harm was unknown or unclear; 2 cases of

[20] These categories were adopted from those used in the triennial reviews of serious case reviews (Brandon et al., 2020)

intimate partner violence; and 2 cases occurring within the contexts of institutional care (one a secure centre and the other a young person who went missing from his foster placement and was found deceased).

The remaining quarter relate to self-harm (suicide or death related to drug or alcohol use), with the majority of these likely influenced by intrafamilial violence, abuse or neglect. Other studies have also noted the under-representation of extra-familial harm, including youth violence, in SCRs[21].

Table 9: Contexts of harm in SCRs/CPRs (n=71)

	No. (per cent)
Intrafamilial (adult-child, or child-child) harm	46 (64.7)
Self (likely intrafamilial maltreatment related)	8 (11.2)
Extrafamilial (unknown age of perpetrator) harm	6 (8.4)
Self (other)	5 (7.0)
Institutional care context	2 (2.8)
Self (no clear source of harm)	2 (2.8)
Extrafamilial (intimate partner) harm	1 (1.4)
Self (likely peer-related violence)	1 (1.4)

In Table 10, it can be seen that nearly 40% of ASRs/ APRs concerned cases where the source of harm was without a perpetrator, primarily including cases such as self-neglect and substance abuse. A further quarter of these cases occurred within institutional contexts (examples include physical violence occurring within residential accommodation and vulnerable adults going missing from their accommodation). Nearly a fifth involved adult peer-to-peer violence, with a further 11% adult family violence. Only a small number involved interpersonal contexts. All DHRs concerned interpersonal violence.

Table 10: Sources of harm in SARs/APRs and DHRs

	SARs/APRs (n=45) No. (per cent)	**DHRs (n=10) No. (per cent)**
Self or no clear source of harm	18 (40)	-
Institutional or care context	11 (24)	
Adult peer-to-peer violence or abuse	8 (18)	-
Intrafamilial (adult-adult)	5 (11)	-
Intimate partner violence	3 (7)	10 (100)

Overlapping vulnerabilities

This final section considers how prevalent key vulnerabilities of relevance to the VKPP programme are across reviews. We considered how common vulnerabilities such as child sexual exploitation, criminal exploitation, financial exploitation, domestic abuse and trafficking were across the reviews, even where these were not stated to be the incident or concern that triggered the review. We examined reviews for the presence of either

[21] SCIE (2019) ibid.

suspected or actual vulnerabilities and Table 11 below demonstrates that some vulnerabilities are present across different review types.

The most common vulnerability that is part of the wider context of these vulnerable children and adults is domestic abuse, evident in almost 70% of SCRs/CPRs, 40% of SARs/APRs and throughout all of the DHRs. Missing children or adults were present in a quarter of all SCRs/CPRs and SARs/APRs, and minimally in DHRs. Stalking and harassment most commonly appeared in DHRs, but a small number of SCRs/CPRs and SARs/APRs had concerns related to stalking within them. Suspected or actual child sexual exploitation was a feature of 22% of SCRs/CPRs even though only one review was undertaken explicitly in relation to CSE. Child criminal exploitation and trafficking hardly featured, in only one SCR each.

Table 11: Vulnerabilities within reviews

	SCRs/CPRs (n=71) No.(%)	**SARs/APRs (n=45) No.(%)**	**DHRs (n=10) No.(%)**
Child sexual exploitation	16 (22)	1 (2)	1 (1)
Child criminal exploitation	1 (1)	0 (0)	0 (0)
Domestic abuse	49 (69)	18 (40)	10 (100)
Female genital mutilation (FGM)	0 (0)	1 ()	1 ()
Financial exploitation	0 (0)	9 (20)	1 (1)
Missing	18 (25)	11 (24)	1 (1)
Stalking and harassment	2 (3)	2 (4)	4 (40)
Trafficking	1 (1)	0 (0)	0 (0)

Summary

This section has examined some key characteristics of the 126 reviews analysed. It demonstrates the wide variety of serious cases that police encounter in their daily business, although it also highlights some important gaps in our learning about vulnerability, particularly in relation to peer-to-peer harm among children, serious youth violence and young people transitioning into adulthood. Cumulatively, we see that there is scope for learning about particular forms of harm across different types of reviews; with domestic abuse appearing most commonly across all three. The findings also tell us that learning about the lived experiences of children and vulnerable adults is limited where key protected characteristics are not reported or explored.

Introduction to the themes

The remainder of this report analyses the police role in reviews of these types, against key themes of the 'perennial issues' framework (as introduced in Figure 1). These feature specifically because they appear most prominently in the reviews:

(1) identification of risk
(2) management of risk
(3) evidence and investigation and
(4) victim engagement and the care and support of people through the criminal justice system (these two separate themes have been considered together as one).

It was impossible, in the analysis, to separate out the theme of 'collaborative working' from the other major themes, given the focus of these reviews on the ways in which agencies worked together to protect and support children and vulnerable adults. Instead, and given the clear salience of partnerships for the police in their safeguarding role, collaborative working will act as a summary section drawing together the most important themes that emerged. The remainder of the themes as shown in Figure 1 do not tend to be examined as issues within the types of the reviews considered in this report, and therefore do not form part of the findings presented here.

The identification and management of risk – but more specifically, the identification of risk – is the most common gap in police practice emerging from these reviews. This importantly shapes the rest of the findings in that unidentified, or misidentified risks, often negatively influenced onward policing activity in respect of the risk either by an absence of risk management or ad hoc and reactive strategies. Risks cannot be managed or reduced, for example, if they are not identified in the first place and, consequently, the reviewers of serious cases would not, therefore, have the opportunity to examine risk management practice or investigations that may have been warranted if the risk had been correctly identified.

We have analysed each incident of police practice against one of these themes, although we acknowledge that there is overlap. For example, whilst an officer is collecting information about an investigation, they are simultaneously assessing risk to a victim. Similarly, when an officer collects information to inform an assessment of risk, this may form part of the intelligence used to inform an investigation. Throughout both of these processes, officers should be delivering a professional and sensitive service to victims during their engagement with the criminal justice system.

The key questions this analysis has focussed on are:

- How do the police feature in reviews of serious cases?
- What are the most prominent gaps in police practice, as they emerge within the different kinds of reviews?
- Are there any key differences in the way police respond to different kinds of cases? (e.g. child versus adult, or different vulnerability types).

Identification of risk

The National Vulnerability Action Plan 2020-2022 (v2) relevant actions

Action 2.1.1, 'recognition and response' seeks to ensure that recognising and responding to vulnerability is everyone's business, especially at first point of contact.

Action 2.6.2, 'officer norms' recognises that officer norms will change from exposure to aspects of criminality/ vulnerability and that these need to be reset so that thresholds of acceptability are maintained.

The recognition and identification of risk is a key stage for the police in protecting vulnerable people and relies upon a wide range of specialist and non-specialist police officers and staff. Vulnerability must be identified in order to appropriately assess the risk and target effective support and protection. This section considers police practice in reviews as it relates to the identification of risk or vulnerability and the related safeguarding and support needs of victims and suspects, either at initial or later contacts. Onward policing activity in relation to risk assessment and management is considered in the next section.

Recent inspection reports have been generally positive about police understanding of risk and vulnerability. The latest PEEL (police effectiveness, efficiency and legitimacy) inspection report, for instance, acknowledges significant improvement in this area of practice over time:

> *"Forces have greatly improved their ability to protect vulnerable people and support victims. Almost all the frontline staff we spoke to have a good understanding of vulnerability and its importance. Over half of forces attracted positive comment on their understanding of the nature and scale of vulnerability. This area has seen the greatest improvement in grades since our previous inspection"* [HMICFRS, 2020; p. 12][22].

A thematic HMICFRS (2019)[23] inspection report on child protection identified that police are getting better at recognising and responding to risk and signs of vulnerability in children. Police are found to be using more sophisticated risk assessment processes to assess, prioritise and respond to signs of risk and, where the risks to a child are obvious, these processes are found to be applied consistently. In respect of adults, an HMICFRS inspection

[22] HMICFRS (2020) *PEEL spotlight report: Diverging under pressure*. London: HMICFRS. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/peel-spotlight-report-diverging-under-pressure-2018-19-overview.pdf

[23] HMICFRS (2019) *National child protection inspections: 2019 thematic report*. London: HMICFRS. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/national-child-protection-inspections-2019-thematic-report.pdf

on crimes against older adults found that initial police decisions about whether a victim was vulnerable were mainly accurate[24].

Despite the positive comments within inspections, there is also room for improvement noted. No force was graded as 'outstanding' within the PEEL report in terms of effectiveness at protecting vulnerable people and supporting victims, highlighting specific concerns about assessing risk and initial response. Child protection inspections found that where risk or vulnerability is not directly presenting or disclosed, there is room for improvement for the police around their understanding of the nature and extent of vulnerability. And in relation to older adults, wider concerns were raised about the assessment of victim needs.

The reviews in our sample provide further consideration around where some weaknesses in practice in identification of risk still lies. Missed opportunities in the identification of risk were evidenced in 67, or 53%, of reviews. It is important to note that that risks were deemed to have been *correctly* identified in the remaining half of cases. Risks were missed in relation to children under 13, adolescents aged 14-17, adults over the age of 18 and suspects/ perpetrators, as shown in Table 12.

Table 12: Who/what risks were missed

Who, or what, unidentified risks related to	Number of cases
Suspects / perpetrators	23
Adults (18+)	17
Children (under 13)	16
Adolescents (14-17)	11

Unidentified risks in suspects

Unidentified risks related to suspects were present in 23 reviews, 8 of which were SCRs, 9 SARs and 6 DHRs; 9 of these appeared to be underpinned by officers' lack of awareness or understanding of vulnerabilities. Examples include missed opportunities to recognise: that a young person suspected of perpetrating sexual abuse also had safeguarding needs; the risk of an adult spending time with a young person and the concurrent potential for CSE; the instigators of domestic abuse, where a victim could also be an aggressor; stalking behaviours; and adult risk toward other adults.

Unidentified risks in adults

Unidentified risks in adults were identified in 17 reviews, across all review types. In SCRs and DHRs, these risks were primarily related to domestic abuse, whereas in SARs/APRs, the risks tended to relate to mental health needs, substance abuse and self-neglect (the latter two often closely intertwined with mental health needs). Two key patterns were evident in the examples.

[24] HMICFRS (2019) *The poor relation: The police and CPS response to crimes against older people*. London: HMICFRS. Available at: https://www.justiceinspectorates.gov.uk/hmicfrs/publications/crimes-against-older-people/

First, like some of the cases involving children who are not the focus of a police response, adults *who were not the focus of a police response* but reside in a household where violence or abuse may be occurring tended to be overlooked. Despite being exposed to violence within their own homes, or having a disability impairing their ability to protect themselves, these needs went unnoticed by police and adults were not included in risk assessments nor were adult safeguarding referrals made, effectively rendering them 'invisible'.

One reviewer of a joint SAR/DHR commented that while potential risks to everyone in the household where domestic abuse is occurring should be considered, that these are *"more likely to be recognised and acted on, when there are children in a household affected by domestic violence. Unfortunately, the evidence from this SAR / DHR is that there is less awareness and understanding of the issues when the affected person is an adult, even if they are particularly vulnerable, due to physical disability or other care and support needs"* [Joint SAR & DHR LN]. Even where children are present, however, adult vulnerabilities could be overlooked, as in the case example below.

Case example

One example concerns a possible cuckooing case within a SAR, although the term cuckooing was not used. A number of young people had been spending time at a vulnerable adult's home (Adult A). It was clear, and appropriate, that the police had concerns about the young people however this may have deflected their attention away from his needs as a vulnerable adult. Adult A eventually moved into the home of another adult (Adult B), a move viewed by the police as positive in resolving their concerns about the young people. However, they did not consider the risks from Adult B, who had a history of violence. This case illustrates the dangers of binary approaches ('victim' or 'perpetrator'?), when in reality both the adult and the young people in this example demonstrated vulnerabilities and required safeguarding.

Second, *assumptions and/or bias* in police and partner agency responses and decision-making were evident in a number of cases, particularly relevant where substance abuse or significant mental health needs may be part of the context of the victim and/or suspect. These biases tended to develop in response to repeat calls into call handling centres by vulnerable adults (sometimes perceived as 'nuisance callers' or their concerns explained away because of 'mental health problems') or when police repeatedly responded to call-outs. The following extract from a SAR articulates the influence of biased views on responses to regular intoxication on a vulnerable adults' wider mental health needs. The reviewer argued that the police and health response

> *"suggests a cultural issue in our treatment of adults who present as highly intoxicated. Police officers were quick to deal with the possibility of anti-social behaviour and an ambulance arrived at the scene. Both agencies reported that they frequently see people who are highly intoxicated, not all of those individuals are, or need to be, conveyed to a police station or to a hospital. However, in this case it appears that assumptions were*

made about Adult D's situation that lead professionals to overlook the need for a formal risk assessment to protect Adult D from further harm" [ASR D].

A key recommendation from this reviewer was that those who are regularly intoxicated should not be considered less at risk simply because they are known to be alcohol dependent. While the responsibility for any mental health assessment in this case would have been borne by the health professionals, police can challenge decisions when they have confidence in their ability to identify vulnerability and risk.

In another case, a vulnerable adult was assessed as having a recognised learning disability. Yet, neither police nor partner agencies questioned his capacity, despite knowing about his disability. Police and partners appeared biased towards his presentation and behaviour, labelling him as 'troublesome'. As a result, none of the professionals adhered to the Mental Health Act 2015 which would have required a capacity assessment to be undertaken. As above, while responsibility would normally lie with other professionals to undertake such an assessment, the reviewer found that the police had poor understanding of the legislation and how this should be applied. Had they been better familiarised with it, they would have been empowered to challenge partners around decision-making in this case.

In other examples, referrals to the police about vulnerable adults who went missing or were found by members of the public in a troubled state did not result in police being deployed to ensure the safety of the adult, which in turn meant that opportunities to identify risks and support needs were missed. This appeared to be explained by resourcing issues within one force, who were experiencing high demand at the time, but in others, assumptions were made about the caller's situation which led police to believe a response was not necessary. Accepting that deployment of officers may not be possible in every case, these cases raise questions about how and when police can consider appropriate risk assessments to support decision-making and/ or involve appropriate partners to support vulnerable persons.

Unidentified risks in children

Unidentified risks around children emerged primarily in SCRs/CPRs and DHRs, although there was child safeguarding learning identified in a small number of SARs/APRs.

A notable theme, evident in 13 of the 17 cases where unidentified risks to children under 13 were present, the focus of police intervention was not the child but an adult. In most of these cases, police were responding to domestic abuse and therefore focussed on the parent/carer of the child and/ or the suspect. Children were, in many ways, 'invisible' to police who were narrowly focussed on the incident in hand rather than cognizant of wider vulnerabilities, as a quote from one review exhibits: *"Little consideration seems to have been given to the safeguarding needs of Sibling 4, who was, according to Mr X when interviewed by officers, watching television alone downstairs"* [SCR AP].

The focus, by some officers, on domestic abuse incidents took their attentions away from wider needs within the family that posed child protection concerns. Examples included missed opportunities to recognise: the impact of a mother's substance abuse on her child; the risk of a new partner moving into the household; and a mother's own needs (as a young mother who had been in care) in caring for her child. In one SAR, a vulnerable adult with

mental health needs often mentioned children he was associated with, yet none of the professionals involved (including the police), pieced this information together, which meant no child safeguarding activity was undertaken by police or other partner agencies.

There were three cases of unidentified risk where the focus of police response was on the child. These concerned: a child's status as 'looked after', which was not as a matter of course recorded on police systems, preventing partners from developing a full picture of risk; a disclosure of sexual abuse not investigated because police did not appear to fully appreciate female adult to male child abuse; and poor recognition of a mother's inability to protect her child in the context of her own vulnerabilities.

Unidentified risks in adolescents

All but one of the unidentified risks to adolescents related to young people who were the direct focus of police contact and related to a range of vulnerabilities such as mental health needs, criminal exploitation, trafficking, missing episodes, and sexual abuse, including CSE. In some cases, risk assessments were not completed or were not accurate or comprehensive, and therefore young people's vulnerabilities were not identified and recorded. There was evidence the police did not always recognise the indicators of complex vulnerability such as criminal exploitation and trafficking, and as a result prioritised young people's criminal activity over their safeguarding needs. There was also evidence in some cases of child sexual abuse and exploitation that officers and other partner agency professionals still believed young people were culpable in their abuse (evidenced in the way police and professionals recorded their information). One young person was an indirect focus of police activity; he was living apart from his mother who was experiencing domestic abuse. However, the risk assessments undertaken with his mother identified the children directly living with her, but neglected to include her son living with his father at another location. He therefore remained invisible to services, and as a result, his mental health and emotional wellbeing were not assessed and support not provided.

What can the police do? Improving the recognition and identification of risk

The reviews here demonstrate examples of police working well in the identification of risk or identifying ways to improve this within forces, such as through the implementation of systems and processes designed to support the earlier identification of risk related to children and adults; clear and detailed recording of victim needs and relevant onward referrals; and ensuring that new learning related to risk and vulnerability is incorporated to guidance and training for officers.

The ***Vulnerability and Violent Crime Programme*** within the ***Knowledge Hub*** provides examples from forces of practice and strategies to improve officers' recognition of risk and vulnerability and support the earlier identification of risk. These include force-wide training programmes focussed on empathy, group-think and unconscious bias; force-wide campaigns around early identification; force-wide promotion of professional curiosity; 'reality testing' to understand staff awareness of vulnerability, followed by bespoke training and courses; training to improve standards of risk assessment; implementation of new processes and teams dedicated to early identification of high risk offenders; new

programmes promoting closer working between police and Independent Domestic Violence Advisors; and development of academic partnerships focussed on bespoke and hidden areas of vulnerability.

Summary

The identification of vulnerability and risk was the most common 'missed opportunity' identified in our analysis. In many cases where risk went unidentified, onward police responses were either missing or may have been ad hoc and/or inappropriate. Particular areas for improvement is in the identification of risk or vulnerability related to children or vulnerable adults who are not the direct focus of a police response. In relation to vulnerable adults, police appear in some cases to struggle with identifying risk and vulnerability which may be related to mental health needs. There is still some evidence in these reviews that the victim/ offender overlap in relation to adults is still misunderstood, and that some officers may still struggle to understand the dynamics of exploitation.

Risk assessment and management

The National Vulnerability Action Plan 2020-2022 (v2) relevant actions

Action 2.2.1 'appropriate action' aims to ensure that staff – in response to identified risk – understand and utilise appropriate pathways including how to access partner provisions and are empowered to challenge or escalate decisions.

The PEEL inspection report graded 33 forces (out of 43) as 'good' in terms of protecting those who are vulnerable from harm and supporting victims, with the remainder graded as 'requires improvement' or 'inadequate'. Still, no force was graded as 'outstanding' and, while some forces have improved in this area with time, this suggests there are still improvements to be made across all force locales. This section considers accuracy of risk assessment and then onward risk management, where these activities featured in these reviews. Practice examples were considered under 'risk assessment' where they involved police either as a single-agency assessor or where they contributed, or referred to, a multi-agency assessment process (usually via a Multi-Agency Safeguarding Hub (MASH), or similar). Practice examples were considered under 'risk management' where they concerned managing the risk to victims only. Any other aspect of investigation, such as evidence gathering, recording crime, conducting background checks and pursuit of perpetrators (as a way of managing risk) have been included under the 'evidence and investigation' section of this report.

Risk assessment

Risk assessment involving the police featured explicitly in two ways: initial risk assessments made in call handling rooms to determine priority of response and how the victim should be contacted; and risk assessment of domestic incidents using the Domestic Abuse, Stalking and Harassment (DASH) tool[25]. Police inevitably also make multi-agency contributions to risk assessments within Multi-Agency Safeguarding Hubs (MASH) or similar, given that police are seen to be a key agency involved in these structures[26]. However, these reviews shed little light on the police-specific involvement in MASH activity, and therefore we do not cover this in detail here.

[25] A new domestic abuse assessment tool – Domestic Abuse Risk Assessment (DARA) - has been developed and piloted by the College of Policing in response to research revealing that the DASH did not always help officers to identify coercive and controlling behaviours. (see Wire, J. & Myhill, A. (2018) *Piloting a new approach to domestic abuse frontline risk assessment.* London: College of Policing)

[26] Home Office (2014) *Multi-Agency working and information sharing project*. London: Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf

Initial risk assessments

Only one case identified a problem with initial risk assessment within call handling rooms, related to a domestic abuse case where stalking was involved. Despite force policy in applying the THRIVE[27] model of risk assessment, the call handler did not follow this and, as a result, did not fully appreciate the seriousness of the caller's situation, resulting in a scheduled, rather than an immediate, appointment that delayed positive action by the police. There is little detail provided about the reasons why the call handler did not follow force policy and ask the questions dictated by THRIVE. Whilst this was not a widespread issue within the reviews we analysed, it points to the importance of attention to staff training, development and management within the control room, as these staff are often the first port of call for those reporting crimes.

Risk assessment for domestic abuse

All of the 126 reviews were examined for police use of the DASH. Although domestic abuse was part of the wider context in 77 cases, the reviews only examined, in-depth, the use and application of the DASH in 40 cases. Examination of the police role in DASH assessments was available in 31 cases; although within individual reviews, the DASH was sometimes completed more than once in response to multiple domestic incidents.

The DASH was completed by the police when it should have been, in 26 of these 31 cases. Where the DASH was not completed but arguably should have been, these were not completed because the person reporting the domestic incident declined to take part or could not be contacted (although this should not stop police from completing one); officer error, forgetting to complete it following concerns after a visit to a family home; failure to recognise potential abuse by a carer; failures to update a DASH checklist with new information; and in one case, it is not possible to know why a DASH was not completed.

Although on the whole, police completed a DASH as required when attending domestic incidents, problems were evident with insufficient grading of risk on the DASH in 15 cases, 6 of which were SCRs/CPRs, 2 joint reviews and the remainder DHRs. In all of these cases, domestic abuse was identified by officers, but assessment of risk was inaccurate and, in hindsight, should have been higher. This meant that appropriate onward risk management was not initiated. A range of issues influenced the incorrect grading of risk in these cases. Where information was available to clarify this, these included:

- limitations of the DASH in capturing sibling abuse and coercive control
- overly optimistic views about relationships where domestic abuse is occurring
- too great a focus on incidents, rather than wider / historical patterns of domestic abuse
- gendered assumptions of who perpetrated the violence / abuse
- assessing risk in the absence of all relevant information (including information from abroad)
- lack of awareness and understanding of coercive control

[27] A risk assessment methodology that assesses 'threat, harm, risk, investigation opportunities, vulnerability of victim and engagement'. It is used by some forces in the UK to aide prioritisation of an appropriate and proportionate response.

- absence of consideration of cultural influences on victim and/or suspect's views of the nature of relationships
- negative bias towards victims who may present as chaotic, violent or troubled and
- inaccurate judgements about adults due to the absence of children in home.

Even where officers may incorrectly grade risk, systems should be in place to review these assessments, and in some cases, such processes were not established, or were only engaged when incidents were assessed as high risk. This often meant that those graded as low or medium would be exempt from oversight, even where multiple incidents occurred. These patterns highlight that police may struggle to determine the trigger point for a referral to MARAC, as a number of cases involved repeat referrals not assessed as high risk. Police may, using their professional judgement, refer onto MARAC even if the threshold has not been met, but it was not always clear whether officers were aware of thresholds and processes around this system.

Multi-agency risk assessment

Outside of initial risk assessments and single agency (police) risk assessment of domestic abuse, the reviews detailed a range of problems with the risk assessment of children and vulnerable adults. However, the practices in question in these examples tended to relate to deficiencies in partner agency practice rather than that of the police given their professional responsibilities. There were a small number of cases, however, where the role of police in multi-agency assessment was clear, and in these cases, we learn that:

- police have a significant role in making appropriate referrals to relevant safeguarding agencies to support multi-agency risk assessments. Children and vulnerable adults who are not referred on when they should be do not benefit from a risk assessment and may be exposed to risk and left unprotected and unsupported.
- risk assessments are undermined when officers (and partners) do not expressly seek to determine the views and wishes of children under police protection. Asking systematic questions of children and young people in this way would form the basis of a good risk assessment.
- risk assessments should take into account information and recommendations from other force areas when cases are transferred into new locales to build a full and historic picture of risk and vulnerability.

Risk management

Following identification of risk and risk assessment, the police will have varying roles in managing the determined risk. Domestic abuse risk management featured quite heavily across the reviews and is, therefore, considered separately here to other types of cases.

Risk management in domestic abuse cases

The role of police in risk management in the 26 cases where the DASH was completed included appropriate referrals to other agencies, arrest and charging, development of safety plans, signposting and provision of safety advice, and other bespoke interventions. In 17 domestic incidents where a DASH was completed, the review provided no information about risk management activity. This may be because no risk management was required, no risk

management occurred or it may be because the reviewer did not report on risk management because it was deemed not to be relevant to the case.

Risk management in domestic abuse: absence of risk management

In a quarter of the 26 cases where a DASH was appropriately completed (3 of which were SCRs, 1 SAR and 2 DHRs), reviewers noted an absence of appropriate onward risk management. In two cases, risk management appeared to be negatively influenced by a lack of understanding of domestic abuse in non-intimate partner relationships, and in another, the point at which to trigger a referral to MARAC following repeat domestic incidents. In one case, the full conditions of a non-molestation order were not available on the Police National Computer, which prevented officers from arresting the suspect. In the final two DHRs, risk management activity appeared to be influenced by the ways in which officers perceived the victims and their credibility. Importantly, the assessment of risk should never be seen as the 'outcome': risk management activity must follow on from an assessment.

Risk management in domestic abuse: referrals for safeguarding and consideration of risk

Where risk management activity following a DASH was identified by reviewers, the most common action was for the police to make appropriate referrals to single agencies such as children's social care, adult social care or multi-agency panels.

Multi-agency Risk Assessment Conference

A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed[28]. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. Broadly speaking, the functioning of the MARAC process was considered in 38 cases, crossing all three types of reviews. While the overall functioning, impact and outcomes of MARAC are out of the scope of this research, we have looked at 15 cases where the interface between police and MARAC was explicitly considered within reviews. In 7 of these cases, police appropriately communicated with MARAC or referred a case to MARAC for consideration.

In 8 cases, referrals to MARAC were either not considered, were not made, or disagreements between police and partner agencies about referring to MARAC were evident. In some cases, while referrals were eventually made to MARAC, reviewers believed there were earlier opportunities to refer that were missed. It was not always clear why referrals to MARAC were not made when it would have been warranted, but several reviewers hypothesised that risk was not well recognised. Clarity in thresholds for referral and local escalation procedures should be in place to support officers in engaging with the MARAC process.

There were occasions where it appears that officers may have struggled to determine when repeat incidents not graded as 'high' should be referred. In one case, 4 incidents graded as

[28] SafeLives (2014) *Frequently asked questions: Multi-Agency Risk Assessment Conferences (MARAC).* SafeLives. Available at: https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

standard or medium had been assessed but a MARAC referral not made, despite a threshold policy of 3 incidents. It suggests inconsistent awareness of procedures and officers' failure to engage their professional judgement. MARAC procedures allow for individual officers to make referrals if their professional judgement suggests a need. The following quote illustrates one such case:

> *"DV incident 10 was 3 days after Carl's release from custody. This was followed by 3 more reports of similar incidents, over a period of 4 weeks. Carl was clearly ignoring police warnings to stay away and his reported behaviours were increasingly abusive and controlling, causing high levels of fear and distress to both Lynn and Natalie. At this stage, it should have been recognised that risks were escalating, and professional judgement should have resulted in a referral for MARAC discussion, with a view to a more pro-active and targeted approach to risk management"* [ASR LN].

One final case example demonstrates that referrals to MARAC can be influenced by officer bias towards victims. In this case involving domestic homicide, officers responded to nearly 20 call outs to domestic incidents but only one MARAC referral was made after the 18th incident, over the course of many years. The reviewer considered that officer norms likely played a considerable role in diminishing responses to the victim. Officers appeared influenced by the presentation of the victim, who presented as chaotic, troubled and often times violent herself. It is possible their bias toward her meant that instead of taking each incident on its own merit, officers reacted on the basis of previous contacts with her. This was a complex case that would likely have benefitted from a multi-agency perspective on risk management.

Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) were established by the Criminal Justice Act 2003 to protect the public from serious harm by sexual and violent offenders[29]. While MAPPA was mentioned in 13 reviews, only 4 of these reviews identified practice learning specifically for police in the referral of offenders to MAPPA to manage their risk. In one of these cases, MAPPA meetings – led by police in this case – were found to be working well with effective information sharing processes in place. The remaining three cases suggest that knowledge of MAPPA, thresholds and the referral procedures appeared to be inconsistent among officers, particularly those who are not specialists, as the following excerpt illustrates:

> *"The police had sufficient information to refer through the MAPPA process…as a category 3 offender. The information they had was not known to Probation services and was largely misunderstood by non – specialist police officers who were not familiar with the MAPPA processes and the rationale for referral. As a multi-agency process, MAPPA could have provided the opportunity for risks to be understood and interpreted, and supported agencies to work together to prepare a detailed and robust multi agency Risk Management Plan"* [ASR AM].

[29] HM Prison & Probation Service (2012) *MAPPA guidance 2012 (version 4.5)*. London: HMPPS. Available at: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

Risk management in domestic abuse: Safety planning, signposting and referrals for support

The development of safety plans was noted in three cases, signposting to agencies for support was offered explicitly in two cases, and in 7 cases, officers made appropriate direct referrals to domestic abuse services. In all cases, these were noted to be appropriate actions by the police, although victims did not always take police up on their offers of support. In one SCR, force policy was followed and the mother was provided with support:

> *"Following the Police's contact with the family in April 2016 and the resulting DASH assessment, a safety plan was undertaken in line with Police policy. The mother was subsequently visited by a Police Community Support Officer who discussed the plan with her and provided her with a Domestic Abuse information pack"* [SCR CG].

It is possible that these risk management activities occurred more widely, but the absence of detail in other reviews means it is not possible to know how extensively police did – or did not – offer appropriate support in these ways.

Risk management in other cases of child and adult safeguarding

Police risk management activity in respect of other child and adult safeguarding cases was most often reflected in these reviews in terms of the contribution of police to multi-agency activity. The most common area of police practice identified by reviewers as problematic is in terms of police engagement in multi-agency safeguarding meetings.

There were missed opportunities in 14 cases for effective police engagement in multi-agency meetings concerning children, usually strategy meetings. Six of these cases involved police non-attendance at planned strategy meetings; five involved the failure of both police and partner agencies to initiate strategy meetings where they would have been warranted; in one case, police held minutes of a strategy meeting that were inaccessible to partner agencies and were deemed to be inaccurate and incomplete; in another, police delayed a strategy meeting; and in a final case, police made single agency decisions when they should have involved health as a partner. Multi-agency decision-making, management of risk and insufficient protection and support for children and/ or vulnerable adults were some of the outcomes of these missed opportunities.

It is not possible to know why these missed opportunities occurred in 7 of the cases. However, in four cases, policies or procedures were not followed, were unclear or were absent. In three cases related to non-attendance at strategy meetings, police explained that high volumes of requests to attend meant they could not get to all meetings. In a final two cases, researching errors led to an inaccurate belief on the part of the police that they held no relevant information that would suggest the need for them to attend. As a result of non-attendance, the police contribution to multi-agency meetings was minimal and the picture of risk for the victim and/or suspect was partial.

There appeared to be passivity regarding police involvement in *adult* multi-agency safeguarding meetings on the part of both police and adult safeguarding partners. In all three cases, there was no evidence that partners actively sought to engage police, despite

police holding relevant information about risks, nor that police sought to proactively engage in adult safeguarding processes themselves, as described further in the case example below.

There is a clear sense from these reviews that police are more heavily engaged in multi-agency risk management in cases involving children than they are in cases involved vulnerable adults. This is not solely a criticism of police, but the adult reviews gave the impression that police were not considered for involvement in multi-agency risk management as much as the police did not see a role for themselves.

Case example

There is a recognised – and perhaps uncomfortable – distinction between safeguarding children and adults. This was raised, as an issue, in the 2009 'No Secrets' consultation[30], where participants were found to perceive adult safeguarding as 'behind' child safeguarding. Safeguarding children was seen as being better resourced, better developed and given a greater priority than adult safeguarding. The report recognised many other differences between the two safeguarding areas including different legislation, different policy, different court systems and different approaches to mental capacity. It seems that this uncomfortable distinction still remains, and is particularly evident in the policing arena, as the recent HMICFRS (2019, p. 6) inspection report on older adults raises:

> *"Adult safeguarding was described to us as the 'poor relation' of safeguarding arrangements, with inconsistent local partnership work to consider what protections or support might need to be put in place for vulnerable adults. Forces told us of a focus on children over adults, and we found a lack of understanding of what their duties were under the Care Act 2014 regarding adults at risk".*

While this inspection report was focussed on 'older' adults (which could relate to any adult aged 50 or over, as there is no common national police definition of an older person), our reviews suggest this is a wider issue for the adult safeguarding arena, equally applicable to younger adults.

A joint SAR/ DHR was carried out on 'Harry', aged 22 when he was murdered by two people, one of whom he was believed to be in an 'on/ off' relationship with and he may have been the father of her child. This met the threshold for a DHR review and, given the vulnerabilities present for the victim and the perpetrators, a SAR was also conducted. A number of agencies became involved following incidents and threats arising from the relationship between Harry and the perpetrators (who were convicted for his murder and received life imprisonment). The reviewer raised the broad question about weak engagement with the adult safeguarding agenda, as this quotation illustrates:

> *"At operational level there appears to have been a marked lack of awareness of adult safeguarding and a tendency to treat many of the incidents involving Harry as being*

[30] Department of Health (2009) *Adult safeguarding: A report on the consultation on the review of 'No Secrets'*. London: DH. Available at: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_102764

of a relatively low level of priority. Nor did the police appear to be sufficiently engaged in adult safeguarding at the partnership activity level. They appear generally not to have been invited to any of the meetings called to review efforts to safeguard Harry. Clearly some responsibility must fall on the partner agencies issuing the invitations to these meetings but there was also a responsibility on the police to adopt a far more proactive approach to partnership working in this field. This is in marked contrast with the police's very active and automatic involvement in the safeguarding children arrangements in respect of Karen's unborn baby" [Joint ASR & DHR, H].

Summary

This section has examined the learning from this sample of reviews of serious cases in respect of risk assessment and management. The primary area of concern from these reviews relating to risk assessment relate to the use and application of the DASH. The DASH was found to have been appropriately completed in most instances, but grading of assessments demonstrated inaccuracies underpinned by a range of tool- and knowledge-related issues. Risk management appeared particularly problematic in the intersection between the police and partner agency relationships or processes.

Victim engagement and care, and supporting vulnerable people through the criminal justice system

A range of guidance documents set out the expectations on police to engage with, and care for, victims and witnesses. The *Code of Practice for Victims of Crime*[31], for example, sets out 13 entitlements for victims, which include their rights to: be kept informed about investigations and what they can expect from the criminal justice system; have a needs assessment; and be referred to organisations supporting victims of crime. The Association of Chief of Police Officers (ACPO) *guidance on safeguarding and investigating vulnerable adults*[32] and College of Policing *Applied Professional Practice* (APP) relating to domestic abuse and other areas of vulnerability provide further detail about the expectations on police to treat victims, both children and vulnerable adults, with professionalism, sensitivity and respect.

The National Vulnerability Action Plan 2020-2022 (v2) relevant actions

Action 2.4.1, draws specific attention to the voice of the victim.
The aim of this action is for forces to develop clear processes to ensure 'the voice of vulnerable victims and witnesses' are heard.

Action 2.24, recognises that officer norms will change from exposure to certain aspects of criminality and vulnerability and that these need 'reset' so that thresholds of acceptability are maintained.

The reviews analysed here demonstrated incidents of good police practice with children and vulnerable adults that reflected expectations for practice in current guidance. We saw examples of officers: recognising victim needs and making appropriate referrals for support; speaking to children and vulnerable adult victims to understand their wishes, views and expectations; planning thoughtful communication strategies to keep victims and their families informed about the progress of investigations; and demonstrating awareness of, and, care for highly vulnerable victims. Young people have told researchers that they value consistency within their relationships with police[33], and we found a good example of demonstrable multi-agency commitment to maintaining a positive, consistent relationship with a vulnerable adolescent:

[31] MoJ (2015) *Code of Practice for Victims of Crime*. London: MoJ.
[32] ACPO (2012) *Guidance on safeguarding and investigating the abuse of vulnerable adults*. London: ACPO and NPIA.
[33] Beckett, H. & Warrington, C. (2015) *Making Justice Work*. Luton: The University of Bedfordshire. Available at: https://www.beds.ac.uk/ic/recently-completed-projects/making-justice-work/

> *"Child R had a close relationship with a Neighbourhood Police Officer, this officer was originally assigned to work in the neighbourhood and spent many hours with her talking through her difficulties. Her mother said she would just talk and the officer would listen. Although the officer left their post in February 2015, they would be brought in by the Social Worker to support Child R at key times or by the police to facilitate an interview. Arguably this responsiveness was good practice and individuals worked hard to respond to Child R's expressed wishes"* [SCR CR].

Whilst positive engagement with and care of victims was evident in cases, such practice was not consistent across the reviews.

Engagement with, and care of, children

In 13 SCRs/CPRs, there were missed opportunities to effectively engage with and support children and young people during the course of a police response or investigation. Whilst these 13 reviews represent a wide range of contexts and circumstances, a common theme running through most of these cases were missed opportunities to hear the child's voice.

Eight cases related to adolescents, and involved vulnerabilities such as sexual violence, missing, youth violence, asylum seeking and a young carer present at his mother's death. In five of these 8 cases, young people were not spoken to directly by the police during the course of the police call-out or visit, which meant that opportunities to identify the impacts of abuse or neglect, further risk, or support needs were missed. There may not always be an opportunity to do so, but police should be finding ways to work with partners or adopt other creative ways to prioritise children and young people's voices. This is particularly salient where adolescents may appear developmentally mature. As the following quotation illustrates, making assumptions about young people's views and needs can mean that officers miss critical moments to intervene and refer for support:

> *"This Joint Review was clear that assumptions were made about KG in practitioners contact with him and KW; his mature and sensitive approach meant that he was seen as being able to cope and there being little impact on him. For example, on one occasion, where KW was displaying psychotic behaviour and was, 'covered in faeces', he was described by attending Police Officers as being 'independent' and not distressed. However, KG described this event when met as part of the Joint Review process in traumatised terms. This is a significant learning point about not making assumptions about what a child is thinking or feeling, nor about the impact of the harm on them necessarily being seen in their responses"* [Joint SCR and SAR, KW].

In other cases involving adolescents, their engagement and care was compromised by a one-dimensional focus on their status as potential or actual youth crime offenders, where a more holistic approach would have been to suspend binary labels of 'offender' and 'victim' and see the young person as someone with experiences of victimisation and/or perpetration[34].

[34] A helpful short film by Firmin, C. (2015) on the 'victim-perpetrator' overlap can be viewed here: https://www.uobcsepolicinghub.org.uk/responding-to-cse/videos

The reviews also tell us that even within individual cases, the police may get some aspects of their engagement with young people right, but miss other opportunities to support them, as the following case example illustrates.

Case example

A young person was found hiding in the back of a lorry, seeking refuge in the UK. The police appropriately followed custody procedure by using a commissioned translation service to communicate with him. Although the police had some doubt about his age, in the absence of an age assessment, they treated him with the legal status of being a child which resulted in his swift release from arrest and custody, and escort to a location nearer to Children's Social Care who would be responsible for finding him safe accommodation, promoting his welfare needs and assisting him in the asylum-seeking process. Such practice is in line with that promoted in the Children's Society 'Seriously Awkward' report[35], which highlights the importance of ensuring that age assessments do not constitute a barrier to support. Whilst this was good practice, a systematic and comprehensive needs assessment was not undertaken by police and partners which meant they did not have a full picture of his mental health needs. Finally, when the police escorted him to his temporary accommodation, they did this as a single agency when it would have been in the young person's interests to ensure a joint escort with social care. This would have demonstrated a sensitivity to the distress and fear the young person was likely to have felt in a new country and in his contact with the police.

Four cases related to younger children, all involving intrafamilial abuse and/or neglect, and in one case domestic abuse. In all four cases, the children's voices were not sought or captured by the police or other partner agencies. In one case, officers were found to lack confidence in speaking to younger children. In the remaining cases, the reviewers found that officers' responses were too 'adult-focussed', meaning that the risk and needs of the adults who were the subject of police response were prioritised over the wider safeguarding needs of children who may have been present in the household, as this quotation illustrates:

> *"There are instances where K was not the main focus and interventions were adult focused. For example, the Police response on 27th August 2014. On such occasions K's voice was not sought. There was no focus by CSC or the Police about the impact of the parental circumstances on him, physically or emotionally"* [SCR K].

[35] The Children's Society (2019) *Transitions to adulthood: The case for a cross-departmental taskforce*. London: The Children's Society.

What can the police do? Prioritising the child's voice

One force acknowledged the need to take an active approach to child safeguarding to ensure a child-centred approach. This involves strengthening organisational culture and ensuring clarity of expectations, responsibility and procedures:

"an organisational culture that is child centred and child focused; that ensures that the child/young person is 'seen' (or considered, when working with parents, even if absent – and referrals made if parents' presentation gives cause for concern); that ensures that the child or young person's 'voice' is heard; that safeguarding is considered in all circumstances including identifying an officer responsible for any safeguarding action needed in all police operations" [SCR Ak].

Engagement with, and care of, adults

Missed opportunities to engage with, and care for, adults were evident in 16 reviews, observed across SCRs, ASRs and DHRs. A majority of these problems related to the care and support needs of victims of domestic abuse. Two additional cases involved vulnerable adults with mental health needs. Several themes within this were evident.

First, some reviews highlight the importance of keeping promises made to victims. Examples include a promise by police to refer a mother for support and a promise made to accompany a victim of domestic abuse to collect her belongings, but for unknown reasons, neither of these things occurred. Although the reviews do not make it clear why these commitments were not upheld, they are likely to have been perceived as disappointments by the victims, with a knock-on effect to victims' confidence in the police. One reviewer felt that a broken promise to a vulnerable adult was not only dangerous to him, but reflected a wider apathy of officers towards adult safeguarding:

> *"It is possible to perceive the apparent police failure to follow through on the commitment they gave to Harry on 15th May 2015 to visit and warn John and Karen about the texts they had sent Harry threatening to kill him, as characteristic of a lack of engagement with the safeguarding adults' agenda. Generally, their approach was characterised by a tendency to treat each incident in isolation, to infrequently follow their policy of making vulnerable person notifications and to adopt an informal as opposed to formal approach except when there was the clearest possible evidence of criminality"* [Joint ASR & DRH, H].

In the remainder of cases, the voices of victims and their needs were not prioritised or taken seriously, despite clear messages from victims that they were frightened or distressed. This manifested in different ways but such examples were typically found in cases of vulnerable adults with mental health needs and victims of domestic abuse. Repeat callers into call handling centres who were elderly and/or may have mental health needs were at times downgraded in risk, which meant that police were not dispatched. It seems clear that in

these cases, the victims' vulnerabilities were either not recognised or minimised, despite an escalation in distress or the number of calls.

In cases where domestic abuse was part of the context, there was worrying evidence about the impact of police response and communication on these victims. For example, delays in responses to domestic incident reports appeared to damage victim confidence in the police and exacerbate mental health needs:

> *"The family said that the failure of the police to attend on 20th November 2015 was very distressing for Sarah. She "locked herself away" and felt increasingly vulnerable. Her family saw how terrified Sarah became of Kevin. On 30th December 2015 Sarah's elder son felt that she had a moment of clarity regarding Kevin and her son asked her to call the police again. Sarah told him that she couldn't, saying "they don't listen" and that "she was so tired." Her elder son therefore phoned the police on her behalf. When he rang, the elder son described how his mum had been let down by the police and said he told the police that Kevin was "going to kill my mum and kill himself. That's what is going to happen." The family said that by this point Sarah was downtrodden and broken"* [DHR Sa].

It is not always clear why such delays occurred but in one case of domestic homicide, procedural disagreements over Home Office counting rules between two police locales delayed a response to the victim's report of domestic abuse – a response that runs counter to the Code of Practice for Victims of Crime and had a palpable impact on the victim who *"didn't want to bother the police with petty phone calls"*. A positive result from the learning event was a clarification of procedures to ensure that the victim's needs would be put first when responsibility for an investigation is in question.

Police communication with victims also featured, demonstrating how poorly communicated decisions (however unintentional) could send the wrong messages to victims, reinforcing feelings of helplessness:

> *"David was spoken to and denied everything. The case was filed due to insufficient evidence. This appears to have sent the message to Alina that incidents were not worth reporting if she did not have proof that David was the culprit as she subsequently mentioned her lack of evidence to several friends and colleagues when explaining why she was not reporting an incident"* [DHR Ali].

Most worrying were examples of insensitive communication which appeared to blame the victim, particularly evident in cases where officers questioned the victim's credibility or viewed them in some way to be culpable for their abuse. While not prevalent across the reviews, these examples (all occurring within cases of domestic homicide) are a reminder that thresholds of acceptability (in other words, officer norms) may be affected by exposure to complex cases of domestic abuse, requiring strong policies towards training and supervision to support officers working with these types of cases.

What can the police do? Addressing officer norms

The VKPP Knowledge Hub provides examples of how forces are working to address officer norms. These include training programmes on various aspects of vulnerability, including domestic abuse which draw in experts and aims to raise awareness about vulnerabilities. One force is taking a more holistic approach by embedding a 'trauma-informed' framework into its every day practices, language, behaviours, policies and procedures.

Summary

Where missed opportunities were found relating to the care of victims, crucially we found that the victim's voice was missing. The examples here showed some evidence of lack of skill and confidence on the part of officers in seeking the voice of very young children, but we also saw evidence of assumptions being made about adolescents' presentations. There were further examples of police failing to speak directly to vulnerable adults about their views and wishes also. Sometimes police did not keep commitments made to victims – or were perceived to have let them down. The findings here also point to the need for continued work to improve police officers' engagement with victims of domestic abuse and stalking and harassment.

Evidence and investigation

This section considers findings related to evidence and investigation within the 126 reviews that were analysed. These are relevant to, and inform, the actions as set out in the NVAP related to evidence and investigation.

The National Vulnerability Action Plan 2020-2022 (v2) relevant actions

Action 2.4.2 'Evidence and investigation'. The aim of this action is to develop competent frontline police and staff responders who use professional curiosity to ensure that the early investigation is maximised to gather best evidence.

Action 2.4.3 'Evidence-led prosecutions'. Develop and utilise in more effective ways early evidence gathering techniques and the use of 'evidence-led' prosecutions in all appropriate cases (wider than domestic and child abuse)

Reviewers identified good practice in this area of policing in a number of ways. We found examples of thoughtful and appropriate consideration of the need to arrest where this was not in the interest of a child or young person; speedily processing interviews and charging to minimise distress in vulnerable young people; appropriate arrests and cautions in cases of domestic abuse; proactive consideration of relevant orders; and thorough, skilled and determined evidence gathering and investigations, as detailed here:

> *"It is commendable that the police were able to compile sufficient evidence to secure convictions for Mother relating to the separate incidents involving Rose and the other child. Furthermore, as detailed earlier, Father and his family, and the carers of the child assaulted were all very positive regarding their experience with the police investigation team who brought the whole case to trial"* [SCR LK].

As evident in previous sections however, there was also inconsistent practice revealed within the sample of reviews. We found missed opportunities in this broad theme of evidence and investigation in 36 (28%) of the reviews. Within this, practice was categorised against key aspects of investigations including: recording and researching, evidence gathering, disruption, and management of risk and pursuit of suspects. Missed opportunities in the pursuit of suspects was most common, evident in 15 cases, followed by evidence gathering in 8 cases, disruption in 8 cases and researching and recording in 6 cases. It is important to remind the reader that the significant under-identification of risk in many of the cases may explain why strategies to manage suspects did not emerge more prominently.

Management and pursuit of suspects

Missed opportunities within this category of policing work were found equally across SCRs (n=5), SARs (n=5) and DHRs (n=5).

Child cases

Notably, three of the five child cases concerned limited investigation into sexual exploitation, two involving female children and one involving a male child. The fourth case concerned ineffective management of risk in a case of child neglect and the fifth case in this group related to sibling domestic abuse.

The three CSE cases similarly involved an absence of proactive pursuit of perpetrators. The examples suggest that officers were not equipped to effectively identify risk which, as noted in the earlier section has direct impact on the course of an investigation. Evident in the cases was a lack of understanding about the dynamics of CSE and its impact on disclosures. This manifested in various ways, through police acceptance of young people's accounts (such as retractions) at face value, a lack of professional curiosity about young people's relationships with unknown adults and dismissive attitudes towards female to male CSE. These assumptions by police meant that investigations and further evidence gathering did not occur.

In the fourth case, the police relied on a written agreement with parents in the case of neglect, when in hindsight a proactive approach to build a case of criminal neglect would have been a more robust approach. In the final case (a sibling domestic homicide), an insufficient understanding of domestic abuse between siblings was further undermined by the limitations of the DASH in assessing sibling-sibling abuse and coercive control. This alongside a perceived lack of evidence prevented the police from building a case earlier to take to the Crown Prosecution Service (CPS).

Adult cases

Gaps in the investigation into, and pursuit of, suspects in adult cases related to two specific vulnerabilities: mental health and domestic abuse. Four SARs concerned failures to progress or prosecute where it appears officers were unable to identify mental health risks or where assumptions or biases about victims' and suspects' credibility or capacity influenced police actions in relation to suspects. The remaining six cases related to domestic abuse. In some cases, missed opportunities to investigate or arrest suspects appeared to be influenced by officers' biases about victims and their perceived culpability, which had clear impacts on victims' confidence in the police and their willingness to support prosecutions. Delayed arrest of suspect and subsequent release also impacted on the victim's willingness to support prosecution. In some cases, police did not act despite knowing that suspects were breaching orders or where they had sufficient evidence to arrest for a crime. In most of these latter cases, the reviews shed little light on the reasons why these missed opportunities occurred. In several cases, the use of Police Information Notices (PINs) were used to minimal effect, although a recent inspection report by HMIC and HMCPSI now recommends against their use entirely[36].

[36] HMIC and HMCPSI (2017) *Living in fear – the police and CPS response to harassment and stalking*. London: HMIC and HMCPSI.

Evidence-led prosecutions

It is notable that evidence-led prosecutions (or previously 'victimless' prosecutions) were mentioned in only two of the 126 cases reviewed, both in relation to domestic abuse: in one case a 'victimless' prosecution was pursued by CPS but failed due to the victim's ongoing relationship with the suspect and in the other was considered by police but discounted based on their view of the victim's limited credibility. Despite suspected CSE in 18 cases, domestic abuse contexts in 77 cases, suspected financial abuse in 10 cases and stalking behaviours in 8 cases, there was no mention of evidence-led prosecutions having been considered by police.

Evidence gathering

Eight SCRs and one DHR showed gaps in evidence gathering. These gaps do not appear to follow any particular pattern regarding vulnerability types, evident in cases involving sexual abuse and assault (including CSE), trafficking, domestic abuse, suicide and physical and emotional abuse.

Examples of gaps include police not tracing or talking to witnesses, forensic evidence on phones and computers not taken in a timely way, and police accepting verbal evidence rather than waiting for a written medical report. In some case, these gaps were underpinned by resourcing. For example, examination of phones and other devices were challenged by the backlogs in forensic departments. In other cases, opportunities to gather early evidence were missed because officers did not recognise indicators of vulnerabilities such as sexual assault and trafficking. In many of these cases, the 'forensic window' had closed and therefore opportunities to progress investigations, pursue prosecutions, support victims and build their confidence in the police.

Disruption

Explicit reference to disruption activity was evident in 9 cases, 8 of which presented missed opportunities. Seven cases related to sexual abuse (six cases were about CSE), one related to criminal exploitation and one to manage the risk of a young person in the care of local authority. While one case involving CSE was found to have held effective disruption meetings to consider all possible options to protect the young person, the remaining cases detail missed opportunities. Six of these cases were beset by systems or processes that hindered or delayed consideration of protective activity, including delays in allocating a case to an investigating officer; disruption not integrated into wider safety and protection plans; a new CSE scheme which had not yet fully embedded; and poor multi-agency collaboration. In one case, police assumptions that the young person was a 'willing participant' in CSE prevented robust consideration of protective measures. In the remaining cases, the reviews do not provide sufficient context to understand why effective disruption was not considered or did not occur.

Recording and researching

Standard policing practice of conducting background checks, recording crime and checking all available police IT systems for information presented themselves as gaps in practice in 6 cases, 4 SCRs, a SAR and a DHR.

Summary

Approximately one-quarter of the reviews highlighted missed opportunities or errors in practice in evidence and investigation. Most commonly, the reviews highlighted missed opportunities to pursue perpetrators. A number of cases involving actual or suspected CSE showed lingering biases about victims and the dynamics of CSE which meant relevant investigative pathways were not taken. In adult cases, investigations were hampered by officers perceiving victims to lack credibility or to be culpable in their own vulnerability. The reviews revealed little innovation in terms of evidence-led prosecutions. This was mentioned in only a small number of domestic abuse cases, and none were successful. Reference to disruption activity was minimal, and in some cases disruption may have been beneficial. It is also important to note that in some cases, there were errors in basic policing practice that affected recording of information and systematic effective checking of police systems.

Collaborative working

The National Vulnerability Action Plan 2020-2022 (v2) relevant actions

Action 2.2.1 'taking appropriate action', to ensure staff understand and utilise appropriate referral pathways including how to access partner provisions and are empowered to challenge or escalate decisions.

When a child or adult is identified as being vulnerable, opportunities arise for professionals to work together to protect them from harm. Collaborative working is enshrined in *Working together to safeguard children* (2018) and *Care and support statutory guidance* (section 15) (2020) and police are identified as key partners in cooperation.

We found evidence in many of the reviews included here that police effectively collaborated with partners to support children, families and vulnerable adults. However, we also found that police missed opportunities to initiate or engage collaboratively with partners in 85 reviews, or 67% of cases. It is important to bear in mind that these instances of missed opportunities overlap with the other sections in the report. Problems with multi-agency working identified in these reviews is by no means a problem limited to the police, but it is beyond the scope of this report to address gaps in practice for other agencies. Instead, here, we focus on the key areas for police to make improvements to their contribution to multi-agency working.

Information sharing

Problems with information sharing by the police were evident in 52 reviews; this is 41% of our sample of 126 reviews. Different types of information sharing problems were found within this, shown in Table 15. In a small number of reviews, more than one of these themes was present within a single review.

Table 15: Information sharing problems

Information sharing problem	Number of reviews
Information not shared by police with partners	38
Information shared by police but quality is poor	10
Information shared by police but is delayed	5
Information not shared by police with other police within their force or in other forces	5

Information sharing or referrals from police to partners

Information sharing from police to partners was identified as problematic in 21 (30%) of the 71 SCRs/CPRs in this analysis (including the two joint reviews); in 16 (25%) of the 45 SARs/APRs; and in only 1 DHR.

In 12 of these cases, it was not possible to understand why information was not shared when it should have been. Across the remaining cases, information was not shared most commonly because of an absence of an effective procedure or process for sharing information or because risks were not identified (and so information was not shared).

In 14 cases, an absence of a procedure or process for sharing information was the problem, although there was no 'single' procedure or process identified as consistently lacking. Examples include the absence of a process for the police to:

- record the status of a looked after child, which meant that incidents involving them were not automatically passed to children's services;
- share information involving multiple vulnerabilities (domestic abuse, child safeguarding, adult safeguarding) with all relevant partners (see case example below);
- share information with partners when investigations cross borders;
- absence of a process for sharing domestic abuse incidents with health visitors;
- absence of a process for police to share information safely and confidentially with hospital clinical staff when accompanying vulnerable adults not under the Mental Health Act;
- absence of a formal mechanism for sharing information with probation services;
- absence of knowledge about mechanisms for referring vulnerable adults to Fire Services;
- policy of adding multiple incidents to an already existing safeguarding report which can lead to the new information being missed by relevant partners;
- absence of established processes for information sharing with adult social care.

An absence of a system or process for sharing information – or an ineffective one – means that agencies who would benefit from information about a child or vulnerable adult do not receive that information and work with only a partial picture of risk, as the following excerpt from one SCR illustrates:

> *"The attending officers completed and sent notification forms to the Adult Social Care Safeguarding team and Children's Social Care, as well as completing a Domestic Abuse Risk Assessment (DASH). What this meant in practice was that different forms were sent to different agencies by the attending police officers despite the fact that, with hindsight, it is clear that the information may also have been useful to other agencies. As a result Children's Services did not receive the Domestic Abuse Risk Assessment form; Adult Safeguarding did not know that a CYP notification form had been completed; the primary mental health team, IAPT, did not receive the Police CA12 and so on. That this was the case should not be interpreted as a criticism of individual police officers, who were following established procedure"* [SCR CG].

Unidentified risks – as detailed in the earlier section - underpinned failures of police to share information or make referrals in 11 further cases. Among SCRs/CPRs, unidentified risks

related to domestic abuse were common, which meant they were not always referred to MARAC appropriately, as noted in the earlier section on risk management. In the cases of non-referral to MARAC, this appeared to be influenced by: mis-identification of domestic abuse; officer norms clouding identification of risk; failure to recognise stalking behaviours; poor recording of risk; and confusion over whose responsibility it is for making a referral.

In one further case, a young person whose contact with the police concerned his gang associations also displayed indicators of criminal exploitation, but these were not effectively identified. His criminality was effectively prioritised over his needs as a victim, which meant a referral to the National Referral Mechanism was not made. In adult cases, a broad range of vulnerabilities were not identified, including escalating mental health needs and repeated substance abuse call-outs.

Basic errors could also underpin failed information sharing. In a few cases, police did not share information because they believed they did not hold information about a perpetrator or incident, but it was later discovered that comprehensive checks had not been undertaken and the police actually did hold that information. In one case, there was individual officer error, forgetting to complete a DASH checklist which meant it was not passed onto a Central Referral Unit to review, which would have then led to a referral to children's services.

Quality of information shared

In 10 cases (7 SCRs and 3 SARs), information was shared by the police with partners but the quality of information shared was compromised in some way. In most of these cases, the information shared was limited because police did not include all relevant information that was known to them.

In six cases, it is not possible to know why the quality of information was affected, but in two police had not effectively carried out checks on their systems which meant information shared with partners was only partial. In another case, police were not explicit about their expectations for the referral which was received by Adult Social Care as 'information' rather than a 'request for safeguarding support'.

Case example

Basic researching errors could affect the quality of referrals and information, as in the following example of an SCR:

> *"There was a reference to the sexual abuse on the missing documentation completed earlier after Mother's initial report to the Police, but this was not mentioned in conversations during the safe and well check with KA carried out by a different Officer. It is noted within the safe and well report that KA "did not make any allegations in relation to the sexual abuse". The Officer recalls not asking KA directly about a specific allegation as the Officer did not notice that an incident of sexual abuse had been mentioned by Mother on the initial missing report. On completing the documentation to share on to Children's Social Care, the second Officer saw reference to the sexual abuse on the missing report and therefore added that KA had not disclosed any abuse in the safe and well check, although KA had not been questioned in more detail other than the standard safe and well questions as above. Had the information on the*

report been read thoroughly prior to the safe and well check, more questioning of KA could have taken place to explore what Mother had already reported. Consequently the information shared by Police with Children's Social Care regarding the sexual abuse, but as part of the missing report, was minimal" [SCR KA].

Delayed information sharing

In five cases, information sharing by the police with partners was delayed, 4 of which related to SCRs and one to a SAR. There is no clear pattern to the incidents in terms of the type of case or age of child or vulnerable adult, with incidents relating to a range of vulnerabilities including sexual assault, child sexual exploitation, criminal exploitation, domestic abuse and a vulnerable adult.

Explanations for delayed information sharing were only available in two of these cases, both relating to resourcing and workload issues. In one case, police did not regularly attend strategy meetings, and, although the review does not make clear why their attendance was poor, in other reviews, non-attendance at these types of meetings has been attributed to difficulties in responding to the volume of requests for attendance. In another case, the Multi-agency safeguarding hub (MASH) had a backlog of cases which meant that a missing incident was not shared with children's social care for over two weeks as illustrated in the following excerpt from the review:

> *"In mid-June 2016 at (2.40am) Charlie was found alone in a park. The fifth core group meeting was held two days later but not attended by parents. The key social worker had not been made aware of the missing incident, therefore it was not discussed and did not influence the child protection planning process. This issue was raised within the practitioner event where it was identified this significant new information increased the level of risk for Charlie who had not been reported as missing in accordance with the written agreement. Knowledge of this information could have resulted in the key social worker seeking legal advice much sooner.*
>
> *The police learning summary confirms this information was not shared with the key social worker for a further 17 days, despite the two investigations already underway. A police protection order (PPO) should have been considered at the time of the incident. The learning summary also makes a recommendation for facilitation of the police MASH to review referrals and if the child is already part of an investigation then the referral should be forwarded as a priority to the Contact Centre. There was a significant delay in processing the case through the MASH due to a backlog of cases within the system"* [SCR CS].

Delayed information sharing by the police with partner agencies affected the multi-agency decision making processes, hindered a current, clear picture of risk and delayed safeguarding action for these children and vulnerable adults.

Police-police information sharing

The five cases of police-police information sharing gaps revealed no particular pattern in terms of the type of cases or vulnerabilities involved. They concerned: (1) police control rooms not sharing relevant information on a vulnerable adult with front line officers; (2) officers not flagging vulnerability so that other officers would be alerted to this; (3) absence of joint arrangements among three force areas for collating and sharing information about

CSE; (4) poor collaboration between two forces where a case had been transferred out of one and into another; and (5) absence of a system in place to share information about families on child protection plans with community police officers, to help build a picture of risk.

Multi-agency working and decision-making

Aside from information sharing and referrals, a range of other problems were evidenced in the reviews related to the ways that police communicate and engage with partners. The problems primarily involved either police non-attendance at strategy meetings (as detailed in the section on risk management) or a failure by both police and partners to initiate multi-agency discussions or strategy meetings when they should have been (in 18 cases) or joint visits or decision making (in 14 cases). In six further cases, police did not escalate concerns with partner agencies where this would have been warranted.

There is no apparent pattern of these problems according to any particular vulnerability, but there does appear to be a pattern relating to safeguarding adults in a similar way identified in earlier sections. In the cases involving children, the problems varied but included police and partners failing to initiate a s47 investigation when this should have happened, a lack of conversations with partner agencies during investigations and record-keeping around this, consideration of involving partners in supporting victims, misunderstandings – on the part of partners – about the police role in welfare checks, and failing to undertake joint visits.

In adult cases, it was common that police and partners did not proactively discuss strategies for safety planning and responses to repeat calls from vulnerable adults with, for example, on-going mental health needs or substance abuse. This was not specific to any one partner agency, but manifested in incidents involving housing, health and mental health partners, as the following example from a SAR illustrates:

> *"Miss A was regularly involved with the Police, whether directly because of her behaviour when intoxicated or when contacted by [accommodation] staff when she didn't return from the community. The failure by [accommodation] and the [health trust] to develop and implement a joint strategy with the Police to manage Miss A's behaviour, despite the MDT Review Forms being routinely shared with the health trust, is also a cause of concern. Likewise, the failure of the Police to identify the need for such a strategy, normally contained in a 'trigger plan' is also a cause of concern, though it is unrealistic to expect the Police to have a detailed understanding of the causation of or the possible options for the management of Miss A's behaviour…it would be reasonable to expect them to have policies and procedures in place to ensure a consistent and safe response to adults who repeatedly come to their attention"* [SAR MA].

Finally, in six cases (all of the SCRs), problems were identified with police escalation of concerns that they had about partner agency decisions taken. In five out of six cases, police did not escalate the concerns they had about partner agency decisions; and in one, they did challenge children's social care about a decision to cancel a child protection conference but the reviewer felt they did not go far enough to escalate their concerns. It is unclear in all cases why police did not escalate concerns they held. It may be that force or LSCB policies were not clear enough about the process for escalating concerns; police may have lacked the

confidence to escalate, deferring to partners with particular expertise; or they may have simply have lacked a reflective space to discuss these kinds of concerns.

Summary

Reviews of cases of death and significant harm focus on how agencies worked together, which means it is unsurprising that collaborative working was such a significant theme. Collaborative working affected all other areas of policing, from identification of risk through to evidence and investigation and care of the victim. Information sharing, unsurprisingly, remains problematic. The reviews evidenced problems in police sharing information with partners and identified issues of quality and timeliness. Although we focussed on the police role in this analysis, it was also evident that partners did not always effectively share information with the police, impacting on policing activity. This is a thematic area we will consider further going forward. Other aspects of multi-agency working were identified as problematic too, particularly attendance at relevant child protection meetings. It also appeared less likely that police would attend multi-agency meetings with partners in adult safeguarding cases – and equally unlikely for partners to include police in those meetings.

Conclusion: Key findings aligned to the National Vulnerability Action Plan

This report has presented the findings of an analysis of 126 reviews of death and significant harm. It has identified missed opportunities and gaps in police practice, aligning these directly to the National Vulnerability Action Plan (2020-2022, v2). Eight key findings in particular are aligned to the NVAP, as set out in Table 16 below. These findings provide evidence to support the continued need for inclusion of these actions in the plan. No additional recommendations to those within the NVAP are made on the basis of these findings. Additional considerations around data recording and researching are raised in Table 17, as are considerations on the quality of learning from reviews.

Table 16: Key findings as aligned to the National Vulnerability Action Plan

Identifying & managing risk **NVAP Action 2.1.1** **'Recognition and response'** Ensure that recognising and responding to vulnerability is everyone's business, especially at first point of contact	**Key finding 1:** Identifying vulnerability that may increase a child or vulnerable adult's risk of harm was the most common gap in practice for the police within the reviews examined. Sexual violence including child sexual exploitation, criminal exploitation and stalking and harassment were the most common types of vulnerabilities to be missed. Risks and vulnerabilities were also missed when they related to children or vulnerable adults who were not the main focus of the police response.
Identifying & managing risk **NVAP Action 2.1.2** **'Mental health'** Acknowledging that mental health (MH) can impact across all forms of vulnerability. Forces to consider any links to MH as part of their vulnerability assessment, differentiating from other vulnerabilities where possible and ensuring individuals receive appropriate signposting, guidance and care	**Key finding 2:** Mental health needs featured regularly in reviews of vulnerable adults, often linked to other behaviours such as substance abuse and self-neglect. Within these cases, officers commonly missed opportunities to identify mental health needs which had a range of negative impacts on management of risk, sensitive victim support and investigation. Police and multi-agency partners appeared less likely in vulnerable adult cases to work together to manage risk and support them than in child cases of significant harm and death.
Supporting vulnerable individuals **NVAP Action 2.1.3** **'Access to services'** Ensure all staff know where and how to access service provision	**Key finding 3:** The reviews evidenced some cases where officers did not make support referrals to partner agency services, such as to Independent Sexual Violence Advisors, when this may have been helpful to victims. It is not always clear why this did not

for all strands of vulnerability, especially at the local neighbourhood level	happen, but may be related to officers lacking knowledge about local service availability and referral pathways.
Collaborative working **NVAP Action 2.2.1** **'Appropriate action'** In response to identified risk, ensure staff understand and utilise appropriate referral pathways including how to access partner provisions and are empowered to challenge or escalate decisions	**Key finding 4:** While the reviews evidenced many appropriate safeguarding referrals to other agencies and processes made by the police in these cases, they also showed that sometimes referrals did not occur when they should have. Referrals to MARAC and MAPPA could be problematic for example, with thresholds and processes unclear to officers. The reviews also evidenced that sometimes officers held concerns about decisions made (or not made) by partner agencies, yet did not escalate their concerns.
Victim engagement and care **NVAP Action 2.4.1** **'Voice of the victim'** Develop clear processes to ensure that 'the voices of vulnerable victims and witnesses' are heard	**Key finding 5:** Police sometimes missed opportunities to talk to children and vulnerable adults to ascertain their views and experiences, their wishes and their support needs. Sometimes police made assumptions about the way a child or adult presented in lieu of speaking directly to them; in other cases, officers lacked the confidence and skill to do so (in cases of very young children).
Evidence and investigation **NVAP Action 2.4.3** **'Evidence-led prosecutions'** Develop and utilise in more effective ways early evidence gathering techniques and the use of 'evidence-led' prosecutions in all appropriate cases (wider than DA & child abuse)	**Key finding 6:** Evidence-led prosecutions appear to have had limited consideration in all types of reviews where domestic abuse was a key part of the context. Evidence-led prosecutions were considered in only a small number of domestic abuse cases, but were discounted and not pursued.

Developing the workforce **NVAP Action 2.6.2** **'Officer norms'** Recognise that officer norms will change from exposure to aspects of criminality/ vulnerability and that these need to be re-set so that thresholds of acceptability are maintained	**Key finding 7:** Preconceptions or negative attitudes prevented some officers from identifying vulnerability that may increase a child or vulnerable adult's risk of harm, delivering appropriate risk management, providing sensitive victim support and carrying out effective investigations. Particularly in the context of repeat incidents, some officers appeared to apply preconceptions of victims which would influence decision-making, rather than taking each incident on its own merit. These police responses were observed across a range of vulnerabilities including child sexual and criminal exploitation and missing children; domestic abuse cases; and adult safeguarding cases, particularly involving mental health needs and substance abuse.
Crime prevention and long-term problem solving **NVAP Action 2.7.1** **'Working with communities'** To work with communities to build confidence, improve understanding and increase reporting especially with marginalised groups	**Key finding 8:** Within the reviews where domestic abuse is part of the wider context, and particularly in DHRs, there is evidence that victims of domestic abuse and stalking and harassment find it difficult to report crimes to the police. Sometimes this is because victims do not recognise the abuse as a crime or do not feel it is serious enough to report. Some victims in the reviews did not report because they lacked confidence that the police would take them seriously. Family members and friends are often unaware of how and when they should help and support victims of domestic abuse.

Additional considerations

Additional findings not directly aligned to the NVAP (2020-2022, v2) but which have implications for the actions within it is described below in table ES2.

Table 17: Additional considerations for forces and future NVAP refresh

Researching and recording The reviews evidenced common officer errors in recording and researching that often had impacts on risk identification, management and investigation. Inevitably, some of these errors may also impact on the ability of forces to identify vulnerability and risk. Forces should consider their systems for assessing the quality of information recorded about vulnerability and crimes. This may be done through audits and dip-sampling strategies as well as on-going staff development of skills in recording and researching.
Quality of reviews While the reviews offer rich insight into policing practice in cases of death of and significant harm to children and vulnerable adults, there were some limitations to the overall quality of learning

contained within the reviews. Reviews in general vary in length, quality and methodology and the extent to which it is possible to understand the learning from a 'systems' approach. Some reviews are better than others at describing practice clearly and accurately, exploring the reasons underpinning missed opportunities or poor practice, identifying good practice and what this looks like, and determining whether the learning is a localised issue or one that is relevant to police practice more widely. Protected characteristics are not always reported within reviews, which limits what can be learned about the lived experiences of children and vulnerable adults in their interactions with the police. Recommendations at the end of reviews often highlight multi-agency messages rather than single-agency learning, despite the identification of missed opportunities by specific agencies within the narrative of the reviews themselves; in other words, learning identified within the reviews does not always translate into a direct recommendation for the police. This means police may be missing important learning if their focus is solely on recommendations contained at the end of reports.

These learning points may be something that learning and development staff and police leads may wish to consider when collating the learning and that police leads may wish to consider, particularly within their role as potential commissioners of reviews.

APPENDIX A: Methodology

Sources of information

This research analysed information about the role of the police in cases of death and significant harm in three types of publicly available statutory reviews. The terms of reference for *Serious Case Reviews* (in England) / *Child Practice Reviews* (in Wales), *Safeguarding Adult Reviews* (in England)/ *Adult Practice Reviews* (in Wales) and *Domestic Homicide Reviews* can be reviewed in Table A1 below. Statutory reviews consider the circumstances of the people involved in the incident, the events leading up to the incident, and how any services worked with the people involved. They provide, therefore, a useful source of detailed learning about the role of the police in such cases.

A1: Terms of reference of reviews included in this analysis

Source	Legislation/ guidance and oversight	Purpose
Serious Case Reviews in England (or Child Practice Reviews in Wales)[37]	**Guidance:** Previously the Local Safeguarding Children Boards Regulations 2006[38] Working together to safeguard children 2018[39] SCRs are overseen by the Department for Education and commissioned by Local Safeguarding Children Boards[40]	Undertaken where: (a) abuse or neglect of a child is known or suspected; and (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child[41].
Safeguarding Adult Reviews in England (or Adult Practice Reviews in Wales)	**Legislation:** Care Act 2014, Section 4418 SARs are overseen by the Department of Health and Social Care and are commissioned by Local Safeguarding Adult Boards	Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.
Domestic Homicide Reviews	**Legislation:** Section 9(3) of the Domestic Violence, Crime and Victims Act 2004	A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —

[37] Now termed 'Child Practice Reviews' under the new safeguarding arrangements

[38] Statutory guidance on Serious Case Reviews changed in July 2018. However, all of the included reviews had been carried out under the framework provided in Working Together 2015 or 2013 which is described below.

[39]

[40] ADD New arrangements

[41] Department for Education (2015) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. London: HMSO. p. 75 [NEED TO CHECK ON THIS]

	DHRs are overseen by the Home Office and commissioned by Local Community Safety Partnerships	(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

How we identified reviews and how many we found

Sourcing the reviews occurred in different ways according to the review type. Table A2 below details our process for each type of review and indicates the number of reviews in total we identified and scanned for inclusion in our sample. The number of SCRs/CPRs and DHRs carried out is not publicly available so we have not been able to estimate the percentage of reviews identified, with the exception of SARs.

A2: Where we found the reviews for inclusion in our analysis

Review type	Where we found them	Number of reviews scanned using inclusion criteria
SCRs/CPRs	The NSPCC compiles these reviews in a repository on their website. Many, but not all SCRs/CPRs can be found here. We searched the repository for these reviews and we also requested relevant reviews directly from forces.	281
SARs/APRs	There are no publicly available repositories that have collated a full set of these reviews[42]. They are published on Safeguarding Adult Board websites, which were searched by our team.	311
DHRs	Similarly, there are no publicly available repositories compiling all DHRs in one place. Although it is possible to identify at least some DHRs through Community Safety Partnership websites, we took the decision to analyse only a small number in order to test our template. We identified reviews through liaison with the Staff Officer for the Domestic Abuse Portfolio and requested examples from a third sector agency.	10
Combined reviews	Across our searches, we identified a number of joint reviews.	7
Total reviews scanned for inclusion		609

[42] The Social Care Institute for Excellence (SCIE) have set up a SARs library but this is not yet comprehensive. See their website at https://www.scie.org.uk/safeguarding/adults/reviews/library

How we selected cases for inclusion in the analysis

We scanned 609 reviews in total between November 2018 and September 2019 to consider whether they fit our criteria for inclusion. Table A3 details our inclusion criteria and final number of reviews selected for inclusion, by type of review.

Table A3: How we selected cases for inclusion in the analysis

Review type	Time frame	Inclusion criteria
SCRs/CPRs	All SCRs/ CPRs where the incident or circumstance that triggered the review occurred on or after January 1st, 2016 were eligible for inclusion.	All remaining criteria was the same for all three types of reviews. Reviews were selected for inclusion where: -Police were involved with the child, adult or family in the timeline of the review. -There is explicit reference to police practice within the review; this could be either omissions in practice or good practice identified.
SARs/APRs	All SARs/APRs published since April 2015. This date was selected as it marked the period following the introduction of SARs through statutory legislation.	
DHRs	All DHRs where the homicide that triggered the review occurred on or after January 1st, 2016 were eligible for inclusion	

Table A4 displays the number of reviews selected for inclusion in the analysis, as well as those excluded on the basis of set criteria. Almost a quarter of SCRs/CPRs, 14% of SARs/APRs and all DHRs identified were selected for inclusion because they fit the above criteria. Two combined reviews (one combined SCR and DHR and one combined SCR and SAR) were also included.

Table A4: Number / percent of cases included, and excluded by reason

Inclusion/ exclusion status	SCRs/CPRs Number(%)	SARs/APRs Number(%)	DHRs Number(%)	Combined reviews Number(%)
Included	69 (24.6)	45 (14.5)	10 (100)	2 (28.6)
Excluded: out of date	134 (47.7)	113 (36.3)	-	3 (42.9)
Excluded: out of jurisdiction	5 (1.8)	-	-	-
Excluded: post incident involvement only	22 (7.8)	25 (8.0)	-	1 (14.3)
Excluded: No police involvement	6 (2.1)	45 (14.5)	-	-

Excluded: Document too brief, unknown if police were involved	9 (3.2)	28 (9.0)	-	-
Excluded: Document not available	2 (.7)	-	-	-
Excluded: no police learning identified	29 (10.3)	50 (16.1)	-	1 (14.3)
Excluded: date unclear	5 (1.8)	5 (1.6)	-	-
Totals	**281 (100)**	**311 (100)**	**10 (100)**	**7 (100)**

Almost half of SCRs/CPRs, over a third of SARs/APRs and over half of the combined reviews were excluded because they did not fit the date criteria set out in Table 2. None of the DHRs were excluded because they were requested on the basis of the criteria above.

Only a small number of SCRs/CPRs were excluded because they concerned locations outside of England and Wales. Small numbers of reviews were excluded because police were only involved in the cases post-incident, but the review did not concern the investigation and therefore no learning for police practice was identified.

Police were not involved in cases in a small number of reviews. In most of these cases, the child or adult subject to the review had support needs and were being cared for in the home or in care contexts. No crimes or abuse or violence were evident in the lead up to the deaths that would have warranted police involvement.

In a small number of reviews, full SCRs/CPRs or SARs/ASRs could not be found or accessed, although learning documents had been published about them. These tended to be short two-page summaries of key themes, and made no mention of police so it was not possible to understand whether, and to what extent, police were involved in these cases and what sort of learning was applicable to them.

Some SCRs/CPRs and SARs/ASRs had police involvement but very little was written about their involvement or no clear learning and analysis about their involvement and this lack of context meant it was difficult for us to assess whether there was any learning to be gleaned from the reviews.

Finally, small numbers of reviews contained no clear date of incident which triggered the review, so were excluded, and in two cases, the full SCR/CPR could not be obtained.

How we examined police practice within the reviews

Using a bespoke template created for this project, relevant case characteristics were extracted and entered into an SPSS database (a statistical software package). These have been descriptively analysed and presented in the 'About the cases' section of this report. A qualitative analysis was undertaken on the reviews in NVivo 12 (a qualitative software programme), coding any extract related to police practice within the reviews according to

broad themes as presented in Figure 1. This figure reflects the College of Policing (CoP) 'perennial problems' framework and has been used to structure this report. Not all of the ten themes have been used, however, as reviews of serious cases are focussed on the ways in which agencies worked together. This means, for example, that themes such as 'staff wellbeing', 'developing the workforce' and 'professional and ethical conduct' tend not to feature heavily in these reviews. Even among the remainder of the themes, the practice featured in the reviews is primarily related to 'identifying and managing risk', 'victim engagement and care', 'evidence and investigation' and 'collaborative working', with fewer relevant findings among the remaining themes.

A 'systems' approach to the analysis allowed us to try and understand 'why' missed opportunities occurred, but this was not always possible. Reviews tended to describe the missed opportunities, but not explain them. Where it was possible to understand a broader 'systems' explanation for the practice, we have noted this.

Figure 1: The College of Policing 'perennial problems' framework

The ten overarching 'themes' in Figure 1 above do not always readily appear, however, in the types of reviews we have looked at. SCRs/CPRs, SARs/ASRs and DHRs tend to be focussed on the ways in which agencies worked together in these cases, so in this way, it is unsurprising that collaborative working features heavily in the reviews.

APPENDIX B: Reviews: A briefing note on quality

Quality of reviews of serious cases[43]

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

[43] 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)

areas of vulnerability and we hypothesised that examining practice across different types of 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

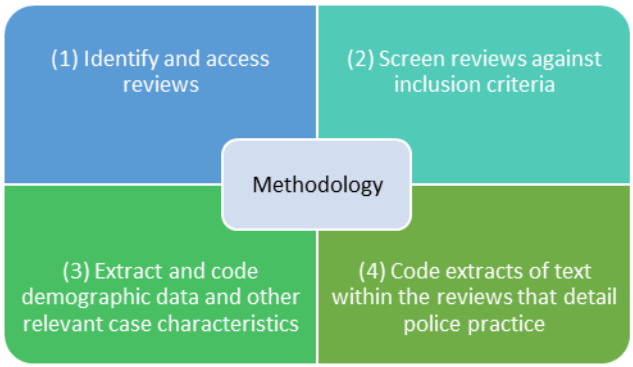
Four key research questions guided the research:

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[44]) to administer review processes they feel are most likely to promote effective learning and improvements[45]. 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[46]. Additionally, other experts have commented on the variable quality of reviews, seen as too long and detailed and lacking in clarity[47], although length of reports appears to be shortening and streamlining over time[48]. The Child Safeguarding Practice Review Panel have produced guidance[49] 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

[44] 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.

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

[46] 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.

[47] 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.

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

[49] 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[50]. 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[51]. 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[52]. 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.

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[50] Department for Education (2018) *Working together to safeguard children*. London: DfE.

[51] 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.

[52] 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.