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## Preventing child deaths

Bernard Gallagher  
Senior Research Fellow  
Centre for Applied Childhood Studies  
University of Huddersfield

In the week I began to write this editorial, City and Hackney Local Safeguarding Children Board (LSCB) published an executive summary of the serious case review (SCR) into the deaths of 10 year old Antoine Gamor-Ogunkoya and his 3 year old sister Kenniece in London (City and Hackney LSCB, 2008). Both had been killed by their mother, Vivian Gamor. Antoine had been beaten with a hammer and Kenniece had been suffocated with clingfilm. Their mother was convicted of manslaughter on the grounds of diminished responsibility in August 2007 and was detained indefinitely under the Mental Health Act 1983 (BBC, 2008; Community Care, 2007). The deaths of these children, and the release of this SCR, are a powerful, though dreadful, reminder - if one was needed - of the terrible abuse that children can suffer. They also act as a very forceful pointer that preventing child deaths is the most important challenge in child protection.

Such events also focus attention on the release earlier this year of a series of major documents in the UK, each of which is concerned, in part at least, with practice in the areas of child deaths and serious injury. Although these documents originate from a number of different perspectives, they are all concerned ultimately with prevention. Taken together, they can be seen as marking a critical phase in the response to child deaths. In the interests of clarity and precision, these documents are listed here, along with the countries to which they apply:

- The second and third biennial analyses of SCRs, which were commissioned by the then Department for Education and Skills (DFES). These cover SCRs carried out in England in the periods 2001-2003 (Rose and Barnes, 2008) and 2003-2005 (Brandon et al, 2008a).
- Research into 'early starter' child death overview panels in England (Sidebotham et al, 2008)
- The first report from the Confidential Enquiry into Maternal and Child Health (CEMACH) that specifically focused on child deaths (Pearson, 2008) (England, Wales and Northern Ireland).

- Updated guidance for radiological investigations of suspected non-accidental injury (The Royal College of Radiologists and Royal College of Paediatrics and Child Health, 2008) (UK)
- The third joint chief inspectors' report on arrangements to safeguard children (Ofsted, 2008) (England)

These publications highlight some good practice. Rose and Barnes (2008, p.4) found that 'there was evidence of some family involvement' in SCRs, as required by Working Together (HM Government, 2006). The joint chief inspectors note that 'many LSCBs plan to make further changes to their serious case review arrangements to introduce greater rigour and objectivity' (Ofsted, 2008, p.68).

Much of this work though focuses on the failings of practitioners, managers, agencies and local authorities. Brandon and colleagues found that there was hesitancy sometimes in challenging the opinion of other professionals, and some sections of the police failed to make the link between domestic violence and risk of harm to children, (Brandon et al, 2008a). Although CEMACH had a much wider brief than deaths through abuse and neglect, the issues it raises include the adequacy of services to children who self-harmed or who were involved in substance misuse, and those who were at risk of suicide. It also states that 'there were situations where failure to follow-up patients who did not attend for their appointments was associated with later death' (Pearson, 2008, p.5).

These publications reveal deficiencies in the child death review process as well. Sidebotham et al (2008) discovered that although many LSCBs had established rapid response protocols, some of these related only to infant deaths as opposed to all unexpected child deaths. The joint chief inspectors report that there was considerable variation in the quality of both individual and overview SCRs (Ofsted, 2008).

These authors make clear - but do not necessarily make any allowance for - the sometimes acute difficulty of work in this area. This is, perhaps, best brought out by Brandon et al (2008a). They state that 'families tended to be ambivalent or hostile towards helping agencies, and staff were often fearful of violent and hostile men' (p.5) and 'the theme of older adolescent children who were very difficult to help emerged powerfully' (p.6) The Royal Colleges draw attention to the stressful nature of investigations, 'especially when the child is suspected of suffering multiple injuries or when a pattern of injuries suggests that the child may have been abused' (The Royal College of Radiologists and Royal College of Paediatrics and Child Health, 2008, p.7).

As the preceding discussion illustrates, the release of these documents renders this themed issue of *Child Abuse Review* (CAR), on child deaths, extremely timely. (Indeed, papers authored by members from two of the above teams are included in this issue.) Inevitably, in their focus on 'what went wrong', the above documents address the negatives and omissions of statutory child protection practice. In contrast, the first paper in this themed issue by Colin Pritchard and Ann Sharples (Pritchard and Sharples, 2008)

offers a wider and more positive assessment of practice in the area of child deaths and therefore represents an important counterbalance to the tenor of the above work.

Colin Pritchard and Ann Sharples analyse World Health Organisation data on child deaths in ten developed countries, including England and Wales. They compare rates for a number of different categories of child death across approximately a 25 year period. The most relevant information for readers of CAR will be that pertaining to deaths by homicide among children aged 0-14 years. The average annual homicide rate for this age group in the period 1974-1976 in England and Wales was 24 per million (pm). By 2000-2002, this rate had declined to eight pm. In addition, England and Wales had gone from having the third highest rate of child homicides to the third lowest.

The authors are frank about not knowing the precise reasons for this decline. They are likely to be correct in their assertion that 'various changes in policies, health and social care practices, and welfare provision will have been factors' (Pritchard and Sharples, 2008, p?). The key point they make is that 'the direct practice contributions of the CPS [child protection services]' is a factor in the decline of child homicides in England and Wales. This paper provides tentative evidence at least that practice has prevented child deaths.

The paper is also valuable in that it provides an all important international perspective. It demonstrates major differences between industrialised nations in their death rates and in trends in death rates. The United States has the highest rates for most categories of child death. In case we should become complacent, it is worth noting that a number of countries, Italy and Spain in particular, have lower rates than England and Wales across various child death categories. Again, the reasons for these differences are not known. There would seem to be a pressing need for comparative research to identify the reasons for these differences. This could inform both practice and policy, and hopefully prevent further child deaths.

The second paper in this themed issue moves from the international or macro perspective to the other end of the spectrum, carrying out what is, by comparison, a micro-level examination of practice. Marion Brandon and colleagues (Brandon et al, 2008b) draw upon the third, biennial study of SCRs. They studied all the SCRs that had been carried out in England and notified to the Commission for Social Care Inspection.

The immediate focus of this paper is upon thresholds and in particular the apparent preoccupation with thresholds among practitioners. As the authors note: 'Thresholds into and between services emerged as a significant theme in the biennial analysis of cases .....The preoccupation with thresholds was one of a number of interacting risk factors' (Brandon et al, 2008b, p.?). The paper is also about the pressures, sometimes very severe, that practitioners face in this area of work, and which might explain their concern with thresholds.

Informed by an ecological transactional perspective (Cicchetti and Valentino, 2006), the authors make a number of recommendations as to how practice should respond to these challenges, and thereby prevent child deaths or serious injury. These comprise, for instance, enhanced supervision and training, and the development of a practice mindset that asks not only how individuals are behaving but also *why* they are behaving as they are.

I would like, though, to emphasise the policy/political and societal perspectives that are suggested by this paper but may be overlooked. The authors distinguish profound problems in the child protection system: 'there was frequent reference to staff absence through ill health or staff vacancies (front line and managerial), a backlog of unallocated work and very high case loads' (Brandon et al, 2008b, p.?). Resources were a particularly acute issue: 'local authorities' pressures on resources often lead to a push for a reduction in the numbers of children looked after. This makes it difficult for workers to provide services for hard to help young people who tend to spurn help' (Brandon et al, 2008b, p.?).

The notion that child protection is 'everyone's responsibility' is becoming increasingly promoted (see, for example, NSPCC 2007), including by government (DCSF, 2007). If child protection is to be truly everyone's responsibility then this must include politicians and the public. If politicians and the public are seriously committed to child protection, and most importantly the prevention of child deaths, then they cannot allow the under-resourcing of child protection to persist. This under-resourcing has been highlighted elsewhere (Gallagher, 2007; Pugh, 2007). As Marion Brandon and her colleagues note:

'Every Child Matters acknowledged the contribution of high vacancy rates to practitioners' pressures and promised workforce reform, better working conditions and more resources .... These improvements were not in place when these reviews took place in the immediate aftermath of the Victoria Climbié Inquiry nor have they been instituted at the time of writing' (Brandon et al, 2008b, p.?)

The third paper in this themed issue is by Emily Douglas and Jennifer Cunningham (Douglas and Cunningham, 2008) who discuss the work of the US equivalent of the English SCR, the Child Fatality Review Team (CFRT). Douglas and Cunningham studied CFRT reports published from 2000-2007. Their objective was to compile and evaluate the problems and recommendations identified by these teams. Some of the issues CFRTs deal with would not be familiar to SCRs. These include a focus upon the criminal prosecution of perpetrators and the role of mandatory reporters.

In general, though, CFRTs raise many of the same concerns as their English counterparts. These include, for instance, poor communication, inaccurate assessments and inadequate training. Moreover, the authors' references to 'overloaded case workers .... high turnover and dissatisfaction' (Douglas and Cunningham, 2008, p.?) indicate that practitioners in the US are operating under some of the same pressures as their UK colleagues. The authors highlight the 'problems that plague the professions that respond to child maltreatment' and 'the failures of the nation's social service system' (Douglas and

Cunningham, 2008, p.?). This suggests that the issues and pressures they have identified may be rooted - as they are in the UK - in more fundamental problems in the child protection system.

This paper is novel in what it has to say about the child death review *process* in the US. Although CFRTs have existed in the US for 30 years, there is considerable variation in how they operate. There are differences in the categories of death covered, organisational membership, practitioner presence, legislative basis, funding, legal powers, the information they request and the level of political administration at which they function. Given the size of the US, and its complexity in terms of political administration, it is to be expected that there would be some variation in the operation of CFRTs. Nonetheless, it is astonishing that there is so much variation in the way in which they operate. Part of the explanation for this may be that: 'the child fatality review movement lacks official, coordinated, national leadership' (Douglas and Cunningham, 2008, p.?)

The impression of CFRTs being marginalised is reinforced when one considers the extent to which they have been researched. The authors explain that 'the products of the review process, however, remain unexamined' and 'with the exception of one U.S. state .... CFRTs have never been subjected to an extensive evaluation and we do not know the true usefulness of the reviews' (Douglas and Cunningham, 2008, p.?). It may be that in each of the 'countries' of the UK with, for example, their smaller size, more centralised political administration and stronger statutory child protection system, there will not be such divergence in the operation of the child death review process. This is certainly not what is suggested by the publication of the documents listed at the start of this editorial. Douglas and Cunningham's research should act as a warning to the UK that the child death review process must be enabled to evolve towards the optimal model, and that this should be properly supported through research.

The fourth and final paper in this themed issue is a short report, by Joanna Garstang and Peter Sidebotham describing the establishment of a training programme on managing childhood deaths (Garstang and Sidebotham, 2008). As the authors note, *Working Together to Safeguard Children* (HM Government, 2006) expects LSCBs in England to 'put in place procedures both to respond rapidly to individual unexpected childhood deaths and to review all childhood deaths in a systematic way' (Garstang and Sidebotham, 2008, p.?). This, and other developments, led the authors to conclude that there would be a need for a multi-agency course on the management of unexpected childhood death. Prior to any launch, though, the authors had to verify whether there would be a demand for such a course and what its precise content should be. Their evaluation revealed that there was a need for the proposed course and also that the content was appropriate. This report casts an interesting light upon the development of an important resource for practitioners concerned with child death.

This paper also raises some more basic issues about the ability of agency workers not only to respond to child deaths but also prevent them in the future. Many health trusts, police services and children's services departments (CSDs) did not have protocols in place for a rapid response to unexpected child deaths and/or for an overview of all child

deaths. Most respondents from health, police and CSDs had not received training in the management of unexpected child death and certainly not in a multi-agency setting. These findings underline the importance of ensuring that the development of the child death review process, throughout the UK, is properly supported, both locally and nationally. As the reports identified at the start of this editorial indicate, this is a key period in terms of the development of the response to child deaths in the UK. Even more recent initiatives suggest that this development is set to intensify. These initiatives include publication at the end of July 2008 of a Government consultation paper setting out its proposals for reforms in the law in relation to, amongst other areas, infanticide (Ministry of Justice, 2008). This follows the release by Law Commission, approximately 18 months ago, of the report *Murder, Manslaughter and Infanticide* (Law Commission, 2006) in which it made recommendations as to how the law should be changed, and a subsequent consultation exercise. In addition, the Welsh Assembly has announced, over the summer of 2008, that there is to be an all-Wales pilot of child deaths reviews - focusing upon child suicides. The aim is to introduce a full child death review scheme from 1st April 2010 (Welsh Assembly, 2008).

All of these developments are concerned with improving the response to child deaths and serious injuries but ultimately with preventing them. The articles contained in this themed issue will, I believe, make a further, important contribution to these objectives.

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