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Serious and Fatal Injuries to Infants with Discrepant Parental Explanations: Some Assessment and Case Management Issues

The objective of this study was to examine the challenges faced by child protection systems in assessment and case management where babies and infants have received serious and fatal physical injuries in the context of discrepant parent/carer explanations. Thirty-eight case files or review records of children under the age of 2 with serious or fatal physical injuries were examined. Qualitative methods were employed to identify issues relating to types of parent/carer explanations, factors of concern in addition to the injuries and child protection system responses to the families. Findings indicate that the initial safety response by child protection systems to babies with serious injuries with discrepant explanations can be inadequate. Assessment of further risks could be inconsistent, especially in cases where there are few other factors of concern apart from the injury. There is a need for the development in the UK of more systematic decision-making processes to achieve more consistent standards of assessment and case management of high-risk infants and to minimize false-negative and false-positive predictions of further risk.

KEY WORDS: physical injury; explanations; assessment; case management

'More systematic decision-making processes to achieve more consistent standards of assessment and case management'

Our combined experience in child protection practice, management, evaluation and research over more than two decades highlights that there is a particular group of cases that present significant challenges to child protection systems

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and courts in relation to decision-making about future risks. These are cases where there has been serious physical injury to babies, infants or young children and where there are discrepant parent/carer explanations regarding the cause of the injury.

'Significant challenges to child protection systems and courts'

The definition of 'serious injuries with discrepant explanations' (SIDE) comprises infants (0–24 months) who have been subject to any or combinations of: head/brain injuries, fractures, burns, severe bruising, adult bite marks, poisoning or suffocation. 'Discrepant explanations' refers to an associated feature where parents/carers (singly or jointly) offer: no explanations, inconsistent explanations, conflicting explanations, or explanations that are not compatible with expert medical opinion.

Fatal case reviews (known as Part 8 Reviews in England and Wales) illustrate that some babies who initially present in SIDE circumstances, subsequently die following further abuse:

> 'Extensive severe bruising to baby Bianca's face and body was noticed when she was two weeks old. She was admitted to hospital the same day where the consultant paediatrician formed a firm view that the bruising was non-accidental. However, contrary to the advice of the paediatrician, Bianca was returned to the care of her parents while criminal and child protection enquiries continued. During the next few weeks she was seen by professionals to have further facial bruising. Medical opinion was not sought. At the age of 8 weeks, Bianca was re-admitted to hospital by ambulance with extensive bruising to her body and severe head injuries from which she died.' (From a Part 8 Review summary)

'Misjudgement of the immediate safety needs of very young babies is typical'

Misjudgement of the immediate safety needs of very young babies is typical of many abuse fatalities evidenced by Part 8 Reviews. Meta-analyses of samples of fatal case reviews also highlight the absence of appropriate assessment practice (Department of Health, 1991; Falkov, 1995; James, 1994; Reder and Duncan, 1999; Munro, 1999; Sanders *et al*., 1999).

Assessing the likelihood of accidental or non-accidental explanations being the cause of SIDE injuries is a major challenge for child protection systems. There is a substantial medical literature focused on diagnostic factors and dilemmas (e.g. David, 1999; Geddes *et al*., 2001; Leventhal, 2000; Male *et al*., 2000; Wilkins, 1997). For example, a recent study of subdural haemorrhages in 33 infants noted the difficulty in determining between accidents and abuse (Jayawant *et al*., 1998). The authors concluded that 82% of the subdural haemorrhages were highly suggestive of abuse. A clear history of shaking was eventually obtained in 14 cases (42.5%), although this was never the first explanation offered. Often

'Often causation and responsibility remain unresolved'

causation and responsibility remain unresolved. In a review in the USA of 30 case records of severely physically abused children under the age of 5 years, Miller *et al.* (1999) noted that in over 50% of cases the identity of the perpetrator remained unknown.

Given the extent and far-reaching consequences of these problems, there is a surprising lack of published research regarding assessment and child protection case management of families where young children have sustained serious injuries. It is in such uncertain contexts that child protection workers must assess the immediate safety needs of seriously injured children following injury and the longer-term likelihood of recurrence of injury-causing events. In the UK, official assessment guidelines (e.g. Department of Health, 1988; Department of Health *et al.*, 2000) omit a specific detailed focus on the injury incident of concern. In addition, the technical and social policy issues involved in the assessment of SIDE cases (to minimize the likelihood of both false-positive and false-negative identifications) are not addressed. This paper reports on a research project which explores these issues.

Method

Child protection case management issues arising in SIDE cases were examined from two perspectives via two samples. The first sample was of cases that were predominantly non-fatal (the assessment sample); the second sample was predominantly fatal (the Part 8 Review sample).

Assessment Sample

'Systematic analysis by the three authors of extensive NSPCC case records'

From a total of 203 referrals to an independent child protection assessment service provided by the National Society for the Prevention of Cruelty to Children (NSPCC) between 1986 and 2000, cases were identified that involved serious injuries to children where the parents'/carers' explanations were discrepant with professional opinions as to how the injuries could have been caused. Twenty-one cases fell into this category, involving 26 children aged 0–24 months.

The methodology comprised a systematic analysis by the three authors of extensive NSPCC case records. Files typically included combinations of: sets of child protection case conference minutes; police statements by parents and professionals; medical opinions of injuries; reports from social services, guardians ad litem and medical

staff to conferences and courts; other assessment reports, e.g. psychologist, family centre; NSPCC assessment case notes and reports; court judgements; and miscellaneous professional correspondence.

The cases were referred from several local authorities and originated from southern seaside towns and rural communities reflecting a mix of social deprivation and affluence. All of the families had at least one white British parent. Five of the families had a second parent with either Eastern European, South American, West Indian, Afro-Caribbean or Chinese family backgrounds.

In accordance with standard procedures of qualitative data analysis (Bogdan and Taylor, 1975; Denzin and Lincoln, 1994), analytic memos were continually composed in relation to emerging questions, themes, issues and hypotheses that emerged from the systematic consideration of the data. These memos serve as the basis for the development of the initial categorization system, which evolves through successive versions with amendments, additions and integration of categories as further cases are analysed. In addition, an external multidisciplinary group of expert professionals provided comments on the developing analysis, serving as an important source of methodological triangulation (Neimayer and Resnikoff, 1982). A parallel quantitative analysis recorded the number and types of all injuries; the nature of parental explanations for suspicious injuries; and other recorded factors of concern.

'Analytic memos were continually composed in relation to emerging questions'

This method generated an exceptionally rich source of data, with extensive descriptions and impressions of cases from the multiple perspectives of the many professional groups involved, as well as detailed accounts of the views of the parents and other family members. Such documentary analysis has significant methodological and ethical advantages in the sensitive field of child protection research due to its non-intrusive nature. Also, data and analysis stem from a clinical setting—a perspective that has been noted to be often lacking in child protection research. Consequently, we hope the material will indeed speak to the 'clinician's plight in the trenches' (Ratiner, 2000). Limitations stem from the nature of the non-representative opportunity samples of documents that were originally created for other purposes. Consequently, the analysis provides a sensitizing function in relation to significant issues (Knafl and Howard, 1984), and generalization across other child protection systems cannot be assumed.

'Data and analysis stem from a clinical setting'

Part 8 Review Sample

Part 8 Reviews are undertaken by Area Child Protection Committees (ACPCs) under guidance contained in *Working Together to Safeguard Children* (Department of Health, 1999). They are formal reviews of interagency child protection practice in cases where children have been unlawfully killed or seriously injured in circumstances giving rise for concern. Seventeen Part 8 Review reports (relating to 19 children in the 0–2 years age group, where 17 children died from their injuries and two suffered permanent serious disability) were analysed in accordance with the instrument developed for the assessment sample. This was an opportunity sample obtained mostly via NSPCC membership of seven ACPCs in the home counties of England. These reports contained significantly less detailed information than the extensive files in the assessment sample.

'Seventeen Part 8 Review reports were analysed'

Across both samples, there was a total of 45 children aged between 0 and 2 years, from 38 families. Table 1 gives gender characteristics.

Results

This paper reports on the analysis in relation to:

- Types of injuries
- Parent/carer explanations
- Outcomes
- Assessment and case management issues

The Injuries

In the assessment sample, there were 146 discernible documented injuries to 26 babies and infants (two-thirds male) across the 21 cases. The most common injuries were bone fractures (71% of cases). Fifteen babies sustained a total of 58 fractures (including a total of 28 rib fractures between four cases). Most striking was the very young age at which

'The most common injuries were bone fractures'

Table 1. Gender characteristics of samples

	No. of families	Injured infants aged 0–2 years		
		Male	Female	Total
Assessment sample	21	17 (65%)	9 (35%)	26
Part 8 sample	17	14 (74%)	5 (26%)	19
Total sample	38	31 (69%)	14 (31%)	45

SIDE injuries occurred. One-third of the cases involved at least 18 fracture injuries to babies between 2 and 10 weeks old. The earliest injury involved three fractures (femur and $\times 2$ tibias) to a girl aged less than 3 weeks old. One-third of the cases involved injuries that had been recorded at the time to be life-threatening or the cause of permanent disability. Lack of follow-up information means that this is almost certainly an under-recording of injury-related permanent disability.

'Almost certainly an under-recording of injury-related permanent disability'

Another notable feature was that in 13/21 cases the fractures were preceded by a relatively minor injury (most commonly a small bruise to the face or trunk) which had been seen and recorded by a professional. Professionals observing these precursor bruises accepted parental explanations (e.g. baby lying on dummy) or lack of explanation very readily. By and large, such bruises were interpreted as a benign, unusual and unexplained event rather than as a potential indicator of mounting parental tension.

A similar pattern was noted in relation to professionals' observations of babies in the very early weeks of life who were reported by parents to be constantly crying and sleeping/feeding poorly. Examination of records shows that in a number of these cases the fractiousness of the baby would in all likelihood have been connected with serious injuries already sustained (especially rib fractures and brain damage) that were not apparent to the observing professional—most probably as a consequence of shaking (Carty and Ratcliffe, 1995; American Academy of Pediatrics, 1993).

In the Part 8 Review sample, the most frequently recorded injuries were subdural haemorrhages; retinal haemorrhages; skull fractures; fractures of ribs, long bones and neck; and poisoning. As in the assessment (non-fatal) sample, the vulnerability of babies in the very first weeks of life is strikingly apparent. While the incidence of fractures seems similar, there appears to be a higher proportion of brain injuries in the fatal group. Both samples of children suffered violence sufficient to break bones; those who died were more likely to have experienced impact injuries to their heads or to have been severely shaken as part of the assaults.

'The vulnerability of babies in the very first weeks of life is strikingly apparent'

There is a distinction within the group of fatal SIDE cases. The fatal injury was the first known injury incident in 5/17 of the fatal cases. In contrast, two-thirds of cases (12/17) involved situations where infants had previously been treated for SIDE injuries. These children were subsequently re-injured, sometimes on several occasions, ultimately with fatal consequences.

Age of Parents

In these samples, most serious and fatal abuse to children aged between 0 and 2 years predominantly occurred in households containing one single or both natural parents who were in their early to mid-twenties. Stepfathers had little presence or involvement. This is consistent with other fatality reviews such as Reder *et al.* (1993) in the UK; Levine *et al.* (1994) in the USA; and Wilczynski (1997) in the UK and Australia; all of whom reported similar findings in relation to parental age and family structure.

Parent/Carer Explanations

'Part 8 Review reports rarely contain relevant information subsequent to the child's death'

As Part 8 Review reports rarely contain relevant information subsequent to the child's death, data in this section on parent/carer explanations come solely from the assessment sample. Types of recorded parent/carer explanations (or lack of them) were reviewed from the documents for each injury. Responses included:

- No explanation forthcoming
- Accident (involving parent/carer/sibling)
- Accident (self-inflicted)
- Accusation of another
- Admission of responsibility (tacit, partial or full)
- Insistence on non-abuse explanations

In two-thirds (14/21) of cases, at the point of initial investigation, no explanations were forthcoming. When an explanation was made (either immediately or after a delay), most commonly these referred to an 'accident' of some form. These were split roughly equally between those said to involve the parent and those that did not:

> A baby girl of nearly 3 weeks sustained three leg fractures (both tibia and one fibula). Her parents maintained that the injuries had occurred accidentally while the baby was being passed between them during the night.
>
> The parents of an eight week old baby maintained (after initially offering no explanation) that the multiple rib fractures must have been caused inadvertently by the mother in a hospital while she was holding the baby for eye drops to be administered.

In six situations, parents/carers stated that the injuries must have been self-inflicted by the infant:

> A 6 week old baby boy sustained a spiral fracture to his tibia. Parents stated that this must have been caused by the boisterous baby trapping his leg in an awkward position while sleeping.

Also noteworthy were explanations where one parent (either immediately or subsequently) accused the other:

> In a family where a previous baby had died (in circumstances that we consider suspicious) a 10 week old baby lived with both natural parents. Shortly after the father left home to live with another woman, the baby sustained five fractured ribs. Mother claimed that these must have been caused by the baby's father during contact. During an assessment interview she subsequently tacitly acknowledged that she must have caused the injuries by 'squeezing him too hard'.

'One parent (either immediately or subsequently) accused the other'

In only 4/21 cases did degrees of admission of responsibility emerge over time that could be construed as being fairly explicit:

> A five week old baby was found to have multiple fractures of different ages and bilateral retinal haemorrhages. Both parents initially denied having any knowledge how these injuries had occurred. Several weeks later in an assessment interview the father acknowledged that he might have 'unintentionally' caused the injuries. He committed suicide a week later.

A common pattern (7/21) was for lack of initial explanation to be followed by the emergence of a sequence of different accounts as criminal and child protection investigations continued. Explanations sometimes developed as (depending on interpretation) parents either attempted to identify the unknown cause of the injuries or endeavoured to concoct a plausible explanation that the child protection system would accept without implicating themselves criminally.

'Lack of initial explanation to be followed by the emergence of a sequence of different accounts'

What Really Happened?

The cases in this study, both fatal and non-fatal, suggest that it is not common for unequivocal clarity to emerge over time as to the true cause of injuries and identification of the person(s) responsible. In this context, in Table 2 we present our own best judgements from the documents we have analysed from both samples regarding likely responsibility for the fatal and non-fatal SIDE injuries.

Ascriptions to the categories of 'natural father', 'natural mother' and 'new male cohabitee' have been made with some confidence on the basis of known disposition of cases. When it is clear that one or both must have been responsible, we have ascribed the injuries/deaths to the 'either or both parents' category. Consequently, it can be seen over the two samples that 87% of the injuries and deaths are adjudged to have been caused by either or both natural parents. A step-parent (all male) is seen as being responsible in only

'87% of the injuries and deaths are adjudged to have been caused by either or both natural parents'

Table 2. Likely responsibility for SIDE deaths and injuries

	Researcher's judgements re responsibility for SIDE deaths and injuries					
	Either or both parents	Natural father	Natural mother	New male cohabitee	Not possible to attribute responsibility	Total
Assessment sample	7 (33%)	3(14%)	7 (33%)	2 (9.5%)	2 (9.5%)	21
	Total involving natural parent: 17 (80%)					
Part 8 Review sample	9 (53%)	5 (29%)	2 (12%)	0	1 (6%)	17
	Total involving natural parent: 16 (94%)					
Total sample	16 (42%)	8 (21%)	9 (24%)	2 (5%)	3 (8%)	38
	Total involving natural parent: 33 (87%)					

8% of the whole sample. (In the sample of SIDE children aged over 2 years that will be reported elsewhere, this figure is considerably higher.)

Outcomes: Reunification and Re-Injuries

Systematically gathered, long-term follow-up data specifically about SIDE cases are practically non-existent. Recent research has, however, evaluated re-abuse outcomes from general child protection system case management. These findings indicate that between one-third and one-quarter of abused children were known to have been re-abused (follow-up periods ranged from 20 months to 10 years) after they had come to the notice of child protection agencies (Cleaver and Freeman, 1995; Farmer and Owen, 1995; Gibbons *et al.*, 1995). It was noted that when re-injuries did occur, the proportion that were severe was very low (Gibbons *et al.*, 1995).

Table 3 indicates key outcomes in the assessment sample.

'In 7 out of 17 cases, reunification resulted in known further injuries'

In 7/17 cases, reunification resulted in known further injuries. The extent and severity of the re-injuries was mixed. One child died (cause of death officially recorded as natural, but with a clearly neglected and badly bruised body). Three children sustained further fractures; and a further three significant bruising.

In the four other cases in the assessment sample, the child protection task was related to assessment of the immediate safety of unborn or new babies where there were histories of serious and fatal SIDEs with previous children. The outcomes of these four cases were that three of the babies (having been removed at birth) were reunified at some stage with their natural parents (two cases) and single mother (one

Table 3. Assessment sample outcomes

Outcome	No.	Total
Reunification with some combination of family members	15	17
Permanent separation from parents/carers & extended family	2	17
Reunification to same household as at time of injuries	8	15
Re-injury rate in this group	5	8
Reunification to changed household as at time of injuries (or placement with extended family)	7	15
Re-injury rate in this group	2	7
Total reunifications ended on child protection grounds	2	15

case). In the other case, the baby was placed for adoption. Re-injuries are known to have occurred in one case: a subsequent sibling to the baby of the single mother sustained a SIDE injury several years later.

Assessment and Case Management Issues

In our judgement, the assessment sample included examples of excellent child protection practice by local interagency child protection systems. Effective practice included combinations of:

- Systematic attention to immediate safety needs of the injured baby
- Subjecting parental explanations to thorough scrutiny in an open-minded way
- Following child protection procedures
- Establishing neutral yet supportive relationships with parents
- Commissioning independent assessments
- Provision of appropriate family support services
- Involvement of civil court proceedings for judicial endorsement of child protection plans following assessment.

'It is our impression that children's lives were saved by diligent and prompt actions'

Although it is impossible to prove, it is our impression that children's lives were saved by diligent and prompt actions by social services and health workers. Also, many (but by no means all) injured children and siblings were successfully reunified with their parents or wider families as a consequence of effective support provided by these professionals. Having acknowledged such generally unreported effective practice, we must, however, turn to matters of concern.

Inadequate Child Protection Responses

'Serious and fatal violence to babies can erupt quite unpredictably'

In 13/17 of the fatal cases, the baby had died in the absence of formal child protection interventions. This signifies that serious and fatal violence to babies, on occasions, can erupt quite unpredictably in families where there have been few or no previously recorded significant concerns. However, in all but two of these 13 cases, the Part 8 Review reports stated (or intimated) that the level of concerns known to professionals prior to the fatal SIDE injury *should have led* to child protection procedures being invoked to assess the safety needs of the children prior to the fatal incidents. A quite inappropriate level of professional tolerance of observed harm or threat to babies/infants without child protection interventions being triggered was apparent in some cases.

'The failure to implement basic well-established procedures'

It is not surprising (given the purpose of Part 8 Reviews) that the analysis of the fatal sample identified problematic child protection case management involving inadequate implementation of procedures and absent or poor assessments. It was unusual for a Part 8 Review to conclude that local child protection procedures were at fault. Instead, repeatedly, it was the failure to implement basic well-established procedures by professionals from all agencies which was highlighted as being the significant factor in relation to deaths that were considered to be preventable.

The major failings in professional judgements identified by the Part 8 Reviews involved the absence of appropriate assessment of situations of concern (apparent in 9/17 cases) and the practice of social services in categorizing referrals of serious concern as 'child in need' rather than 'child at risk'. In effect, 'child in need' designations virtually guaranteed that no assessment of the child or family would occur, and may have falsely reassured other professionals (particularly Health) that the welfare of the child about whom they had expressed concerns would be looked into.

'Essentially similar cases were responded to in very different ways'

Throughout both samples, assessment and case management practice was significantly inconsistent. Essentially similar cases were responded to in very different ways, seemingly dependent on which particular group of professionals happened by chance to become involved. In several cases, initial assessments did not specifically and sufficiently consider the immediate safety needs of the injured babies. Child protection practice also reflected notable biases and presumptions. This was particularly so in relation to a significant minority of cases (roughly a quarter) which did not reflect the presence of traditional child abuse risk indicators. Professional responses to these mostly middle-class, articulate and resourceful families were problematic. Seriously injured

babies were returned home on the basis of recorded beliefs that abuse does not happen in loving middle-class families. Alternatively, when protection measures were taken, these cases were particularly prone to become stalemated for long periods prior to extended and highly contentious civil court hearings. These issues are considered in more detail elsewhere (Dale *et al.*, 2002).

'Beliefs that abuse does not happen in loving middle-class families'

Discussion

The cases of serious and fatal physical injuries with discrepant parent/carer explanations reported in this paper highlight the vulnerability of some very young babies (particularly boys) to severe physical abuse. Recent incidence research in Wales has indicated that 1 : 880 babies are seriously physically abused in the first year of life (Sibert *et al.*, 2002). Given that research on child abuse fatalities suggests that only a small proportion of parents who are violent to their babies actually intend to kill (Falkov, 1995; Stroud and Pritchard, 2001; Wilczynski, 1997), chance clearly plays a major part in respect of whether similar assaults prove fatal or not.

At the time of initial investigation of the serious injuries in the assessment sample, in two-thirds of cases no explanation was forthcoming. This was often associated with delays in help-seeking (and in reporting a death). In our view, the combination of lack of explanation and delay in help-seeking is a strong (but not definitive) indicator that care has been inadequate, that the injuries are non-accidental, or both. Explicit acceptance of responsibility for causing the injuries emerged in only four cases. Following immediate likely psychological reactions of shock and denial, there are few incentives in child protection systems for parents to acknowledge losing control and causing serious injury to a baby. Admission of responsibility can be counterproductive to the parents' relationship and wider interests given the implications that this is likely to have regarding criminal and civil court proceedings. Overall, expectations that professional interventions will elicit the 'truth' in SIDE cases about what exactly happened appear to be ill-founded.

'Few incentives in child protection systems for parents to acknowledge losing control'

There can be few more demanding tasks in the field of human services than that of undertaking initial investigations into the circumstances of babies who have sustained serious physical injuries. Or, assessments of surviving siblings and new babies in families where a previous child has died in SIDE circumstances. By definition, the investigative and assessment challenges in these cases occur in a context where significant information is missing. Many cases reflected the

need for more thorough initial investigations. In particular, as Macdonald (2001), Munro (1999) and Scott (1998) have also noted, a systematic and neutral approach to the testing of the evidence-based possibility and probability of relevant hypothetical explanations was often lacking.

To explore rigorously the details of serious injury incidents and family factors is not inherently an anti-partnership approach. It is in the interests of the children and their parents/carers that all possible explanations are thoroughly considered. Not only is this most likely to reduce false-positive identifications by identifying non-abuse causes, it also establishes detailed records of incidents in cases where subsequent, or multiple, injuries occur and where a retrospective analysis of patterns of injuries can be confirmatory of abuse.

'The child protection process can become confused by the multiplicity of factors'

In attempting to assess risks of re-injury, the child protection process can become confused by the multiplicity of factors which generate contradictory opinions, heightened emotions and conflicting proposals. One scenario involved parents/carers and the child protection system informally endeavouring to broker agreements about how the injuries might have occurred. As noted, some parents' explanations tentatively evolved either in a genuine search for the 'truth' or as an attempt to negotiate a plausible 'no blame or consequence' compromise that the child protection system was willing to accept as the basis for the child returning home. To some extent, this process resonates with the legislative and social work aim of attempting to develop a 'partnership' relationship with parents (Holland, 2000). While worthy in principle, it was clear that some parents were more skilled and effective in negotiating the basis of this than were their social workers, and that this led to some compromised child protection decisions.

'False-negative perspectives can result in subsequent fatalities'

Failure to recognize the need for stringent safety measures at the stage of the initial injuries risks a false-negative judgement, i.e. it is erroneously assessed (or simply assumed) that the chance of recurrence of serious injury is low. Case examples such as 'Bianca' illustrate that false-negative perspectives can result in subsequent fatalities. It is also vital to recognize the implications of false-positive assessments. These are less demonstrable but occur when it is wrongly adjudged that the risk of recurrence is high, reunification with parents is not allowed, and permanent care system arrangements are unnecessarily enforced. False-positives also include cases where genuine non-abuse explanations have not been recognized or have been wrongly discounted. The question arises as to what proportion of injured infants and

young children who are diverted permanently to substitute carers could, with appropriate monitoring and family support services, have been safely and successfully returned to the care of their parents/natural families (Essex *et al.*, 1995; Lusk, 1996; Paterson, 1997; Prosser, 1992; Turnell and Edwards, 1999).

In the study reported in this paper, nearly 90% (15/17) of the injured infants in the assessment sample were (either quickly or eventually) returned home. These reunifications were split roughly equally between those who returned to exactly the same household where the injuries occurred and those where the composition had changed (or placed with extended family). Re-injuries occurred in just under half of these cases (7/15), predominantly where the child had been returned to an unchanged household. In a similar study in the USA, 16/30 seriously injured infants had been quickly reunified with parents/carers. At 9-month follow-up, one had been re-injured and removed from home again. The safety of several of the other reunified children gave the researchers considerable cause for concern (Miller *et al.*, 1999).

These findings indicate that when previously seriously injured children (where the circumstances and responsibility for the injuries remain unclear) are returned to parents/carers, the outcomes are mixed. Some children do very well in terms of safety and standards of care, while others are re-injured, sometimes fatally. Outcome figures from this research should not be used as the basis for supporting recommendations about future risk or reunification (or not) in any individual case. The samples are small, and have less than ideal follow-up information. They are also context-specific. It is clear in the American study that significant psychotherapeutic and parent education resources were offered to the parents involved. In our assessment sample, most of the cases had also arisen in areas that were comparatively well resourced in terms of the quality and variety of assessment, therapeutic and family support services.

'When previously seriously injured children are returned to parents/carers, the outcomes are mixed'

Conclusion

Given the mixed outcomes, a major challenge for child protection practice lies in improving risk assessment procedures. There are no risk-free options in child protection work. The causes of child abuse are multifactorial; severity includes chance elements; and human behaviour is inherently unpredictable. Adverse outcomes will always occur. The technical challenge is to minimize avoidable error; and the social policy issue is to clarify to what extent child protection and family

support services should err in the direction of false positives or false negatives.

One influence of *Messages From Research* (Department of Health, 1995) on child protection assessments in the UK has been to promote the predominant view of abusing parents as being helpless, poor and doing their best in difficult circumstances. While much relatively minor child abuse does occur in situations where parents are susceptible to the multiple and cumulative negative effects of social deprivation and absence of effective family support services, the SIDE cases reported in this paper seem qualitatively different. In nearly three-quarters, there were combinations of significant factors (including a severe violent event to an infant, serious domestic violence, parental personality and mental health concerns, and substance misuse) that set these families apart from the *Messages* model of essentially well-meaning but overstressed parents and carers.

'The SIDE cases reported in this paper seem qualitatively different'

The *Assessment Framework* is weighted toward the valuable principles of identification of holistic child needs and the avoidance of unnecessary child protection system interventions. However, one disadvantage of this focus is that the *Framework* does not incorporate the many lessons to be learned from the substantial body of research that has focused on child abuse fatalities. Risk assessment practice needs to distinguish more reliably and consistently cases where initial separation on the grounds of safety is required, and between cases with potentially good and poor outcomes from reunification. The *Assessment Framework* does not sufficiently highlight knowledge of combinations of factors that may signify serious risk, particularly to infants, and consequently does not greatly assist practitioners in their efforts to draw these distinctions.

'The Assessment Framework does not sufficiently highlight knowledge of combinations of factors that may signify serious risk'

A revision of the *Assessment Framework* to integrate the 'risk' research with the 'needs' research would make an important contribution towards minimizing adverse outcomes stemming from naïve or aberrant professional judgements in cases of serious injuries to infants. This would promote greater consistency and validity in the crucial decisions that need to be made about this most vulnerable group of children—a vulnerability highlighted by the preventable death of baby Bianca.

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