

Critical and Radical Social Work

Enhancing Learning for the Future: A Document Analysis of Serious Child Safeguarding Case Reviews with Romani and Traveller Communities in England --Manuscript Draft--

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Key messages (if applicable):

1. When a Romani or Traveller child suffers a serious injury or death because of abuse or neglect, there also exist examples of escalating socio-economic disparities, burgeoning structural inequalities, fear of CWS, and adversarial relationships with professionals.
2. Documented fear of CWS is arguably the legacy of a child protection system constructed by non-Romani and Traveller people for non-Romani and Traveller people, which, if not exercised with care, can exclude the Romani and Traveller perspective.
3. Trauma-informed practice could be used to equip CWS with the knowledge, values and skills needed avoid reciprocated dynamics of fear and helplessness within the helping relationship.

Key words/short phrases:

Child protection; Gypsy; Roma; Traveller; trauma-informed practice; child welfare services

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Abstract

Integrating document analysis with the core principles of critical social research, this study aims to dig beneath the surface of historically specific social structures of Child Welfare Services. Analysing the descriptive content presented in twelve Serious Case Reviews published after the death or serious injury of a Romani or Traveller child in England, this study shines a light on how the child welfare system worked, including how ideology and the presence of reciprocated feelings of fear and helplessness concealed the processes that contributed to the harm that was experienced. Seeking to extend a detailed analysis of the strengths and weaknesses in policy, procedure and practice, the paper concludes by reflecting on valuable learning points for child protection professionals working with Romani and Traveller children, families, and communities.

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Introduction

Across the globe, Child Welfare Services (CWS) draw upon research efforts and policy initiatives to improve the theoretical, disciplinary, and strategic approaches to safeguarding and child protection practice (Laird, 2017). In England and Wales, a proportion of the learning needed to inform these efforts is taken from government-commissioned summary reports of Serious Child Safeguarding Case Reviews (SCSCRs), initiated to identify practice and system failures and improve safeguarding responses when a child experiences severe or fatal harm (Brandon et al., 2020 and Dickenson et al., 2022). Published every three years, these reports provide a thematic analysis of the strengths and weaknesses in policy, procedure, or practice as an enabler of continuous professional development within CWS.

Despite research efforts to analyse and improve the theoretical, disciplinary, and strategic approaches to safeguarding and child protection practice, the government-commissioned reports can only provide an overview of detailed findings presented in hundreds of SCSCRs (Preston-Shoot, 2018). Focusing on the way that CWS operates, and the way that child protection professionals, including social workers, police, teachers, medics and allied health and housing officials, measure and respond to child safety, the location of marginalised identities, including the perspectives of Romani and Traveller children, families and communities, can be 'Othered' or come to matter least (Powell, 2016).

The most recent government-commissioned analysis of SCSCRs highlights the limited ability of professionals to effectively engage, collaborate, and build meaningful relationships with Romani and Traveller children (Dickens et al., 2022). While these analyses provide valuable insights into the intricacies and challenges of child protection practice in the broadest sense, they fall short of proposing the specific theoretical, disciplinary, and strategic changes required to enhance interactions with this diverse community of communities. Consequently, the thematic findings presented in the summary report fail to shed light on the nuanced contextual dynamics relevant to child protection. Addressing this limitation is arguably crucial for

advancing the effectiveness of CSW and the protection of Romani and Traveller children in the future.

Integrating document analysis with the core tenets of critical social research (Harvey, 1990), this study intends to dig beneath the descriptive material marshalled by twelve SCSCRs, published after the death or serious injury of a Romani or Traveller child in England. The unique contribution of this study enhances existing government-commissioned analysis of SCSCRs to identify key learning points for CWS professionals working with Romani and Traveller children, families and communities.

Before moving on, it is important to clarify that the terms 'Romani' or 'Traveller'. The term 'Romani' includes 'Roma' and 'Romani (English) Gypsies'. The term 'Traveller' specifically refers to 'Irish Travellers'. While a more in-depth exploration of the distinctions among these ethnic minority groups could be valuable, such details are beyond the scope of this article. For readers seeking a comprehensive introduction to this topic, we recommend the book (authors own). This accessible foundation text provides insights into the unique cultures and challenges faced by 'Roma,' 'Romani Gypsies,' and 'Irish Travellers' within the British context.

Serious Child Safeguarding Case Review

The Serious Child Safeguarding Case Review (SCSCR) process in England and Wales is informed by the Children Act 2004 (as amended by the Children and Social Work Act 2017). They are initiated when a child experiences severe or fatal harm and are designed to identify practice and system failures and improve safeguarding responses (Dickenson et al., 2022).

For each SCSCR, an independent review author is commissioned to appraise case files, interview practitioners, families and surviving children and produce a summary report with clear recommendations for improvement (HM Government, 2023). The reviews are not conducted to hold individuals, organisations, or agencies to account. Most SCSCRs are accessible online via the National Case Review Repository of the National Society for the Prevention of Cruelty to Children (NSPCC). This repository is a web-based library service, launched in November 2013, to provide a comprehensive collection of reviews undertaken in the United Kingdom. It has over 2,000 case reviews and contains thematic analysis reports from dating back to 1945.

Every three years, the British government commissions a thematic analysis of SCSCRs. Although these summary reports intend to provide crucial insights for CWS (Dickenson et al., 2022), Preston-Shoot (2108) argues that most recommendations are repetitive and oversimplistic. Recognising the need for a more nuanced scrutiny of practice, child welfare scholars draw on the SCSCRs archived in the NSPCC National Repository to advance knowledge in specific areas of child protection practice. Notable examples include the examination of child homicide by Hardley (2014), the exploration of the voice of the child as articulated by Laird (2017), and the study of maternal filicide by Sidebotham and Retzer (2019). Other areas of concentrated research encompass the experiences of Black children by Bernard and Harris (2019), the analysis of extra-familial harm by Firmin (2023), and the exploration of the challenges faced by families with no recourse to public funds by Jolly and Gupta (2024).

Methods

Between September 2023 and January 2024, the NSPCC's National Case Review Repository's 'Advanced Search' function was used to identify SCSCRs relevant to the study. Search terms included 'Gypsy', 'Roma', 'Romani' and 'Traveller'. Fourteen reviews were initially identified and then screened for relevance based on the report summary. Two SCSCRs were rejected for lack of relevance to Romani and Traveller communities and twelve reviews, published between 2007 and 2022, remained for inclusion. Once identified, the reviews went through a rigorous process of document analysis.

Analysis

According to Bowen (2009), document analysis provides a reliable and systematic procedure for reviewing SCSCRs. As a qualitative research paradigm, Bowen (2009) summarises Corbin and Strauss (2008) to describe document analysis as a useful method for scrutinising and interpreting the textual data embedded in documents published in the public domain, extracting meaning and advancing empirical knowledge. Consequently, document analysis was chosen as the preferred method for this study as it could help to facilitate a meticulous and methodical exploration of themes or issues presented in each of the twelve SCSCRs. The method of using data from published documents to conduct scientific analysis is particularly useful when conducting sensitive research in health and social care research as it offers a more ethically sensitive approach to data collection (Bowen, 2009).

The analytic procedure began with each author conducting a close reading of each SCSCR, combining elements of content analysis and thematic analysis. Following the advice of Corbin and Strauss (2008), content analysis enabled the research team to organise the significant volume of information into 'summary', 'key findings', and 'recommendation'. A content summary of each SCSCR is presented in Appendix A.

Thematic analysis enabled the research team to identify patterns within the data, enabling emerging themes to become categories for analysis (Fereday & Muir-Cochrane, 2006). This process involved a careful, more focused re-reading and review of each SCSCR. At this stage, predefined codes were not used, instead, each member of the research team read each of the twelve SCSCRs independently, applying the core tenets of critical social research, an approach to analysis that attempted to locate the events summarised in each SCSCR in a wider historical and social setting (Harvey, 1990), to consider whether structural inequalities were re-reproduced in CWS. Focussing on how CWS might contributed to the systemic disadvantages and trauma experienced by Romani and Traveller children, each member of the research team worked independently and performed coding and category construction to uncover themes pertinent to each review.

Throughout the individual coding and category construction exercise, the research team met online on three occasions over a four-month period. During these meetings, the team were able to discuss, debate and refine key findings, agreeing on the emergent codes and categories to be included. At this stage, some codes and categories were developed, and others were discarded. Following the advice of Bowen (2009), these online meetings helped to promote validity and rigour as discrepancies in coding were resolved through team discussion.

After the third meeting, a shared Excel spreadsheet was used for data organisation and further analysis. An initial codebook was also developed based on the shared and agreed thematic analysis of key data. Consistent with the guidance provided by Harvey (1990), an inductive approach to analysis then followed with the team identifying further data contained within the SCSCRs for emergent themes while considering how often certain topics were raised. The subsequent analytical framework is presented in Table 1.

Table 1: Document analysis analytical framework

Analytical theme	Sub themes
Social relations	Disguised compliance, fear, deviance, secrecy, crime, adversarial relationships and extrafamilial harm
The relationship between professionals and the family	Aversive racism, victim blaming, fear, conflict, distrust
Engagement with Romani and Traveller people	Institutionalised racism, reciprocal fear, culture as a risk, assumed lack of parental capacity, blame, inaction
The assumptions made by professionals	Culture as a deficit, culture as strength, learning from the child and family, history and context, nomadism
Risk and protective factors	Learning disability, mental health difficulties, substance misuse, victim blaming, cooperation
Actions and events located in a social and political context.	Racism, fear, helplessness, professional curiosity, management support, social determinants of inequality

As the analysis of data presented in the SCSCRs progressed, the framework was iterated to incorporate new sub-themes. Triangulating data across the twelve SCSCRs served to increase credibility (Eisner, 1991), corroborating findings across data sets, thus reducing the impact of potential biases that can exist in a single study.

Research team composition

It is recognised that document analysis is not without limitation. Methodological weaknesses include insufficient detail to answer the research question (Bailey, 1994), low retrievability of documents, limited data selectivity and biased secondary analysis (Yin, 1994). It is important to note that the SCSCRs analysed in this paper include all reports about Romani and Traveller children held on the NSPCC database at the time of writing. Therefore, this is a finite sample. To help minimise concerns of biased secondary analysis, the team sought to preserve credibility through the sustained application of reflexive practice.

One author is a Romani social worker and two are social workers who do not have Romani and Traveller heritage, but who do work in solidarity with Romani and Traveller people. As such, the identity and positionality of the research team spans several terrains such as social, political and value systems, as well as integrating multiple social categories and social roles.

Throughout this project, the team was able to support each other in a reflexive approach to better understand CWS as described in the twelve SCSCRs identified for inclusion. Recognising that CWS with Romani and Traveller people can take place under complex, uncertain and dynamic conditions, and often in areas that are upsetting or socially and politically sensitive, the team supported one another to understand the child protection practice from multiple perspectives and positions, including the complicated nature of problems, and shifting diverse structural contexts. By engaging in the deeper sophisticated level of reflexivity recommended by (authors own), the team aimed to enhance the emancipatory and transformative possibilities of CWS with Romani and Traveller people in their approach to analysis and reporting.

Ethics

This study is based on the document analysis of SCSCRs that are freely available, in the public domain and featured no human participants. The ethics panel of (authors own) University provided ethical approval for its completion.

Findings

Each SCSCR included in this study suggested that Child Welfare Services (CWS) were limited and limiting in the theoretical, disciplinary and strategic approach to safeguarding Romani and Traveller children. However, they did not always explain why. It was only by analysing these documents that it became possible to use critical social research (Harvey, 1990) to extract key themes, and direct attention toward the historically specific, oppressive social structure and fundamental nature of CWS with Romani and Traveller people.

The complexity of practice

Of the twelve SCSCRs included in the study, four involved a fatality and evidence of neglect or abuse (Oulton, 2008; Carmi, 2015; Eades, 2015; Duncan and Griffiths, 2017) one involved a fatality related to 'sudden unexpected death in infancy', the death of a baby when there is no apparent cause (Walters, 2015). One involved a case where an infant died of dehydration, caused by the fact that no one cared for her after her mother had been unlawfully killed (Ibbetson, 2007). One involved child sexual exploitation (Carwardine and Hartley, 2018), and one involved sexual abuse (Harrington, 2014). Three SCSCRs involved neglect or ill-treatment with harm falling short of death (Tudor, 2016; Duncan, 2020; Ward, 2022). In each review. recommendations for improvements in CWS are made.

Missed opportunities

Eleven out of the twelve Serious Case Scrutiny Reports (SCSCRs) highlighted challenges arising from the management of CWS. Specifically, SCSCRs noted that case work was often led by professionals who lacked experience working with Romani and Traveller communities. While these observations underscore broader concerns related to professional capability, competence, and confidence, they fall short of pinpointing exactly why this limited experience contributed to failures within CWS. Each SCSCR involved a team of qualified professionals, each possessing the necessary qualifications corresponding to their roles and legal obligations to safeguard children. While their direct exposure to working with Romani and Traveller

communities was limited, they did have the requisite qualifications needed to work in child protection.

A more critical analysis of each SCSCR suggests that the challenges reported in each SCSCR lay not in the direct experience of professionals *per se*, but in their reported inability to effectively transfer their basic safeguarding skills to the location and context of child protection practice with Romani and Traveller children. Across each SCSCR, there were recurring reports that CWS struggled to employ the fundamental aspects of professional curiosity, defined by Burton and Revell (2018) as the essential skill of observing, listening and asking direct questions to verifying information and comprehensively assess the lived experiences, perspectives, and realities of the child.

A specific example of the missed opportunity to apply the skill of professional curiosity is demonstrated in the way a child's ethnicity was recorded and understood. Three SCSCRs report the child being from the 'Gypsy, Roma, Traveller community' (Eades, 2015; Duncan and Griffiths, 2017; Ward, 2022), and four others report the child as having a 'traveller background [sic]' (Carmi, 2015; Tudor, 2016, Harrington, 2014). There was also general confusion about the ethnicity of families who were living in brick-and-mortar housing, with some professionals assuming that the ethnicities of Romani and Traveller people were lost once they moved into a house (Walters, 2015). In these examples, CWS failed to ask questions needed to verify information about the child's ethnicity, identity and heritage. Instead CWS were led by generalised assumptions and stereotypical representations of the child, which, as Eades (2015:17) explains, became accepted by CWS as a universal truth:

'The [SCSCR] identified a number of features of the impact of Gypsy Roma Traveller (GRT) culture on the family...Some practitioners commented on the strong family orientation of people from this culture and that they often lived in or around large extended families who provided child care and social interaction and support. However, when neighbouring County Z took A's children into care (legal order) there were no family members either available or suitable to be assessed as carers for the four children.'

The assumptions and stereotypes being described in the above excerpt provide a clear example of how professional curiosity can become lost in the location and context of safeguarding Romani and Traveller children. By failing to verify or disprove taken-for-granted assumptions, professionals missed the opportunity to assess more complex matters related to specific historical events, including how assimilation policies and racism were reproducing structural inequalities within society and CWS.

As professional curiosity is an essential component of child protection practice (Burton and Revell, 2018), the observation that CWS were managed by lead professionals who had no experience working with Romani and Traveller people becomes less important. A more concerning finding is that qualified professionals failed to understand the and day-to-day reality of Romani and Traveller children and tailor their interventions accordingly.

Excluding the Romani and Traveller Perspective

1 Adding to the lack professional curiosity, the reports by Harrington (2014), Carmi (2015),
2 Eades (2015), Walters (2015), Tudor (2016), Duncan and Griffiths, (2017), Carwardine and
3 Hartley (2018), Johnson (2018), Duncan (2020) and Ward (2022), suggest that the ability of a
4 parent to protect the child from harm was affected by complex social factors that were not fully
5 explored or understood by CWS either.
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7 Although the SCSCRs reported families as possessing common cultural traits, related to low
8 literacy, learning disability and limited parenting capacity (Carmi, 2015; Duncan 2020),
9 community violence (Harrington, 2014) secrecy and self-imposed isolation (Tudor, 2016), drug
10 use, criminality, and domestic violence and abuse (Eades, 2015; Walters, 2015), secrecy,
11 (Johnson, 2018) and a reluctance to engage with CSW, including police, social workers, health
12 visitors and housing officials (Ward, 2022), there was minimal consideration of the potential
13 reasons why. Instead, parents were stigmatised and blamed for disguised compliance or non-
14 engagement with CWS.
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16 In each SCSCR there appeared to be an uneasy understanding of the relationship between
17 structural inequality, family and environmental factors, parental capacity, and child welfare. At
18 no time was the Romani and Traveller perspective sought to incorporate a full and verified
19 understanding of how the intersectional impact of poverty, marginalisation, economic, social,
20 and health inequality and racism limited the choices that were available to them. Instead, as
21 shown by Tudor (2016: 42) a complex interplay of professional values, private reactions,
22 structural and systemic forces resulted in the marginalisation of the Romani and Traveller
23 perspective:
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25 *‘...it is not always easy to hear the child’s voice when parents are*
26 *themselves needy, when chaotic home conditions can distract*
27 *practitioners, when resources are limited and there is practice guidance*
28 *and procedures to consider. It is very easy for the child’s voice to*
29 *become lost within the complexities of day-to-day pressures.’*
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31 As suggested in the above excerpt, the Romani and Traveller perspective and the voice of the
32 child can become lost within CSW. This invisibility was particularly understood to form the
33 basis for the vulnerability of Roma children living with child sexual exploitation (Carwardine
34 and Hartley, 2018). At the point of contact and subsequent disclosure, CWS professionals
35 became too focused on verifying the accuracy of the information, losing sight of the child’s
36 lived and reported experience, thus compounding their vulnerability and exposure to harm.
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38 The marginalisation of the voice of the child in CWS meant that some professionals, including
39 those in the position to manage and scrutinise the quality of casework decisions, overlooked
40 unhelpful value judgments about the family’s ethnicity, culture, identity and heritage because
41 they too appeared to be making decisions determined by a stereotypical representation and a
42 lack of professional curiosity. Although each SCSCR recognised the duty of CWS to promote
43 the paramount welfare of the child, they did not consider how professionals can fail to meet
44 this responsibility when the Romani and Traveller perspective is being excluded from the
45 assessment, decision-making and review process.
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47 The exclusion of the Romani and Traveller perspective was not limited to child protection
48 practice. When SCSCRs are initiated, the independent author is required to invite families,
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including surviving children, to participate in the review process (HM Government, 2023). The aim of participation serves to ensure a review that reflects the child's perspective and the family context and the extent to which the cultural background of a child and or family may have impacted professional decision-making (Ibid.). Out of twelve SCSCRs, one enabled the participation of the family (Carwardine and Hartley, 2018). Whilst it is not uncommon for family members to be excluded from the SCSCR process, oftentimes due to ongoing criminal investigations (Preston-Shoot, 2018), the low inclusion of Romani and Traveller people in the SCSCR process is perhaps also indicative of the way that the Romani and Traveller perspective is being excluded by CWS more generally.

Fear and helplessness

A common feature of each SCSCR reflected the presence of reciprocated feelings of fear and helplessness between families and CWS.

On the one hand, professionals were apprehensive about their safety, fearing that the family and community would become violent and aggressive following their involvement (Harrington, 2014). Professionals also became helpless when the family disengaged from CWS (Duncan and Griffiths, 2017). On the other hand, families were fearful that the involvement of CWS would result in the removal of their child and helpless to engage in the child protection assessment (Eades, 2015). While some professionals responded to fear and helplessness by adopting 'unacceptably low expectations of the care that children were receiving' (Harrington, 2014: 32), families would move out of the area (Walter, 2015), refuse to attend appointments with CWS (Johnston, 2018) and in some cases use an alias so that CWS was unable to track the child and family through child protection, health or police databases (Oulton, 2018). Each SCSCR showed that when professionals and parents became locked in a relationship characterised by fear and helplessness, the day-to-day reality of the child was lost to the CWS. Except for the Bromley and Tower Hamlet SCSCRs, where the death of the child was reported as being unpreventable (Walters, 2015; Ibbetson, 2007) fear, helplessness and avoidant behaviour of the parents resulted in the inaction of CWS, which consequently, as Duncan, and Griffiths (2017:21) explain, became a further factor in the abuse and neglect that was suffered:

'Over the course of the SCR there has been much discussion about how professionals found it difficult to challenge and work with Travellers. This was because some professionals felt scared and intimidated, whilst other professionals did not fully understand the culture of the Traveller community or had preconceptions, which they did not question. The knowledge of the professionals about the culture and values of the Traveller community appeared to be at a superficial level and was interspersed with 'stereotypical' views of how Travellers behaved.'

Whilst each SCSC recognised the need to understand and manage the presence of fear and helplessness, only three reports advanced a concrete recommendation for how this should be achieved. In these SCSCRs, the solution was grounded in the identified need for 'cultural competence training' (Carwardine and Hartley, 2018; Duncan, 2020; Ward, 2022) described by Symeou and Karagiorgi (2018) as educational programmes and initiatives designed to increase individuals' understanding, awareness, and sensitivity to different cultures:

1 *Staff require a better understanding of traveller [sic] culture in order to*
2 *feel less threatened and scared about working with this community.*
3 *(Duncan, 2020: 15)*

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5 One major problem with the recommendation for cultural competency training is found within
6 the suggestion offered by Duncan above, that the culture of Romani and Traveller people can
7 be reduced to a technical skill for which professionals can be trained to develop. Although it is
8 important that professionals do not feel threatened or scared when working with Romani and
9 Traveller people, avoidant behaviour must never be conceptualised as a 'cultural process'
10 (Powell, 2016). As shown in Stephens and Rock-Vanloo's (2022) exploration of critical race
11 theory, the behaviour of individuals should not be considered as definitive aspects of a specific
12 ethnicity either. Without careful consideration, providing CWS professionals with 'cultural
13 competency training' may lead to further dangerous stereotyping, minimising the importance
14 of cultural humility and reducing entire populations to simplistic definitions and
15 characterisations (authors own). What is needed instead, as shown in the Southampton
16 SCSCR (Harrington, 2014), is the knowledge and confidence to transfer core skills of child
17 protection practice to diverse locations where marginalised identities can be 'Othered' or come
18 to matter least (Powell, 2016).
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24 ***The construction of resistance***

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26 Each SCSCR recognised the impact caused by a reduction in specialist community services
27 which typically include early intervention services, practical family support programmes, or
28 multi-agency plans, developed to support families and prevent families from falling into crisis.
29 Whilst each report recognised that Romani and Traveller children deserve the highest
30 standards in support and protection, they also made it clear that families can be blamed for
31 inherent weaknesses within CWS.
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36 From the current state of the economy to shifting policies and variable regulatory requirements,
37 to leadership changes and a lack of effective management and collaboration, each SCSCR
38 explained that the work needed to safeguard Romani and Traveller children required new and
39 innovative approaches to emerge and develop (Walter, 2015). It is widely known that CWS
40 deal with complex, high-risk situations (authors own). It takes professionalism and expertise
41 to make tough decisions and stand by them. A child protection professional must bear the
42 weight of responsibility for what they do and for what they decide not to do (Ferguson, 2014).
43 For these reasons, effective child protection demands a great deal from professionals who are
44 responsible and accountable for assessing and managing risk. But, as shown by Harrington
45 (2014: 46) professionals are not always being provided with the support needed to manage
46 these demands effectively:
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52 *'The issues of culture and ethnicity, the legal complexities, the sheer*
53 *number of children involved - all flag up the need for management and*
54 *planning and co-ordination of input from services. It is striking that*
55 *throughout the events there is little evidence of management*
56 *intervention to support staff and direct the case.'*
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1 Within the above extract, Harrington (2014) explains how contemporary approaches to CWS
2 require collective efforts based on effectively managed interactions between professionals,
3 children, families and communities. If a child protection professional is unsupported by CWS,
4 families and communities can be labelled as 'resistant' (Tudor, 2016: 5), 'hostile' (Harrington,
5 2014: 17) 'chaotic' (Duncan, 2020: 23) and 'aggressive' (Duncan and Griffiths, 2017: 19).
6 Where families are labelled in this way, records were made and kept and information about a
7 family was shared and accepted as a universal truth within a wide sphere of professional
8 agency. As shown by Duncan and Griffiths (2017: 30), an assumption that the family would be
9 'noncompliant', distracted the attention of CWS away from the needs and experiences of the
10 child. At the same time, the parents, either unable or unaware of how to challenge or complain
11 about child protection processes, and the labels that they were given, demonstrated their
12 power and self-determination by withdrawing from CWS, further compounding the child's
13 exposure to significant harm. It could be argued that better management systems might have
14 helped to foster professional curiosity, avoid stigmatising language, and support professionals
15 develop trusting relationships with children, families, and communities.
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19 **Is nomadism a protected characteristic or a risk?**

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23 In the Harrow (Carmi, 2015) and Surrey (Ward, 2022) SCSCRs the important tradition, custom
24 and practice of nomadism is considered as an important aspect of family life. In Essex (Eades,
25 2015), Southampton (Harrington, 2014), North Somerset (Tudor, 2016), and Gloucestershire
26 (Oulton, 2018) nomadism was seen as a deliberate strategy used by Romani and Traveller
27 families to escape the surveillance and attention of CWS. As shown by Eades (2015: 13),
28 children who move between Local Authorities were at particular risk of harm because the
29 system used to monitor their welfare is not always effective:
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34 *'[The files] indicate that the family moved frequently between adjacent*
35 *counties and others in the eastern region. They were often homeless*
36 *and sometimes the children were temporarily accommodated by local*
37 *authorities. Some of the moves seem to be associated with periods of*
38 *trying to avoid Children's Services and other agencies...'*
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42 The above extract provides a useful example of how nomadism, movement and mobility were
43 seen by CWS as being indicative of risk. While two reports (Carmi, 2015; Ward, 2022)
44 recognise that the tradition of nomadism was important, the practice of 'travelling' can become
45 problematic when CWS are unable to monitor the child's movements (Harrington, 2014). As
46 surveillance is an important method used to ensure the child is safe from harm (including inside
47 and outside of the home, and online) and prevent them from suffering further harm (HM
48 Government, 2023), there was minimal effort to support children who moved between
49 administrative boundaries, as Harrington (2014, iv) explains:
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54 *'The belief that mother was a 'traveller' together with her effective*
55 *avoidant behaviour contributed to a lack of effective follow up of*
56 *concerns; this highlights the vulnerability of children in mobile families*
57 *and the risk that children can become invisible.'*
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1 The reported observation that Romani and Traveller children who move can become inviable
2 in CWS highlights a significant challenge to child protection and traditional approaches to risk
3 management. Whilst it is always important to exercise caution in the design, implementation,
4 and review of the child protection plans for nomadic children (authors own), it is essential not
5 to assume that abuse, neglect and nomadism coexist, without formal verification of that fact.
6 As shown in two SCSCRs (Ibbetson, 2007; Walters, 2015), service interventions that separate
7 mothers and their children from the community can further jeopardise their safety and welfare.
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10 Discussion

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12 Over the last several decades, scholars have sought to understand and theorise the
13 relationship between Romani and Traveller children, families and communities and CWS (see
14 Cemlyn, 2008). Much of this research recognises that CWS tend to place a central focus on
15 Romani and Traveller people as 'outsiders' who challenge the dominant ideologies of child
16 welfare and circumstances consistent with the provision of safe and effective care (authors
17 own). Often associated with the notion of 'The Stranger' (Simmel, 1950), Powell (2016: 137)
18 contends that Romani and Traveller families are continually stigmatised by CWS as part of an
19 'established-outsider figuration' that maintains a 'sizeable power imbalance' between Romani
20 and Traveller people and child protection professionals. In addition to the concerns about the
21 power imbalance, scholars show that inequalities in CWS can be reproduced through the
22 perpetuation of racist stereotypes about Romani and Traveller cultures (authors own).
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28 In this study, the findings obtained via the document analysis support some of the claims being
29 made in current scholarship. For example, in each SCSCR, the prejudicial opinions of the child
30 protection professional were used to monopolise truth claims about the welfare and wellbeing
31 of Romani and Traveller children. In each example, CWS applied these truth claims to justify
32 inaction.
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36 The unique findings of this study show that the application of these truth claims, in a system
37 that is reducing preventative community-based services (authors own), implementing
38 assessments via compartmentalised service delivery models that reinforce institutional
39 working practices, bureaucratic procedures and remote working locations (Ferguson, 2014),
40 can focus child protection practice on individually targeted interventions that often overlook the
41 child's reality, as Harrington (2014: 28) explains:
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44 *'The failure of the officers to report any concerns suggests that an*
45 *inappropriately high threshold was being used. That is, they may have*
46 *been over-tolerant of matters that should have caused concern – or, to*
47 *put it another way, they had low expectations of the care these children*
48 *would be receiving.'*
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52 Although statutory guidance advocates the use of evidence-informed approaches child
53 protection (HM Government, 2023), the above excerpt indicates that the influence of individual
54 value judgements, unequal power dynamics of CWS and compartmentalised system
55 configurations, can enable considerable discretion in the day-to-day implementation of this
56 commitment. While further research is needed to understand why professionals have low
57 expectations of the care that Romani and Traveller children receive compared to all other
58 children, one possible explanation for this disparity points towards the dominance of
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1 embedded racism, recognised in the literature as 'anti-Gypsyism' (Popoviciu et al., 2013),
2 which the European Commission against Racism and Intolerance (2015: 14) describes as:

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4 *"...a specific form of racism, an ideology founded on racial superiority, a*
5 *form of dehumanization and institutional racism nurtured by historical*
6 *discrimination, which is expressed, among others, by violence, hate*
7 *speech, exploitation, stigmatization and the most blatant kind of*
8 *discrimination".*
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12 Beyond the general description above, it could be argued that anti-Gypsyism exists in CWS
13 when practitioners behave in a way that is openly hostile toward or critical of Romani and
14 Traveller people (Roth and Toma, 2014). When professionals use negative stereotypical views
15 to talk about or represent a 'Gypsy' culture, Wasileski and Miller (2014) and Nuseibeh (2021)
16 each argues that they can also normalise anti-Gypsyism as they dehumanise Romani and
17 Traveller people. One other possible explanation for the low expectations that professionals
18 have of the care that Romani and Traveller children receive is aversive racism (authors own).
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22 The phenomenon of aversive racism has been derived from Kovel (1970), who distinguished
23 implicit racism from the traditional form of explicit racism, which he called 'dominative racism'.
24 According to Kovel (Ibid: 54), the dominative racist 'acts out bigoted beliefs [as the] the open
25 flame of racial hatred'. Aversive racists, in comparison, might sympathise with victims of
26 injustice, support the principle of equality, and regard themselves as non-prejudiced; but, at
27 the same time, possess negative feelings, views and beliefs about others. As Gaertner and
28 Dovidio (2005: 618) explain:
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32 *'The fundamental premise of aversive racism is that many Whites who*
33 *consciously, explicitly, and sincerely support egalitarian principles and*
34 *believe themselves to be non-prejudiced also harbor negative feelings*
35 *and beliefs about Black and other historically disadvantaged groups.*
36 *These unconscious negative feelings and beliefs develop as a*
37 *consequence of normal, almost unavoidable and frequently functional,*
38 *cognitive, motivational, and social-cultural processes.'*
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43 In contrast to anti-Gypsyism, aversive racism is a subtle form of prejudice that can alter the
44 attitudes of the most well-educated and liberal professionals (Gaertner and Dovidio, 2005). In
45 the context of the current study, aversive racism postulates that professionals, who genuinely
46 believe that they exhibit and uphold the values of the CWS, feel fearful and helpless when
47 interacting with members of the Romani and Traveller community and become unable to
48 transfer the most rudimentary aspects of practice to this location and context.
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52 Whether some of the findings of this study emerged as a result of anti-Gypsyism or aversive
53 racism is a matter for subsequent research. In the meantime, it is important to consider what
54 the SCSCRs and the knowledge of anti-Gypsyism and aversive racism can offer on how to
55 improve the theoretical, disciplinary, and strategic approach to safeguarding and child
56 protection practice.
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58 59 **Overcoming fear and helplessness with trauma-informed practice** 60 61 62 63 64 65

1 The findings presented above suggest that the documented mistrust of CWS is arguably the
2 legacy of a child protection system constructed by non-Romani and Traveller people for non-
3 Romani and Traveller people, which, if not exercised with care, can exclude the Romani and
4 Traveller perspective. Whilst each SCSCR suggests that child protection systems do not need
5 reform, they do suggest that practices need to be reframed. It is within this context that trauma-
6 informed practice, rather than a well-rehearsed recommendation for cultural competence,
7 emerges as the potential solution to the challenges that are reported.
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11 Instances of trauma, as delineated by Levenson (2017), defined as specific events or
12 experiences posing both physical and psychological threats, eliciting reactions of helplessness
13 and fear, were documented in each SCSCR. Notably, Walters (2015), Carwardine and Hartley
14 (2018), Duncan (2020), and Ward (2020) provided explicit references to such traumatic events.
15 For some families, exposure to trauma unfolded in the distant past, encompassing incidents
16 related to childhood adversity such as bullying, exposure to violence, eviction, school
17 exclusion, family separation, and the forced removal of a child. Conversely, for others, the
18 trauma was more recent, involving experiences of hate speech, stigmatisation, racism,
19 unemployment, environmental hazards, criminalisation, separation from the community, and
20 restricted access to healthcare services and housing. Simultaneously, certain professionals
21 appeared to experience trauma through their interactions with and interpretations of Romani
22 and Traveller communities, leading to a sense of fear and helplessness that limited their ability
23 to effectively safeguard and protect the child. The presence of trauma, fear, and helplessness,
24 experienced by both the family and CWS, manifested in the reported inability of both parties
25 to effectively prioritise, promote or recognise the paramount welfare of the child.
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32 Recognising the key priority to unlock relations trapped in a location defined by fear and
33 helplessness, a 'trauma-informed practice' model, identified by Levenson (2017) as a
34 strengths-based approach, which seeks to understand and respond to the impact of trauma
35 on people's lives, has the potential to foster collaborative engagement between CWS and
36 Romani and Traveller children, families, and communities, establishing a secure environment
37 conducive to trust, choice, collaboration, and empowerment (Henshaw, 2022). By learning
38 how to adopt trauma-informed practice with Romani and Traveller people, Levenson's (2017)
39 research suggests that CWS could begin to acknowledge and address the prevalent feelings
40 of fear and helplessness, understand the effect of anti-Gypsyism and aversive racism and
41 raise expectations about the day-to-day reality of Romani and Traveller children.
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46 Each SCSCR showed that some Romani and Traveller families had developed coping
47 mechanisms, often involving avoidance of specific situations that could trigger trauma,
48 including contact with CWS. Employed as a tool for ongoing professional development,
49 trauma-informed practice could be used to equip CWS with the knowledge, values and skills
50 needed to comprehend how child protection interventions may inadvertently replicate
51 dynamics of abusive interactions within the helping relationship (Mersky et al., 2019). By
52 recognising CWS involvement as a potential trigger, professionals could consider how to apply
53 key skills needed to ensure safety, trust, choice, collaboration and empowerment throughout
54 each stage of the child protection process.
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59 The strength of a trauma-informed approach to child protection lies in its status as a practice
60 philosophy that can help to reframe CWS (Levenson, 2017) and fortify the rapport between
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families and professionals, fostering avenues for posttraumatic growth (Connors-Burrow, 2013; Flynn, 2023). As suggested in this study, the central element for a trauma-informed approach with Romani and Traveller families requires child protection practice to consistently demonstrate professional curiosity, compassion, cultural humility and respectful engagement. It is therefore imperative for CWS to be cognisant of the contextual backdrop of historical oppression, racism, socio-economic deprivation, and the marginalisation of Romani and Traveller people so that appropriate action can be taken to ensure that structural inequalities and racist acts are not reproduced in child protection practice. As shown by Atwool's (2019) study of trauma-informed practice with indigenous people in New Zealand, acknowledging and addressing the enduring effects of complex trauma, manifested through historical and contemporary experiences, is crucial to effective child protection. Such considerations are poised not only to address the challenges to effective working relations but more importantly, to protect the welfare and wellbeing of all children living with the risk of significant harm (Levenson, 2017).

A crucial barrier to the advancement of a trauma-informed approach is the absence of concrete proof of concept or demonstrated efficacy within Romani and Traveller communities (Unwin et al., 2023). The lack of robust evidence-based guidance on how to apply trauma-informed practices with Romani and Traveller people raises concerns about the potential misdirection of efforts. For example, some professionals may apply trauma-informed practice models to only regulate and control feelings of fear and helplessness, rather than fostering an environment for exploring and expressing these emotions openly and honestly (Ainsworth and Hansen, 2014). While each SCSCR highlights how 'negative' emotions can impede child protection processes, a trauma-informed approach should ideally emphasise strategies aimed at managing and reducing the experiences of fear and helplessness, identifying the root cause of these emotions (Atwool, 2019). Without careful implementation, there is a risk that trauma-informed practices might inadvertently contribute to the normalising of fear and helplessness, thereby further stigmatising families for failing to engage with or understand child protection policies, practices and strategies over which they have little or no control.

Limitations

It is important to note that the SCSCRs included in this study were written by independent authors who presented findings based on their interpretation of the information collected throughout the review process. This study can only report on the content and themes of each SCSCR, which may or may not fully represent the events that led to the death or injury of a Romani or Traveller child. The study also considered twelve SCSCRs taken from the NSPCC repository. It may be the case that there are more SCSCRs, not held on that database, that could shed further light on the findings that are presented. Further research is needed to validate the findings presented herein in consultation with Romani and Traveller children and families with lived experience of CWS.

It is also important to note the limitations associated with critical social research. Although critical social research is described as an approach to social inquiry that attempts to critically engage with prevailing conceptualisations of the social world (Harvey, 1990), the methods used for analysis are not fully established or agreed. For this reason, the application of critical social research can lead to confirmation bias whilst overlooking alternative perspectives (Corbin and Strauss, 2009). It is hoped that the analytical procedures described in the methods

section, along with the sustained approach to reflexivity, go some way to reducing concerns about bias and subjectivity in analysis and subsequent reporting.

Conclusion

This document analysis of twelve SCSCRs indicates that when a Romani or Traveller child suffers a serious injury or death because of abuse or neglect there also exist examples of socio-economic deprivation, structural inequalities, fear of CWS, and adversarial relationships with CWS. Utilising data contained within these reviews, this study has endeavoured to deepen our comprehension of this phenomenon, enhancing child protection practice with Romani and Traveller children, families, and communities. By shedding some light on the pervasive feelings of fear and helplessness, experienced by both families and professionals, this study applied critical social research to highlight trauma-informed practice as one possible solution to improve the theoretical, disciplinary, and strategic approaches needed to protect the lives of Romani and Traveller children in the future.

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Appendix 1: Summary of Child Safeguarding Practice Reviews included in this study

Author	Location	Background	Findings	Recommendations
Ward, M. (2022)	Surrey Safeguarding Partnership	This is serious case review of the B family, who are part of the Gypsy, Roma, Traveller community and live on a council-run Traveller site. The report was commissioned after one of the children, Child C, was seriously wounded by a sibling playing with knives in October 2019	The report identifies several key issues that affected the safeguarding of the children, such as ongoing community violence on the Traveller site, which the parents were unable to protect the children from, an insufficient understanding and engagement of some agencies with the Gypsy, Roma, Traveller culture, and the limitation of the single-family casework.	The report makes several recommendations for improving the local safeguarding system, such as increasing multi-agency understanding of and reporting procedures regarding community-based violence and ensuring access to specialist advice for practitioners and their supervisors working with Gypsy, Roma and Traveller families.
Duncan, A. (2020)	Norfolk Safeguarding Children Board	This is serious case review of Child AG, who was admitted to hospital in September 2018 with severe malnutrition and healing fractures. AG was the fourth child in a sibling group of six, who were living in a caravan with their parents from a travelling community. The family had a history of neglect, domestic abuse, and non-compliance with services. The children were subject to a child protection plan (CPP) and later a child in need plan (CIN).	The report identified six areas of practice learning related to the limited awareness of domestic abuse, poor assessment of parents' learning disability, limited awareness of neglect and malnutrition, poor professional supervision and management, poor information sharing and communication and the absence of cultural competence,	The report made 12 recommendations for the Norfolk Safeguarding Children Partnership (NSCP) and its partner agencies, covering training and development. tools and guidance and leadership and governance
Carwardine, J., & Hartley, M (2018)	Unnamed Local Safeguarding Children Board	This is a serious case review of the multi-agency response to the sexual abuse and exploitation of two sisters, Charlie and Sam, who were Roma migrants living in the UK with their parents.	The report identified several examples of good practice, as well as areas for improvement in assessment, management, responsiveness and information sharing.	The report made several recommendations for the SCB and its partner agencies, such as developing a multi-agency protocol for the assessment and support of children from migrant families, especially those from minority ethnic communities and those who have experienced trauma and adverse childhood

Author	Location	Background	Findings	Recommendations
				experiences and promoting a culture of professional challenge and escalation, and providing training and support for practitioners to raise and resolve concerns.
Johnson, D. (2018)	Derby Safeguarding Children Board	This is a serious case review of the involvement, care, and support of agencies in relation to Child 1, a nine-year old Roma Slovakian boy who suffered severe burns and neglect by his parents in Derby City in 2016. The report examines the multi-agency practice, identifies the learning points, and makes recommendations for improvement.	The report finds that there were several missed opportunities to identify and respond to the risks and safeguarding concerns for Child 1 and his siblings. The report highlights the following key issues: the lack of effective assessment and information sharing, the lack of engagement and understanding of the parents' capacity and willingness to change, the lack of monitoring and report of the plans and outcomes, the lack of escalation and challenge by professionals, and the impact of service changes and resource constraints on the support for Roma families.	The report makes 10 recommendations for Derby Safeguarding Children Board and its partner agencies, covering areas such as: improving the assessment and analysis of risk and need, enhancing the communication and collaboration between professionals and agencies, ensuring the participation and voice of children and families, strengthening the quality assurance and supervision processes, and addressing the specific needs and challenges of working with Roma families.
Duncan, A., & Griffiths, S. (2017)	Hertfordshire Safeguarding Children Board	The is about a serious case review regarding Child AG, who was severely malnourished and neglected, and had healing fractures of varying ages. AG was the fourth child in a sibling group of six, who were subject to a child protection plan (CPP) under the category of neglect. The family had a traveller background and had moved from a neighbouring county due to violence and intimidation from their neighbours. The parents had learning difficulties and reported domestic abuse.	The report identified six areas of practice learning: the recognition of neglect and malnutrition, the impact of the parents' learning difficulty, the cultural competence in working with families from the Travelling community, the role of the paediatrician, the supervision and management oversight, and the communication and information sharing. The report analysed the strengths and weaknesses of the practice in each area and highlighted the key learning points and recommendations.	The report concluded that the case of AG was complex and challenging, and that there were missed opportunities to identify and respond to the risks and needs of AG and his siblings. The report made 12 recommendations covering the themes of: neglect, malnutrition, learning difficulties, Traveller culture, paediatric assessments, supervision, communication, and training. The report also suggested some actions for child welfare services to monitor and

Author	Location	Background	Findings	Recommendations
				evaluate the implementation of the recommendations.
Tudor, K. (2016)	North Somerset Safeguarding Children Board	This is serious case review of a three-year-old child named Holly, who was admitted to hospital in December 2015 suffering from severe neglect by her parents. The report examines the involvement of various agencies with the family and identifies the learning and recommendations for improving safeguarding practice.	The report identifies three main learning themes: Identifying, Understanding and Working with Neglect; Application of Thresholds; and The Voice of the Child. It also highlights the challenges and barriers to effective practice, such as the family's resistance to intervention, the lack of communication and information sharing among agencies, the impact of culture and learning disability on parenting, and the inconsistency in applying the thresholds for referral and assessment.	The report makes several recommendations for the North Somerset Safeguarding Children Board and the agencies involved, such as developing a tool kit for working with neglect, providing training and supervision for practitioners, ensuring a multi-agency approach to early help, respecting culture but not at the expense of children's well-being, and listening to and acting on the voice of the child.
Walters, A (2015)	Bromley Safeguarding Children Board	This is serious case review of the death of Child E, a 12-week-old baby who was looked after by his maternal aunt, Ms P, along with his twin brother and two older siblings. Child E died of sudden unexpected death in infancy (SUDI) in March 2014, while sleeping in a caravan with Ms P and four other children. Child E's parents were both in prison for various offences and had a history of drug and alcohol abuse. The report examines the involvement of various agencies with Child E and his family, and identifies lessons learned and recommendations for improvement.	The report finds that the child's death could not have been prevented and there were several areas of good practice by some agencies, such as the police, the children's guardian, and the hospital that delivered Child E and his twin. However, there were also significant gaps and weaknesses in the assessment, communication, and coordination of services for Child E and his family, especially by Bromley Children's Social Care, Croydon Health Services, and Croydon Education Service.	The report makes several recommendations for each agency involved, as well as for the Bromley Safeguarding Children Board, to address the issues identified and to improve the safeguarding of children in similar circumstances.
Carmi, E. (2015)	Harrow Safeguarding Children Board	This is serious case review of the death of Baby F, an 11-month-old boy who drowned in a bath after being left unsupervised by his mother in August	The findings highlight systemic weaknesses in ante-natal midwifery services, professional difficulty in dealing with avoidant parents,	The findings cover themes such as midwifery services, homeless and mobile families, police welfare checks and powers of

Author	Location	Background	Findings	Recommendations
		2014. Baby F and his two siblings had been subject to child protection plans under the category of neglect since April 2014. The report examines the multi-agency safeguarding system and the professional practice involved with the family.	repeated inadequate response to referrals by children's social care, lack of understanding of the role of police welfare checks and emergency protection orders, lack of involvement of father and wider family, and the detrimental impact of homelessness and mobility on the children's welfare.	protection, referrals from members of the public, supervision and management oversight, family history and involvement, and good practice examples.
Eades, L. (2015)	Essex Safeguarding Children Board	This is serious case review of the Baby John case, commissioned by the Essex Safeguarding Children Board, to examine the circumstances and decision-making that led to John suffering non-accidental injuries in the care of his parents, who were both known to have histories of drug use, criminality, and domestic violence.	The report found that there were significant gaps and inconsistencies in the information sharing, assessment, and planning processes across the agencies involved with the family. The report also found that the risks to John were not fully understood or addressed, and that the strengths-based approach to the child protection conference may have contributed to a lack of professional challenge and rigour. The report also highlighted the lack of consideration of the parents' Gypsy Roma Traveller culture and its impact on their mobility and engagement with services.	The report made a number of recommendations for the Essex Safeguarding Children Board and its partner agencies, covering areas such as legal planning, child protection conferences, discharge planning, commissioned services and cultural awareness. The report also suggested some additional recommendations to further improve the safeguarding practice and outcomes for children in Essex.
Harrington, K. (2014)	Southampton Local Safeguarding Children Board	This is serious case review of Family A, a family of seven children who were abused and neglected by their father, Mr A, over many years in Norfolk and Southampton. The report examines the involvement of various agencies and identifies lessons to be learned and recommendations to improve safeguarding practices.	The family was known to agencies in Norfolk between 2004 and 2011, with recurring concerns about neglect and physical abuse of the children. However, no substantial or continuing intervention was made by the local authority.	The report analyses the key issues and lessons arising from the case, such as the significance of ethnicity and culture, the management and direction of the case, the accommodation and parental consent issues, the family and friends care, the neglect and

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				sexual abuse, the elective home education, the good practice, and the reporting process. The report also identifies the key causative factors and lessons learned from the case.
Oulton, O (2008)	Gloucestershire Safeguarding 1. Children Board	This is serious case review of a serious case report conducted by Gloucestershire Safeguarding Children Board after the death of Conor, a 9-month-old boy, from non-accidental head injuries in July 2007	The report identifies the areas of policy and practice that need strengthening, such as information sharing, risk assessment, recording, and working with Gypsy and Traveller families. However, the report concludes that there was no evidence that any weakness in policy and practice contributed to Conor's death, and that it is unlikely that any intervention would have prevented it.	The report makes six recommendations for improving the safeguarding of children in similar situations, such as enhancing the process for logging child welfare concerns by the police, accessing education records when a referral is accepted by social care, producing good practice guidance for working with gypsy and traveller families, and raising the difficulties in recording and sharing information on these families nationally.
Ibbetson, K. (2007)	Tower Hamlets Local Safeguarding Children Board	This is serious case review of a serious case report conducted by Tower Hamlets Local Safeguarding Children Board (LSCB) after the death of a six-month-old infant ('E') and her parents in February 2007. The report examines the services provided for 'E' and her family by various agencies and identifies lessons and recommendations for improving child protection practice.	The report finds that the deaths could not have been prevented by different professional action, as the key events leading to 'E's death took place outside of the knowledge and control of professionals. However, the report also finds that there were several points when professionals should have responded differently and provided a more effective service, such as considering the complex history of the case, challenging the parents' presentation, and working more	The report makes recommendations for action in several areas, such as policy, practice and training in relation to domestic violence and drug misuse, pre-birth assessment of pregnant drug users, information sharing protocols, planning and reporting services for children in need, and the involvement of parents in assessments. The report also asks the LSCB to consider how to secure a better understanding of domestic

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			collaboratively across agency boundaries.	violence and drug misuse in services to safeguard children in Tower Hamlets.