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The multiple and competing functions of local reviews of serious child abuse cases in England

JONATHAN DICKENS
University of East Anglia, Norwich, UK

LAURA COOK
University of East Anglia, Norwich, UK

JEANETTE COSSAR
University of East Anglia, Norwich, UK

CYNTHIA OKPOKIRI
University of East Anglia, Norwich, UK

JULIE TAYLOR
University of Birmingham, Birmingham, UK

JOANNA GARSTANG
University of Birmingham, Birmingham, UK

Abstract
When children are killed or seriously harmed from abuse or neglect, there is pressure to 'learn the lessons' to prevent similar events. England has a long-established system of locally-based multi-agency reviews for this, but the recurrence of tragedies and repetitive findings raise questions

Corresponding author:
Jonathan Dickens, University of East Anglia, Norwich, UK.
Email: J.Dickens@uea.ac.uk

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about its effectiveness. Reflecting and building on our research into reviews completed between 2017 and 2021, we analyse the complexity that routine criticisms of inter-agency working disguise, and argue that reviews are shaped by their multiple, competing functions. The stated purpose is to improve practice. Within this are other overt but ambiguous goals: establishing what happened, accountability, reassurance and commemoration. Then there are covert functions: to dissipate public outrage, deflect attention from underlying causes, and distort understandings of the work by making it seem straightforward. Reviews would benefit from paying more attention to the dynamics of frontline practice and the local actions to implement the lessons.

Keywords
child protection, local child safeguarding practice reviews (LCSPRs), serious case reviews (SCRs)

Introduction

Periodically, awful cases of child abuse and neglect hit the national news headlines in England and become the focus of public distress and anger. Invariably, there are professional and political promises to find out what went wrong and 'learn the lessons', often with claims to make sure this sort of thing 'never happens again'. In some cases these lead to high-profile inquiries and recommendations for extensive reforms to inter-agency child protection procedures and practice. Significant examples earlier this century are the inquiries into the cases of Victoria Climbié (Laming 2003) and Peter Connelly ('Baby Peter': see Haringey LCSB 2008, 2009).

At the time of writing, the most recent high-profile cases were those of Arthur Labinjo-Hughes and Star Hobson, in 2021–22. Nadhim Zahawi, the secretary of state for education at the time, made the usual calls for the lessons to be learned (Zahawi 2021) and ordered a national review by the Child Safeguarding Practice Review Panel (initially on Arthur's case: Star was added later) (CSPR Panel 2022a). What is less well-known is that locally-based multi-agency reviews of serious child abuse cases take place all the time, often with little national press coverage, if any at all. They were previously called 'serious case reviews' (SCRs) but are now known as 'local child safeguarding practice reviews' (LCSPRs). Since reliable nationally-held records in England began in 2004, there have been over 1700 such reviews (Dickens et al. 2022b). This begs the questions of why the necessary lessons have not been learned (or at least, not applied), and what changes to reviews might lead to improvements in practice.

To explore these questions, we reflect and build on findings from four studies that we undertook over the period 2020–2022. These were the final periodic analysis of SCRs (2017–19), a history of SCRs from 1998 to 2019, and the first two annual reviews of LCSPRs (those completed in 2020 and 2021). The four studies were conducted separately, but the shared themes became apparent as we analysed the data. The article addresses the policy functions of reviews, rather than using them to assess what 'really happens' in child abuse cases. As we show later, local reviews are unreliable guides for that: instead, they give a particular, rather hackneyed and limited interpretation of events, the family circumstances and the professional responses.

The article is in four parts. First, we summarise the history of local case reviews and outline the new learning structure and review process that came into being in England in 2018–19. We then describe our research methods and the principal ethical considerations. The third part focuses on findings regarding inter-agency working and information sharing. We show how the ways that they are reported tend to disguise the variety and complexity of practice, giving the impression that the work is relatively straightforward and improvements can easily be achieved through managerial changes such as a new organisational structure or improved technological systems. This leads into the fourth part, where we discuss the multiple purposes that local reviews serve, both expressed and disguised. We argue that the features for which reviews are so often criticised, such as delivering 'the same old messages' and being long-drawn out, actually serve to meet their covert functions of dealing with the cases in a way that is least likely to produce systemic change. We draw out two ways that reviews might be adapted to be more useful for improving practice.

Our focus is England, but the pressures to learn from these difficult cases are familiar in the other countries of the UK and other high-income nations (see Biesel et al. 2021). The terminology and organisational contexts may vary (currently, Scotland has learning reviews, Wales has child practice reviews and Northern Ireland has case management reviews: NSPCC 2022), but our findings and analysis speak to a wider audience than England alone.

Local reviews of serious child abuse cases in England

The system in England for local reviews of cases where children have been killed or seriously harmed, and abuse or neglect is known or suspected, was established in 1988, in the first edition of the statutory guidance *Working Together* (DHSS and Welsh Office 1988). The guidance has been revised, sometimes extensively, on numerous occasions since then. At the time of writing the current version is the 2018 edition (HM Government 2018a), which introduced the new LCSPR system. (A draft revision was published for consultation

in summer 2023, but this did not propose any changes to the guidance on local reviews.)

There had been reviews of serious cases for a long time before 1988 (see DHSS 1982 and DH 1991; for other summaries, Corby et al. 1998; Dingwall 1986; Munro 1999; Parton 2004; Reder and Duncan 2004a) and the new system was designed partly to reduce the frequency of high-profile inquiries, which were seen to have fed into a hostile media portrayal of social workers, as well as to save costs and time. The expectation was that from now on reviews would normally be undertaken locally and in private. The 1988 guidance did not require that the report should be published, although it did specify that the media and public should be kept informed. The position on publication has changed over time, and since 2010 there has been a requirement that the full report (anonymised) should be published unless there are compelling reasons for not doing so.

The 1999 revision of *Working Together* expanded the guidance on case reviews and emphasised that they should be carried out, as far as possible, so that they were a learning process not an ordeal; and that 'at least as much effort' should go into acting on the recommendations as conducting the review (DH et al. 1999: 94). It also established a system of periodic overviews, for disseminating the lessons nationally.

The first of the periodic overviews was published in 2002, covering the years 1998–2001 (Sinclair and Bullock 2002). Our 2017–19 study was the ninth and final overview (Dickens et al. 2022a). Details of all the periodic reviews are in our overview of the history of SCRs (Dickens et al. 2022b). All can be accessed for free on the SCR website hosted by *Research in Practice*: scr.researchinpractice.org.uk.

Whenever a case does hit the headlines, the criticisms tend to be that despite all the time and money spent on reviews, the same shortcomings occur again and again. These came to a head in 2016, in a review of local safeguarding children boards (LSCBs), the co-ordinating body at the time for the work of local child protection agencies (Wood 2016). Wood was unsparing in his criticisms of the SCR system, its high costs, long delays in publication, and the variable quality of the reports:

> Despite guidance to the contrary, the model of serious case reviews has not been able to overcome the suspicion that its main purpose is to find someone to blame. Although there has been some improvement in the quality of some reviews the general picture is not good enough and the lessons to be learned tend to be predictable, banal and repetitive (Wood 2016: 8).

The government response (DfE 2016) committed to replacing SCRs with a new system of local and national reviews, with the aims of greater consistency; improving the speed and quality of reviews; ensuring that they are

proportionate to the issues under investigation; capturing and disseminating the lessons more effectively; and making sure that the lessons inform practice.

The new learning structure and review process in England

The new system came into being in 2018–19. The national Child Safeguarding Practice Review Panel was established in summer 2018. There was a transitional period, from June 2018 to September 2019, during which time LSCBs were gradually replaced by local child safeguarding partnerships and the new LCSPR system phased in.

The guidance for the new system was set out in the 2018 edition of *Working Together*, and practice guidance issued by the national Panel, which was updated in 2022 (CSPR Panel 2022b). The ambition was to move away from the old model of SCRs, to be more succinct and analytic, with a clear focus on learning, rather than describing what has happened – to get to the *why* rather than the *what.* The aims of the review process are given as being '… to identify improvements to be made to safeguard and promote the welfare of children' and '… to prevent or reduce the risk of recurrence of similar incidents' (HM Government 2018a: 82).

If a child has died or been seriously harmed, and abuse or neglect is known or suspected, the local authority concerned must submit a 'serious incident notification' (SIN) to the Panel. This is followed by a 'rapid review' on each of these cases, which should normally be completed within 15 working days (this is the Panel's expectation, not a statutory requirement). If the local partnership identifies a need for further learning, then it should commission an LCSPR. The *Working Together* guidance sets out criteria which the partnership must consider when deciding whether to commission an LCSPR, but even if a case meets these, it does not have to instigate one: 'It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice' (HM Government 2018a: 87). Rapid reviews are not published, but the reports on them and the decision on the LCSPR are sent to the Panel.

The LCSPR is undertaken by a reviewer who is independent of the case, but the local partnership should determine the 'key lines of enquiry' to be followed, setting these out in the rapid review. (The reviewer may decide that different or additional issues should be pursued.) This element of variability in the precise aims and methods of each review makes them different to nationally prescribed inspections, and gives grounds for caution in comparing them; but despite this, common themes and approaches soon emerge. It is standard practice to involve practitioners in the review, possibly through individual interviews but often in group discussions; it is also standard practice to invite family members to participate, and the child/young person if it is a

case of serious harm rather than a fatality (Morris et al. 2015 helpfully discuss the benefits and complexities of family involvement). The statutory timescale for completing the review is six months, as it was for SCRs.

Reports should identify learning points and make recommendations, but it is for local partnerships to decide what should be taken forward and make a relevant action plan. Reports should be written with publication in mind (i.e., so that there is no need for subsequent redaction). Reports should be published on the local partnership website, but only have to remain there for one year; they should also be published in the online national case repository maintained by the National Society for the Prevention of Cruelty to Children (NSPCC), where they remain beyond the one-year point. If there are serious concerns about confidentiality, reviews can be published anonymously in the repository (i.e., without identifying the local partnership).

The local reviews are complemented by national reviews on particular cases or more general themes, commissioned by the Panel. Examples are reviews on children at risk from criminal exploitation (CSPR Panel 2020); and on safeguarding children under 1 from non-accidental injury caused by male carers (CSPR Panel 2021).

The Panel's national review into the murders of Arthur Labinjo-Hughes and Star Hobson was published in May 2022. Over the period it was being undertaken, running separately but with exchange of ideas, there was a government-commissioned 'independent review of children's social care', 2021–22. Its final report was also published in May 2022 (MacAlister 2022). Both reviews made recommendations for changes to child safeguarding policy and practice in England, and at the time of writing (summer 2023) there is a raft of new initiatives and pilots underway on a two-year timescale (DfE 2023a). It is uncertain what will happen after that, especially as the timescale takes them past the next general election.

The research studies

Methods

Study 1: The review of 2017-19 SCRs

The aim of this study was to identify common themes across the reviews and draw out the implications for policy makers and practitioners (Dickens et al. 2022a). There were 235 cases where there had been a serious incident notification to the DfE, and we were able to get 166 completed reports. The main reason for reports not being available was delay in completion, often attributed to waiting for the conclusion of criminal proceedings. We used a mixed methods approach, with a quantitative analysis of factors such as the ages

and gender of the children, family circumstances and the nature of the abuse that led to the SCR, and an in-depth qualitative analysis based on a sample of 49 cases. We also held two online ‘knowledge exchange events’ with local child safeguarding professionals to explore how the reviewing of serious cases and the practices they reflect have changed over time, and the messages to take forward. These events were run in collaboration with *Research in Practice*.

Study 2: The overview of the history of SCRs

This was based on a thematic analysis of the nine periodic reviews (Dickens et al. 2022b). The aim was to identify the key challenges, changes and continuities over time.

Studies 3 and 4: The two LCSPR reviews

The 2020 review reported on 33 LCSPRs, all that were available at the time (Dickens et al. 2021) and the 2021 review on 84, all those that had been completed and submitted to the CSPR Panel in the calendar year 2021 (Dickens et al. 2022c). This gave 117 completed LCSPRs, from 372 that had been initiated since the new system began in 2018. This is fewer than a third, although we could not have expected any that were started in the second half of 2021, because of the six-month timescale. We should also appreciate the impact of the Covid-19 crisis over 2020 and 2021 on all the agencies involved.

In Study 3 we also looked at a sample of 135 rapid reviews completed between January and December 2020 (approximately 25%). In Study 4 we were supplied with the relevant rapid reviews and SIN forms for the 84 reports, if available.

The briefs for the two LCSPR studies were to provide an overview and understanding of the key issues, themes and challenges that had been discussed in the reviews. As with the SCR studies this was done through a statistical picture of the key features, and in-depth qualitative analysis of a sample. For the second LCSPR study, we were also asked to investigate what actions local partnerships had taken to implement the recommendations. For this, we took a sample of 24 reviews. We looked for evidence on the partnerships’ websites and asked them to complete a survey and attend an online focus group (22 participated).

Ethical considerations

Research ethics approval was given by the research ethics committee in the school of social work at the University of East Anglia. One of the key

ethical issues, for local safeguarding partners, reviewers, the national Panel and us as researchers, concerned the tensions and balances between, on the one hand, transparency and the potential for learning, and on the other, confidentiality and the wellbeing of all involved. Our focus groups revealed profound concern and differing views about how much detail should be included in the final report, not only because it might make the child and family identifiable, but because of the impact it might have on surviving children, family members and practitioners, now or in the future. Nearly all the reports were already published and in the public domain, but we were conscious that our overview reports reach a wider audience, so we were careful about how much detail we gave about the cases and never identified the local agencies; beyond that though, we explored the issues in depth in the focus groups and our meetings with the Panel. The Panel's guidance is that it is impossible to guarantee anonymity and reviews should aim for 'sufficient context to enable the lessons to be meaningful but avoid unnecessary sensitive information' (CSPR Panel 2022b: 25), but where these lines should be drawn is ambiguous and contested.

As an example of the tensions, we found that many reviews did not specify the child's ethnicity, with some explicitly stating that this was to help preserve anonymity; but this obscures a vital dimension for understanding the family's situation and the services they may or may not have received (Dickens et al. 2022c, 2023). Even when the racial/ethnic background was specified, it was unusual for reviews to analyse how this shaped the child's and family's lives, and how practitioners and services responded to them. One of our recommendations to the Panel from Study 4 was that reviewers should specify the racial/ethnic background, and other characteristics such as age, gender, disability and sexuality, unless there are overwhelming reasons not to do so (Dickens et al. 2022c). The ethical justification is that this is necessary to ensure proper learning. The Panel agreed with this. In their 2021 annual report (published in December 2022), the Panel specified that giving 'central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families' would be one of its six key practice themes for 2023 (CSPR Panel 2022c: 27).

Looking beneath 'the same old messages': The example of inter-agency working and information sharing

Despite the repeated criticisms of reviews for regurgitating 'the same old messages', a closer analysis of the findings about child safeguarding practice since 1998 reveals a picture of change, continuity and complexity, the limitations of reviews in conveying this and the limited willingness of national government

to hear the messages. To illustrate this, we look at the findings on inter-agency working and information sharing, the heart of the child protection system, and at the time of writing, the subject of many proposals for reform.

Inter-agency working and information sharing are frequent subjects of criticism in the reviews, but it is important to appreciate that they are both very broad terms and cover a wide variety of issues. For example, information may not be conveyed in the first place, or it may be lost, or it may be received but not properly understood; and the gaps may occur between services within the same agency, between different agencies within a local authority area, or when families move to new areas. Furthermore, information exchange may be thwarted by technical factors, such as unreliable IT systems or systems that do not 'speak' to one another, or by individual factors (e.g., a practitioner who does not realise the potential significance of a piece of information for another agency, or who is feeling too overwhelmed to read a referral carefully and follow it up), or any combination of these. A regular theme is the importance of discussion, not relying solely on written/digital referrals, to ensure information is properly understood, and a common criticism is that practitioners did not show an appropriate level of 'professional curiosity' or 'challenge' to ask for more information, or clarification of the information they have been given from families or other professionals (Dickens et al. 2022c, 2023; Garstang et al. 2023). But an individual's practice is shaped by their organisational context and culture (e.g., workloads, responsibilities, supervision, support), and whilst such factors are often mentioned, they are rarely applied rigorously to the analysis of what 'went wrong'.

Improved arrangements for inter-agency working and information sharing have been regular recommendations over the years, both in case-based reviews and wider policy reviews (e.g., Wood 2016). The principal recommendation of the CSPR Panel's national review of the Arthur and Star cases was another call for improved inter-agency working, this time through the creation of 'multi-agency child protection units'. The aim is for skilled workers from different professional backgrounds to be co-located and work closely together throughout the process, from investigation to decision-making, with new national practice standards (CSPR Panel 2022a). The recommendation might be considered rather predictable coming from a multi-agency body, a reform cast in its own image. The government's response (DfE 2023a) was to undertake to establish up to 12 'pathfinder programmes' to pilot the units together with other changes to the child protection system recommended by the independent review of children's social care; but the changes will bring their own challenges.

Organisational changes and restructurings can be serious obstacles to multi-agency working. They mean that new processes and procedures for inter-agency communication have to be created and learned by staff. They may strengthen some relationships but are likely to weaken others. Compulsive reorganisation is an 'old problem' in the sense that it was

identified in the first of the periodic SCR overviews (Sinclair and Bullock 2002), but nothing has happened to slow it down: if anything, it has become more demanding. The 2018–19 changes to the system for local inter-agency working are just one example; there have also been continual changes to structures for other relevant agencies, notably health services and schools. Additional hurdles are created by increased commissioning of services from private and third-sector agencies (ADCS 2022; CMA 2022; Jones 2015).

Some of the problems with information sharing have also been seen to rest on misunderstandings about data protection legislation and misgivings about breaching confidentiality. The independent review of children's social care called for a strengthening of guidance and legislation on information sharing, with a target of 'frictionless information sharing' between local authority and partner systems, and between different local authorities, by 2027 (MacAlister 2022). The government's response was to launch a survey of local arrangements and to set up two pilot projects. One is to develop a data and information sharing agreement that could be used as a model across the country, the other to undertake research into ways of overcoming 'cultural and behavioural barriers' to sharing information (DfE 2023a: 186). In a literature review commissioned to underpin this work, Feinstein et al. (2023) highlight the dilemmas that professionals face of satisfying the competing imperatives for privacy *and* information sharing, and also observe that improved systems for information sharing will not necessarily lead to improved responses to children's needs, without sufficient investment in the services required to meet them.

The government's answers to the challenges of information sharing focus on improved ICT systems, including the use of the child's NHS number as a 'consistent child identifier' (DfE 2023b), and the messages from the reviews about the importance of services and of inter-personal communication, dialogue and trust between professionals are downplayed. Furthermore, they miss the lessons of previous initiatives to solve the problems through enhanced digital and data-based systems (Feinstein et al. 2023; White et al. 2010). The strength and persistence of the issues, despite repeated government guidance about the 'myths' of data protection (e.g., HM Government 2018b), point to the deep-seated social and cultural issues of family privacy and the importance of confidentiality. Some may regard these as an awkward hindrance, but they may also be seen as important barriers against an over-intrusive state, and changing them will be complex and contested. It is neither fair nor realistic to pin responsibility for solving this societal dilemma on local agencies and individual practitioners.

The multiple functions of local reviews

One of the challenges for assessing whether local reviews are effective is that they have multiple functions. These functions are not always compatible,

some are explicit and some are unstated, some are intended whilst others may be unintentional but serve powerful social and political purposes. In this section we analyse the tensions, in two stages. We start by considering four overt but ambiguous goals and the difficulties for local reviews to satisfy them all; we then go on to identify three hidden policy functions.

Overt functions

The 'overall purpose' of LCSPRs, as set out in *Working Together* 2018, is 'to identify improvements to practice' (HM Government 2018a: 87) but reviews have long had other important goals and sub-goals (see Dingwall 1986; Reder and Duncan 2004b). Even if not officially required, these shape the conduct of the review and the contents of the report. First, to understand what improvements might be needed it is necessary to find out what happened. One of the regular criticisms has been that reviews spend too long on this, being overly descriptive rather than analysing the information; but some background and detail is necessary because without a clear and accurate picture of the family, what happened to the children, and how staff and agencies acted, the analysis will be flawed. As well as that 'how much?' tension there is a more fundamental ambiguity: as Butler and Drakeford (2005) have pointed out, it is misleading to think that reviews can ever produce an objective, incontrovertible picture of what 'really happened'. Rather they are socially constructed to create an 'official' truth: 'Inquiries, as much as any other medium of communication, devise and develop accounts and interpretations of events that aim to persuade others of their particular understandings' (Butler and Drakeford 2005: 236; and see Masson 2006, who takes a 'social constructionist' approach to the Climbié inquiry).

The most striking example of the way that different versions of the 'truth' can be constructed is the re-writing of the SCR about Peter Connelly, in 2008–09. In the face of the furious political and media storm about the case, Ed Balls, the relevant secretary of state at the time, ordered Ofsted to evaluate the submitted SCR (Haringey LCSB 2008). It assessed the review as inadequate, and Balls then ordered that a new one be undertaken (Haringey LCSB 2009). Jones (2014) draws attention to the way that the second review focuses much more narrowly on Haringey children's services department, cutting back discussion about the roles of other agencies. Warner (2015) draws attention to the 'tone and moral language' of the second review, and the way it emphasises the need for practice to be more 'authoritative'. We would add that whilst the second review introduces thoughtful observations on the policy, organisational and local contexts, it does not apply them critically in the analysis of what happened.

A second important role is to hold agencies to account for their actions or inactions. Public accountability is one of the reasons for the publication of the

reports, and there is an expectation that agencies will acknowledge and learn from any mistakes. Intriguingly, however, the *Working Together* guidance denies this purpose, saying that reviews '… are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose …' (HM Government, 2018a: 84). There are several possible explanations. One is that the guidance is distinguishing between public accountability and professional or organisational accountability (for which other processes exist, such as disciplinary proceedings and inspections); and/or that it is distinguishing between two senses of 'being accountable' – being required to give an account of what has happened, and being blamed for it. But although a review is not a disciplinary procedure, its findings might lead or contribute to one; and even short of that, people's careers and reputations are on the line. It is disingenuous to imply otherwise.

The suggestion that reviews are not intended to hold organisations and individuals to account attracts little or no credence amongst local professionals. In our focus groups, they talked about the stress of going through a review, which was not alleviated by the assertion that reviews are not disciplinary processes. There were some who said that if done well, practitioner involvement could help their own learning and provide 'closure' for them as well as improving the quality of the recommendations, but our analysis of the 2021 LCSPRs found that it was often unclear what had been learned from practitioners. (From a sample of 20 reports, only five gave a clear account of the learning from practitioner involvement: Dickens et al. 2022c.) It is possible there was useful learning during the process that is not attributed to them, perhaps because the reviewer did not want to risk identifying or appearing to blame individuals, but such gaps and dilemmas indicate the tensions between different aspects of accountability, transparency through publication and in-depth learning through honest, reflective discussion. These need to be acknowledged rather than denied. Managing them is challenging, but learning about the experiences, decisions and actions of practitioners needs to be conveyed more clearly.

A third goal, linked with accountability, is to reassure politicians and the public that the lessons have been learned and practice is now improved, or at least, action is underway to ensure it is. This is, however, an expectation that is often unmet, because the repeated tragedies and repetitive messages suggest the lessons have not been learned. To change this, it is important that partnerships have clear action plans, published alongside the review, for disseminating lessons locally, implementing changes, monitoring their effectiveness and reporting on progress and outcomes. This was a specific topic for Study 4 and our survey and focus group showed that determined and creative work does go on in this regard (Dickens et al. 2022c). The focus is usually on disseminating the lessons through training and online briefings, which, given staff turnover, need to be ongoing and doggedly followed up. There were also accounts of

service innovations, such an initiative in one area to work with minicab firms, hotels and licensed premises to raise awareness of sexual exploitation. Such work should be publicised. At the moment, the repetition of findings feeds into stereotypes of poor-quality work and naïve practitioners.

A fourth goal is to serve as a 'memorial' to the child. Again, this is not a requirement in the guidance, but it can be seen very clearly in some reports, which make a point of talking about the child's positive qualities, how people remember them, and that the learning from the review will at least be a positive legacy and tribute to them (and see Cooper and Whittaker 2014: 261, who discuss the Climbié inquiry as a 'process of public mourning'). This can be very moving, and it is important to keep the child at the forefront of the review, but it is an odd sort of commemoration (not naming the child and family) and it is equally important not to lose objectivity. The commemoration element can add to the pressure on local partnerships to hold an LCSPR – it is hard to say no if this is taken to imply that the partnership thinks there is nothing to be learned from the death of a child.

Covert functions

As long ago as 1990, Malcolm Hill identified 'the manifest and latent lessons of child abuse inquiries' (Hill 1990). The manifest lessons concern factors such as poor risk assessments and poor inter-agency co-operation, the type of issues that have become routine findings. The latent functions were to 'appease public disquiet' and 'define the nature and causation of child abuse in ways which detach it from wider social processes and responsibilities' (Hill 1990: 207). With over thirty years' more evidence we can see more clearly how local reviews achieve these hidden functions, by dissipating criticism and demands for change, deflecting attention from underlying causes and distorting understandings of practice.

Dissipation

Recall that one of the aims of local reviews when they were introduced in 1988 was to keep child abuse cases out of the media spotlight, and despite the publication of the reports this continues to be one of their unstated but politically essential functions. Politicians and professional leaders can deal with the heat of the initial scandal by saying that a local review will take place to investigate matters fully and its findings will be published in due course. The widespread delays in concluding the reviews and publishing the reports then give time for public and political anger and demands for change to dissipate. (As noted earlier, delays are often attributed to protracted criminal investigations, but the Panel's guidance is that this should not automatically delay a review: CSPR Panel 2022b.)

It is relatively unusual for a case to escape the controlled processes of a local review and become a national scandal. Media coverage of the criminal investigation and subsequent trial is usually the key factor (this also has implications for anonymity, because a quick internet search using information from the review can often uncover the names of the child and family by matching the trial reporting). The Peter Connelly case is a notable example. Public outrage did not die down because it was stoked by the *Sun* newspaper (Jones 2014) and the speed with which the second SCR was completed. Ironically, one of the things for which reviews are so often criticised, the length of time they take, turns out to be an effective way of meeting one of their underlying policy functions.

Deflection

Whilst the slow and private progress of local reviews may allow public interest to dissipate, reviews also keep the focus on the local level, deflecting attention from hard questions about the national context and causation. Focusing on the national context would mean looking more closely at the impact of deprivation and inequality (e.g., ADCS 2022, Bywaters and Skinner 2022, Taylor et al. 2023), and (as discussed above) at the availability and quality of services to support children and families, and the policy tensions between state intervention and family autonomy. Such issues are certainly mentioned in SCRs and LCSPRs, but usually incidentally, a brief and soon forgotten element of contextualisation rather than an analytic tool and structure. Similarly, hard questions about human behaviour, emotions and motivation are rarely addressed – how could someone treat a child so appallingly over such a long time? How could one adult allow another to treat a child that way? Improving professionals' understanding of these aspects would be a way to increase the chances of identification and timely action to help parents and protect children.

Problems facing the parents such as inter-partner violence, drug and alcohol addiction, mental ill health, learning disability, extreme poverty, and backgrounds of having been abused and neglected themselves, are regularly identified in the reviews because they are, sadly, not unusual amongst families who might be known to child protection services. However, the precise combinations and circumstances of each family are unique (see Skinner et al. 2021), and what leads a particular parent to behave abusively is not usually explored; nor is how would a social worker (or any other professional) recognise this amongst all the other cases that look so alike but do not lead to death or significant harm.

Equally, reviews tend not to get to grips with questions about why professionals did not act in response to what they had seen or been told. As noted earlier, a frequent criticism is that practitioners showed a lack of 'professional curiosity' or did not use 'professional authority', but all too often the reviews

do not push further as to why that might be (Dickens et al. 2023). Frontline practice is rarely explored, such as what happened in the encounter with the parents, what was observed and said, what was asked and pursued or not, and why; aspects such as uncertainty, avoidance, stress, panic and fear are rarely mentioned or analysed (and see Cooper 2005, Ferguson 2005). Reviewers may be reluctant to do this for fear of appearing to blame individuals, but it leaves another big gap in the learning from reviews.

Distortion

Local reviews can also give a distorted picture of practice. This happens for three main reasons. First is the tendency for the reviews to echo one another, to pick up on the issues and language used in previous reviews – 'professional curiosity' is a leading example, but other clichés are 'thinking the unthinkable' or 'hidden in plain sight'. Whilst there may be some useful insight in these notions, the repetition takes away their impact and leaves a sense of being a 'ready-made' solution, the 'banal' findings criticised by Wood (2016), not shedding any great light on the matter.

The second reason for the distortion is the search for wider, national learning from these local reviews. In this process the local lessons become generalised and lose their impact. There may be useful lessons for the agencies involved about what went wrong in this particular case and what action they can take to prevent a recurrence, but in making the switch from local learning to learning for the whole country the detail is ironed out and the lessons tend to become, once again, banal.

Third, public understandings of child safeguarding work can be distorted by the cumulative impact of so many reviews. We are not accusing any authors of being deliberately misleading, but by reviewing events from a position of hindsight, by looking for general themes and influenced by previous reports, the reviews build a composite picture of predictability and simplicity, that obvious signs are missed, that practitioners are often naïve and incompetent, and that the English system is poor at protecting our children. But there are alternative perspectives. Arguably the safeguarding system in England is as effective as it can be at protecting children, given that child protection is only one of its goals – there are also imperatives to support families, respect family autonomy and diversity, use coercive intervention only as a last resort, and keep within budgets. Given these tensions, some sad outcomes are inevitable (Dingwall et al. 1983). That is not to negate the aim of trying to reduce the number, but greater honesty is required about the policy, resource and organisational contexts, as well as the fallibility of individuals. Furthermore, reviews of particular cases do not give a picture of the whole range of work that agencies undertake and do not capture successful work.

One way to redress the distortion would be to give more attention to the actions taken to implement the recommendations. The six-month timescale for LCSPRs might constrain this, but given the lengthy delays in completion that so frequently occur, agencies usually have to start taking action based on the rapid review, so it should be possible for LCSPRs to comment on this (some do). Partnerships are required to produce annual reports and these include accounts of follow-up activity, although this information is easily lost in what tend to be lengthy documents. It needs to be given greater visibility.

Conclusion

Local reviews are only one of the elements that shape child protection policy and practice, and many of the others are more powerful. These include national policy and legislation, budgets, inspections, scandals and organisational changes. It is also necessary to take account of professionals' understandings and attitudes, the availability (or not) of services for families, and the need to balance powers of intervention with other social imperatives such as family autonomy. We should not dismiss the contribution that local reviews can make, but it is important to take a realistic view. They are costly in terms of time, money and the heavy impact they have on the agencies and individuals involved, and a proportionate approach is needed to what can be learned from them, notably to be cautious about expecting local reviews to produce original national lessons.

There is a large dose of magical thinking in the repeated calls to 'learn the lessons' and prevent child abuse deaths happening again – that new technology, new guidance or a new organisational arrangement will make all the difference. As we have argued throughout the article, greater realism and honesty is required. And if the aim is to cut out learning that is 'predictable, banal and repetitive' (Wood 2016), there should be a high threshold for cases to proceed from the rapid review to an LCSPR. Working against that however are the other functions of local reviews, such as public accountability and commemoration, which make it hard for local partnerships to reduce the number of LCSPRs. Then there are the covert but powerful functions, about managing the fallout from these cases by dissipating anger, diverting attention from national issues, avoiding difficult questions about human motivation and behaviour, and keeping local agencies in the spotlight for blame. Findings that are predictable, banal and repetitive meet these purposes rather well.

A good starting point for change would be to acknowledge these policy tensions, and how reviews are shaped and trapped by them; but beyond that, there are two ways that reviews could be adapted. First would be to focus more explicitly on the details and dynamics of frontline practice, the actions and 'in the moment' reasoning of the practitioners; and second

would be to report more on the actions local agencies have taken in response to the review. Neither of these suggestions is problem-free – there will still be the tensions between in-depth inquiry into what happened and some professionals feeling accused, and between a comprehensive picture of follow-up actions and some seeing repetition. Such dilemmas are inevitable given the competing and contested functions of local reviews – any 'solution' will have its contradictions. But changes are necessary if reviews are to have a better chance of contributing to their stated goal of improving practice, and these two would be positive steps forward. They would help to meet the accountability and reassurance goals and be a powerful memorial to the child.

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Author biographies

Jonathan Dickens is emeritus professor of social work at the University of East Anglia, Norwich, UK. His research interests focus on the interfaces between social work, social policy and the law, in child protection work, care proceedings and work with children in care. He led the research team from the University of East Anglia and the University of Birmingham on the four studies reported in this article.

Laura Cook is lecturer in social work at the University of East Anglia, Norwich, UK. Her research interests focus on decision-making and the concept of professional judgement in social work. She is particularly interested in the role of emotion and intuition in social workers' assessment of risk.

Jeanette Cossar is associate professor of social work at the University of East Anglia, Norwich, UK. Her research interests include children's understanding of abuse and neglect, their views about the services they receive and the extent to which they feel involved and participate in decision-making.

Cynthia Okpokiri is lecturer in social work at the University of East Anglia, Norwich, UK. Her research interests include a focus on frontline child protection practice, and on theorising Black parenting within Western and African contexts.

Julie Taylor is professor of child protection at the University of Birmingham, UK. She has a longstanding research interest in child neglect. Current interests include child sexual abuse, disclosures of abuse, and child abuse linked to faith and belief. Julie led the Birmingham side of the team on the four studies reported in this paper.

Joanna Garstang is a consultant community paediatrician, designated doctor for child death for Birmingham and Solihull, and clinical associate professor in child protection at the University of Birmingham, UK. Her specialist areas are safeguarding children, child death review and sudden unexpected death in childhood.