Report to ACPOS

Report of literature review of recommendations of child abuse inquiries in respect of the Police Force

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1. INTRODUCTION & METHODOLOGY

Introduction

This study was commissioned by ACPOS through the Scottish Child Protection Network. The aims of the research were to**:**

- Identify and list all the UK National Inquiry Reports and published Significant Case Reviews since the Clyde Report (1992)
- Provide an analysis of recommendations specific to the police
- Identify key themes arising from the analysis

The report will briefly outline the methodology used in the research and will highlight findings from the various documentation reviewed.

The report is laid out as follows -

- Findings from recent Child Abuse Inquiries in Scotland
- Findings from a sample of serious case reviews in Scotland
- Summary of the multi- agency and police specific issues and recommendations of key child abuse inquiries, inspection reports and biennial reviews. This summary will be complemented by the inclusion of findings specific to police from a sample of 20 serious case reviews chosen at random from the websites of local authorities in England in order to provide more detailed case examples.
- Discussion

Methodology

The strategy for undertaking the literature review involved -

Initial broad scoping study of the literature available though

- Electronic databases, internet and research registers
- Search of bibliographies, reports/ studies

This was supplemented by

- Hand search of key journals

- Contact with relevant organisations in order to identify any grey literature, NSPCC, Children 1st

Study Selection

- Identification of inquiry reports and published significant case reviews which have recommendations relevant to the police
- Identification of other literature directly relevant to the study

Charting the data

A data charting form was produced which included

- Author, year of publication, study location
- Background to the inquiry: child and family circumstances
- Nature of abuse
- Brief summary of action taken by all agencies
- Action take by the police
- Summary of full recommendations
- Specific recommendations relevant to the police - internal and multi-agency

Collating, summarising and reporting the results

- Analysis of recommendation specific to the police
- Analysis of interagency recommendations
- Discussion of key themes arising from the analysis

2. FINDINGS Scotland

2.1 Background

The Clyde Report (1992)

On 27 February 1991 nine children of four families residing in the island of South Ronaldsay in Orkney were removed to places of safety by social workers acting under the authority of Orders granted under S37 of the Social Work (Scotland) Act 1968 with the assistance of members of the police force. The removal of the children followed allegations of ritual sexual abuse. The children remained in care until 4th April 1991 when the Sheriff Court found the proceedings to prove the grounds for referral were incompetent and before the evidence was led the children were returned to their homes. The Reporter subsequently won an appeal against the Sheriff's decision but decided to abandon further proceedings in the Sheriff Court to prove the grounds.

The Orkney Inquiry came in the wake of similar ritual abuse cases in Rochdale and Cleveland in England and in Ayrshire Scotland.

The report heavily criticised social work services and police and made 194 recommendations relating to child care practice. The Inquiry had a significant impact on child protection policies and procedures. Below are some of the recommendations most relevant to police and social work

Lord Clyde made a number of recommendations in a number of practice areas

- The child's needs required to be the centre of all agency attention and the views of the child should be elicited and encouraged
- Reform in the field of child law – this clearly led to the introduction of new emergency protection orders (CPO, Assessment Order, Exclusion Order)
- The CPO was to be presented in front of a Sheriff thus tightening up the whole process of removal of a child to a place of safety – strict criteria was developed and required a Sheriff to hear evidence and to grant a CPO
- Local Child Protection Committee's required to work together to secure children's needs were being met and child protection processes were effective and efficient in protecting children in their area
- Police and social work were to identify appropriate supports for officers/workers who were regularly working in the area of child sexual abuse
- All agencies were required to address training issues for all staff and to raise awareness of child sexual abuse and to identify agency roles and responsibilities
- The whole investigation process was criticised for a lack of clarity around the actual child interviews undertaken by police and social work – resulting in the launch of new joint investigative interviews procedures which clearly defined the process of a joint investigative interview – children should not be interviewed on more than 3 occasions without careful consideration and agreement that this is necessary and appropriate

- Joint training was to take place between police and social and this continues to be the case today with the national joint training programme
- Child protection case discussions should be convened in all cases of child sexual abuse
- Enquiries required to be made of all agencies involved with a child and their family where there are child protection concerns
- Consideration was to be given to seeking consent from a parent from the outset of the investigation – this was deemed to be best practice – however, it has been agreed that where this may put the child at further risk this is not required
- Police and social work should be seeking consent as part of the investigation process
- All LA areas were required to develop inter agency child protection procedures emphasising the role of agencies in the protection of children – guidance was to make distinction between managerial and operational responsibilities
- National guidance was to be developed – Protecting Children A Shared Responsibility was a key document developed in 1998
- Removal of a child was to be considered only when no alternatives exist and the urgency of the risk requires immediate action
- Where sibling groups were separated there required to be careful care planning to ensure regular contact and placements were constantly kept under review
- Significant changes were recommended in relation the hearing system and the 1st day hearing process, review processes for parents and the overall hearing processes

Police

Rec 186 More extensive police training in work relating to matters of child care should be provided particularly in the work of interviewing children

Rec 187 It should be recognised that the experience of dealing with cases of suspected child sexual abuse involves as much stress for police officers as it does for social workers and requires a corresponding degree of support

As a consequence of the Clyde Inquiry there was a radical review of child protection processes nationally resulting in the publication of local inter agency child protection procedures and guidance of the joint investigative interview of children by police and social work. In addition the report was instrumental in reviewing child care law and introducing far greater rigour in the process of removing children from their carers. With the introduction of emergency orders (CPO) it was necessary to convince a Sheriff that a child should be removed to ensure their safety and protection. There were significant changes in the hearing system and parents were given far greater rights of appeal and involvement in the CP process. Sexual abuse was given far greater media coverage and raised the whole issue of whether ritual abuse existed or not.

Report of the Scottish Executive Child Protection Audit and Review (2000) - It's everyone's job to make sure I'm alright

Following the death of Kennedy McFarlane (included in inquiry reports in next section), the Scottish Executive undertook a child protection audit and review. This was undertaken by a multi-disciplinary team comprising of education, medicine, nursing, police, Scottish Children's Reporter Administration and social work professionals with assistance from Scottish Executive analytical services. Interviews were conducted with workers from statutory and voluntary agencies and young people. Information was obtained from Childline Scotland and Children First and Parentline.

The review recommended that all agencies review their procedures and processes and put in place measures to ensure that practitioners have access to the right information at the right time. All agency files should contain a succinct, comprehensive and readily accessible chronology of events or concerns. Single page contact information should be provided by all agencies for directories and web pages to ensure easy access for the public. Information about how to access services and the process of intervention post-referral should be provided. Regular audits of practice should be undertaken and reported to the Scottish Executive and local Child Protection Committees. The report recommended that the remit and structure of CPCs be reviewed by the Scottish Executive to include annual auditing and reporting by the constituent members of CPCs on the quality of single and inter agency child protection work, and the provision of information and training to a range of agencies and the public. In addition the Scottish Executive should strengthen the dissemination of knowledge and research about abuse and a long term study should be commissioned on the effectiveness of current practice in the area. It was recommended that child fatality reviews be introduced in Scotland. Recommendations were made with regard to the development of Children Services Plans and integrated provision of children's services. Consideration should be given to the pooling of services and a cost benefit analysis of current arrangements should be undertaken. The report recommended that a new approach be taken to tackling risks and needs of the most vulnerable children including those born to alcohol or drug misusing families where there has been a history of neglect and families where there have been previous child deaths. Changes to the referral process to the Children's panel were recommended. The development of computer-based information systems and a single assessment framework was a key recommendation to address issue of joint information sharing and assessment. The Scottish Executive and partners should consult on minimum levels of professional knowledge and skills required in this work. Finally, it was recommended that a national implementation team should be formed to take forward the above recommendations and a further national review be undertaken.

Specific issues relating the police in the body of the report were failure to check on criminal convictions of a man prior to a case conference, failure to undertake extensive interviews with family members of neighbours and to take forensic samples from alleged abusers. Where medical opinion was sought the review found that social work and police were highly dependent on medical opinion as to whether abuse had taken place. While joint planning of interviews between social work and police was a feature of good practice, co-location did not result in a significantly better handling of cases. Delays in conducting interviews occurred when children moved across police or local authority boundaries causing delay as case responsibilities were being discussed. Police, as with other agencies did not have formal systems for feeding back to the referrer.

Getting it Right for Every Child

In 2008 the core Scottish social policy framework for working with children is the GIRFEC practice model. In summary, GIRFEC promotes action to improve the well-being of all children and young people. Eight areas of well-being have been identified as areas in which children and young people need to progress in order to do well now and in the future –

- Healthy
- Achieving
- Nurtured
- Active
- Respected
- Responsible
- Included
- Safe

GIRFEC is under pinned by shared principles and values, a recognition of children's rights and builds on the strategic pillars of Scottish Government policy for children and young people and the Concordat which emphasises that Scotland's young people will be –

- Successful learners
- Confident individuals
- Effective contributors and
- Responsible citizens

GIRFC builds on research and practice evidence to help practitioners focus on what makes a positive difference for children and young people and to act to deliver these improvements. The GIRFEC approach is about how practitioners across all services for children and adults meet the needs of children and young people, working together where necessary to ensure they reach their full potential. It promotes a shared approach and accountability that

- Builds solutions with and around children, young people and families
- Enables children and young people to get the help they need when they need it
- Supports a positive shift in culture, systems and practice
- Involves working together to make things better

When two or more agencies need to work together to provide help to a child or young person there will be a Lead Professional to co-odinate that help. Assessment and planning can draw on the GIRFEC practice model which promotes the participation of children, young people and their families. There are three main components in the practice model –

- Eight well being indicators
- The My World Triangle
- The Resilience Matrix

Her Majesty's Inspectorate of Constabulary for Scotland Thematic Inspection Domestic Abuse (2008)

While this thematic inspection focussed on domestic abuse, specific mention was made to the links between domestic abuse and child protection issues. The report emphasised that there was a need to ensure that specialist Domestic Abuse Officers work alongside child protection officers in order to facilitate effective information sharing and case management. Whatever the arrangements are for joint working, communication between and DAOs and other specialist officers should not be hindered by unnecessary organisation boundaries. It was expected that forces would review any nationally endorsed approach to risk assessment and domestic abuse in the light of the findings from the Getting it right for every child pilots.

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3.2 Scottish Inquiry Reports since 2000

The inquiry reports analysed were Caleb Ness (CN), Carla Nicole Bone (CNB), Colyn Evans (CE), Danielle Reid (DR), Kennedy McFarlane (KM), Eilean Siar (ES).

Interagency recommendations and issues

There were a number of general themes which emerged from the review of interagency recommendations in the Scottish inquiries.

Communication and information sharing

Communication and information sharing between agencies was a recurring recommendation across inquiry reports. (The most significant issue was in relation to recommendations in respect of communication and information sharing between agencies) One of the key findings was the need for clarity between police and social workers as to the kind of information shared prior to the Child Protection Case

Conference [CPCC], for example previous criminal convictions of parents were not related to the CPCC(CN) A further issue which arose was in relation to the need for early discussions of concerns, even when a formal child protection investigation is not taking place.

In the case of KM, police were not involved until after the death of the child and could have provided information on the cohabite of the mother and would have been able to inquire into the child's eye injury and drug ingestion. The importance of developing productive interpersonal relationships was highlighted in the KM inquiry where a recommendation was made that all staff should have access to advice in this area. In the case of CE there appeared to be no agreed management processes in place between agencies which resulted in information sharing being compromised. In the case of DR the need for the development of multi-agency processes which involved an evidence-based analysis, action plan and review was highlighted. The need for the creation of a multi-agency chronology of key events and contacts which is coordinated by the lead professional and regularly reviewed was a key issue in the ES report.

Decision making processes

Leading on from communication and information sharing a further recommendation in X reports highlighted the need for agencies to ensure that decision making processes were clearly understood and evidenced from the initial referral right through to CPCC. In the case of KM a formal stage for initial case discussion at referral stage was recommended. The need for social work and police to build on best practice and produce a structured action plan for implementation as part of Standard Operational procedures was highlighted in the CE report.

Need for risk assessments and the development of risk assessment tools

Recommendations regarding the development of risk assessment tools were present in several reports (CN, DR, ES). In the CN report the recommendation was that interagency tools for risk assessment should be developed as a priority to underpin decision making during investigations. Similarly the development of a standardised multi agency risk assessment tool was recommended in the case of DR.

Training, Support and supervision

Most reports recommended that more training take place (CNB, CN, KM, ES) and identified a number of areas. The need for further development of interagency training was identified in several. Targeted training for senior managers in Child Protection was recommended in the CB inquiry. In the ES report it was recommended that al staff engaged in protecting children have access to confidential counselling which is separate from line management and that senior managers should realise the need for staff to have formal and informal opportunities to share their thoughts and feelings with colleagues.

Police specific issues and recommendations

Communication and information sharing

The CE inquiry found that police failed to share information with other agencies when CE was arrested following an incident where CE self harmed. The CN inquiry recommended that police work with social work to produce a new pro-forma invitation, (from social work to police), which would provide more information to police. In this case the police were unclear as to the types and relevance of information, that they could share with social work with regard to offences which on the surface did not relate to child protection, e.g. breach of the peace and prostitution. The report stated that these offences have a direct bearing on the protection of children as they related to lifestyle. With regard to communication between the police and the Reporter, the DR report recommended that the OP/48/1 form should be delivered to the Reporter within 24 hours.

Decision making

A key issue in the CE report was the lack of response of police to requests for initial risk assessments for a child displaying sexually abusing behaviour. The DR inquiry found that there was poor initial recognition and decision making in relation to a serious allegation of a potential child death. Recording and transparency of decision making processes was raised in several cases. In the CE case it was recommended that the force should ensure that all decision making procedures and processes should be documented. The report noted that there was no formal multi agency case discussion process. In the DR case it was found that in taking action on referrals all officers should be aware of and use specialist staff. The same report argues that, in terms of progressing an inquiry senior officers should be aware of taking child protection issues to a satisfactory conclusion. It also noted that improved recording of decisions needed to be undertaken by officers, from sergeant to superintendent level, was required in order to provide an audit trail of decision making and demonstrate clear lines of accountability. The auditing and monitoring of cases should be intensive and robust.

It also recommended that senior officers on duty overnight worked in a similar way to those on duty during the day, completing the equivalent documentation in relation to a rationale for decision making. The inquiry in the DR case found there was a gap between policies and practice on the ground and recommended that the force review this gap. The same report found that there was a lack of adequate referral to more specialist police staff, e.g. CID. This concern with regard to the police involving specialist staff in investigation was raised in the ES report. It recommended that in major crime investigations where a witness or potential subject is a vulnerable adult, the police should commission a psychological assessment to advise on the person's capacity to give evidence and on the length and number of interviews which should be undertaken with them.

Risk Assessment

The CE report stated that all incidents of inappropriate sexual behaviour require to be investigated by social work and police and a decision reached as to the nature and context of the incident in order that action can be taken if required. The appropriateness of using the risk assessment tools Tayrep and Risk Matrix, which were designed for adult sex offenders with young people was questioned. Similarly, the DR report stated that all enquiries require risk assessment of dangers involved to any child.

Data management

Data management issues arose in several cases. One element of data management is the recording of information and decision making. A series of entries in the CE case were not recorded on the Sex Offenders Data Base and the police Scottish Intelligence Data Base (SID). In the case of DR the inquiry found that documentation was scanty, there being inadequate documentation provided by senior decision making officers. The second element is the use and adequacy of various data management systems. In the CE case police were recommended to address the data management issues highlighted in the report. The same report recommended the continued development of VISOR's interface with SID and ANPR in respect of giving other relevant agencies access to the system. In addition it was recommended that work should progress nationally through the ACPOS Sex Offenders Working Group and Visor Implementation Team to consider whether a standardised approach across the eight forces to working with sex offenders is achievable and within what time frame.

The transfer of data between forces was criticised. The review also indicated that a Crime Type Indicator should be added on disposal of a case as a matter of routine and within a reasonable timescale. In the DR case it was noted that there was an inadequate IMPACT computerised system and concerns were raised that police did not have a flagging system whereby they automatically notify other agencies of a violent person. It recommended that the IMPACT be reviewed urgently with regard to human error in flagging, and that an automated flagging system for daily reports be put into place .The review should also consider the ability of the system to incorporate child protection material in a satisfactory way. This report was concerned that police information and intelligence was not readily available to other agencies and recommended that the VISOR system had to be fully implemented with urgency throughout Scotland to track violent or dangerous offenders to allow access of information for other agencies.

Differential approaches to types of abuse

The CN inquiry found that police had a differential approach to investigating sexual abuse and physical abuse with uniform officers often investigating less 'serious physical abuse offences. It concluded that although officers were JII trained they may have no experience in child protection so may not know what to look for with regard to other forms of abuse, other than sexual abuse.

Training, Support and Supervision

As noted in the discussion of inter-agency issues, the necessity for training was an issue in several cases. Two reports recommended specific training for supervisors of child protection cases (CB, DR). The DR report also noted that there was no rolling programme of training in the force and recommended intensive awareness training on child protection procedures for all non-specialised officers. This would ensure that all police officers had an understanding of child protection responsibilities and processes. The ES report recommended that police managers should ensure that they have staff who are appropriately trained in JII or can arrange to have staff recruited, temporarily, from elsewhere.

Child Protection Officers status, service and conditions

In one Scottish inquiry report the status of Child Protection Officers in the police was discussed. The CNB report recommended that senior officers in the police confirm the value that the force places on child protection work and confirm the level of skills necessary to carry out the tasks sensitively and effectively. It is suggested that the lack of value placed on this work exacerbates the problem of staff shortages. The same report recommended that senior managers ensure that staff have the opportunity to express their grief and sometimes anger at the crime in a safe place.

Staffing issues were also highlighted in the CE report, where concerns were raised that due to pressures of work, cases which required police involvement, were left dormant. This also applied to police involvement in undertaking joint risk assessments with social work when the Offender Assessment Unit was under resourced. Staffing issues on public holidays was also raised as an issue in the DR report. The same inquiry recommended that CID coverage on public holidays should be reviewed to ensure that there was at least one DI on duty, and that Crime Management Unit staff and Central Child Protection Unit staff should be on duty 365 days a year. Area Commanders should also hold briefings 365 days a year. It also suggested that there should be a more standardised and robust system for police management reviews.

2.3 Scottish Significant Case Reviews (SCR's)

This analysis will identify the interagency recommendations which are relevant to the police and the police specific recommendations emerging from Scottish SCRs. 22 Child Protection Committees (CPC's) responded to requests for information and 31 SCR's were analysed provided by 13 CPC's. Of the CPC's who responded 8 indicated that they had conducted no SCR's under the new guidelines and one indicated that three case reviews had been undertaken but that there had been no significant issues for the police.

It is to be noted that some responses provided included minutes of reviews, summaries of minutes, and others a summary of recommendations drawn form several SCRs. Therefore, it is not possible in this analysis to provide an exact number of times that a particular recommendation was made. However the analysis of the individual and summary recommendations does provide clear evidence of the significant issues and recommendations contained within the SCRs.

Interagency issues and recommendations

There were a number of general issues which arose from the reviews which resulted in recommendations for all agencies.

Communication and information sharing

The need for the frequent sharing of information was a key feature of most of the reviews, with the emphasis being on the need for information to be shared and recorded frequently (SCR3) and in a formal and planned manner ensuring that no gaps occurred in any record (SCR8&9). The need for a protocol on clarity and purpose was identified in SCR11-14, in order to ensure that there is clarity about the purpose of sharing information, how it will be used and the consent given for that sharing.

Initial information gathering and sharing

Several reviews identified issues around early information gathering and sharing. SCR 26 recommended that Tactical Assessment and Coordination multi agency meetings needed to widen their remit across neighbourhoods. This was to ensure that vulnerable families are identified at an early stage and that information is shared in order to put intervention strategies for vulnerable children and young people into place. The need for CPCCs to provide multi agency guidance on identifying vulnerability and early intervention was recommended in SCR3. SCRs 11-14 recommended that sharing information about parents misusing substances should be a minimum requirement of all agencies. However, this review cautioned that sharing information should not be seen as constituting a referral for action to investigate unless specifically stated. Furthermore, in sharing information it was essential to understand the roles and responsibilities of all agencies involved. With regard to early identification, the availability of public information documents was an issue raised in SCR2, where a recommendation was

made that all agencies review the availability of information, especially relating to the new child protection helpline. At the initial referral stage, the importance of agencies in receipt of referrals providing feedback to referring agencies was emphasised in (SCRs 8&9). These reviews also recommended that all agencies should not assume that police or social work are aware of a child's circumstances.

Assessment

Reviews emphasised that it was essential that following the gathering and sharing of information process, a rigorous (SCR3) and robust (CSR10) assessment took place both within and between agencies (SCR10). This need for a thorough risk assessment was specified in a number of reviews. Specific risk factors identified included:

- the impact of mental health on parenting (SCR1)
- parents with hearing impairments (SCR16)
- hostile parents (SCR8&9)
- abuse of animals in the household (SCR8&9)
- incidence of domestic abuse (SCR4&SCR27)

The complexity of assessing parenting capacity where parents misused substances was emphasised in many reviews resulting in a range of recommendations for multi agency working. Parental substance misuse was mentioned in the following SCRs 5,11-14,15,18,22,27,28. In 4 cases a child or young person had died as a result of substance misuse. In 2 cases this involved a young person dying from alcohol abuse, and in 1 a child dying of drug misuse. One case involved a child who died from the injestion of heroin. SCRs 11-14 recommended that there needed to be a national discussion about the thresholds for intervening in families who are misusing substances and caring for children, and that an additional ground of referral to the Reporter be considered with regard to children who are likely to come to harm because of parental substance misuse.

Recording

The standard of recording in case files was a concern for a number of review. Concerns were expressed about the accuracy, legibility, coherency and accessibility of child protection records, leading to recommendations for reviewing recording systems and for regular audit and review (SCR4,27). SCR 10 recommends that when two or more workers come together for what they perceive to be a meeting, there is a need to accurately record the discussion and ensure all relevant people receive copies of the minute so that there is a linkage between strategic planning and operations. The need for all professionals to use full names and titles in records is emphasised in SCR4. A significant issue with regard to recording was that intra and inter agency chronologies needed to be constructed including both the agency's involvement and child and parent histories (SCR1, ,7 8&9,16, 31). Particular concerns were raised with regard to Missing Persons Alert and the formal IRD process in SCR 26&27, with recommendations that a shared, electronic, standard and comprehensive multi agency form be developed and being used by agencies to accurately record decisions and the rationale for those decisions.

Child Protection Case Conferences

Recommendations from many reviews with regard to the conduct of CPCCs were made highlighting issues relating to -

- clarity of purpose
- requirement to attend
- provision of reports and the quality of those reports
- confidentiality
- clarity or roles and responsibilities
- recording of decisions
- identification of outcomes
- follow up of decisions both action plan and deregistration

The necessity of all agencies to ensure attendance at both multi agency meetings and Child Protection Case Conferences was identified in (SCR 3,6,8&9). Issues arose in SCR 6 regarding one representative considered to be not suitably qualified or experienced to represent that agency in that meeting and therefore important information had not been shared. The necessity for all participants to be briefed and debriefed was a recommendation in SCRs 6,8&9. The quality of reports and assessments presented at the CPCC was a concern in SCRs 4&6 and led to recommendations with regard to the necessity of detailed and accurate reports, echoing recommendation with regard to general recording discussed in the previous section. The recording and minuting of decisions was a further concern. In particular, how dissent was dealt with prior to and during the meeting was raised in SCR 1,6,20 leading to recommendations with regard to process and training. In general, the lack of clear recording of decisions and plans of action led to recommendations which highlighted the need for professionals to demonstrate how outcomes were to be taken forward, and how agency responsibilities were made clear (SCR 10). SCR 15 also recommended that consideration be given as to how decisions are reached as to whether a case discussion requires to be convened. The importance of following up de-registration action plans was recognised in SCR 17. A broader recommendation which emerged form SCRs 11-14 was that the clarity and purpose of the CPCC be reviewed and consideration given to different ways of meeting e.g. telephone conferencing which would be timetabled and would assure that all professionals could attend.

Awareness raising and training

Many of the reviews made recommendations specifically around training and development identifying the need to review existing basic awareness raising programmes highlighting the following areas for future development -

- Emergency protection conditions which needed to be satisfied (SCR1)
- Escalating needs of children and young seeking out of hours services (SCR7)
- Sharing of relevant information between agencies (SCR4)
- Significant impact of neglect and parental problems and a child's safety and development (SCR15)
- Discernment of patterns of parental behaviour after a series of individual incident (SCR 15)

- Dissent between agencies (SCR20)
- Possibility of a young person being involved in substance misuse (SCR 8, 23, 26)
- Assessment of gypsy and travelling families as part of equality and diversity training (SCR26)
- Thresholds in assessment of neglect (SCRS 2, 11-14
- Confidentiality and protocols for sharing information (SCR11-14)
- Needs of children and young people with significant learning difficulties with particular emphasis on issues of sexuality (SCR4)
- Nature of risk assessment training for staff (SCR6)
- Role of adult services in child protection(SCR4)
- Roles and remits of all agencies in child protection (SCRs11-14)
- Children in need of care and not just child protection (SCRs11-14)
- Alcohol misuse in an area (3)
- Families working with substance misuse (3. 11-14, 23, 27).
- Nature and impact of mental illness (SCR1)
- Vulnerability and early intervention (SCR 3)

Guidance and protocols

A variety of recommendations were made with regard to the need to develop or revise protocols. The following areas were identified -

- Impact of parental mental illness (SCR1)
- Identification of vulnerability and early intervention (SCR4)
- Interagency guidance for working with vulnerable adults (SCR4)
- Parental support during the child protection process (SCR4)
- Convening children in need meetings (SCRs 11-14)
- Pregnancy (SCR7)
- Underage sex (SCR30)
- Transition from children to adult services (SCR4)
- Information sharing (SCR11-14
- Confidentiality (SCR11-14

Police specific issues and recommendations

Communication and information sharing: child protection process

In the Scottish SCRs analysed several areas of concern emerged with regard to communication and information sharing. Early sharing of information was an issue in SCR 23. In this case of a young person admitted to hospital for taking heroin, it emerged that police had had significant previous knowledge of substance misuse both by the young person and her mother. Police had previously found the mother had been in possession of controlled drugs and noted that she was ‘heavily pregnant’ but had not referred her to social work in respect of her unborn child. The school had also previously contacted the police on previous occasions expressing concern about the young

person's use of drugs. There did not appear to be a coordinated response by the police. This review noted that the Family Protection Unit supervisor should have made early contact with social work to discuss the investigation with regard to police being called to the school because of concerns about the young person's use of drugs. The review stated that this would have resulted in a joint approach to the concern and joint investigation and intervention. The police did not adhere to the JIIT protocol, with no planning, briefing or debriefing meetings, and no briefing forms were used. Furthermore information from police to social work was not conducted according to existing protocol i.e. from a police manager to a social work manager. One recommendation from this review was a requirement to ensure that an appropriate response is provided when police identify a situation where children, including babies, may be adversely affected by drug misuse. A second recommendation highlighted the need to ensure that initial referral discussions, planning, briefing and debriefing meetings and attendance at formal child protection meetings are carried out in line with Force and Inter Agency guidance.

The issue of communication and information sharing was raised in SCRs 11-14. In this case the report recommended that a Scottish wide approach should be taken where drug searches are undertaken and there are children in the house, in addition to referring to health, social work and the Reporter by the JLO, the JLO should also identify in the report the contact details of the police officers who carried out the search. The report stated that this would enable other professionals to make contact with the police who conducted the search so a more detailed account of interviews could be given and a more complete assessment of a child's needs made.

Communication and information sharing: access to police records

The need for consideration of how other agencies may access police records, as appropriately, or how different recording systems may be better managed was raised in SCRs, 7 11-14, 26-7. In SCR 7 a young person died from alcohol abuse after both police and social work out of hours had been involved that evening. This review recommended that both police and social work out of hours service review their record keeping process to ensure that both parties have access to information to enable a comprehensive assessment of risk to be undertaken and decision making to be properly informed. Access by other agencies to police intelligence was an issue raised in SCRs 11-14 which considered that police intelligence about potential activities of a parent or carer of children needed to be accessible to other agencies with appropriate safeguards. The review recommended that discussion take place within the appropriate police bodies to explore whether and how additional flagging systems could be included in the Scottish Intelligence data base system so that services with a duty to protect children have access to information. It suggested that the FPU could be a key place for those agencies working to protect children to access appropriate intelligence reports.

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Police recording and data base

Several reviews raised concerns about the police recording and data base. With regard to consistent and accurate recording SCR30 recommended that Police should ensure that each incident is recorded on IMPACT system and subsequent enquiries are recorded and carried out in an expeditious manner. The difficulties in gathering

information from other police forces was highlighted in SCR6, where important information was not gathered from another force. While data bases were not mentioned in this review this finding could relate to SCR 7 in which a recommendation was made that records should be reviewed and updated to ensure that all staff have access to all information and that this information should be recorded in chronological order detailing all police involvement with children an young people. SCR 27 found that the police recording system INFO should be reviewed as it was no longer fit for purpose as it is an incident focussed data base which is difficult to search and does not lend itself to the building up of chronologies. The review finds that this, when coupled with the numerous other force and national recording systems which do not communicate with each other leads to research regarding siblings and significant other being a complex and time consuming activity.

Risk assessment

The issue of ensuring a risk assessment takes place and the communication of clear decisions was raised in SCR25. This related to the lack of notification by police to other agencies that an adult with outstanding allegations/charges relating to a child moves to another area. While the assessment of the police was deemed to be reasonable by the SCR this is clearly an area for future vigilance.

Child Protection Case Conferences

SCR 23, discussed above, and SCR 6 made specific recommendations with regard to police attendance at case conferences. In SCR 6 the issue of who is the appropriate officer to attend a child protection meetings was raised. In this case an officer on attachment for six months had attended the CPCC and provided a report. The review notes that the officer had been advised that the role was to attend and provide information. The officer had no information so none was presented. This review recommended that only FPU officers would attend CPCCs and officers on attachment would only attend if they had been involved in the investigation from start to finish. Officers would be required to be briefed and debriefed. Furthermore, all pre birth CPCCS should be attended by a DS.

The issue of the process of providing reports and the quality of reports was also raised in SCR 6. The review recommended that as well as the officer in charge of the investigation providing the report to the CPCC, this should be sent to the DS as a quality assurance mechanism in order to allow any additional information to be added.

3. FINDINGS UK Other than Scotland

3.1 Joint Chief Inspectors Reports England and Wales

Safeguarding children. A joint chief inspectors report on arrangements to safeguard children (2002)

Interagency issues and recommendations

This report draws on findings of a wide range of inspection activity from individual inspectorates. Overall, it found that there was inconsistency in how agencies interpreted their safeguarding responsibilities. While there was evidence of good working together arrangements they noted a number of concerns. There was a reluctance by some agencies to refer to police and social work. There was a reluctance to share information between agencies, with some agencies not seeing themselves as responsible to CPCs and others unsure of their duties to share. Issues of workload management, staff shortages and lack of induction, training and supervision were highlighted. Concerns were raises about the lack of coordination between CPCs, Domestic Violence Forums and Multi-Agency Protection Agencies and lack of national guidance in this area was noted. With regard to CPCS the report recommended the reviewing of constitution and membership of CPCs and of the arrangements for SCRs. It also recommended that the need to clarify explicit information sharing arrangements and arrangements with regard to accessing and maintaining the Child Protection Register. The report recommended that the Home Office reviewed arrangements for MAPPPs and for the relationship between MAPPPs and CPCs. It recommended that a national policy framework should be established and national standards for probation and police re the joint management of potentially dangerous offenders.

Police issues and recommendations

With regard to police issues, the report draws on the HMI Thematic Inspection of Child Protection 1999. It found that there were examples of good liaison between police and social service equivalents, in social work and in probation and, that specialist Child Protection officers had developed skills in joint interviewing that had earned the respect of social workers. The HMI Inspection had found that police led most of the Memorandum of Good Practice interviews and these were skilled. However several areas of concern were identified.

At a practice level, there was a concern that social work did not contact police with all relevant cases, were slow to respond and that social work thresholds were set too high. There was a lack of cooperation from other agencies. It found that management of Child Protection Teams was usually at a DS level, but in most cases the DS was also carrying a substantial caseload, which left little time for management duties. Police

representatives on CPCs often did not have the authority to take decisions and this was particularly serious where police and CPC boundaries were not co-terminus. Lack of co-terminosity was also problematic with regard to working with probation and court services. Reorganisation of police forces had a detrimental impact on Child Protection Teams. There were concerns with regard to the quality of interviews led by police who were not trained and there was a serious lack of knowledge about child protection amongst uniformed police officers. It argues that police officers must lead joint interviews as they are experienced in collecting evidence for legal scrutiny.

At a policy level the report found that child protection and potentially dangerous offenders did not appear in police or crime disorder plans as priorities and there was little evidence of chief police officers engaging with child protection. Concerns were raised with regard to the lack of local and national strategy in relation to MAPPPs. At a local level, in some areas there were routine meetings and others single case meetings. These were chaired by untrained police officers. Records lacked details of assessments and decision making and confusing terminology was used. With regard to data management, there were few formal referring systems and while all police forces were using Matrix 2000 to assess sex offenders, three versions were in use. Furthermore local MAPPPS were not complimenting this with sufficient intelligence and not all local forces used all the information available to assess risk of harm. The report noted that a new Assessment Tool OASys was to be introduced and jointly developed. At that time there was no National Sex Offenders register, no secure resourcing, no legislative powers to manage sex offenders, no policy re itinerant offenders travelling abroad although the National Criminal Intelligence Service did have a data base on those unregisterable or non- traceable. The report emphasised that under the Children Act (1989) the police had a duty to protect children from abuse, however this extended to other duties such as protecting child witnesses, care issues for missing children child prostitution and pornography. It emphasised that the police also had a duty to protect by managing and monitoring sex offenders using the process of risk assessment and MAPPPs. This would be mainly, but not exclusively with social services within the *Working Together* framework. A key police recommendation in the report was that the police should review the role, remit, location, status of force child protection units to ensure that all abuse of children is dealt with to a consistently high standard.

Safeguarding children. A joint chief inspectors report on arrangements to safeguard children (2005)

General issues and recommendations

The report initially responded to the issues raised in the 2002 report. It noted that there had been significant changes of policy since the Victoria Climbie inquiry. The *Every Child Matters* programme, underpinned by Children Act 2004, provided outcomes for children in 5 key areas being healthy, staying safe, enjoying and achieving making a positive contribution and achieving economic well being. There had been established a National Service Framework for children young people and maternity services set out 10 year change programme. Overall the report found that in the previous three years the status of child protection and welfare had improved however some concerns remained.

At a local level priority to safeguarding children had increased and the status of child protection work had improved. There were concerns that some agencies were still giving insufficient priority to this work, differing thresholds were applied by social work in child protection and family support work and there was a lack of understanding of the role of social work by other agencies. Continuing difficulties in the recruitment and retention in some agencies affected their ability to safeguard children and deliver the *Every Child Matters* programme. Of particular concern was the safeguarding of children with disabilities (particularly in residential settings), children in long term hospital, looked after children and children in an out of area placements, children seeking asylum an in custodial settings and families in court proceedings. Specific concerns were raised with regard to giving children a voice in proceedings and in relation to behaviour management techniques in residential settings. A recommendation to DfES and the Home Office was to consider holding a national consultation on LSCBs in order to develop appropriate links across all agencies, manage dissemination of learning from serious case reviews, to progress accountability and support forward planning and governance between LSCBs and the children's trust governance arrangements. Recommendations to DfES, DH, the Youth Justice Board and the National Offender Management Board centred around safeguarding children away from home and cared for. General recommendations called on all agencies to prioritise the safeguarding of children, to review their approach to safeguarding in line with requirements of the Children Act 2004 to identify issues, policies and procedures and ensure there is a regular quality assurance and monitoring systems. All agencies should ensure that staff working with children with disabilities, private fostering and asylum seeking children know how to recognise signs of abuse and have an awareness of child protection procedures. There should be regular audits of recruitment and staff checking procedures should be in place. They should review their safeguarding polices to take into account children with disabilities.

Police issues and recommendations

The report stated that there had been a significant change in the police force with regard to the status of child welfare and child protection work. It was considered that in part this was because all officers in child protection units were required to undergo initial CID training. The report stated that undertaking this training had also contributed to a greater awareness of child protection issues throughout the course. All but one of the police forces inspected had clear child protection procedures and guidance. The review highlighted areas of concern or development. Although most forces had a child protection policy, less than half forces had included child protection as a priority in their plans. The report suggests that this was mainly because there was a lack of focus on safeguarding children at a national level. Child protection is not a national priority area nor is it currently monitored by means of a national performance indicator. Specific areas for future development were highlighted. Police were now paying close attention to issues of diversity across most areas of activity. However diversity was not as clearly integrated into child protection policies and procedures as was the case in adult crime. In police forces limited auditing was taking place with regard to child protection and there was over reliance on supervision to make sure standards are met. The report stated that management information collected was primarily quantitative and gave little indication of the performance of Child Abuse Investigation Units.

Sometimes there was a lack of clarity between police and social work about the status of an investigation and the criteria for deciding if an investigation required to be jointly undertaken. Similarly police roles in strategy discussions and case reviews were not always well- defined. The report stated that comprehensive new guidance from ACPO on child abuse investigations would clarify the role of police. With regard to the findings of the Bichard Report, staff in Child Protection Teams were subject to a particularly high level of vetting. It was considered that there were still gaps in specialist training for police officers involved in child abuse investigations. ACPO was addressing this through commissioned training.

The report suggested that clarification was needed between agencies relating to young people who commit offences including when a young person has been in police custody, has been remanded in care of the council or been remanded in custody in a secure setting. With regard to missing children, joint protocols with police and residential schools were increasingly common but some staff were not aware of these. In 2005 ACPO issued guidelines to all forces with regard to managing, recording and investigation of missing persons to ensure greater consistency. Cases of domestic violence in the presence of children were not automatically recorded, however recent inspection work found this was being addressed. The recommendation to the Home Office, ACPO and the Association of Police Authorities was to consider introducing national performance indicators for the police for child protection and the investigation of child abuse to give it due priority.

3.2 Child Abuse Inquiry Reports / Serious Case Reviews England and Wales

In this section the report will summarise the findings from inquiry reports and summary reports pre the Victoria Climbie report of 2002. More detailed attention will be given to the inquiry into the death of Victoria Climbie which resulted in the major child protection programme *Every Child Matters.* Findings from 2 biennial reviews (2001-3, 2003-5) of serious case reviews commissioned by the Government (England and Wales) will be summarised. This latter section will be complemented by the inclusion of findings from a sample of 22 serious case reviews chosen at random from the websites of local authorities in England in order to provide more detailed case examples.

Pre the Victoria Climbie Inquiry report

NSPCC report on child deaths from abuse 1973-2000 (2001) 2nd edition

The report stated that there had been problems with coordination identified in the reports. A UK wide protocol to ensure consistent joint investigation was recommended. The report recommended the establishment of systematic review teams to include, police, public health and social work. Increased joint training was recommended. Specific concern was expressed by two authors of the report with regard to a culture of suspicion within the police force with regard to sudden infant death syndrome, leading to children being removed form parents when the death may be non-accidental. Officers provide medial assistance at the scene and call for police surgeon or doctor as necessary. A visual check of early records is undertaken and an early report submitted. The report recommended that consideration needed to be given on how to preserve the scene.

Campbell, D (1994) Department of Health (1994) Report into the workings of ACPCs Report 2

This report made general recommendations with regard to the working of ACPCs to address specific issues around the development of interagency training and the need to develop leadership skills within the committees. The role of middle management of each agency with respect to their responsibilities within the ACPCs required further work and finally ACPS should ensure their role and reporting procedures were known to the local community. It was considered that police had difficulty in keeping child protection a high priority at area and divisional level and child protection was seen as a 'soft option'. The complexities and subtleties of a child protection investigation was not always acknowledged across the police forces. A culture clash was noted between police and social work and a clear command structure and a 'drop everything approach was recommended. Frustration on behalf of the police with regard to the lack of co-terminus boundaries was acknowledged.

James, G. (1994) A study of 30 recent child protection committee case reviews conducted under the terms of Part 8 of Working Together under the Children Act 1989

In this report concern was expressed at the use of single agency investigation by the police which meant that criminal charges did not necessarily ensure that the child was safe without the need for a child protection case conference. Some excellent and some less pleasing involvement of police in joint investigation was noted. Poor practice in this respect meant that in some cases there was lack of sufficient evidence to pursue a prosecution, leaving the child unprotected. It was noted that the role of police in initial inv previous police involvement. Concern that police could be bound by CPC decisions not investigate what would otherwise be a serious case.

Lost in Care (2000) Report of the tribunal of inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clywd since 1972

The report is based on 259 complainants and 129 verbal testimonies into the sexual and physical abuse in care homes. While there was a major police investigation, initially no criminal charges were brought which fanned dissatisfaction with the police role. One of the person's to whom adverse reference was made was a former superintendent of the police. Concerns were raised about the influence of freemasonry on police actions. The report found that the investigation in Anglesea was thorough and had not been influenced by freemasonry. There had been three major police investigations. Issues were raised with regard to the first investigation at the lack of coherent liaison with social work, the need to approach such investigations with sensitivity but there were no substantial criticisms of the final two.

The police investigation into Gwynedd and Clywd was subject to greater criticism. Police were criticised pressured in to undertaking a longer and wider inquiry into the alleged paedophile ring. The response of all agencies to children and young people absconding from school and homes was inadequate. Victims of abuse stated that they had told police but had not been believed and were returned to the schools/homes. Recommendations included that a log of all incidents, complaints and absconsions at children's homes should be kept in local police stations and made accessible to social work as required. Police officers should be reminded periodically that an absconder from a residential or foster home may have been motivated to abscond by abuse at that home. They should be advised that when apprehended an absconder should be encouraged to explain his/her reasons for absconding. The rule of practice should be that that any absconscion is reported as soon as possible by the Director of Social Services between senior police and local authority. Finally when an internal investigation into staff conduct is taking place in any agency, police nor any other agency should single handedly determine the conduct of the investigation.

H.M. Government (2000) Learning the lessons. The government response to Lost in Care (2000) Report of the tribunal of inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clywd since 1972

The government response, with regard to recommendations to the police stated that procedures had been agreed with regard to children's homes to report incidents but that no log was in place as yet. It emphasised the need for information sharing between police and social work. It stated that as a rule of practice that any absconsion should be reported as soon as possible to the social work field worker. Guidelines had been issued jointly from ACPOS and the Local Government Association with regard to best practice when a child absconds from care. Police will be reminded that a child should not automatically be returned to their care placement. It was decided that there needed to be an interagency review of best practice between police and social work. Finally, it confirmed that it is good practice for police and social work to liaise regularly where criminal and disciplinary investigation are taking place in order to agree timescales and appropriate monitoring. Where disciplinary and criminal proceedings are proceeding at the same time and there is a significant risk of criminal proceedings being jeopardised, employees may not be able to be given a full explanation when a criminal case is pending but police will not be able to determine disciplinary issues.

The Victoria Climbie Inquiry

In all Lord Laming made 108 recommendations in his report into the death of Victoria Climbie (VC). 17 of these were general aimed at government and dealing with issues of management in organisations, including aspects of inter-agency work and 18 were specific to the police involvement in the case. Two Metropolitan Police Force (MPF) child protection teams were involved, Brent and Haringey.

Interagency issues and recommendations

Several of the general recommendations were in respect of establishing a ministerial Children and Families Board and national and local agencies for children and families, and defining their roles and responsibilities. It was recommended that the Department of Health should amalgamate the, then current, Working Together guidance with the National Framework documents into one simplified document. This document would establish a 'common language', provide a step-by-step guide for monitoring a case and would replace the child protection register with a more effective system. The focus on interagency case conferences would not be on whether to register or not, but rather to establish an agreed plan to safeguard and promote the welfare of the child. It was recommended that interagency training should be developed and evaluated by government inspectorates. The government was recommended to issues guidance on the Data Protection Act 1998, the Human Rights Act 1998 ,common law rules on confidentiality and the sharing of information between professional groups in circumstances where there are concerns about the welfare of children and families. Finally, Lord Laming recommended that the government should explore the setting up of a national children's database on all children under the age of sixteen.

Police issues and recommendations

Police protection of children

The inquiry recommended that, save in exceptional circumstances, no child is taken into police protection until he or she has been seen and an assessment of his or her circumstances been undertaken. The inquiry noted that legislation required both the child and parents are informed of the reason for a police protection order, that a an independent supervisory and designated police officer is required to investigate the circumstances of the case in order to determine if police protection is appropriate. In the case of VC this did not happen, neither did a direct discussion take place with hospital staff. It recommended that police forces must review their system for taking children into child protection and ensure that they comply with the Children Act (1989) and Home Office guidelines, and that in particular it should ensure that an independent officer of at least inspector rank acts as the designated officer in all cases. The report recommended that Chief Constables and police authorities must give child protection investigations a high priority in policing plans thereby ensuring consistently high standards of service by well resourced, well managed and well motivated teams. Furthermore, the Home Office must ensure that child protection policing is included in the list of Ministerial priorities for the police.

Crimes against children

The report stated that had VC been an adult her case would have received prompt attention, as any victim of assault should be seen within hours, instead of which VC was not seen by police. After police received a phone call to say that VC had scabies police protection was lifted and the case closed. No child memorandum interview was conducted, nor was an interview with the alleged perpetrator. The report recommends that Chief Constables must ensure that crimes involving a child are dealt with promptly and efficiently, and to the same standard as equivalent crimes against adults. It adds that any suggestion that child protection policing is of a lower standard should be eradicated.

Communication and interagency working

The inquiry raised a number of issues with regard to communication and working together, blurred roles in investigation and lack of adherence to working together arrangements. The inquiry stated that there had been blurred and confused management roles between police and social work with no serious analysis and cross checking of material and several police officers assumed that social work would take lead role in the investigation. The report stated that the principle function of the police is prevention and detection of crime, therefore, police are the lead agency in a criminal investigation. It recommended that the Association of Chief Police Officers (ACPO) must produce and implement a standards based service as recommended by Her Majesty's Inspectorate of Constabulary in the 1999 thematic report *Child Protection.* With regard to working together arrangements under *Working Together* guidelines, the

inquiry found that there was a four day delay between the time VC was taken into hospital and police being notified by social workers. The background to this was agency and inter-personal difficulties between social work and police, with police not taking a lead in investigations or raising issues of communication between the two agencies. The inquiry recommended that social work must strictly adhere to the guidelines and on receipt of a referral which may constitute a criminal offence must inform police at the earliest opportunity. Also that the working together arrangements must be amended to ensure that police carry out completely and exclusively any criminal investigation in case of suspected injury or harm to a chid, including evidential interview with a child victim. It states that this will remove any confusion about which agency takes the lead or is responsible for certain actions.

Training, Support and Supervision

The inquiry found deficiencies in supervision of junior investigating officers and recommended that in cases of serious crime against children, supervisory officers must, from the beginning take an active role in ensuring that a proper investigation is carried out. With regard to training, the report recommended that through Centrex and ACPO a national training curriculum for child protection officers must be devised and implemented as recommended by Her Majesty's Inspectorate of Constabulary in the 1999 thematic report *Child Protection*. In addition the report recommended that Chief Constables must ensure that officers working on child protection teams are sufficiently well trained in criminal investigation and that there is always a substantial core of fully trained detectives on each team to deal with the most serious inquiries. The issue of who was accountable for child protection teams in terms of both strategy and operations was raised in the report. It recommended that the Home Office through Centrex must add specific training related to child protection policing to the syllabus for the strategic command course in order to ensure that all future police chiefs have adequate knowledge and understanding of child protection teams.

Data management

Recommendations were made with regard to IT equipment and data base systems. The inquiry found that there were insufficient IT facilities and few OTIS (system which enables communication across the MPP) terminals in the child protection teams. A further system CRIS had technical problems. The CRIMINIT system was slow. The inquiry notes that MPP intended to install PROTECT and MERLIN systems. The inquiry recommended that the Police Information Technology Organisation evaluate the current IT systems in child protection and make a recommendation to Chief Constables who must ensure their police forces have in use an effective child protection data base and IT management system.

3.3 Findings from the biennial analyses of serious case reviews, 2001-3, 2003-5 and sample of individual case reviews

The two reports focus on the process and functioning of serious case reviews (SCR) and emergent trends and themes in child protection work drawn from the analysis of the SCR reports. The first study has a broader focus. The second study returns to the broad themes of the first report but then focuses on inter-acting risk factors in intervention.

Report: Improving Safeguarding Practice. Study of serious case reviews 2001-3

The aims of this study were to

- Review and identify their implications for policy and practice for the period 2001-2003
- Identify key themes common to the recommendations
- Ascertain whether case review reports resulted in action plans derived from the findings and if plans were implemented within the recommended timescales
- To consider what helped or hindered their implementation
- To ascertain if review processes led to any changes in policy or practice at local level
- To identify from the reviews any lessons for policy and practice at a national level

The process and functioning of SCRs findings and recommendations for future developments

The report found that SCRs make an important contribution to understanding what happens in circumstances of significant harm. However, Local Safeguarding Children Boards (LSCBs) require to develop a stronger learning culture in which SCRs are only one source of knowledge for improving safeguarding practice.

The report stated that the critical decision in commissioning a review is the appointment of an independent chair and there is evidence that LSCBs rely on informal contacts to find suitable people. Therefore, consideration needed to be given to resource trained, credible experts in this field that can operate in an open and transparent way. With regard to the quality of overview reports arising from SCRs, this was found to be dependent on the agency management reviews and their chronologies and this can be time consuming for agencies. Chronologies and genograms were considered useful in SCR reports, however the research found that that they had been overlooked or poorly presented in a number of cases. The formulation of recommendations and the creation of action plans at the conclusion of the overview were described as being completed hurriedly, when they require reflection and a strategic approach. The requirement to invite family members to contribute to case reviews was considered a major development although it was considered that their involvement requires careful consideration and planning. However, there was evidence that the views of the child

were not always sought and communication was more likely to take place between professionals and parents/carers rather than with children. The completion of the overview report was often described as being accompanied by some uncertainty and confusion, as it was being written at a time of high level activity with regard to handling the outcome of the review. It was found that there was poor recording with regard to ethnicity and lack of specific expertise to assist SCR's in understanding issues relating to families from different cultures and languages.

Overall, the report found that greater consistency was required with regard to what cases require to be reviewed under SCR processes and that different CPC's operated different threshold criteria despite written guidance. It indicated that there was a need to identify individuals with relevant experience to chair – need for trained, experienced and credible chairs to be identified. Management overview reports require to improve in standard and chronologies and genograms should be standard within all SCR's'. The developing involvement of parents would require careful planning and facilitation. More careful creation of action plans with specific outcomes which could be audited was required. Managing the outcome of the reviews and writing executive reports which would become public documents was a complex task. Translating findings into recommendations needed attention as the review of SCRs showed recommendations did not always follow from findings. Factors which helped implementation included recommendations which were in line with other national or local developments so that the outcome of the review could act as a further lever for change. SCR's were generally regarded as a valuable and important response to child deaths/serious incidents where there were suspicious or concerning circumstances . However, there were a range of views about their impact locally and how far lesions from the reviews were being learned. The report suggested that a whole system approach was required, this would involve developing a culture of a learning organisation by engaging agency staff regularly in examining practice in cases of "near misses".

Emerging Chid Protection Practice Themes in the review of cases SCRs

The review identified a concern that in many SCRs there was a loss of focus on the child, with attention being paid to adult members of the family/household. The SCR undertaken by Sir Christopher Kelly on Ian Huntley highlighted the complex nature of family involvement and the need to ensure that family members are kept informed. He suggested the need for a family liaison model similar to that practiced in the police force, where families were supported throughout the process and this included the reading of the report. There was evidence of poor assessment and analysis where risk indicators were not recognised and assessments not acted upon. There was a concern that professionals were over optimistic about cases, particularly about parenting capacity. Decisions were often made in isolation with poor information sharing between agencies. Evidence was found of poor recording. The review found that Child Protection procedures were often not followed. The report noted that some agencies who had expressed an interest in attending a review had been refused. Management issues included lack of management oversight, insufficient supervision and poorly trained or inexperienced practitioners/managers. The issue of confidentiality is explored in the research and highlighted the dilemmas surrounding confidentiality of information concerning family members and others in the household. Two issues were noted – first the explicit withholding of information by professionals on the grounds of respect for the confidentiality of key family members .The second issue is the contribution family

members make to the review and what they are prepared to have recorded and considered as part of the review.

The review found that there was a strong correlation of children living in neglect and a range of other parental issues e.g. addiction, mental health. There was also found to be a high number of children who are experiencing neglect in the context of a range of other family difficulties, and children living in circumstances where domestic violence prevailed, co-existing with other problems in their families such as substance misuse and mental ill health were the subject of SCR's indicating challenges for effective service provision to safeguard the welfare of children. The vulnerability of older children in the family was often overlooked, as was the vulnerability of children in transition.

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Report: Analysing child deaths and serious injury through abuse and neglect: what can we learn? 2003-5

The aim of the study was to use the learning from SCR's to improve multi agency practice at all levels of intervention including universal services and early intervention. It also aimed to analyse the ecological-transactional factors (which we also refer to as inter-acting risk factors) for children who become the subject of SCR's. As such the findings are of less relevance to police. A brief overview will be given of the key findings before turning to the specific issues concerning the police.

Overview of findings

The report provides statistical information on several aspects of the child and family's personal, familial and social circumstances.

The children
2/3 of children died and 1/3 of children were seriously injured. Almost half were under the age of 1 yr – many babies had non fatal injuries (often head injuries). ¼ were aged 1-5 yrs further ¼ were over 11 yrs – significant minority over 16 yrs – these young people were being significantly harmed or dying (many committed suicide)

Parents & Carers (sub sample of 47 cases)
Evidence of house moves for 1/3 of children and another 1/3 were living in poor housing conditions. Only a small minority had family support. Evidence of domestic abuse was found in 2/3 of cases and mental health and substance misuse were evident in well over half of the sample. In 1/3 of families there was evidence of coexistence of all three potentially problematic behaviours.

Agencies working with families
83% of families had previously been known to social work services. Little more than half were open to social work at the time of the incident. A number of cases had been closed by services for weeks/days before the incident. Only 12% of children were on the CP register

Families & Practitioner Interface
The research found that families practitioners were frightened to visit family homes of hostile families. Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm of the child and cases drifted. Where parents made it difficult for professionals to see children or engineered the focus away from allegations of harm, children went unseen and unheard. When reluctant family engagement was coupled with frequent moves of homes, records were often sketchy or inaccurate and practitioners would not be aware of the sequences of events or behaviours which might be indicative of serious risks of harm to the child or children.

How did agencies work together, share information and challenge one another?
The report identified that communication issues between agencies were prominent. There was hesitancy in challenging the opinion of other professionals which appeared to stem from a lack of confidence, knowledge, experience or status. There was a lack of thorough comprehensive social history

Typology of cases & Implications for Safer Practice
The report identified the broad but overlapping themes of neglect, physical assault, hard to help older children (aged over 13 yrs) who experienced "agency neglect, numerous childhood adversities in the majority of the cases reviewed identified that professionals had not always understood the complex combination of neglect, parental conflict, parental mental health problems and parental substance misuse.

The report examines the themes identifying factors relating to the child's mother, the child's father, the environment, the children, and engagement with agencies. There is a discussion of agency context and organizational climate which focuses on social work and health agencies. The review revealed that there were numerous childhood adversities in the majority of the cases under scrutiny and that professionals had not always grasped this. Neglect, parental conflict, parental mental health, parental substance misuse, family stress, lack of social support, families with younger children and parental history of abuse were found in different combinations in many cases. It stated that practitioners need to be curious and to think critically and systematically and workers must feel they and their agency have done their best for the child. It stressed the importance of practitioners being aware of the interacting risk and protective factors and stresses that analysing how they are playing out in the child and family dynamics is a vital step in this process.

A key issue for police was domestic violence. In domestic abuse cases police were often the main agency in contact with the family. The review identified the issue of a failure by police officers to make the link between domestic abuse and child protection.

Report: The Bichard Inquiry Report (2004)

The Report

A public inquiry report in to child protection procedures in Humberside Police and Cambridgeshire Constabulary, particularly the effectiveness of relevant intelligence

based record keeping and vetting practices since 1995 and information sharing with other agencies. This report makes recommendations on matters of local and national relevance.

Background

On 17 December Ian Huntley was convicted for the murders of Jessica Chapman and Holly Wells. Following his convection there was public outcry as it became apparent that Huntley had been known to agencies prior to the death of both young girls. He had come to the attention of Humberside police on 8 separate allegations of sexual abuse between 1995 and 1997 (and investigated in another). This information had not come to light during Cambridgeshire Constabulary vetting checks which were being carried out by Soham Education services in 2001 prior to his appointment as school janitor**.**

Issues for Humberside Police

- A key failing was the inability of Humberside Police and social work services to identify Huntleys pattern of behaviour early. Each agency viewed each incident in isolation and no links across information were made.
- Corporate and systematic failings in the way the police managed their intelligence systems. The process of creating intelligence on their main data base was severely flawed (CIS Nominals). Police officers appeared to have a lack of understanding of what and how information was recorded. Training in the use of the system was inadequate and this led to confusion during the Inquiry and records being deleted.
- There was no common understanding of what was understood by “weeding”, “reviewing” and “deletion” – consequently a significant number of records were lost without adequate review. It was unclear whether information was an error of judgement or simply a mistake, however, the “haemorrhaging” of intelligence cast doubt on the usefulness of Humberside police records.
- This situation was compounded by the fact that other police systems were not being properly used. Information was not being properly recorded on the CIS Crime system – police were unaware of the potential information contained on their data systems and there was failure to interrogate the systems adequately. The CIS2 system introduced in 1999 allowed officers undertaking vetting checks were nota ware they could access the CIS Crime system.
- At no time, during the various contacts with Huntley did the record creation system work.
- Social work services failed to share information with the police – consequently from 1995 had the police had a greater knowledge of the information held by social work the circumstances may have been different. Bichard acknowledged that it is uncertain if the outcome could have been changed – but he does indicate that this was a missed opportunity
- Humberside police failed to acknowledge the importance of intelligence. In 2002 the then Director of Intelligence recorded that there was an “alarming lack of

knowledge as to what constitutes intelligence, how it should be recorded, stored, disseminated and weeded".

- The police initially used Data protection as a reason for the lack of records, however, during the inquiry police acknowledged that the lack of recordable data was not due to data protection legislation, but rather a failing on the part of the police to collect and record all data. Bichard concluded that officers were nervous about breaching the act – he did not indicate that the legislation required to change, but rather police and other agencies were better trained to understand its relevance and boundaries.

Cambridgeshire Constabulary

Were involved in handling the vetting processes of Huntley. They too made mistakes –

- Inputted Huntley's DOB wrongly
- Checking the Police National Computer (PNC) under name of Ian Nixon and not Huntley
- Bichard concluded that Cambridgeshire failed to request via Fax information from Humberside as part of their vetting processes
- There were difficulties with Cambridgeshire Constabulary Criminal Records Bureau (CRB) while not systemic or corporate they were viewed as serious. Evidence revealed a unit which were experiencing work and resource pressures, confused work process not clearly defined, a lack of performance/monitoring/audit processes and poor training and guidance. Staff were struggling to deliver a service in the run up to the introduction of the national CRB.
- Police intelligence systems were not able to link with each other and commented on the fact that Scotland was introducing a national IT intelligence data base which could be accessed by all force areas. This was a major failing in the intelligence process. The review commented on previous reviews relating to the Police National Computer into the recording of police intelligence which highlighted a failure of forces to record intelligence appropriately – this had been over several years.

General

The Home Office introduced a Code Of Practice to ensure that progress is made and improvement continues. The quality and timelines for entering data were to be monitored via the Police Format Framework and Performance Baseline Assessments.

An national IT intelligence and a secure PNC were key recommendations of the inquiry.

A lack of practice across the 43 police force areas made the loss of valuable information through deletion more probable as in Humberside.

A National Code of Practice which covers record creation, retention, deletion and information sharing which was easily understood was a key recommendation

The review concluded very serious failings in senior management in Humberside Constabulary.

There were criticisms of ACPO for failing to set intelligence standards (quality of data input and timelines for input)

Recommendations for Improvement

1. A new system for recording those working with vulnerable children & adults
2. A national IT intelligence system (this has already been implemented in Scotland)
3. Clear guidance on record creation, retention, review, deletion and the sharing of information
4. Referral of sexual offences against children and subsequent action - social work should report all incidents of under age sex to the police and guidance was to be produced for social work to fully record all cases where a decision is taken not to inform police and all such decisions should be reviewed by external audit
5. Training for all who are involved in appointing people to work with children.

Cann J (13.07 date not known) Assessing the extent of discretionary disclosure under the multi- agency public protection arrangements (MAPPA

Research was undertaken as part of the Home Office review of management of child sex offenders in England and Wales. The focus of the research was an examination of the principle of discretionary disclosure to third parties not otherwise involved in their management. The research provided a snapshot between January and June 2006. There was a variation in areas having disclosed and differences in the methods by which disclosure was initiated and in the procedures which followed. For example , in some areas social work gained information via MAPPA processes and in others via child protection procedures. The recommendations were to revise existing MAPPA guidance to include protocols regarding processes for disclosure with offenders managed at MAPPA level 1, to develop the guidance to include procedures for undertaking disclosure via child protection procedures. The report stated that practice should be consistent both across and within areas, although this should not interfere with the current flexibility of disclosure which allows police and probation officers to use their discretion. Finally, it should be a requirement for all areas to record when a decision has been made and to whom the guidelines for such recording.

4. FINDINGS FROM THE SAMPLE OF SERIOUS CASE REVIEWS

4.1 Findings from the sample of Serious Case Reviews

The analysis of the random sample of twenty two Serious Case Reviews provided more detailed case specific information with regard to police specific issues and recommendations. The key areas identified relate to interagency working, communication across forces and within forces, processes of referral and notification, data management and response to domestic abuse incidents involving a child. Some specific child protection issues were also identified in individual cases

Interagency communication

Recommendations for police to improve general interagency communication arose in a number of SCRs (Bristol 2008, Hull Kirklees 2008, 2006, Sheffield 2005, Lincolnshire 2005, Lincolnshire 2007). In some cases concern had been expressed with regard to police procedures and protocols with regard to notifying concern to other relevant agencies. In one case police did not routinely contact social work following attending at an incident of domestic violence where there were children in the household (Sheffield 2005). In this case it was identified that police failed to undertake follow up checks other than an area search and failed to check on the welfare of other individuals or children at the home address.

A review in Hull (2006) examining the death of a child through arson, recommended that police who attended incidents for reasons relating to safety (fires, domestic violence, assaults) should be reminded of the need to make inquiries about the presence of children and complete the necessary referral forms to the Family Protection Unit. It also recommended that when police have established that a child is in the house during an investigation they must do an analysis of risk to determine the referral mechanism to Children and Families, through Common Assessment, Safeguarding processes or through Child Protection procedures. This same review identified that liaison between police and fire services needed to be addressed. In both police and fire service, not all incidents of fires were routinely reported to the other agency. (There had been a history of 16 incidents in 15 years in this household). The SCR recommended that the liaison between the police and fire services should be renewed in the light of that review. In another case of a child dying as a result of fire, it was identified that there had been previous involvement of the police with regard to domestic abuse and this had not been referred to relevant agencies. This review recommended that police policy should be changed to ensure that there was no element of discretion on the part of officers investigating domestic violence as to when child concerns were notified and that notifications should take place whether children were present in the household or not. The Newcastle 2008b report also recommended that there should be removal of discretion with regard to the reporting of domestic violence.

The Bristol (undated) review identified lack of interagency communication with regard to boys and young men with sexually harmful behaviour. In this case it was recommended that in order to improve interagency working the police investigation team should have the lead in all investigations of sexual abuse involving a child whether as victim or perpetrator, including non-familial cases, in order that multi agency procedures are complied with. In a case where three girls were missing from care, sexually exploited and falsely imprisoned, liaison between police and social services were criticised and the need for all agencies to ensure good cross agency and cross border interagency work took place and Missing from Care protocols followed. In a later review in Lincolnshire (2007) the necessity for police and the Crown Prosecution Service (CPS) to consider making inquiries of health and education in all serious or significant case reviews was identified. The necessity for improving liaison arrangements when in non emergencies police support is required for the completion of a formal mental health assessment was identified in one SCR (City of Hackney 2008). The Devon (2008) report recommended that police respond to all historical requests for information.

Recommendations were made with regard to improving the nature or processes of information sharing in the Warwickshire (2008) review which recommended that this should be done electronically. Along with Gloucestershire (2008), the Warwickshire review also recommended that agency chronologies should be made available to all agencies. The Warwickshire review further recommended that when information is shared or received with regard to serious child welfare concerns, there should be a discussion between the two agencies as to what steps are necessary, including possible recode checks to establish whether any previous child welfare concerns exist in relation to the individual in question.

The provision of information by police to the CPS was a feature of three case reviews (Bury 2006, Gloucester 2008, Sheffield 2004). The necessity to engage in early consultation with the CPS where children had communication difficulties was identified in the (Bury 2006) review alongside the recognition that such a conversation should include discussion of strategies for evidential interviewing of child victims or witnesses. This review also recommended that police should ensure that they re-circulate procedures for the use of suitably qualified and experienced people for interviewing children with learning disabilities. The need for police to inform the CPS of incidents of domestic violence arose in the Gloucester and Sheffield reviews. The failure of the police to give accurate information to the CPS about previous incidents of domestic abuse was criticised in the Gloucester review and a recommendation made that the police should record each requests for help as a separate incident. The Sheffield review noted errors in the police file to the CPS relating to domestic abuse and the review recommended that supervising investigative officers should ensure all cases are properly progressed to the CPS and that communication with the CPS is in writing.

Distribution of police intelligence was a feature of several reviews (Sheffield 2005, Northumbria 2008). The necessity for police officers to carry out checks on individuals present in homes, to re-attend the address at a later date and to complete a crime submission report when an offence, in this case domestic violence, is suspected of taking place was also identified by the Sheffield (2005) review. The need to remind officers that that they have the capacity to request follow on strategy discussions during complex or protracted investigations was highlighted in one review (Haringey 2008). Following the sexual abuse of a 9 year old child the Peterborough (2008 review)

recommended that the CRB and police are reminded that information on child protection allegations against prospective foster or adoptive parents must be included in CRB checks.

Communication between and within police forces

Information sharing between constabularies was commented on and recommendations for improvement made in four cases (Bristol 2008a 2008b, Lincolnshire 2005, Sheffield 2004, Newcastle 2008a Newcastle 2008b). The need for information about drug warrants to be communicated to Child protection Teams was a feature of Bristol 2008a. In the Bristol SCR the concerns related to the importance of sharing intelligence between force areas where it is known an offender moves to or frequents and in the Lincolnshire SCR they related to the tracking of children missing from care.

Communication within forces was a significant issue in three cases. One was in relation to the accuracy and completeness of information passed between Domestic Abuse and Family Protection Units (Gloucester 2008, Newcastle 2008b). The second was concerned with the role of Communication centre staff (Newcastle 2008a). The review recommended that there should be continued awareness raising traning of staff, specifically 1st response officers/ supervisors and enquiry clerks to develop their awareness and knowledge with regard to the submission of child concern notifications (CCN). This awareness raising would include what constitutes a concern for a child, the importance of submitting a CNN and when to submit a CNN. In this case the issue of concern was domestic violence. The report stated that submitting a CNN for every arrest a young person is involved in would overwhelm agencies but it recommended that consideration should be given to force policy with regard to the police information that clerks would include when carrying out checks for children referred to CCNs. This would address the issue of those children who come into regular contact with the police but who are not arrested for criminal offences and would alert concerns for children at an early stage. Sheffield and Nottingham (2008) case review and London Borough of Redbridge recommended that the police should treat assaults on children as high priority.

Data Management

The recording and management of data was an issue in two serious case reviews. The Barking and Dagenham (2008) review recommended that the LSCB ensure that the Metropolitan Police, in conjunction with other agencies to which reports are generated by the MERLIN data base are sent, should review the effectiveness of the current system. Concerns were raised about the consistent completion of MERLIN and the consequent police notification to other agencies. This was linked to the efficacy and common understanding of risk assessment. The review also recommended the consideration of how other agencies would be notified when a child's identity and address were not known. The Sheffield and Nottingham (2008) case review recommended that the police forces should ensure all 6 intelligence systems are streamlines so they can be checked simultaneously whenever a request is made form another agency for a CRIMS check and that an audit of police intelligence systems should take place to ensure that any

individual who is involved in repeated child abuse allegations is duly recorded (irrespective of a prosecution or not).

Training

A number of areas for additional training were required. Interagency or police only training in the area of domestic abuse was recommended in two reviews (Essex 2006, Newcastle 2006). Awareness training with regard to fire raising offences was recommended for all agencies and joint training for police and fire officers was recommended focussing on language, expectations and thresholds in the Hull (2006) review. A recommendation to address the lack of training for working with boys and young men with sexually harmful behaviour to raise the levels of understanding and interagency work as recommended by the Bristol (undated review).

Specific child protection issues in individual cases

- Clearer practice guidance with regard to work with gypsy travellers (Gloucestershire (2008).
- Police should consider the safeguarding of children when issuing an Osman warning (Hull 2006)
- Review by dip sample of Child Abuse Investigation Team investigations to see if the two considered by the review were reflective of the team's general standards (Haringey 29006)
- When police obtain information about the whereabouts of a missing person, who returns to an area, this should be recorded either as intelligence or a report and if this is not the case the reason needs to be known.

5. CONCLUSION

The report of the literature review of recommendations of child abuse inquiries in respect of the Police Force has drawn together a range of historical and contemporary literature. A summary of issues is presented below.

The analysis of the UK wide literature identified consistent key general themes and police specific issues with regard to child protection work.

General child protection and interagency working

- Inconsistency in interpreting roles and responsibilities
- Reluctance to share information
- Lack of induction, supervision and training
- Lack of coordination between different forums
- Differing thresholds
- The voice of the child being lost in child protection inquiries
- Difference of agency culture
- The need for a common language
- The need for chronologies in case notes and reports
- Lack of management oversight
- The issue of confidentiality needs consideration
- Reluctance of practitioners to work with hostile families
- Misjudgement of apparent cooperation of parents
- The need to be aware of the interacting risk and protective factors
- Revise existing MAPPA guidance to include protocols regarding processes for disclosure

The remit and conduct of Local Safeguarding Children Boards and Serious Case Reviews

- The need for Local Safeguarding Children Boards to develop a stronger learning culture
- The need for LSCBs to recruit resource trained and credible experts in their field
- The need for considered reports and actions plans to be made following SCRs.
- Careful consideration of involvement of family members in SCR processes

Police specific concerns

- The issue of workloads of police mangers in child protection
- The concern re low status of police child protection teams (earlier reports)
- The lack of knowledge of uniformed officers re child protection
- The need for improved interagency information sharing e.g. fires, assaults and in particular domestic abuse, people within and external to the force of child protection issues.
- The need for improved interagency information sharing with regard to boys and young men with sexually abusive behaviour
- The need for improved communication between police and CPS
- There should be no discretion in the reporting of domestic abuse and full and accurate information should be given to relevant agencies
- The need for sharing of intelligence as appropriate with other agencies
- The lack of national and local strategies with regard to MAPPS
- Lack of focus of child protection at a national policy level
- The need to incorporate diversity policy into child protection work
- Limitations to management information collected
- The need to develop and adhere to protocols on abscondees and missing persons
- The need to ensure that crimes against children are treated as seriously as crimes against adults.
- The need for managerial supervision and support
- The need for child protection training as appropriate to role and level.
- Inadequate data management systems, proliferation of systems locally and nationally that were not connected.
- Corporate and systematic failings in the way police managed intelligence systems
- The need for information sharing and cooperation between police forces.

The review of the literature identified general child protection practice and interagency and police specific concerns which related directly to policy and practice in Scotland.

General child protection and interagency working

- Information and communication sharing to be improved, particularly in respect of frequency and clarity of the kinds of information shared pre and during CPCs
- Clarity of roles and responsibilites required
- The need for a protocol on the clarity and purpose of information sharing
- The need for intervention strategies for vulnerable families and children
- The need for early discussion of concerns

- The need for rigorous and robust assessment processes
- The assessment of parents with substance misuse issues a serious concern
- Standards of recording of concern. Need for a comprehensive multi agency electronic system
- The need for a multi agency chronology of events
- The need for coordinated action plans
- Clarity is required into decision making processes
- Targeted training required
- Public information documents to be more widely available
- Child protection case conferences concerns with regard to clarity of purpose and roles and responsibilities, attendance, provision and quality of reports, recording of decision and tracking outcomes.
- Areas for awareness raising an training identified
- Need for development of protocols identified.

Police specific concerns

- Failure of police to share information at all stages of the investigation, early sharing of information important
- Importance of sharing information re lifestyle which may not appear to have direct connection with child protection
- Poor initial recognition and decision making.
- JIT protocol to be adhered to at all stages in line with force and interagency guidance
- Data management concerns with regard to recording of information
- The inadequacy of existing data bases.,
- Concerns with regard to systems for sharing information within and between forces and with other agencies.
- Recording of decision making to be improved in order to provide audit trail
- Lack of adequate referral to more specialised areas of police force
- All incidents of inappropriate sexual behaviour to be investigated by police
- Appropriate use of risk assessment tools to be considered.
- Rolling programme of changes needed.
- Status of child protection work, support and staffing issues to be addressed.
- Scottish wide approach to be taken with regard to when drug searcher undertaken and referral to child protection made. Identification of officers who investigated to be communicated
- The need for consideration of how other agencies can access policed records, including intelligence information.
- Police representative at CPCs should have adequate information, training and experience.
- Quality of information and reports to CPCs to be considered.

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