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Serious case reviews 1998 to 2019: continuities, changes and challenges

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Part 1: Introduction

Serious case reviews (SCRs) were introduced in the first edition of *Working Together*, published on the same day as the Cleveland inquiry report in July 1988. They were replaced by a new system of local child safeguarding practice reviews (LCSPRs) in 2018-19. There was a transitional period over that last year, when a case might go to one or the other, depending on whether the local agencies had established a new child safeguarding partnership, but it was no longer possible to initiate an SCR after the end of September 2019.

Government-commissioned periodic overviews of SCRs have reported on the cases and findings from 1998, with the last one covering cases in 2017-19 (Dickens et al 2022a). The purpose of this report is to give a final overview of the major continuities, changes and challenges for SCRs and practice over the 21-year period covered by the periodic reviews.

The report is in six parts. This part gives a brief history of SCRs and the periodic reviews. Part 2 considers some of the definitional issues about what sort of cases fall within the ambit of 'serious case reviews', and the widening types of harm that now come into the child safeguarding system. Part 3 highlights the recurring messages for practice from SCRs. Part 4 sets the SCRs and the practice they reflect in a wider context. It draws attention to organisational changes and restructurings, attempts to improve the operation of the child protection system, and the challenges of rising demand and limited resources for child welfare services. Part 5 focuses on the SCRs themselves, summarising the long-standing concerns about the quality of SCRs, and also important changes that have occurred over the period, regarding publication and the greater involvement of families and practitioners. Part 6 discusses the impact of SCRs (how effective have they been, and how helpful?) and draws out the messages for the new reviewing system.

Continuities, changes and challenges can be understood, in broad terms, as old problems, new problems and hard problems. There are old problems, in the sense of the recurring criticisms that SCRs have made of safeguarding practice, but also the criticisms that have regularly been made of SCRs. There have been new problems, in the sense of changing types of harm, new organisational structures and models of practice, and changing requirements for SCRs. There are hard problems, partly in the sense of how difficult it has proved to tackle the perennial issues, but also in terms of the wider context, the nature of the work and its social, political and legal frameworks.

It should also be remembered that the SCR cases are 'hard cases', in the sense that they are unusual events and it may be misleading to regard them as a fair reflection

of all practice; and of course, the reviewers have the luxury of hindsight. There are relatively few SCRs compared to all the children referred to children's social care (over 650,000 referrals in 2018-19), or all the children on child protection plans (over 52,000 on 31 March 2019). Many of the reviews identify some elements of good practice as well as shortcomings. On the other hand, other research, reviews and inspections find similar problems (e.g. in the quality of assessments, information exchange, availability of services). They are not entirely out of the ordinary, and there are important messages for policy and practice from these hard cases.

So whilst it is concerning to find many of the same messages being repeated, this may not be because practitioners, managers and policy-makers have simply failed to learn the lessons, but rather because the work is complex, often ambiguous and highly challenging. The criticisms need to be understood at three different levels, which continually interact and influence one another – practice, organisational structures and cultures, and also wider social policies and societal values.

The history of SCRs

Long before the introduction of SCRs, there had been locally-based reviews of cases where children had died or suffered serious harm (see DHSS 1982 and DH 1991 for overviews), and the new system in 1988 was designed partly in response to the high profile public inquiries of the 1980s as well as calls for more formal guidance for local reviews (Rose and Barnes 2008: 24). The 1988 guidance was subtitled 'A guide to arrangements for inter-agency co-operation for the protection of children from abuse' (DHSS and Welsh Office, 1988), and the requirements for SCRs – at that time simply called 'case reviews' – were set out in Part 9 (in the 1991 revision of *Working Together* it moved to Part 8, and they became known as 'Part 8 Reviews').

The 1988 guidance specified five main objectives: to establish the facts; to assess whether decisions and actions were reasonable and responsible; to check whether procedures had been followed; to consider whether the services provided matched the needs of the case, bearing in mind resource availability; and to recommend any appropriate action. The aim was that reviews should be completed 'within two or three weeks', and that any lessons to improve services for children and families should be acted upon promptly and effectively.

In 1999, under the Labour government of the time, there was a major revision of *Working Together*. The title changed, reflecting a wider focus on prevention of harm and promotion of well-being: *Working Together to Safeguard Children: A guide to inter-agency co-operation to safeguard and promote the welfare of children* (DH et al 1999). One of the drivers for this new approach had been the findings from 20 research studies into the operation of the child protection system that had been

commissioned in the late 1980s by the Department of Health (the relevant government department at the time). The findings were summarised in DH (1995), which highlighted how 'enquiries' into children's well-being had become dominated by an investigative approach, and that in over the half the cases families received no services as a result of the intervention (DH 1995: 39). The messages provoked a call for the 'refocusing' of child and family services for greater support rather than investigation (Platt 2006). Getting the right balances between investigation, protection and support remains one of the oldest and hardest problems and takes new forms as new types of harm are identified, new ways of working introduced and new organisational structures created.

The 1999 edition of *Working Together* expanded the guidance on case reviews considerably, and revised the aims to three: 'to establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together…; what those lessons are, how they will be acted on and what will change as a result; and therefore, to improve inter-agency working and better safeguard children' (DH et al 1999: 87).

The guidance went on to emphasise that the reviews should be carried out, as far as possible, so that they were a learning process not an ordeal; that recommendations should focus on a small number of key areas, with specific and achievable proposals for change; and that 'at least as much effort' should go into acting on the recommendations as conducting the review (DH et al 1999: 94).

There was a requirement that the reports should be submitted to the Department of Health, but there was no central record of how many took place or what the findings were. It became a requirement to publish an executive summary in 1999, and to publish an anonymised version of the full report in 2010, unless there were good reason why not. As well as the two government-commissioned overviews of the earlier reviews (DHSS 1982, DH 1991), there had been other independently initiated research (e.g. Reder et al 1993, Munro 1996, Reder and Duncan 1999) but it was not until the publication of the 1999 guidance that regular government-commissioned overviews were established.

1.2 The periodic reviews of SCRs

The first review (Sinclair and Bullock 2002) covered the years 1998-2001, and comments on the difficulty of finding out how many reviews had been completed. Rather than trying to track them all down and do a comprehensive overview, it took a sample of 40 cases, half from before the 1999 guidance, and half afterwards (it estimated there were probably 90 reviews per year across England and Wales). The second biennial review covered the years 2001-2003, and once again took a sample

of 40 cases (Rose and Barnes, 2008). It was not published until 2008, partly because of difficulties with the incomplete nature of the records.

The third and subsequent reviews have been led or co-led by teams based at the University of East Anglia (with colleagues from the University of Warwick for the 2009-11, 2011-14 and 2014-17 reviews, and the University of Birmingham for the 2017-19 review). For these seven reports, it was possible to determine how many reviews were commissioned over the period and get information on nearly all of them, and then focus on a sub-sample in order to complement the overview with an in-depth analysis of a smaller number. There is data from more than 1,700 cases over the seven later reports.

All the overview reports include a summary of the legal, policy and practice context at the time and what had changed since the previous overview, but the 2007-09 and 2011-14 reports include longer summaries of the history of SCRs, highlighting the continuities and changes in the findings and the reports (Brandon et al 2010, Sidebotham et al 2016).

As well as a careful re-reading of the nine reports and related materials such as the reports from the Munro review of child protection (2010, 2011a, b) and the Wood review of local safeguarding children boards (2016), we also held two online 'knowledge exchange events' with managers and practitioners from local child safeguarding agencies, to hear their experiences of how the reviewing of serious cases and the practices they reflect have changed over time. These were organised by *Research in Practice* in early 2022 and are reported fully in the 2017-19 review (Dickens et al 2022a); we thank those who attended for their helpful insights.

There is a table with details of all the SCR overview reports at the end of this review. All the reports are free to access and download from the Serious Case Review website hosted by *Research in Practice*: https://seriouscasereviews.rip.org.uk/.

The NSPCC hosts the online national case review repository. This was started in 2013, and now contains over 1,500 serious case reviews from England, Scotland and Wales. The NSPCC has also produced a series of thematic briefings which highlight key messages from the reviews, with an emphasis on recommendations for practice. The reviews and the briefings can be accessed free of charge at https://learning.nspcc.org.uk/case-reviews/national-case-review-repository

Part 2: Changing understandings of harm and the profile of SCRs

This part highlights some of the definitional issues about what sort of cases fall within the ambit of 'serious case reviews', and the widening types of harm that now come into the child safeguarding system, notably the increased focus on adolescents and extra-familial harm.

The criteria for a case to be reviewed as an SCR were adjusted in different editions of *Working Together*, but the core elements over time have been that a review *had* to be undertaken if a child had died and abuse or neglect was known or suspected to be a factor; and *could* be called if a child had suffered serious harm, abuse or neglect was known or suspected, *and* there was cause for concern about the way that local agencies and professionals had worked together (the 2015 version of *Working Together* heightened this 'possibility' by specifying that it must be called 'unless there is definitive evidence that there are no concerns about inter-agency working'.)

Inevitably these decisions involve a degree of interpretation, notably whether the harm is considered 'serious', and the extent to which abuse or neglect is seen as a direct cause rather than a background factor (i.e. has it contributed enough to warrant an SCR?). They also reflect levels of awareness of the issues. This is demonstrated by changes in the age pattern, regional differences, and changes in the nature of the harms suffered.

2.1 The changing profile of children in SCRs

The changing age profile of the children over time is shown in Table 1, starting with the third review (2003-05) when fuller data became available. The largest number of cases in each period relate children under the age of 1, but the proportion is lower now than it was at the beginning of the sequence. Under-1s made up nearly half the cases in the 2001-03 and 2005-07 cohorts, but this has fallen to 37% in the final review. The second largest age category is now young people aged 16-17, comprising nearly a fifth of the 2017-19 cohort, twice what it was at the beginning. The increase has come in the last ten years, since 2011, and jumps up notably in the final review.

In this report, n= Total number of cases

Table 1: Age profile of children in SCRs over time

	2003-5 (2 yrs) n=161	2005-7 (2 yrs) n=189	2007-9 (2 yrs) n=280	2009-11 (2 yrs) n=178	2011-14 (3 yrs) total n=293	2014-17 (3 yrs) n=368	2017-19 (2.5 yrs) n=235
Under 1 year	76 (47%)	86 (46%)	123 (44%)	64 (36%)	120 (41%)	154 (42%)	86 (37%)
1-5 years	33 (20%)	44 (23%)	60 (22%)	51 (29%)	64 (22%)	79 (21%)	46 (19%)
6-10 years	11 (7%)	18 (10%)	26 (9%)	21 (12%)	28 (10%)	20 (5%)	20 (9%)
11-15 years	26 (16%)	20 (11%)	40 (14%)	27 (15%)	41 (14%)	63 (17%)	38 (16%)
16+	15 (9%)	21 (11%)	31 (11%)	15 (8%)	40 (14%)	52 (14%)	45 (19%)

The overview reports find that fluctuation in the annual number of SCRs turns on the number of serious harm cases and the 'deaths related to maltreatment' (see further below), both aspects where there is more room for interpretation. The number of SCRs for deaths that are directly caused by maltreatment, where there is less ambiguity, has changed very little, staying at about 28 per year up to the 2014-17 review (Sidebotham et al 2020: 32). It falls in our most recent review, but we need to be cautious about this decrease because of the overlap with LCSPRs.

The overview reports have also consistently found regional differences in the rate of commissioning SCRs, indicating the impact of local interpretations and local culture. The 2011-14 study found that larger authorities tended to carry out fewer SCRs per head of population, and a greater proportion of SCRs on fatal cases compared to serious harm (Sidebotham et al 2016: 33). They suggest that this may reflect the higher child protection workload in these authorities, making them less likely to commission the more 'discretionary' serious harm SCRs. They also found 'a slight, statistically significant trend towards higher rates' of both all SCRs and fatal SCRs in those authorities with higher levels of deprivation (Sidebotham et al 2016: 34).

The balance between cases of death or serious harm changed over the period as well, as shown in Table 2. Cases where the child had died stay in the majority, but the proportion has gone from 66%-33% in 2003-05, to 56%-44% in the final review. This may reflect the wider awareness and understandings of abuse and neglect, including extra-familial harm. (In the 2021 review of LCSPRs the authors found that serious harm cases are now in the majority – Dickens et al 2022b.)

Table 2: Proportions of death and serious harm cases in SCRs over time

	2003-5 (2 yrs) n=161	2005-7 (2 yrs) n=189	2007-9 (2 yrs) n=280	2009-11 (2 yrs) n=178	2011-14 (3 yrs) n=293	2014-17 (3 yrs) n=368	2017-19 (2.5 yrs) n=235
Death	66%	65%	56%	66%	67%	57%	56%
Serious harm	34%	35%	44%	34%	33%	43%	44%

Death and serious harm are themselves broad categories, and in the categorisation used in the overviews, the largest sub-category of death cases is 'death related to maltreatment' – which is itself broad and open to interpretation. It includes (amongst other causes) sudden unexpected deaths in infancy (SUDI) where there are clear concerns around parental care but the death remains unexplained or is attributed to a natural cause; fatal accidents where there may be issues of parental supervision and care; and deaths of older children where there is known to be previous maltreatment, but where that did not directly lead to the death, such as suicide or risk-taking behaviour, including substance abuse (see Brandon et al 2020: Appendix B, pp 248-9).

2.2 Changing understandings of child abuse and neglect

The changing profile of SCRs – more cases with older children, more with serious harm – reflects changing understandings of child abuse and neglect. Some forms of harm that might not have come into the child safeguarding system before, are now more likely to do so. This stems from a number of factors. There is a sharper awareness of long-term harms suffered within the family, such as the impact of neglect, domestic violence, and drug and alcohol misuse (Daniel et al 2011, Brown and Ward 2012, Davies and Ward 2012), and also debates about the impact of poverty and deprivation (e.g. Featherstone et al 2014, 2018; Bywaters et al 2014, 2016, 2018; Bywaters and Skinner 2022; and discussed in the 2017-19 overview, Dickens et al 2022a).

There is also a new awareness of extra-familial harms, such as child sexual exploitation, child criminal exploitation (including 'county lines' exploitation of vulnerable young people for drug-running), online abuse, radicalisation, trafficking, and peer-on-peer violence. The term that has been coined for the need to respond to these new aspects is 'contextual safeguarding' (Firmin 2017; Firmin et al 2019).

Child sexual exploitation and death by suicide are discussed below to illustrate the changing awareness and understandings of harm.

2.2.1 Child sexual exploitation

The issue of child sexual exploitation (CSE) was brought to particular prominence by the report into the abuse of around 1,400 children in Rotherham between 1997 and 2013 (Jay, 2014) and SCR reports into cases in Rochdale (RBSCB 2013) and Oxfordshire (OSCB 2015). The 2017-19 overview found that CSE was known or suspected to be a factor in the backgrounds of 37% of the children aged 11 and over where there had been an SCR, up from 24% in 2014-17; although it notes that the numbers are relatively small and it is not possible to say whether this reflects increased incidence or increased practitioner awareness (or what combination).

There is nothing new about child sexual exploitation, in the sense that is has happened for centuries, but was not called that – 'child prostitution' was a public concern in Victorian times. Statutory guidance on safeguarding children from child prostitution was published in 2000 (DH et al 2000), and revised in 2009, under the new title *Safeguarding Children and Young People from Sexual Exploitation* (DCSF 2009). The 2009-11 biennial review has a section on extra-familial sexual abuse (Brandon et al 2010), but the term 'child sexual exploitation', 'CSE', is used for the first time in the 2011-14 periodic review (Sidebotham et al 2016). The guidance was updated again in 2017, but now non-statutory (DfE 2017).

The 2011-14 report emphasises the importance of 'getting alongside' the young person and building trusting relationship with them. There were some good examples of this, often from unqualified, voluntary or specialist workers, but all too often the child's voice was not heard. Resource issues were seen as a factor *('Lack of staff, high staff turnover, over-use of unqualified staff, inadequate supervision, a lack of professional curiosity and a sense of helplessness and low morale were often identified as reasons for a lack of timely and holistic assessments and appropriate planning*': Sidebotham et al 2016: 129), but also there was evidence of professionals blaming the young women for their behaviour (e.g. 'prostituting herself to pay for drugs'), or denying that CSE was taking place in their area.

2.2.2 Suicides of young people

Figures for the suicide of young people further illustrate the issues of identification and awareness. Suicide is barely mentioned in the first two overview reports. In the second, two of the 45 children (from 40 cases) were reported to have died from suicide (Rose and Barnes, 2008: 79); but from the third review onwards a bigger picture emerges. In the third review, the first with the full database, the researchers found that 14 of the 161 cases were suicides – that is, 9% of all the cases and 13% of the deaths (Brandon et al 2008). The authors warn about the difficulties of identifying suicides with certainty; for example, that it can be difficult to tell the difference between a tragic accident and suicide (Brandon et al 2008: 86). By the time of the final review, 2017-19, the study found 21 suicides in total, 30% of all deaths. Suicides comprised 7 out of the 11 deaths of children aged 11-15 (63%), and 14 of the 18 deaths of young people aged 16-17 – over three-quarters of that group (Dickens et al 2022a).

The example raises fundamental questions about how much suicide has 'really' increased, or whether the increase is because there is greater awareness of it now, so cases are more likely to be identified as suicide (or, what combination of those). The National Child Mortality Database (2021) estimated about two suicides per week by young people aged under-18 in England in 2019-20, so the majority do not lead to SCRs.

Suicide was addressed in detail in the 2011-14 report. The authors noted common characteristics of the cases and the challenges and complexities of the children's lives, including parental substance misuse and domestic violence, time spent in care, and mental health problems including self-harm and involvement with children and adolescent mental health services (CAMHS) (Sidebotham et al 2016: 100). But the majority of young people with such features in their backgrounds do not die by suicide, and the majority of young people who do take their own lives do not have backgrounds of abuse or neglect that would make them the subject of an SCR. There are no straightforward correlations – a point which applies more generally, to all the child and family risk factors, that they cannot be treated as guaranteed predictors of abuse.

2.3 Levels of involvement with children's social care

Over time, the proportion of children who were open cases to children's social care at the time of the incident has increased, from 42% in the 2009-11 overview to 57% in 2017-19 (note though, the data is more complete in the later periods). The 2017-19 overview also showed that 19% were previously known but their case was currently closed; and 23% had never been known (Dickens et al 2022a). For

comparison, in 2009-11, 23% were closed and 21% never known. So the pattern over the period is that the children are open or known to children's social care in the majority of SCRs; but only a minority were on a child protection plan at the time of the incident, or had previously been on one. The 2017-19 overview found that 40 children died or were seriously harmed whilst on a CP plan, out of a total of 168,640 children in England who became the subject of a CP plan over the period. But a further 30 children died or were seriously harmed who had previously been on a CP plan, and a significant number of the children were known or open to children's social care at 'child in need' or early help level.

There are three important implications from these findings, highlighted in the overview reports. First, for recognition that children on CP plans are generally well protected from further serious harm, especially given the complex and challenging policy and practice contexts; but secondly, for a sharper awareness that children subject to 'child in need' plans, especially those close to the threshold for a CP plan, may be particularly at risk of serious harm. The third aspect is that all those working with children and families, in universal and early help services, health, teaching and police, not only local authority social workers, need to be aware of children's need for protection.

Part 3: Key practice issues

There are consistent and repeated messages for practice from SCRs, especially regarding the quality of assessments; the importance of seeing and hearing the child (literally and metaphorically); the nature of relationship-based work and the place of 'professional curiosity' and questioning; weaknesses in inter-agency co-operation and information-sharing; poor decision-making and lack of inter-professional challenge, and the vital role of effective supervision for staff. These are old problems, and the repetition of them over such a lengthy period (and indeed, long before it) has given rise to strong frustrations with the SCR system, for being ineffective, costly and slow, discussed in more detail in Part 4.

It is important to set the SCR criticisms of practice in context. They do seem like 'old problems', but that is because they are hard problems, in two senses: first, the intrinsic difficulties of the work, the competing goals of child protection work and the unstable balances that often have to be struck; but secondly, hard in the context of high pressures and workloads, and restricted resources, including time.

3.1 Developing good practice

Building good relationships with parents, young people and children is generally seen as the key to supporting them and helping them to make the necessary changes in their lives. Important elements include recognising and building on their strengths, listening to their views and talking clearly and honestly with them, and spending enough time with them to do these things. The importance of relationship-based work was recognised by the Independent Review of Children's Social Care (in its interim report of June 2021: Independent Review 2021). At the time of finishing this report, April 2022, the final report was awaited, and it has since been published (MacAlister 2022). Also at that time, the British Association of Social Workers, BASW, was running a campaign to uphold relationship based social work, saying that its members were 'frustrated that they are spending too much time on administration tasks, instead of direct relationship-based work with children and families' (BASW website, April 2022). The difficulties of balancing procedural and administrative tasks with spending time in direct work with families is another of the 'old problems' in children's social care. As long ago as 1992, David Howe spoke of the 'bureaucratisation' of social work (Howe 1992), and it was highlighted by the Munro review of child protection in 2010-11 (see below).

The overview of the 2014-17 SCRs commented that relationships with families were 'the primary vehicle for protective practice', and often featured in examples of good practice in the SCRs, but they had to be based on 'a sound grasp' of the family

context and circumstances if they were to be effective in managing 'the complexity of compound and cumulative risk over time' (Brandon et al 2020: 80).

Challenges for relationship-based work include the episodic, incident-focused nature of much intervention (cases being opened and closed again, not always with good evidence that anything had changed), and frequent staff changes and turnover. But reviews also show that other practitioners, not just social workers or health visitors, can provide the sort of relationships that are effective – for example, teachers, youth workers, family support workers, housing officers, police officers, mental health workers, and adult social care workers. The 2011-14 review commented on the frequency of cases not being in child in need or child protection services at the time of the incident, showing that:

> *… more general universal and specialist services play an important role in the child protection system. This means that practitioners from these services need to be alert to the opportunities to work to prevent serious maltreatment and also to pass on information and refer on concerns about abuse or neglect* (Sidebotham et al 2016: 241-2).

A further challenge is the potential for loss of focus and objectivity, noted in the 2014-17 review. This highlighted problems arising from over-familiarity or over-optimism, such as small improvements on one area detracting attention from other risks and the experience of the child. In one example, workers did not recognise that the mother and her extended family were deliberately misleading them (Brandon et al 2020: 80). Balancing support for the parents with a clear focus in the wellbeing of the child is one of the 'old problems' and 'hard problems' for child safeguarding work.

3.1.1 Signs of Safety

A notable example of a relationship and strengths-based model of practice that has been widely adopted in recent years in England is the 'Signs of Safety' approach. It was promoted as part of the DfE children's social care Innovation Programme (see Part 4.3 below). By 2020 it was being used 'in some form' by two-thirds of local authorities in England (Baginsky et al 2020: 7; see also Munro et al 2020).

Baginsky et al (2020: 8) characterise it as 'a strengths-based approach to child protection casework … underpinned by a commitment to work collaboratively with parents/carers and children to conduct risk assessments and safety plans that focus on a family's strengths, resources and networks'. Their evaluation found 'little evidence to support the claim that SofS leads to better practice or reduced risk for children' (Baginsky et al 2020: 12). The response from Signs of Safety is that this tells us more about the quality of implementation than the impact on families, and they highlight how difficult it is to introduce 'another set of demands into a busy and

complex environment without clear commitment and making it fit' (Murphy 2021). The point is a crucial one: that practice has to be understood in its organisational contexts (cultures, leadership, resources) and its complexities (e.g. to support families and safeguard children, to intervene swiftly and to give people time).

3.2 Recurring issues

3.2.1 Assessments

Poor assessments were mentioned as one of the most frequent concerns in the first review of SCRs (1998-2001), and this criticism is repeated across the subsequent reviews. Given that around half the cases that led to SCRs were not in the child in need or child protection systems at the time of the incident, the quality of 'front door' assessments is crucial. Another recurring concern is reluctance or inability to revise assessments of a child or family in the light of new information, or to see things only from one point of view – say, neglect – and therefore not recognise warning signs about other forms of maltreatment (Brandon et al 2010: 55). This point is repeated in our discussion of child sexual abuse in the 2017-19 overview (Dickens et al 2022a).

3.2.2 'Losing sight' of the children

Another common criticism, across the period, is of 'losing sight' of the children:

> *Children were missing or invisible to professionals in a number of ways. They include young people who were hardly consulted or spoken with, siblings who were similarly not engaged, young people who were not seen because they were regularly out of the home or were kept out of sight, non-attendance at school, young people who absconded, ran away or went missing and children who chose not to or were unable to speak because of disability, trauma or fear* (Brandon et al 2010: 55).

The topic is discussed in depth in the 2017-19 overview, highlighting that 'listening' to children and young people is not only about speaking with them, but also about observing and assessing their behaviour, being alert to what this might indicate about what they have experienced (Dickens et al 2022a).

3.2.3 Working with men

The first review noted that there was often a lack of information on significant males, such as fathers, step-parents and partners, and stressed the importance of comprehensive family assessments 'especially histories of male figures' (Sinclair and

Bullock 2002: 15). Shortcomings in assessing and engaging with men continue as a major theme across the period: for example, the 2007-09 overview commented that:

> *Rigid thinking may also exist about father figures as 'all good' or 'all bad', and men may be perceived, primarily, as posing a threat to workers. While the father, stepfather, or mother's partner might pose a risk to the child's safety, he may, on the other hand, act as a protective presence, or have important information and insights into the children's safety* (Brandon et al 2010: 55).

3.2.4 Race and ethnicity

The first periodic review found that:

> *Information on the ethnic background of children and carers was sometimes vague and also unsophisticated in that it failed to consider features of the child's culture, language, religion and race, as specified in the Children Act 1989* (Sinclair and Bullock 2002: 19).

The authors highlighted the importance of addressing these issues when undertaking an assessment:

> *For example, the child and family's ability to speak and understand English; their familiarity with services in order to gain access to them; the impact of racism or uprooting from their country of origin and the significance of cultural or religious practices* (Sinclair and Bullock 2002: 19).

The issue recurs across the period and has been noted by other researchers. The 2014-17 review quotes a paper by Bernard and Harris (2019), who studied a sample of 14 SCRs published between 2010 and 2017 and found that details of ethnicity were often missing or poorly recorded, a lack of focus on the daily realities of life for the children and little evidence of the views and feelings of the children. They say:

> *…the SCRs consistently highlight a lack of professional curiosity about the children's lived experiences within their cultural and ethnic context. For the most part, though the ethnicity is stated in the SCRs, they tend not to comment in any meaningful way to gain an understanding of the lived experiences of the child* (Bernard and Harris, 2019: 259).

3.3 The families' circumstances

Domestic violence was reported in over half the cases in the 2017-19 report, 55%; poverty was noted in almost half, 49%, and parental separation in 48%. Mental health problems were reported in 55% of the cases, and were particularly likely to

affect the mother. Alcohol misuse was reported in 34% of the cases, as was drug misuse and adverse experiences in childhood. One or both of the parents (or the mother's partner) had a criminal record in 32% of the cases, and this was usually the father. The criminal record was for violent offences in almost one in five cases, 19% (Dickens et al 2022a).

These patterns are broadly consistent with previous reviews: for example, the 2009-11 review found that two-thirds of the cases featured domestic violence, nearly 60% parental mental ill health, and 42% reported parental substance misuse. '*At least one of these characteristics was evident in 86% of the cases while all three factors were present in just over a fifth of the cases*' (Brandon et al 2012).

But just presenting these statistics does not really capture the truly grim circumstances in which many of the families were living and, of course, in which the children were being brought up. Reading the individual reports brings home the multiple and compound difficulties facing many of the parents, particularly the mothers – violent and controlling partners, mental ill-health, drug addiction, histories of abuse and being in care, poor quality and insecure housing, other children taken into care, financial and material deprivation. There were similar backgrounds of need for the young people getting drawn into criminal activity or taking their own lives. One is left with a sense of great sadness for the whole family – the children being brought up in these circumstances, and the parents for whom (usually, not always) life has been and still is very hard, with little hope of lasting change.

It is not surprising that the adversities and the fear of losing their children sometimes makes parents uncooperative and even hostile. All the overview reports mention hostility, and all but one 'disguised compliance' (that is, an apparent willingness to co-operate but not doing so – for example, repeatedly making and missing appointments). The 2003-05 overview commented:

> *In many cases parents were hostile to helping agencies and workers were often frightened to visit family homes. These circumstances could have a paralysing effect on practitioners, hampering their ability to reflect, make judgments, act clearly, and to follow through with referrals, assessments or plans. Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to 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* (Brandon et al 2008: 10).

3.4 'Professional curiosity'

A fundamental criticism that repeats over the period is that practitioners from all disciplines can be too ready to accept parental accounts and the views of other professionals at face value, without showing sufficient curiosity about whether these explanations are right (Sidebotham et al 2016: 245). Lord Laming (2003: 205) argued that workers should act with 'respectful uncertainty' in his report on the Victoria Climbié case, and other terms that have been used for this sort of open-minded and questioning approach are include 'healthy scepticism', 'authoritative practice' and 'professional curiosity'. The latter phrase appears for the first time in the 2005-07 review, but the concepts behind it go back to the first one, in the criticisms made there of poor assessments.

The notion of professional curiosity touches on a fundamental tension for social workers and other practitioners who are trying to build effective relationships with families and can also find themselves criticised for not showing trust and taking account of the family's perspective. Striking the right balance in each case is at the heart of professional practice:

> *Building strong relationships with children and families is crucial to reducing maltreatment. However, trust needs to be placed with care … Approaching families with respect and an open and questioning approach is often referred to within the SCRs as professional curiosity* (Sidebotham et al 2016: 245).

The reviews show that building strong relationships can be a particularly great challenge *'when needy, suspicious, frightened or desperate families and children are faced by overwhelmed practitioners*' (Sidebotham et al 2016: 245). In such situations, the 'chaos and confusion' in the family's lives may be reflected in practitioners' thinking and actions. Practitioners need support to think clearly and compassionately – from regular, effective supervision, high-quality training, and having the time to think reflectively and analytically:

> *Supervision can be used to check rigid thinking about families and fixed views about the source of harm or potential harm to children. For example believing that the source of the harm was neglect might preclude the thought that the child might also be physically or sexually harmed* (Sidebotham et al 2016: 244).

3.5 Inter-agency communication, information-sharing and challenge

Problems with inter-agency communication and co-operation, poor information-sharing and poor record-keeping are other regular findings. Again, the message is that practitioners need time, support, suitable training, effective IT, and an organisational culture that supports them to work constructively with other professionals and agencies. The SCRs show that there are technical and human aspects to effective information-sharing.

Electronic databases and information-sharing have become much more prominent, routine features of practice since 1998. These can be invaluable tools, but the 2003-05 SCR overview emphasised that they are just that – tools, not answers in themselves, and do not replace the 'power of personal contact' (Brandon et al 2008). Digital information-sharing systems are not a substitute for good professional communication. The latest review, 2017-19, makes the same finding, but notes the workload pressures that have reduced the opportunities for professional conversations and meetings (Dickens et al 2022a).

Procedures and IT systems need to be user-friendly and reliable, and 'speak to each other'. Some SCRs show that this is not always the case. Further, practitioners need to know how to use them effectively, to input accurate and complete data, without being dominated by them. The 2009-11 overview found *'some suggestion that practitioners end up being bound by these procedures, with an over-reliance on electronic recording systems and pro-formas and working strictly to criteria rather than critically thinking about cases'* (Brandon et al 2012: 83).

Additionally, there is a danger that electronic information-sharing systems can offer false reassurance that information has been received and properly understood, and the 2005-07 review quotes one SCR which had concluded that '*professionals still need to understand the importance of contacting and involving other professionals who may have had dealings with the family*' (Brandon et al 2009: 61). The pressures of effective communication about the information being shared are intensified when families move across agency boundaries, and cases show the challenges of keeping up with some highly mobile families. In some cases there was evidence of families moving in order to avoid detection; but families might also be moved as a result of housing policies.

Some of the problems with information-sharing have been seen to rest on misgivings and misunderstandings about breaching confidentiality, and these may point to wider social and cultural issues. The fear of breaching data protection law was noted in the

first of the periodic reviews and is discussed in depth in the 2011-14 review. The authors draw the following conclusions:

> *Our reviews of serious case reviews spanning more than ten years suggest that, despite national guidance and legislation, there are deep cultural barriers to effective information sharing among professionals …. It appears that, in spite of outrage at children's deaths, abuse and sexual exploitation, our professional, legal and political cultures continue to emphasise the right to privacy, fuelled by public fears of a 'nanny state', and excessive surveillance and scrutiny …* (Sidebotham et al 2016: 164-5).

The authors call for wider cultural change to accept that children's safety deserves a higher priority than individual privacy.

Effective inter-professional working also includes staff having the confidence and support to ask questions and pursue issues when they are unhappy about the decisions or actions of other professionals, and most importantly being open themselves to receive questions and challenge. In the third review, covering 2003-05, the study found:

> *There was hesitancy in challenging the opinion of other professionals which appeared to stem from a lack of confidence, knowledge, experience or status. Although there were some good examples of incidents of confident professional challenge, sustained challenge was difficult, and differences of opinion or judgment were rarely pursued to a satisfactory conclusion* (Brandon et al 2008: 10).

This continues to be a theme throughout the reviews, and is discussed again in the 2017-19 report (Dickens et al 2022a). It found that unresolved professional disagreements were a frequent feature of the cases, particularly regarding the level of risk, thresholds and the need for escalation: '*These were often cases where one agency had information that indicated risk to the child, yet this was not accepted or understood by the wider professional network*'. Two messages for practice are highlighted: that professionals need to 'translate' the information known to them to other professionals outside their discipline, so that its significance is understood; and that there should be an inter-agency culture, as well as clear guidelines, that makes it easy for professionals to raise concerns around decision-making as a way of 'resolving professional differences'.

Part 4: Context and systems

In terms of the wider national context, the period falls fairly evenly into two spans of political and policy leadership: the Labour years,1998-2010, and the Conservative-led years of 2010-2019. The period has seen great challenges and many changes. The Association of Directors of Children's Services, ADCS, has an invaluable timeline on its website showing key events, policy changes and developments in children's services since 2007 (https://adcs.org.uk/safeguarding/article/timeline).

This section looks at three aspects of this wider context. First it summarises the extent of organisational changes and restructurings over the period, because even if these are intended to improve practice in the long run, they tend to jeopardise good practice as they are introduced. Second, it reviews various attempts to improve the operation of the child protection system, particularly the Munro review of 2010-11, because if they had been successful they should have reduced the occurrence of the sorts of problems that SCRs tend to find. Third, it highlights issues of demand and resources, because the tensions of meeting increasing needs within restricted budgets are also likely to affect practice, and therefore the findings of SCRs.

4.1 Organisational changes

Prominent organisational changes include the move from local authority social services departments to children's services departments; area child protection committees to local safeguarding children boards and now child safeguarding partnerships; primary care trusts were established and then replaced by clinical commissioning groups (CCGs), which were in turn subsumed into integrated care systems (ICS) in summer 2022. Ofsted took on the inspection of local authority children's services, and its role had a bearing on the expectations of SCRs, discussed below. On the policing and law-enforcement side, multi-agency public protection arrangements (MAPPAs) and multi-agency risk assessment conferences (MARACs) have been established, and the probation service has undergone a major restructuring. For schools, there has been the academisation programme and related changes to accountability and funding structures.

Organisational changes absorb resources, attention and energy, which can detract from the focus on children and their families. As the 2014-17 overview put it

> *A changing service landscape not only puts pressure on resources but also on services and staff to understand those changes and the implications for families they work with* (Brandon et al 2020:102).

This is an ‘old problem’, because the dangers of children ‘falling through the gaps’ in a time of organisational change was noted as long ago as 1974, by Olive Stevenson in her minority report to the Maria Colwell inquiry. They can lead to a loss of organisational ‘memory’, through losing staff and breaking up established teams, and mean that new processes and procedures for inter-agency communication have to be created and learned by staff.

The issues were identified in the first of the periodic reviews:

> *The agencies involved also display a tendency for continual reorganisation with the result that inter-agency relationships effective in the past may no longer be possible and the changed situations require regular review. Indeed, some past good practice may have to be re-learned in what are virtually new contexts* (Sinclair and Bullock 2002: 58).

4.2 Reforms to the child protection system

Just a year after the publication of the 1999 *Working Together* guidance came the death of Victoria Climbié in 2000, followed by the Laming inquiry (2003), which provided the impetus for the *Every Child Matters* programme and the Children Act 2004. Within four years the ‘Baby Peter’ case became a national scandal. Peter Connelly died in 2007 but the case hit the headlines after the criminal trial in late 2008. There were two SCRs, because the first one was deemed to be ‘inadequate’ by Ofsted, and the Secretary of State at the time, Ed Balls, directed that Haringey LSCB commission a new one. Both are available online (Jones 2014 compares and contrasts them). A ‘social work task force’ was established to address the perceived weaknesses in the profession, and Lord Laming was commissioned to write a progress report on the reforms he had recommended in the Climbié report.

Laming’s progress report includes a detailed discussion of SCRs (Laming 2009: 63-70). He emphasised the importance of timely and effective learning, which should be the most important consideration in assessing their quality. He recommended that SCRs should address practice within individual agencies, as well as inter-agency co-operation. He was against publication of the full reports, for reasons of the child’s and family’s confidentiality, and favoured ‘high-quality’ executive summaries. The report also noted discontent from LSCB members about Ofsted evaluations of SCRs, which had been introduced two years before, notably that they thought the evaluations focused more on the quality of the written report than its effectiveness for learning. The Ofsted evaluations are discussed further in Part 5.1.1 below.

4.2.1 The Munro review of child protection

The general election of spring 2010 brought a change of government, and one of the early actions of the Conservative-Liberal Democrat coalition was to commission a new review of the child protection system, led by Professor Eileen Munro. The purpose was to ask how social workers could be helped to make good professional judgments about children, without unnecessary bureaucracy and regulation, but with transparency and accountability. The review produced three reports (Munro 2010, Munro 2011a, Munro 2011b) and a progress report a year later (Munro, 2012).

Munro concluded that the child protection system in England was 'an over-standardised system that cannot respond adequately to the varied range of children's needs' (Munro 2010: 5). She called for various adjustments to the procedural systems, but more than that, a change of culture across the multi-agency child protection system, to put the emphasis on learning and improvement rather than compliance and blame. She found that SCRs 'have not fostered a learning culture which supports improved practice' (Munro 2010: 9).

Munro used a systems approach to understand why the child protection system had evolved as it had, becoming increasingly prescriptive:

> *Each new reform, in isolation, has often been well designed, but the problem lies in the cumulative effect they have been having on practice. …more managerial focus is being given to complying with top-down regulation, and often further locally designed procedures, than to providing a personalised service that matches the variety of needs of children and young people* (Munro 2010: 12).

As noted earlier, this proceduralisation is an old problem for child safeguarding work. Munro argued for less prescription and more room for professional judgment. Her use of a systems approach was extended to a recommendation that SCRs should be conducted using a systems methodology. The idea is to understand events, practice and decisions in their whole context, to avoid unfair blame of individuals and changes that fail to address the root causes of the problems.

The 2013 edition of *Working Together* advised that SCRs could use 'any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro' (page 67). This was a much shorter document, down to 97 pages from the 390 pages in 2010, but there is need for caution before claiming that there had been a substantial reduction in overall prescription. Parton (2014) observed that the 2013 version gave links to 45 pieces of supplementary or additional guidance, and these added up to no less than 3,500 pages of material. (The Munro progress report in 2012 commented that it was better

to talk of ‘moving some guidance’ to professional and local levels, rather than removing it: Munro 2012: 10). The 2018 edition has links to nearly 90 other items of guidance, from the DfE, other government departments and external organisations.

4.3 Demand and resources

The years covered by the SCR overviews have seen a substantial increase in the demands on local authority children's services. Table 3 illustrates this with an overview of the changes for selected years, on key dimensions such the number of referrals, the number of safeguarding inquiries under s.47 of the Children Act 1989, and the number of children on child protection plans. Looking at the full data for the period shows that there have been some overall year-on-year decreases, and there is variation between local authorities (some will go down in a year even through the overall trend is upwards), but the trends are clear. The causes are complex: the number of referrals and s.47 inquiries can be seen to rise suddenly in the aftermath of child abuse scandals, so it is about the varying *perceptions* of risk as well as any actual changes in risks and need, and there are also the widening definitions of harm, as described earlier in Part 1.

Table 3: Patterns of demand and response in local authority children's social care, selected years 1998 to 2019

	Referrals over year	Children in need on 31 March	s. 47 enquiries over year	CP plans on 31 March	Children looked after on 31 March
1998	Not available	Not available	Not available	31,600	53,300
2004	572,700	388,200[1]	72,100	26,300	61,100
2010	603,700	375,900	87,700	39,100	64,470
2015	635,300	391,000	160,150	49,690	69.540
2019	650,900	399,500	201,200	52,300	78,140

Sources: DfE annual data on children in need, and children looked after by local authorities in England.

The change of government in 2010 brought in the 'austerity' programme, cutting back central government spending in order to reduce the national deficit and reform Britain's finances, but also aiming to reform society, by reducing the role of the state and encouraging greater self-reliance, and greater involvement from the private and voluntary sectors in welfare provision. The vision is captured in then-prime minister

[1] From children in need census week in February 2003.

David Cameron's 'speech on opportunity' in summer 2015, after the Conservatives had won that year's election (Cameron 2015).

The impact on local authority children's services was profound. The final periodic review of SCRs (Dickens et al 2022a) summarises the findings of two reports by National Audit Office, which calculated that local authorities in England experienced a real-terms reduction of government funding of 49% between 2010-11 and 2017-18 (NAO 2018). In this context, they had to focus their spending on the most acute services, such as child protection and services for children in care, and make cuts in other areas, notably preventive and early intervention services, such as children's centres (NAO 2019).

Funding to promote new programmes to support families, protect children and improve outcomes has been available through the government's Innovation Programme for children's social care since 2014. Funds have been available for local authorities and voluntary organisations to bid for grants to develop services. Funding amounted to £200 million over the period 2014-20; for context, the total annual expenditure on local authority children's services in England in 2017-18 was £9.4 billion (DfE 2018). The DfE Innovation Programme website has extensive information about the wide range of projects, and the overall evaluations (round 1, Sebba et al 2017; round 2, FitzSimons and McCracken 2020).

The key messages from the round 2 evaluation highlighted the importance of practice that is relationship-based, strengths-based, and holistic; time for staff to do this work; integrated multi-disciplinary specialist support; and good multi-agency collaboration. The authors observed that the additional funding from the Innovation Programme was 'an overarching, critical enabler of projects achieving their aim … This highlights how crucial adequate funding of children's services is to the achievement of good outcomes' (FitzSimons and McCracken 2020: 4).

4.3.1 Poverty

Evidence of poverty in the families that became subject to SCRs was more prominent in the last two periodic reviews than previously. It was noted as a factor in 35% of cases in the 2014-17 report, and 49% in the 2017-19 cohort. Whether this reflects a 'real' increase in poverty amongst the SCR population, a change in reporting style or some combination of those is open to debate; but the SCRs do highlight the challenges that arise for safeguarding practice.

The damaging impact of poverty on children's and families' wellbeing is acknowledged across professional, academic and political perspectives: the nature of the harm, what the causes are and what should be done about it are more

contentious. In a literature review for the Department of Work and Pensions (DWP), Ridge (2009) categorised four main types of effect. There are psychological effects such as loss of self-esteem, anger, depression and anxiety; physical effects, on people's health; relational effects, on social and personal relationships; and practical effects, as poverty limits people's choices and options for parenting (Ridge 2009: 19). All of these may increase the likelihood of children suffering harm, either through direct effects, such as material hardship, or through indirect effects such as parental stress and neighbourhood conditions. There is no direct causal link with maltreatment (not all poor children are abused and not all abused children are poor) but the 2014-17 report noted that '*Poverty created additional complexity, for example, stress and anxiety in families. It is also an important factor alongside other cumulative harms'* (Brandon et al 2020: 219).

The DWP 'households below average income' data show that in 2018-19, 30% of children in the United Kingdom were living in households in relative low income after housing costs (AHC), adjusted for household size (that is, below 60% of the median income for that size of household: DWP 2020: 8). (Note – these figures are for the UK, not just England. There were 14 million children in the UK, so 30% is 4.2 million.) This 30% figure is 4% lower than it was in 1999, the start of our review period, and the same as it was in 2010 (DWP 2012: Table 3.1).

Absolute low income takes the 60% of median income threshold from 2010-11 and then adjusts this in line with inflation. On this measure, 26% of children were living in families in absolute low income AHC in 2018-19. This figure cannot be compared to the 1999 figure, because the baseline year was changed to 2010-11 by the Child Poverty Act 2010. Previously it was 1998-99 (DWP 2012: Table 3.1).

Compared to the overall population, children are more likely to be in low income households (DWP 2020: 8), but there are various factors that affect its impact on children, including the depth of poverty and the length of time they spend in it (HM Government 2014). Also, the likelihood of living in a low income household varies for different groups: it is more likely for Black children and those from Pakistani or Bangladeshi backgrounds; children in households where no adult is working, or in part-time work; living in families where someone is disabled; living in rented accommodation; or living in London, where housing costs are especially high (DWP 2020, detailed breakdown 2018-19 tables).

The 2017-19 review of SCRs found cases where practitioners struggled to differentiate between conditions of poverty and signs of serious harm from abuse or neglect. It highlights two types of risk that poverty creates for effective safeguarding practice: one, that focusing on the financial and material circumstances could lead practitioners to miss the signs of maltreatment; but equally, there is a risk of

becoming inured to the effects of poverty, and not responding to the direct and indirect harms that it can cause.

Part 5: The review reports: characteristics and critiques

As well as the recurrent concerns about practice that were raised by SCRs, there was a long history of concerns about the quality of SCRs themselves. These came to a head in the Wood review of 2016 (discussed further below), which concluded that the SCR was a 'discredited model' (Wood 2016: 50). This section summarises the criticisms that were made of SCRs, as a basis of learning for the new system.

Over the years, the key criticisms have been:

- Reviews often being overly long and descriptive – sometimes with very detailed chronologies and irrelevant material that detract from focus and clarity
- Describing what had happened without exploring why
- Reviews not always giving a clear picture of the child's daily life and experience (in particular, relating to their racial, ethnic or religious background), or their views
- Bland recommendations (they need to be specific and lend themselves to 'SMART' action plans)
- Too many recommendations to be manageable ('recommendation overload')
- Highly variable quality, often down to the knowledge and skills of the individual reviewer
- Delay in publication, meaning that the opportunity for change has passed
- Lack of evidence of actions being taken to implement the lessons.

The intriguing point is that many of the criticisms that SCRs made of practice, were also criticisms that were made of them – notably, about the apparent lack of professional curiosity, not asking the 'why? questions, and not giving a clear picture of the child's experience and perspective.

5.1 Evaluations of SCRs

5.1.1 Ofsted 2007-11

Ofsted (the Office for Standards in Education, Children's Services and Skills) took over the inspection of local authority children's services in April 2007. As part of this, it started to evaluate SCRs, and published six reports about them between 2008 and 2011 (Ofsted 2008, 2009, 2010a, 2010b, 2011a, 2011b). It ceased to evaluate them after that in line with one of the recommendations of the Munro review.

The final report gives an overview of the four years of evaluations, 2007-08 to 2010-11. It states that the aim was not to evaluate the quality of professional practice or

service delivery in relation to the incident; instead, it was to assess the extent to which the review had succeeded in identifying lessons to be learnt from the events, and the action that therefore needed to be taken (Ofsted 2011b: 28). As noted earlier, it was not always perceived like this by local professionals (Laming 2009).

In the first year, 2007-08, out of 41 reviews that were assessed, none was rated as outstanding and 14 as inadequate. By the final year, 2010-11, five of the 117 SCRs evaluated were rated as outstanding, and six as inadequate (Ofsted 2011b: 28). Ofsted described this as 'a continually improving picture', but the overall tone of their reports is critical of SCRs and the practice behind them.

Primary reasons for inadequate ratings over the four years were that the terms of reference were not sufficiently focused, and that the overview report did not sufficiently analyse or challenge the information it was given. Other concerns included the length of time they had taken, and failing to address issues of race and ethnicity. As regards the *practice* being described, the Ofsted evaluations highlighted familiar problems. These included staff not following good practice guidelines and procedures (rather than the agency not having those procedures), poor assessments, not pursuing the necessary tasks, ineffective inter-agency working, not questioning the views of other professionals and agencies (or indeed their own), too often taking the parents' account at face value, and losing the focus on the child.

5.1.2 The Serious Case Review Panel 2013-17

Working Together 2013 announced that the government would establish a national panel of independent experts on serious case reviews. It was charged with advising LSCBs to ensure that appropriate action was taken to learn from serious incidents, the application of the SCR criteria, the appointment of reviewers and the publication of reports (SCRP 2014). The panel comprised a practising barrister with experience of family law, the head of the government body that investigated aircraft accidents and serious incidents, a newspaper columnist (later replaced by a senior officer from the Children's Commissioner), and the chief executive of the NSPCC whose background was in schools' reform. It published reports in 2014, 2015 and 2016, and was replaced by the Child Safeguarding Practice Review Panel in line with the reforms recommended by the Wood review.

Its first report drew attention to what it considered to be 'a deep reluctance in some instances to conduct SCRs'. It acknowledged the financial and workload implications of SCRs and argued that a 'proportionate approach' should be adopted. It expressed itself 'bemused by the number of different types of investigation, review or audit that LSCBs hold up as an alternative to carrying out an SCR' and suspected that 'on many occasions they are proposed as a way of evading publication' (SCRP 2014: 6).

As for the quality of the SCRs, the Panel found this ‘disturbingly variable’, with examples of irrelevant detail, not asking why, not focusing on the child or addressing his/her perspective, and recommendations that were not clear, focused or addressed to specific individuals or organisations. It commented that

> *Reports that fail to look at human motivation and at the crucial roles played by fear, exhaustion, overwork, timidity, wilful blindness and over-optimism are unlikely to determine the root causes of critical decisions* (SCRP 2014: 7).

Similar concerns were expressed in its 2015 report, where it noted that its first report had led to the reinstatement of the periodic reviews of SCRs (SCRP 2015). It also noted that the DfE was funding the Learning into Practice Project (LiPP), aimed at improving the quality of SCRs, by developing ‘quality markers’ and exemplar reports.

5.1.3 The Wood review 2016

Wood highlighted problems that SCRs were still perceived as being about allocating responsibility for what went wrong, despite years of assertions that they were about learning not blame; the great cost of SCRs; long delays in publication; and recommendations that

> *… tend to be predictable and or banal, unfocussed and not addressed to specific individuals or organisations, e.g. better information sharing; more communication between partners; more curious inquiry; do more to engage the young person/family* (Wood 2016: 51).

Wood recommended a system of ‘rapid inquiries’ and ‘local learning inquiries’, within a national learning framework. The government response (DfE 2016) committed to replacing SCRs with a new system of national and local reviews, with the aims of greater consistency; improving the speed and quality of reviews, including through accrediting authors; ensuring that reviews are proportionate to the issues they are investigating; capturing and disseminating the lessons more effectively, and making sure that the lessons inform practice.

5.1.4 The Learning into Practice Project 2016

The Learning into Practice Project was undertaken by the NSPCC and SCIE (the Social Care Institute for Excellence) and published 18 ‘quality markers’ in 2016 (NSPCC/SCIE 2016). These offer detailed and practical guidance on 18 key aspects of the SCR process, including decision-making, commissioning, involving family members, involving practitioners, publication, implementation and evaluation. Three aspects where notable change did happen over the 1998-2019 period are publication, family involvement and practitioner involvement, discussed below.

5.2 Changes in the practice of SCRs

5.2.1 Publication

There have been ongoing debates about the publication of SCRs, especially the implications for confidentiality and the length of time often taken. Publication of the full report has been required since 2010, unless there are compelling reasons why not, and the guidance is that the reports should be written with publication in mind – that is, not needing to be redacted prior to publication.

There has certainly been a major change of approach to publication since 1999, when the *Working Together* guidance required that executive summaries only be published. But in practice, even executive summaries raised questions about how much information was necessary for transparency and accountability whilst respecting the confidentiality of the children and other family members, as noted in the 2001-03 overview report (Rose and Barnes 2008). The overview of the 2003-05 SCRs found that only 17 executive summaries from the 161 reviews were fully accessible on LSCB/ACPC websites, with the availability of others more restricted. The overview commented that there were:

> *… clearly problems of confidentiality … both for the family concerned and staff involved, in making these reports available to the public, but since some areas are able to overcome this difficulty the problem may not be insurmountable* (Brandon et al 2008: 16).

The 2009-11 overview report noted a pronounced drop in the number of SCRs in the second year, and suggested that one of the reasons for it could have been the introduction in summer 2010 of the requirement to publish SCR reports (Brandon et al 2012; and see Morris et al 2015). The panel of independent experts was suspicious of a reluctance to publish reviews, as noted above.

The 2018 edition of *Working Together* emphasises that a key consideration should be the avoidance of harm to children and vulnerable adults, rather than the strict preservation of confidentiality (which is unlikely anyway if there has been a criminal trial) (HM Government 2018). The confidentiality and harm aspects have acquired an extra intensity over the course of the review period because of greater expectations about the involvement of family members in SCRs, discussed below.

As regards the length of time taken to publish summaries or reports, there have been enduring problems with long delays. These were often attributed to delays in concluding criminal investigations or coroners' inquiries, and not wanting to interfere with those processes. The 2005-07 review called for an agreement that SCRs should

go ahead and executive summaries be published, '*unless discussions with the Crown Prosecution Service and coroner reveal a cogent reason why there should be a delay*' (Brandon et al 2009: 87). But those are not the only causes of delay, and the 2011-14 review identified others, including debates at the beginning about whether the case met the criteria for an SCR and what kind of review to hold; delays during the process, such as a change of lead reviewer/ author, the instigation of performance and disciplinary proceedings, or concerns about the quality of the report; and delays at the end, in the preparations for the release of the report, including managing the impact on family members (Sidebotham et al 2016: 214).

Publication of the findings in some form is necessary if the aim is that lessons should be learned more widely than the local level, but how this is best done does raise some 'hard problems'. The challenges of achieving the right balance were apparent in the 'knowledge exchange events' we held in early 2022, to help us identify key lessons from SCRs (Dickens et al 2022a). There was a careful discussion about the tensions between giving full information to underpin learning, and respect for the families' privacy and feelings. Some attendees argued that the impact of SCRs can be limited if they try to sanitise what has happened – they need to avoid professional jargon and 'say it like it is'. Others emphasised the importance of being sensitive to how children and other family members may feel about full details being made public, especially when the reports are easily available on the internet and can be spread without control.

5.2.2 Family involvement

The 1999 edition of *Working Together* required LSCBs to consider *whether* to involve family members in SCRs; the 2006 edition strengthened the requirement to consider *how* to involve family members (emphases added). By 2013, the guidance was that families, including surviving children, *should* be invited to contribute to reviews, and 'They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process' (HM Government 2013).

The second periodic overview was published in 2008 and discusses the 2006 guidance on family involvement. It highlights the balances that had to be struck between the public interest and individuals' rights (which themselves involve balances between the right to be heard and the right to privacy), and comments

> *This is made more complex when there are different family members' interests to be taken into account, both within and between families involved and some of whom are likely to be children. … Second, there is the balance to be found between the influence of family members' involvement on the*

> *direction of the review and maintaining a dispassionate inquiry into the events* (Rose and Barnes 2008: 35).

A paper by Morris et al (2015) draws attention to further challenges, including the need for adequate support throughout the process for family members, as well as clear explanations at the beginning. This is notably to do with the likely traumatic nature of the discussions, and that their accounts will be weighed against others and may not be definitive. Morris et al (2015) also note the possible need to manage professional resistance to involving perpetrators, or to the messages about practice coming from the families.

The warnings are helpful and are echoed in the NSPCC/SCIE (2016) quality marker on family involvement. When done well, family involvement can shed new light on the case. The 2014-17 overview has a quotation about the benefits of involving a mother who had learning difficulties:

> *And we felt that the depth of her understanding wasn't properly grasped when the practitioners were involved so that was crucial… if we hadn't held that meeting with her the whole review would have been weakened in terms of our understanding* (Brandon et al 2020: 185).

5.2.3 Practitioner involvement

The guidance on involving practitioners has also strengthened over time. The 1999 guidance had an expectation that practitioners should be involved, but the 2005-07 overview found practitioners feeling 'peripheral' to the process and none of the staff they interviewed felt satisfied with their level of involvement: '*Most felt left out and wanted much better feedback and support*' (Brandon 2009: 93). In the 2013 guidance the requirement was that 'professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith' (HM Government 2013: 66). By the time of the 2014-17 review, the mood was that it would now be '*unthinkable to carry out a review without involving practitioners*' (Brandon et al 2020: 185).

There are a number of models for undertaking reviews (the 2011-14 report found 'at least nine' – examples are SILP, the significant incident learning process, the SCIE model, the Welsh practice review model and appreciative inquiry) and the participation of practitioners is typically a key feature. Practitioners are usually involved through discussion groups, although may be interviewed individually (although to be clear, SCRs are not disciplinary processes). It is helpful for reports to specify the agencies, professional groups and grades represented, and whether the participants were directly involved in the case; and also, what has actually been learned from them.

Despite the emphasis on involving practitioners, the Wood review (2016) noted that SCRs can still be experienced as accusatory and blaming. In one of our knowledge exchange events there was concern that they could 'grind practitioners into the ground'. However, others welcomed the greater involvement of practitioners, and said if done well it could be a positive step, to help their learning and provide 'closure' for them, and improve the quality of the recommendations (Dickens et al 2022a).

5.2.4 Length, detail and recommendations

Over the years there have been many criticisms of SCRs for being over-long, with irrelevant details and recommendations that were too numerous and unlikely to be effective. The first overview report commented on recommendations that 'appear somewhat platitudinous and that lack any indication of how they might be done' (Sinclair and Bullock 2002: 56).

The 2011-14 overview found that reports were much shorter than in predecessor reviews with an average length of 48 pages, compared to earlier reports which were 'often in excess of 100 pages', and generally had fewer recommendations – more than two-thirds of them had fewer than 10, and almost all fewer than 20, compared to an average of 47 in the 2009-11 study (Sidebotham et al 2016: 18). These reductions held steady in the 2014-17 overview.

In the 2017-19 cohort, there was an average length of 33 pages, and an average of 10 recommendations, from a sample of 33 cases. The length ranged from 9 to 63 pages, and the number of recommendations from 0 to 23. Although the average number of recommendations had risen from 7 in the previous two studies, less than a quarter of the SCRs had more than 10 (8 of the 33 reports), so there is evidence of a continuing trend towards shorter reports and fewer recommendations.

The 2011-14 overview covered SCRs completed after the Munro review and the widespread adoption of systems models. It noted a distinction between learning points and recommendations and drew lessons for good quality reviews based on this distinction. It emphasised that *learning points* should be clearly linked to the findings, and there should be questions for the LSCB, to promote deeper reflection, leading to a response and action plan to address the lessons. Where there is a clear case for change, then there should be specific *recommendations*, again with a response and action plan developed by the Board. There should be 'a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies' (Sidebotham et al 2016: 19).

Part 6: Messages for policy and practice

6.1 The impact of SCRs

Looking back over the series of government-commissioned overviews, and the raised profile of SCRs over that period (e.g. through the expectations of publication), we see a rather ambiguous picture of their impact on policy and practice. The emphasis of SCRs, since 1999, has firmly been on learning to improve inter-agency working and safeguarding practice, although they do still have a function in holding agencies to account for their actions and decisions. Public accountability is one of the reasons for the emphasis on publication, as well as sharing lessons. Reviews serve multiple purposes, as Hill (1990) identified over thirty years ago, speaking of the 'manifest and latent' functions of child abuse inquiries. This complexity lies behind the ambivalence of many practitioners and the fear of being blamed (as noted by Wood 2016), even though the rhetoric focuses on 'learning lessons' rather than attributing blame. But there certainly has been change and learning over the period, and we do see great efforts to implement it at local level. Our knowledge exchange events with nearly 100 safeguarding practitioners and managers gave an inspiring picture of the work that goes on (described in the overview report on the 2017-19 SCRs: Dickens et al 2022a).

But SCRs were only one part of a much wider system of change and learning (as are LCSPRs now). We should not dismiss their contribution but it is important not to over-estimate their power to achieve widespread change. There are many other forces that shape safeguarding practice, and many of them rather more powerful than SCRs, as discussed earlier: national policy and legislation, national budgets, organisational changes, national scandals, changing understandings of what counts as a safeguarding issue, the availability of other services for families, other social imperatives. There are also other sources of research and knowledge (see below).

It also has to be said that some of the messages from SCRs have been counter-productive: rather than increasing understanding they have contributed to an illusion of simplicity and predictability.

The recurrent findings about poor assessments, not seeing and listening to the children, not engaging with men, poor information-exchange, not 'challenging' parents or other professionals and so on, have given a sense of 'here we go again, the same old failings'. Lord Laming showed the frustration in his 2009 progress review, writing in capitals, 'NOW JUST DO IT' (page 7). But a deeper analysis of the cases and the professional practice, taking account of the detail and the wider context, would give a better informed view.

From a distance, the findings of the reviews make practice seem obvious, and without doubt the principles should be thoroughly known. But practice takes place in particular circumstances, with particular individuals, and is not as simple. So, for example, it is not necessarily straightforward to exchange information if you are very busy yourself, and you know other people are very busy too; if you have tried to do it before and been put off by the response; if it is not clear who you should inform; if you are not quite sure whether the information you have is significant; if you are concerned about damaging your relationship with the family, provoking things on a suspicion, before you are certain; if you are worried that you might be blamed for breaching someone’s privacy; if the electronic system you are required to use is hard to understand or malfunctioning; if you know there are no services to meet the need anyway. These may not be good reasons not to do it, and are easily seen as poor decisions in hindsight, but nevertheless they are powerful human reasons why a practitioner might not.

Staff may be inexperienced or exhausted; there may be capability issues; their workload may have too large or too demanding; they may be anxious or even scared (this can apply to their relationships with other professionals as well as with families). They will have their own views about the case and about all the other work they have to do. Workers need good working conditions with good quality supervision and support to manage these pressures and think clearly. Supervision should be regular, alert, easily accessible and responsive; but their colleagues and managers are also likely to be under great pressure. They may not have the skills, the experience or the time to offer the necessary support.

Another aspect of the simplification of practice has been the repetition of catchphrases and slogans, not always very helpful – examples are ‘disguised compliance’ (actually, the non-compliance is being disguised) and ‘think the unthinkable’ (a nonsensical phrase). The repeated calls for ‘challenge’ are particularly misleading. Practice takes place in the context of relationships, with families and other professionals, and some of the families are very vulnerable and/or hostile (and equally, other professionals can be intimidating or struggling). Confrontation can easily alienate people and is unlikely to bring positive change. In practice, ‘challenge’ is a subtle and complex notion. If done well it can help to produce change, and may even be experienced as something positive rather than critical; but it has to be done with great skill and empathy, not to damage the chance of change by making people feel angry, hopeless or humiliated.

Equally, the findings about the circumstances of the families – the prevalence of domestic violence, mental health problems, alcohol and drug misuse, poverty, poor living conditions, backgrounds of abuse or neglect in parents’ own childhoods – all of these can give the impression that it was ‘obvious’ the children were at risk and should have been removed sooner. It makes it look predictable, but it is not. From a

distance the cases look the same, but it is the subtle differences between them, the dynamics of particular people acting and interacting in particular situations, that makes the outcomes unpredictable. There are many cases that look similar but the children are not killed or do not suffer serious harm (they may suffer harm because of poor parenting and poor conditions, but not 'serious' enough to warrant compulsory intervention by the state). Even the 'obvious' indicators of risk are not cast-iron predictors of serious harm (see the critique of the 'toxic trio' by Skinner at al 2021 – although it was never claimed that this was a guaranteed predictor).

Even when there are indicators of risk, these will not usually warrant immediate action to remove the children. The test in the courts is that the child 'has suffered or is likely to suffer significant harm' (not just 'harm': s 31 of the Children Act 1989), and the courts cannot make an order unless it is necessary to do so (the 'no order' principle). So children will, quite properly, be left in circumstances where there is risk of harm. Multi-agency working is central to how the risk is meant to be managed, but there will always be risk. Uncovering and analysing what those risks are, balancing them against the strengths and positives in the situation, the child's timescale for change, the child's views and feelings, the suitability and availability of services to help – these are the difficult decisions that have to be made.

Having said all that, there has also been positive and practical learning from SCRs. The knowledge exchange events showed how much goes on to implement the lessons at local levels. One example of innovative work arising from an SCR was to engage with the licensed trade, hotel staff and taxi drivers, offering free training and ongoing support for them to recognise the signs of sexual exploitation and report it. This does not mean that it will never happen again, but it does help to create a safer environment. That sort of change can be hard to quantify, but it is no less important for that.

The events showed that messages from SCRs were disseminated to frontline staff via training events and a range of other methods: staff supervision, 'bite size' learning sessions, single-page briefings, online seminars, powerpoints and 'Sways', and safeguarding newsletters. One danger that was identified was 'information overload', making it hard for staff to keep up and absorb the lessons; another challenge was to sustain the changes, as new pressures arise and staff move on.

The 2014-17 overview report noted a comment from a participant in one of their workshops: '*There seems to be limited evidence to show that SCRs are an effective way of achieving sustainable system wide change and yet a huge industry has been created around it'* (Brandon et al 2020: 217). The same thought has been expressed in other evaluations. Our knowledge exchange events did suggest there is positive change, but it is difficult to specify it precisely and measure it because it is unlikely that the SCR will be the only influence behind it (there may be learning from other

areas, or from criticism in other reports), and so much else is going on (reorganisations, new national policies, other local innovations).

6.2 The new context

The national Child Safeguarding Practice Review Panel (the Panel) and the new system of rapid reviews, local child safeguarding practice reviews (LCSPRs) and national reviews has been in existence since summer 2018. It is still relatively early days for the new system and there has been the Covid pandemic to contend with. By the end of December 2021, 372 LCSPRs had been initiated since they started, but only 117 completed and submitted to the Panel (see Dickens et al 2022b). But our review of the 2021 LCSPRs did find evidence of the new approach beginning to take hold, as understandings and experience developed, at all levels – the Panel, local partnerships and review authors.

The Panel is building a useful body of work to promote good practice in child safeguarding work. It has published two annual reports (for 2019 and 2020: CSPRP 2020a and 2021a, respectively), and a number of thematic reviews – on children at risk from criminal exploitation (CSPRP 2020b); sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (CSPRP 2020c); safeguarding children under 1 from non-accidental injury caused by male carers (CSPRP 2021b). The Panel's national review into the murders of Arthur Labinjo-Hughes and Star Hobson was published in May 2022. The UEA and University of Birmingham team has written two annual reviews of LCSPRs (Dickens et al 2021 and 2022b).

The Panel, local safeguarding partners and reviewers are able to draw on the extensive body of knowledge from 21 years of SCRs to inform the requirements, expectations and operation of the new system. There are also the messages for practice from the NSPCC briefings, available on the national case review repository website. The wider messages from SCRs have been the hardest to implement – about the importance of reasonable workloads, sufficient and experienced staff, a good range of services to support children and families, challenging but supportive supervision, effective IT systems, the subtle skills of practice, clear and courageous thinking to 'ask the next question' of families and other professionals, inter-agency working and communication, getting the right balance of supportive and investigative priorities. That is because the conditions to achieve many of them lie beyond local level – they require national understanding, prioritisation and funding. SCRs sometimes mention these issues, but more often concentrate on local systems; the problem is that without national change, the impact will always be restricted.

As well as the SCRs and LCSPRs, there is knowledge about safeguarding practice, management and policy from independent research into issues such as neglect, relationship-based work, day-to-day practice, inter-agency working, communicating with children and young people, and the impact of poverty and inequality (references cited throughout this report and our final SCR overview).

There are also messages from Ofsted inspection reports, and a number of useful reports from joint targeted area inspections (JTAIs). These are inspections by Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, and her Majesty's Inspectorate of Probation. They have produced reports focusing on multi-agency working in cases of child sexual exploitation and missing children (Ofsted et al 2016), children living with domestic abuse (Ofsted et al 2017), neglected children (Ofsted et al 2018), child sexual abuse in the family environment (Ofsted et al 2020a), and children with mental ill health (Ofsted et al 2020b).

The point of this selective list of publications is that there is a wide range of knowledge about child safeguarding, from diverse sources, and many of the messages are well-known and repeated across them and over the years. We do not need to do so many reviews to learn these lessons again and again; rather, the challenge is to get the messages out to the people who need to hear them, in time to make a difference and in ways that are easily digestible, for busy, under-pressure workers and supervisors. Initial training and CPD training should cover safeguarding principles and practice for all the professional groups, but local practice messages need to get out quickly and powerfully without having to wait for formal courses.

As for the SCR reports themselves, the key messages over the years have been about the variability of quality, being too descriptive and not analytic enough, with too many recommendations, and too slow. These are all aspects that the Panel is prioritising in their guidance and advice to partnerships and reviewers.

There are also the challenges of a shortage of reviewers (making it hard to commission suitably experienced and independent authors), and of involving families and practitioners. Both of these groups can add to the information and learning of the review, and practitioners can learn through their involvement; but there are messages from the evaluations of SCRs and our knowledge exchange events that participation can be painful for both groups, and has to be managed skilfully.

A possibility is to have fewer LCSPRs by making them a pronounced 'step higher' than the rapid reviews, with clear and focused lines of enquiry coming from them to take the learning a significant stage further (see our review of the 2021 LCSPRs, Dickens et al 2022b). LCSPRs should aim to look in more depth at the dynamic between individual actions and decisions, family circumstances and the wider

organisational, professional and social systems within which practitioners work. Greater use of thematic rather than case-based reviews could help with this.

Completing the learning in rapid reviews should be more manageable for local agencies, in terms of time, staff and cost, and if well done would still produce useful local lessons. It would, however, reduce the chance for practitioner and family involvement, and be less transparent in that the rapid review is not written up for publication. One way of dealing with this would be for a learning summary and action plan to be published. In deciding whether or not to take a case forward to an LCSPR, partnerships have to weigh the nature and extent of the harm and the potential for useful learning, and the need for accountability, to demonstrate to agencies, the families and the public that they have learned any necessary lessons and are determined to implement them.

Finally, we should remember that reviews of serious cases do not only have practical and accountability purposes; they also have a deeply important symbolic and cathartic role (Hill 1990). The death or serious harm of a child or young person is always distressing, and the child abuse deaths in SCRs are truly awful to read about. It would never be acceptable to say there is nothing to be learned from them, and in some ways the reviews become a memorial to the child. It often turns out that the shortcomings are the familiar ones, but we need to keep learning from them, in ways that are proportionate, contextual and compassionate.

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Appendix A: Table of the periodic reviews of SCRs

	Title and date of publication	Authors	Years covered	No. of SCRs
1	*Learning from past experience: A review of Serious Case Reviews* (2002)	Ruth Sinclair and Roger Bullock	1998-2001	A sample of 40 cases; estimates 90 reviews per year
2	*Improving safeguarding practice: Study of serious case reviews* (2008)	Wendy Rose and Julie Barnes	2001–2003	A sample of 40 cases; estimates 90 reviews per year
3	*Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005* (2008)	Marian Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black	2003–2005	189
4	*Understanding Serious Case Reviews and their Impact: A biennial analysis of Serious Case Reviews 2005-07* (2009)	Marian Brandon, Sue Bailey, Pippa Belderson, Ruth Gardner, Peter Sidebotham, Jane Dodsworth, Catherine Warren and Jane Black	2005-2007	161
5	*Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009* (2010)	Marian Brandon, Sue Bailey and Pippa Belderson	2007-2009	268

	Title and date of publication	Authors	Years covered	No. of SCRs
6	*New learning from serious case reviews: A two-year report for 2009-2011* (2012)	Marian Brandon, Peter Sidebotham, Sue Bailey, Pippa Belderson, Carol Hawley, Catherine Ellis and Matthew Megson	2009-2011	184
7	*Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014* (2016)	Peter Sidebotham, Marian Brandon, Sue Bailey, Pippa Belderson, Jane Dodsworth, Jo Garstang, Elizabeth Harrison, Ameeta Retzer and Penny Sorensen	2011-2014	293 (NB 3 years)
8	*Complexity and challenge: A triennial analysis of SCRs 2014-2017* (2020)	Marian Brandon, Peter Sidebotham, Pippa Belderson, Hedy Cleaver, Jonathan Dickens, Joanna Garstang, Julie Harris, Penny Sorensen and Russell Wate	2014-2017	368 (NB 3 years)
9	*Learning for the future: Final analysis of serious case reviews 2017-19* (2022)	Jonathan Dickens, Julie Taylor, Laura Cook, Jeanette Cossar, Joanna Garstang, Nutmeg Harris, Eleanor Molloy, Natasha Rennolds, Julia Rimmer, Penny Sorensen and Russell Wate.	2017-2019	235 (NB 2.5 years)

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