

Understanding Serious Case Reviews and their Impact

A Biennial Analysis of Serious Case Reviews 2005-07

Marian Brandon¹, Sue Bailey¹, Pippa Belderson¹,
Ruth Gardner¹, Peter Sidebotham², Jane Dodsworth¹,
Catherine Warren¹ and Jane Black³

¹ University of East Anglia

² University of Warwick

³ NHS Norfolk



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² *University of Warwick*

³ *NHS Norfolk*

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.

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Authors

Marian Brandon, Sue Bailey, Dr Pippa Belderson, Dr Ruth Gardner, Dr Jane Dodsworth, and Catherine Warren are members of the Centre for Research on the Child and Family in the School of Social Work and Psychology, UEA. Dr. Ruth Gardner is also employed by the NSPCC. Jane Black is a Designated Nurse, NHS Norfolk and Dr Peter Sidebotham is from Warwick University.

Disclaimer

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Executive Summary

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected. They are carried out under the auspices of Local Safeguarding Children Boards so that lessons can be learnt locally. Every two years an overview analysis of these reviews throughout England is commissioned to draw out themes and trends so that lessons learnt from these cases can inform both policy and practice. This is the 4th such biennial analysis of reviews notified during the period April 2005 - March 2007. This national study has explored the ways in which serious case reviews can help to understand more about the children at the centre of the reviews, the families within which they were living and professional interventions to protect them.

Key Findings and Learning Points

The chaotic behaviour in families was often mirrored in professionals' thinking and actions. Many families and professionals were overwhelmed by having too many problems to face and too much to achieve. These circumstances contributed to the child being lost or unseen. The capacity to understand the ways in which children are at risk of harm is complex and requires clear thinking. Practitioners who are overwhelmed, not just by the *volume* of work but also by its *nature*, may not be able to do even the simple things well. Good support, supervision and a fully staffed workforce is crucial.

The local overview reports often provided insufficient information to achieve a clear understanding of the case and the incident which led to the child being harmed or killed. Information about men was very often missing and in many reviews so was information about the child. Service provision and inter-agency working cannot be fully understood in isolation from a full analysis of the case and of the agencies' capacity and organisational climate.

Reluctant parental co-operation and multiple moves meant that many children went off the radar of professionals. However, good parental engagement sometimes masked risks of harm to the child.

Background

The study draws out key themes and trends and their implications for policy and practice using a transactional ecological approach to make sense of inter-acting risk factors in the 189 children's cases. It also explores the way reviews are commissioned and scoped; how they are published and how key messages are disseminated and put in place locally. The learning from the study will feed into a longer term development project for serious case reviews nationally. The study builds on the third biennial analysis of reviews undertaken between 2003-2005 (Brandon et al 2008a) using the same methodology, so that results from both studies (350 cases over four years) can be compared and contrasted. Caution needs to be exercised in the interpretation of findings since causal connections cannot be made between characteristics of children or their parents and the likelihood of serious injury or death. The ecological transactional perspective has demonstrated once again how complex and multi-faceted the cases are which in turn makes interpretation of the findings equally complex.

FINDINGS

Comparisons with the 2003-05 study

A number of patterns emerged from the comparison of findings from this study (189 reviews from 2005-07) with findings from the 3rd biennial analysis (161 reviews from 2003-05). These include a very similar age profile for the children, similar numbers known to children social care at the time of the incident and similar proportions of children who were the subject of a child protection plan. In both studies two thirds of the children at the centre of the serious case review died and a third were seriously injured. The same high levels of current or past domestic violence and / or parental mental ill health and / or parental substance misuse, often in combination, were apparent.

The Children

How old were the children? Over two thirds of the children were aged under five and almost half were less than a year old. Only a small minority were 6-10 years old. Almost a quarter were young people aged over 11 and 11% were much older adolescents of 16 and 17. It appeared that the youngest child in the family had a heightened level of vulnerability and risk of harm.

What happened to the children? Two thirds of the 189 children died, and a third were seriously injured or harmed. The highest risk of maltreatment related deaths and serious injury are in the first five years of life. Physical assault was the major cause of death for this age group. Most of the older adolescents died through suicide. A third of the children experienced serious harm, often through neglect (including accidents and house fires). Issues of neglect were often present in those children who died. Sexual abuse was the prime concern in 1 in 12 cases.

Were there known child protection risks? At the time of the incident, 17% of the children were the subject of a child protection plan. The major category of concern was neglect. In a third of the 189 families there were known child protection risks as either the index child or a sibling were at some time the subject of a child protection plan. Just over half of the children were known to children's social care at the time of the incident. Neglect was the most common pre-existing factor in those children or siblings who had been previously known to children's social care. The needs and distress of the older young people were often missed or too challenging or expensive for services to meet.

Were the children subject to a legal order and/or accommodated? 19 of the children (13%) were either the subject of a legal order or accommodated under section 20 of the Children Act 1989 at the time of the incident. These children were mostly living in foster care, semi-independent units, residential homes, hospitals or mother and baby units.

What were the patterns of health use? A third of the 40 children studied in depth had a history of missed health appointments and therefore restricted oversight of their care and development. Six of the 17 infants had been admitted to hospital. A third of the children had a low birth weight.

The families

A detailed study of 40 serious case reviews revealed that almost half (45%) of the families were highly mobile and were living in poor conditions. Half of the parents/ carers had criminal convictions. Many families were overwhelmed, with poor or negative family support. Nearly three quarters of the children lived with past or present domestic violence and / or past or present parental mental ill health, and / or past or present parental substance misuse. These three parental characteristics often co-existed.

Three quarters of the 40 families did not co-operate with services. Patterns of hostility and lack of compliance included: deliberate deception, disguised compliance and “telling workers what they want to hear”, selective engagement, and sporadic, passive or desultory compliance. Reluctant parental co-operation and multiple moves meant that many children went off the radar of professionals. However, good parental engagement can sometimes mask risks of harm to the child.

The professional responses

The enmeshed interaction between overwhelmed families and overwhelmed professionals contributed to the child being lost or unseen. In spite of copious procedural guidance, practitioners and managers were often unclear about what they could or could not do, or should or should not do and about confidentiality. Assumptions were frequently made that others were visiting the family or seeing the child, or taking charge of the case as the lead professional. At times the enthusiasm for a strengths based approach precluded seeing and weighing up the risks of harm to the child.

Practice Note:

Clearly the existence of previous evidence of poor or inadequate parenting should not militate against the possibility of change, but any assessment should take account of past or potential patterns of behaviour or concerns.

Fixed thinking: There were a number of ways in which fixed thinking inhibited a full understanding of the child’s circumstances. **Neglect:** Once the assessment or child protection plan which focused on neglect had been made, this sometimes prevented other forms of harm, like physical injury, being considered. ‘**Rough handling**’ injuries were in some cases seen as less serious acts of inconsiderate and careless parenting rather than an indicator of much more grave underlying concern about physical injury.

Fathers and men: A number of issues emerged including the dearth of information about men in most serious case reviews; failure to take fathers and other men connected to the families into account in assessments; rigid thinking about father figures as all good or all bad; and the perceived threat posed by men to workers.

Lack of co-operation was also found among a third of the families *not* known to children’s social care suggesting challenges for making the voluntary Common Assessment Framework (CAF) work. While ContactPoint is intended to give knowledge of children’s whereabouts, the existence of this database and the presence of information, will not necessarily help workers to clarify the degree of priority or concern that leads to information being communicated and action taken.

Unrealistic expectations were sometimes placed on staff with low level generic child care qualifications working in health (and social care and education) and early intervention services to prevent neglect and abuse.

Practice note:

When professionals with low levels of confidence consider a child is at risk of harm and others do not, they will struggle to challenge the decisions and behaviour of their multi-agency colleagues.

Findings about the serious case review process

The content of serious case reviews

Most overview reports failed to provide enough information to achieve a clear understanding of the case and the incident which led to the child being harmed or killed. The focus on inter-agency working often meant there was little detail about the child, about the parents' past and very little about men in these families. It was difficult to gain an understanding of the family's environment, especially regarding whether they were living in poverty. In spite of the focus in the serious case reviews on the ways that agencies worked together, the serious case review documentation included little about the agencies' context and 'climate' and their capacity to safeguard children effectively. Service provision and inter-agency working cannot be fully understood in isolation from a proper ecological analysis of the case, including the agencies' climate and capacity. The overview author is well placed to highlight agency context and staff capacity.

Practice note:

Serious case review overviews should specifically include quality background information about the child, the family and those in the child's household, and detail about the agencies' capacity and organisational climate.

The serious case review process

Only two of the 106 reviews undertaken in 2005-2006 were completed within the required four month time scale. This seems to be an unachievable time scale; six months to complete a serious case review would be more realistic.

Practice Note, Scoping:

Reviews need to be scoped over a sufficiently long period to make sense of the child's circumstances and the services offered. To keep within reasonable timescales, early child and family history could be summarised in a 'light touch' chronology.

Although Ofsted's role was thought to have improved the quality of Individual Management Reviews, there was uncertainty about the meaning and value of total 'independence' of the overview report author and a concern that reports could become 'formulaic'. Family involvement was becoming common practice and learning from the child death overview processes was seen as helpful in normalising this. Reasons for not involving family members included ongoing court proceedings, causing delay, and family sensitivities.

Local inconsistencies were reported about which staff had access to overview reports and whether executive summaries were made public, but in all LSCBs embedding the learning in practice was taken seriously. Examples of positive practice in monitoring recommendations and making them achievable were given. Dissemination of learning included briefing seminars, training events, newsletters and bulletins or brief reports outlining key issues. Capacity problems could however cause cuts in dissemination activities. A positive LSCB media strategy helped to avoid defensive responses to media interest.

Interviews with a small number of practitioners showed the profound and long lasting impact of being involved with a case where child died or suffered a serious injury through abuse or neglect. Although loss of professional confidence was reported to be an early consequence, most practitioners recovered their confidence and were able to challenge others' decisions if they felt a child was not safe. Good support, especially from the team, was valued.

Practice Note:

In this study no practitioner who was interviewed felt adequately involved in the serious case review process or its subsequent learning. The learning from serious case reviews needs to start with these practitioners.

Chapter 1: The Serious Case Review Process and its Policy, Practice and Research Context

Introduction

This chapter describes the serious case review process and highlights the current policy, practice and research context of these most grave child maltreatment cases. Although this study is an analysis of serious case reviews undertaken in England between the period of 2005-07, the findings will sit alongside the numerous evaluations that have been taking place in 2008 and 2009 of children's services and multi-agency working practices (especially Lord Laming 2009). Many, but not all, of these reports were prompted by the harrowing death through abuse of a young child known as 'Baby P,' who was himself the subject of a serious case review.

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected and are carried out under the auspices of Local Safeguarding Children Boards (LSCBs) so that lessons can be learnt locally. They are considered to be a significant part of the *Working Together* guidance (HM Government 2006, Joint Chief Inspectors 2008:65). In his report into the progress of child protection in England, Lord Laming comments that serious case reviews are an important tool for learning lessons and are now generally well established, with support, in principle, from all services (Lord Laming 2009:63). In the government's initial response to the report, the Secretary of State, Ed Balls, underlines the centrality of these reviews which he says "*play such a crucial role in learning lessons and supporting improvement locally*" (Rt Hon Ed Balls 2009:4). Lord Laming's recommendation that *Working Together to Safeguard Children* (HM Government 2006) be revised has been accepted and the Secretary of State has confirmed that the eleven recommendations concerning serious case reviews from the Laming Progress Report will be taken into account in the planned revisions of this guidance.

The circumstances under which a serious case review should be carried out are outlined in detail in Chapter 8 of *Working Together*, (HM Government 2006) and are, when a child dies (including by suicide) and abuse or neglect are known or suspected to be a factor in the death. They may also be undertaken when a child has sustained a potentially life threatening injury or serious and permanent impairment of health and development through abuse or neglect. Criteria for initiating a serious case review include the murder of a parent if a homicide review is being undertaken, and the death of a child by a parent with a mental illness. Criteria for a possible review also include the case giving rise to concerns about inter-agency working to protect children from harm. It is important to stress that the circumstances of only a small minority of children who suffer serious injury through abuse will be subject to a serious case review.

Chapter 7 of *Working Together* 2006, sets out a process for the overview of all child deaths (under 18 years) thereby extending the focus beyond child abuse and neglect towards a wider, more public health oriented model to enable the identification of preventable deaths. This approach followed evidence, from the US in particular, that a review of all child fatalities might enable better identification of the causes of child death and lead to the introduction of initiatives for better prevention (Covington 2007). Sidebotham and colleagues' study of the 'Early Starter' Child Death Overview Panels found confusion about the links between child death and serious case review processes (Sidebotham et al 2008). It is clearly important that the different processes for reviewing child deaths fit together effectively.

The stages of a serious case review

The following section describes the serious case review process in England. Processes in other parts of the United Kingdom are described, briefly, later in the chapter. The trigger for consideration that circumstances warrant a serious case review is the notification of a serious incident involving a child.

Local authorities are required to notify Ofsted of all incidents involving children that are serious enough that they may lead to a serious case review, including where a child has died or suffered significant harm as a result of abuse or neglect, or that have attracted national media attention, (Joint Chief Inspectors Report 2008:66).

The responsibility for receiving notifications of a serious incident transferred from the Commission for Social Care Inspection (CSCI) to Ofsted in April 2007. At the same time, a new national protection database for recording all serious incident notifications was developed by DCSF.

The decision to undertake a serious case review is made by the Local Safeguarding Children Board (LSCB), and Boards are offered advice about whether the *Working Together* criteria for a review are met by advisers from the Government Office. Where a child has died, the LSCB is required to draw on information available from the professionals involved in reviewing the child's death, as set out in Chapter 7. In cases that give rise to concern but that do not meet the criteria for a full serious case review, *Working Together* suggests that it may be valuable to conduct individual management reviews, or a smaller scale audit of individual cases. Key elements of the serious case review process in England, are outlined below:

Where a case arises, the LSCB should establish a serious case review panel, involving at least the local authority children's service, health, education and the police. The panel decides whether the case should be the subject of a serious case review, applying criteria set down in Working Together. Each service involved conducts an individual management review of its practices to identify any changes that should be made. The LSCB also commissions an overview report from an independent person, which brings together and analyses the findings of the individual management reports and makes recommendations. (Joint Chief Inspectors 2008:65-66)

This summary of the process does not include the important later stages of the review where the learning is disseminated, incorporated into local policy and practice and the plan of action arising from the review is monitored. Chapter 4 considers the serious case review process in more detail.

The evaluation of serious case reviews

From April 2007, Ofsted also took on responsibility for evaluating the quality of serious case reviews in England including assessing the extent to which the review was considered to fulfil its purpose. Ofsted undertake this assessment by reviewing the involvement of agencies, the rigour of analysis of the available information and the capacity for ensuring that the lessons identified are learned (Joint Chief Inspectors 2008:66). In its first yearly report, Ofsted acknowledged their responsibility to provide more guidance and support for LSCBs (beyond the descriptors of gradings) in understanding what it requires (Ofsted 2008). Where reviews were judged to be 'inadequate', the case for 40% of those examined, (Ofsted 2008:31) the main reasons given were that reviewers had not kept to the required four month timescale for completion of the review, and the poor quality of individual management reviews. Less

attention is paid to what constitutes a successful review although the Ofsted report does indicate that:

a good set of recommendations usually followed from a good overview report and a good set of individual management reviews, based on appropriate terms of reference (Ofsted 2008:40).

Many contributors to the 2009 Lord Laming Progress Report commented that people were unsure about the way in which Ofsted made its judgements about serious case reviews. Others were concerned about an over-emphasis on the quality of the written report rather than the subsequent learning. This critical response led Lord Laming to recommend that:

Ofsted should focus its evaluation of Serious Case Reviews on the depth of the learning a review has provided and the quality of recommendations it has made to protect children (Recommendation 42, Lord Laming 2009:90).

Learning from the serious case review process

The three other nations in the UK have somewhat similar approaches to England for the review of child death and serious injury through maltreatment, although Scotland did not set up its systems until 2007 (Vincent 2008). All UK processes have been established to promote learning and not to attribute blame. However there is widespread debate across the four nations, prompted not least by the biennial review from Rose and Barnes (2008), about whether the current models of serious case review ('significant case review' in Scotland and 'case management review' in N Ireland) are the best or the only way to learn lessons. For instance, approaches which seek to learn lessons from effective safeguarding practice are being considered as a better way to proceed (Vincent 2008).

While *Working Together* is clear that a serious case review is not intended to establish culpability, as this is a matter for coroners and criminal courts, Lord Laming found that reviews were sometimes perceived as holding individuals or agencies to account which potentially threatens learning from the process (Lord Laming 2009:64).

The Social Care Institute for Excellence (SCIE, Fish et al 2008) propose an alternative method for undertaking reviews of serious cases, including 'near misses' where practice and decision making could have been improved, which could be applied to serious case reviews. This approach emphasises professional learning and moves away from a person-centred, fault finding, investigation. It spurns the search for a single causal chain, drawing instead on systems theory to examine the wider practice context across agencies (Fish et al 2008). The model offers a clear, but flexible, structure for case reviews and a typology based on work in the area of patient safety. The method proposed however, has not yet been fully tested for usefulness with serious case reviews. The two cases on which the model was applied were 'non serious' to ensure voluntary participation, an approach which ignores the reality of reviewing cases under scrutiny.

The avoidance of a search for culpability advocated by Fish and her colleagues is in line with Lord Laming's recommendation, and the *Working Together* (HM Government 2006) guidance. The proposed move away from "formal fact finding" and reduction in the formality of reviews raises the question of how agencies deal with the problematic issue of disciplinary matters which cannot always be ruled out in these cases. Investigating practice and learning are not easily compatible. Although there is much to commend this as a possible alternative method for carrying out serious case reviews, it is time consuming (using a team of interviewers with continuous opportunities for discussion) and would be difficult to sustain if a number of cases needed to be undertaken concurrently. However there is considerable interest among LSCBs in England (and throughout the United Kingdom) in taking up what is

becoming known as the SCIE model, and the results from fuller testing will reveal more about its utility.

Learning from research and biennial analyses of serious case reviews

This is the fourth biennial analysis of serious case reviews in England. The Government requirement to carry out these regular analyses was initiated in *Working Together* 1999 and was reiterated in the revised edition of *Working Together* in 2006 (HM Government 2006). The purpose of the biennial analysis is to draw out key themes and trends and their implications for policy and practice. The current study builds specifically on our work in the third biennial analysis (of reviews undertaken between 2003-05), where we used a transactional ecological approach to make sense of interacting risk factors present in the cases studied. Our previous analysis was the first national study to analyse all serious case reviews from the given period (rather than a smaller sub-sample) and the current study similarly examines all the available reported cases. It also uses the same methodology so that results from the two studies, (involving a total of 350 cases over the four years) can be compared and contrasted (Brandon et al 2008a).

The current study also adds to the findings of the first two biennial analyses. The first was carried out by Sinclair and Bullock (2002) who examined reviews from 1999-2001 and highlighted the dearth of enquiry into the impact of serious case reviews. Rose and Barnes (who undertook the second biennial analysis of reviews from 2001-2003, Rose and Barnes 2008) responded to this research gap by putting the impact of reviews at the centre of their analysis. Both studies contributed to the growing evidence base on system and practice failings identified in studies of child death and serious abuse. These included deficits in inter-agency working, collecting and interpreting information, decision making, and in aspects of relations with families. Dysfunctional elements of the serious case review process were also highlighted by Rose and Barnes who called for LSCBs to develop a stronger learning culture.

Sinclair and Bullock also noted that '*child abuse is rarely related to a single cause but rather to the interplay of several factors in particular circumstances*' (2002 p26). Their argument underpins our use of an ecological approach to understand the way in which the children at the centre of serious case reviews faced interacting risk factors. The importance of understanding the interplay of different factors in maltreatment from an ecological standpoint has been highlighted in longitudinal studies (Blair et al 2006, Sidebotham et al 2003,2001,2002) and informed a recent evidence based review of maltreatment in high income countries.

The ecological model conceptualises maltreatment as multiply determined by forces at work in the individual, in the family, and in the community and culture, and suggests that these determinants modify each other. Thus parental risk factors can be modified by the environment and community (Gilbert et al 2008:11).

Acknowledging how these factors play out at a societal, as well as an interpersonal, level is crucial. Gilbert et al's (2008) evidence based review noted close links between socio-economic inequalities and deaths from child abuse worldwide. It also found that poverty, parental mental health problems, low educational achievement, alcohol and drug misuse and exposure to maltreatment as a child, are all associated with parents maltreating their children. Children who have already been abused or neglected are at a heightened risk of being re-abused (Hindley et al 2006). In spite of a close association with maltreatment, the presence of these factors tells us little about the *severity* of possible maltreatment and does not, in any way, predict a likelihood of serious injury or death to a child.

The recurring nature of findings from studies of child death and serious injury through abuse call into question the effectiveness of using the learning from serious case reviews to alter practice (Dingwall 1989, Sinclair and Bullock 2002, Parton 2002,2004). Perhaps it is time to focus more energy in considering *why* these themes are so persistent and *why* preventing children being killed and seriously harmed is so difficult. The approach we have adopted in this and our previous (2003-05) analysis is to try to understand more about both the circumstances which might trigger the death or serious injury of these children and young people and the factors which influence the behaviour of practitioners who are working with them and their families.

We are again guided by an ecological-transactional perspective drawing particularly on work by Howe (2005), and Cicchetti and Valentino (2006). The approach is complex and requires a dynamic, not a static, understanding and assessment of children and their families, and of human development across the life span.

An ecological-transactional perspective views child development as a progressive sequence of age- and stage-appropriate tasks in which successful resolution of tasks at each developmental level must be co-ordinated and integrated with the environment, as well as with subsequently emerging issues across the lifespan. These tasks include the development of emotion regulation, the formation of attachment relationships, the development of an autonomous self, symbolic development, moral development, the formation of peer relationships, adaptation to school, and personality organization... Poor resolution of stage-salient issues may contribute to maladjustment over time as prior history influences selection, engagement, and interpretation of subsequent experience...
(Cicchetti and Valentino 2006 p143)

This perspective fits well with the National Assessment Framework and its ecological roots (Department of Health et al 2000). It emphasises that carers' experiences of being parented themselves and the history of their own relationships with family, peers, partners and professionals will influence their sense of themselves and others. These emotional histories, cognitive models and current life stressors will affect carers' states of mind and the way they understand and interpret the needs and behaviour of their children. A dynamic ecological explanatory view of parent-child interaction should allow practitioners to spot warning signs at an earlier stage, based on less information. This way of thinking stresses that **it is what is done with information, rather than its simple accumulation, that leads to more analytic assessments and safer practice** (Brandon et al 2008a, Chapter 4).

As we noted in our 2003-05 analysis, it is parents who have enjoyed more sensitive and psychologically available relationships during their own development who tend to have more complex, differentiated and nuanced understandings of their own and other people's thoughts, feelings and behaviour. This extends to parents' ability to recognise, understand and respond to their own children's needs and behaviour in a sensitive, psychologically connected manner. If parents are insensitive and psychologically unavailable when their children experience distress and emotional dysregulation, there is a risk of setting in motion a train of developmental setbacks (Brandon et al 2008a Chapter 4).

Aims and Objectives of the study

This study offers an examination of the set of serious case reviews arising from incidents which occurred during the two-year period 1 April 2005 to 31 March 2007, and were initially notified to CSCI/DCSF. The study was carried out over twelve months (March 2008 to March 2009) by a team based in the School of Social Work and Psychology at the University of East Anglia, working in conjunction with Dr Peter Sidebotham from the University of Warwick and Dr Ruth Gardner based jointly at the National Society for the Prevention of Cruelty to

Children (NSPCC) and the University of East Anglia. The large research team included academics, researchers and clinicians, some of whom have current clinical experience of working in health and with Local Safeguarding Children Boards. The team continues to model, in some respects, the different knowledge base and perspectives of multi-agency groups working with children and families.

A central aim of the study follows on from the previous report of cases from 2003-05 (Brandon et al 2008a); it is to learn from the analysis of interacting risk factors present in the cases under review and to transfer this learning to everyday practice and to the process of serious case reviews. Feedback from the previous study has led us to believe that practitioners, clinicians and decision makers have found this a helpful way to think about the work with children and their families. In order to assist with the study, a central steering group was established at the Department for Children Schools and Families comprising policy makers, researchers, academics and operational managers who acted as a sounding board for work in progress. A local consultation group of expert practitioners with expertise in paediatrics, substance misuse and operational facets of Local Safeguarding Children Boards also provided useful feedback in earlier stages of the study.

Regional seminars were organised by the Department for Children Schools and Families in October and November 2008 to disseminate early findings from the current analysis. These regional seminars also presented findings from the national evaluation of the Child Death Overview Panels by Dr Peter Sidebotham and colleagues (Sidebotham et al 2008). Comments from seminar participants are included in Chapter 4.

The research questions for the current study are drawn directly from the guidance in *Working Together* (2006) and also specify the theoretical approach which guides the research team and the analysis.

Research Questions

- To identify common themes and trends across review reports, using an ecological-transactional approach and drawing out the implications for policy and practice;
- To explore the use of classifications of child deaths to provide linkage with the work of Child Death Overview Panels
- To explore the way in which reviews are commissioned, and the scoping of reviews, and how they are published and how key messages are disseminated locally;
- To discover what mechanisms are put in place locally to implement the findings and to monitor their implementation;
- To ensure that the learning from the study is captured so that it can feed into a longer term project to develop and implement a revised method of conducting national reviews.

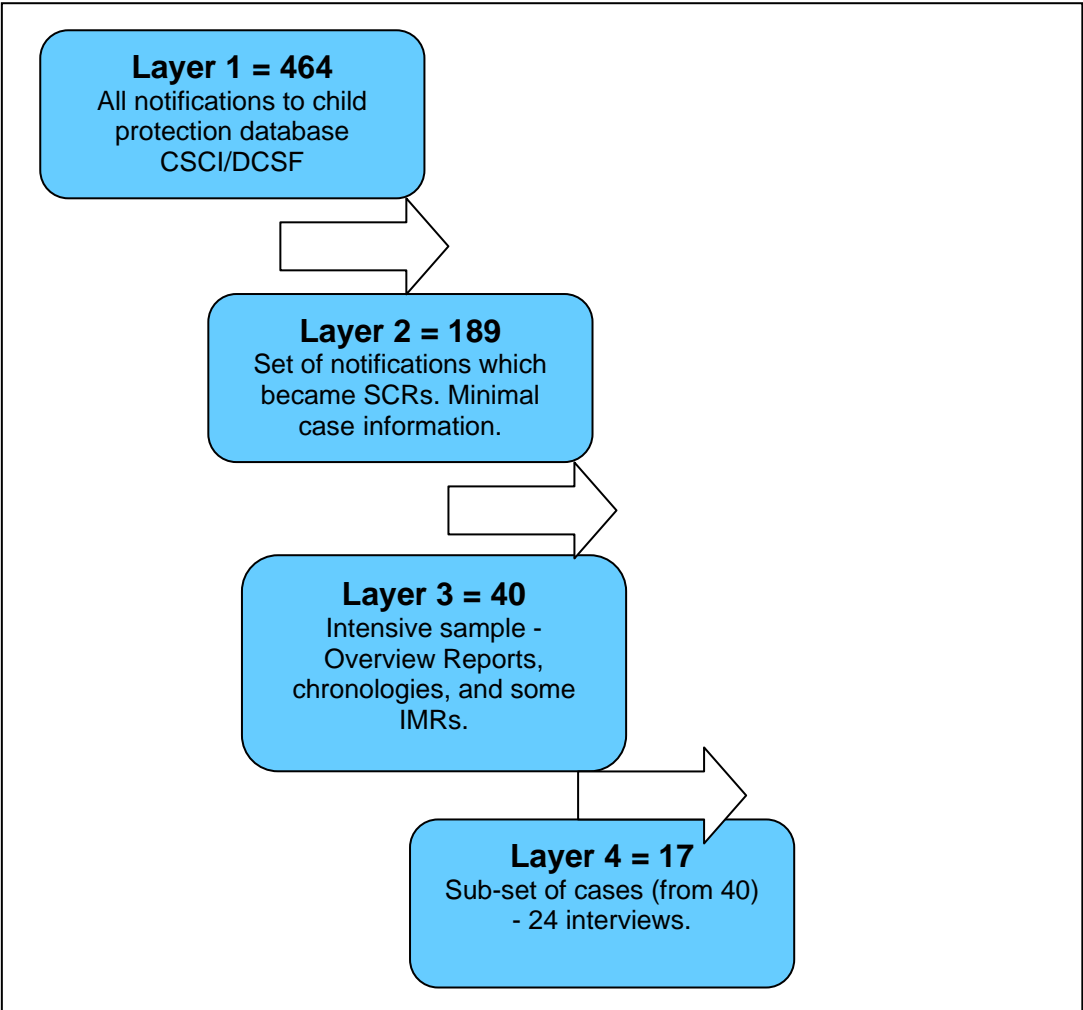
The methodological approach to the study sample

The study offers an examination of minimal information concerning all available serious case reviews (189) arising from incidents which occurred between 1st April 2005 and 31st March 2007. It further scrutinises an intensive sample of 40 reviews relating to the same period. Telephone interviews were held with members of the LSCBs and practitioners (a total of 24 from 17 cases) who had been involved with the serious case review or worked with the child or family at the time of the incident which prompted the review.

In order to manage and make sense of the relatively large number of reviews in the study, the 'layered reading' approach used in the last study (developed originally for the study of serious case reviews in Wales) was again adopted (Brandon et al 1999, 2002, 2008a). This involved building information about both the 189 cases and an intensive sample of 40 cases from layers of initially minimal, and later more detailed information as it became available. As we indicated in our previous study, the story of each child's death or serious injury makes very powerful reading. As a result one feature or theme can take on a disproportionate significance. While it was important to acknowledge the individual differences of each child or young person, it was also essential to consider each case objectively as part of a larger whole of 189 or 40 reviews. The layered reading approach allowed the children and their circumstances to be studied respectfully, and systematically. This approach also helped the research team not to be overwhelmed, emotionally, by the material at the outset of the study.

The study was carried out in four connected phases as illustrated in Figure 1:

Figure 1: The research process in layers



The research process

Layer 1 - identify the serious case reviews from the 464 notifications

The first phase of the study was to establish which of the 464 notifications of critical child care incidents reported to the child protection database (CSCI 2005), progressed to become a serious case review. For clarity, these child protection notification reports are referred to throughout the report, as the *database notification reports*. Locating the full number of serious case reviews was beset with challenges which are explained in Appendix 1. In all, 189 notifications were judged to have led to a serious case review. This is likely to be a lower figure than the actual number conducted since not all reviews were available to be provided to the research team for scrutiny.

While 106 reviews were provided by DCSF in the first year from 2005-06, a lower number of 83 reviews were provided from the second year 2006-07. This apparent fall in the number of serious case reviews in the second year is almost certainly illusory. It is explained, not least, by the fact that at the time the information was provided to the research team, for nearly 30 cases in the last 6 months of the two year period, the decision to carry out a serious case review was either pending, or the information on the database notification report had not been updated or was unclear (see Appendix 1).

We confronted a parallel set of challenges when identifying the number of serious case reviews in the 2003-05 study (Brandon et al 2008a). The 161 reviews identified for this period were probably an even greater underestimate of the totality of reviews undertaken, and it would not be accurate to claim that there has been an increase in serious case reviews carried out over the two time periods, on the basis of these two figures.

Layer 2 - analyse the 189 cases

The next phase of the study involved the analysis of the minimal information from the database notification reports to produce descriptive statistics about the children, their families, the environment in which the children were living, and also some detail about professional involvement in the 189 cases. In addition, the free text 'case outline' narrative sections of the database notification reports were used to further illustrate the findings. The aim of this phase of the study was to build a picture of the cohort as a whole, without allowing any individual reviews to dominate the thinking and learning.

Layer 3 - analyse the intensive sample of 40 cases

The Department for Children Schools and Families supplied redacted overview reports, and some chronologies and individual management reviews, for 63 serious case reviews from within the two year period. From this pool, 40 children's cases were selected to make up the 'intensive sample'. Cases were chosen to produce a stratified sample, reflecting a balance of key demographic characteristics, for example age, gender, death / injury and ethnicity of the child or young person at the centre of the review, and to give a regional spread of cases.

A database notification report was not available for 5 of the 40 cases so this sample cannot be considered to be a complete subset of the larger group of 189 cases.

A summary was compiled for each of the 40 cases using a similar template to the one used in the 2003-05 study. Notes were made on key features of the case, the background and characteristics of the child and family, the interaction of both risk and protective factors, professional involvement, levels of intervention and patterns of family cooperation with the relevant agencies, the structure and quality of the report itself, timescales of the review, and

any involvement of the family in the review process. The completed summaries were scrutinised to extract themes, and to provide quotations to support Chapters 2 and 3.

Layer 4 - Interviews about the impact of serious case reviews

Telephone interviews were carried out in relation to 17 of the 40 intensive sample cases to explore the effectiveness of the serious case review process in securing learning and to understand more about the impact of the work on professionals. A total of 24 telephone interviews were conducted: 17 with a member of the LSCB who directed or was a key player in the review process and follow up, and 7 with a practitioner / clinician who had been working with the child or family at the time of the incident which prompted the review. Five of the practitioners came from a variety of health settings, and two from children's social care. All Government Office regions were represented in the interviews.

There was a slightly different focus to the two sets of interviews. The broad aim of the interview with the LSCB member was to understand how the process of the review and its subsequent learning connect. The emphasis in the practitioner / clinician interview was to learn more about the personal impact of being involved with a case that becomes a serious case review and to understand the perceived influence of the case on their professional networks. Interviewees were reassured that information and opinions used in the report would not identify any individual case, or the child and family concerned, or any professional, or the authority or agency involved. All those interviewed approved a draft of the chapter including any quotes or information they had given.

Brief questionnaires asking about the impact of serious case reviews on LSCB's learning and about their impact on practitioners were distributed at the DCSF regional dissemination seminars in the autumn of 2008. Findings from the analysis of this survey are included in Chapter 4. For more details about the methodology please see Appendix 1.

Limitations of the Study

The key limitation of the research is posed by the idiosyncrasy of the population studied. The cases used for this study are those notified to CSCI / DCSF which subsequently became subject to a serious case review. Whilst the majority of cases of *fatal* maltreatment should be included, to meet the *Working Together* criteria for inclusion, this is still subject to local interpretation and the figures cannot be assumed to represent the total number of children who died from abuse or neglect. One third of the 189 children, about whom a serious case review was held, did not die and survived the circumstances which prompted the serious case review. It should be noted that only a minority of serious injury cases are subject to a serious case review.

The mix of fatal and non-fatal cases and the broad ranging criteria for inclusion have a number of implications for the way these data can be used and the comparability of these findings with other studies.

- Firstly, the database notification report classification does not equate to death registration nor to the outcome of any criminal proceedings, indeed in most cases neither the registered cause of death nor the status of any criminal investigation are recorded.
- The separate cases of death and of serious injury are not *necessarily* similar. Where possible, and where it contributes to understanding, we have distinguished deaths from non fatal serious incidents throughout the report.

- The outcome of death or serious injury in these cases does not imply that maltreatment cases with a similar profile will have a similar outcome of death or serious injury.
- Caution needs to be exercised when comparing our study with other studies relying on base data, for example child homicide populations or studies of serious abuse or neglect. Other studies of serious case reviews in England (and the UK), which have a mix of fatality and serious injury cases, *are* comparable but wider cross national and international comparisons are more difficult.

By nature this study is primarily descriptive and retrospective, and it has been neither appropriate nor possible to match the cases to any denominator population. For this reason, it is important to reiterate that causal connections cannot be drawn between findings about characteristics of children or families and a likelihood of serious injury or death. Where possible, comparisons have been made in Chapter 2 with the general population of England but more detailed comparisons would require, not least, matched populations taking account of gender, age ethnicity, social status and levels of deprivation. Such comparisons are not currently possible, although it is hoped that with the introduction of wider child death review processes it may, in future, be possible to compare maltreatment-related death with other child deaths. Gaps in the data point to probable under-estimates of true incidences of some characteristics, for example domestic violence.

All of these limitations mean that caution must be exercised in the interpretation of findings and how they can be generalised. However the awareness of these challenges and the determination to grapple with them should, in time, provide better access to accurate information, a more robust methodology and a stronger evidence base.

Finally it is important to stress that a study of serious case reviews is not a study of typical safeguarding practice. The practice failings identified repeatedly in studies of serious case reviews can be interpreted as implying that reviews are a touchstone for all safeguarding practice, but this is not the case. Death and serious injury of children through abuse is, thankfully, a relatively rare outcome. However, more does need to be known about routine child protection work and its effectiveness (Cawson et al 2000). To achieve this, comparisons could be made between serious case reviews and matched cases with a similar profile but different outcome. These comparisons could be carried out, initially, by LSCBs. The Children's Commissioner has commented that the majority of safeguarding work is successful but this observation needs to be backed up with better evidence so that successful outcomes for children can be celebrated and learning can be gleaned from *positive* practice.

Chapter 1 Summary

- The Government consider that serious case reviews play an important part in learning lessons and supporting improvement locally. Recommendations concerning serious case reviews from Lord Laming's Progress Report (2009) will be taken into account in the planned revisions of *Working Together*.
- There is widespread debate about whether the current models of serious case review are the best or the only way to learn lessons. Approaches which seek to learn lessons from effective safeguarding practice are being considered as one of a range of options for future development.

- This is the fourth biennial analysis of serious case reviews in England, which was undertaken on cases occurring between the period 2005-07. It draws out key themes and trends and their implications for policy and practice using a transactional ecological approach to make sense of inter-acting risk factors present in the cases studied. It builds on our third biennial analysis (of reviews from 2003-05) using the same methodology, so that results from the two studies, (involving a total of 350 cases over the four years) can be compared and contrasted (Brandon et al 2008a).
- Caution needs to be exercised in the interpretation of findings from this, or any other study of serious case reviews. Studies of serious case reviews are not studies of typical safeguarding practice. Causal connections cannot be made between characteristics of children or their parents and the likelihood of serious injury or death.
- The ecological transactional perspective has shown us again how complex and multi-faceted the cases are making interpretation of the findings equally complex.

Chapter 2: Characteristics and circumstances of the children and their families and agency involvement

Introduction

This chapter considers the characteristics of the children who were the subjects of serious case reviews in the period 1st April 2005 to 31st March 2007 and also information about their families and agency involvement. The findings refer to 189 cases where information provided from the database notification reports (Child Protection Database Reports, Commission for Social Care Inspection [CSCI] 2005) indicated that the notification became a serious case review. These reports are completed when a serious or critical child care incident is notified by the local authority (see Chapter 1 and Appendix 1). From 2005- 2007 critical incidents were reported to CSCI but from April 2007 onwards, notifications were made to Ofsted.

Two thirds of the 189 children (123) died and a third (66) were seriously injured or harmed (which is the same proportion as cases from 2003-05).

Where pertinent, comparisons like this are made with children who were the subject of serious case reviews from this previous period (161 cases). The full analysis of these earlier cases is presented in our report for the Department for Children, Schools and Families (Brandon et al 2008a).

The database notification reports comprised 'tick box' sections and a free narrative 'case outline' section. Data drawn from the 'tick box' section were always checked against any information provided in the free-narrative portions of the reports. The information in the narrative sections was of variable quality and just under half (44%) of reports contained a clear outline of the story of the child or the case. Others presented only limited information or sketchy details. It should be noted that these reports were completed at a very early stage when little may have been known about the circumstances of the children. Sometimes the reports were updated when new information became available and the story of the case review process was often revealed in this way. For a small number of cases (5%) the database notification reports only revealed information about the case review process and offered nothing about the children or their families.

When considering these findings, it should be remembered that we cannot assume that the figures are representative of all serious occurrences of child injury or death where abuse or neglect was a factor. The sample comprises cases where Local Safeguarding Children Boards deemed it was appropriate and/or necessary to hold a serious case review. Therefore, it is important to bear in mind that two interpretations are often possible:

- a) that the results genuinely reflect the wider picture of serious instances of child injury or death; and / or
- b) that the results reflect the decision making processes regarding which cases are raised to serious case review status.

More light is shed on the differences between notifications that become a serious case review and those that do not in Appendix 1 and in Chapter 4. In the tables in this chapter, data for 2005-2007 are shown in shaded columns, while the earlier data for 2003-2005 are un-shaded.

Wherever percentages are recorded in tables they always relate to the population for whom information is available which may vary, and is shown in each table as n =. The percentages displayed in the tables below may not always total 100 because of rounding. Case illustrations (in italics) are adapted from the free narrative section of the database notification reports.

Characteristics of children

Age

A breakdown by age of the 189 children and young people subject to a serious case review is displayed in Table 1 (with the years 2005-6 and 2006-7 listed separately). The lower number of 83 children, for the second year 2006-2007, reflects the fact that at the time of analysis (Summer 2008), serious case review status had still not been decided for nearly thirty of these more recent cases. There are no grounds for assuming that fewer serious case reviews were finally undertaken in the second year.

Table 1: Age at time of incident

	Frequency 2005-06 (n=106)	Frequency 2006-07 (n=83)
<1yr	47 (44%)	39 (47%)
1-5yrs	24 (23%)	20 (24%)
6-10yrs	13 (12%)	5 (6%)
11-15yrs	9 (9%)	11 (13%)
16-17yrs	13 (12%)	8 (10%)
All ages	106 (100%)	83 (100%)

In Table 2 a number of comparisons are made:

- The 189 children's cases are compared with the 161 cases from 2003-2005 (Brandon et al 2008a).
- Comparisons are made with children aged under 18 in the general population.
- Comparisons are given with the population of child deaths.

Table 2: Age at time of incident, retrospective and population comparisons

	Frequency 2005-07 (n=189)	Frequency 2003-05 (n=161)	Population age distribution in England of under 18's * Mid-2006	National numbers (%) age distribution of deaths under 18 years** England and Wales
<1yr	86 (46%)	76 (47%)	620,100 (6%)	3,368 (64%)
1-5yrs	44 (23%)	33 (21%)	2,892,200 (26%)	629 (12%)
6-10yrs	18 (10%)	11 (7%)	2,972,900 (27%)	317 (6%)
11-15yrs	20 (11%)	26 (16%)	3,188,900 (29%)	499 (9%)
16-17yrs	21 (11%)	15 (9%)	1,322,600 (12%)	468 (9%)
All ages	189 (100%)	161 (100%)	10,996,700 (100%)	5,281 (100%)

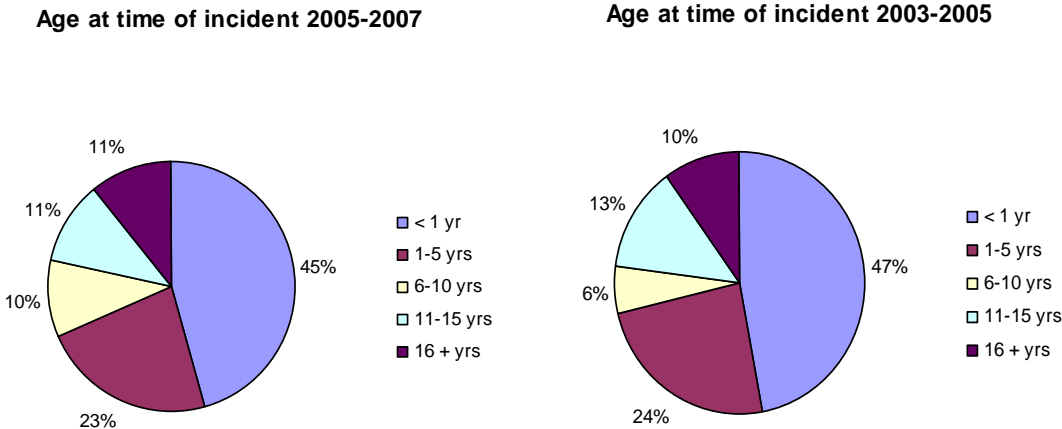
* Key Population and Vital Statistics; Table A3 p.93 ONS (2006)

** Mortality Statistics (2006) ONS

The proportion of cases concerning infants under one year was almost identical in both two-year time-frames, comprising just under half of all cases. The later cases for 2005-2007 have somewhat fewer 11-15 year olds than the 2003-2005 cases (11% compared to 16%) and a slightly higher percentage of 6-10 year olds (10% compared to 7%). (Figure 2 shows the similarity very clearly).

In the population generally, only 6% of under 18s are less than one year old. The age profile of the serious case review population has more in common with the age profile for all child deaths, (see last column Table 2) than with the general child population (Table 2, column three), though with a lower proportion of deaths in children aged under 1 and a higher proportion in those aged 1-5 years. The high proportion of all deaths in the under 1 age group is influenced by perinatal causes of mortality which may account for this discrepancy to some extent (see also Table 15).

Figure 2: Age of child at time of incident



When the age profile of the children is studied in more detail, the high proportion of very young babies in the cases is particularly striking (Figure 3). Nearly 30% of the 189 children were under 3 months at the time of the incident, and half of these were less than one month old. Care should be taken when interpreting the graph, however, since the bars represent varying lengths of time, ranging from a one month period for the very youngest babies, to a series of five year periods from age six onwards.

Examples of these very young babies included those who were known to a number of agencies and those who were receiving only universal services.

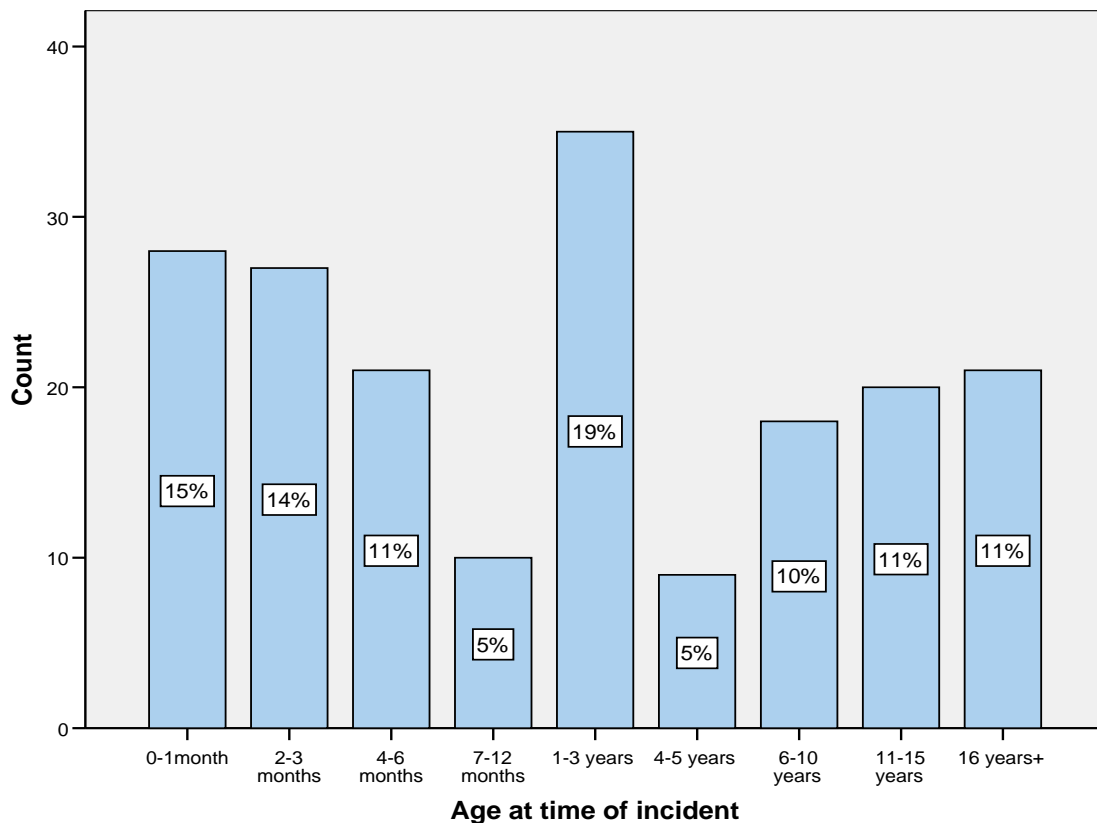
Baby resided with mother in sheltered housing - mother has mental health problems. Baby found dead by relative. Not known to children’s social care.

Mother alerted emergency services. Child had fractured skull and an old rib injury. Father has been charged with murder. Mother previously in care/diagnosed with schizophrenia.

X was shaken by her father, and admitted to hospital the same day where she died. Father convicted of her manslaughter and given a custodial sentence. The judge accepted his mitigation that he lost his temper and this was out of character.

It is worth noting that the database notification reports provided full and robust data on the age and gender of the 189 children.

Figure 3 Age categories



Almost half of 189 children were under one year of age and a third were very young babies under 3 months. This repeats the findings of the last biennial analysis and reinforces the importance of the safeguarding role for health staff (especially midwives and health visitors) working with young babies and their families, as noted by Lord Laming (2009). 'Progressive universalism,' offers a more targeted health visiting service to families assessed as having a higher level of need. But if this need is not identified in the antenatal period, or soon after, the children will not get access to this additional support and monitoring by health professionals.

Gender

There were somewhat more boys than girls (56% boys, 44% girls) and this is consistent with our findings from the previous 2003-2005 study. Moreover, international comparisons note that boys are at a greater risk of child death by injury or homicide than girls (Unicef 2001). A higher number of the incidents involving boys resulted in deaths rather than serious injury (72% for boys and 57% for girls).

A closer examination of gender alongside age, indicates that slightly more serious case reviews were undertaken for younger boys than girls (Table 3).

Table 3: Gender and age

Age group	Gender 2005-07 (n=189)	
	Female (n=83)	Male (n=106)
<1yr	34 (41%)	52 (49%)
1-5yrs	17 (21%)	27 (26%)
6-10yrs	11 (13%)	7 (7%)
11-15yrs	10 (12%)	10 (9%)
16 + yrs	11 (13%)	10 (9%)

Figure 4: Gender and Age

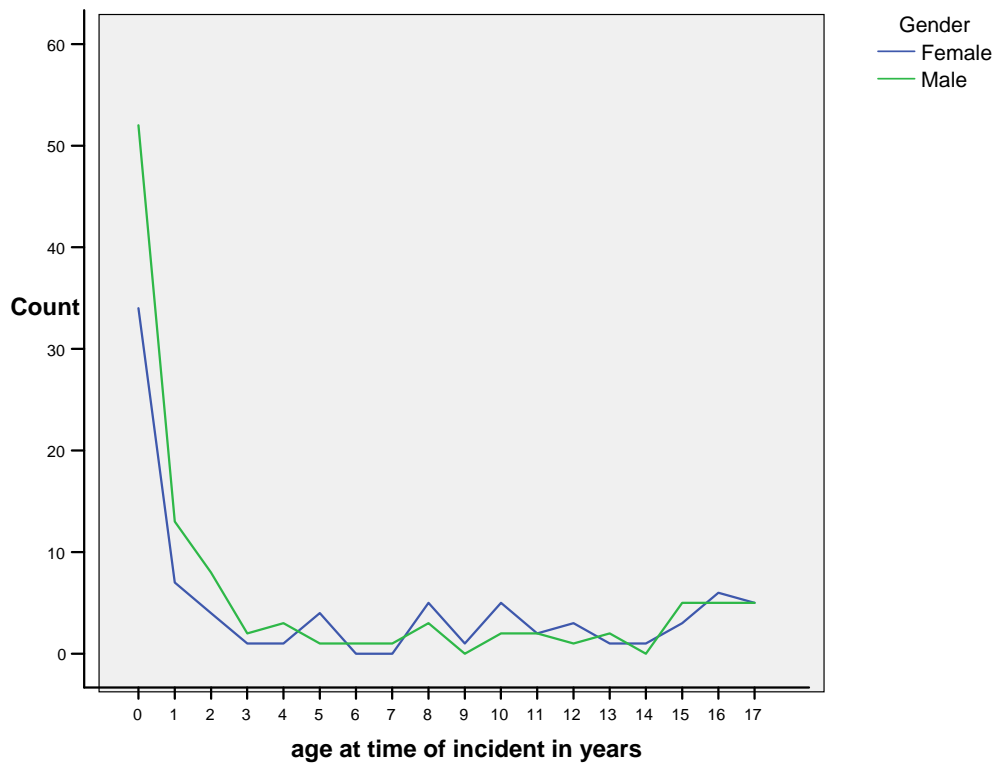


Figure 4 illustrates, graphically, the age and gender patterns, showing that more infant boys than infant girls are the subject of a serious case review, and illustrating that the gender difference narrows for somewhat older children.

Ethnicity

The ethnicity of the children studied in 2005-2007 closely reflects that of the children in 2003-2005 (see Table 4 and Figure 5). Just under three quarters of the children were classified as white in both time periods. The current study shows a higher proportion of children of mixed ethnicity, and a lower proportion who are black British. Ethnicity was recorded for 173 (92%) of the children in the 2005-2007 and for 136 (84%) in the earlier study.

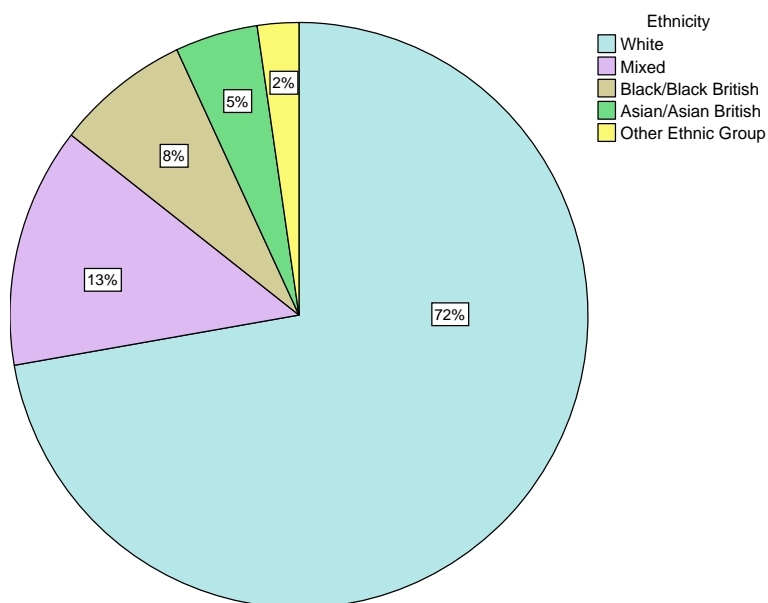
Table 4: Ethnicity

	Frequency 2005-07 (n=173)	Frequency 2003-05 (n=136)	All children in need (2005)*	Under 16s in the UK population (2001 Census)	New births in 2005 (ONS)**
White	125 (72%)	101 (74%)	80%	88%	78%
Mixed	23 (13%)	8 (6%)	6%	3%	4%
Black/Black British	13 (8%)	17 (13%)	7%	3%	10%
Asian/Asian British	8 (5%)	8 (6%)	4%	6%	6%
Other Ethnic Group	4 (2%)	2 (1%)	2%	1%	3%

* DfES 2006a **ONS 2008c

In Table 4 various figures are offered for comparison. The ethnic distribution of all ‘children in need’ is given, for a sample week in February 2005 (Department for Education and Skills 2006), having omitted those returns where ethnicity was not stated. The ethnic distribution of all under-16s in the UK comes from the 2001 census (ONS 2001/2002). Since almost half of the children for whom a serious case review was held were aged under one, the last column of Table 4 gives the ethnic distribution of babies born during the 2005 calendar year. White children are slightly under-represented in our 2005-2007 set of cases, although if the comparison is made with the ethnic distribution of new births the under-representation is not significant.

Figure 5: Ethnicity



Siblings

Approximately a quarter of the children who were the subject of a serious case review were only or first children, and a further third had one sibling (see Table 5). The 2003-2005 cases showed a similar pattern. Although there was a greater number of *very* large families with five or more siblings in the earlier study, this time more children did appear to be living in somewhat smaller ‘large families.’ Almost a quarter of the families in 2005-07 (22%) had 4 or more children (the index child plus three siblings). Nationally, only ten per cent of children

live in a family with four or more children (Bradshaw 2006). Bradshaw's study highlighted the known stresses and difficulties that large families bring - particularly poverty, thus risks of harm may be more acute in bigger families.

x was the fourth child of eight by the third of mother's 3 partners.

There were seven sets of twins (4%), double the small number (2%) in the 2003-05 study. This is somewhat more than the national average of 1.5% of all deliveries (NHS maternity statistics England 2005-6). The extra demands made by multiple births are known to place increasing pressure on parents - particularly when the babies are premature or more difficult to feed or care for. Being a twin may therefore present an additional risk of harm to a baby, especially when the family is facing other difficulties.

Table 5: Number of Siblings

Number of siblings	Frequency 2005-07 (n=177)	Frequency 2003-05 (n=152)
0	42 (24%)	41 (27%)
1	54 (31%)	50 (33%)
2	42 (24%)	28 (18%)
3	20 (11%)	13 (9%)
4	11 (6%)	7 (5%)
5 and over	8 (5%)	13 (9%)

Information on the number of siblings and their ages was provided in 94% of the database notification reports, but the relationship of full, half or step sibling was difficult to determine and it was not always clear whether siblings were living at home with the index child.

Birth order

At the time of the incident, a quarter were only or first children and nearly half (44%) were younger children (see Table 6 and Figure 6). However, interpretation of this finding should be treated with caution - since 46% of the cases relate to babies aged under 1 year of age, many *will* be the youngest children. The hypothesis that the youngest child might have a heightened level of vulnerability and risk is tentative, but the vulnerability of young babies is clear.

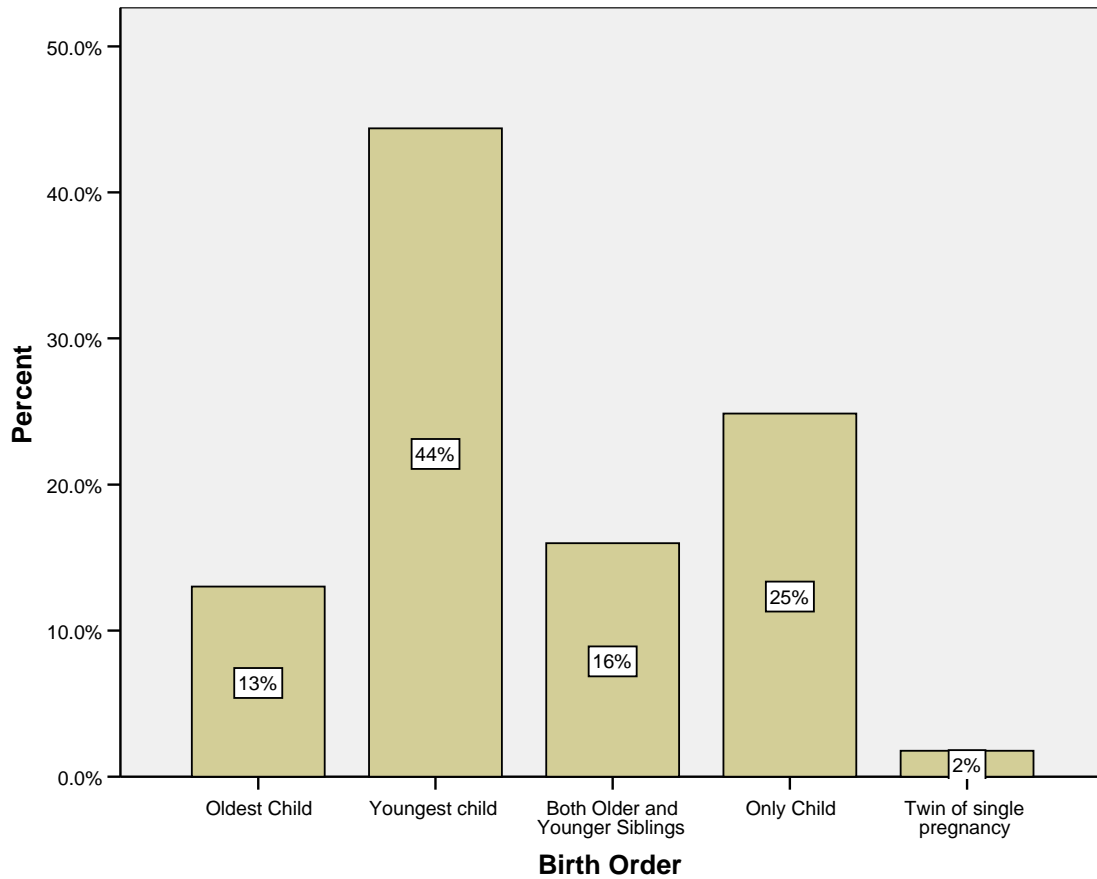
Table 6: Birth Order

	Frequency* 2005-07 (n=169)
Oldest Child	22 (13%)
Youngest child	75 (44%)
Both Older and Younger Siblings	27 (16%)
Only Child	42 (25%)
Twin of single pregnancy	3 (2%)

*Note these figures exclude those cases where researchers selected the youngest sibling as the 'index child' where SCRs had been conducted for several siblings within the same family.

Figure 6 shows the possibility of a heightened vulnerability for the child who is the youngest in the family.

Figure 6: Birth Order



Children who were the subject of a child protection plan.

At the time of the incident, 29 (17%) of the children were the subject to a child protection plan (see Table 7). Although this is a higher proportion than the 12% of children in the 2003-05 study who were listed on the child protection register, it is not a statistically significant difference. A further 19 (11%) had been the subject of a plan in the past. Of those children who were, or had been the subject of a child protection plan, 11 were listed in the category of physical abuse, 7 in the category of sexual abuse, 7 in the category of emotional abuse, while the highest listing was 30 in the category of neglect (see Table 8). Some children’s names appeared in more than one category.

Table 7: Index child subject of a child protection plan

	Frequency 2005-07 (n=175)
No	127 (73%)
Yes*	29 (17%)
Has been	19 (11%)

* 4 additional cases were removed (serious injuries) where not clear if the plan was prior to or post incident.

The two following examples of children of different ages who were the subject of a child protection plan at the time of the incident, reveal the complexity of cases where the risks of harm to the child are thought to be primarily those of ‘neglect.’

Bruising was noted on the child, (aged under 1) when police were called to an incident of domestic violence. At the time of the incident, child x’s name was on the child protection register, having been initially registered under the category of neglect. A component of the child protection plan was that (mother’s partner) should not reside at, or visit the home address. Following this incident, it became apparent that three professionals had information that (mother’s partner) was seeing the child’s mother at the home address. Children’s social care were not aware of this

S died from an epileptic fit (aged 9 yrs). No medical assistance was apparently sought. S was on the child protection register under the category of neglect (related to medical neglect ie failing to deal appropriately with health needs, and poor school attendance). The siblings’ names had all been listed on the child protection register in the past

Table 8: Category under which child the subject of a protection plan

	Category of plan* 2005-07 (n=46)
Physical abuse	11
Sexual abuse	7
Emotional abuse	7
Neglect	30

*Category of plan missing for 2 children. Children may be named in more than one category.

Table 9 shows that 26 (21%) of the children had siblings who were the subject of a child protection plan (or ‘on the register’) at the time of the incident, while 22 (18%) had siblings who had been similarly so in the past. Of these, 15 were recorded in the category of physical abuse, 6 sexual abuse, 9 emotional abuse. Neglect was again the highest category with 26 siblings listed (see Table 10) - Neglect is discussed further in Chapter 3. Nationally the largest category is neglect (43% in 2005-06) followed by emotional abuse (21%), physical abuse (16%), sexual abuse (8%) with 11% of children in mixed categories (DfES 2006b).

Table 9: Siblings subject of a child protection plan

	Frequency 2005-07 (n=123)
No	75 (62%)
Yes*	26 (21%)
Has been	22 (18%)

*7 additional cases removed from analysis where unclear whether the plan was prior to or post incident (Where the index child is an only child, sibling information is not relevant which accounts for the lower n=123 in this table).

Table 10: Category of child protection plan: siblings

	Category of plan* 2005-07 (n=44)
Physical abuse	15
Sexual abuse	6
Emotional abuse	9
Neglect	26

*Category of plan missing for 4 children. Children may be named in more than one category.

In almost a third of the 189 families (61, 32%) either the index child or a sibling were currently, or had in the past, been the subject of a child protection plan.

Legal status

At the time of the incident, some of the children were the subject of legal orders or were 'looked after' under section 20 of the Children Act 1989, (see Table 11). Thirteen per cent (19) of the children or young people were the subject of a care order or supervision order and five per cent (8) were accommodated under section 20. One child had been adopted at the time of the incident.

The deaths of two children whilst 'looked after' were believed to be caused by sudden infant death syndrome including one child who died only weeks after her birth.

x was born prematurely and there are indications that she was suffering withdrawal symptoms from certain drugs. x went straight from hospital to the foster placement. Cause of death currently unknown.

The death of a second very young baby occurred while he was fostered together with his young mother. These cases remind us that children and young people who are the subject of a serious case review, including those who may be looked after, are not all experiencing abuse or maltreatment at the time of the incident. In these circumstances, past neglect or maltreatment usually, but not always, has an important bearing on the present circumstances.

Table 11: Legal status at time of incident

	Frequency* 2005-07 (n=148)
No legal order	114 (77%)
Section 20 accommodation	8 (5%)
Care Order	16 (11%)
Other	10 (7%)

*19 cases (relating to serious injury of a child) were removed from this analysis as the legal status given related to a change in circumstances *following* the incident.)

The older young people who were looked after were living with foster carers, in supported housing, in a secure unit, youth offending institution or a mental health unit. Some of these young people's deaths revealed uncertain causes and whether the death was as a result of an accident or suicide was sometimes unclear. Most of the 'looked after' young people had a long history of neglect and maltreatment, rejection, difficult behaviour and multiple placements.

Death at (name of institution), previously accommodated, hard to help (age over 15). On occasions mum had refused to have her home because she felt that she was being disruptive and she was unable to manage her behaviours. During these periods of accommodation x was placed in a variety of foster placements and children's homes. Following her last discharge from accommodation, she went to a hostel and B&B with intermittent periods of return home.

As in our last study, it appears that for young people who are hard to help, the support they receive (as in this young woman's example) can dwindle and become minimal.

Where were the children living?

At the time of the incident most of the children (83%) were living at home or with relatives (see Table 12). Seven children were living with foster carers, and the other young people were in various other settings, including semi-independence units, residential children's homes, hospital / clinics or women's refuges.

Table 12: Where living at time of incident.

	Frequency (n=189)
Living at home	148 (78%)
Living with relatives	10 (5%)
With foster carers (short term, long term or short break)	7 (4%)
Hospital, mother and baby unit and residential children's home	7 (4%)
Semi-independence unit	5 (3%)
Other	10 (5%)
Not yet known	2 (1%)

Disability

The categorisation of children on the database notification report as 'disabled' appeared to encompass a wide range of disabilities including learning disabilities, developmental delay, and chronic medical conditions such as cerebral palsy and cystic fibrosis. It is not clear which criteria were applicable for the 14 children (8%) listed as disabled in the reports (see Table 13).

Disabled children are known to be at an increased risk of maltreatment. A US population based epidemiological study recorded 9% of maltreatment for non-disabled children, and 31% for disabled children (Sullivan and Knutson 2000). Although an apparently lower proportion of disabled children than this were present in this study, (and an even lower proportion in the previous study), since almost half of the children were very young babies (in both studies), any medical condition might not yet have been diagnosed. There is also a widespread debate about whether disability might be a cause, or a consequence, of the maltreatment (Gilbert et al 2008). This is illustrated here by the finding that six babies from this study were apparently disabled as a consequence of the injury which prompted the serious case review.

Table 13: Disability

	Frequency* 2005-07 (n=187)	Frequency 2003-05 (n= 161)
No	173 (93%)	153 (95%)
Yes	14 (8%)	8 (5%)

*6 other children were recorded as having disabilities but these cases were removed since the disability was caused by the incident itself. All six cases involved physical injuries to young babies under 5 months of age.

Children who were noted to have a disability prior to the incident (rather than as a result of the incident) ranged in age from 2 months to 17 years old.

The disabilities that were apparent in very young babies were often linked with their prematurity,

W was a very premature baby who died from multiple organ failure and dehydration. The initial post mortem suggests neglect.

A small number of families had more than one child with a disability or complex health needs and the families' struggle to cope with the children's complex needs was apparent.

Two year old x suffered asphyxia at birth and as a result was profoundly disabled. x's older sibling had been unwell for some months with an undiagnosed condition... which was subsequently diagnosed as (a serious illness). The children's names were both placed on the child protection register. At the time of the conference there was concern about x's bruising and concerns that the parents were not meeting the complex medical needs of x and his sibling.

An eleven year old child who died whilst in foster care had severe disabilities and complex health needs, but also unexplained injuries. One example of the small number of cases where a parent killed themselves and their child, included a mother who caused her own, and her disabled son's, death.

One of the teenage suicide cases involved a young woman with Asperger's syndrome.

x had a long history of mental health problems combined with Asperger's syndrome and had made previous suicide attempts. She had been looked after (for several years) and was living in supported accommodation.

Another young man who was the subject of a review, with autistic spectrum disorder and learning disabilities, was the perpetrator of harm to the child.

x and his family are well known to children's services. All the children have been on the child protection register (in the past). x has learning disabilities and a diagnosis of autistic spectrum disorder. A number of other agencies have been involved with x including CAMHS and the learning disability team.

The incident

Incident type

In this 2005-07 set of serious case reviews, two thirds (123) of the children died, and a third (66) were seriously injured or harmed as a result of the incident, or circumstances, which prompted the review. This 65%/ 35% split is comparable to the 2003-2005 set of case reviews (see Table 14).

The 'serious injury' group included a small number of unusual cases involving the death of someone other than the index child, for example where the child had witnessed the murder of their mother by their father. In these cases, the incident was categorised as a serious injury to the child, since this best reflects the emotional harm that the child suffered.

Table 14: Incident type

	Frequency* 2005-07 (n=189)	Frequency 2003-05 (n=161)
Death	123 (65%)	106 (66%)
Serious Injury	66 (35%)	55 (34%)

*Results produced after checking further information identified that at least nine cases were incorrectly classified (6 serious injuries classified as deaths and 3 deaths that were classified as serious injuries)

Table 15 shows the breakdown of incident type (i.e. death or serious injury) for children of different ages. The older children who die and those who are seriously injured form a similar pattern in both studies (although slightly fewer of the oldest adolescents died in 2005-2007). A higher proportion of the very young babies died (almost three quarters) in comparison to 2003-2005, when 58% died and a higher proportion survived their injuries. This position is reversed, however, for the children aged one to five years in this study and 46% of these young children survived. The very high number of adolescents who died in both studies is a reflection of the many suicide cases in this age range. We also noted earlier in the chapter that across the age ranges, proportionately more boys than girls died (72% of boys died compared to 57% of the girls).

Table 15: Incident type by age group

Age Group	2005-07 (n=189)		2003-05 (n=161)	
Age Group	Death	Serious injury	Death	Serious injury
<1yr	61 (71%)	25 (29%)	44 (58%)	32 (42%)
1-5yrs	24 (55%)	20 (46%)	26 (79%)	7 (21%)
6-10yrs	9 (50%)	9 (50%)	6 (55%)	<6
11-15yrs	12 (60%)	8 (40%)	16 (62%)	10 (39%)
16 + yrs	17 (81%)	<6	14 (93%)	<6

Criminal proceedings

Criminal proceedings for the alleged perpetrators of the abuse or neglect had been undertaken or were underway in 38% of the 189 cases (see Table 16). The notification reports indicated that criminal proceedings were possible for a further 37% of the children's cases. Little information was available to determine the end result of a criminal trial and to know how many cases reached a successful prosecution.

Table 16: Criminal Proceedings

Criminal proceedings	Frequency 2005-07 (n=158)
No	40 (25%)
Yes	60 (38%)
Possible	58 (37%)

Incident Cause

Table 17 shows the *prime* reported cause of the incident in comparison with the 2003-05 study. This includes both cases of death *and* serious injury (ie fatal and non fatal) so the figures differ from those in the analysis of the fatal cases which follows. The category 'other' includes unexplained cases, those where there was no information, children who were deemed responsible for the incident which prompted the review and children who were witness to an incident (for example where a father killed a mother).

Table 17: Type of injury / harm

	Frequency 2005-07 (n=189)	Frequency 2003-05 (n=161)
Physical assault (of which head injuries to babies under 1 year)	73 (39%) (26, 14%)	81 (50%) (25, 16%)
Sudden infant death	5 (3%)	5 (3%)
Overlaying	11 (6%)	6 (4%)
Neglect (incl. accidents, house fires)	30 (16%)	33 (21%)
Poisoning / overdose	11 (6%)	7 (4%)
Sexual abuse	16 (8%)	6 (4%)
Suicide / self harm	23 (12%)	14 (9%)
Gone missing	0	6 (4%)
Other / unexplained / no information	20 (11%)	3 (2%)

Analysis of the child death cases

Within the 189 cases there are 123 child deaths. This section considers only those children who died, extending Sidebotham's classification of unexpected infant deaths (Sidebotham 2007). One of the clear lessons to come out of previous biennial analyses is that maltreatment-related deaths and other serious incidents do not form one homogeneous group, but rather fall into a number of distinct but overlapping subgroups. For example the detailed analysis of 47 serious case reviews in the last biennial analysis revealed three separate groups: physical assault, neglect and agency neglect of teenagers (Brandon et al 2008a). Sidebotham's analysis of unexpected infant deaths produced five broad groups of maltreatment-related fatalities (Sidebotham 2007). These classifications differ in relation to

the characteristics of the victims and perpetrators, the mode of death and the intentions behind the death. This analysis was further tested here for children and young people of all ages in the following classifications:

- A Infanticide and “covert” homicide
- B Severe physical assaults
- C Extreme neglect / deprivational abuse
- D Deliberate / overt homicides
- E Deaths related to but not directly caused by maltreatment, including suicides and deliberate self harm

Of the 123 deaths, it was possible to assign 82 (67%) to one of the above categories (Table 18); a further 20 deaths (16%) presented as sudden unexpected deaths in infancy (SUDI) with no clear pointers to maltreatment as a direct cause of death, and in 21 (17%) the category was not clear, suggesting, possibly, a need for further refinement of the categories.

In England and Wales, in 2005-6, there were a total of 55 homicides of children and young people under the age of 16 recorded in the British Crime Survey (Coleman et al 2007), 24 of these being children aged under one year. In the same time period, there were 36 deaths of children and young people aged under 15 registered as due to assault (9 aged under 1 year), 4 deaths registered as due to intentional self harm, and a further 78 deaths (20 aged under 1 year) as undetermined intent (ONS 2006, 2008). It is clear from these data that not all maltreatment related deaths are recorded as homicides or deaths from assault. Ascertaining the true incidence of maltreatment-related deaths is difficult, but the figures of 55 homicides or 36 deaths from assault in a two year period must be considered underestimates.

Table 18: Death / Incident categorisation*

	Frequency 2005-07 (n=123)	Percentage of the 123 deaths	Percentage of the 189 cases
A Infanticide / covert homicide	7	6%	4%
B Severe physical assault (fatal)	27	22%	14%
C Extreme neglect (fatal)	<6		
D Deliberate / overt homicide	9	7%	5%
E Death related to but not directly caused by maltreatment and: Suicide	17	14%	9%
F SUDI, category not clear	20	16%	11%
G Death, category not clear	21	17%	11%
Total deaths	123	100%	65%

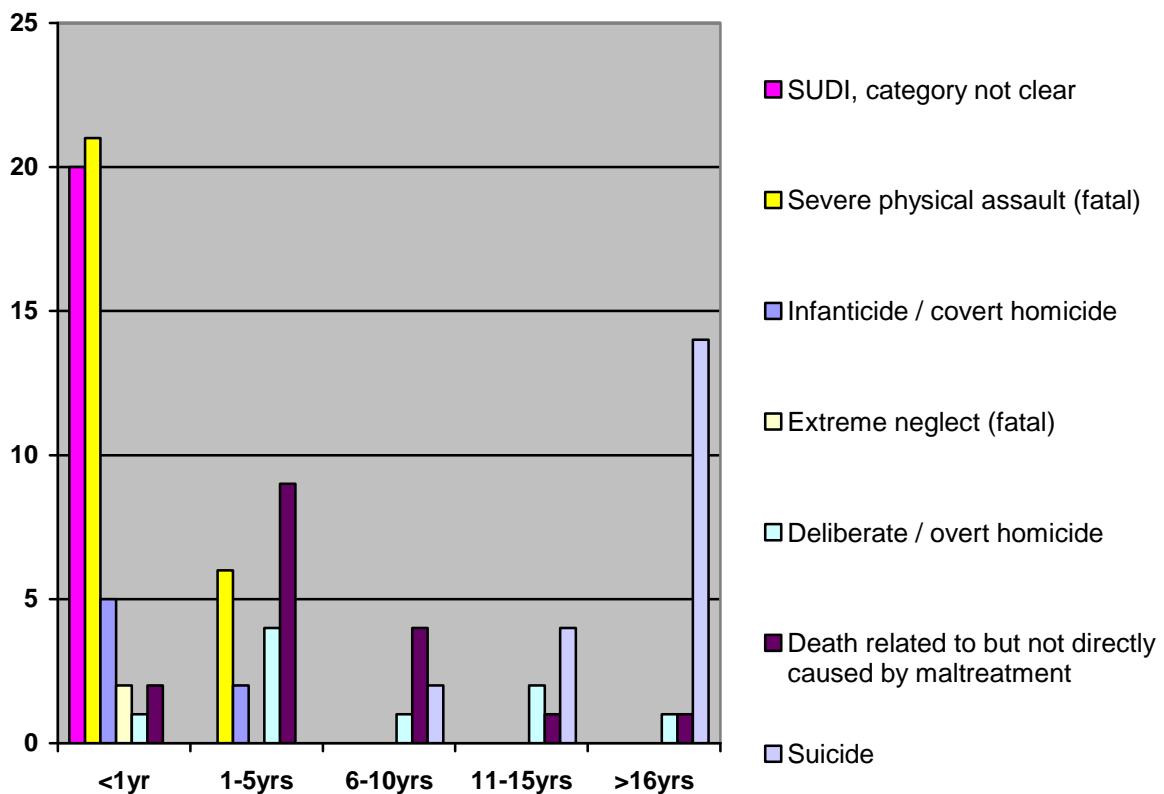
* This categorisation was developed by Sidebotham (2007)

In our study, the age profile of the different categories of maltreatment related deaths (using data from the 7 groups - see Appendix 1 for protocols) reveals some striking differences amongst these deaths (Figure 7).

- Severe physical assaults, the commonest category, are concentrated in infants and those aged under 5, as are cases of severe neglect and covert homicides.
- In contrast, the more overt homicides occur throughout the age spectrum.
- Apparent suicides and deaths from deliberate self harm occur from age 8 upwards. Some of these may be related to previous child abuse, although this was not an obvious factor in all cases.
- The SUDI cases form a distinct group which may include some covert homicides and may also include some deaths in which parental neglect may have played a role, for example through infants sleeping in dangerous environments.
- Finally, the deaths related to but not directly caused by maltreatment occur throughout the age spectrum, with a peak between 1 and 5 years. Many of these could be related to parental neglect, and include several deaths from house fires.

Excluding the suicides, it is very clear that the highest risks of maltreatment related deaths are in infancy and the first five years of life.

Figure 7: Age profile of the different categories of maltreatment related deaths



A: Infanticide or covert homicide

Seven children's deaths were categorised as covert homicide or infanticide. All were boys and mostly aged under 1 year and all were either an only child or the youngest child in the family. Some babies were abandoned or disappeared and the actual cause of death was unclear from the notification. Other deaths included possible poisoning or possible asphyxiation (with the possible asphyxiation cases showing some other signs of injury). Generally these families were not known to child protection services (71%). It is important to

recognise that it was not possible to determine with any certainty from the records available whether there had been any intent to kill, so the cases were assigned to this category only where, in the opinion of the researchers, this was a strong possibility.

B: Severe physical assaults

This was the largest category, accounting for 22% of all deaths. The majority (21) were infants aged less than a year and both boys and girls were vulnerable. A small number of children (15%) were, or had previously been, the subject of a child protection plan. 96% were an only or youngest child in the family. The majority of the deaths, (60%), involved non-accidental head injuries, including both skull fractures and intra-cranial haemorrhages. Nine children experienced multiple injuries, including a small number who had head injuries in conjunction with other injuries. There were a very small number of fatal abdominal injuries.

C: Neglect

Interestingly there were only a very small number of children whose death was deemed a direct consequence of extreme neglect. All children in these circumstances were aged under 1 but their families were already known to child protection services and they or their siblings had been the subject of a child protection plan. These children showed evidence of severe malnutrition, presenting as sudden unexpected deaths in infancy (SUDI) or multi-organ failure with dehydration. It is of note that a number of the other cases of SUDI or where the death was deemed to be related to but not directly caused by maltreatment showed some evidence of neglect, although this was not considered to be directly responsible for the death. Children with a similar profile were also evident in the serious injury / harm group.

D: Overt homicide

This category was used where there was some indication from the notification report that there was likely to have been some intent to kill the child. Of the 9 children, 6 were aged under five, although the age profile differed from that of the severe physical assaults. 6 were boys. 7 were either only children or the youngest in the family. In 5 cases more than one family member had died, in most where the suspected perpetrator had apparently committed suicide after killing others. A very small number of older boys had been killed by peers in fights. 22% of these children were or had previously been the subject of a child protection plan.

E: Deaths related to but not directly caused by maltreatment, including suicide and sudden unexpected deaths in infancy (SUDI) (F)

Twenty of the infant deaths presented as sudden unexpected deaths in infancy (SUDI) with no clear indication of maltreatment as a direct cause of death. In all of these cases it is presumed that there must have been some concerns to trigger a serious case review, although the nature of these concerns was not always clear from the notification report. Three quarters were boys, a higher proportion than that reported for all sudden infant deaths in other studies. A minority of children's families had previously been known to child protection services (fewer than six). In 13 of the SUDI cases, there was a possibility of overlaying or asphyxia, although this is difficult to confirm at autopsy, so should not be taken as a definite conclusion. Drug and or alcohol misuse was noted as a factor in most cases where 'overlaying' was a possible cause of death.

(Mother) has a history of alcohol and drug misuse. Allegation is that at the time of X's death (mother) was drunk and under the influence of drugs. It is believed that x was overlain. The investigation is ongoing.

It is recognised that some of these SUDI cases may have been covert homicides, which by their very nature remain hidden.

Among the children who died were 20 apparent suicides, with ages ranging from pre-teenage to 17. Half were boys. The mean age amongst the girls was younger (14.5 years compared to 16.1 years for the boys). Details of the cases were limited, but of those where information was available, 7 young people were currently or had been the subject of a child protection plan. There was other information to indicate that 4 more young people were known to children's social care. Of the 20 suicide cases, 6 young people had previously been accommodated by the local authority; a number (fewer than six) had a reported history of offending behaviour; a similar number had previously been investigated for possible sexual abuse, and in a couple of cases there were questions about bullying as a contributory factor. 11 of the deaths involved hanging, and a small number involved drug overdoses; for the remainder, the method of death was not clear.

X (aged 16) had mental health problems, depression and an allocated Community Psychiatric Nurse. She had been previously known to children's social care because of domestic violence and offending. We now believe that an older man, began grooming x from the time she was 11 years old.

The remaining 17 deaths, which appeared to be related to, but not directly caused by maltreatment, included 6 (35%) girls and 11 boys (65%) whose ages ranged from 0-16. Of these deaths, up to 12 were likely to be related to parental neglect, although this was not the primary cause of death. If these 12 are added to the small number of deaths directly caused by neglect, 11% of all deaths could be considered due to neglect. There were 8 children who died in fires, the majority being infants and very young children dying in house fires; in at least one of these there were some indicators of parental neglect, and it is possible that neglect played a role in others.

Recent referral to children's social care from health about deteriorating family situation - family acknowledged situation had slipped - outcome: no social work involvement but ongoing SureStart support. Reported as a tragic accident, but police report the possibility that the fire was started by a child raising questions about supervision.

A very small number of other deaths in this category included road traffic accidents, drowning, accidental asphyxiation, and being given methadone by parents as a calming measure. There were also a very small number of fatalities due to natural causes, where there was some indication that the parents had failed to seek appropriate medical care or medicate the child adequately themselves.

Other case characteristics

To conclude this chapter, a range of further, somewhat limited, but important information from the database notification reports was available about the 189 cases. Given that the details here were often sketchy because they represented what was known at the time of notification, and on occasions were absent altogether, the frequency with which factors were reported in the 189 cases are highly likely to be underestimates. The most frequently mentioned parent characteristic was 'domestic violence'. For child characteristic 'more than one child abused' usually meant more than one child abused within the same family, but on rare occasions this concerned children abused from different families. The most commonly mentioned maltreatment types were physical abuse and neglect. Similar characteristics had featured prominently in the 2003-05 case reviews. Some of the characteristics are discussed in more detail below.

Table 19: Case Characteristics

	Frequency mentioned 2005-07
Parent characteristics:	
Domestic Violence	49
Mental health problems- parent	32
Drug misuse - parent	28
Alcohol misuse - parent	19
Child of teenage pregnancy	18
Parent is a care leaver	5
Parent in Care	4
Child characteristics:	
More than one child abused	39
Serious Illness	15
Mental health problems - child	8
Drug or alcohol misuse - child	10
Factors related to case:	
Physical abuse	58
Long-standing neglect	33
Recent neglect	31
Sexual Abuse	29
Shaken Baby Syndrome	19
Emotional abuse	15

The column sums to more than 189 as 2 or more factors are cited in many cases.

Domestic violence

Although the evidence of domestic violence from the database notification reports was limited, and certainly an underestimate, the mention of domestic violence permeated all types of reviews concerning babies, children and adolescents. As previous studies of serious case reviews have found (Reder and Duncan 1993,1999,Sinclair and Bullock 2002, Rose and Barnes 2008), domestic violence often coexists with other aspects of problematic parenting and is closely associated with all types of abuse and neglect.

The children were subjected to severe neglect, associated with (mother's) alcohol misuse and domestic violence against her by (previous partner).

Domestic violence was also known to be a feature of most of the small number of cases where the child's father murdered their mother (and sometimes the child as well).

There had been a number of referrals to the police about domestic abuse and harassment. These had been passed to children's social care. It also appears that (the child's mother) confided in staff at the child's school about her difficulties.

There is further discussion about the characteristics of the children and their parents and carers in the next chapter.

Sexual Abuse

There was more evidence concerning sexual abuse in this two year period than in the 2003-05 study. While being the *prime* cause which led to the serious case review in 16 cases (see Table 17), it was an *additional* factor in a further 13 cases (29 in total, see Table 19). Sexual assault occurred across the age ranges. It contributed to the death of a small number of infants and to serious injury or harm for a small number of pre-school aged children. In many instances, children were physically, as well as sexually assaulted.

Injuries included multiple injuries to legs, shins and face. There were sexual connotations to the abuse.

Sexual abuse was found in families where there was also long standing emotional and physical neglect and physical abuse. In a small number of cases the sexual abuse was perpetrated by a child or adolescent.

The concerns ... include serious sibling sexual abuse occurring over a number of years as well as emotional and physical abuse and neglect.

Some of the sexual abuse cases involved the presence of a sex offender in the family and the serious case review, in these circumstances, was concerned, primarily, with failures in the MAPPA or MARAC arrangements which were designed to protect children.

Many of the reviews about older adolescents provided information about past sexual abuse. Sexual abuse was present in the history of some of the young people who committed suicide.

There had been an allegation that she had been sexually abused by her father following a disclosure by her brother that he had been sexually abused and that he believed she had too.

Parental Substance Misuse

Parents' substance misuse was sometimes closely linked to the child's death or serious injury (and as we mentioned earlier was a feature of some of the cases where the child had died through 'overlying'). A small number of deaths (fewer than six) were as a result of the child ingesting their parent's drug, most often methadone. Sometimes the ingestion was accidental but in one case a father admitted to giving his baby methadone.

Following D's death, post mortem showed ingestion of drugs. .. Father has admitted to giving the baby methadone, but not immediately before death. Reason was to calm the baby.

In the area where this review originated, LSCB literature was updated to provide information making it clear that giving babies or children methadone is highly dangerous and may cause serious harm or death. It was also noted in this report that giving babies methadone: "*appears to be acceptable practice within the drug community to calm babies down*".

Chapter 2 Summary

- This chapter provides a profile of the 189 children, their families and some detail about involvement of agencies using available information from the database notification reports. It also provides an analysis of the children's death or serious injury.
- Two thirds of the 189 children (123) died and a third (66) were seriously injured or harmed (which is the same proportion as cases from 2003-05).
- Almost half of the children (45%) were aged under one, almost a quarter were aged 1-5 years (23%) and 10% were 6-10 year olds. Older children comprised almost a quarter of the cases overall with 11% aged 11-15 and 11% aged 16 or over. The age profile was remarkably similar to the cases from 2003-2005.
- At the time of the incident, 29 of the 189 children (17%) were the subject of a child protection plan, and a further 11% had been the subject of a plan in the past. The major category listed was neglect. A fifth of the children (21%) had siblings who were the subject of a child protection plan at the time of the incident. Overall, in almost a third of the 189 families (61, 32%) either the index child or a sibling were currently, or had in the past, been the subject of a child protection plan.
- Nineteen of the children (13%) were either the subject of a legal order or accommodated under section 20 of the Children Act 1989. Most of the children were living at home or with relatives (83%): the remainder were living in foster care, semi-independence units, residential homes, hospitals or mother and baby units.
- When the deaths of the children were classified (separate from the serious injury cases), physical assault accounted for the largest proportion of deaths, and mostly occurred to infants and children aged under five (22%). The next largest groups were sudden unexpected deaths of an infant (16%) and suicide of mostly older adolescents (16%). Deaths related to, but not directly caused by maltreatment, (14%) occurred throughout the age spectrum (for example fires etc). The highest likelihood of maltreatment related deaths is for children in the first five years of life.
- Information about parental and child characteristics was limited but domestic violence was known to be present in 49 cases, parental mental ill health in 32, parental drug misuse 28 and, parental alcohol misuse in 19 cases. Disability was known for 14 children and child drug or alcohol misuse was evident for 10 children. 15 children had a serious illness or complex health needs and 8 children had mental health problems. Often many of these parental and child characteristics occurred in combination and the presence of these features is likely to be underestimated.
- In 39 families (21%) more than one child was abused. Physical abuse was highlighted in 58 cases, long standing neglect in 33, emotional abuse in 15 and sexual abuse in 29.

Chapter 3: Key themes, understanding the cases from an interacting risk perspective

Introduction

This chapter reviews and incorporates the learning from key themes which emerged, primarily, from the study of an intensive sample of 40 cases. The 40 children's cases were selected from a pool of 63 serious case review overview reports during the period 1st April 2005- 31st March 2007 which were provided by the DCSF. The cases were selected to represent all regions in England and, where possible, to share demographic characteristics with the 189 children discussed in Chapter 2.

Each theme represents an area of risk in relation to the child's safety which, in interaction with others, can produce a volatile situation requiring very skilled management. Themes linking family behaviour and circumstances and professional responses are considered first and factors relating to children of different ages are considered next. We then provide an analysis of levels of intervention and different patterns of family co-operation with agencies. Composite case studies and extracts from the overview reports (and some individual management reports) are used throughout the chapter to illustrate a number of different themes. The chapter concludes with evidence about the adequacy of information in the serious case review.

Emerging themes

The themes are listed in three domains (as in the 2003-05 study): factors related to the child and the child's experiences, factors relating to the family and the family's environment, and factors linked to agency practice (Table 20). In this study the family and practice / professionals domains are strongly connected. In many of the cases there was a discernible mirroring of behaviour in the family and in the agency responses (Mattinson 1975). This pattern appeared to make it difficult for professionals to see and understand what was going on in families and to accurately gauge the risks of harm that children were facing from their carers, or others. Factors related to the child appeared somewhat separately alongside the enmeshed family and professionals domains. This disconnection is illustrated in Table 20.

**Table 20: Themes emerging
(n= 40)**

Child factors and experiences	Family and environmental factors	Practice/professionals, agency factors
Child missed, lost , isolated, assaulted	Child missed, lost or not seen	Child missed, lost or not seen
'Ecological niches' for children of different ages	Chaos, overwhelmed families with low expectations	Overwhelmed practitioners and managers, low expectations
Prematurity, low birth weight, neonatal abstinence syndrome	Unsupported families or negative support	Unsupported workers,
Illness, complex health needs, disability	A "toxic" caregiving environment for the child (domestic violence, mental ill health, substance misuse etc learning disability	Children invisible or assumption that other people are seeing the child
Hard to help	Good dads, bad dads, men not known about	Efforts not to be 'judgemental' , low levels of challenge, 'silo' practice
Suicide	Rough handling	Professional uncertainty about what can/can't or should/ shouldn't be done,
Unhappiness not known about	'Accidents waiting to happen'	Fixed views – neglect, rough handling, men off the radar' cases
Bullying	House fires, multiple moves, poor living Conditions	Thresholds and boundary disputes
Risk taking behaviour, substance misuse, sexual exploitation	Large families	Lack of cultural sensitivity / over sensitivity.
History of neglect and rejection		
Going missing		

At first glance the themes appear very similar to those which emerged from the last biennial analysis of cases reported from 2003-05. This should not, of itself, be surprising since we know that studies of serious case reviews and inquiries tend to produce similar findings and highlight similar flaws in policy and practice, not least because these studies scrutinise some of the most challenging aspects of safeguarding children. Yet there are also a number of differences. Differences between this and the 2003-05 analysis include differences of degree, for example, more evidence of children living in highly mobile families, more issues relating to serious sexual abuse, and more cases involving fires. Also, by employing an ecological transactional understanding, it becomes clear that there are numerous individual differences for each child. Every child's case reveals a multitude of different factors and variables making predictability difficult and leading to a quality of unexpectedness. The cases are, therefore, confusingly, both similar and different to each other. They also share similarities with families that a range of practitioners and clinicians would be familiar with in their day to day work with children and their families.

The baby (x) lived with her mother, father, sister and two half siblings in the family home. X's father had been known in the past to children's social care and mental health services. X's mother has a history of depression, and overdose episodes. Previous children's social care involvement focussed on supporting x's mother to parent her oldest child who had a range of challenging behaviours. Mother and father are known to the police and have offences relating to domestic violence, to being drunk and disorderly, to public order, assault and possession of cannabis.

This case has many clear factors indicating risks of harm, yet the baby's circumstances are not dissimilar to many other instances where children and babies live at home with their parents and do not die (as in this case).

The invisible child

From within the spectrum of inter-connecting factors, one overarching theme dominates - the enduring problem of the child being 'lost'. The theme of children not being seen or heard is a feature of most studies of serious case reviews, including the recent Ofsted report (2008). The missing child was even more prominent in the current set of reviews than in our previous study of reviews from 2003-05. There are different interpretations of the children being 'missing' or 'invisible' to professionals. They include young people who were insufficiently consulted or spoken with, siblings of the index child who were not interviewed, young people who were not seen because they were out of the home or were kept out of sight, and children who chose not to or were unable to speak because of disability, trauma or fear.

During both police and children's social care enquiries into the allegations it appears that the children were either not seen or spoken to in any detail and no direct work was undertaken during children's social care involvement.

The last date that X was seen by any professional prior to events leading to her death (at age 11 months) was for her first immunisations at her GP surgery. Health professionals continued to visit the family home from this point up to the time of X's death, leaving messages on numerous occasions and seeing other family members, but not X.

There were lost opportunities to speak to the young person about his perceptions and feelings; therefore there is little understanding of the "child's world". The core assessment was not shared with (x), nor were his views sought; he was of an age and understanding to have the core assessment discussed with him directly.

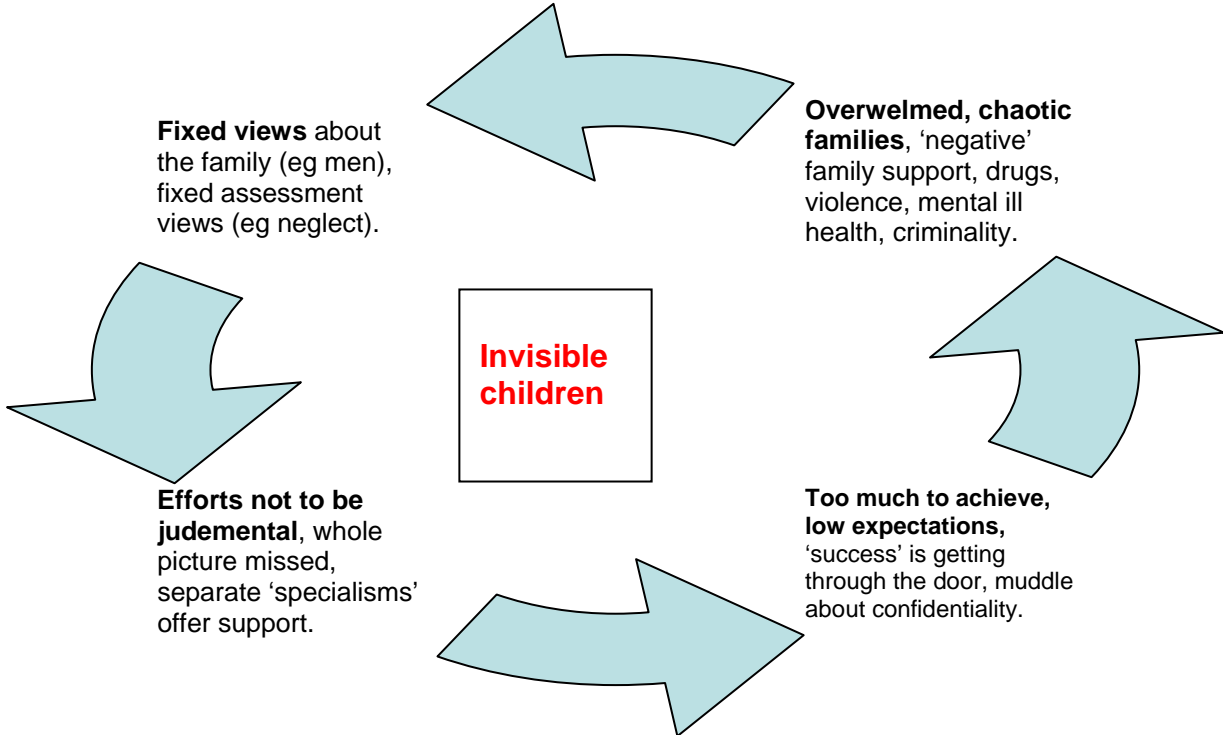
This time (2005-07) there were no serious case reviews prompted by children who had actually 'gone missing' but the metaphorical absence or invisibility of the child was evident, not just in relation to practitioner contact, but also within the serious case review process itself. A number of overview reports included almost nothing about the child, only about the systems which failed to protect the child, rendering the young people as invisible in the review as they had been to the agencies at the time. The key implication of the lost child is that practice is not child centred (Nice 2004).

This widespread loss of focus on the child comes in spite of concerted attempts in the 'Change for Children Programme,' which followed the horrific death of Victoria Climbié, to put children at the centre of services and professionals' thinking. The failure to keep the child 'in mind' draws parallels with the way many families are unable to keep the needs, feelings and safety of their children 'in mind' and perhaps has other links with practitioners' reluctance to connect with the child, understand the child, or even to touch the child (Ferguson 2009).

Analysis of interacting parent /professional themes

The simple circular model of interactions (Figure 8) shows how a number of the themes in Table 20 can be mutually reinforcing. The figure reveals how the chaotic behaviour in families can be mirrored in professionals' thinking and actions and that both families and professionals can ignore and neglect the child or baby in this negative cycle.

Figure 8: Chaotic families: the mirroring of behaviour in families and professionals



Being overwhelmed

Both families, and to a lesser extent professionals, appeared to be overwhelmed with too many problems to face and not enough personal or material supports or resources to achieve stability or safety.

Overwhelmed, unsupported families

There were a number of factors which contributed to families being overwhelmed, physically, materially, and emotionally. There was evidence that almost half of the children and young people (45%) had moved numerous times. Some children and their parents were living, periodically, with friends or extended family in overcrowded and inadequate accommodation, for example one child lived with four adults and five other children in a two bedroomed flat. Another child and his siblings lived in a family which had moved eight times in a single year and the children had attended seven different schools between 2006 and 2007.

Many children lived in families with poor support from their kin, or where there were primarily negative relationships with extended family. An overview report noted that a young mother had recently been 'beaten up' by her own mother in an ongoing family feud. In another family the maternal grandmother was supplying her pregnant daughter with drugs. Another paternal grandmother living in the family had convictions for criminal damage, assault and being drunk and disorderly and was known to be "volatile" under the influence of alcohol. When this kind of precarious living situation is coupled with parental domestic violence (evident for just over half of the parents or carers) or maternal depression (present in more than a quarter of families) or parental learning disability (evident for at least six families) a high risk environment for maltreatment or serious or fatal accidents is produced.

Fires and other accidents raised important issues about environmental dangers and about the broader links between neglect, maltreatment and deprivation. One overview report made this connection.

Death or serious injury from fire poses a serious and recognised risk in deprived families; children from deprived backgrounds are 37 times more likely to die from smoke, fire or flames. (Staying Safe: a consultation document p3). In this case the need to offer advice about fire safety was recognised, but delayed while the family were in temporary accommodation.

Some children living in 'overwhelmed' families were known to be neglected, but their circumstances were not judged to reach the threshold for services from children's social care. Other families where serious case reviews indicated that accidents were 'waiting to happen' were well known to children's social care. A police visit reported:

two males drinking, house smelling of cannabis, bedroom doors removed, no beds or bedding only mattresses on the floor, floors covered with rubbish, child's cot made of planks nailed together.

This visit occurred three months after the children ceased to be the subjects of child protection plans. The family had low expectations of themselves and their ability to cope with most aspects of life including parenting. These low expectations appeared to be shared by professionals working alongside them and they deepened over time. In these circumstances professionals often tacitly accepted domestic conditions and a caregiving environment which were hazardous to the children's safety, to their welfare, and to their development.

Family and environmental characteristics for the 40 children

Just under half (18) of the 40 children and their families had moved frequently and were living in poor conditions, and the same number of children had parents or carers with a criminal conviction.

Over half of the children (21) lived with current or past domestic violence. Eleven children were living in families with domestic violence *and* parents or carers who had criminal convictions.

Almost two thirds of the children lived in a household with a parent/carer with current or past mental illness.

13 children lived with a parent / carer who misused substances, either currently or in the past.

Nearly three quarters of the children had lived with current or past domestic violence and/or parental mental ill health and / or substance misuse. The combination of these three problems can produce a toxic caregiving environment for the child

(These are similar figures to the 2003-05 study. See Appendix 2 for more details).

Overwhelmed professionals and organisational capacity

The 'health' of agencies and their capacity to deal efficiently with the volume and demands of safeguarding children work was rarely mentioned in the overview reports or individual management reviews (IMRs), and indeed *Working Together* (2006) guidance does not require that this important piece of information is included. However, some reports did emphasise the strain that front line workers in key agencies were facing, for example in children's social care,

...overwhelming workload, high staff turnover and vacancy rates alongside very high numbers of unallocated cases over a period of several years.

One social work team, elsewhere, was said to be "one of the busiest in the county" and in the same case, health visiting services were said to be subject to 'frequent and confusing changes of managers.' There were similar problems in the midwifery service:

Unfortunately high levels of sickness within the area resulted in a fragmented core service being provided by a team of midwives unfamiliar with the area, or the practice. This resulted in a loss of the overview that continuity would have provided.

Similarly, in another area where the health visiting team were experiencing capacity problems and staff shortages due to summer leave, no continuity was offered to a vulnerable family with a new baby. In an attempt not to become overwhelmed, the health visitor transferred the case to another team because of temporary GP registration. Absence of practitioner contact and delay in allocation mean the children are lost to professional oversight.

*The passing around of vulnerable families who are at or just below the threshold of child protection should be avoided. The waiting around for allocation to a named practitioner can create a dangerous delay whereby families run the risk of being totally unsupported. It is at such times that children may suffer due to being **invisible** from parts of the health and social care network.*

It should be noted that in a small minority of cases there was evidence that the level of staffing in agencies was good and 'capacity' was not a problem. Nor were delay and lack of contact with the family always a feature. In this respect, full staffing does not of itself, prevent children being seriously harmed or killed.

In previous studies of serious child abuse, we emphasised the importance of a fully staffed, fully supported workforce who are able to do the basic job properly (Brandon et al 1999, 2002). In his recent report into the progress of child protection, Lord Laming again emphasises the crucial role of a well supported workforce (Lord Laming 2009). In the report into the death of Victoria Climbié, Lord Laming a central message was the importance of "doing the simple things properly" (p105). However, others have commented that protecting children is *not* simple and that it is perhaps unhelpful to describe these complex matters of relationship and professional judgement as 'simple' (Ferguson 2005, Stevenson 2009). The capacity to understand the ways in which children are at risk of harm requires clear thinking. Practitioners who are overwhelmed, not just with the *volume* of work but by the *nature* of the work, may not be able to do even the simple things well (Cooper et al 2003, Cooper 2005).

One health visitor who was reported to have found her contact with one family "overwhelming," gave an example of how this affected her feelings, her behaviour and her thinking

with hindsight ...she noted that the family focussed her attention on the older children and she found (their) aggression and distrust of other agencies difficult to manage.

In retrospect she could recognise how the family had not just deflected her attention but drained and disabled her capacity to think and see clearly. The complexities of dynamics within families like this are amplified when parents seek to avoid or evade professionals (as we discuss later in the chapter). Where families are hostile or hard to engage practitioners can have low expectations of what can be achieved. Sometimes just getting through the door feels like a major achievement and there is little energy left to use the time with the child or family productively. From the family's point of view, there may be similar low expectations and lack of trust with most agencies. This issue has to be addressed jointly by the professionals working with the family.

Our early findings about low expectations were highlighted by Lord Laming's progress report (2009:23). However, it is not necessarily *sympathy* for parents that produces low expectations (although a later section discusses professionals' reluctance to judge families). Instead, or in addition, it may be that professionals are too overwhelmed to raise their expectations.

Lack of professional confidence and professional uncertainty

Had the social worker and police felt able to challenge the GP's decision, (the child) could have been referred to the paediatrician

Professionals with low levels of confidence will struggle to challenge the decisions and behaviour of their multi-agency colleagues when they feel the child is at risk of harm.

The individual management review (IMR) from the police in this case noted that police challenge of colleagues who are perceived to be more experienced in child protection was unlikely:

Officers attending the visit...are unlikely to challenge the decisions of a GP and a social worker who they would undoubtedly consider to be experienced in such matters.

In spite of a raft of procedural guidance, practitioners and managers were often unclear about what they could or could not do, or should or should not do in these cases. Assumptions were frequently made that other people were visiting the family or seeing the child, or taking charge of the case as the lead professional.

The panel noted there seemed to be evidence of uncertainty on who should take the lead in co-ordinating concerns.

Where no one was really sure what was happening, as in the example given above, everyone seemed to be frozen into inactivity. In this context of uncertainty and diffidence, clear decision making and action does not take place, and children remain unprotected. Being in a muddle about confidentiality also characterised a number of reviews. Widespread uncertainty about the laws governing data protection and privacy was picked up in Lord Laming's progress report (2009:40).

Parental substance misuse, parental mental ill health and domestic violence and poor living conditions

The environment in which the child lives is crucial to his or her health, safety and well being. Living with adversity compromises the life opportunities of the child and of the child's parents. As in other studies of serious child abuse and child deaths, we found evidence of many parents and carers struggling with mental ill health, domestic violence, substance misuse and poverty, often in combination (see Appendix 2 for more detail). Nearly three quarters (29) of the children lived in an environment where one or more of these factors were present. We emphasised in our 2003-2005 study, (Brandon et al 2008a) that the presence of these characteristics, even when they co-exist, do not *predict* serious abuse or death of a child. They do, however, increase the *risks* of harm to the child and often present a hazardous and frightening home life for the child, and a toxic caregiving environment.

There was evidence of past or present domestic violence in the living circumstances of over half of the children. Most examples included physical violence towards or between partners but in two cases there was no evidence of violence, instead abusive control was exercised by the husband over his wife. Fleeing domestic violence was given as a reason for some children being continually on the move. Later sections of the chapter, discussing parental co-operation, outline how violent partners were often also hostile to professionals. Indeed domestic violence, substance misuse and parental mental ill health are difficult to discuss in

isolation since they form the backdrop to many of the themes elaborated in this chapter, including the sections which follow (Cleaver et al 1999; forthcoming).

The risks of harm associated with parental substance misuse are well documented in the literature (ACMD 2003, Forrester et al 2006, 2007) and were apparent in many serious case reviews. Approximately one in three of the 40 children lived in households where either one or both parents were misusing substances. However, it is difficult to determine, on the basis of fatal and serious injury cases alone, how significant these risks are in comparison to those substance-misusing parents who do not maltreat their children. A number of additional concerns were often present in cases where substance misuse featured, including the parents' apparent denial/minimisation of their drug habits and the impact of these on their children; poor compliance with routine and specialist health care; an apparent lack of engagement with their child; and in some cases evidence of aggressive behaviour. It is not clear to what extent any of these factors exacerbated risk of harm to the children but they need to be taken into account in assessments.

Similar issues arise for parental mental illness (Cleaver et al 1999, 2007 and forthcoming) and almost two thirds of the children were living in families with parents or carers with current or past mental health problems, including stress, depression, post-natal depression, bulimia, self-harm and attempted suicide (see Appendix 2).

Working Together emphasises that “as with mental illness in a parent, it is important not to generalise or make assumptions about the impact on a child of parental drug and alcohol misuse” (HM Government 2006:9.18). It is possible that this gives a confusing message and we found in a small number of cases that this may have contributed to a reluctance on the part of professionals to refer the children of substance misusing parents to children’s social care. The guidance in *Working Together* states that:

Where children may be suffering significant harm because of their own substance misuse, or where parental substance misuse may be causing such harm, referrals need to be made by Drug Action Teams or alcohol services, in accordance with LSCB procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children’s broader needs to be assessed and responded to.

This statement implies that all such children should be referred for assessment, but some serious case reviews suggest that the guidance is not interpreted in this way, but rather that such children may only be referred if there is substantial evidence of significant harm.

Parental substance misuse guidance

It may be opportune to review the evidence in relation to parental substance misuse and potential harm to children, and consider issuing clearer *Working Together* guidance requiring that all children living with substance misusing parents receive an assessment. If parents (or the child) are seeking help this can be through the Common Assessment Framework. If parents are not seeking help this should be through a referral to children’s social care.

Efforts not to be judgemental becoming failure to exercise professional judgement

There was reluctance among many practitioners (including among health and social work staff working with children) to make negative professional judgements about a parent. Workers, including those in adult-led mental health services, domestic violence projects and substance misuse services were keen to acknowledge the successes of the often disadvantaged, socially excluded parents who were using their services. This could even occur when the child was the subject of a child protection plan. One pregnant mother's failure to make progress was discounted by the multi-agency grouping in an effort not to judge her harshly, or to lower her self esteem yet further:

x presented as a pleasant young woman who had complex needs and professionals felt compassionate towards her and she was given repeated chances to improve matters and to reduce and manage her drug use.

a tendency towards justification and reassurance that all was well, rather than more objective consideration and investigation of what had occurred.

The recent emphasis on strengths based approaches and the positive aspects of families (for example in the Common Assessment Framework [HM Government 2006b]) arguably discourages workers from making professional judgements about deficits in parents' behaviour which might be endangering their children. A determination to follow a strengths based approach without at the same time weighing up any risks of harm to the child, was apparent in a number of reviews. However we know of practice which does address a lack of safety for the child while actively engaging the parent first in recognising unsafe situations and secondly in improving them (for example Signs of Safety in Gardner 2008).

Silo practice

'Silo' practice was evident in a number of the reviews and was defined well in one overview report:

Failure of professionals to look at aspects of the children's needs outside of their own specific brief

In another case where a parent had mental health problems the overview report identifies good empathic practice by the GP, but also insular 'silo practice'. A recommendation is made about how communication across health professionals can be improved so that children can be kept in mind and better safeguarded.

When a parent or carer with children presents with mental health difficulties that could impact on the well-being of the child/ young person GPs must liaise with the health visitor or school nursing service.

In cases where adult focused workers perceive their primary role as working within their own sector, engaging with and treating the adult in the household, failure to take account of children who may be present in the family can follow. One child, who was fatally stabbed, was totally overlooked in the home while the needs of the adults took priority, so much so that the mental health worker who assessed the lodger (who subsequently killed the child) recorded '*not applicable*' in the section on child care. Since the lodger was not a parent and not in a formal caring role, the mental health worker assumed that child care was not relevant.

Lord Laming has noted the persistent challenges of working across organisational boundaries and the way that co-operative efforts dwindle when services and individuals are under pressure (Lord Laming 2009:37).

Practice challenges are illustrated in the following case study. This, as all other cases studies, is a composite case drawn from the 40 cases studied in depth in this chapter.

Case Study - Adam aged 4 months

Key features of the case

- Co sleeping and alcohol misuse
- Parental mental ill health
- Apparent cooperation with numerous services
- Delayed assessment by children's social care

Theme of the Case

Adam lived with his mother Tracey, who was 25 yrs old and had a history of alcohol misuse problems and depression. There had been very recent contact with children's social care following concerns about Tracey getting drunk and co-sleeping with her baby. Adam died aged 4 months from Sudden Infant Death Syndrome, but whilst sleeping in bed with his mother who had been drinking.

(i) Child's needs / characteristics/behaviour

Adam had a normal delivery. There were no concerns about his health and development. There was little other information about Adam.

(ii) Mother's / carer's history / profile / parenting capacity

At age 15, Tracey became known to children's social care because of difficult behaviour at home. She left home at age 15 and moved in with a boyfriend. She had a number of abusive and violent relationships, was drinking heavily at age 18. Between the ages of 18 and 21 she made five suicide attempts, all whilst under the influence of alcohol. Tracey first sought help from her GP in relation to alcohol misuse, anxiety, and suicide attempts when she was 20. There was a recurring pattern of returning to alcohol misuse following breakdowns in relationships or other significant problems.

(iii) Father's / carer's history / profile / parenting capacity

Beyond some evidence of alcohol misuse there is very limited information about Adam's father, but he was in regular contact with his son. Adam's parents had a problematic relationship and separated before his birth when Adam's father was just 21

(iv) Wider family and environment

Tracey had problematic relationships with her parents, particularly her father and the difficulties continued after Adam was born. However Tracey told the social worker and health visitor that she had lots of good support from her mother who visited most days and sometimes looked after Adam. Tracey had a pattern of house moves, with a period of being homeless. There is no mention of supportive friendships.

(v) Professional involvement

Tracey attended ante natal appointments and during the pregnancy had been well and stable. There had been no concerns from midwifery or health visitors about Adam's care for the first two months after which time Tracey began drinking again and was prescribed anti-depressant medication for post-natal depression. At the time of Adam's death, Tracey was given assistance from mental health, alcohol and probation services (following alcohol related crimes) and help with debt and housing difficulties.

Three referrals about Adam were made to children's social care but an assessment was not undertaken until the third referral. An initial assessment was completed by a social work assistant and more probing questions might have been asked by a qualified social worker. There were many problems with professionals not sharing information and not being fully aware of the whole picture. Social workers did not carry out a holistic assessment, did not obtain information from other agencies and did not consider background details. Assessments were delayed and not sufficiently thorough.

(vi) Analysis of interacting risk and protective factors:

Numerous risk factors suggest that Adam should have been considered to be a child in need of protection. These include Tracey's mental health difficulties, previous suicide attempts, criminal behaviour, alcohol misuse, her acrimonious relationship with Adam's father and abusive relationships with previous partners and difficult relationships with her family. Crucially, agencies involved were aware that Tracey was co-sleeping with Adam whilst drinking and taking anti-depressant medication, both of which heightened the risks of harm to Adam substantially.

Protective factors included Tracey's positive attitude to the pregnancy and good preparation for the birth. When not drinking, Tracey demonstrated insight into her relationship with Adam's father, recognising her inappropriate behaviour and aggression whilst drunk. Once Adam was born she provided appropriate physical care, attended clinic, ensured Adam was immunised and engaged with a range of professionals.

Tracey appeared cooperative as she allowed professionals into the home and accepted referrals being made, but she often didn't turn up to appointments or follow advice and she falsely denied drinking. There was much help-seeking behaviour (for example the false allegations to the police about Adam's father, and presenting at A and E with injuries following drinking bouts).

What could have been done differently?

More awareness of both historical and current concerns would have heightened the perception of risk of harm and more could have been done to protect Adam.

'whilst alcohol, neglect and co-sleeping arrangements were all contributory factors in the death of Adam, an equally significant issue was the poor communication and lack of information sharing within and between professional agencies...appropriate information sharing and thorough assessments...would have identified the risk factors to which Adam was exposed. Child protection enquires should certainly have been undertaken and protective action taken which may have prevented Adam's death'

- A referral should have been made to children's social care for a pre- birth assessment in the light of Tracey's long history of alcohol misuse, alcohol related crime, suicide attempts etc.

- Vital information about Tracey's past history of depression and suicide attempts was not included in midwifery records.
- Better assessment practice: children's social care carried out a late and insufficiently detailed Initial Assessment, undertaken by an unqualified social worker. The assessment didn't explore Tracey's background, her involvement with other agencies, or the involvement of the father in Adam's life. Seeking information from other sources would have identified a wealth of information.
- Professionals should have been aware of the dangers of co-sleeping while under the influence of drugs and alcohol. In these circumstances, alone, consideration should have been given to removing Adam from his mother's care.

Practice Note:

Co-sleeping with a baby does not pose a known risk of harm to the child unless there are other risks present in conjunction with the co-sleeping. Significant risks exist when a parent has used alcohol or drugs.

Fixed views about the family

There were examples of flawed professional judgement and rigid or fixed thinking. Once a view had been formed there was a reluctance to revise a judgement about the family, or about individual family members. Similar patterns have been identified before (Munro 1999, Reder and Duncan 1999). These occurred in relation to a number of separate but often connected issues.

Neglect

Many reviews revealed a particular 'neglect case' mindset. In these cases thinking tended not to encompass any other harm or danger to the child other than from the prime concern of *poor physical (and emotional) care*. In one case, harm from physical injury was discounted as a threat over the longer term in spite of two section 47 enquiries for physical injury which had been carried out recently. It appears that once an assessment has been completed or a child protection plan which focuses on neglect has been made, this may preclude other forms of harm being considered.

Similarly a 'neglect' mindset can preclude the need for emergency action. A paediatrician had to fight extremely hard to persuade a hospital colleague to admit a child with life threatening failure to thrive since the colleague's view was that "*Neglect is not a medical emergency.*" A number of serious case reviews provided evidence to the contrary and speedy hospital admission saved at least two children's lives.

These issues perhaps cast a different perspective on the reason why neglect cases continue to 'bump along the bottom'. Working with neglect in constructive ways is considered in detail by Gardner (2008) and Horwath (2007), among others.

Rough handling

The use of both the concept and the terminology of 'rough handling' may mask the risks of physical injury or death for babies and older children. In one case, using the term 'rough handling' had the effect of down-playing concerns and therefore delaying a protective response for a young child.

A 'child concern' referral was made to social services 'out of hours' service, it seemed to reduce the potential seriousness of the injuries as they had been described as the result of 'rough handling'.

This serious case review recommended that any injuries sustained by children due to inappropriate handling by parents or carers should be viewed as non-accidental, and when describing such injuries, professionals should avoid the phrase 'rough handling'.

The use of this phrase to describe this type of injury has been an issue in previous serious case reviews. A concern has been raised that the phrase initiates a 'mind-set' amongst professionals about the level of seriousness and therefore risk indicated by such injuries. A view is often formed that these injuries are less serious acts of omission indicating inconsiderate and careless parenting rather than, as in this case, an indicator of much more underlying serious concerns and injuries.

Men, and male caregivers

There is now clear evidence that positive and negative dimensions of fathers' and mothers' life histories can *jointly* influence their parenting and its impact on their children's lives (O'Brien 2004). This has been called a 'double dose' (Dunn et al 2000) or the 'double whammy' effect (Jaffee et al 2003).

many... now argue that the quality of fathering as well as mothering mediates children's psychological outcomes (O'Brien 2004:16).

This section considers the role of men as caregivers, and not just fathers. Our approach to making sense of men in households is taken primarily from the child's perspective. We work from the premise that men who are regularly part of a family are likely to have a high level of day to day contact with the child. Even if this is not the case, their presence will have a crucial impact on the caregiving environment generated for the child. While it is important to know the status of each man's relationship with the child (for example, are they the father or step father? do they have parental responsibility?), this is less urgent than the need to consider in what ways the mother's husband or boyfriend or partner, or lodgers or other adults living in the family, might pose a risk to the child's safety or, conversely, act as a protective presence.

Different but connected issues emerged from the reviews in relation to men in families which were similar, in some ways, to Scourfield's categories of practitioners' perceptions of men in child protection work as a threat, as no use, as irrelevant or absent (Scourfield 2001, 2006). The themes in relation to men in this study were primarily:

- the dearth of information about men in most serious case reviews,
- the failure to take men into account in an assessment
- rigid or fixed thinking about men as 'all good' or 'all bad'
- the threat posed by men to workers

There was, yet again, scanty information about men in most reviews, particularly in relation to an understanding about past history. This pattern reflects the wider problem of the lack of information about and lack of engagement with men in child health and welfare more broadly (Haskett et al 1996). The information that was available sometimes highlighted the tentative engagement by and with men and fathers:

The (health workers) were aware of the father being very much in the background and not participating. Rather he was an onlooker standing in a darker part of the room.

Improving knowledge about fathers in serious case reviews was made possible in a small minority of cases where overview authors asked for amendments to independent management reviews where there were important gaps in information.

The failure to know about or take account of men in the household was also a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse. The failure to take account of men in assessments occurred sometimes even when good information was available,

There was significant information about the family in general, and one of the parents in particular (step father) which would - and indeed should - have contributed to assessments and led to further enquiries.

There were instances of 'unknown' males in some households at the time the child was killed or injured. There appeared to be a minimalist "need to know" attitude to sharing information about the appearance of new men in a household so that unless specific questions were pursued (for example in relation to domestic violence) the presence of an unknown male would not be passed on and these men became invisible to practitioners working with the family or child.

Fixed thinking about men

A continuation of the theme of 'fixed thinking', discussed earlier, occurred in connection with the way men were perceived in a polarised way as primarily 'good' men (good dads) or 'bad' men (bad dads). This attribution linked to whether fathers were thought of by professionals as reliable or unreliable, trustworthy or untrustworthy. By adopting this restricted way of thinking it was possible, for example to discount a 'bad' dad's concern about the welfare of the children in his ex-wife's care.

The acrimony between (mother and father) and (father's) use of the complaints system may have overshadowed his relationship with children's social care. Father's concerns may have been undermined or minimised as he was seen as manipulative and unreliable. If this is the case, this may account for some of the lack of a child centred approach by the professionals both towards the elder children and to (the baby).

In another case a child's father was considered to have made marked progress on a domestic violence programme. This improvement influenced workers views and they saw him in a fresh light as a reformed 'good dad' rather than the old 'bad dad.' They were not however able to reappraise their opinion in the light of contradictory new information. A rigid pattern of thinking has some parallels with the 'start again syndrome' identified in our previous report (Brandon et al 2008a) where past history and past patterns of behaviour and

poor parenting are not taken into account. In this example professionals' memory of the severity of past domestic violence faded. The apparently reformed father was given a fresh start and the assessment that he was 'no longer a risk' to his child prevailed, to the ultimate detriment of the child. The "*professional tide of optimism*" among the multi agency grouping was said to be influenced primarily by those running the domestic violence programme who were not experts in parenting. Their view was that the parents were now a "*model couple*" who had been unfairly treated by children's social care. This viewpoint overshadowed the opinions of those who thought that past history should signal continuing concern. The dominant, optimistic, attitude was not satisfactorily challenged.

Clearly the existence of previous evidence of poor or inadequate parenting should not militate against the possibility of the ability to change, but it was important for any assessment to be aware of potential patterns of behaviours or concerns.

This example highlights the importance of recognising or seeking *patterns of behaviour* affecting child welfare or safety rather than making assumptions based on character or personality. The optimism about adults, and in this respect about men in families, shifts the focus away from the child.

However, it is important to note that in some cases there was evidence that men acted as positive figures in children's lives (a point also noted by Lord Laming 2009). These examples could include men who were unrelated to the child. One young man stayed regularly with a former stepfather and his new family. This step father and his partner gave a sense that they had known and understood this troubled young man well.

He (the young man) was a joker who could not be serious, even at school. He was happy at home but not with outside life. He was timid, weak and a loner. He did not mix and could not defend himself outside the home. He wanted to be noticed and clung to (stepfather) always wanting to help and be involved. However, he made friends in the street where we live.... and was not bullied when playing out like he had been (at home)

Fear of men

When fathers were noted to be aggressive to staff and to pose a threat to their safety, it was also possible that fear clouded professional judgement.

Indication of controlling and aggressive behaviour by [the father] ... should have raised questions about the potential for domestic violence.

A father's hostility to social workers partly explained the tacit reliance on health visitor support in one family with complex needs where there were clear risks of harm to the children.

The large number of children in the family with their escalating health needs meant that trying to meet them must have been a nightmare. (The children's mother) had no support from her partner who claimed that his agoraphobia meant that he could not leave the house...professional view of the seriousness of the situation was under- estimated..... More sustained and proactive support was required rather than the uncoordinated, reactive pattern of response.

The fact that remedies to enhance knowledge about children's missing male kin were so rare is disappointing given the substantial body of literature now available on fathers and family support services (Phares 1996, O'Brien 2004, Daniel and Taylor 2005, Gardner 2008). These messages are also highlighted in the Department for Children Schools and Families 'Think Fathers' programme and the 'Reach Out Think Family' publication (Cabinet Office 2007).

The ages of the children and their ecological niches

Finding ways to understand children within their linked age and cultural environment is crucial given the apparent ease with which they slip from view. One way of approaching this is to consider the concept of the ecological niche, an adaptation of Bronfenbrenner's ecological model (Bronfenbrenner 1979, Super and Harkness 1986). The specific vulnerabilities that the children bring to their physical and caregiving environments can be seen to occur in different age ranges which fit into age linked ecological niches. These are similarly reflected in the age profiles for different categories of maltreatment related fatalities demonstrated in Chapter 2.

Finkelhor identifies three ecological niches found in patterns of homicide in international studies into which the 40 children in the intensive sample have been grouped (Finkelhor 2008:40):

1. a pre-school, family based environment, with a neo-natal sub-environment;
2. a middle childhood, somewhat protected, mixed school and family niche;
3. an adolescent, risk exposed, transition to adulthood niche.

Factors which link to these three different age/environment groupings are evident in the table of themes. Understanding children and young people in this way may help us to understand the particular risks of harm and protective factors they encounter from their environment, from others, and also for the older children, from within themselves.

The types of homicide suffered by children are related to the nature of their dependency and to the stage of their integration into the adult world. Among the factors that may well change across childhood and across these niches are the victim-offender relationship, the locale where the homicide occurs, the nature of the weapon, the motives involved, and the contribution the victim makes to the crime in terms of risk taking and provocation. These homicide variations provide a good case for assuming the importance and utility of a developmental perspective on child victimizations... (Finkelhor 2008:40).

The pre-school family based environment

26 children were aged 0-5

17 were under one year, and the other children ranged in age from 2 to 5 years. Half of the children (13) were known to children's social care (while 18 families had been known in the past).

4 children were the subject of a child protection plan (2 babies from birth and 2 preschoolers).

2 children were the subject of a court order (one care order, one contact order).

For one of the preschoolers with a child protection plan, a care order was in place, for the other a care order was planned.

The physical vulnerability of these young children mean that many die from acts of force and violence that would not cause the death of an older child. Physical neglect and the failure to take care of the needs of a dependent child occur most often for this youngest group. Older children, who are no longer so dependent, have more possibilities to physically move, run out of the way or fend for themselves.

Pre-school victims of homicide appear to be mostly cases of fatal child abuse that occur as a result of a parent's attempts to control a child or angry reactions to some young child's aversive behaviour - uncontrollable crying, hitting parent or siblings, soiling himself or herself, or getting dirty, for example (Finkelhor 2008:39).

Babies born prematurely with low birth weight are harder to look after, more difficult to feed and may cry more. This may in turn prompt angry reactions from a parent (Similar aversive behaviour can also come from disabled or chronically ill children.) A baby's stay in the hospital special care baby unit can inhibit the bonding process. In one case where a baby was in the neo-natal unit for some weeks, family members were only able to visit infrequently and most days "staff noted that there were no enquiries or visits from the family" and expressed their concerns. Distance from the hospital, lack of finance and lack of child care arrangements contributed to this situation and a difficult early environment for the baby. These types of clear warning signs are not always followed up assertively.

These early disadvantages can have lasting consequences and prematurity and low birth weight can be markers for difficulties throughout the life course. Most of these young children do not have the normal protective oversight offered to older children by school and would only be known (informally) to school based practitioners if they had older siblings at school. Some young children were attending SureStart or other pre-school facilities where some protective oversight should be available.

Children's health and development

Although information about the well being of children at birth was scanty, especially for older children, there was evidence that almost a third (8) of the 28 children for whom the information was available, had been born early (see Appendix 3).

Six of the 17 babies aged less than one year had already been admitted to hospital, and one child had been admitted nine times. Three of these youngest children had been taken by their parents to A&E at least once.

See Appendix 3 for more information about the children's health contacts.

Middle childhood

4 children aged 6-10

One child aged 6, two aged 9 and one aged 10.

Two children were known to children's social care but all four had been known in the past. No children of this age were the subject of a child protection plan or court order (although one had previously had a child protection plan).

The very small number of young people in middle childhood who are the subject of a serious case review in this (and the last biennial) study might be thought to reflect the lower level of emotional and physical demands children of this age make on their caregivers. However, although children of this age do not feature prominently in homicide studies this age group presents most often at Accident & Emergency Departments, with unexplained injuries thought to be linked to maltreatment (Woodman et al 2008). So although these children may rarely be the victims of serious injury and death from abuse or neglect, it does not mean they escape maltreatment.

The lower number of children of this age subject to a serious case review might be attributable to a higher level of protection offered by their environment. Children of this age should be in school for six hours or so a day. School can build children's resilience and act as a respite from difficulties and privations at home. School can provide oversight and formal or informal monitoring of a child's welfare and well being. For example, in this study, a child's father was not allowed unsupervised contact with his daughter and the school was able to raise the alert when the child was collected by her father. Another mother confided in her son's school staff about her experiences of domestic abuse and harassment.

The four children in this age range could not be protected by their environment. The children's death or serious injury linked to domestic violence, parental mental ill health, sexual abuse and neglect.

Some of the middle childhood and older children had a history of early minor health problems, most notably problems with eyes, ears, speech and language. Sight and hearing problems are not uncommon and most children respond well to early treatment or grow out of the difficulties, but delay in treatment can make the impairments less straightforward to repair. These factors can have an impact on parent-child interaction and there are some links between hearing problems and behavioural difficulties, particularly in combination with other family problems. There were cases of middle childhood (and older children) with a range of common childhood problems who developed behaviour problems before they were five years old. Children and young people with this kind of profile may possibly be more vulnerable to bullying or even to sexual abuse - particularly if health problems which mark them out as different from their peers, persist untreated.

Adolescence

10 young people aged 11-17 years.

All but two of the children were over 13 and three were over 16 years of age.

5 young people were known to children's social care, although all but two young people had been known in the past.

2 were the subject of a child protection plan, including one who also had a care order in place. Another young person was a care leaver.

Although most of the children were of school age, two had already left school. Many of those young people who were still on school rolls had patchy attendance, prompted by numerous house moves, truancy or school exclusions.

Nine of these young people died, seven as a result of suicide or an overdose. One of the two youngest children lost her life through an accident outside the home while the other child was killed together with his mother and siblings by his father. Self harm accounted for the serious incident case.

There were two groups of adolescents, those who were well known to a number of agencies, usually including children's social care, and those who had apparently low level needs at the time of the incident. Both groups were 'on the margins' in different ways. The neglect of adolescents is considered in a literature review by Stein and colleagues (Stein et al 2009).

One adolescent, receiving low level services only, was a carer for his disabled brother at home, and struggled both at school and in his home community where he was bullied. He found a more protective environment staying regularly with extended family.

He did not mix and could not defend himself outside the home.... However, he made friends in the street where we live.... and was not bullied when playing out like he had been (at home).

Other older children were well known to agencies and had profiles characterised by risk taking behaviour, substance misuse and sexual exploitation. The struggles of these young people with long histories of difficulties are exemplified in the following case study.

Case Study Kelly aged 15

Key Features:

- Rejection
- Missed opportunities for intervention at an earlier stage
- Risky behaviour- sexual exploitation / substance use / criminal behaviour / use of violence
- 'Hard to help' young person

Themes of case and background

Kelly lived with her mother, Marie, her sister and her stepfather Jason. From the age of 12, Kelly's anti-social, aggressive and risk taking behaviour spiralled out of her control. By the time she was 13 a care order had been made and Kelly was placed in a succession of foster homes and latterly in residential care. Kelly's death at 15 was suspected suicide.

(i) Child's needs / characteristic / behaviour

At age 8 Kelly was noted to have special learning needs, low self-esteem, and difficulties in relationships with other children. Her difficult behaviour resulted in exclusion from school by the time she was 13. Kelly's behaviour became violent and aggressive, and her substance misuse (alcohol and drugs) increased. She ran away from home repeatedly, sleeping rough and having sexual relationships with adult men, one of whom supplied her with drugs. Kelly had convictions for criminal damage, assault, and intoxication.

(ii) Mother's history / profile / parenting

Kelly's mother Marie's relationship with Kelly's father failed when Kelly was a baby and there were periods of homelessness when Kelly was young. There was sporadic violence between Marie and step-father Jason which Kelly witnessed. Marie asked for help with Kelly's behaviour before she was an adolescent, but as Kelly's behaviour worsened, Marie became increasingly disengaged and unwilling to co-operate with services. Early into Kelly's adolescence she refused to allow Kelly to return home and blamed her daughter for disrupting family life.

(iii) Father's history/profile/parenting

There is no information about Kelly's father

(iv) Wider Family

There little information about her step-father Jason. There is some evidence of fighting between Jason and Marie when they were both drunk and on one occasion Kelly alleged that Jason assaulted her during one of these drunken fights.

Maternal grandparents offered support when Kelly was young but not as she grew older and more difficult.

(v) Professional involvement

A Statement of Educational Needs was undertaken when Kelly was 8. Referrals to children's social care were not accepted. There was no offer of parenting support in the early stages when Kelly's mother asked for help; no follow up of Kelly's allegation of physical assault from her stepfather and no response to concerns about risky early sexual behaviour.

Professionals continued to miss opportunities to both offer support and to instigate child protection procedures. The prevailing professional attitude was that Kelly's behaviour was her own responsibility. Even once Kelly was in care no one pieced together the wider picture and recognised the warning signs of going missing, abuse through coercion into exploitation and substance misuse. By the time a range of coordinated support was offered, Kelly would not comply with plans and persisted with her dangerous and risk taking behaviour. Although professionals tried hard to engage with Kelly latterly, they mostly met with resistance.

(vi) Analysis of interacting risk and protective factors

As she moved in to adolescence Kelly's risky behaviour escalated. Her mother and stepfather disengaged from Kelly switching between blaming her and showing no concern. As rejection from her mother deepened, Kelly's behaviour became more extreme, more violent and more damaging to herself and others. Kelly was entrenched in cycle of drugs, crime and sexual exploitation before agencies recognised the high levels of risk and the extent of her vulnerability. Kelly's increasingly dangerous behaviour typifies that of many young people with similar family histories and feelings of low self-esteem who find attention, solace and excitement in taking risks and then become trapped in a downward spiral of addiction and abuse which confirms their feelings of low self-worth (Dodsworth 2008).

Key issues / what could have been done differently?

Early, preventative intervention. There were many opportunities to offer parenting support when Kelly's mother asked for help. The outcomes of the Special Educational Needs plan could have been followed up and Kelly could have been listened to from this time. Her behaviour became a way of speaking - but she was still not heard.

A holistic assessment. A holistic assessment of Kelly and her family, incorporating an understanding of the parent's histories and of Kelly's needs and behaviour could have been completed at the onset on problems, initially via the Common Assessment Framework. This way, early help, or appropriate specialist services, including child mental health services, could have been mobilised and coordinated to stem an escalation of problems and pre-empt school exclusion and Kelly's behaviour spiralling out of control.

The need for a lead professional. An allocated lead professional could have ensured that information was more effectively shared, appropriate assessments undertaken, plans more effectively coordinated and reviewed. Additionally, the lead professional could have insisted that Kelly be given a voice about services.

Lord Laming points out the importance of early intervention for older children and adolescents and not just for young pre-school aged children:

Teenagers who are starting to disengage from school or show signs of anti-social behaviour can also benefit from preventative and early help and support (Lord Laming 2009:24).

Further examination of what young people need from services is considered later, in the sections concerning cooperation and access to services.

Thresholds of intervention and patterns of co-operation

Building on the work of the 2003-05 biennial review (Brandon et al 2008a), the 40 children were plotted on a chart, as last time. Figure 9 represents two interconnected dimensions:

1. Different levels of intervention (adapted from Hardiker et al 1991 and Mesie et al 2007): Levels 1 and 2 i.e. universal services and additional needs (combined and shown along the bottom half of the chart) and Levels 3 and 4 i.e. children in need, children subject to a child protection plan, court order or other statutory or specialist tertiary services (combined and shown in the top half) and

2. Different categories of co-operation between families and agencies providing services: Lack of Co-operation or Co-operation (shown left to right along the horizontal axis).

Children's cases were plotted to represent these features at the *time of the incident* or circumstances which prompted the serious case review. As in the previous study, a number of cases had been 'closed' to specialist services days or weeks before the incident. A more detailed chart is displayed in Appendix 5.

Figure 9: Threshold map of level of intervention and degree of family or young person’s co-operation with agencies at time of incident (n=40)

Levels 3 and 4 Children in need/with CP plan/statutory specialist/tertiary services.	15	6
	14	5
Levels 1 and 2 Universal services/additional needs/targeted services	Lack of co-operation	Co-operation

Levels of intervention

The examination of levels of intervention revealed a somewhat similar pattern to the 2003-05 study with a spread of agency involvement across all levels of intervention evident in the 40 reviews. As last time, just over half (21, 53%) of the children were receiving high level services above the threshold for intervention from children’s social care at the time of the incident (Levels 3-4, top quadrants). For the remainder of children, (19, 47%), only additional needs or universal level needs had been recognized (Levels 1-2, bottom quadrants).

The problems with children not reaching the threshold for services from children’s social care and hovering on the borders was apparent in this and the previous biennial analysis (Brandon et al 2008a and b). Lord Laming highlights the enduring threshold problem and warned that local authorities that adopt very high threshold criteria run the risk of legal challenge (2009:30).

For the many children who did not come to the attention of children’s social care, abuse or neglect should have been considered a *possibility* by all who came into contact with the child. These children serve as a reminder of Lord Laming’s comment that “*child protection does not come labelled as such*” (Cm 2003). This comment continues to have significant implications for *all* practitioners who should be aware of the risks of significant harm to children across all levels of need and intervention (Brandon et al 2008a and b).

Children's social care involvement

Just over half of the children (21) were known to children's social care and were receiving level 3 or 4 services at the time of the incident. This is very similar to the 55% of families receiving this level of service in the 2003-05 study.

Of those children being helped by children's social care, 5 were the subject of a court order (4 care orders, 1 contact order).

More than three quarters of the children's families (i.e. either parent or any children in the family) had received services from children's social care at some point in time (78%). This compares with 87% of families in the 2003-05 study.

6 of the 40 children were the subject of a child protection plan - the same proportion as the children in the 2003-05 study.

Transience and being 'off the radar' cases, CAF and ContactPoint - in Level 1 and 2 cases

All children should have been receiving universal health and (if old enough) education services, but the high level of mobility for almost half of the children's families meant many were not receiving even these baseline services. Some children were not registered, or were registered only temporarily, with a GP or were often absent from school.

A number of children and their families receiving low level services were 'off the radar' of professionals who might have been able to offer supportive services and have some oversight of the children's well being and safety. Being out of the sight of professionals was exacerbated by numerous moves and fragmentation of records.

In this case the family's chaotic pattern of address changes and the inevitable fragmentation of records was an important part of the children's life and should have been recognised as an additional risk factor rather than just being a factor which made it more difficult to engage the family... Effect of mobility was exacerbated by poor school attendance.

ContactPoint has been set up to avoid children going off the radar in this way and one young person's case was recommended by the serious case review as a good training example for ContactPoint. This national database is intended to provide the possibility of giving professionals knowledge about children's whereabouts. However, the existence of this database, and the presence of information of itself, will not help workers to clarify the degree of priority or concern that leads to key information being communicated.

Once they have information available to them about other professionals involved, professionals still need to understand the importance of contacting and involving other professionals who may have had dealings with the family.

Indeed, the existence of ContactPoint could mean a lack of action because one professional may feel reassured that another worker is already involved.

The same issues hold true with the use of the Common Assessment Framework (CAF, HM Government 2006b). Although the brief, preliminary, but holistic assessment offered by the CAF might provide a better picture of things in the round, it can only be a starting point for delivering better services and again requires professionals to go beyond what they see as their own agency's priorities.

However this will only happen if professionals are prepared to step a little outside of their specific professional remit.

CAF challenges

Many of these families are not straightforwardly voluntary or co-operative which provides considerable challenges for making the voluntary CAF system work.

A number of transient families were on the threshold of receipt of services from children's social care and the threshold wrangles identified in our last report persisted (Brandon et al 2008a). Lord Laming commented that restricting access to services provides missed opportunities for avoiding a downward spiral.

This undermines the very purpose of section 17 of the Children Act 1989, which is to provide early support to children and families and prevent the escalation or risk which can lead to a child being harmed. Local authorities that adopt very high threshold criteria run the risk of legal challenge" (Lord Laming 2009:30).

Transience and being 'off the radar' - in Level 3 and 4 cases

Children receiving higher level services from children's social care and other agencies were also often prone to going 'off the radar'. In one case a young mother was in regular contact with social workers until she started a relationship with a new boyfriend when she vanished from professional view. This relationship included domestic violence and agencies did not know about the new violent partner although information about past violence towards children could have been known from his relationship with a previous partner.

Insufficiently qualified staff at all levels of intervention

Some overview reports noted that staff working at both levels 1 and 2 and with cases on the threshold of receipt of services from children's social care, were not appropriately qualified to assess or deal with the level of complexity evident in the children who required family support services. One overview report noted that the service requested has to fit the skills of the staff - but an alternative view is that the staff should be suitably qualified to offer the service that the child requires. Oversight and monitoring were suggested to improve safeguarding in such cases, but for a child to have professional oversight and expertise at a distance may not be adequate. In one case, a SureStart family support team were all qualified at NVQ level 3 but none had a professional level qualification. The line manager was also not a qualified social worker.

There are arguably unrealistic expectations placed on staff with low level generic child care qualifications who are working in early intervention services to prevent neglect and abuse. Complex neglect cases can be below the threshold for initiating child protection enquiries, and even below the threshold for assessment by children's social care. In these instances it is also often unqualified workers who undertake the bulk of the direct work. All their energies may be expended on making a relationship with the parents and dangers to the child may be missed.

One LSCB suggested that the use of the 'Graded Care Profile' with children and families (Srivastava et al 2003) would help clarify and provide evidence of aspects of neglect more clearly to provide a justification for a referral to children's social care or, alternatively, provide better evidence that the child's needs would be likely to be met by interventions at an early stage.

The use of unqualified health visiting assistants in well baby clinics to weigh and therefore observe and monitor babies' development was also called into question by one overview report author. Even if such staff have received satisfactory Criminal Records Bureau checks and child protection training, they may not have the skills and expertise to notice, for example, a child with faltering growth as a result of abuse or neglect.

In other circumstances staff were professionally qualified, but nevertheless had insufficient skills, training or supervision to deliver the best care to children and their families.

Levels of co-operation

Figure 9 (the threshold box) represents evidence about engagement with services by parents, carers, or older children into two broad categories of 'co-operation' and 'lack of co-operation'. 'Co-operation' includes willingness to engage with agencies and persistent help seeking. The broader concept of 'lack of co-operation' includes hostility, avoidance of contact, many missed appointments, disguised or partial compliance, and ambivalent or selective co-operation. In this sample of 40 cases, there were no examples of neutral co-operation.

Protocols for child / family co-operation

Not co-operative, actively avoiding involvement / hostile

Refusal to engage with services or actively hostile / violent. Actively avoiding or eluding agencies or moving frequently, going missing. Many or most missed appointments with most services. May include disguised compliance.

Low co-operation

Reluctance to engage, some missed appointments/generally not good at keeping appointments. May avoid / elude some agencies, not others. May withdraw and disappear (developing into not co-operative).

Neutral / some co-operation

Take it or leave it view about services, or patchy engagement. Not avoiding or refusing services but professionals may need to work to engage family. May be passive co-operation.

Co-operation

Good engagement, keeps all or most appointments, seeks and uses help easily. May self refer.

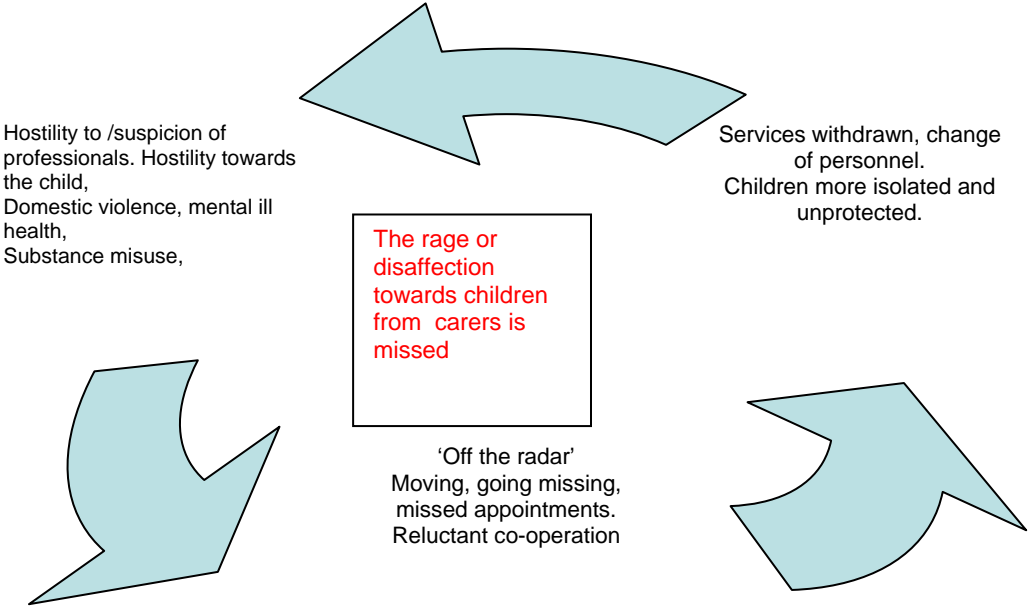
Highly co-operative or persistently seeking help

Pattern of a high level of, possibly, panicky help seeking from many different agencies. Needing constant reassurance.

It was difficult to assign children or their parents to any one of the 5 single categories of co-operation (listed overleaf) as parents' behaviour was changeable and many often showed different behaviours with different professionals. Also, the child's mother might be co-operative while the father was hostile, or (less often) vice versa. The examples given illustrate the complexities which would have presented challenges to staff when understanding the family dynamics and making decisions in safeguarding practice. It is, therefore, *not* helpful to consider the different types of co-operation as a continuum representing increasing or diminishing levels of co-operation, as suggested in the previous biennial analysis (Brandon et al 2008a:89), but rather as fluid, overlapping categories which can change very quickly. Figure 9 shows that in almost two thirds of the cases studied in depth there was 'a lack of co-operation' at the time of the incident, and this often included overt hostility, and sometimes threats, towards staff.

It is important to note that a range of factors influence the way that families engage with services and sometimes professionals can provoke co-operation or hostility with their own behaviour. There are numerous reasons why families might lose the motivation to engage, for example negative experiences of services, being in denial about their problems, fearing children will be removed if problems are admitted, getting no support for non-acute problems or an overwhelming amount of support when problems become so bad that they meet service thresholds (HM Treasury and Department for Education and Skills 2007p 85). In other instances, poor co-operation and hostility can be minimised and overlooked. The diagram below sets out a common chain of circumstances and behaviours where there was hostile or difficult co-operation. Hostility can, however, be modified by positive engagement skills of staff and should not be considered an inherent or unchangeable attribute (Forrester et al 2006, 2007).

Figure 10: Hostility to professionals and harm to children



Hostility in Level 3 and 4 Services

Professionals were not always aware of hostility towards colleagues as families often engaged selectively with some workers while reserving extreme hostility and violence towards those from other agencies. This was evident in one family receiving level 3 services (i.e. from children's social care and others).

*This review has demonstrated the difficulties of working with families who only partly co-operate and give inconsistent responses and presentations. There were times when face-to-face presentation, particularly to certain individual workers, was reasonably positive. At such times, the couple appeared to be compliant, even co-operative... the parents' accounts and explanations appeared to be reasonable and credible... And the assessment of the children gave no obvious cause for concern... On the other hand (father's) presentation and behaviour to a large number of workers and organisations was aggressive, threatening, and hostile..... There were separate incidents of (father) displaying aggressive or abusive behaviours towards workers from **eleven** separate agencies.*

The extent of this father's controlling, deceitful behaviour and his history of violence was not known until after the child's death.

Disguised compliance was evident in other parents who were described as 'assessment savvy', adapting their behaviour and presenting as compliant when needed. Once a favourable assessment was completed by children's social care the level of co-operation and extent of contact with agencies slipped substantially and the child was rarely seen. This went unrecognised, not least because each professional thought that others were making contact and that someone was seeing the child on a regular basis.

Some children's parents' refusal to co-operate signalled an end to services being provided and an end to any possibility of oversight of the children's care. In a number of families where babies died or were killed, patterns of maternal or parental co-operation were very poor, with limited antenatal care, and limited contact after discharge. This included missed routine checks, missed immunisations and failed appointments.

The case (of a baby born with neo-natal abstinence syndrome) was referred to children's social care, and an initial assessment started. This was never completed due to the family's lack of willingness to co-operate.

Other examples of withdrawal of co-operation, for example never being present for planned appointments, from mothers who had previously co-operated well, was not always noticed by professionals working with chaotic families with multiple problems and shared low expectations of progress by the family and the workers. Good practice in relation to missed health appointments is later and in the next chapter.

Hostility in levels 1 and 2 services

In a very small number of families receiving level 1 or 2 services the middle class, professional status of the parents reinforced their control and their capacity to prevent agencies from challenging their views and intervening to protect the child. The need to override parental consent in some circumstances was outlined in one overview report.

Overriding parental consent

It appears that (school) staff sensitivity to a parent's wishes, paradoxically prevented them liaising with other relevant and appropriate agencies to share concerns and verify information... The panel recognises that it is good practice to gain parents' consent to see a child (for a medical examination) but when a child has suffered significant harm this consent could and should be over-ridden.

In two case examples the alleged professional qualification of the parent (medical in both cases) was found to be fabricated and part of a web of deceit and control. Deliberate deception is very hard to deal with. There must be an element of trust in family and worker relationships and although 'respectful uncertainty' needs to accompany the trust, it can take time to recognise and combat clever exploitation of this trust.

Low co-operation / reluctance to engage in levels 3 and 4 services

There were a number of families who engaged reluctantly or in a desultory fashion and co-operated only minimally or sporadically. But with concerted efforts from helping professionals, they could often be 'won round'. These families were generally not good at keeping appointments and had "a tendency to avoid professionals".

Both parents had a long history of non-cooperation with statutory agencies. Once (the baby) was born there was contact from the midwife and health visitor but that contact appears to be down to the persistence of the professionals involved.

Sometimes the considerable efforts needed to establish a basic level of co-operation masked the lack of progress in ensuring the child's safety. "Although some agencies feel they have a reasonable working relationship with mother, there is little evidence of progress." The overflowing ashtrays and matches left lying around the house were, in retrospect, signs of the risk of the fire that followed.

Missed health appointments

- More than a third of the 28 children (for whom the information was available) showed a history of missed appointments for immunisations and developmental checks.
- Maternal attendance at ante-natal appointments was, at best, 'partial' in nearly half of the 24 cases where this information was available. (See Appendix 3 for details)

Good Practice with missed health appointments

In some areas, a pattern of missed health appointments are seen as a trigger for *enhanced* professional effort to engage and not a withdrawal of service. Indeed this more vigilant approach to missed appointments is a recommendation from the 2004 National Service Framework for Children.

A pattern of failed parental engagement with substance misuse services was noted to signal the potential for serious risk of harm to a child:

Mother failed to engage with the substance misuse service on other than an intermittent basis. Such failure to engage has clear implications for the safeguarding of vulnerable children where the carer concerned has significant drug dependency problems and there is evidence that a child is at risk.

In this situation where the mother was minimizing both her offending behaviour and her dependency on drugs, her engaging personality and apparent willingness to reduce her dependence on drugs blinded practitioners to the reality of 'disguised compliance'. The risks of harm to the child were, again, magnified when services were withdrawn due to the mother's non-compliance with numerous referrals.

Also typical of other parents with this type of engagement was ignoring contact when it threatened or challenged them and seeking out contact when it was likely to provide wanted resources, for example housing. Similarly, passive co-operation can be mistaken for active co-operation. The social worker records in one case note that parents seemed able to '*work the system and tell us what we want to hear*'. When the unborn child was made the subject of a child protection plan, children's social care recorded that '*no work has been completed due to lack of parent's engagement*'. The lack of response with the plan left the child at risk of the serious accident and injury which ensued. The fact of her father 'working well' with alcohol services left professionals feeling that something had been achieved and this was highlighted as good practice by the overview author, even though serious harm befell the baby. While good practice in this sphere is not denied, successful engagement with alcohol or drug services should not encourage complacency about risks of harm to the child. One overview author indicated that parental engagement and co-operation were good there but there were other suggestions of ambivalence and detachment. For example, the deputy head teacher reported concern about '*mother's detached attitude when they have talked to her in the past*' and a reluctance to discuss what a nursery nurse had described as mother's '*brisk*' attitude towards her children and her reluctance to follow behavioural advice.

Low levels of reluctant co-operation are illustrated in the following case study.

Case Study - Harvey (aged 4)

Key Features:

- *Neglect and physical injury*
- *Harvey and his two half siblings were subjects of to a child protection plan*
- *Overwhelmed mother*
- *Missed health appointments, low co-operation, passive resistance to help*

Theme of case and background

Harvey was the oldest of three siblings and lived with his mother and stepfather, but was in regular contact with his birth father. The family lived in poor conditions and struggled with debt and homelessness. Harvey and his half siblings were all the subject of a child protection plan in the category of neglect. Harvey had a history of bruising and died in an accident at home. There was a pattern of low co-operation.

(i) *child's needs / characteristics / behaviour*

Harvey was the oldest of three children and was said to be loud, noisy and challenging - and hard to say no to. His progress at nursery was good but his attendance had tailed off. Harvey had had many minor illnesses. He had also had a number of bumps to the head for which appropriate medical attention was not sought.

(ii) *mother's history / profile / parenting*

Harvey's mother, Lorraine, had been physically and emotionally abused as a child and her mother continued to be violent towards her as an adult. As an adult Lorraine had a succession of minor ailments and presented as quiet, subdued and overwhelmed. Her parenting skills were said to be unacceptable and inconsistent. There was limited interaction with the children with little emotional warmth or stimulation. She did not grasp professionals' concerns about her children and would sometimes leave the children in the care of a young teenager.

(iii) *father's history / profile / parenting*

Harvey's father Darren had been known to children's social care and to CAMHS as a child. He had a history of depression, problems with alcohol and a tendency to get involved in fights after drinking. He was in regular contact with his son, and bruises were noted on Harvey when he was in his father's care as well at home with his mother and stepfather.

(iv) *Family and wider family environment*

Harvey's step father Dean had been known to children's social care and to CAMHS as a child. He was worried about Harvey's care at his mother's home and made a number of calls to children's social care about his concerns. Dean said he had not bonded with Harvey as he had with his own children.

There were longstanding problems with homelessness and debt and the house was described as an unsafe home environment. All visitors to the house reported it being untidy, dirty and chaotic. There was conflict, at times violent, with extended family.

(v) *Professional involvement and community services*

Harvey attended a nursery. All three children were the subject of a child protection plan which was extended after a year. Care proceedings and voluntary accommodation were being actively considered at the time of the accident which caused Harvey's death. Health and children's social care worked together closely with regular core group meetings. There was a pattern of missed health appointments for the children and Lorraine.

(vi) *Analysis of interacting risk factors*

There had been a sharp decline in this family's functioning after Harvey's parents separated two years previously. Lorraine moved in with Dean her new partner and had two more children (and was expecting a fourth). There was a downward spiral of debt, homelessness and many moves. A pattern of missed health appointments began from this time. The mother's capacity to care for the children decreased with each new birth. There was a "passive resistance" to help from this "overwhelmed" mother who was becoming increasingly emotionally detached from her children - especially Harvey, and was exhibiting signs of 'depressed neglect'.

There seems to be an increasing emotional detachment from mother to Harvey and she feels he would be better off with his father for now. The new baby will be here in a couple of months and that will put pressure on the family.

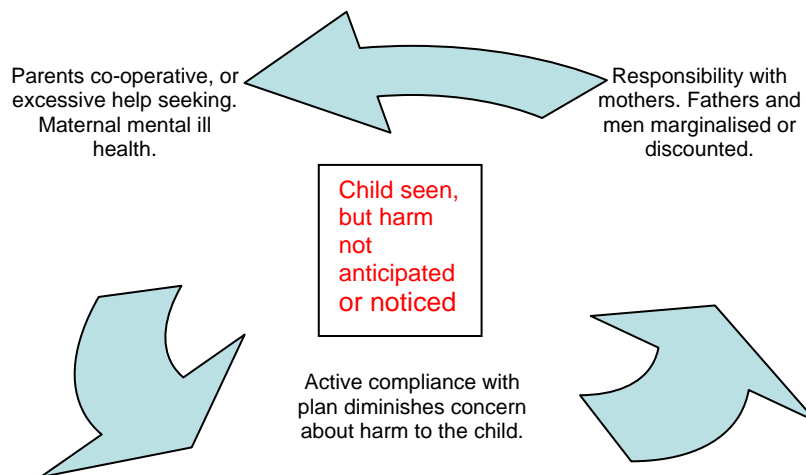
A “*catalogue of bumps and bruises*” was noted for the mobile children and especially for Harvey. Harvey had so many bruises and falls that dyspraxia was considered but discounted. Instead Harvey and his sibling’s care was interpreted more broadly, but very worryingly as ‘*basic needs not met*’. The quality of caregiving at Harvey’s father’s was unknown. As well as being frightening, he might have posed a risk to Harvey’s safety. Alternatively Harvey might have relished the positive attention and playfulness he received in his father’s care in contrast to the detached caregiving he met at home.

What could have been done differently?

Not enough attention was given to injuries. Although dyspraxia as a reason for the bruises was discounted, this was not taken into account. Care proceedings for Harvey, and possibly his half siblings, should have been initiated earlier.

The balance in cases of neglect is between allowing enough time for interventions to demonstrate some success and knowing when to call time because of lack of progress.

Figure 11: Apparently good co-operation



Co-operation

There was active co-operation from the families of five of the 40 children. In all of these cases the young child or baby suffered physical assault. In these families appointments were kept and parents and carers were receptive to advice. Parents were thought to engage appropriately with professionals and brought babies and children to health professionals to seek treatment for a variety of minor ailments, or with older children, they attended meetings at school.

Three of these five families had low level involvement from universal services only. There was no evidence from anything about their pattern of engagement, or indeed any other factor, could have warned staff from any agency about the dangers to the child. This was not the case for the other two 'co-operative' families. For one baby, the pre-birth assessment concluded that the parents were vulnerable. Active compliance by parents with the support plan appeared to diminish professionals' concerns about poor weight gain and minor bruising, rather than prompting them to investigate further.

In another example parents approached agencies asking for support with their parenting, and the mother (who had long standing mental health problems) repeatedly spoke of her intentions to harm her son, being open with health and social care professionals about her difficulties and about her feelings towards her child, even when these were negative or potentially dangerous. The parents were co-operative at all times but vacillated between being adamant that they did not want their child removed and the mother saying that she couldn't cope and wanted her son taken into care.

Panicky, anxious help seeking

There were four of the 40 children whose mothers shared a pattern of persistent, panicky, over anxious help seeking. Two of the mothers had current or past eating disorders. The focus of concern was the baby or child's health and it was primarily health agencies which were approached for support. For example, one mother made numerous contacts with the GP, with NHS direct, with the out of hours service, the minor injuries unit, and the paediatric clinic. All these contacts occurred alongside regular visits from the health visitor over a period of less than two months. Combined with this persistent, almost obsessive help seeking for these families, was avoidance of contact, sometimes on the same day.

The mother often sought advice on the same evenings of days where the health visitor, midwife or nursery nurse had visited but had not been able to gain access.

These mothers could not contain their panic and wait for planned appointments. They needed help most often in the evenings and at night time when their stress and the baby's or toddler's demands mounted. Understanding where the risks of harm to the child came from was different in all four cases (serious unexplained injury, serious sexual assault, induced illness and starvation through neglect) but the failure to cope was evident in all the families. In these types of families, because the anxiety of the mother is so prominent, the father or other members of the family are marginalised or just not seen and the risks of harm that other family members pose to the child or other family members' capacity to nurture the child or support the mother are not properly evaluated.

With premature babies suffering from a number of health problems, or for a mother with mental health problems and a complicated and distressing obstetric history, a high degree of maternal concern and anxiety is perhaps to be expected. However, the relentless pattern of help seeking and the degree of parental despair was not known or understood by health professionals.

Co-operation and Adolescents

The group of 'hard to help' young people neglected by agencies, who emerged in our 2003-05 study, were also apparent in this study and shared the same profile of long agency involvement and years of high intensity services. As last time, these young people might have been amenable to help if they had been offered the right approach. One young person who killed himself was seen as a nuisance and not easy to work with.

His erratic, risky lifestyle and limited capacity to engage made him difficult to help. From an early age his anti-social behaviour predisposed public services to see him as a nuisance from which others should be protected. On the other hand he was a vulnerable child and young man who was failing to thrive against the 'Every Child Matters' criteria...Although he presented as difficult and uncooperative, there are signs that he could and did respond in some situations. I have noted, elsewhere, a judge's injunction that uncooperative children are insufficient excuse for not persisting.

Other young people receiving only level 1 and 2 services, without a history of long term engagement might, or might not, have responded had they been offered help, but this help did not materialise. One young woman who killed herself was said to only accept support from her small group of close friends. There were a number of occasions when agencies had an opportunity to engage with her but help was not forthcoming.

In two adolescents' cases which involved arson and suicide, there was good engagement with the parent or carer but not with the young person him or herself. For one young man who killed himself, his uncle's endeavours to seek help on his behalf, and provide stability after 8 moves in 8 years, came too late. Following the nephew's move away from home, the uncle contacted children's social care to request a social worker, and was given advice about benefits and education, but 'no further action' was agreed by the team manager, even though the uncle had indicated that '*things had got violent*' at the point when the young man had left the parental home. The uncle had contacted the new school to secure support for his nephew, and this was being put in place at the time the boy died.

There were a number of adolescents among the intensive sample of 40, like Evan, who had never gained access to the services they needed.

Case Study: Evan (age 16)

Key features:

- *Multiple moves*
- *Instability and isolation*
- *No access to mental health or other support for Evan*
- *No one knew Evan*

Theme of case and background

Evan lived with his mother and sister, but had a poor relationship with his mother. His father had left home when he was 11 and there was no contact for several years. His sister had recently gone to stay with their father and Evan had also wanted to live with his father. Evan and his mother were in temporary accommodation and since his father had left home they

had been constantly on the move. Evan killed himself after an argument at home with his mother.

(i) child's needs / characteristics / behaviour

From the age of 12, Evan suffered intermittently with low mood, poor appetite, and problems with sleeping. He ran away from home periodically from the age of 13. His mother said he found it hard to complete any tasks and was easily flustered and lacked concentration but Evan did well at school although his attendance was poor. He took an overdose of painkillers at age 16. Soon after this he was involved in a fight at school for which treatment was needed at A& E. Evan talked to the A&E doctor about bullying at school and the poor relationship with his mother.

(ii) mother's history /profile / parenting

Evan's mother was aged 20 at the time of Evan's birth.

(iii) father's history /profile / parenting

Evan's father was 26 at the time of Evan's birth. There was a history of domestic violence, allegedly causing Evan's mother to flee for her safety.

Sibling

Evan's sister (aged 14) was a victim of bullying like Evan. She lived with her father at the time Evan died.

(iv) Family Environment

The family were living in poverty and additional financial problems were linked to misuse of housing benefit. There were recurrent housing problems and the family was constantly moving.

(v) Professional involvement and community services

"No one professional seems to have known them (Evan and his sister) or been able to gain access to them for any substantial length of time." "Even the schools did not get to know them well enough to identify other problems (other than non school attendance)."

Evan's mother visited a GP on 3 occasions to ask for help with her son's depression, but did not take up any appointments offered. No one made any direct contact with Evan and all offers of help were through his mother.

The family were referred to children's social care (CSC) on three separate occasions and self referred at least twice. But CSC staff treated each individual presentation of the family in isolation from the previous history. Even when the previous history was known the response was minimal, based only on the current presentation. The level of response should have taken into account the whole history of problems that the family had experienced and also the fact that the mother had never taken up the offer of any of the services.

(vi) Analysis of interacting risk factors

Since the family was constantly on the move Evan was never able to keep the appointments for his depression and was constantly changing school. At the time of his suicide this young man did not appear to be known by anyone. It is only possible to guess the sense of loneliness, isolation and lack of stability he must have felt.

Evan's mother's selective co-operation with agencies, and rent fraud, would have made her appear 'manipulative', not deserving of help and an irritant to professionals coming into contact with her. On one occasion when she went to school to intervene on her son's behalf, she was banned for being abusive to other pupils. She was probably frightening to professionals (and to her son). No one considered why she needed to move around so much (she turned down numerous offers of permanent housing) and keep her children at home, away from school. Was this to make sure others didn't control her? She had some insights into Evan's needs and problems but was overwhelming and threatening to Evan.

Early experiences for Evan of living with domestic violence compromised his sense of home as a safe place - instead it was a frightening and unpredictable place. His father left home when he was 11 and his mother was constantly talking about the threat posed by father. There were very frequent house moves after the parental separation including periods of homelessness, attributed to fleeing from father's violence (the need for this is disputed in the SCR). Evan's emotional problems surfaced from this time. Changes of house and school meant lack of stability and further lack of predictability for Evan and his sister. Poor school attendance also meant lack of a predictable stable environment in which to meet peers and make friends. Although Evan was mostly withdrawn and closed with low mood and depression and bullied at school, there were occasions of his being involved in fights and fighting back.

What could have been done differently?

*"mobility and lack of parental co-operation are common factors and need to be recognised as a risk factor that should **heighten** concern rather than simply being a reason why children don't receive a service over many years. More effort is needed precisely because the family is mobile"* (from Overview Report)

ContactPoint is intended to help in cases like Evan's. However, once information is available about other professionals involved, workers still need to understand the importance of contacting and involving other professionals who may have had dealings with the family. The same issues apply to CAF which potentially provides a better picture of the child and family in the round.

Nobody outside of the family knew or cared about Evan - CAF should help this but does it?
Learning Points:

- All professionals should consider the impact of domestic violence on children as a specific risk to their good welfare (in this case teachers didn't - CSC scarcely did either). The combination of mobility and debt heightens the risks to the young person's welfare.
- School was the obvious starting point for children to be 'known' outside of the family. It did not seem as if the school staff knew the children or were sufficiently concerned about their welfare. The chronic and extreme non school attendance and constant moving should have triggered concern rather than a bureaucratic non school attendance referral.
- Young people need to be offered help in their own right not just via a parent. A&E staff saw Evan alone but then involved his mother, which Evan was ambivalent about. It should be possible to 'twin track' the response to involve the parent but give Evan a separate route to independent help.

- CAMHS help needs to be more accessible. No clear diagnosis of depression or mental illness was made and no help offered. The point after Evan's overdose was a key time to offer help. Rigid age limits exacerbated the problems since at age 16 Evan was no longer eligible for a children's mental health service.

There were other instances of withdrawal of co-operation from a young asylum seeking mother (a child herself) once her request for asylum had been refused and deportation was planned. The hardships suffered by this young family were extreme and her stress was communicated but not followed up. The young mother's decision to 'go missing' put her child at increased risk of harm and reduced the likelihood of protective intervention. A literature review of the neglect of adolescents is now available (Stein et al 2009).

Access to mental health services for adolescents

A number of cases of older adolescents and young parents demonstrated that CAMHS help needs to be more accessible. Contact with CAMHS is often made through parents and even older young people may find it difficult to attend appointments without their parents help and co-operation, as in Evan's case. In level 1 and 2 intervention cases depression or other symptoms of mental illness were not diagnosed so no help was offered. At times, as in Evan's case, this was because young people did not attend follow up appointments. One overview report helpfully quoted NICE guidelines (2004, 2005) and pointed out the key role for the GP in these circumstances.

NICE (2005) state that health care professionals should make contact with children and young people with depression who do not attend follow up appointments. As GPs are the hub of information regarding their patients it would seem valid for the GP to take the lead in undertaking the follow up.

Rigid age limits also impede access to appropriate mental health support. Sixteen year olds like Evan should be eligible for a children's mental health service. Standard 9 of the National Service Framework for Children, Young People and Maternity Care stipulate that CAMHS should provide services from 0-18 years (see also DH National Review of CAMHS 2008). However young people like Evan are often caught in the transition to adult services where there may be long delays before help is offered. Adult mental health services have different methods of following up missed appointments often putting the onus on the patient themselves rather than realising that the young person may need help to attend. Furthermore, children who are the subject of child protection plans are often excluded from CAMHS services (Gardner 2008).

Suicide and helping

A literature review of risk and protective factors for suicide and suicidal behaviour stressed the interplay between a number of risk and protective factors. Suicide is complex and risks and protective factors can change with circumstances. This literature review found gaps in the evidence for suicide risks for young people, especially looked after children, but offered better evidence in relation to protective factors for adolescents.

A number of coping skills requiring an element of self-agency appear to be protective against suicidal behaviour particularly among adolescents, including self-control and self efficacy, instrumentality, social adjustment skills, positive future thinking and sublimation. Being in control of emotions, thoughts and behaviour can mediate against suicide risk associated with sexual abuse among adolescents (McLean et al 2008:7).

A supportive school environment appears to offer some protection against suicide for adolescents as does good access to healthcare professionals. Access to treatment by a health professional may be protective against repeat suicide attempts. Engaging in sport may also provide some protection against suicide for adolescents. Good relationships with parents appear to mitigate against suicide risk in adolescence including for those who have been sexually abused, and those with learning disabilities. Positive maternal strategies can be positive for adolescents (McLean et al 2008).

The serious case review process

Chapter 4 considers more detail about the serious case review process. However some issues emerged from the examination of themes from the intensive sample of 40 cases. Primarily, this concerned the inadequacy of most serious case reviews in providing enough information to aid a full understanding of the case and the incident which led to the child being harmed or killed. Serious case review overview reports contained:

- Limited information about the family. There was often very little detail about parents' past and very limited information about men in families.
- Limited information about the child (the best information was often in chronology, and was not always picked up by the overview author.
- Some reviews left out a consideration of the child's circumstances and restricted themselves to a critique of processes, for example systems designed to protect children from adult offenders like Multi Agency Public Protection Arrangements (MAPPA). In some reviews, as well as no information about the child, there is no reassurance that there are robust plans for the safety of the individual child (who had suffered serious sexual abuse) after the serious case review.
- Limited information about the family's environment e.g. poverty
- Limited information about the agencies' context and 'climate' and their capacity and to safeguard children effectively.

Unless more information is provided about the child and his or her family, and their relationships and behaviour within and beyond the family, it will not be possible to understand *why* the child was seriously harmed or killed. Service provision and inter-agency working cannot be fully understood in isolation from a proper ecological analysis of the case. This theme has also emerged in relation to wider child death reviews, both from the English study (Sidebotham et al 2008) and from work in child death review teams in the USA. The focus on establishing whether there are lessons to be learnt about the way in which local professionals and agencies work together to safeguard and promote the welfare of children can often miss out or ignore crucial *understanding* about the child and his or her family. Similarly, broader lessons about the impact of parental characteristics like substance misuse, domestic violence and mental illness on the child can also be lost.

Chapter 3 Summary

- This chapter analyses themes which emerged from the 40 serious case review overview reports. These themes are considered in relation to three interconnecting child, family, and professional domains and as interacting cycles of practice. Although the themes are very similar to those from the 2003-05 study, it is the individual *differences* in each child's case that pose the most challenges for understanding and hence for practice. The cases also share similarities with families that many practitioners would be familiar with in their day to day work.
- An interacting cycle shows how the chaotic behaviour in families can be mirrored in professionals' thinking and actions and that both families and professionals can fail to see the child. In many cases both families and professionals were overwhelmed and with low expectations of what could be achieved. Professionals were overwhelmed not just with the volume of work but by the nature of the work. Efforts to think the best of parents made some professionals reluctant to judge the parents' behaviour as harmful to the child. Fixed views about the family made it difficult to think differently about new risks of harm to the child.
- The vulnerabilities linked to the children's age and environment are considered within three age linked 'ecological niches' of a pre-school family based environment (aged 0-5 years, 26 children), the more protected middle childhood niche (aged 6-10 years, 4 children) and an adolescent niche (aged 11-17 years, 10 young people).
- Thresholds of intervention and co-operation are analysed. Just over half of the families (21) were receiving services above the threshold for children's social care intervention, (although three quarters of the families had received such help in the past). For the remaining children and their families only additional needs or universal level needs had been recognised. The high level of mobility (almost half of the children experienced frequent moves) meant that many were not receiving even universal services.
- Three quarters of the families did not co-operate with services. Patterns of hostility and lack of compliance could change rapidly in families. They included: deliberate deception, disguised compliance and "telling workers what they want to hear", selective engagement, and sporadic, passive or desultory compliance. Sometimes hostility or missed appointments led to a withdrawal of services and less oversight of the child. Hostility is not necessarily unchangeable and can be modified by positive engagement skills from staff. However, good parental engagement can mask risks of harm to the child. Reluctant parental co-operation and multiple moves meant that many children went off the radar of professionals.
- There was past or present domestic violence and/ or parental mental ill health and /or parental substance misuse in almost three quarters of the 40 families.
- Case studies are used to illustrate a number of themes including co-operation and adolescents. Better ways of providing mental health services for adolescents is considered.
- Many serious case reviews did not provide enough information to aid a full understanding of the case and the incident which led to the child being harmed or killed. Better information in reviews is needed about the child, parents' and carers' histories and the capacity and climate of the agencies.

Chapter 4: The Serious Case Review Process and its Impact

Introduction

This chapter provides findings and views about the serious case review process and its impact. It begins with a consideration of timescales and delays and then explores the various stages of the serious case review process from the perspective of 24 interviewees. The impact of being involved in a case that comes to review is discussed from the point of view of practitioners and clinicians. Although the interviews discussed reviews held in 2005-2007, all interviewees talked about current issues so their thoughts have relevance for practice with children and families and serious case review practices now. A summary of views from group discussions at regional seminars is given and these findings reinforce the comments made by the interviewees. The chapter concludes with respondents' views about changes needed to the serious case review process.

Timescales and delays

Timescales and delays as themes were apparent both in information about the 189 cases and in the interviews. The 189 child protection database notification reports provided information about the process of the serious case review, including timescales. Delay was often reported and a number of reasons were provided to explain why the process had become protracted. The guidance for timescales, issued in Working Together 1999 and 2006, emphasises the need for speed in the completion of reviews (four months) and the importance of the immediacy of learning from the review itself.

'Working Together' (2006) guidance for timescales:

8.14 Reviews will vary widely in their breadth and complexity, but in all cases, lessons should be learned and acted upon as quickly as possible. Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the Review Panel, whether a review should take place. Individual organisations should secure case records promptly and begin work quickly to draw up a chronology of involvement with the child and family.

8.15 Reviews should be completed within a further four months, unless an alternative timescale is agreed with the Commission for Social Care Inspection Region at the outset. Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges that a review cannot be completed within four months of the LSCB Chair's decision to initiate it, there should be a discussion with the Commission for Social Care Inspection Region to agree a timescale for completion.

Reasons given for delays in the child protection database reports

Examples of delay were found in the database notifications, which in many instances tracked the progress of the review. They included the following issues:

- Delays in receiving single agency reports (Individual Management Reviews) which held up the process;
- Problems in identifying a chair for the serious case review panel or in finding an appropriate overview author;

- The complexity of the case. Negotiations about timings were evident throughout the chain of responsibility:

Overview panel considered agency requests for an extension to submit their internal management reviews as issues relating to child and family are very complex, ranging over several years. The Chair of the Overview Panel agreed the request for an extension.

- Awaiting the completion of criminal or care proceedings was a common reason for holding up publication of the review:

.It was agreed that, the SCR would not be complete until the outcome of the inquest into (the child's) death was known as they may well have implications for the findings of the SCR.

ACPC has agreed to carry out a SCR, but on legal advice action at this stage will be limited to preparing chronologies. Analysis of the information will begin once the care proceedings are completed.

- Criminal proceedings could also delay or preclude family involvement in the review itself - a theme which is returned to later in this chapter:

Due to police proceedings unable to contact parents to ask if they wish to be involved.

- In some instances, separate investigations or parallel reviews were taking place which complicated and extended the exercise:

However, there is a separate police investigation linked to the case which is ongoing and could have a bearing on the outcome of the review. It is a very complex case.

- Agency capacity affected the conduct of the review as well as operational practice and sickness and absence were recorded as reasons for delay:

There has been some delay. The independent author of the overview report has experienced health problems and also a manager in a key agency has only just returned (from) six month's extended leave.

- Amendments to the documentation, changes in the scoping of the review or requests for additional information all took time:

Draft of SCR report was produced but it was sent back by the LSCB - the Director of Children's Services said they were looking for more definite (less woolly) recommendations.

How long did the serious case review take to complete?

An analysis was made of the timescales involved between the notification of the incident and the submission of the serious case review for 106 database notification reports from the first year from April 2005-March 2006. Information on timescales and delays was, however, often unavailable or incomplete and only 58 database notification reports yielded sufficiently detailed information about dates to be included in the analysis.

The duration between the ‘time of incident’ and a confirmation that a serious case review was to be begun ranged from less than 1 week to 58 weeks (see Table 4). *Working Together* (2006) stipulates it should take one month, and 53% were in fact confirmed within this one-month time frame. The time taken between confirmation that the review was to be undertaken and submission of the review paperwork ranged from 3 to 20 months. Only two reviews (5%) were completed within 4 months and in accordance with *Working Together* guidance (1999 and 2006).

On average it took significantly longer to confirm that a serious case review was to be undertaken when a serious injury rather than a death was under review (half had been confirmed after nine weeks for serious injury cases compared with half being confirmed after two and half weeks when a death had occurred).

Table 21: Progress of serious case reviews: April 2005- March 2006

	Death	Serious Injury	All cases
Median duration from time of incident to ‘SCR confirmed’	2.5 weeks (n=42)	9.5 weeks (n=16)	4 weeks (n=58)
Range	<1 - 58weeks	<1 - 46 weeks	<1 - 58weeks
Median duration between confirmation of SCR to completion	11.5 months (n=30)	10 months (n=10)	11 months (n=40)
Range	3 -17 months	7-20 months	3 -20 months

Information on timescales and delays was often unavailable or incomplete, leading to a reduced final sample size.

Delay in SCR completion

The evidence we have provided, backed up by the reasons for delay and the information from interviews with members of LSCBs, suggest while some delay can be reduced, the current timescales, as set out in *Working Together* (HM Government 2006), are unrealistic.

Wales have a six month timescale for the completion of similar reviews and this may be more feasible.

What interviews revealed about the serious case review process

A total of 24 telephone interviews were completed in relation to 17 of the serious case reviews, they included:

- 17 interviews with individuals who were closely involved with the serious case review process (mostly SCR sub committee chairs, or Head of Safeguarding or overview report authors)
- 7 interviews with practitioners or clinicians, (from a range of posts in health and children’s social care).

Both sets of interviewees were asked questions in relation to the specific serious case review with which they had been involved. Whilst all of these SCRs had started between 2005 and 2007, respondents also talked about current practice (late 2008). Interview questions are in Appendix 1. All those interviewed have seen and approved early drafts of this chapter and care has been taken to preserve the anonymity of interviewees and the children, families and colleagues they are discussing.

Views are offered (in italics below) about the various stages of the serious case review process. This is followed by a consideration of the personal and professional impact of serious case review work and reflections on the process.

The number and volume of serious case reviews

The number and volume of serious case reviews conducted in any single area is likely to affect both the process of the review and its subsequent learning. Most areas held two or three reviews over the two year period, a minority undertook only one while others held as many as six, seven or eight reviews. Staff in areas conducting several reviews simultaneously or consecutively had different pressures from staff in areas which carried out only one or two reviews over the two year period and, in some respects, had a different approach to the tasks.

I think the real sub-text for us all, is precisely how many cases you have on at that particular time, because there is a limit as to how many cases you can learn lessons from in any one go.

The decision to hold a serious case review

The decision to convene the review therefore needs to be understood from within a range of contextual factors. These include the demographic characteristics of the area, the volume of notifications which potentially met the serious case review criteria, and as mentioned above, the number of reviews undertaken recently (Other factors are also discussed in this section).

The decision is made by a serious case review sub committee of the LSCB (or equivalent) which meets regularly (for example monthly or 6-8 weekly), or is specially convened when needed, to discuss whether cases which have been notified as a 'critical child care incident' meet the criteria laid down in Chapter 8 of Working Together 2006. These criteria are not always thought to be easy to apply:

In the previous Working Together it was a much simpler criterion to apply - was there learning to be learned and was it serious enough? In the new Working Together I don't think it is very helpful as it has such complexity to it that it's possible that you could argue that you would do very few now.

In contrast, other respondents thought the criteria were now so broad that it was possible to make the decision to include more cases for review. Deciding whether or not to hold a serious case review is often not straightforward. However some cases, especially where there has been a child death, were deemed easier to determine than others. Sometimes discussions with the Regional Government Office and Ofsted take place to clarify whether the criteria have been met and a review is required. Once a decision to proceed has been reached, a recommendation to hold the review is made to the chair of the LSCB who holds the ultimate authority to convene the review (*Working Together* 2006 s8.11)

Some cases appeared to provide opportunities for specific learning which might sway the decision in favour of convening a serious case review:

It was not a normal case for scoping, the criteria for doing this case were very unusual – we wanted to look at the interface between adult mental health, and children’s services and to find out what lessons could be learned for adult mental health services.

Other determinants prompting a serious case review were a consideration not just with the immediate circumstances of the child’s death (or injury), but with the organisational response. With one case, it was understanding why the ‘*huge network*’ of people involved with the family had not been able to anticipate a teenage suicide:

Often you get that sense of ‘Oh dear we have done something wrong’, but that was not the case in this one. It was more about ‘how could we not have seen all this? How did the pieces not come together?’

Cases which do not lead to a serious case review

Where cases are considered to share very similar circumstances to previous reviews held in the same area, this might dissuade the panel from conducting a review:

If we had a similar case come up again I am not sure that we would feel it worthwhile to replicate the whole process again just to come up with similar lessons. ... maybe we don’t do it all again we revisit the effectiveness of our Action Planning before.

In some circumstances where cases do not meet the criteria for a serious case review, a number of LSCBs have found other means of ensuring that the learning is captured, for example holding a management review or gaining more information:

If we feel that a case does not meet the threshold, but there are lessons that could be learned, we have this multi-agency review process that effectively mirrors the SCR process but is not bound by such tight timeframes and does not get reported to Ofsted, so we would not be quite so obsessive about the processes. So the reports might not be absolutely in the format but we would make sure that we were able to find the information to reach a finding.

Determining the scope of the review, and shaping the terms of reference

‘Scoping the review’ usually takes place alongside the decision about whether or not to hold the serious case review.

The initial suggestion for the scoping comes from the SCR panel; the panel which decides to recommend, it has information from the safeguarding children service and finds out as much as it can about what is known about the family. So the panel make the initial proposal.

Presumptions may be made about which of the *Working Together* criteria take priority so ‘we included the essential ones about learning lessons and understanding where things had gone wrong’. A common approach was to then consider specific themes and issues which emerged from the individual case.

Which period of the child or family’s life to be covered in the review varied from three months to more than a decade. Keeping the timeframe manageable was a key concern.

The chronologies are so massive it is unbelievable and so difficult. However, I do believe you have to have flexibility and certainly now, we will look at a timeframe that makes the panel feel comfortable, whilst making sure we are not missing key areas.

Long time frames make it very difficult to complete the review within the four month deadline required by *Working Together* 1999 and 2006. However, reviews which cover only three months of a child's life will rarely produce anything other than very superficial learning about agency responses. They will also offer little understanding about family dynamics or why the death or serious injury might have occurred.

Practice Note:

Some areas developed ways of keeping the scoping period brief but capturing better information about the family for example through a brief summary of earlier history.

Recently we have said, this is the specific timescale we want to consider, but we will have a summary of relevant historical information outside that....So these eighteen months would be the period where we would be doing the detailed chronology, but we did decide to include summary information with regard to earlier history particularly in regard to the siblings.

Other means of capturing earlier history were by using a 'light touch' chronology until the point when it was necessary to move to a 'heavy touch' chronology.

The agency context and resources

We asked whether agency context and consideration of available resources (e.g. staff sickness or absence) at the time of the death or incident featured in the scoping. This contextual information is not specifically required by *Working Together* 1999 or 2006. In light of this it is perhaps not surprising that terms of reference rarely include the need to establish the agency context or the capacity of staff to carry out their roles effectively. This limits the understanding of factors which contribute to missed opportunities to protect children from harm.

Regarding the terms of reference, in the past we have been a little bit harsh about this because we have never talked about the context in which they were working. For example, if social care were working with a large number of agency people we never allow people to say it was a difficult time. We only allowed them to say looking at the policy and procedures and going through all the issues that we required them to go through, what was the level of competency of your worker at the particular time? Now of course they are wanting us to pursue that context more.

Resources were also an issue in relation to other stages of the review process and crop up again as an issue at various points in the chapter.

The terms of reference (or scoping) might be reappraised at the first meeting after the overview writer has been appointed:

We discussed whether to include a specific term of reference in respect of domestic abuse and decided not to as we felt it was intrinsic in the other terms of reference.

The overview author is well placed to highlight agency context and capacity issues.

Practice Note: A key role of the overview author

The overview author responds to themes that emerge from the single agency reports (IMRs). It is at this point that issues relating to agency context and climate may be brought to light, for example staffing problems in health or workload pressures in children's social care. This information can provide important contextual understanding about why mistakes may have been made:

Because on the one hand we need to deal with the issues and practices, on the other we do not want to hang people out to dry, particularly when we know there are other factors, a context that is affecting performance.

Dealing with blame and blame seeking is discussed later in the chapter.

Commissioning the individual management reviews and the overview author

Once the recommendation to go ahead with the review has been approved, the individual management reviews (IMRs) and overview report authors are commissioned. The emphasis on the quality and independence of the overview author means that the importance of the quality of the individual management reviews (IMRs) is sometimes overlooked.

One of the things I am leading on in the LSCB is to try and sharpen our IMR processes. What I am concerned about is that externally people are talking about having an independent overview writer as though this somehow 'magics' everything to be good. If you have a truly independent overview writer, they are absolutely dependent on the quality of the IMRs and being able, literally, to understand the thinking and the way that different agencies and systems operate.

We have revised how we are doing our IMRs, before if there was information that was missing from an IMR we would go back and ask. Now we are less tolerant and would ask people to re-submit and this is because they will be judged by Ofsted on the quality. This has been a real positive from the new process.

Others thought that the IMRs did not need to be perfect and that too much concern about the detail of the IMR could detract from the learning.

It is a problem detracting from the real learning we are supposed to be getting from the process.

Being clear about the exact definition of an independent author was a current concern for many interviewees who were waiting to see how Ofsted were interpreting the Working Together 2006 guidance in their new inspectorial role. This has been a preoccupation since Ofsted starting grading serious case reviews in 2007/8.

We do not know yet what Ofsted's view of the independent author will be... We have been criticised in the past because of this independence issue. We had several going through at the time when it changed over and you cannot change it when you are part way through. You will not get an 'outstanding' if you have not got an independent author. And this has changed since April (2007). Only two weeks ago we heard that independent means that they must not be on the safeguarding board or any of the sub-committees so basically you just have to buy somebody in from outside.

Achieving this level of independence was thought by some to come at a cost. There was a fear that the overview reports could become formulaic if the same small pool of independent authors completed all reviews.

I think also there may be issues if we adopt the approach favoured by Ofsted - that they have to be done by an external independent person. I think there have to be safeguards to ensure that each review is done afresh since it could become just a formalised way of dealing with things.

Since the Ofsted grading of serious case reviews (from April 2007), the quality of the overview author has taken on even greater significance.

The quality of the overview writer and how you manage that is ...one of the things we are having to grapple with. We have been lucky so far, but I am aware of other LSCBs who have not been so lucky, in terms of having to do repair jobs on some flawed overview reports.

Finding a good overview author who could meet current requirements was a common difficulty. Some LSCBs had a pool of regular report writers but others did not have a steady supply of authors on which to draw.

Time and cost of overview reports

Interesting issues emerged in relation to the time needed to complete an overview report (two to three weeks was the usual amount of time needed) and the payment of overview writers. Some LSCBs were bound by resource constraints and negotiated fees, while others said they would pay what the job demanded and normally paid what they were billed. Payments were sometimes made on an hourly or a daily rate but the total charged for reports tended to be between £5,000 and £10,000 with a few costing more or less. It was acknowledged that this work was very costly and took up a sizeable amount of resources in relation to both money and time.

It is a chunk of budget - particularly when we have not got a budget. But it is inevitable - we cannot get away from the cost and I think people accept in principle that it is right that we should be going to independents. There is no peer commissioning or market for the process to be done. I think there is some kind of interest in getting some kind of reciprocal arrangement whereby within a region or a consortium of authorities people could do reports for each other so that there would not be any cash cost, but I am not convinced that would be seen as independent - but also in terms of people who have already got very busy full time jobs I am not sure how you would free them up for the time needed to do it.

Interviewees were clear that these burdensome costs did not affect the number of cases that go to review however.

Ability to do the work is the most important thing. If you go on the cheap it may be a mess and it may be that you have to redo the whole thing.

When the individual management reviews and overview report are complete and agreed they are signed off by the Chair of the LSCB and (from April 2007) sent to Government Office and Ofsted.

Involvement of family members in the review

Ultimately the only people who know what has gone on in a family are the family members.

The publication of somewhat revised guidance in Working Together 2006, adds extra weight to the earlier requirement (Working Together 1999) to *consider* family involvement.

I think that now this is on the agenda in the latest Working Together 2006. It was not usual or the expectation prior to this.

'Working Together' (2006) guidance for family involvement:

8.12 The Review Panel should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference. Relevant issues include the following:

... How should family members contribute to the review, and who should be responsible for facilitating their involvement?

The interviews revealed differences in the approach to involving family members. Some were struggling either to gain confidence in this process or to overcome the barriers to participation. All could see the moral and practical benefits that accrued from family involvement and for some, the impediments were not thought to be insurmountable.

We think as a matter of principle it is very important that the parents are given an opportunity to say what their view was of the services provided to them. I think they often throw helpful light on what it was like for them; what has been the impact of services and whether they felt that they had been listened to.

Practice Note:

Positive experience of involving families provides tried and tested ways of managing this part of the SCR process. Careful planning and clarity of thinking is necessary to make this work:

The general practice is that someone from the safeguarding children's service and the overview author meets with the family. So two people meet with them, and one takes a note of the meeting and the other leads the questions and the family through the process, and listens to what they have to say. Our general view is that this is not about challenging a family - their view may not be entirely accurate or fair but they have their own subjective experience which we need to listen to carefully as the points they make are often very telling.

Writing letters to family members inviting their participation was a matter of routine in most instances. However there was a range of practices. Lack of response to an isolated letter might be interpreted as lack of willingness to participate whereas in another area a preliminary letter was the first part of providing a wider set of information for engaging in dialogue with the family.

The invitation to the interview is a kind of follow up to a letter that was sent at the very beginning in which we say we are involved in this process and we do say if they want to get legal advice (so, for example, if they are involved in criminal processes). So right at the beginning we set out that we are going to be involved in this serious case process and that the focus is to learn what lessons we can about how the services have been working and that we will contact them in due course and invite you in for an interview. We will follow that up two or three months later with... 'we are now inviting you in'. I know we have only had experience on two or three occasions, but people have been very keen to come and have given useful views and information - not a very complicated process.

Meeting with the family at the earliest opportunity was thought by some to be important as the family's information and viewpoint could affect the progress and shape of the review.

I have actually met with parents on two occasions recently and with both cases, I have felt that it would have been even more helpful to have met with them sooner. Particularly in this case, what they told us would have raised other questions. If we had had those questions at the start we might have progressed in a different way. It was about how they perceived the availability of services, in what way they perceived them to be helpful or not. I think they would have prompted us to ask questions that we did not ask.

Learning from the experiences of the child death overview processes (CDOP) were thought to be helpful in normalising the involvement of family members in these sensitive cases.

It is very difficult, different agencies are trying different ways to try and engage people and now the CDOP process where you tell people what is going on will make it easier because everyone will be told and they will see it as part and parcel of the process and they will feel more included.

Finding ways to involve family members is nevertheless complex and the decision about whether and how to do this appeared to be governed by three key additional factors: ongoing court proceedings, timings (often related to the progress of trials) and perceived family sensitivities. The issue of timing was increasingly in the mind of interviewees as a delay in the completion of a serious case review was perceived to be more likely to incur a lower Ofsted ranking. In some instances this led to non-involvement of family members.

Court proceedings might exclude parents who were witnesses but not other family members who were not contributing to the trial. There may be other reasons wider family members are excluded. 'Family sensitivities' were said in many cases to be the reason why the family had not been asked to participate especially where a child had died.

Not being able to interview parents or other family members, for whatever reason, was a frustration for some overview writers.

I know I could have interviewed this woman, and the man, and it wouldn't be the absolute truth, but I am sure I could have learnt something. Particularly about fear; she was afraid, why did she not take advantage of what was available? I think without that one tends to demonise, to say 'this was just a wicked woman - why bother to talk to them, it doesn't get us anywhere'.

It was clear that although all interviewees appreciated the benefits of involving family members, some LSCBs were more practised and more confident than others in making this happen regularly in serious case reviews. This positive practice needs to be communicated in the form of training and website links, and then to be regularly reviewed and evaluated.

The impact of court proceedings

If family members were involved in court proceedings this compromised their ability to contribute to the serious case review. Ten interviewees discussed the court proceedings' widespread influence over the serious case review process. The final completion of the review paperwork and publication of the executive summary was often held up by a court case, by the wait for the case to finish or even anticipating an appeal after the case had concluded. One person suggested that the serious case review should be kept wholly separate from any court proceedings and asked for clearer guidance for panels.

It raises the thorny issue about whether the SCR is anything to do with the court process or should it be regarded as quite separate. Local authority lawyers are very nervous about infringing on the courts with the implication that you cannot publish something when there are court proceedings still in place. I think there needs to be clearer guidance to SCR panels about when you could regard it as a separate process. You are looking at rather different things. We are looking at the services provided to a family; we are not interested in who caused the death - that is a matter for the courts.

Practice Note: Challenging court proceedings as a reason for delay

Many interviewees were unhappy that the serious case review was thought to take second place to court and criminal proceedings and was seen as being less urgent than due legal processes.

The LSCB has the authority to insist that a serious case review should not be held up, and to assert that the serious case review process is an important part of its safeguarding role.

The presumption should therefore be that the SCR process will go ahead, as planned, and that the review will be published, unless discussions with the Crown Prosecution Service and coroner reveal a cogent reason why there should be a delay.

In the case of an agreed and reasonable delay, negotiations should take place which would allow the action plan to be implemented, as far as possible, even though eventual publication of the report might be delayed.

The agency that requires the delay (for example the Crown Prosecution Service) should provide written reasons for submission to the Government Office / Ofsted.

After the serious case review - monitoring recommendations

There was not general agreement about when the review was 'finished'. Some saw the end as the submission of the paperwork while others viewed this point as the beginning of the learning. Other interviewees said they had never thought about this but acknowledged that clarity would be helpful.

In spite of this uncertainty, almost all interviewees said they had robust tracking mechanisms to monitor recommendations. Boards tended to scrutinise regular updates of the action plan at the serious case review panel, or the quality and assurance sub committee, or a coordinating implementation group. Two areas used a 'traffic lights' approach for the progress of the actions. Actions sometimes extended further into an audit of practice

Once the actions plans have been signed off by the SCR sub-committee the quality assurance team picks off ones to see if they have been embedded into practice. This is done via audits and inspections.

An example was offered of recommendations which were unlikely to be properly followed up because of the multi-agency resource implications.

Although we build review dates into the recommendations we do not get that back. So the action plans should be tracked through that group according to the dates put in on the action plans. I am sceptical that the resource issues are addressed or tracked because as they are multi-agency, it is difficult to know what kind of authority there is to request another agency to provide resources.

Any value from LSCBs spending significant amounts of money at the front end of serious case reviews is wasted, and the object of the review is lost if learning at the later stages is missed because of resources.

One LSCB's good practice example of a 'thematic tool' to plan, monitor the progress and learn from the serious case review is listed in the next Practice Aid box. Further detail about this tool can be found in Appendix 4.

The follow up of recommendations did seem, for the most part, to be tightly structured and managed, but it was acknowledged that this did not prevent the same sort of cases re-emerging.

The only reservation I have is when three years later the same thing happens and you ask, 'why'?

Practice Note: Monitoring the SCR recommendations

Durham LSCB uses a 'thematic tool' to monitor the SCR which is broken down into seven core areas. These issues mirror the key areas raised by the majority of case reviews. These can be added to in order to meet the needs of individual LSCBs.

1. Communication issues
2. Management issues
3. Information sharing
4. Training
5. Practice issues
6. Procedural
7. Performance Manager

As a response to the recommendations, action plans are submitted to the LSCB by the agencies, these are collated into case action plans. The information is also copied into the thematic tool. Each recommendation, corresponding action, deadline etc. is added to the tool under the appropriate theme. For example issues related to the need for procedural changes will be entered onto the procedures tool.

These tools are monitored on a three monthly basis by the Serious Case Review Monitoring Group. One month prior to the monitoring group meeting the thematic tool is sent to LSCB partner agencies with a request that they review the progress of their actions and provide an update using the template. This is collated and presented to the monitoring group in advance of the meeting.

The monitoring group report to Durham LSCB on a three monthly basis.

Completed actions are removed from the active tools and stored in a master copy.

Advantages are said to be as follows:

- If agencies are handling several SCRs over a period of time the use of the thematic tool avoids the risk of any of the numerous actions being mislaid.
- Increases accountability.
- Provides written evidence of progress and completed actions with the facility to monitor deadlines including deferred deadlines.
- Copies of the relevant tools can be given to appropriate task groups to take forward thematic work. E.g. the policy and procedures task group use the Thematic Tool (procedures) as a working tool to prioritise and agree their work programme.
- The master copy allows identification of recurrent themes which helps us understand whether practice is changing as a result of the SCR.

Did the recommendations reflect the learning? Were they SMART? (Specific, Measurable, Achievable, Realistic, Timely)

Most of those interviewed did feel that the recommendations in the review accurately represented the key learning from the case, although some felt they were not all clearly measurable, nor should they be, for example when they concerned the need for attitude change. Most felt that their recommendations were much more 'SMART' than in the past but they were still improving in this respect and this was reflected in changes to the action plans.

I think one of the things we are struggling with is how you make sure that they are SMART without becoming reductionist (a tick box exercise). I think one of the next stages is around that key questioning as to 'what difference has it made?' 'What are people now saying about how they would approach this problem differently?' I think we need to do more work on this. We do check that if managers say they are going to do a workshop that they have done it, that if we say we are going to put it into procedures, that we do and if there is a resourcing issue that needs taking up that someone has done some action around it. What I don't think we check is that we are clear that the outcomes would be different, that there would be different practice and that people's thinking would be different in the way they approached it. That is much harder to check.

Some authors were still making too many recommendations and inevitably, with large numbers of recommendations, not all of them can be acted upon. If recommendations are prioritised, this will aid decision making and review and reduce delay as some can be implemented at once.

If only they would only pull out the key ones. They might have 20 things that they have found, 15 of those might be things that they can deal with quite easily but let's have the 5 big ones. If you are going to get each management review coming out with 20 or 30 thinking they are doing a good job, you have then got your 90 odd recommendations coming to a Serious Case Review Panel. It is extremely hard for the Serious Case Review Panel to try and second-guess which of those agencies' recommendations were the most important. We can challenge them, but it would be far easier if they gave us the ones that they felt needed to be done.

Inconsistency in access to overview report and executive summary

There was considerable variability regarding which groups of people had access to the overview report and executive summary from each review. At the point of completion and final agreement of all the paperwork, the review is (since April 2007) sent to Ofsted and lodged with the LSCB for information. But beyond this there was no evidence of common practice about distributing the overview report and executive summary and learning the lessons. Most areas said the overview report would be available to a senior officer in those agencies which had been involved in the review and it was apparent that some allowed access to the training sub committee of the LSCB to provide a context for drawing up training. Restricted access was emphasised because of the sensitivity of the material in overview reports,

The overview report is obviously a very confidential document so it is not expected that it is photocopied and handed around to everyone in the organisation.

Executive summaries are written with confidentiality in mind so were much more widely circulated and many were available to the public (as is required by Working Together 1999 and 2006) usually through being published on LSCB websites. However, concerns that the case would still be identifiable were often seen to preclude public accessibility, and hence media scrutiny, nor were the family always given access to this summary.

I don't think it (executive summary) was made available to the family directly. I am not even sure that it is on the website, because we are having discussions about another one coming up; the trial is going on at the moment. I don't think we have had a clear enough policy on that at the moment. I think there are difficulties, I know of an example where it was the practice to put summaries on the website and journalists picked it up some years later and went to the family. So it is tricky no matter how much we think we have anonymised these things.

Relationships with the media were mentioned by eleven interviewees and most areas had a clear media strategy. Self scrutiny and, on some occasions, learning seemed to be threatened by media scrutiny which was often perceived as exclusively hostile. Unfortunately reduced access to information could lead to more scrutiny in a vicious cycle.

Well, obviously you have to be careful about confidentiality issues, but in this particular case I think we were very, very self-critical in terms of the analysis that was done and that led to negative comments and negative media coverage especially from the local press.

Dissemination of learning from reviews

There were a number of means of passing on the learning from the reviews. In some instances separate sectors were, on the whole, left to spread the messages among their own staff in the way they saw fit, with little overall coordination from the overarching LSCB.

We struggle with how key messages are disseminated amongst professionals because what we find is - a lot of anxiety builds up when files are duplicated for discussion etc. There is no real de-briefing. What I would like is for the Chair and some members of the panel to meet with the area for social care.... or all involved and say this is what we found.

Most areas offered at least a presentation of findings and learning from the review to senior managers, for example to the safeguarding board and to three local forums. Some areas asked overview authors to provide a number of multi-agency seminars which were publicised and booked in the same way as other safeguarding training. A popular method of disseminating key learning more widely was by offering awareness raising or specific training or 'road shows' on themes that emerged from either a single review or from groups of reviews. One area produced two extensive briefing seminars on vulnerable babies which addressed the way in which agencies work together and respond to a range of family difficulties. The briefings were followed by a document which was widely circulated and included health information about 'how dangerous it is to be between 0 and one year old'.

In areas with large professional populations to serve, these events can be staged on a rolling basis.

We run these several times a year because we have between 40 and 50 thousand people who work with children in the city and we run a rolling programme. It is always more difficult to get messages to the non-big statutory agencies.

In this large metropolitan area when the SCR linked training is offered, we were told that care is taken to ensure that the lessons have an impact on workers who might think that the issues are not relevant for them or do not ring true for their particular post or role.

Other ways of disseminating lessons are formally via emails, or in regular newsletters or through a bulletin of lessons, or a brief report outlining themes and characteristics of a number of reviews. Some of these themes include, for example, substance misuse and parenting, child-centredness, emotional abuse and neglect, and the quality of assessments.

Raising awareness of risk of harm to children through understanding and applying the learning from chronologies was the theme of a workshop in response to one review.

Capacity problems affect training as well as operational work to safeguard children from harm and dissemination from serious case reviews may be susceptible to cuts.

At that time we were producing a bulletin of lessons to be learned from a number of SCRs... The messages would have been included in our training programmes as routine. There is a training coordinator on the safeguarding board and a member on the SCR sub-committee for that reason. I speak in the past tense because we have had some staffing problems in our safeguarding business office so some of those things we had started to do we have not had the capacity to continue.

The impact of being involved in a case that becomes the subject of a serious case review

Involvement of practitioners in the review

Interviews with practitioners and clinicians revealed that they did not feel particularly involved in the serious case review process, "*I felt quite on the periphery*", and anxieties were raised,

... when I came back off holiday, all the records were taken. It was all done so quickly it was strange. It does make you very worried when your records are taken.

Although it was common practice to interview staff at the individual management review stage, we did not find that it was usual to include them beyond this,

Somebody comes in and does a short interview or meeting with the people involved, but then our involvement ends until the outcome is known, so I would prefer more involvement. It is like you advised earlier, (as part of the research) you will provide a transcript for me to check that what I said was what I meant to say and particularly in cases like this where people are feeling emotional about it, if it can be revisited at some point it would be more helpful before the outcome of the SCR. I think having a greater involvement would help the learning process rather than giving the information so many months later.

Few practitioners we spoke to had ready access to the overview report or executive summary even though they had been closely involved with the child or family at the time of the incident and had contributed to the review. Most practitioners would have liked to see the end product of the review, and be debriefed on its content:

So it would have been good to see the executive report to get a sense of the family. Because there were so many issues around (the family) and the fact that the baby died in the care of (a relative) and there were issues about ... her, but she was devastated. It would have been nice to have all that information back.

Another practitioner did see the overview report but was not taken through it or debriefed in any way

No one read through the report with me, I was given a copy to read in the office and had to hand it back after reading it. In hindsight, it would have been useful to have read it through along with my line manager, analysing information together and having reassurance from them, that my ... role and actions at the time, were satisfactory. Generally, I just felt excluded from the whole process.

It was rare for practitioners to be involved in the later stages of forming the recommendations or of implementing them. None of the practitioners felt satisfied with their level of involvement in the review process. Most felt left out and wanted much better feedback and support, and valued this on the occasions when it was provided.

There was panic but I did get support from my line manager and I was offered time to discuss if I wanted to, if I really felt upset. Colleagues gave me support and it was nice to have (the child protection specialist) come and talk to me afterwards. This was not part of the SCR but after the event. She clarified that my records were fine and it was just an issue about documenting discussions around the family with the senior (manager).

Practice Note: involving staff in the serious case review

As we had some real issues around staff morale, I did an IMR recently where instead of going out and interviewing everybody separately and leaving people anxious about what has been said, I did a round robin. I asked all those involved in the case to write up their evaluation of what has happened and then sat everybody around a table and we talked it through. In the sense of finding out what really went on and also in doing it in the least damaging way for the professionals involved, I thought this was a model that worked much better.

The model of serious case reviews proposed by SCIE (Fish and colleagues 2008) may also be an effective alternative approach.

The emotional impact

The interviews, particularly those with the seven practitioners, illustrated the emotional legacy of the work on professionals,

I am emotionally scarred by this.

The word 'devastating' was often used when we asked about the impact of this work. However, understanding the root of the impact is not straightforward and can come from a number of factors, as one respondent explained,

I guess it is in some ways difficult to disentangle how much it has impacted on me because of this particular clinical case,... or because it was a serious case review, ... or because of some of the issues which have arisen from it and how that has impacted on me personally.

The emotional and professional impact on practitioners was not always sufficiently acknowledged.

Although I was an important part of the investigation, I felt that I was just a number in a pot and although I do not feel blamed, I do not think that I was supported through that role, and the impact of it was ever reflected. I would like to see the practitioners involved in the case more involved in the SCR process.

Finally my general thought is that (practitioners) are excluded from the whole process, our actions are scrutinised (which is understandable) and then we're left to get on with it, with little support during the process and at the time the report is published.

Concern that practitioners were not supported through the serious case review process was shared by many LSCB members we interviewed who were deeply involved in, if not responsible for, managing the review process. They appreciated the anxiety caused by the time lag between the event and the various stages of the review and suggested that reviews should be more interactive. An example of how to manage the process better whilst offering support to staff is given below.

The shock of being told and telling

People often talk about the exact moment they are told they have cancer, well I remember in the same way distinctly the phone call I got, which was out of hours (I was on holiday in fact) which was at my sister's house, and a senior social worker phoned to gather information.

Learning about the death or serious injury of a child caused a sense of shock for all involved.

I was just shocked and upset for the baby.

I did get a really big shock because I was so involved with the family unit and I had not even seen the baby. So it did get to me.

I was the one that had to ring up the health visitor and advise her of the death and that was very unpleasant because she was shocked and upset for the family.

The encroachment into ordinary life and people's thinking about their own family was also evident.

The impact on me was that I have got a daughter who at the time was at a similar age. This was anybody's daughter... So yes, I did do a lot of hugging of my daughter.

Because of the profound sense of shock at the time of being told, one respondent suggested that staff who are closely involved with the family should be given a brief period of time away from work to gather themselves. A small number of those interviewed said it was helpful that they had been on leave when they heard about the tragedy as this had enabled them to compose themselves before getting back to the demands of front line practice.

Loss of confidence and self scrutiny

The early professional impact of the case on some practitioners was loss of confidence,

I guess, initially, it made me completely lose all my confidence. It made me question my trust in any of my judgements. I almost started to doubt my clients' histories, and became quite suspicious, although that has improved over time.

All seven practitioners interviewed talked in detail about the process of self scrutiny they engaged in.

...one always goes into a process of self-scrutiny in all these situations ... you look to see what could you have done differently, what could services have done differently and in what way have you acted in any way less well than you should.

For most this included an element of self criticism and personal blame.

You do put some blame on yourself and you are wanting some answers and wondering if it is something you have or have not done.

This can lead to a questioning of everyday practice and professional judgements and a loss of confidence.

I remember thinking that dad came across as a very nice gentleman on the phone and I thought "Goodness, my assessment of people is so wrong".

For all those interviewed, the impact of being closely involved with the case was enduring, and affected individuals differently throughout the various stages of the review, and often the parallel court process too. It was particularly stressful for practitioners who were continuing to work with the family whilst giving evidence in court. For one person the loss of confidence came to a peak during court proceedings.

...whilst the court case was going on it completely knocked my confidence in child protection in general.

For some, the response at the end of a long period of self scrutiny has been to practice more defensively, becoming more risk averse. Others have regained their confidence and built in additional personal and professional safeguards - for example always seeking a second opinion in uncertain paediatric decisions. Some practitioners have not felt the need to be any more cautious and considered that their usual practice, for example of careful documentation, had been vindicated.

Professional Challenge

Building on their restored confidence, six of the seven interviewees said they were determined to challenge other professionals' opinions, even if they were more senior in status, if they felt a child was not safe:

It is every professional's responsibility to say "No, I disagree".

I guess if I am concerned and they are not, I am a bit like a dog with a bone I tend to keep highlighting concerns.

Wherever they sit in the hierarchy, at the end of the day they are just a person. And at the end of the day it is about the child.

All six talked about the importance of professional challenge and gave examples of the way in which they have followed through concerns, and encouraged others to do the same.

I have situations where health visitors tell me how worried they are about children and about conferences they have been to and how children's services do not seem to be addressing it. I continue to encourage them to both document it and take it higher and continue. And, at times, I have had some involvement as well because I think it is very stressful if you are worried about a family and other people are not.

Lord Laming's term 'respectful uncertainty' (Cm 5730, 2003) was thought by some to be a helpful way of thinking about how to challenge colleagues and especially senior colleagues. One interviewee gave an example of the way she and a colleague had recently persuaded a GP to refer a child to hospital and to phone the family to say he had second thoughts about what he had diagnosed and asked the parents to take the child to hospital. She acknowledged, however, that this challenge takes both confidence and training.

I think it is having the confidence and the training to do that and some professionals may not have that. They may not have the same number of updates in child protection, and I think the more SCRs that can be discussed in training the more beneficial it will be.

Professional challenge is also said to be easier in the context of good trusting professional relationships where a disagreement is not seen as a threat, or a slight, or a comment on professional competence.

Practitioner Anger

Some practitioners spoke about feeling angry and this anger seemed to stem from dissatisfaction with the way the family were treated after the death of a child, and from not being personally involved in the serious case review process, including not being involved in deliberations after the initial interview had been completed:

All I kept hearing was snippets of things and (I had) no idea whether they were right or wrong.

Support

Almost all of the practitioners spoke highly of the support they received from their team, or particular members of their team "what helped was just being able to share with colleagues".

I think I have a very, very supportive ... team and none of us are very dogmatic people. We are all people who want to go cautiously, carefully and try and get things right and I think that helps because as a team we are able to look at things together and look at how things happen in other situations and work out a way forward.

When readily accessible support is lacking, practitioners are left isolated and vulnerable

I was peer supervisor for the (health practitioner) and I think she felt quite abandoned by her own agency, I think they work more on their own whereas I do work within a team. She worked within a (health setting) and had her support elsewhere. So did not have the supportive network that I had.

Supervision

The importance, adequacy and frequency of supervision in both health and social care were highlighted in a number of review recommendations and were a feature of many of the interview discussions. One example given, of six monthly safeguarding supervision for health visitors, was thought by the interviewee, to be insufficiently frequent.

When I compare it with the supervision that social workers and the community mental health team have, it is woefully inadequate really for the kind of cases we are holding and dealing with.

What should be included within the ambit of supervision was raised as an issue, for example recognizing that failure to attend health appointments is an important sign that things are not right in vulnerable families. It was stressed that missed appointments should be logged and followed up. However it was pointed out that this has to occur in the context of busy health practices and hard pressed out patient clinics.

Ensuring that staff vacancies and absences are dealt with systematically in supervision was also raised, particularly for health visitors carrying cases where there were risks of harm to children. The importance of a well staffed health visiting service was raised by Lord Laming's Progress Report (2009:58).

Another supervisory and support issue raised was the low level of experience of some social workers carrying out child protection roles.

I know that when I was interviewing social workers and trying to make sense of this, the issue I did focus on was that the person who had undertaken the initial child protection enquiries was not of a level of experience within our expected standards. They were not a level three worker and they were doing child protection enquiries without direct team manager support. So one of the recommendations in the social care section of the report (and it is for social care alone) is about the level of social care worker allocated to a case. Where you have to use a level two worker, then you must supervise that appropriately and not leave them to get on with it.

Informal supervision, group supervision and good team work was also said to have a role in good safeguarding practice and it was important not to have anyone working in isolation.

Although we have clinical supervision on a regular basis, we also discuss as a team any issues around the families we have so that if one is off sick or on holiday we can pick up on that.... we cover for each other.

Practice Note: Supervision

The findings from the interviews highlighted key points to improve supervision. These include:

- the need for regular and sufficiently frequent supervision;
- that key issues are monitored and followed up (including missed appointments);
- that supervision should consider continuity of approach to the family;
- that extra support for less experienced workers should be provided; and
- the creation of a structured sharing of uncertainty in order to reach the best possible response to concerns.

Impact on the team

Most practitioners acknowledged that the case had also had a significant impact on their immediate colleagues but there were different views on the issue of whether the case had affected normal practice in the team. One health respondent thought the serious case review had not affected practice in her team because they had always worked together well, with an individual and a shared case load and were aware of each other's 'problem families'. Another person said that their team did not believe they needed to change their normal practice until the feedback from the review - so in this example learning from the review was crucial in helping the team understand what needed to be different.

Changes made in individual teams included a structured approach to sharing anxieties where clinicians phone a colleague to gain a second opinion on an uncertain case of child abuse. Rather than encouraging defensive practice, this approach allowed practitioners to hold and carry a considered degree of risk of harm to the child (in the child's best interests) rather than routinely admitting a child to hospital to 'play safe'.

.. the easy solution is to decide, if you like, to do everything to everybody, every time. The difficulty is that that suggests there is no harm done that way, but actually that is not true.

The impact of the case on working together and working across agencies

Interviewees were not always certain that the case had made an impact on the way that agencies worked together, particularly between health and social care colleagues:

I still think there are a lot of problems between the different agencies .That has not improved at all; particularly social services liaising with health is a big issue at the moment.

I would like to think it did, but I have no evidence to say it has or it has not. I would hope it would improve sharing information. On the ground floor in my role it is very frustrating most days trying to undertake welfare checks with other agencies, particularly doctors, who do not see our process as an important role. Obviously, they have patients coming in all the time and we ring up for welfare checks and information but we go to the bottom of the pile; but it is always important.

Trust and easy exchange between colleagues within and between work settings is essential for robust safeguarding.

We do have two child protection nurses, one of whom used to be a health visitor and is brilliant, but we do not have a specific children's services social worker attached to the hospital now. This is real shame because it is really handy to be able to say "This is a bit strange let's chat to..." The problem is that it is a minefield in the NHS to try and talk to the people that you really want to.

The dangers of the 'silo mentality' pointed out in the previous chapter were again discussed in relation to the practice at the centre of some reviews.

The panel were concerned that professionals adopted an adult focussed approach and appeared to fail to appreciate the vulnerability and the damaging impact of the mother's behaviour over a period of time.

At a management level, the recent creation of adult safeguarding boards has provided scope for improving the links between children's and adults' services.

The really significant changes relate to the fact that it was a real catalyst for the adult safeguarding board. It was very timely especially as they have modelled their board on the children's board. It was very timely for them to see how things crossed over between the two boards and it was a very good beginning for them.

Reflections on the serious case review process

Reflections on the serious case review process came from two sources: from the interviews and also from written feedback from Government Office regional dissemination seminars. The views of interviewees are presented first.

Not attributing blame

This case was like a witch hunt at one point and this is no way of doing things. It is tough enough without people distorting what you said and did; that is not helpful.

The move away from attributing blame was thought to be crucial to learning, and essential if defensive responses to reviews were to be avoided. This was mentioned by seven interviewees.

I think the difficulty is that there is always so much blame, if it was not seen as somebody's fault all the time it would be so much easier, because if it is seen as somebody's fault there has to be retribution and we will struggle to keep staff.

It was suggested by some that those who were distanced from practice were keener to attribute blame in the serious case review. Casting or avoiding individual blame sometimes served to avoid addressing serious organisational problems like staff absence and sickness.

... let's face it if someone does not turn up to a six week check (i.e. child's first developmental check) then that clearly needs following through but when everybody is on leave and everybody is struggling to carry very large numbers of vulnerable families - that is the nature of the business we are involved in, sometimes things are not quite as they should have been and one of the issues that has been raised is how we can highlight vulnerable families on caseloads so that when someone goes off sick, it is clear which ones we should be prioritising and follow up. Those kind of issues should come out of it, but "Oh this person did it wrong, we're going to get them" kind of attitude, has no place in safeguarding because it does not lead to people being able to share their experiences in a non-judgemental way.

Understanding and using inter acting risk factors

The interacting risk factor approach to making sense of not just complex family relationships and circumstances but also professional involvement seemed to form the bedrock of the practice of some of those we interviewed. This approach helped one clinician to spot the way that a child's needs had been overlooked. It also helped to clarify what should be done next to help the child and the family.

I also became aware of the number of factors that had contributed to the child's needs not having been recognised to that point or not having been addressed at that point. ... I suppose my approach, as it is with any other case, is to look at what the contributing factors are and what factors you can change, that is what treatment you have to do... In my initial report, (my police statement), I kind of recognised that mum's depression as well as the substance use, together with the past difficulties she had faced - in terms of loss of the previous child and various other things that had impacted on her functioning, and in terms of the relationship between her and the father of the older children - were all impacting on her mental state. There were straightforward questions about benefits that she was not getting ... and other things and so that in a sense, it was highlighting all the different things that needed addressing and I could try and help this person function better.

This ecological transactional model of understanding and decision making, as we said in Chapter 1 and in our previous report, (Brandon et al 2008a, especially Chapter 4) is dynamic, interactive and complex. It goes beyond the focus on a single injury or event as this practitioner appreciated.

But actually making a contact, talking to families, spending time addressing and evaluating their responses to the child - all contribute to your decision-making. Making a statement in relation to a particular injury does not take into account other parameters and it is not always a black and white thing.

One interviewee felt that the parents' histories should have been explored more.

When I look back at this family, I think I needed to explore the parental developmental attachment and relationship history in more depth. I was aware of the increased vulnerability factors anyway, but I had only two contacts with dad and I think I should have explored much more his background, and how he was parented ... It's easy to say in hindsight but it is difficult when there is so much to be covering at each visit.

Using an ecological transactional approach with its emphasis on understanding helps to foster objectivity and compassion rather than a potentially vengeful vilification of parents who harm their children. It allows tough decisions to be made to remove children from their parents care and also makes it possible to work productively with parents in the majority of cases when children stay home or are returned home.

I am conscious that there are often situations where things have not been as good as they should have been and sometimes it has dragged on far longer than it should have done before people say "Enough is enough" and out. But equally, I am conscious that the vast majority of children in child protection scenarios, even if they are removed at the time, end up going home and this is subsequently vindicated.

Working with hostility and passive co-operation

Being both authoritative and helpful were mentioned as important responses in the context of family hostility.

The last frontier in my view, in respect of child protection, is the hostile, unco-operative, dangerous family. So far we have demonstrated only too well that we do not know how to deal with this kind of family. We do not know how to be authoritative and helpful and we back off them so they run circles around services.

Understanding the difference between active and passive co-operation, particularly in the context of families without obvious adversities was raised as an important concern.

I think some of the more difficult areas are around recognising the difference between passive and active co-operation. These were quite well-off, polite parents who did not raise people's hackles in terms of being difficult but the difference between that and parents who have a shared understanding about what needs to change is quite an important one. We have talked about it but it is a knotty problem. It is a Baby P problem in that the mother appears to have "co-operated".

The implication of children not attending appointments was raised as an important feature of lack of co-operation particularly in relation to understanding neglect, which had to be addressed more coherently.

There was a general pattern of tightening up following this SCR on children not attending appointments. This was a family with a pattern of not engaging and staff have become more focussed and more skilled when they deal with families where chronic neglect is a feature. It has brought home how these issues can be addressed more purposefully.

Respectful uncertainty was recommended even in the face of overt co-operation.

When a parent points out a bruise they may be asking for help or seeking reassurance. This has now been included in the x Primary Care Trust training.

Thresholds

In Chapter 3, and in our previous study, we linked thresholds and levels of co-operation (Brandon et al 2008a and b). Problems with thresholds were discussed by a number of those we interviewed. For one person this was in relation to thresholds being too high and the key threshold being 'vulnerability' rather than 'significant harm':

I think agencies are having difficulty in coming to terms with the need for early intervention. The threshold is no longer significant harm, it is vulnerability and all agencies have a responsibility to work at that threshold now and not wait for clear evidence of significant harm or risk of it. They need to ask whether there is an indication that the child may need additional services.

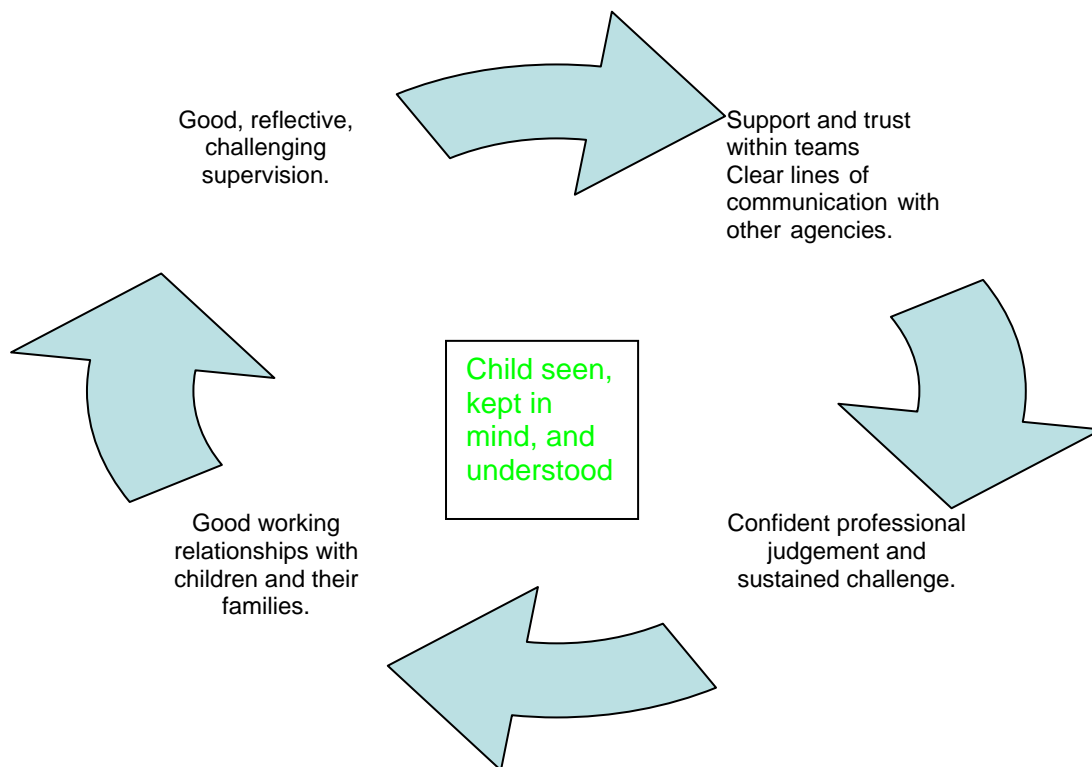
People could argue it is still early days to be achieving things, but I do believe our understanding of the threshold at which we need to be concerned about children needs to change. It is far too high, but the government is pinning its hope on the delivery of early intervention etc. But these things take time to incorporate into the practice let alone embed into the practice so that it becomes the way you work as staff.

Another interviewee identified the problem of switching from a family support to a more coercive child protection mindset once the initial decision had been set.

I think that, in this case, the issue was that it is quite difficult for people to change horses once a case is labelled as family support not child protection. There are potentially very different approaches within wider family support/ safeguarding in its broadest terms where the focus is on support, consent and the more coercive child protection processes. There were critical points in this case where the decision about this was made or could have changed.

The findings from the practitioner interviews prompted a cycle of positive day to day practice where the child is kept in mind, seen and understood.

Figure 12: Positive practice cycle



Views on the serious case review process from the regional dissemination seminars

Nine regional dissemination seminars took place in October and November 2008, at which findings from the Child Death Overview Panel 'Early Starter' Study (Sidebotham et al 2008) and early findings from this Biennial Study of Serious Case Reviews 2005-07 were presented. Feedback was sought from those attending the seminar in relation to two questions posed. Seminar participants were members of LSCBs and other managers and practitioners from a range of sectors. A total of 61 responses were provided from group discussions (groups were approximately 6-8 in number) where participants were asked to discuss and write their responses to two specific questions:

1. What is the impact of being involved in a case that becomes a serious case review on practitioners / clinicians from different agencies and,
2. What are your suggestions for doing a serious case review differently which could help the learning.

The written responses mirrored many of themes which emerged from the interviews.

i) Emotional impact on the practitioners involved

Uppermost in the feedback were comments about the overwhelming and negative nature of being a practitioner in a case which goes to serious case review. Forty-seven of the sixty one groups commented on this. Particular words occurred with some frequency:

Feelings of failure, guilt or being made a scapegoat	21
Fear, anxiety	20
Threatening, threatened	8
Stressful	6
Emotional impact	8

The words 'upset', 'traumatic', 'devastating', 'under scrutiny' and 'vulnerable' were all used at least twice, while the words 'frightening', 'uncomfortable', 'confusing', 'demoralised', 'bruised' and 'panic' were given a single mention in the written feedback. Five groups mentioned the added stress when the media became involved: "*the media wants a scapegoat, but we want lessons learned*".

ii) Impact on practice

'Blame', 'guilt' and 'culpability' were frequently mentioned, alongside a fear that one had let down the child and/or the family: "*what could we have done better?*" These feelings were said to affect confidence and lead to a questioning of judgement, actions and competence. Practitioners would question whether the outcome had been in any way predictable, and what might have been done differently. Four groups mentioned the fear that poor practice might be identified and lead to disciplinary measures, and one response concerned the "*tendency to blame coalface workers, and the management withdraw*".

It was perceived that this set of attitudes was likely to lead to more defensive practice (mentioned by 13 groups) with both individual practitioners and agencies seeking to justify their own practice and actions. There is "*an effect on judgement, which can make people more risk averse*". Defensiveness could spread to record keeping, where the focus can shift to justification.

The review process was said by one group to "*focus on negative aspects of work rather than positives, and can therefore undo all good work achieved, destroy teamwork and reduce morale*".

iii) Isolation and lack of support for practitioners

Another recurring theme from the group comments was the lack of support and supervision of practitioners involved in serious case reviews (8 group mentions), and the need for an immediate support service. Practitioners are likely to feel 'out on a limb' and isolated. There can be a lack of knowledge and understanding of what will happen next in the review process, and a

"period of uncertainty whilst awaiting outcomes; a step into the unknown". "The length of time the review goes on, one is carrying anxiety for a length of time, especially if court case or media involvement".

iv) Capacity issues

A further preoccupation (18 mentions) was the time consuming nature of reviews, the workload pressure they impose, and the unrealistic and tight timescales. The following comments illustrate these worries:

“time commitment, completing on top of the day job”

“length of time causes anxiety and hinders other work”,

“lack of resources to do a good job”.

It is feared that the emphasis on the review, which *“becomes an over-riding priority”* could lead to *“not doing the day job, with the risk of other things being missed”*. The *“unpredictable cost and pressure on the budget”* of a review was also noted.

Staff stress arising from a serious case might lead to illness, whilst it was noted that a case could *“impact on an individual’s career pathway”* or be *“career changing”*. The possible effects on staff retention and difficulty in filling job vacancies were described.

v) Implications for multi-agency working and relationships

A subsidiary theme which emerged from the group comments was the negative impact that the serious case review process could have on relationships between agencies. One group commented that the SCR process *“did not build trust between partners on an LSCB”*, and there was mention of *“splits between agencies and within staff groups”*. Two groups highlighted

“a need for consistency between agencies” and the fact that *“different agencies have different approaches to both internal management reviews and overview reports, and these need to be resolved into a common approach for the SCR process”*. One group noted the *“different cultures in different professionals and organisations about learning lessons or allocating blame”*.

vi) Involvement by Ofsted and Government Offices

Overall disquiet was expressed about the role of Ofsted in serious case reviews and the detrimental impact that this had had on morale and practice. One group noted that *“the links and relationship with Ofsted and the Government Office needs clarity”*. Various groups considered that the marking of reports created stress, and did not improve learning.

vii) Positive outcomes

There were some comments made on positive aspects which can arise from the serious case review process. The process *“could highlight good practice”* and there could be *“a positive impact if the process is handled correctly and outcomes achieved”*.

“Ultimately may be vindication, for example if good practice highlighted - although may be a long process. Can bring positive change.”

viii) Debriefing and learning from serious case reviews

One group in particular centred their comments on the need to handle the debriefing process sensitively, at the independent management review stage as well as after the overview report has been written. They note that *“issues will be different for staff in different agencies, and levels of involvement”*. Another group noted that the debriefing process was likely to re-awaken the emotional impact and bring back all the original anxieties.

When overall learning was considered there were positive as well as negative comments from the perspective of the impact on practitioners:

“Group feedback can be very positive and help to share the burden of guilt”

“Enthusiasm to learn can bring professionals together”

“Knowing SCRs will be graded does not improve the learning

“Process does not lend itself to helping learning - interview, hand over notes, seize files. Doesn't generate a learning culture”

“Shock impact of individual cases sometimes diminishes the impact of the learning”

“In some cases practitioners don't hear and the SCR has no effect”.

Other comments covered the need for lessons from reviews to be disseminated promptly, and for feedback to reach all practitioners and not to stop at middle management.

Suggested changes to the SCR process from the interviews

Interviewees were also asked whether changes should be made to the serious case review process to improve the learning. Many suggested streamlining the process, being more discriminating about the major issues and more specific about what needs to change. Other ideas focused on practicalities or particular aspects of the process like extending timescales, involving practitioners more, having explicit standards for overview and IMR authors. The need for people with specialist knowledge to be involved in the serious case review was emphasized, for example expertise in neo-natal health when carrying out reviews of cases involving very young babies.

Some suggested changes involved streamlining the process, while others entailed more extensive case review work. Some suggested moving away from the emphasis on written material to a more interactive method based on talking.

I think we rely too much on what is written, and we must get behind that and get people to tell us what they think went wrong. We lose a rich vein of knowledge, experiential knowledge.

This could include earlier, more immediate, dissemination, for example,

Maybe something more radical; setting a day aside for all those involved in the case plus somebody else got together in a room and at the end of it someone produced a report that went out the following day might be a radical idea. I know there are many reasons why that is not possible, not least the issues around criminal and coroner investigations, care proceedings that are going alongside. But in some cases a swifter process more akin to de-briefing and learning the lessons would be less cumbersome than the current process, less resource hungry and more effective.

A similar method, designed to include practitioners more fully, was described in a Practice Aid box earlier in this chapter. This 'debriefing' model has potential problems however, and the interviewee who proposed it also pointed out that it requires careful planning. A co-facilitator is needed but care should be taken that the two people directing the day do not join together to 'gang up' on an individual member of staff who may not have performed well. An advantage of this more open method as a replacement for individual interviews was said to be avoiding a one sided perspective.

Some suggested using a similar, systems or critical incident approach,

...bringing people together as a team, rather than doing things in each agency. So you bring together all the key players and construct the chronology together and look at the critical points when things might have gone wrong.

This approach emphasizes learning, preferably before a disaster occurs.

A kind of open systems approach to cases and reviews might create a learning ethos. We do, however, need to create independently of them a learning ethos in our organisations. Some people get on the defensive with SCRs.

The findings from both the interviews and the regional seminars about what goes wrong in the serious case review process can be summed up in a negative cycle - where fear and blame dominate and the child is absent. A positive cycle shows how this can be turned around.

Figure 13: Negative serious case review cycle

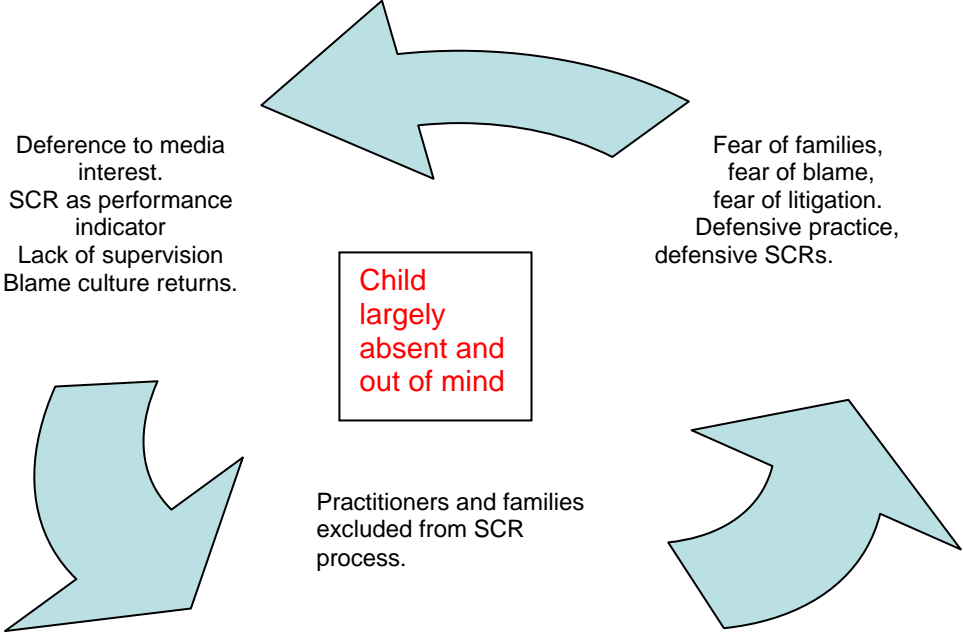
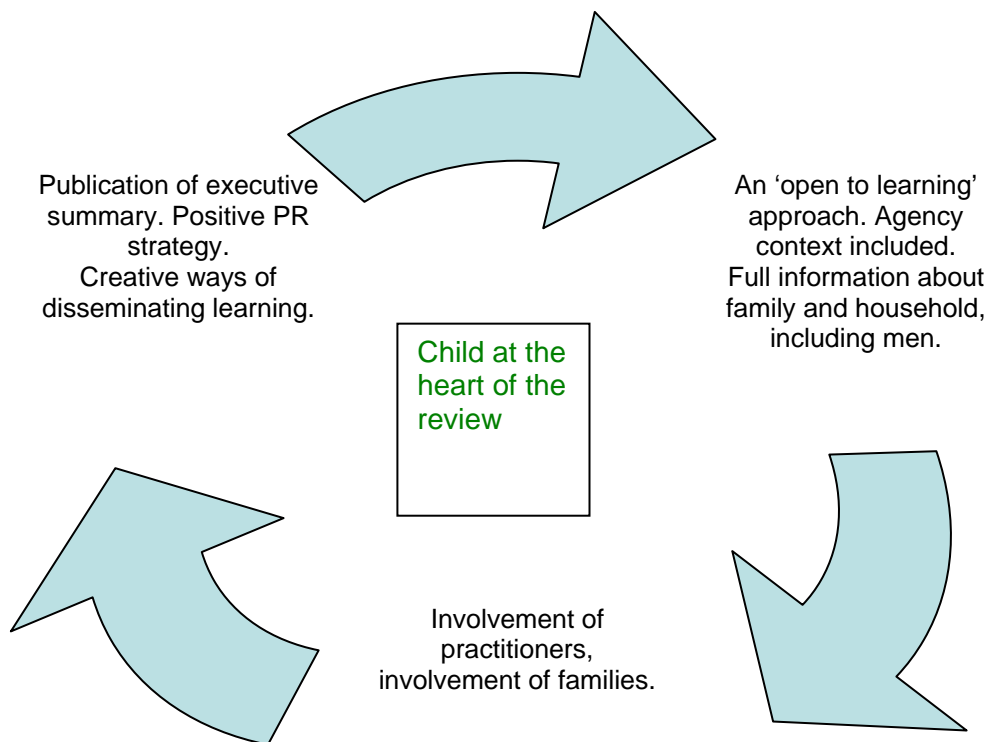


Figure 14: Positive serious case review cycle



Chapter 4: Summary

- This chapter considers aspects of the serious case review process and the impact, for professionals, of being involved in a serious case review. Analysis is provided of 17 interviews with members of LSCBs involved with the SCR process in 17 of the cases from 2005-2007 and 7 interviews with practitioners from health and children's social care who had been involved with the child or family in some of these 17 cases.
- Only two of the 106 reviews undertaken in 2005-2006 were completed within the required four month time scale, which is not a manageable time scale. Six months would be more achievable.
- The interviews provide comments about each stage of the SCR process:
 - Reviews need to be scoped over a sufficiently long period of time to make sense of the child's circumstances and services offered. To save time, early history can be summarised in a 'light touch' chronology.
 - The overview author is well placed to highlight agency context and the capacity of staff to carry out their roles effectively.
 - Ofsted's role was thought to have improved the quality of Individual Management Reviews. But there was some confusion about the meaning and value of total 'independence' of the overview report author and a concern that these reports could become 'formulaic'.

- Family involvement was often common practice and learning from the child death overview processes was helpful in normalising this. Reasons given by some areas for not involving family members included ongoing court proceedings, causing delay, and family sensitivities. Delay caused by court proceedings can be challenged by the LSCB.
 - There were inconsistencies in access to overview reports and executive summaries.
 - Embedding the learning in practice was taken seriously. Examples of positive practice in monitoring recommendations and making them achievable were given. Dissemination of learning included briefing seminars, training events, newsletters and bulletins or brief reports outlining key issues. Capacity problems affected training and in some areas dissemination activities had been cut.
- The impact of being involved in a serious case review was profound and long lasting. Loss of professional confidence was an early impact but most practitioners / clinicians recovered their confidence and were able to challenge others' decisions if they felt a child was not safe. Good support was valued. Practitioners did not feel adequately involved in the serious case review process or its subsequent learning. Interviews with practitioners produced a cycle of positive practice with families where the child was clearly kept in mind.
 - Views from participants at regional dissemination seminars reinforced the interview findings.

Chapter 5: Understanding and Protecting Children

This report has explored the way in which serious case reviews can help us to understand more about the children at the centre of the reviews, the families they were living in and professional interventions to protect them. The findings from this study have implications for policy, for day to day practice and for conducting better serious case reviews. The ecological transactional perspective has shown us again how complex and multi-faceted the cases are which makes interpretation of the findings equally complex. Careful interpretation is needed since these reviews are not necessarily typical of safeguarding practice and it is important to avoid making unfounded predictions and claims. This chapter brings together and triangulates the analyses from the separate parts of the study to consider some of the key inter-acting risk factors that emerge and links them to current debates about protecting children. The implications of these findings are applied to the content and process of serious case reviews, to policy and to practice with children, young people and their parents and carers. Finally, we address the implications for alternative approaches to research into child protection practice and serious case reviews.

The timing of the publication of this study means that its findings will inevitably be considered alongside the many reports and enquiries into the death of Baby P (whose serious case review does not feature in this analysis as it is outside of the time frame). Children's suffering is very hard to bear. Public sorrow at Baby P's death expressed itself in anger and outrage and the need to cast blame. It is important however, that policy makers and those in the front line of services adopt a calm, contained and measured but compassionate response to child death and serious injury through abuse and neglect.

When things went wrong, the practitioners and clinicians interviewed for this study also reported being shocked, upset and distressed by the fate of the children with whom they were working. They had needed to find ways of making sense of what had happened and also of living with these feelings of distress in order to carry on their day to work both with children and families and running services. The calm reflection and measured responses of those we interviewed allowed them, in time, to practice with renewed confidence.

Using the ecological transactional perspective to understand

We have continued our use of the ecological transactional perspective from the 2003-05 study to understand what is happening in families and also to understand the inter-action between families and workers. The approach helps to explain what drives and triggers parents' responses and their behaviour. We explained that the ecological transactional perspective requires a dynamic, not a static understanding and assessment of children and their families. Central to this approach is the need to take account of carers' experiences of being parented themselves and the history of their own relationships with family, peers, partners and professionals. All of these dimensions of experience influence carers' sense of themselves and how they see others. Parents' and carers' emotional histories, cognitive models and current life stressors, like poverty, domestic violence and ill health, affect their states of mind and the way they understand and interpret the needs and behaviour of any children in their care. The past, present and future need to be understood through this lens. Understanding will be limited if this does not happen, as one of our interviewees explained.

I think I needed to explore the parental developmental attachment and relationship history in more depth. I was aware of the increased vulnerability factors anyway, but I had only two contacts with dad and I think I should have explored much more his background, and how he was parented ... It's easy to say in hindsight but it is difficult when there is so much to be covering at each visit.

Practitioners and their managers are also affected by the demands and stresses of everyday work with children and families. The way that services are offered to children and families and the way that support and supervision are provided to staff also needs to be considered from within this perspective.

A dynamic ecological explanatory view of parent-child interaction which takes account of environmental and cultural factors *and* the links with workers and services should allow practitioners to spot warning signs of maltreatment at an earlier stage, based on less information.

Practice Note:

A key message from this and the 2003-05 study is that it is what is done with information about children, their families and the environments in which they live, rather than its simple accumulation, that leads to more analytic assessments and safer practice.

Understanding the children

In this, and the 2003-5 study, the youngest pre-school aged children, and especially the babies, were the most vulnerable to death from abuse and neglect. Two thirds of the 189 children were aged under five (in keeping with the previous study). These young, developmentally vulnerable children are wholly dependent on their carers for nurture and survival. Physical assault was the single highest cause of death or serious injury for these young children, but physical neglect and the failure to take care of the needs of these highly dependent children also occurred most often for this group. Even amongst those dying of serious injuries, issues of neglect were often present as well, and neglect was the commonest pre-existing factor in those children or siblings who were previously known to children's social care.

More than a third of the children (for whom we had this information) were born early or with complex health needs and one in six had a known disability. These factors make children harder to care for and from an ecological transactional perspective add to the risks of suffering significant harm.

While the youngest children are the most vulnerable to death from abuse or neglect, the next most vulnerable group were adolescents (who made up almost a quarter of the 189 children). Adolescents have also been influenced by the caregiving they received and carry the legacy of early rejection and maltreatment with them. Most of the older adolescents in the study died, many from suicide. The group of 'hard to help' young people neglected by agencies, who emerged in our 2003-5 study, were also apparent in this study and shared the same profile of long agency involvement and years of high intensity services. As last time, these young people might have been amenable to help if they had been offered the right approach. Some young people were seen as a nuisance and not easy to work with. These young people may be at risk of harm from themselves and from the environment they find or put themselves in, often as a result of past maltreatment, or untreated mental health needs. Many children who have suffered abuse and neglect go on to suffer further maltreatment, which is a chronic condition for many children, and has lasting effects (Hindley et al 2006).

There is less public concern however, on behalf of the vulnerable adolescents who feature repeatedly in serious case reviews and homicide statistics. Evidence from this and the 2003-05 study shows that their needs and distress have often been missed or have been too challenging, or expensive for services to meet. This suggests a level of 'agency neglect' of

this vulnerable group of young people, many of whom are on the cusp of adulthood (Stein et al 2009). A high proportion of these young people will have had similar damaging early experiences to Baby P.

The way that children of all ages were able to slip from view was a powerful theme of this report (and many other studies of serious case reviews). Seeing the world from the child's point of view and understanding the risks of harm he or she faces, is dependent on front line staff getting to know the child. Many of the young people at the centre of the review, (particularly the 47% not known to children's social care) were not well known, or no longer well known, to any professional. Some children were not even known at school (other than by reputation) because of numerous absences or exclusions (almost half of the children lived in highly mobile families who moved frequently). Knowing the child and understanding their viewpoint and their circumstances requires a relationship to be established, which should of itself be helpful,

...the more you try to see the world from the child's point of view and the safer you make him feel, the better his behaviour is likely to be and the more likely you are to find ways of further improving it (Perry and Szalavitz 2008:245).

A starting point is to have a sound understanding of the child's day to day experience of life at home (or wherever they are living) but this is not possible without first seeking to discover what the infant, child or adolescent thinks and feels, as a person, not just someone potentially 'at risk of harm'. Being interested in what happens in the child's day, and what life is like at home helps to understand the child, or infant, as a real person. (The HOME Inventory, published to support the use of the Assessment Framework focuses on the child or young person's experiences in the home environment that are relevant to their development. Use of the HOME Inventory takes the child and their primary carer through what happened in a specific day [Cox and Walker 2002; Cox 2008]). For older children and adolescents who may no longer be living in their birth family, it is crucial to understand the legacy of early experience at home and the impact this has, for good or ill, on their daily lives.

Understanding the families

The chaotic behaviour in many families was often mirrored in professionals' thinking and actions so that both families and professionals failed to take account of the needs of the child. In many cases both families and professionals were overwhelmed and had low expectations of what could be achieved. Efforts to think the best of parents made some professionals reluctant to judge a parent's behaviour as harmful to the child. Fixed views about the family and about men (for example, as all good or all bad) made it difficult to incorporate information about new risks of harm to the child into thinking and action.

The information garnered from the reviews revealed that where a child was being hurt or neglected, the relationships around that child were often abusive as well (Gardner and Brandon 2009:178). Almost three quarters of the children in both this and the 2003-05 study had been living with past or current domestic violence and or parental mental ill health and or substance misuse – often in combination. Some of the reviews showed, in retrospect, that apparent co-operation was feigned, and that parents and carers withheld the truth and were not willing or able to protect the child. Each family member may have their own version of the truth and pretence in order to placate a violent partner or conceal substance misuse. This behaviour/way of looking at the world can become habitual. Patterns of co-operation are difficult to detect in day to day practice but workers need to be alert to looking for patterns and to the fact that a parent's behaviour can change rapidly, especially if a new partner joins the family.

The degree of compulsion afforded as part of a child protection plan (17% of children were the subject of a child protection plan), or even a care order does not, of itself, always protect the child. There are tools which can be used alongside the Assessment Framework (Department of Health et al 2000) that can help workers understand the neglect the child is experiencing (like the Graded Care Profile, Strivastava et al 2003) or understand more about strengths and risks of harm in the family like Signs of Safety (Turnell and Edwards 1997). But these tools cannot detect feigned compliance; professional judgement, good supervision and a skilled use of multi-agency expertise and knowledge are essential.

Reluctant parental co-operation and multiple moves meant that many children and families went off the radar of professionals. Sometimes hostility or missed appointments led to a withdrawal of services and less oversight of the child. Hostility is not necessarily unchangeable and can be modified by positive engagement skills from staff so that a good relationship can be established. A good relationship is crucial to helping children and families but we found that good parental engagement could blind practitioners to risks of harm to the child.

'Respectful uncertainty' (Cm 5730 2003) needs to be part of a practice mindset alongside rigorous, systematic thinking and analysis. Practitioners need to pool specialist expertise and be more alert to the way in separate factors (poverty, temporary housing, child disability or ill health, domestic violence, mental ill health etc.) come together. This was illustrated well by one clinician we interviewed who thought and practised in this way.

I suppose my approach... is to look at what the contributing factors are and what factors you can change ... I recognised that mum's depression as well as the substance use, together with the past difficulties she had faced - in terms of loss of the previous child and various other things that had impacted on her functioning, and in terms of the relationship between her and the father of the older children - were all impacting on her mental state. There were straightforward questions about benefits that she was not getting ... and other things and so that in a sense, it was highlighting all the different things that needed addressing - and I could try and help this person function better.

A deeper grasp of parents' and carers' states of mind and the way they understand and interpret the needs and behaviour of their children provide important clues about whether they can or cannot keep them safe (Howe 2005). The parents' current behaviour, history and the way they think and feel, need to be understood in order to grasp *the meaning* of the child to each parent (and to other people living in or regularly visiting the household). What was this parent's own experience of childhood and relationships – do they feel loved and loveable or do they unrealistically expect the child or baby to make them feel loved and worthy? Does the child, instead, make them feel angry and disappointed? Does the baby's crying or the toddler or adolescent's tantrum make them feel threatened, frightened, or powerless? (Howe 2005, Finkelhor 2008).

Understanding the workers

One of the greatest lessons I've learned in my work is the importance of simply taking the time, before doing anything else, to pay attention and listen. Because of the mirroring neurobiology of our brains, one of the best ways to help someone else become calm and centred is to calm and center ourselves first - and then just pay attention' (Perry and Szalavitz 2008:244-245)

The mirroring that we discerned between families and workers' behaviour in chaotic families is recognized in psychodynamic theory (Mattinson 1975) but also in brain science, which is increasingly used to inform work with children as Perry and others have shown (Perry 1997, Batmanghelidjh 2006). Practitioners need the time to be able to become calm and to get to know the children they work with. They also need the knowledge to be able to understand the child and make sense of complex family dynamics and circumstances. This has been recognized in Lord Laming's Progress Report.

...ultimately the safety of a child depends on staff having the time, knowledge and skill to understand the child or young person and their family circumstances" (Lord Laming 2009:10).

Time is also essential if workers are to pay attention to their own responses and practice thoughtfully. The capacity to understand children and their families and the ways in which children are suffering or likely to suffer significant harm requires clear thinking. Practitioners who are overwhelmed, not just with the *volume* of work but by the *nature* of the work, will struggle to think, understand and make good decisions. The measures Lord Laming recommends being put in place to help staff deal with the emotional demands of child protection are an important recognition of the impact of the work on practitioners. He acknowledges that this support will need the infrastructure of "*a system of good line management that is creative, empowering and sensitive to the individual needs of frontline staff*" (Lord Laming 2009:20).

Yet Lord Laming also recommends new performance indicators for child protection and this proposal has been endorsed in the Government response to his Progress Report (Cm 7589 2009). There will always be a tension in balancing sensitivity to staff needs with high standards of delivery measured by performance management targets. Outcome measures and targets can impinge on good, safe practice with children (Henricson 2007, Cooper et al 2003). There will always be issues of availability, prioritisation of services and budgetary restraints which have an impact on staff's ability to stay focused and recognize and understand the dynamics of maltreatment.

Because working with children and families is difficult and stressful, practitioners need to work in safe 'containing' organisations that allow them to be curious and encourage them to puzzle over what is happening in families. Organisations need to deal helpfully and supportively, not defensively, with the complexity of practice and decision making. Ruch makes a good case for reflective practice which offers a response to cases, like many of the case reviews in this report, which can appear confusingly 'similar yet different'. Reflective practice:

acknowledges the uniqueness of each individual and practice encounter and the diverse types of knowledge required to address the complex issues these encounters generate (Ruch 2007:660).

Ruch contends that such practice combines an acknowledgement of complexity, uncertainty and risk with an emphasis on the importance of technical-rational knowledge and bureaucratic systems for effective interventions. Reflective practice does not provide child specific knowledge or research evidence, although it does help to make sense of interactions between the practitioner, colleagues and families. It is also compatible with other overarching perspectives like the ecological transactional approach we advocate. Many are suspicious of an emphasis on theory and feel that action is more important. Yet without a clear theory to organise and make sense of complex circumstances and relationships, action may be ill thought through. Information on its own, without analysis will not make sense. Without a guiding theory and firm knowledge base analysis may be avoided, deferred or flimsy and superficial.

Having confidence in a theoretical framework, for example an ecological transactional perspective, helps practitioners (and managers) to be more aware of how factors are playing out in family and child dynamics and dynamics between professionals and families. Thinking critically and systematically helps to avoid potentially dangerous over-reaction. As we have said before, it is essential that professionals are alert to the way in which difficulties *interact* if they are to understand the child's experience of day to day care and have a better appreciation of how harm might arise, and not just in children's services. (For example to understand the impact of the demands of a premature new baby, on a substance misusing mother with mental health problems and also on her new partner who has a history of domestic violence.)

Supervision

Effective, regular supervision that concentrates on the dynamics of practice and the worker's emotional responses is crucial, and not just for social workers. To be effective, supervision cannot be restricted to management performance targets. This is recognised in Lord Laming's Progress Report, in the Government's response to his progress report and in plans for supporting newly qualified social workers. The supervision needs of those in health and education and the children's workforce generally, also require a degree of priority. Working with children and families is complex and demanding for everyone. If safeguarding is 'everyone's business' then all those working with children have a right to good, accessible, supervision at all levels of intervention.

Findings from the interviews with practitioners and LSCB members highlighted key points for improving supervision for all those working with children.

Practice Note: Supervision

- the need for regular and sufficiently frequent supervision;
- that key issues are monitored and followed up (including the child and family missing appointments);
- that supervision should consider continuity of approach to the family;
- that extra support for less experienced workers should be provided; and
- the creation of a structured sharing of uncertainty in order to reach the best possible response to concerns about a child.

Training and multi-agency working

The importance of on going training was similarly highlighted in reviews and in the interviews. The tendency towards 'silo practice' that we found, where professionals preferred to work within the comfort zone of their own specialism, underlines the importance of joint child protection training. This should continue to be offered not just for those working with children but also to the adult workforce and any groups of workers coming into contact with children and families. The introduction of adult safeguarding boards was suggested as a helpful way of sharing knowledge, information and awareness between adults' and children's services.

We found a number of difficulties and potential hazards in multi-agency safeguarding work. Practitioners were often under the impression that others or 'someone else' was keeping in contact with the family or doing the essential task of seeing and speaking with the child. Professionals' working together can be tentative with the perceived responsibilities and priorities of separate agencies overshadowing the safeguarding responsibility. Lord Laming noted the way that co-operative efforts between agencies dwindle when services and individuals are under pressure (Lord Laming 2009:37). The 'respectful uncertainty' needed in work with families is also required in multi-agency working where challenge of other professionals' opinions or judgments may be necessary. An organizational climate which supports and encourages sustained professional challenge is essential if the difficult tasks of recognising and responding to harm to the child are to be more effective.

Understanding the serious case review process

The content of serious case reviews

Most of the serious case reviews we scrutinised failed to provide enough information to achieve a clear understanding of the case and the incident which led to the child being harmed or killed. Unless more information is provided about the child and his or her family, their environment (for example the impact of living in poverty) and relationships and behaviour within and beyond the family, it will not be possible to understand *why* the child was seriously harmed or killed. Without this understanding there is limited benefit to be gained from carrying out a serious case review. Political sensitivities sometimes precluded the inclusion of good information about the agencies' context and 'climate' and whether the separate agencies had sufficient staff to safeguard children effectively. Service provision and inter-agency working cannot be fully understood in isolation from a proper ecological analysis, not only of the case, but also of the agencies' climate and capacity.

Policy note:

Serious case review overview reports should specifically include quality background information about the child, the family and those in the child's household as well as detail about the agencies' capacity and climate.

The serious case review process

The reasons uncovered for widespread delay in the serious case review process reflected similar struggles that practitioners and managers were facing in working with children and families. Low levels of resources and capacity made it difficult to find the time and the right personnel to complete the reviews. The complexity of the cases made it difficult to gather and make sense of the information. The sustained professional challenge that was often lacking in practice was reflected in the LSCBs' reluctance to set out protocols for challenging court proceedings or other institutional processes as a valid reason to delay the review. The

same problems of understanding what could or couldn't be done and uncertainty about the boundaries of confidentiality were as evident among those driving the serious case review process as they were in multi-agency practice with children and families.

In spite of these apparently intractable problems, many interviewees said they were becoming more confident about the way their own areas carried out reviews. They were keen to share good practice from various stages of the process; ways of scoping the reviews to make them manageable but not lose the story of the child and the parents and ways of involving families to be able to understand their versions of the truth about how they used services. Many could also pass on tips about how to track action plans systematically; they could discern the essence of what was learnt from each review and explain how the learning had been passed on to others via roadshows or briefings or through the distribution of pamphlets and fact-sheets. The many interviewees who voiced growing confidence about these reviews were also able to give concrete examples of ways of improving both the process and the learning.

The risk of a return to defensive practice in serious case reviews

We were told that this goodwill and enthusiasm in the face of considerable challenges risks being eroded. The study provided evidence for the potential for a retreat into a blame culture and defensive practice in carrying out serious case reviews. This was largely attributed to the need to obtain a good Ofsted grading. Although the greater degree of scrutiny and the expectation of a higher standard of reviews were said to be producing improvements, there was also evidence from interviews and regional seminars held in autumn 2008, that the Ofsted Inspection systems were contributing to an incapacitating drop in staff morale. This was coupled with a concern from interviewees about the prospect of a slide into formulaic reports that will pass muster with the Inspectorate. These are worrying developments. If a target driven culture risks undermining thoughtful child centred practice, it can also threaten effective serious case reviews.

A number of changes to serious case reviews in the revised edition of *Working Together* have already been outlined in the Government response to Lord Laming's progress report. Suggestions from those who contributed to this study can be considered in these revisions and can also form part of a longer term study of the best ways to conduct these sensitive and difficult enquiries.

Policy / Practice Note: changes to serious case reviews

- The four month time scale for the completion of reviews is considered to be too short and not to be manageable. A six month timescale would be more achievable.
- Reviews need to be scoped over a sufficiently long period of time to make sense of the child's circumstances and the services offered. To keep within a reasonable timescale, early history can be summarised in a 'light touch' chronology.
- The overview author is well placed to highlight agency context and the capacity of staff to carry out their roles effectively. The overview author can also request that Individual Management Reviews which do not include sufficient information, for example about men in families, are revised.
- Reasons given by some areas for not involving family members included ongoing court proceedings which caused delay. Reviews should be more actively managed by LSCBs and delay caused by court proceedings should be challenged.
- No practitioner interviewed in this study felt adequately involved in the serious case review process. The learning must start with these practitioners.

Serious case reviews and prediction of death or serious injury

The lessons arising from serious case reviews are intended to inform the future management of child maltreatment, where possible to prevent mistakes so that cases do not 'go wrong' and children do not die or suffer serious injury. However, the lives of children which are illustrated in this study (and in the 2003-05 study) are the reality of life for very many vulnerable children. The majority of children seen by a social worker for an initial assessment, by a paediatrician for a child protection assessment (and even for emotional and behavioural disturbance), and by a health visitor for enhanced visiting, will share some or many of the background factors of children and young people in this study. These include living in families with domestic violence, drug misuse and mental ill health where the child's needs are subordinate to the adults'; living in families where there is partial or poor engagement with services and professionals; experiencing frequent moves and changing relationships between caregivers; living with a disability or with unrecognized and untreated mental health needs. These factors are all identified as being important to record in a core assessment. As in the 2003-5 study, these difficulties echo many of the key indicators for the recurrence of maltreatment (particularly where neglect was known to exist) which were not seen or acted upon with sufficient urgency (Hindley et al 2006).

Many of the factors which present a risk of maltreatment and adverse outcomes for children (Gilbert et al 2008, Cabinet Office 2007), will be present in the lives of a proportion of children below the threshold for services from children's social care (47% of the 40 children's cases we studied in depth were receiving level 1 or level 2 services at the time of the incident which prompted the serious case review). These will include children attending well baby clinics, SureStart nurseries or other early years provision and in any teacher's class. It is important to reiterate that these are not risk factors which predict *death or serious injury* but they are (especially in combination) risk factors for maltreatment and emotional harm, where child death or serious injury is always a possibility. Recognising these risk factors is an important step in helping and protecting children at all levels of intervention. This is acknowledged by Lord Laming and in the Government response to his Progress Report:

It would be unreasonable to expect that the sudden and unpredictable outburst by an adult towards a child can be prevented. But that is entirely different from the failure to protect a child or young person already identified as being in danger of deliberate harm (Lord Laming 2009:3).

The largest proportion of serious case reviews in both the 2003-05 and 2005-07 studies concerned cases of physical assault and many of these children were not known to children's social care. These may have been isolated acts of violence and may have been unpredictable, but the factors which clustered to make this violence possible, or even likely, were often present. There is mounting evidence about the presence of domestic violence in these families. The risks of harm for very young children associated with repeat attendances at Accident Emergency services and /or hospital admissions that we found in both studies are being reinforced by evidence from larger population studies (González-Izquierdo et al in press, Woodman et al 2009).

It is difficult to determine the extent to which serious case reviews are predominantly made up of cases of sudden and unpredictable outbursts. This will always be a challenge since the cause of the child's injury or death is often very difficult to discern. Different categories of child death, for example those explained in Chapter 2, will always be imprecise, not least, because the *motivation* of the parent or carer who harms or kills a child is unknown. What we do know, however, is that the distinction between the profiles of children with known risks of harm (for example those who are the subject of a child protection plan) and those without these acknowledged risks of harm (children not currently known to children's social care) is not straightforward. The evidence from both the serious case review studies (2003-05 and

2005-07) shows that many children not known to children's social care are living with high levels of vulnerability which can quickly tip into high risks of harm. Staff working with these children, are often carrying high levels of anxiety.

Further research possibilities

We emphasised in Chapter 1 that a study of serious case reviews is not a study of typical safeguarding practice and that more needs to be known about routine child protection and safeguarding work. In order to be clear about the extent to which serious case reviews are, or are not typical of safeguarding practice, it would be helpful to compare serious case reviews with matched cases with a similar profile but with a different outcome. Investment needs to be made into this type of research which may also provide better examples of positive practice and what makes the difference in prompting better outcomes.

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Appendix 1: Methodology

Phase 1 - identifying the serious case reviews

It was not always clear from the 'type of notification' section on the database notification reports whether or not cases had progressed to become a serious case review. The initial task of the researchers therefore was to devote time to scrutinising all 464 reports to ascertain whether a SCR had in fact gone ahead. This involved careful reading of case outlines and progress updates in order to establish what decision was reached.

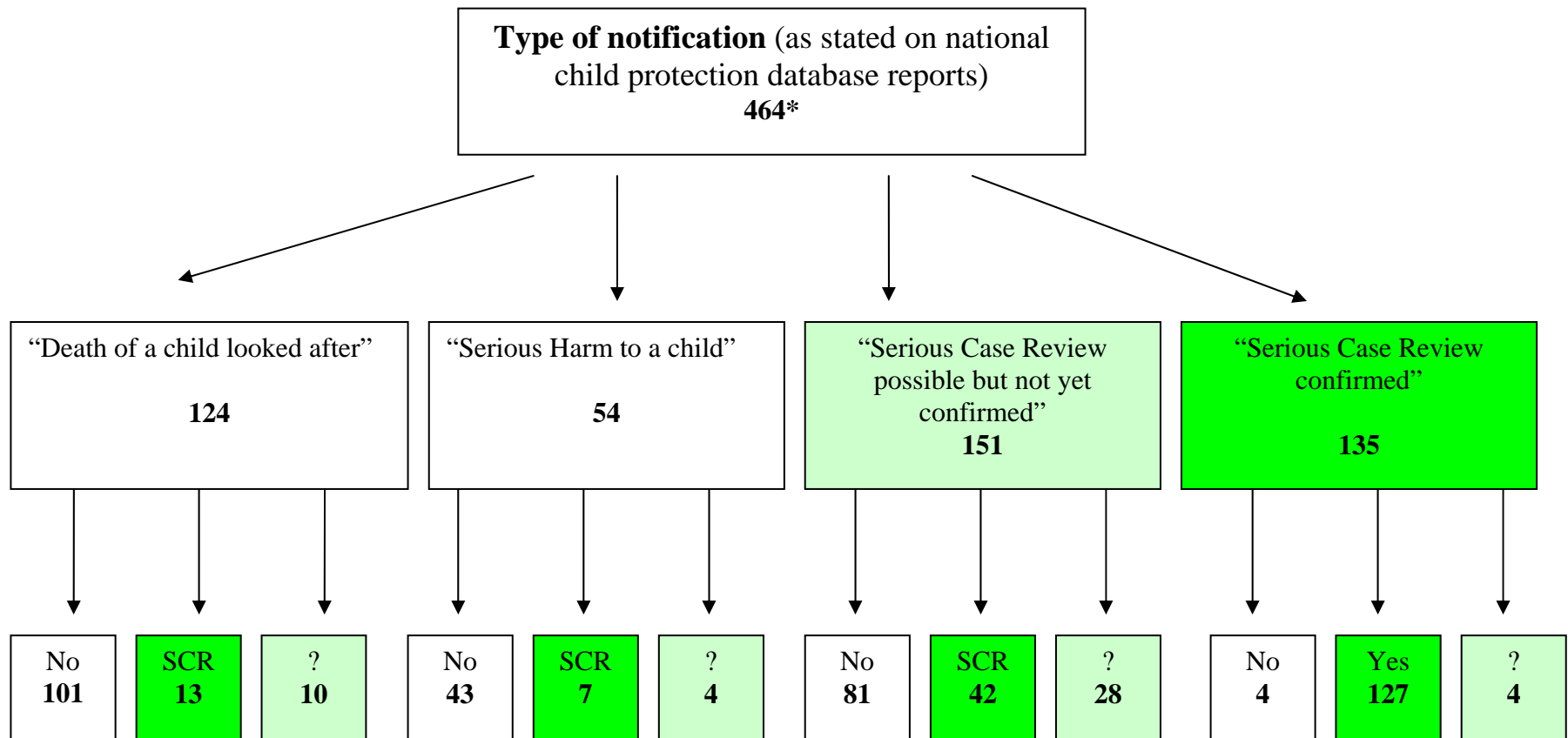
The database contains four types of notification of a 'critical child care incident' ('death of a child looked after', 'serious harm to a child', 'serious case review possible but not yet confirmed' and 'serious case review confirmed'). All four types of notification were found to produce serious case reviews, as shown in the flow chart on the following page. This flowchart lists the numbers in each of the four types, with the shading in the second and third row demonstrating which notifications went on to become a serious case review, as illustrated by the figures in the dark green boxes. The researchers judged that 189 of the cases led to a serious case review.

This task of identification was complicated by the fact that:

- In a small number of cases (4) serious case reviews were recorded as 'confirmed', but had not gone ahead.
- The four categories used on the database notification reports are not mutually exclusive. Thus, 'SCR confirmed' / 'SCR possible' categories can also include cases of 'Death of Children Looked After' or 'Serious Harm to Child'.
- A total of 46 cases were 'still to be determined'. This indicated either that the decision to undertake a serious case review was pending or the information on the form had not been updated/was unclear. This occurred most often for notifications in the last quarter, from January to March 2007 (when 21 of these 46 cases whose status was unresolved or not updated occurred).

Appendix Table A1: SCR undertaken, by Quarter

Quarter	SCR undertaken			Total incidents
	No	Yes	Still to be determined	
Apr 05 - June 05	27	20	4	51
Jul 05 – Sep 05	25	25	4	54
Oct 05 – Dec -05	33	31	2	66
Jan 06 – Mar 06	35	30	4	69
Apr 06 - June 06	26	19	1	46
Jul 06 – Sep 06	32	20	3	55
Oct 06 – Dec -06	31	22	7	60
Jan 07 – Mar 07	20	22	21	63



*13 additional reports were excluded from analysis. These comprise 10 instances where multiple reports related to a single case. Where separate reports had been made for a number of siblings, the youngest sibling was selected as the ‘index child’. In addition, there were two duplicate forms and one test case.

One of the criteria for a notification to the child protection database is the death or serious injury of a 'Looked After' child (indeed it is a statutory duty to notify Ofsted (prior to April 2007, and for the cases discussed here notification was to CSCI) of the death or serious injury of a child who is looked after by the local authority). Many of these sad occurrences were reported as accidents or deaths of children with life threatening illnesses. For the purposes of this analysis, where there was no indication that a serious case review would have been applicable, these cases of death/injury of a Looked After child through accident or natural causes were excluded (76 such cases were removed). This left 153 cases which could, potentially, have led to a serious case review. The analysis also excluded 46 cases where it remained unclear whether a serious case review had been undertaken.

The interviews reported in Chapter 4 also shed some further light on the difficulties of deciding whether or not a notification meets the criteria for a serious case review.

When the database reports were scrutinised to discover which notifications became a serious case review, researchers were struck by the apparent similarity between many of the 'SCR confirmed' and the 'no SCR' cases. For this reason comparisons were made to further test whether the cases that were converted to a serious case review differed from those that did not on basic characteristics of the age, gender and ethnicity of the child, and whether the incident led to death or serious injury. The comparison was also undertaken to help inform the interview stage of the project, reported in Chapter 4, which sought (in part) to explore why certain cases become selected for a serious case review.

There is some indication (although not statistically significant) that more notifications concerning younger children are selected for a serious case review, while older children's cases look to be less likely to progress in this way. All other factors revealed little apparent difference between deaths or incidents that are subject to a serious case review and those which do not receive this degree of scrutiny. However there were regional differences as to the proportion of notified cases which progressed to a serious case review, which might suggest differences in approach in terms of the frequency of initial notification.

Appendix Table A2: SCR undertaken by age

	SCR undertaken	
	No	Yes
<1 year	61 (40%)	86 (46%)
1-5 years	26 (17%)	44 (23%)
6-10 years	12 (8%)	18 (10%)
11-15 years	27 (18%)	20 (11%)
16 years +	45 (18%)	21 (11%)
Total	153	189

Appendix Table A3: SCR undertaken by gender

	SCR undertaken	
	No	Yes
Female	66 (43%)	83 (44%)
Male	87 (57%)	106 (56%)
Total	153	189

Appendix Table A4: SCR undertaken by incident type

Incident type	SCR undertaken	
	No	Yes
Death	106 (69%)	124 (66%)
Serious injury	47 (31%)	65 (34%)
Total	153	189

Appendix Table A5: SCR undertaken by ethnicity

Ethnicity	SCR undertaken	
	No	yes
White	101(76%)	125(72%)
Mixed	13 (10%)	23 (13%)
Black / Black British	9 (7%)	13 (8%)
Asian / Asian British	3 (2%)	8 (5%)
Other Ethnic Group	7 (5%)	4 (2%)
Total	133	173

Phase 2 - Analysis of the notification database reports

The researchers developed a coding framework, and completed coding sheets for all of the 189 cases which had been identified. This detailed information relating to child and family characteristics, type of incident and progress of the review was derived from the obligatory fields in the notification report, and supplemented by information given in the free text sections. The data were entered into SPSS (statistical package for the social sciences) for quantitative analysis, and the resulting frequencies and cross-tabulations form the basis for the discussion in Chapter 2 of the characteristics and circumstances of the children and young people, and their families.

In addition the free text case outline sections of the notification reports were collated, and used qualitatively to identify themes in the cases, and to provide quotations for illustration. Information in the 189 reports on the date of notification and the progress of the case review was used in the section in Chapter 4 on timescales, and reasons for delay.

Phase 3 - Analysis of an intensive sample of 40 cases

Having selected the 'intensive sample' of forty cases from the 63 redacted overview reports supplied by the Department for Children Schools and Families, a summary was compiled for each of the 40 cases, using information included in the overview report, and the chronology (if available). The template used for this stage of the research is included at the end of Appendix 1. Notes were made on key features of the case, the background of the child and family, the interaction of both risk and protective factors, professional involvement, patterns of family cooperation with the relevant agencies, the structure and quality of the report itself, timescales of the review, and any involvement of the family in the review process.

The completed summaries were scrutinised to extract themes, and in addition provided quotations to support Chapters 2, 3 and 4. The summaries were also used to select cases for the telephone interview stage of the research, and inform the design of the interview schedules and the choice of questions.

Information from the overview reports and chronologies for the intensive sample of forty was entered into a coding framework, to capture key details of the case and characteristics of the child and parent(s), with a particular emphasis on health contacts and attendance at health appointments. These data were loaded onto SPSS (statistical package for the social sciences) for quantitative analysis. This framework is reproduced at the end of this Appendix.

Phase 4 - The interview stage of the research

From the intensive sample of forty cases, twenty 'interview cases' were selected, taking into consideration a number of factors including:

- At least two cases to come from each of the nine government office regions
- A balance of ages of the child at the centre of the review
- A balance of child death and serious injury cases.

Interviews were planned in these twenty cases with two interviews per case; one with a member of the LSCB, and the second interview with a clinician or practitioner who had worked with the child and family.

Once a potential LSCB had been selected, an appropriate person to approach was identified. On occasions this was the notifier of the case itself, whose details we had, or alternatively someone identified from the LSCB website, for example the LSCB Chair or the Head of Safeguarding. A phone call was made or an email was sent, with a brief elucidation of the study and our request for the LSCB's cooperation. A written invitation to participate, an information sheet, a consent form and the outline of the questions which would form the basis of the interview were then sent by e-mail. Copies of the interview schedule are included at the end of Appendix 1. It was stressed that all data gathered through the interviews would be confidential to the researchers, and that in collating information and opinions for the report it would not be possible to identify any individual case, nor the child and family concerned, nor any professional, nor the authority or agency involved.

Seventeen of the twenty LSCBs responded positively and were able to identify an appropriate LSCB member to talk to. All Government Office Regions were represented in the interviews in the following proportions: North West (3) North East (2), Yorkshire & Humberside (1), West Midlands (2), East Midlands (2), Eastern (2) London (2), South East (2), South West (1). Seven of the interview cases (41%) were in respect of a baby under one year, which fairly closely reflects the 46% of the full set of 189 notified cases who were aged under one year. A further four cases (24%) were in relation to a child aged between one and five years, exactly reflecting the proportion of children of that age in the full set of 189 notified cases.

At the time of that first interview a number of the LSCB contacts were able to suggest a practitioner involved in the case whom they were prepared to approach on our behalf. In the event gaining access to LSCB members was more straightforward than securing interviews with practitioners, which often proved problematic. This was either because no identified practitioner was involved with the child at the time of the incident, or the practitioner could not be located, or the key practitioner had moved out of the area, or was unwilling to participate in the study. Seven practitioners / clinicians agreed to talk to the research team, five from a variety of health settings, and two from children's social care.

The resulting twenty-four interviews were conducted by telephone, using semi-structured schedules which had been sent by e-mail to interviewees ahead of the planned discussion. Interviews lasted between half an hour and an hour and a quarter, with most taking around forty minutes. With the consent of those interviewed, interviews were recorded and transcribed, and the transcripts were returned to the interviewee for checking and approval. The interviews were then entered in a computer programme (NVivo) for handling, sorting and classifying qualitative data, and this facilitated the identification and categorisation of themes. Initially three interview transcripts were studied independently by three researchers and then discussed to discern consistency among the researchers in identifying preliminary themes. As a result, Nvivo codes were established and all interviews were then coded by a single researcher for systematic thematic analysis.

Quotations from the interviews are used to illustrate the themes and findings discussed in Chapter 4. Each interviewee was sent a draft of this chapter, containing only his or her comments, and given the opportunity to amend these comments, or to request that something be omitted completely. Some amendments were suggested during this phase, but no deletions were requested. Finally the draft chapter, including quotations from all the interviewees, was sent to every interviewee, to ensure that everyone was satisfied with the assurances we had given regarding anonymity.

Analysis of feedback from the regional dissemination events

Nine regional dissemination seminars, organised by the DCSF, took place during October and November, 2008. Each seminar (with the exception of the event in the North-West) was attended by one of four members of the UEA research team and provisional, interim findings from the study were fed back to the regional audiences. Following a presentation of the current study, participants formed themselves into discussion groups of, on average, eight people and were asked, as a group, to consider and give a written response to two questions:

Firstly, what did they consider was the impact of being involved in a case that became a serious case review on practitioners / clinicians from different agencies and, secondly, what would be their suggestions for doing a serious case review differently, in order to help the learning.

From these nine regional events a total of 61 group responses were provided, representing the discussions held by approximately 450 people. Responses were collated and analysed, and feed into the discussion presented in Chapter 4.

A framework for categorising cases of fatal child maltreatment

Recognising that child maltreatment fatalities do not form one homogeneous group, this system attempts to provide a framework for categorising fatal maltreatment, to facilitate further analysis. The coding has been developed to allow for allocation to “possible” groups where a particular category is suspected but not clear, and to “other” or “not clear” categories as appropriate.

Categories of maltreatment-related deaths

A Infanticide and Covert Homicide

Although the term “Infanticide” has a precise legal definition in the UK, I use it along with the term “Covert Homicide” to describe a group of fatalities, usually of very young infants, many shortly after birth and typically perpetrated by the mother using “non-violent” means, or in which the cause of death is not immediately apparent. These differ from the group of severe physical assaults. This category would include deaths as a result of exposure, asphyxiation, drowning, strangulation or poisoning where there is some indication that there was some intent to kill (as distinct from accidental deaths from these causes).

Exclude deaths where there are obvious severe physical injuries e.g. non-accidental head injury or multiple injuries (category B); or evidence of homicide which is apparent from the start, e.g. stabbings, obvious strangulation, multiple killings (category D). Exclude deaths which are considered to be a result of accidents (category E).

A1 Possible infanticide / covert homicide

Use this where this category is suspected, but there is limited evidence.

B Severe physical assaults

This is probably the largest group of maltreatment-related deaths, and certainly the most well-recognised. Includes cases of severe physical violence with or without associated neglect. The mode of death in these cases is typically a violent assault, most commonly an inflicted head injury, including shaking and shaking-impact injuries, but also multiple injuries and abdominal injuries. Other deaths may include the use of firearms, beatings, stabbings and strangulation but where there was not an obvious intent to kill.

Exclude deaths where there is some indication that the perpetrator set out to deliberately kill the child (category D).

B1 Possible severe physical assaults

Use this where this category is suspected, but there is limited evidence.

C Extreme neglect / deprivational abuse

Use this category where the direct cause of death is extreme neglect or deprivation of the child's needs, e.g. through starvation or exposure, or where there is evidence of deliberate failure to respond to medical needs of the child.

Exclude deaths in which the neglect appears to be a reflection of parental incompetence, related to learning difficulties, physical or mental ill-health, or other environmental circumstances (treat as deaths related to but not directly caused by maltreatment - category E). Exclude abandonment of very young infants (category A). Exclude accidental deaths related to poor parental supervision (category E). Exclude cases where neglect contributed to the death, but there is no evidence of persistent neglect in other areas.

C1 Possible extreme neglect / deprivational abuse

Use this where this category is suspected, but there is limited evidence.

D Deliberate / overt homicides

This fourth group of fatalities overlaps with the first category of infanticide/covert homicide, in that there would appear to be an intent to kill the child; but differs from that and other groups in the age profile, in the victim and perpetrator characteristics and in the typical mode of death. In these deaths, the fact of homicide is likely to be immediately apparent. Include deaths caused by stabbings and firearms; include severe beatings where there appears to be an intent to kill. Include homicides with associated sexual assaults; include cases of killings of multiple family members or of multiple killings with subsequent suicide of the perpetrator ("extended suicides"). This may include deaths from house fires with evidence of arson with intent to kill (Kotch et al., 1993) and there have been a number of high profile cases of young girls abducted, sexually assaulted and finally murdered by unrelated adults.

Exclude severe injuries where there is no evidence of intent to kill (category B); cases where the homicide is not immediately apparent (category A).

D1 Possible deliberate / overt homicides

Use this where this category is suspected, but there is limited evidence.

E Deaths related to but not directly caused by maltreatment

There are a large number of deaths which are felt to be related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death. Include sudden unexpected deaths in infancy (SUDI) with clear concerns around parental care, but not sufficient to label as extreme or persistent neglect (category C). Include fatal accidents where there may be issues of parental supervision and care, including accidental ingestion of drugs or other household substances; drownings; falls; electrocution; gunshot wounds; and fires. Includes those children dying of natural causes whose parents may not have sought medical intervention early enough. Include deaths of older children with previous maltreatment, but where the maltreatment did not directly lead to the death, e.g. death from an overwhelming chest infection in a child severely disabled by a non-accidental head injury; suicide or risk taking behaviours including substance abuse in young people with a past history of abuse.

E1 Possible deaths related to but not directly caused by maltreatment

Use this where this category is suspected, but there is limited evidence.

F Sudden Unexpected Death in Infancy (SUDI), Category not clear

Use when the case has examined a SUDI but the category is not clear. May incorporate some cases of covert homicide (category A), or SUDI related to but not directly caused by maltreatment (category E) or any of the other categories. If possible assign these to categories A1 or E1 rather than F; use this category only if there is no clarity as to which other category should be used.

G Other death, category not clear

Include Serious Case Reviews where a child has died, but there is no indication from the case summary as to which category it should fit into.

Template developed by the research team for analysing Overview Reports

The summary of each overview report should include the following:

- A summary of the key features of the case and the family using the 'Case Summary Template'
- Completion of a 'Brief Chronology and Key Details of Professional Involvement'
- Useful quotes
- Consideration of any issues which might inform the telephone survey and the interview schedule
- Highlight pattern of health use (including how accessible/available) and patterns of family / child co-operation

CASE SUMMARY TEMPLATE

- **Key features of the case** (Include patterns of family cooperation)
- **Child and Family background**
 - child's needs / characteristics / behaviour
 - mother's / carer's history / profile / parenting capacity
 - father's / carer's history / profile / parenting capacity
 - wider family and environment
- **Professional involvement**
- **Analysis of interacting risk and protective factors to include:**
 - (i) summary of risk and protective factors and supports
 - (ii) analysis of family cooperation
 - (iii) a hypothesis about the nature, origins and cause of the need / problem / concern.
- **What could have been done differently?**

SUMMARY OF THE 'SCR' PROCESS

- Further thought on the structure and quality of the overview report
- Further thought on the structure and quality of other attached reports
- Timescales of the SCR and anything impeding timely submission (e.g. court, sickness).

Involvement of the family in the SCR process?

Schedule for health markers for index child

Case No. d.o.b. Date of incident

1. Child born: term / premature / low birthweight / in SCBU / no info? (tick as applicable)

2. Child with: disability / chronic illness / complex health needs / no disability / no info (tick as applicable)

If yes, details

3a. Hospital admissions for index child up to 10 years prior to toi? YES / NO INFO (circle appropriate answer)

If YES dates of admissions and reason for each admission

3b. Hospital admissions for index child more than 10 years prior to toi? YES / NO INFO / child <10

If YES dates of admissions and reason for each admission

4a. A&E attendances up to 10 years prior to toi? YES / NO INFO

If YES dates of admissions and reason for each admission

4b. A&E attendances more than 10 years prior to toi? YES / NO INFO / child <10

If YES dates of admissions and reason for each admission

5. GP registration in child's lifetime (circle appropriate answer)

Continuous GP registration
Lapses in GP registration
Removed from GP list
No information

6. GP registration for family over last 5 years

Continuous GP registration
Lapses in GP registration
Removed from GP list
No information

7a. Ante-natal appointments for index child

Attended
Partially attended
Mainly missed
Not known

7b. Immunisation and universal development checks for index child

- Attended
- Partially attended
- Mainly missed
- Too young
- Not known

7c. Specialist health appointments for index child (please list i.e. audiology, SLT)

- Attended
- Partially attended
- Mainly missed
- Too young
- Not known

8. NHS Direct / Walk in Clinic / ambulance service within month of toi for index child (specify timespan) (tick as applicable)

.....

9. HV contact for index child (ie active open case) at TOI YES / NO INFO / NA

Frequency of contact

10. HV contact for another child in family at TOI YES / NO INFO / No other child

Frequency of contact.....

11. MW contact for index child (ie open case) at TOI YES/NO INFO/N/a too old

Frequency of contact

12. MW contact for another child in family at TOI YES / NO INFO / no other child / Other children too old

Frequency of contact

13. Other specialist health care contacts for index child in up to 10 years before TOI (with time span, briefly)

- School Nurse YES / NO INFO / NA
- Community Paediatrician YES / NO INFO
- SALT YES / NO INFO / NA
- CAMHS YES / NO INFO / NA
- DAT YES / NO INFO / NA
- Other (specify) YES / NO INFO

Any other researcher comments:

Interview schedule for SCR sub-panel chair or other LSCB member

Interviewer:..... Date:.....
Interviewee:..... Region:..... Case no.....

- 1) Just briefly before we start, how many SCRs did your LSCB carry out in this 2 year period (March 2005-April 2007) and were any happening concurrently?**
- 2) By what process was the decision made to hold an SCR on this case?**
- 3) What were the specifics about this case that made it meet the criteria for an SCR?**
(were there other similar cases which might not have become a SCR)
- 4) How did you decide who would be the overview writer?** (do you have a pool of overview writers?)
- 5) How were the terms of reference of the SCR determined? Did this include consideration of the resource context?** (eg. Case loads, case composition, supervision)
IMR arrangements (especially re health)
- 6) Working Together requires that you consider how family members should contribute to the review. How did you do this, and what was the outcome in this case?**
- 7) How long did the review take to complete (from x beginning to x ending)** (and how do you determine beginning and ending? - were there tensions in completing on time, if delays, what caused these, e.g. court?)
- 8) Who was the overview report made available to?**
- 9) How/where was the executive summary published/ made available?** Did this influence how it was drawn up?
- 10) How were the key messages disseminated locally?** (e.g. training, road shows etc)
- 11) Do you think that the recommendations reflected the key messages/learning?** (and were they SMART?)
- 12) What mechanisms were put in place to implement and monitor the recommendations?**
(eg. were action plans tracked or were other approaches used; were there resource issues involved in implementation?)
- 13) Has this SCR led to any specific changes? If so what?** (for you, your immediate colleagues, and separate agencies)
- 14) Do you have any suggestions for doing this or other SCRs differently, which would help the learning?**

Anything else to add? Thank you very much for your help.

Interview schedule – for professional

Interviewer:..... Date:.....

Interviewee:..... Region:..... Case no.

The first set of questions are about the case and the second set are about the SCR process in this case.

The Case

- 1. What was your role in the case?**
- 2. How has this case had an impact on you?**
(eg your thinking and practice and emotionally)
- 3. In what ways has this case had an impact on your team?**
(e.g. thinking/attitudes and practice)
- 4. In what ways has this case had an impact on other teams/other agencies?**
- 5. How has this case had an impact on the way agencies work together** (specify individual agencies) **Has it affected the contribution of individual agencies?** (specify agencies)

The SCR process

- 6. Moving on to the SCR process, from your perspective, what were the lessons to be learnt in this case?**
- 7. Did you feel involved in the SCR throughout?**
(Did you see the overview report or the executive summary? When and how? e.g. who informed you or took you through it?).
- 8. How were you involved in deciding the recommendations and ensuring their appropriate implementation?**
- 9. What helped or hindered the learning from the SCR ?** (were there any blocks to learning being achieved)
- 10. Has this SCR led to any specific changes? If so what** (for you, your team or other agencies)
- 11. Do you have any suggestions for doing this or other SCRs differently, which would help the learning?**

Anything else to add?

Thank you for your help.

Appendix 2: Child and Family characteristics of intensive sample of 40 cases

Characteristics of child / parents / carers	Intensive sample (n=40)
Incident	
Death	27 (67%)
Serious injury	13 (33%)
Child characteristics	
Male	20 (50%)
Female	20 (50%)
Age under 1 year	17 (43%)
Age 1-5 years	9 (23%)
Age 6-10 years	4 (10%)
Age 11-15 years	7 (17%)
Age 16 and over	3 (7%)
Prematurity	8 (20%)
Known problems or vulnerability at birth (SCBU, low birth-weight etc.)	15 (38%)
Known disability	7 (17%)
Known A & E attendances	18 (45%)
Known hospital admissions	12 (30%)
Known audiology, ophthalmology needs	8 (20%)
Known speech and language therapy needs	3 (7%)
Family characteristics	
Single child	12 (30%)
2 child household	9 (23%)
3 child household	11 (28%)
4 or more children in household	8 (20%)
Frequent house moves	18 (45%)
Domestic violence - current	12 (30%)
Domestic violence - past	19 (48%)
Domestic violence - current and / or past	21 (53%)
Maternal substance misuse - current	6 (15%)
Maternal substance misuse - past only	3 (7%)
Paternal substance misuse - current *	5 (13%)
Paternal substance misuse - past only *	3 (7%)
Either parent, current or past substance misuse	13 (33%)
Maternal mental health problems - current	11 (28%)
Maternal mental health problems - past only	10 (25%)
Paternal mental health problems - current *	5 (13%)
Paternal mental health problems - past only *	6 (15%)
Either parent, current or past mental health problems	25 (63%)
Learning disability	6 (15%)
Criminal conviction(s)	18 (45%)

* incidence of paternal problems likely to be significantly under-represented as information generally unavailable

Appendix 3: Health Markers for intensive sample

The intensive sample of 40 cases was scrutinised for mention of contacts with various health services, ranging from ante-natal care through to appointments for the child, and the child's history of hospital admittance and Accident and Emergency attendance.

Non-attendance at key appointments

The forty cases were checked for non-attendance at key appointments at two early stages: ante-natal appointments, and immunisation and standard baby/child development checks. This information was not necessarily available, but depended on the scoping of the review and how far back the chronology was taken. In nearly half (46%) of the 24 cases with adequate information, maternal attendance at ante-natal appointments was, at best, partial.

Appendix Table A6: Attendance by mother at ante-natal appointments by age of the child at the time of the incident

Attendance by mother	Child aged under 1 year at t.o.i.	Child aged over 1 year at t.o.i.	All children
Attended	9	4	13 (54%)
Partially attended	2	2	4 (17%)
Mainly missed	3	2	5 (21%)
Totally missed (or concealed pregnancy)	2	-	2 (8%)
Total (for whom data are available)	16	8	24 (100%)
Data unavailable	1	15	16

As might be expected, ante-natal information was frequently not included in the histories of the older children, with this information lacking in approximately two thirds of the overview reports of the cases where the child was over one year of age at the time of the incident. By contrast there were reviews for some of the older children which did give very full chronologies, including pre-birth information.

Appendix Table A7: Attendance at child development checks and for immunisations

	Child aged under 1 year at t.o.i.	Child aged over 1 year at t.o.i.	All children
Attended	5	6	11 (39%)
Partially attended	0	5	5 (18%)
Mainly missed	3	2	5 (18%)
Baby too young	7	Not applicable	7 (25%)
Total (for whom data are available)	15	13	28 (100%)
Data unavailable	2	10	12

Presentation of the child for immunisation and the standard development checks was often sporadic. Where this information was given, just over half of the reviews for the children aged one and over showed a history of missed appointments. In the youngest age category, a significant number of the babies were injured or died before they were old enough to have attended their first immunisation appointment.

Prematurity and problems at birth

For eight of the 28 children (29%), for whom the information was available in the overview report, there was evidence of prematurity. (Table A8)

Appendix Table A8: Prematurity of children subject to SCR

	Under 1 year	1 – 5 years	6 years and over	All ages
Premature	3	4	1	8
Full term	11	3	6	20
Total (for whom data available)	14	7	7	28
Data unavailable	3	2	7	12

Where the data were available exactly half of the reviews noted problems at birth, which included emergency caesarean deliveries arising from foetal distress, low birth-weight and the need for admittance to the special care baby unit. (Table A9)

Appendix Table A9: Birth characteristics of children subject to SCR

	Under 1 year	1 – 5 years	6 years and over	All ages
No problems at birth noted	8	3	4	15 (50%)
SCBU	4	3	0	7 (23%)
Low birth-weight not requiring SCBU	1	0	1	2 (7%)
Emergency caesarean and foetal distress	1	1	2	4 (13%)
Concealed birth	2	-	-	2 (7%)
Total (for whom data available)	16	7	7	30 (100%)
Data unavailable	1	2	7	10

Prematurity and low birth-weight may result in a baby who can be very demanding of the parents, and in addition the baby's stay in the SCBU can inhibit the bonding process.

The reporting of birth problems are rarely noted in the reviews and chronologies for the older age groups, however the fact that these factors are not noted may not necessarily imply that they were not present. Factors such as prematurity and low birth weight may often be markers for later problems.

Hospital attendance

Health chronologies were sufficiently full for 34 (85%) children in the intensive sample to map how frequently the child had been admitted to hospital, and provided data on A&E attendances for 35 children.

Appendix Table A10: Frequency of admittance to hospital by age

Number of admissions noted in Overview Report	Under 1 year	1 – 10 years	11-17 years	All ages
No admissions	10	9	3	22
1 admission	4	1	1	6
2 or 3 admissions	0	1	1	2
4 or 5 admissions	1	1	1	3
9 admissions	1	0	0	1
Number of children	16	12	6	34

Appendix Table A11: Frequency of attendance at Accident and Emergency

Number of attendances noted in Overview Report	Under 1 year	1 – 10 years	11-17 years	All ages
No attendances	13	4	0	17
1 attendance	2	4	4	10
2 or 3 attendances	1	3	0	4
4 or 5 attendances	0	0	2	2
7 attendances	0	0	1	1
8 attendances	0	1	0	1
Number of children	16	12	7	35

The older children were, in one respect, more likely to have attended A&E or to have been admitted to hospital, since they had been alive for longer. On the other hand, the reviews and chronologies were on occasions less reliable for the older children, in that their early history of attendances and admissions might be omitted, or be insufficiently detailed.

Appendix 4: SCR Thematic Monitoring Tool

SERIOUS CASE REVIEW THEMATIC MONITORING TOOL

Communication

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Management

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Performance Management

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Practice

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Procedures

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Recording

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Training

CASE	AGENCY	RECOMMENDATIONS	ACTIONS	TIMESCALE	LEAD OFFICER	PROGRESS EVIDENCE

Appendix 5: Thresholds of Intervention and Patterns of Co-operation

Level 4 Services for children at high risk (including child protection registration and regulated/restoratory services)	* *	* * * * * * *			
Level 3 Children with complex needs (including the Social Services threshold of Children in Need)	*	*1 * *		* * * *	* *
Level 2 Children with additional needs	* * * * *	* * * * * * * *		*	*
Level 1 Universal Services for all children and families		* *		* *	*
	1 Not co-operative eg. Avoiding involvement/hostile	2 Low co-operation Inc passive coop	3 Neutral/Some co- operation	4 Co-operative	5 Highly co- operative/persistent ly seeking help

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