

A study of serious case reviews between 2016-2018: What are the key barriers for social workers in identifying and responding to child neglect?

Abstract

Child neglect is the most common form of maltreatment but is also one of the most complex. Neglect has a long term negative impact on children and young people's development and wellbeing, and can cause harm to children and young people. This study used documentary analysis to consider twenty recent serious case reviews (SCRs) that had taken place in England and where neglect was a feature in order to examine the barriers which exist for social workers to identify and respond to neglect in a timely, appropriate and effective manner. A thematic analysis was used to identify and separate key themes in the data collected from the SCRs. Four main themes were identified and explored in this study with the aim of gaining further insight and understanding of the complexities of working with neglect. These were challenges in terms of the definition of neglect and how to identify it, the use of tool kits when working with families when children may be at risk of neglect, the impact of organisational cultures on practice and the voice of the child.

Introduction

Child neglect is the most common form of maltreatment in the UK, as well as being the most common reason for a child to be made a subject of a child protection plan (Action for Children, 2015). The number of children under a child protection plan in England increased by 96% between 2002 and 2016, and it is estimated that 46% of children are subject to a child protection plan due to neglect (Bentley et al., 2017).

Despite it being estimated that one in ten children in the UK have experienced neglect (NSPCC, 2017), there exists a dearth of literature specifically about neglect compared to child abuse and other forms of maltreatment. The majority of the literature refers to 'abuse and neglect', with most of the focus being placed on information around abuse, which is considered easier to identify (Tanner and Turney, 2003). Research has shown that neglect is often not acted upon until a crisis has occurred, and without a trigger such as this, there is a danger that vulnerable children are left in neglectful environments for too long without appropriate interventions being made (Daniel, Taylor and Scott, 2011).

A previous examination of serious case reviews (SCRs) from 2009-2011 identified neglect as a factor in 60% of SCRs, making it more widespread than previously thought (Brandon et al., 2013). The Children Act 2004 requires that children's services authorities in England establish Local Safeguarding Children Boards (LSCB) to ensure that key agencies involved in safeguarding children are coordinated in their work. One of the tasks of LSCBs, as set out in Regulation 5, is to undertake reviews of cases where lessons can be learned (Carr and Goosey, 2017). Working Together to Safeguard Children (WTSC 2015) states that a serious case review should take place when:

- Abuse or neglect of a child is known or suspected; and
- Either- i) the child has died; or ii) the child has been seriously harmed and there is a cause of concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

SCRs are written to offer lessons that can be learned from a case in order to improve practice or the way professionals work together to safeguard children (Koubel, 2016). However, SCRs can easily be regarded as documents to express and represent shame and blame of organisations and individuals involved (Warner, 2015). Through hindsight and bias, they have a tendency to explore other judgements and decisions that could have been made, and risk creating the notion that safeguarding children is based on common sense and is something that could be performed by anyone (Warner, 2015).

Literature Review

Defining neglect

Neglect can manifest itself in many ways in many different contexts, and is just as damaging as other forms of maltreatment (Barlow et al., 2016). Due to the complexity of neglect and the wide range of potentially neglectful circumstances, Daniel (2017) argues that it is not unexpected that it is difficult to agree on one definition of neglect. Additionally, neglect poses a number of challenges for social workers due to its high prevalence and the wide range of circumstances that may potentially be described as neglectful. Neglect generally refers to an ongoing or chronic lack of care and is linked with cumulative developmental problems for the child (Connolly and Morris, 2012). This is a simple definition and does not capture the complexity that exists in relation to neglect (Daniel et al., 2011) and the fact that for some children neglect can either directly or indirectly lead to death, harm or serious injury (Brandon et al., 2014).

WTSC (2015) highlights the difficulty of assessing neglect as it can fluctuate in both level and duration. According to Daniel (2015) the range of different definitions has over-complicated neglect, which has created uncertainty and difficulties for professionals. The assessment of neglect may vary from one practitioner to another due to the different views about what constitutes neglect, and judgements made regarding neglectful circumstances are often value laden (Horwath, 2007. Turney and Tanner, 2001).

Davies and Ward (2011) highlight a common finding in a number of studies: that of professionals applying high thresholds when working with neglect, and the reluctance to respond in cases of neglect that are not straightforward. When responding to neglect, there is also the difficulty of deciding when to intervene. Neglect is defined as being both persistent and chronic, and it is the chronic and cumulative nature of it which is so damaging to children (Daniel et al., 2011). In regard to the persistence of neglect, there is a clear dilemma attached to determining when neglect meets this criteria, in what circumstances and over what period of time (Dickens, 2007).

Daniel (2015) argues that despite a wealth of research evidence, practitioners are still finding it difficult to apply research to practice. The 'neglect of neglect' may occur as neglect becomes less incident-focused and as a result, practitioners have less understanding of what is meant by, and how to respond to neglect (Gough and Stanley, 2007). A series of tools have been developed to assist social workers and other professionals in identifying, measuring and monitoring neglect, such as the Graded Care Profile 2 produced by the NSPCC. According to Horwath (2007) these tools may be useful in assisting practitioners in identifying the signs and symptoms of neglect by emphasising areas that need examining as well as measuring the different aspects and severity levels of neglect.

However, despite the usefulness of these tools, it is vital to recognise that they cannot provide a definitive answer. According to Dickens (2007), more checklists, frameworks, protocols, procedures and timescales are often proposed as the solution, but these give the false impression that recording information or following rules will provide the answers to the decisions that have to be made. For these tools to be effective, it is essential that practitioners have had appropriate and correct training to use them confidently and understand the value of their use, as well as acknowledging their place alongside professional judgement (Carter, 2012).

Voice of the child

The 'Framework for the Assessment of Children in Need and their Families' established a theoretical and practical approach to the assessment which outlined the principle of effective

work with children and families through child-centred practice. This approach aimed to keep the child the focus of the assessment and to take the child's perspective into account (DoH, 2000). Numerous public enquiries and SCRs where children have died or been seriously harmed or injured have highlighted the failure of professionals to effectively relate to the child or young person in question. This is a phenomenon which has become known as the 'invisible child' (Ferguson, 2017).

Ofsted (2014) explored the effectiveness of arrangements to safeguard children who experience neglect. It found that in chaotic and complex circumstances, children can easily become invisible and their daily lived experiences can remain unexplored, as instead of analysing the impact of the parents' behaviour on their children, the focus is placed upon the adult's needs. It has also been highlighted that professionals may minimise their concerns for a child's safety and welfare by succumbing to the 'rule of optimism', which may potentially prevent a situation from being viewed as neglectful (Calder, 2016). In some cases, it was reported that the child's views, wishes and feelings were not presented at all. This was further highlighted in a qualitative study carried out by Horwath and Tarr (2015), which indicated that social workers struggled to be child-centred during the planning process when working with children living with chronic neglect and only superficially engaged with them.

Organisational context

Social work is experiencing rapid changes both in practice and structure, especially in the context of financial austerity and the reduction of local authorities' budgets (Milner, Myers and O'Byrne, 2015). Munro (2011) emphasised the need to move away from bureaucratic processes in order to have more time to spend with children and their families to develop the professional relationships that are required to safeguard vulnerable children. Social workers are feeling increasingly overwhelmed with administrative tasks and are under pressure to adhere to the tight deadlines of the assessment framework, child protection conferences or the courts. As a result, less time is spent with children and young people, which makes it difficult to fully understand the child's experiences, wishes and feelings (Diaz and Drewery 2016). Consequently, child-centred practice is being compromised (Garrett, 2009. Broadhurst et al., 2010).

Working with neglected children and directly observing the negative impact neglect has on them can be emotionally demanding. Coupled with having to make challenging decisions without adequate supervision and managerial oversight as well as a lack of time to reflect, practitioners may be prevented from fully engaging with the experiences of the children they are working with (Lefevre, 2010). Due to the constraints of the bureaucratic system,

austerity and increasing caseloads, the main priority of social workers and managers is meeting targets and deadlines as opposed to producing high quality assessments that are based on evidence of interventions that work (Diaz and Drewery, 2016).

Supervision is important to allow social workers to develop research-grounded practice, and to ensure that routinised practice is challenged when working with neglect (Tanner and Turney, 2003). Reflective supervision allows practitioners to reflect on bias and values as well as understand when concerns have reached the threshold for significant harm (Ofsted, 2014). Stone (1998) highlights the importance of giving practitioners opportunities to reflect on the details in neglect cases as well as being able to explore the emotional aspects of working with children who are neglected.

Methodology

In order to examine the key barriers for social workers in identifying and responding to child neglect, this study used documentary analysis to collect data from SCRs that had been published between 2016 and 2018. SCRs were accessed via the National Case Review Repository. Only SCRs where neglect was known or suspected to be a factor in the child's death or serious injury/harm were selected.

In certain SCRs, the extent of neglect was apparent by the presence of one or more of the following factors: that the child or children were on a Child Protection Plan under the category of neglect, that neglect was stated as the primary category for the incident, or that neglect was discussed as a longstanding feature of the child's life. In other SCRs, the neglect was apparent to professionals due to missed medical appointments, poor school attendance, poor hygiene, lack of appropriate clothing and lack of supervision.

The National Serious Case Review Repository provides key words and an abstract into the SCRs which were used to identify whether neglect had been a feature in the child's life. The Repository contained 190 SCRs which had been published between 2016 and 2018, of which 86 featured neglect as a factor in the critical incident. This would imply that neglect was a feature in 45% of critical incidents where a child died or sustained serious injury or harm.

From the 86 SCRs that featured neglect as a factor in the critical incident, 20 were randomly selected for in-depth analysis. Thematic analysis was used in order to identify key themes within the data. Based on this, four key themes emerged:

1. Neglect definition and professionals' understanding of the cumulative impact of neglect
2. Multi-professional neglect strategy and use of neglect toolkit to aid practitioners to identify, monitor and track neglect
3. Organisational culture
4. Children's views and direct work

Although there are similar themes and patterns that emerged in these twenty cases, it is important to acknowledge that the lives and experiences of the children and young people featured in the SCRs were all different and unique.

Findings and Discussion

The usefulness of a definition in the identification of neglect

In 15 of the SCRs it was identified that social workers and other professionals had difficulties identifying and responding to neglect. This was despite four of these SCRs featuring children who were subject to a child protection plan under the category of neglect. Although the SCRs provide limited information regarding what the obstacles were to recognise and to intervene in cases where neglect was a feature, some reviews highlighted that professional perspectives may have impacted on social workers' ability to recognise and act on indicators of neglect.

The SCR of Child BW (Blackpool, 2017) illustrates how neglect may be subjective and that what is 'good enough' may vary between professionals. Due to the high level of child poverty in Blackpool, subjectivity may have affected professional judgements because other children in the same area lived in similar circumstances. There is evidence to suggest that in areas of deprivation, the threshold for neglect can be higher (Stevenson, 2007). Although the majority of parents who live in poverty do not neglect their children, there is a link between poverty and neglect (Spencer and Baldwin, 2005. Burgess et al., 2014) and this can be seen as a causal factor (JRF, 2016).

Jones (2016) states that neglect is not one entity, and the issues and difficulties of deciding how to respond to neglect relate to the lack of understanding or clarity about the different types of neglect. This is highlighted in several of the SCRs in this study. In the SCR for Family X (Sunderland, 2017) the classification of neglect was generalised without analysing

why the different issues were present and how this was experienced by the children. Howe (1995) states that the assessment of neglect needs to understand the type of neglect and how the neglect impacts on the child's daily lived experiences in order to effectively intervene.

Despite the range of academic resources which are available to help professionals understand, conceptualise and recognise neglect, over half of the SCRs considered for this research described how professionals underestimated the long term adverse impact of neglect on children and did not understand the children's behaviour as a result of the context they were living in. This study found that in seven of the SCRs where the lack of understanding of the impact of neglect was highlighted, the children were or had previously been on a child protection plan, which is in line with other research (McSherry 2011) Due to increasing caseloads, social workers have to manage their workload which often leads to physical abuse being prioritised over neglect (McSherry, 2007. Stokes and Taylor, 2014). It is still argued that neglect is not viewed as serious as physical and sexual abuse, and often neglect occurs alongside physical abuse, which becomes the main focus of the intervention (Dubowitz, 2007. Connolly, 2017).

The SCR of Child BW (Sunderland, 2017) outlines why the impact of neglect on children should not be underestimated. The children in the family were described as 'resilient, developing independence and the ability to self-care'. However, they were of nursery and early primary school age: these life skills should not have been viewed as acceptable. Importantly, as highlighted in the SCR, children should not be expected to have to become resilient to neglect. There is a danger that social workers become accustomed to, chronic neglect (Horwath, 2007), as well as normalise what they see when they work routinely with neglect (Ofsted, 2014).

The use of evidence-based toolkits to aid practitioners in identifying and responding to neglect

In half of the SCRs featured in this study it was identified that neglect toolkits were not used to aid practitioners in identifying, tracking and monitoring neglect. Out of these ten SCRs two children were on a child protection plan, whilst in four of the children were on a child in need plan. The other four SCRs reported that children's services were carrying out an assessment or had just closed the case. In all of ten SCRs it was identified that there were issues in relation to professionals' response to neglect and how indicators were responded to, and as a result the cumulative impact of neglect remained unknown. Professionals

tended to focus on the immediate presenting problems and there was little evidence of historical risks indicators being considered, which meant that children were left in neglectful situations for too long. In some local authorities, although the neglect assessment tools were available, professionals were unable to use these due to a lack of training. It was noted that one reason for this was due to the rapid and continuous turnover of staff. In a quarter of the SCRs it was identified that there was a lack of multi-agency neglect strategy in place in the local authorities to increase the understanding and awareness of neglect, both within and between agencies working with vulnerable children and families.

The SCR of Baby O (Sunderland, 2016) highlights the difficulties of working with families where neglect is a feature. The times where the family showed slight improvements and the parents were more cooperative made it harder for the social workers to see the full picture and the patterns of neglect. As a result of not using a neglect assessment tool, it was difficult for the social worker and other practitioners to track and monitor the neglect over time, which resulted in the cumulative impact of neglect on the children involved going unnoticed. In the SCR of Emily (Unnamed, 2018) it was highlighted that the absence of framework and assessment neglect tools played an important part in inhibiting the professionals' shared understanding of the neglect that Emily was being exposed to.

The SCRs placed a weight on the importance of a neglect toolkit being used in the assessment of families and a multiagency neglect strategy to ensure that there is a common understanding of neglect between professionals. Although there is a vast amount of guidance and procedures for professionals to assist in assessing neglect, procedural guidance alone is not enough (Laming, 2003). Horwath (2007) argues that the evidence based tools do not assist practitioners in reflecting on how their knowledge about a case is interpreted based on their personal, professional and organisational situation. Additionally, the assessment tools do not recognise the professional and personal beliefs that may influence the judgments that are made. Despite the acknowledgement that professionals' anxieties, personal and professional values, their feelings about the families that they work with, the working context and culture and the practitioner's own situation will all influence how they make judgements, Horwath (2007) argues that there is still an over-emphasis on the use of tools in practice. Sidebotham et al. (2016) claim that assessment tools have varied value and effectiveness, and there is a danger that they may cause practitioners to utilise the tool as a recording rather than a way to gain further understanding and analyse risk.

The majority of the SCRs referred to practitioners making subjective, and at times, personal judgements about whether children were experiencing neglect or not. Research carried out

by Ofsted (2014) identified that social workers believed that the use of a neglect toolkit assisted in the assessment of neglect and the monitoring of potential change over time, and helped to give a clear focus of the different aspects of neglect. It is noteworthy that in half of the twenty SCRs, the absence of a neglect strategy and neglect assessment toolkit were highlighted as being major barriers to professionals being able to identify, monitor and respond to neglect in families. This often led to incidents being looked at in isolation, which prevented practitioners from recognising the patterns of neglect over time.

How prevalent was the impact of organisational culture in SCRs where neglect was a feature?

In 45% of the SCRs it was highlighted that the organisational culture negatively impacted on the practice of social workers. Social work has become dependent on overly bureaucratic systems which has resulted in a reduction in the amount of time social workers are able to spend doing direct work with children and their families (Bowyer and Roe, 2015). Within Lord Laming's progress report (2009) he emphasised the immense pressure that children's frontline social workers are under: 'Low morale, poor supervision, high caseloads, under resourcing and inadequate training each contribute to high levels of stress and recruitment and retention difficulties' (Laming, 2009, p. 44). Bowyer and Roe (2015) report that organisational factors will contribute towards burnout amongst social workers and it is inevitable that when local authorities have staff retention issues, caseloads will rise.

These findings were mirrored in the findings from the SCRs. Six of the twenty SCRs highlighted the presence of high staff turnover and very high caseloads which caused drift and impacted on the day-to-day management of the child protection plans. In the SCR of Baby W and Child Z (Sunderland, 2016) it was found that the family had had five social workers in the space of just six months. The potential negative impact of organisational culture is further highlighted in the SCR for Hertfordshire LSCB (2016) in the case of Family HJ:

The wider context at the time was that the local authority was facing significant difficulties due to high levels of Looked After Children and children on child protection plans, resource issues, high staff turnover and high case-loads. This was thought to be a significant issue in the delay in determining that these children were suffering significant harm.

The situation is illustrated further in the SCR of Child B (Staffordshire, 2017). At the time of Child B's death, the teams in the local authority's Children's Services were operating as one

team due to team managers being off with long-term sickness. This meant that one team manager was managing more than twenty social workers. In addition, the local authority had difficulties retaining and recruiting staff which meant that the team consisted largely of newly qualified social workers and agency staff. It was recorded that the newly qualified social worker working with child B and his family had 43 open cases. This may have caused a deterioration in the quality of practice, decision making and case planning.

The SCR of Baby W and Child Z (Sunderland, 2016) reported that the local authority had been rated inadequate and commissioners were appointed to oversee the improvements to the Children's Services. Further comments were made about the negative impact this had on staff morale, since practitioners were having difficulties working in the local authority at such a challenging time. Kelly (2015) argued that a poor Ofsted rating may cause an increase in staff turnover and workloads, which ultimately will lead to inconsistency for children and families.

It was also highlighted in just under half of the SCRs that there was a lack of supervision, and management were failing to challenge a lack of progress in cases or request evidence of potential change in families where neglect was a feature. In some of the cases, lack of supervision and management oversight was prevalent in the initial stages of the case, while for a smaller number of cases it was evident throughout the case. This implied that cases at times drifted and there were limited opportunities for social workers to receive support and to have their views challenged. According to Laming (2009) 'supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children'. Supervision should be a time for professionals to reflect on their values and biases, and for professionals to be challenged constructively about the progress or lack of progress within a case, and for managers to seek evidence of the actual progress (Laming 2009). Without supervision to enable social workers to reflect on their practice and to have their biases challenged, their professional judgement and decision making may be negatively impacted (Munro, 2010).

Interestingly, there is limited information in the SCRs about the impact of austerity and cuts on both organisational cultures and practice. This is despite funding pressures which are preventing local authorities from intervening earlier in children's lives. There is growing pressure on Children's Social Care and there has been an increase in care proceedings by 145% from 2009 til 2016 (CAFCASS 2017). Despite this growing demand it is estimated that there has been approximately a 25% reduction in central government funding to Children's Social Care. These cuts will have an obvious impact on the quality of children

and young people's services (Action for Children, The Children Society and National Children's Bureau, 2017. Community Care, 2017).

There was also limited information about the potential emotional impact on social workers working with reluctant and sometimes hostile families, as well as the long term impact of working in a context of high caseloads and staff shortages, and with children who are being neglected. Although these issues were discussed in the SCRs there was limited in depth discussion about the impact of these issue on social workers' practice and decision making in cases where neglect was a feature.

To what extent had the voice of the child been listened to and considered?

The right for the child to participate in the assessment process is rooted in child legislation and policy in England (Race and O'Keefe, 2017). The Children Act 1989 highlights that the local authorities should, where possible, ascertain the wishes and feelings of the child and take these into consideration when making decisions that affect them (Carr and Goosey, 2017). In this study, 65% of the SCRs reported that the voice of the child had not been consistently heard or considered and that children were not seen alone or seen frequently enough. The SCRs frequently emphasised that children and young people were not asked about their life and their experiences, hence it was not evident from the case notes and assessments what life was like for those children and young people who experienced neglect. There was little evidence of meaningful direct work being carried out with children, and this was consistent for all the different age groups of children and young people.

Daniel et al. (2010) suggest that children do not signal directly for help when they are neglected and that they are more likely to do so when they are physically and sexually abused. However, the research showed that children will report behaviours that are related to neglect if social worker has built up a positive relationship with the child or young person. In order to build a relationship of trust, it is essential that time is spent with the child or young person in order to ascertain the child's views, wishes and feelings. The SCR of child N (Trafford, 2017) indicates a theme that emerged through several SCRs:

The contacts and observations of the children made by SW2 and SW3 were limited to short visits to the home and none of the children were purposefully engaged in any direct work to ascertain how they experienced day to day life or to establish whether they wished to discuss any worries or concerns.

This is in line with the findings from Ferguson (2016) who identified in his study that most of the time spent doing child protection work consists of relating to children and parents

concurrently. His study found that a large number of children were not seen alone in everyday child protection practice, and that when time was spent with children, it was often too brief. A key theme throughout the SCRs was the difficulty for social workers to remain child-centred when working in chaotic and complex family situations. It was found that professionals became distracted by the needs and reliant on the views of the parents as opposed to the views of the child, which was further highlighted in Horwath and Tarr's study (2015).

The 'invisible child' is a term used when social workers and other professionals have not engaged sufficiently with children, and it is argued that good social work practice should achieve the opposite of this - to make children visible through their work (Ferguson, 2017). Ferguson (2016) highlighted from his study that children may become invisible due to the increasing demands of the bureaucratic system, but also due to some social workers having a limited level of communication skills, play skills and lacking the confidence to build close professional relationships with children.

Several public enquiries and over half of the SCRs that were analysed in this study have highlighted the dangers that can occur when social workers overlook or misinterpret communication from children. Based on the findings from the analysis of the twenty SCRs, it still appears to be the case that vulnerable children are at times still not heard or seen and hence remain invisible. Based on the findings of this study, it may appear that professionals are still over-reliant on children talking about neglect and their experiences, which places too much responsibility on the children themselves to ensure that they are protected and safeguarded (Blyth, 2014). This study found that in eight of the SCRs where the children were on a child protection plan at the time of death or serious harm, five showed that the children were not seen frequently enough and there was little evidence of direct work being carried out. Similarly, this was the case for children who were on a child in need plan at the time of their death or serious harm.

The term 'invisible child' was further highlighted in this study, as in four of the cases no pre-birth assessment had been carried out. The aim of a pre-birth assessment is to ensure that any risks to the unborn baby are identified and that a plan is in place to address the need for support (WTSC 2015). Young babies are extremely vulnerable and dependent on their carers for survival, which is reflected in the high number of SCRs involving children under twelve months (Sidebotham, 2016). This study also highlighted that in two of the families who had large sibling groups, the children were not assessed individually, and the plans were not individualised which meant that the needs of the individual children were overlooked (Family X, Sunderland and Child N, Trafford).

It was highlighted as a common theme throughout the SCRs that professionals can succumb to the 'rule of optimism' when working with families where neglect was a feature. The 'rule of optimism' was a concept developed by Dingwall et al. (1983) and is a term used to describe practitioners see the best in people and are overly optimistic about the intervention improving the outcomes for the child and their family (Doyle and Timms, 2014). This was outlined in the SCR of Charlie and Charlotte (Durham, 2018), where there was limited engagement with the children and professionals thought the children's lives had improved on the basis of limited evidence. However, based on the available information from the SCR, at times they felt unsafe and uncared for, and they suffered pain from dental decay that was left untreated. Charlie and Charlotte's behaviour was a way for them to express their suffering, but this was not understood in the context of their situation and their experiencing chronic neglect. Scott and Daniel (2018) report that cumulative risk is not always identified due to the limited time spent with children and the failure to address and understand their challenging behaviours.

Conclusion

This study has highlighted that neglect and its cumulative impact on children's healthy development and wellbeing must not be underestimated. Despite the wealth of research and information about the negative impact of neglect, in over half of the SCRs which were analysed the effect of this upon a child's healthy development had not been considered or understood. Due to the limited information provided in the SCRs, it has not been possible to gain a full picture of the reasons for this. However, this has emphasised that further training may be required to raise further awareness that neglect is just as harmful as other forms of maltreatment.

The findings from the study have highlighted that recognising and responding to neglect is complex and multifaceted, and needs to be reflected upon in the context of increasing demands and pressures on agencies and the professionals within them, which at times may be overwhelming. The numbers of children nationally who are subject to a child protection plan have risen considerably, and coupled with difficulties in the recruitment and retention of permanent and experienced social workers, this creates a picture of major challenges for agencies trying to safeguard children.

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