Research Report DFE-RR226

Department for Education

New learning from serious case reviews: a two year report for 2009-2011

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

Acknowledgements

The research team would like to extend our thanks to the Department for Education for their support in overseeing this study, particularly Jenny Gray, Isabella Craig and Julie Wilkinson. Thanks are also due to advisory group members for their expert advice and for generously donating their time to comment on the report. Members of the advisory group include: Peter Davies (Child Exploitation and Online Protection), Dr John Devaney (Queens University), Dr Ruth Gardner (NSPCC), Colin Green (Director of Children's Services, Coventry), Poppy Harrison (Youth Justice Board), Christine Humphrey (Department of Health), Professor Ruth Gilbert (University College London), Cathy James (Department of Health), Dr Sabine Maguire (Cardiff University), Sarah Osborne (Home Office), Dr Catherine Powell (Portsmouth PCT), Wendy Rose (Open University), Vera Ruddock (Office of National Statistics) and Professor Mike Stein (York University).

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Contents

List of Tables

3.3 Age at time of incident by gender

3.4 Ethnicity

3.5 Number of siblings

3.6 Birth order

3.7 Disability (prior to incident)

3.8 Index child with a child protection plan

3.9 Index child with a child protection plan (current or past) - category of plan

3.10 Where living at time of incident

3.11 Frequency of occurrence of key factors within the family

3.12 Co-existence of case characteristic

3.13 Family or community context

3.14 Death / Serious injury

3.15 Death / Serious injury by age group

3.16 Number of incidents which occurred in each quarter

3.17 Number of incidents which occurred in each Ofsted region 2009-11

3.18 Number of incidents which occurred in each region in 2009-11

3.19 Categorisation of fatal cases

3.20 Categorisation of serious injury cases

3.21 Incidence of neglect

3.22 Incidence of neglect by age group

3.23 Incidence of neglect by type of fatal injury

3.24 Incidence of neglect by type of non-fatal injury

3.25 Age of the mother at the time of birth of her first (and only) child

3.26 Age of the mother at the time of birth of her first child

3.27 Child's case open or closed to children's social care at time of incident

3.28 Highest level of involvement of children's social care reached

4.1 Child themes

4.2 Family and environment themes

List of Figures

EXECUTIVE SUMMARY

Introduction

Learning from serious case reviews (local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected) is acknowledged to be important. This is the sixth two yearly national analysis of such reviews (from 1 April 2009 - 31 March 2011) and the fourth undertaken by this research team. It produces a number of new insights alongside the recurring messages for practice. It also adds to our cumulative research knowledge of these cases helping to identify patterns and deviations from patterns over time.

Key Findings and Learning Points

- Drawing on the serious case review notifications from the single year 1 April 2009 to 31 March 2010 and comparator data from other sources, we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) in England is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death.

- The complexities of matching national level data from different sources underlines the difficulty of interpretation and prediction so that tracking the extent to which this estimate rises or falls will never be exact. It is important to recognise that there are a wide variety of ways and contexts in which children may die as a result of violence or maltreatment. Different data sources are required to capture the breadth of these perspectives. It should be possible to establish an observatory function to report regularly on numbers and rates of violent and maltreatment-related deaths, and to set these findings in the context of other measures of childhood vulnerability. This however would require collaborative arrangements between the Department for Education, the Home Office, and the Office of National Statistics, to ensure timely sharing of data and agreed parameters for reporting.

- In carrying out this biennial analysis, the research team has built on previous work to develop and design a framework for the qualitative analysis of individual serious case reviews. This involves a process of layered reading of the individual reviews, and coding of data using a theoretical framework built on three core domains: the child; the family and environment, including parenting capacity; and systemic and service issues. There is now a draft framework which can be used for analysing serious case reviews and child deaths at a regional or national level.
- Serious and fatal maltreatment represents the tip of an iceberg; while overall numbers of children dying as a direct consequence of maltreatment may be small, many more children and young people suffer from lower levels of abuse or neglect. We need to learn from the experiences of all these children; every serious case review can provide a potential window on the system (Vincent 2004), allowing us to identify lessons to be learnt for safeguarding and promoting the welfare of children.

- A particular focus of this biennial review was an examination of serious case reviews for children aged 5-10. This highlighted particular issues of hidden adversity in this

age group, the risks of harm to children associated with parental suicide or parental self-harming behaviour, and the potential adverse effects on children linked with parental separation.

- Neglect is a background factor in the majority of serious case reviews (60%), and for children of all ages not just the younger children. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including SUDI and suicide, and in over a quarter of homicides and fatal physical assaults. Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non fatal cases, including physical abuse and sexual abuse.

- A possible sign of improvement in protecting children is the fall in the number of children at the centre of a review with a child protection plan in place - declining from 16% in 2007-09 to 10% for the latest two year period, at a time when overall numbers of children with a child protection plan are rising. A possible sign of improvement in protecting babies is the decreasing proportion of reviews undertaken concerning infants – dropping from 46% to 36% of all reviews.

- An understanding of normal development in childhood is an essential component of child protection practice. Overall, there is a dearth of child development teaching on professional courses for those who will be working with children. Where children have communication impairments the onus is on the professional not the child to find ways of communicating.

- SCR recommendations are still very numerous and the endeavour to make them specific, achievable and measurable has resulted in a further proliferation of concrete or procedural tasks to be followed through. Part of the issue may lie with the skills and knowledge of those conducting the reviews but also with the need to distinguish between learning lessons and making recommendations. The best learning from serious case reviews may come from the process of carrying out the review.

Background

The overall two year analysis includes five inter-linking studies (three of which have already been published) drawing primarily on either the 115 serious case reviews notified to the Department for Education during the single year 2009–10, or the full sample of 184 serious case reviews from the two year period 1 April 2009 - 31 March 2011. The five studies have their own separate research questions and methods, but all are informed by the same approach to the exploration of interacting risks which seeks to understand inter-agency working within the dynamic context of the developing child's world.

Overall, access to a greater number of SCR overview reports for this two year period has allowed us to explore themes in a way not previously possible.

FINDINGS

How many children die as a result of maltreatment?

Drawing on the serious case review notifications from the single year 1 April 2009 to 31 March 2010 and comparator data from other sources[1], we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) in England is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death.

The overall rates of SCRs relating to fatal cases have remained relatively stable over the past 5 years. The highest risks remain in infancy, although a second peak is seen in adolescence. The patterns and nature of these deaths are likely to vary and any further efforts to reduce these rates should be based on a good understanding of the different patterns.

How have patterns of serious case reviews changed?

There is a considerable drop in the number of serious case reviews over the latest two year period – a total of 184 in comparison with 280 cases from 2007-09 (when almost half were serious injury cases). This represents a return to the earlier pattern of fewer reviews (189 reviews during 2005-07 and 161 during 2003-05) and to the previous proportion of two thirds fatality cases and a third relating to non fatal serious injury. A drop in non fatal cases in 2010-11 however may suggest that a new pattern of undertaking serious case reviews is emerging.

Just over a third (36%) of all serious case reviews concerned a baby under one year of age – a drop of more than 10% from the consistent pattern of earlier years. This difference may reflect a change in local decision-making about when to undertake a SCR for non fatal cases, but might also be attributable to the success in spreading awareness among practitioners and community groups of the vulnerability of babies and the risks of harm they face.

The only category of fatality or harm showing much change was deliberate homicide where there was a 10% rise, explained largely by an increase in the number of filicide suicides and perhaps by the Home Office's introduction of Homicide Reviews.

What new learning is there about patterns and behaviour in families?

For the first time we have a clear understanding of the extent to which neglect features in serious case reviews. This sets a good foundation for further exploration of the learning about neglect in these cases. We know that neglect was an underlying feature in at least 60% of the serious case reviews. Past or present neglect was a factor in eleven out of fourteen suicide cases. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including SUDI and suicide (present or past neglect was a factor in eleven out of fourteen suicide cases), and in over a quarter of homicides and fatal physical assaults.

[1] Office for National Statistics, Mortality data from death registrations; Home Office, Crime Statistics; Department for Education, child death overview panel data.

Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non fatal cases, including physical abuse and sexual abuse.

Almost 60% of the mothers were under 21 years of age when they had their first child. Although the vulnerability of many of these young mothers, who were children themselves when they had their first baby, has been recognised, we need to acknowledge that this vulnerability can be lasting and that there may be cumulative stresses and risks of harm when these young first time mothers go on to have more children.

The enhanced vulnerability of disabled children is becoming well recognised and was a feature in 12% of these serious case reviews. The risk of harm went unrecognised in these cases, sometimes where the family presented as loving and cooperative.

What are the changes in agency responses?

At the time of the incident, 18 (10%) of the children had a child protection plan - a marked drop since the previous two biennial reviews, in a period when the number of children with a child protection plan has been steadily rising.

Less than half of the children and families were receiving a service from children's social care (42%). A further 23% of cases had been closed, sometimes because of non-cooperation. In 14% of cases a referral had been made but not accepted, implying perhaps that thresholds to children's social care were set too high, particularly in light of the severity of the difficulties presented at the time of the referrals. Just over a fifth (21%) of the children had never been referred to children's social care.

What have we learnt about children aged 5-10?

Analysis of 21 overview reports from serious case reviews concerning children aged between 5 and 10 years revealed few distinct features that could be linked to children in this particular age group. There were instead many similarities with other age groups, and a significant diversity in the type of cases for these children. Such heterogeneity has particular challenges for understanding and practice.

The primary school years are generally perceived to be a positive time for children and rates of serious harm are low. Nevertheless substantial numbers of children do suffer significant harm and there may be particular issues in this age group around hidden adversity. Most of these children will be seen regularly in school, and when they present well, professionals may be unaware of underlying concerns. In contrast to the pre-school years, there tends to be little direct professional engagement with the parents or the home environment. School staff may be unaware of the circumstances of these children outside of the school environment. Indicators of physical and emotional harm may be harder to detect in this age group. Children who are experiencing neglectful or abusive home environments may not stand out at school as being any different from their peers, or may present with otherwise non-specific emotional or behavioural indicators. Staff in universal services need to be alert to this, and aware of the limitations of seeing children only in the safe environment of the

school. When young children display worrying behaviour such as truanting, running away or stealing food, attempts should be made to understand the child's context and to listen to them, not merely to return them home.

Parental mental health problems featured in a majority of cases, and suicidal or self-harming behaviour was particularly prominent. This may be linked to subsequent harm to children, including through extended suicides. Parental suicidal or self-harming behaviour needs to be taken very seriously, and the potential risks to the children thoroughly assessed. Being a parent is generally perceived to be a protective factor in relation to adult suicide or self-harm; thus when a parent is threatening or actually carrying out suicidal or self-harming behaviour, this protective element may have been lost.

Many children in this age group are affected by parental separation. This may be a context within which children are at risk of suffering significant harm, particularly where the separation is coupled with ongoing domestic violence or controlling behaviour; where there are conflicts around contact arrangements; or where children are caught in the midst of acrimonious separations. Domestic violence featured prominently in these cases, and it was clear in several cases that the impact on children did not stop when the parents separated, often with ongoing threats or controlling behaviour affecting both the mother and her children. Some of these cases highlighted that acrimonious separations can present direct risks to children's safety and welfare, including risks of homicide. Even where the cases do not progress to such extremes however, there is evidence that children suffer emotional harm, potentially being used by parents to get at each other, or being caught in the middle of ongoing conflict.

How might better practitioner knowledge of child development help to protect children?

A good working knowledge of child development is essential for all workers who come into contact with children. However access to good child development training is patchy. Child development is not covered thoroughly in all social work qualifying courses where it is subsumed within the broader curriculum of lifespan development. In health, training in paediatrics generally and child development specifically is desirable but not mandatory for General Practitioners, and there is also a lack consistency in child development training for health visitors and paediatricians. Higher Education Institutions providing qualifying teacher training report that primary school teachers receive very limited child development input and secondary school teachers will typically get none. There is scope for improvement in child development training for all professionals working with children.

An understanding of normal motor development in childhood is an essential basis for evaluating the significance of bruising, and for distinguishing potentially abusive from non-abusive injuries. The need for heightened concern about any bruising in a pre-mobile baby is emphasised by their limited physical self control and independent movement. For toddlers and pre-school aged children, an unusual pattern or site of bruising should provoke curiosity about how and why the bruising is occurring, and how well the child is being kept safe and supervised. This is true for all children including those with disabilities and/ or complex health needs.

For disabled children of all ages there was a tendency to see the disability more clearly than the child. This could mean accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child – for example keeping a child shut in a bedroom for long periods for 'safety'. The onus on communicating with children who have communication impairments should be on the practitioner not the child.

A contextual understanding of the differing reasons why parents appear not to be nurturing their child is very important. It is not helpful to consider poor or faltering weight gain for babies and toddlers as a purely mechanical feeding problem; questions about emotional development, attachment and the parent-child relationship need to be raised.

To get a sense of older children's developmental state, professionals need to understand their developmental pathway over time. Practitioners who did not get to know the young person or make a relationship with them, tended to pay insufficient attention to the impact of maltreatment on their development. Pockets of good development in maltreated young people do not necessarily signal resilience.

What have we learnt about recommendations?

The most startling findings to emerge from the Recommendations Study have been not only the sheer volume of recommendations to emerge from reviews (an average of 47 per review), but also that the largely successful endeavour to make them specific, achievable and measurable has resulted in a further proliferation of tasks to be followed through. Carrying through these, often repetitive, recommendations consumes considerable time, effort and resources – but the type of recommendations which are the easiest to translate into actions and implement may not be the ones which are most likely to foster safer, reflective practice. The typical route to grappling with practice complexities, like engaging hard to reach families, was to recommend more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.

Action plans which are easy to implement tend to be ones that address superficial aspects of procedures and concrete tasks. This focus on creating or adapting local procedures, or arranging training for which the LSCB has the responsibility and capability to monitor and implement via the action plan, can mean that the deeper and wider issues get sidelined or diluted.

The interface between societal issues like deprivation and maltreatment are rarely reflected in recommendations or action plans. These big issues, such as poor environment and bad housing, tend to be thought of as beyond the scope of the review despite *Working Together* (HM Government, 2010:248) inviting consideration of national policy and practice issues. LSCBs may consider that these are issues over which they have little influence even though the potential for a single serious case review to prompt wide ranging change should by now be understood.

Rarely was a research evidence base cited for the recommendations made. This begs the question of the extent to which recommendations were thought to be likely to deliver change, and whether there were clear rationales for making, or not making, recommendations. Part of the issue may lie with the skills and knowledge of those conducting the reviews but also perhaps with need to distinguish between learning lessons and making recommendations. Recommendations can be helpful if they lead to definitive action but implementing them should not be seen to imply that learning has taken place. The best learning from serious case reviews may come from the process of carrying out the review.

Learning for practice

There were a number of insights into the traps that professionals can find themselves in. Practitioners found reasons to believe that unrealistic explanations (for bruises for example) were plausible and didn't question themselves or others or act with sufficient curiosity. Throughout the studies there was a sense of disconnection from the children themselves:- not paying attention to children's emotional development and not thinking about what it's like to be a child living in that family or beyond the school setting; seeing the disability not the child; and most powerfully holding back from knowing the child as a person. Acting on these issues and having the confidence to get to know and work with the child requires a sound knowledge of child development, and especially of emotional development. All of these factors and the anxiety that surrounds working with children and families, point up the emotional toll that working with children, from any discipline and especially social work, takes on the practitioner.

This national analysis again highlights the importance of challenging and reflective supervision which pays attention to the impact of the case and the work on the practitioner and goes beyond procedures and processes. Supervision should foster professional development, encourage practitioners to keep their knowledge up to date and prioritise the time needed to get to know children and families. Strong support and constructive challenge of front line practitioners will not be possible if the agency context is one of overwhelming workloads with a limited capacity, or lack of permission to invest in relationship building or critical reflection.

What next for serious case reviews?

The Munro Review has recommended that serious case reviews be undertaken using a systems methodology that moves away from a focus on the specifics of the particular case to identify underlying local issues that influence practice more generally. The shared learning from this practitioner inclusive approach could offer a sense of catharsis and help to restore workers' confidence.

There are perhaps distinctions, however, to be drawn between doing the review and the recording that will result from the serious case review. There are some potential problems if the proposed typology for carrying out a review is also intended as a format for providing data in individual cases which can be aggregated at a national level. If only agency level data is available and characteristics of the child or family are missing it will not, for example, be possible to continue to build the current research database (which dates back to 2003).

Being able to understand differences and similarities between individual cases and the whole cohort of serious case reviews has provided learning with policy implications. Most importantly, having a national sense of the profile of the children and their families puts the children as real people back at the centre of the review.

Future research could now usefully combine learning from serious case reviews and child death overview panels (CDOP). Bringing together data from these and other national sources has been complex but has produced useful results, not least the possibility of establishing a cautious estimate of any rise or fall in child deaths through maltreatment. A similar exercise can be refined and replicated on a regular basis. A framework for the national analysis of serious case reviews which was developed by the researchers could also be used for regional or national analysis of CDOP data.

Chapter 1: Introduction

Serious case reviews are local enquiries into a child's death or serious injury where abuse or neglect are known or suspected and, additionally in cases of serious injury, there are concerns about inter-agency working. These reviews are influential and acknowledged to be important sources of learning. Key aims of the regular (normally two yearly) independent national analysis of serious case reviews commissioned by the Government are set out in *Working Together* (HM Government, 2006:180; HM Government, 2010:255), they are to draw out key findings from reviews and, in so doing, identify lessons for national policy and practice. The set of studies which make up this current biennial analysis were carried out over 19 months (from 1 December 2010 to 31 May 2012) by teams led respectively by Dr Marian Brandon at the University of East Anglia, and Dr Peter Sidebotham at the University of Warwick, combining research and practice expertise in social work and health.

Although this is the fourth consecutive two yearly study of serious case reviews carried out by the same research team, a somewhat different approach has been taken this time. In line with findings from the study '*Learning from Serious Case Reviews*' (Sidebotham et al., 2010), the government decided that rather than publishing all the findings simultaneously in a single biennial report, smaller reports would be published before the end of the two year period to offer the learning to the practice community as soon as possible. This two year report of serious case reviews therefore comprises significant new findings from two previously unreported studies and brings together, and updates, material from three studies that were published over the past year.

The context for serious case reviews undertaken between 2009-11

The shocking death of a single child through abuse or neglect can prompt national level scrutiny of the way that services come together to protect children. The sets of inter-linking studies of serious case reviews reported here, relate to child deaths and incidents of serious harm which took place between 1 April 2009 and 31 March 2011, in the shadow of a number of reviews, both national and local, in response to the death of the toddler Peter Connelly in August 2007. The Laming Progress Report into the protection of children was concluded and reported in March 2009, while the three reports of the Munro Review of Child Protection were published between October 2010 and May 2011 (HC 330, 2009; Munro, 2010, 2011; Cm 8062, 2011).

Although very different reviews, both Lord Laming and Professor Munro emphasised the complexity and intensity of the task for frontline staff in protecting children; both also underlined the need for excellent staff support and sufficient time to do the job properly. Lord Laming was confident that the legal framework and systems in place were robust and staff should be encouraged to get on with the task of protecting children. Professor Munro sought a deeper change in child protection practice, and especially in the culture of organisations, and made a plea for an understanding that risk, including the risk of harm to children, could only be managed and not eliminated. Munro's use of systems theory to understand the difficulties that beset child protection was extended to a recommendation that serious case reviews should be conducted using a systems methodology.

Lord Laming had recommended that serious case reviews should be more transparent with a high quality executive summary, representing the full report, being made available to the public. The Coalition Government took the concept of transparency further, and decided that Local Safeguarding Children Boards should publish overview reports of all new serious case reviews initiated on or after 10 June 2010. These overview reports are to be published together with the executive summaries unless there are compelling reasons relating to the welfare of any children concerned in the case why this should not happen (Loughton, 2010). This heightened scrutiny of the child protection system and the serious case review process provides the backdrop to the cases of children who died or were seriously injured during the two year period 2009-11 and were the subject of a local serious case review.

Methodology for the inter-linking studies

Aims

As in previous two yearly studies, the overarching aim was again to identify common themes and trends across the 2009-11 review reports drawing out the implications for policy and practice. There were also new aims as listed below:

- To explore the feasibility for a combined interface between SCR and child death review data and explore the utility of other available datasets to provide comparator data;
- To develop and design a framework for the qualitative analysis of individual SCRs which can be applied to other types of reviews;
- To examine the evidence from a sample of SCRs where there is evidence to suggest a lack of child development knowledge or training for practitioners, especially social workers;
- To provide a thematic and critical analysis of recommendations and action plans from 30 serious case reviews.

These aims were pursued in five individual but interlinking studies, and are reported here in separate chapters each with their own research questions and methodology. As already noted, three of the studies were separately published during 2011 as stand-alone reports, and as such may have particular relevance for different audiences. There are however common themes which recur across this entire biennial review.

All of the studies are informed by the same clear theoretical approach of interacting risks, which allows an understanding of inter-agency working within the dynamic context of the developing child from within the child's individual environment (Howe, 2005; Cicchetti and Valentino, 2006). The themes covered in each chapter of the report, and the methodology employed are summarised below, with further details on methodology at the start of each chapter.

Chapter 2. Setting serious case review data in context with other data on violent and maltreatment-related deaths in 2009-10.

Research questions:

- To what extent can serious case review data be set in context with other data on violent maltreatment related deaths?
- Can serious case review and child death overview processes data be usefully put together?

The aim of this study was to provide up to date comprehensive data on fatal maltreatment of children in England and to set these in the context of other relevant data on children's health, well being and possible harm. Analysis was drawn from the single year 2009-10, where 73 of the 115 serious case reviews related to the death of a child. Analysis of these cases enabled comparison with death registration data (ONS), Home Office homicide data and Child Death Overview Panel (CDOP) data provided by the Department for Education. This study was undertaken in the summer of 2011 and first published as Research Report RR167 (Sidebotham et al., 2011b). Some of the data have been updated here. https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR167.pdf

Chapter 3. Background characteristics of the children and families and agency involvement.

Research question:

- What are the themes and trends across all cases notified as serious case reviews for the period 2009-11?

This study and chapter provides a statistical description of all 184 cases which were notified to the Department for Education, and entered on the child protection database (CPD) during the two-year period and which led to a serious case review. More detailed information on the key features of the case was obtained from 139 redacted and anonymised overview reports and/or executive summaries, which were subsequently supplied by the Department for Education. The characteristics of the child, family, family environment, and agency involvement were inputted and analysed using the team's on-going coding framework and SPSS database. Wherever possible, data from the previous biennial reviews dating back to April 2003 are given to enable comparison and provide commentary on trends over time.

Qualitative methods (employing the analysis software package NVivo9) were also used, drawing on fuller information from the 139 redacted and anonymised overview reports, to identify and analyse a number of themes which emerged. These themes included:

- the category of injury;
- maternal age;
- the nature of social care involvement (if any) with the child;
- the extent of neglect;
- the interplay of domestic violence, drug use, alcohol misuse or parental mental ill health in the child's family.

This work took place throughout the full 19 month research study period and findings are reported here for the first time.

Chapter 4. Thematic analysis of 5-10 year olds.

Research question:

- What themes emerge from the serious case reviews concerning children in middle childhood (aged 5-10) – a hitherto under-examined group.

This chapter considers serious and fatal child maltreatment in 5-10 year olds, and findings are published here for the first time. Each anonymised overview report was read repeatedly by the research team for analysis. A summary of the case was produced and the data in the report were coded using a thematic framework. Common themes were then analysed within the three core domains of the child, the family and environment including parenting capacity, and systemic and service issues.

Chapter 5. Child and family practitioners' understanding of child development.

Research question:

- How does practitioners' knowledge of child development have an impact on the case and on outcomes for children?

This work was based on an in-depth analysis of six reviews which were purposively selected to enable the research team to consider how the knowledge that practitioners, and especially social workers, have on child development might have had an impact on the case and on outcomes for the children. The study was completed in the summer of 2011 and a full version published by the Department for Education as Research Report RR110 (Brandon et al., 2011b). Some minor adaptations have been made here.
https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR110.pdf

Chapter 6. A study of recommendations arising from serious case reviews.

Research questions:

- What themes emerge from recommendations of serious case reviews?
- How many recommendations are there and do they match the issues the case raises?
- Can recommendations translate easily into improving practice?

This chapter presents a study of recommendations arising from 33 overview reports from serious case reviews. In-depth work was based on the sets of recommendations from 20 reviews from the early part of 2009-10, which were entered into NVivo and analysed with regard to the themes which were identified. The study was completed in the summer of 2011 and published by the DfE as Research Report RR157 (Brandon et al., 2011a). A briefer version of the study is reported here.
https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR157.pdf

Summary

This is the first biennial review where a rigorous attempt has been made to look at the fatal cases which led to a serious case review in the context of child homicide data, child death overview panel (CDOP) data, and ONS data on child deaths (Chapter 2). Access to a greater number of SCR overview reports has allowed us to gather data that had previously been unavailable. We have been able to discover, for example, the extent of neglect in

serious case reviews and the number of children who were known to children's social care at the time of the incident which prompted the review (Chapter 3). This is also the first serious case review study to examine in depth cases relating to children in middle childhood, a hitherto under-examined group (Chapter 4).

Chapter 2: Setting serious case review data in context with other data on violent and maltreatment-related deaths in 2009-10

This chapter summarises data from serious case reviews notified to the Department for Education during 2009-10. The aim of this work is to provide up to date, comprehensive data on serious and fatal maltreatment of children in England, and to set these data in the context of other relevant data on children's health, well-being and possible harm. This has been achieved through a descriptive analysis of serious case reviews from 2009-10, using data from the database reports. Data are compared to other available data sources including Office for National Statistics (ONS) death registration statistics, Home Office data on recorded homicides, Child Death Overview Panel returns, and the Child in Need census.

2.1 Methodology and sources of data

In our initial scoping a number of discrepancies were identified between the various available sources of comparator data, with respect to the time periods (calendar or financial year) and age groupings. The advisory group agreed to use the financial year (1 April to 31 March) in which the incident/death occurred for all comparisons, and to use the following age groups:

Under 1 year

1-4 years

5-9 years

10-14 years

15-17 years.

Data obtained from all sources were checked for accuracy and consistency, and any obvious discrepancies clarified with the source. Data are presented as descriptive data, with numbers and calculated rates by age and gender, based on mid-year population estimates for children aged 0-17 years in England from the Office for National Statistics. Where appropriate, simple statistical comparisons have been undertaken and presented as cross-tabulations.

Office for National Statistics Data

The Office for National Statistics (ONS) has provided data on population, birth registrations and death registrations. Population data are available from the 2001 Census. ONS provides year-on-year population estimates extrapolated from the 2001 census data. Birth registrations are available by calendar year, by gender and by region. Death registrations are provided by age and gender for the following ICD categories:

a. All deaths from all causes
b. All deaths from external causes (XX)
c. X85 – Y09 = homicide and injury purposely inflicted

d. Y10 – Y34 = injury undetermined whether accidentally or purposely inflicted
e. U50.9 = deaths not yet classified
f. R95 – R99 = ill-defined and unknown causes
g. Suicides and self-inflicted injury (X60-84).

Data on the cause of death for infants under 28 days do not include a single underlying cause and are excluded here. The infant mortality figures, therefore, will be for 28 days to 1 year only. Category U50.9 covers a small number of deaths which have not yet been assigned to an ICD category pending adjourned inquests. The majority (around 80%) of these are ultimately recoded as X85-Y09 (Personal communication: Senior Research Officer, ONS). They are therefore included in that category for the purposes of this analysis.

Home Office Homicide Database

Data on police recorded homicides are provided by the Home Office, broken down by age and gender. The Homicide Index contains information about offences recorded by the police as homicide - murder, manslaughter (including corporate manslaughter) or infanticide. The data refer to the year in which the offence was committed. However, in cases where the victim died some time after his/her injuries were inflicted, the offence date reflects the date of death rather than when the injuries were inflicted. Home Office data include cases that may originally have been classified as 'lesser offences' but which may have been re-classified following the death (where the death was some time after the injury being inflicted) or further investigation. They do not contain information about deaths that were only ever recorded as 'lesser offences', such as causing death by dangerous driving, or causing or allowing death of a child or vulnerable person. The data were correct as at 28 September 2010; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available. More recent data on homicides during 2010-11 are available, but not included here as similar data were not available for all data sources.

Children in Need and Child Protection Plan Data

Children in need data are provided by the Department for Education (DfE). Up to 31 March 2009 data on referrals to children's social care, assessments and children who were the subject of a child protection plan were compiled from the Child Protection and Referrals 3 (CPR3) collection from Local Authorities. From 1 April 2009 figures are provided in the Children in Need Census alongside the number of children in need. Data on children in need and children who are the subject of a child protection plan are included as comparator data.

Child Death Overview Panel Returns

Child Death Overview Panel data are provided by the Department for Education (DfE). Annual returns from all Child Death Overview Panels (CDOPs) in England provide aggregated data on the number of children's deaths reviewed by panels and characteristics of these deaths.

2.2 Data on serious and fatal child maltreatment, England 2009-10

Serious Case Review Notifications

There were 124 cases on the DfE Child Protection Database, which had been notified in the period 1 April 2009 to 31 March 2010. However nineteen related to deaths or serious incidents which had happened prior to 1 April 2009, and therefore belong to the previous year's dataset or, in a few cases, to the even earlier 2007-08 dataset. A further 10 cases were notified after 31 March 2010, but related to incidents occurring between 1 April 2009 and 31 March 2010.

The analysis therefore considers a total of 115 serious case reviews relating to incidents occurring between 1 April 2009 and 31 March 2010 which were notified to DfE, equivalent to just under 1 per 100,000 children aged 0-17. These 115 cases form the basis of the descriptive data. Of these 115 incidents, 73 (63%) were fatal (0.66 per 100,000 children aged 0-17) and 42 (37%) were non-fatal.

Of the 114 serious case reviews for which data were available on age and gender, 61 (54%) related to males and 44 (39%) to babies aged under 1 year (Figure 2.1, Table 2.1). Of the 73 fatal cases 52% were male and 42% aged under 1 year. Rates of all serious case reviews and fatal SCRs were calculated using mid-2009 population estimates for England by gender and year of age. The rates for serious case reviews were highest in infancy (6.63 per 100,000 infants) dropping to low levels during the school-age years, before rising slightly in late teenage years. A similar trend is seen in the fatal cases, though without any rise in adolescence. The rates for all serious case reviews are slightly higher in males (1.08 per 100,000 males aged 0-17) than females (0.99 per 100,000 females aged 0-17); and similarly for fatal cases (0.67 per 100,000 males aged 0-17 versus 0.65 per 100,000 females aged 0-17).

Figure 2.1: Rates of serious case reviews (total and fatal cases) by age and gender

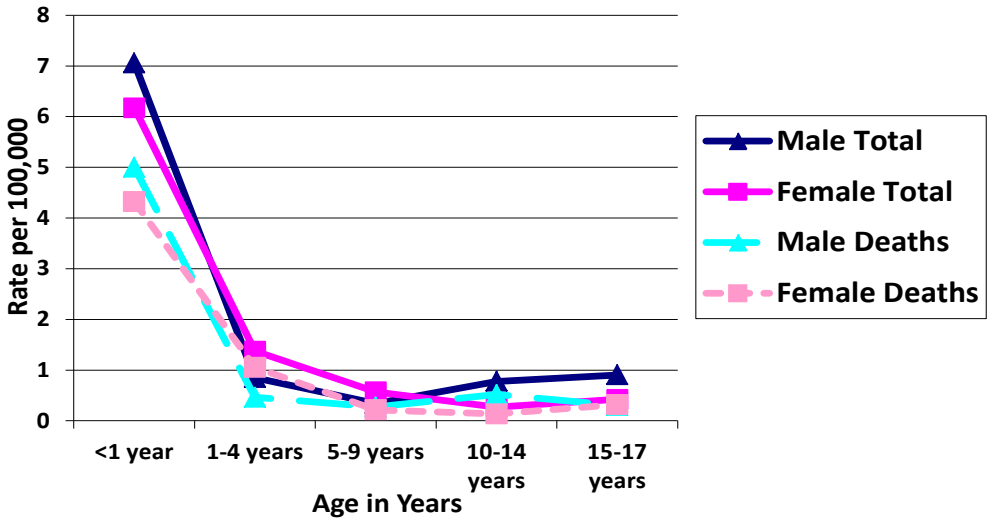


Table 2.1: Age and Gender of cases

All incidents							
Age	**Male**		**Female**		**Total**		
	N	(%)	N	(%)	N	(% in age group)	Rate per 100,000
< 1 year	24	(55)	20	(45)	44	(39)	6.63
1-4	11	(39)	17	(61)	28	(25)	1.11
5-9	5	(38)	8	(62)	13	(11)	0.45
10-14	12	(75)	4	(25)	16	(14)	0.53
15-17	9	(69)	4	(31)	13	(11)	0.67
Total	**61**	**(54)**	**53**	**(46)**	**114**	**(100)**	**1.04**

Fatal incidents							
Age	**Male**		**Female**		**Total**		
	N	(%)	N	(%)	N	(% in age group)	Rate per 100,000
< 1 year	17	(55)	14	(45)	31	(42)	4.67
1-4	6	(32)	13	(68)	19	(26)	0.75
5-9	4	(57)	3	(43)	7	(10)	0.24
10-14	8	(80)	2	(20)	10	(14)	0.33
15-17	3	(50)	3	(50)	6	(8)	0.31
Total	**38**	**(52)**	**35**	**(48)**	**73**	**(100)**	**0.66**

Office for National Statistics Data

During the year 2009-10, there were a total of 54 deaths of 0-17 year olds recorded as due to 'homicide or purposely inflicted injury' or not yet classified; and a further 16 which were classified as 'injuries, undetermined whether accidentally or purposely inflicted' (Table 2.2). These equate to rates of 0.49 per 100,000 children aged 0-17 for homicides, and 0.64 per 100,000 children aged 0-17 for combined homicides and deaths of undetermined intent. During the year 2009-10 there were a total of 2,360 child deaths from all causes (28 days – 17 years). Deaths due to homicide accounted for 2.3% of all child deaths. There were 28 deaths from suicide and self-inflicted injury, of which 22 (79%) were in males and all but two were in the 15-17 age group. There were 239 deaths recorded as ill-defined and unknown causes, of which 153 (64%) were males and 201 (84%) were in infancy. The majority of these unknown causes would be unexplained sudden unexpected deaths in infancy, i.e. SIDS.

Table 2.2: Death registration data (ONS)

Homicide and injury purposely inflicted (including deaths not yet classified)								
Age	**Male**		**Female**		**Total**			
	N	**(%)**	N	(%)	N	(% in age group)	Rate per 100,000	Estimated mid-2009 population
< 1 year	4	**(40)**	6	(60)	10	(19)	1.51	664,000
1-4	6	**(43)**	8	(57)	14	(26)	0.55	2,532,000
5-9	2	**(33)**	4	(67)	6	(11)	0.21	2,863,200
10-14	5	(83)	1	(17)	6	(11)	0.20	3,016,500
15-17	14	(78)	4	(22)	18	(33)	0.93	1,936,500
Total	**31**	**(57)**	**23**	**(43)**	**54**	**(100)**	**0.49**	**11,012,200**

Combined: Homicide and injury purposely inflicted AND injury undetermined whether accidentally or purposely inflicted (including deaths not yet classified)								
Age	**Male**		**Female**		**Total**			
	N	(%)	N	(%)	N	(% in age group)	Rate per 100,000	Estimated mid-2009 population
< 1 year	4	(40)	6	(60)	10	(14)	1.51	664,000
1-4	6	(43)	8	(57)	14	(20)	0.55	2,532,000
5-9	2	(33)	4	(67)	6	(9)	0.21	2,863,200
10-14	8	(73)	3	(27)	11	(16)	0.37	3,016,500
15-17	19	(66)	10	(34)	29	(41)	1.50	1,936,500
Total	**39**	**(56)**	**31**	**(44)**	**70**	**(100)**	**0.64**	**11,012,200**

Home Office Data

There were 52 child homicides recorded by the police for the year 2009-10 (Table 2.3). This gives an overall rate of 0.47 per 100,000 children aged 0-17. In 58% the victim was male.

Table 2.3: Police recorded homicides

Age	Male		Female		Total		
	N	(%)	N	(%)	N	(% in age group)	Rate per 100,000
< 1 year	8	(50)	8	(50)	16	(31)	2.41
1-4	4	(31)	9	(69)	13	(25)	0.51
5-9	2	(50)	2	(50)	4	(8)	0.14
10-14	4	(100)	0	(0)	4	(8)	0.13
15-17	12	(80)	3	(20)	15	(29)	0.77
Total	**30**	**(58)**	**22**	**(42)**	**52**	**(100)**	**0.47**

Children in Need Data

During the year 2009-10 a total of 603,700 referrals were made to children's social care services in England (516,900 children). 395,300 initial assessments and 142,070 core assessments were completed. 44,300 children became the subject of a child protection plan during the year, giving an incidence of 396 per 100,000 children aged 0-17. This is similar to the point prevalence of 39,060 children aged 0-17 (355 per 100,000) who were the subject of a child protection plan at 31 March 2010 (Table 2.4). The prevalence of children being the subject of a child protection plan is highest in infancy and drops steadily to very low levels in later childhood years; however, in terms of overall numbers, over 50% of children who are the subject of a child protection plan are of school-age.

Table 2.4: Children who were the subject of a child protection plan at 31 March 2010

Age at 31 March	Male		Female		Total		
	N	(%)	N	(%)	N	(% in age group)	Prevalence per 100,000
Unborn/Unknown gender					660		N/A
<1	2,300	(52)	2,100	(48)	4,400	(11)	663
1-4	6,400	(52)	5,900	(48)	12,300	(32)	486
5-9	5,800	(53)	5,100	(47)	10,900	(28)	381
10-14	4,400	(51)	4,300	(49)	8,700	(23)	288
15-17	900	(43)	1,200	(57)	2,100	(5)	108
Total	**19,800**	**(52)**	**18,600**	**(48)**	**38,400[1]**	**(100)**	**355[1]**

[1] Excluding unborn/unknown gender children

On 31 March 2010, there were 342,000 children in need in England aged 0-17 (3,161 per 100,000 children aged 0-17), plus a further 6,100 unborn babies or children where the gender was not recorded (Table 2.5). In contrast to the pattern seen in children who are the subject of child protection plans, the prevalence of children in need rises with increasing age.

Table 2.5: Children in Need at 31 March 2010

Age at 31 March	Male		Female		Total		
	N	(%)	N	(%)	N	(% in age group)	Prevalence per 100,000
Unborn/Unknown gender					6,100		
<1	9,700	(52)	9,000	(48)	18,700	(5)	2,816
1-4	41,300	(53)	37,100	(47)	78,400	(23)	3,096
5-9	48,600	(55)	39,300	(45)	87,900	(26)	3,070
10-14	52,500	(55)	43,100	(45)	95,600	(28)	3,169
15-17	32,500	(53)	28,900	(47)	61,400	(18)	3,171
Total	**184,600**	(54)	**157,400**	(46)	**342,000**[1]	**(100)**	**3,161**[1]

[1] Excluding unborn/unknown gender children

Child Death Overview Panel Data

In the year 1 April 2010 to 31 March 2011, Child Death Overview Panels (CDOP) in England reviewed 4,061 deaths of children aged 0-17 years; 2,423 (60%) of those related to children who died before 1 April 2010 and 1,638 (40%) between 1 April 2010 and 31 March 2011. Since the child death overview processes started in 2008 there has been a steady increase in the annual number of child death reviews which are completed by CDOPs. An estimated 71% of all child deaths between 1 April 2008 and 31 March 2011 have been reviewed. There is inevitably some delay in reviewing child deaths due to the need to collect full information with 64% of deaths being reviewed more than 6 months after the death, thus the figures are not directly comparable. Nevertheless they give a reasonable reflection of the overall patterns of children's deaths in this country.

Of the 4,018 deaths reviewed for which data were available, 2,188 (54%) were males. The age breakdown is given in Table 2.6.

Table 2.6: Ages of children reviewed by CDOPs, 1 April 2010 – 31 March 2011

Age	N	(%)
<28 days	1,778	(44)
28 – 364 days	922	(23)
1-4	419	(10)
5-9	261	(6)
10-14	271	(7)
15-17	363	(9)
Unknown	4	(0)
Total	**4,018**	(100)

All children's deaths reviewed by panels are categorised using a hierarchical classification of the cause of death. In this system, a child's death is assigned to the highest category that explains the child's death. The final category of death assigned is given in Table 2.7.

The largest numbers of deaths were from perinatal (36%) or congenital (24%) causes. Nine hundred and fifty seven (24%) deaths were from other acquired natural causes, including malignancy, infection and both acute and chronic medical conditions. Three hundred and forty two (9%) children died of external causes, of which the majority were from trauma and other external factors. Forty seven (1%) deaths were directly attributed to inflicted injury, abuse or neglect and 70 (2%) were from suicide or deliberate self-inflicted harm. Two hundred and ninety nine (7%) deaths remained unexplained. Of the 4,018 deaths for which data were available, 54 (1%) were the subject of a serious case review. The additional cases would represent those in which abuse or neglect was not the primary cause of death but may have contributed, for example some cases of suicide or sudden unexpected deaths in infancy.

Table 2.7: Category of death, CDOP reviews, 1 April 2010 – 31 March 2011

Category of Death	N	(%)
Deliberately inflicted injury, abuse or neglect	47	(1)
Suicide or deliberate self-inflicted harm	70	(2)
Trauma and other external factors	225	(6)
Malignancy	251	(6)
Acute medical or surgical condition	218	(5)
Chronic medical condition	237	(6)
Chromosomal, genetic and congenital anomalies	968	(24)
Perinatal/ neonatal event	1,449	(36)
Infection	251	(6)
Sudden unexpected, unexplained death	299	(7)
Unknown	3	(0)
Total	**4,018**	**(100)**

2.4 Analysis of data on serious and fatal maltreatment

Children in need

In mid-2009, an estimated 11 million children aged 0-17 years were resident in England. 342,000 children (3% of the child population) were deemed to be 'Children in Need' at 31 March 2010 (excluding unborn children and those of unknown gender). The age profile of Children in Need approximates to that of the general population (Table 2.8). There was a slight male excess (54% of Children in Need compared to 51% in the general child population). Of those children, the primary need recorded at initial assessment was abuse or neglect in 148,300 cases (39%). Other common primary needs included family dysfunction (16%), child disability or illness (12%) and acute family stress (10%). 38,400 children aged 0-17 were the subject of a child protection plan at 31 March 2010 (0.3% of the child population). The age profile of those children who were the subject of a child protection plan differed from the general population, with an excess of infants and pre-school children. The gender ratio for children who were the subject of a child protection plan was 52% male, in line with the overall child population ratio.

Table 2.8: Prevalence of Children in Need and children who were the subject of a child protection plan at 31 March 2010

Age	**Mid-year population estimate, 2009**		**Children in Need (at 31 March 2010)**			**Children who were the subject of a child protection plan at 31 March 2010**		
	N	(% in age group)	N	(% in age group)	Prevalence per 100,000	N	(% in age group)	Prevalence per 100,000
Unborn			6,100			660		
<1	664,000	(6)	18,700	(5)	2,819	4,400	(11)	663
1-4	2,532,000	(23)	78,400	(23)	3,094	12,300	(32)	486
5-9	2,863,200	(26)	87,900	(26)	3,071	10,900	(28)	381
10-14	3,016,500	(27)	95,600	(28)	3,169	8,700	(23)	288
15-17	1,936,500	(18)	61,400	(18)	3,171	2,100	(5)	108
Total	**11,012,200**	**(100)**	**342,000[1]**	**(100)**	**3,161[1]**	**38,400[1]**	**(100)**	**355[1]**

[1] Excluding unborn/unknown gender children

The point prevalence of Children in Need and children who were the subject of a child protection plan provides an estimate of the numbers and proportion of children recognised as needing children's social care services at any one time. Equally important are measures of incidence, i.e. the number of new cases becoming the subject of a child protection plan. During the year 2009-10, 43,600 children became the subject of a child protection plan, along with a further 600 unborn babies (Table 2.9). Again the age profile shows an excess

of infants and young children. The actual numbers of children in need and children in need of protection are unknown and are likely to be higher. This is particularly so in relation to children in need of protection, as it is well recognised that a large proportion of child maltreatment does not come to the notice of professionals. Furthermore, some children who have been abused will not become the subject of a child protection plan if it is decided they are no longer at continuing risk of suffering significant harm. The *Lancet* series on child maltreatment estimated that each year about 4–16% of children are physically abused, around 10% experience neglect or psychological abuse, and between 5-10% of girls and up to 5% of boys are exposed to penetrative sexual abuse (Gilbert et al. 2009). More recently, the NSPCC national prevalence study estimated that 3.9 per cent of under 18s had one or more experiences of physical, sexual or emotional abuse, or neglect by a parent or guardian in the past year, and 14.1 per cent of children and young people had one or more experiences of physical violence, sexual abuse, emotional abuse or neglect by a parent or guardian at some point during their childhood (NSPCC 2011).

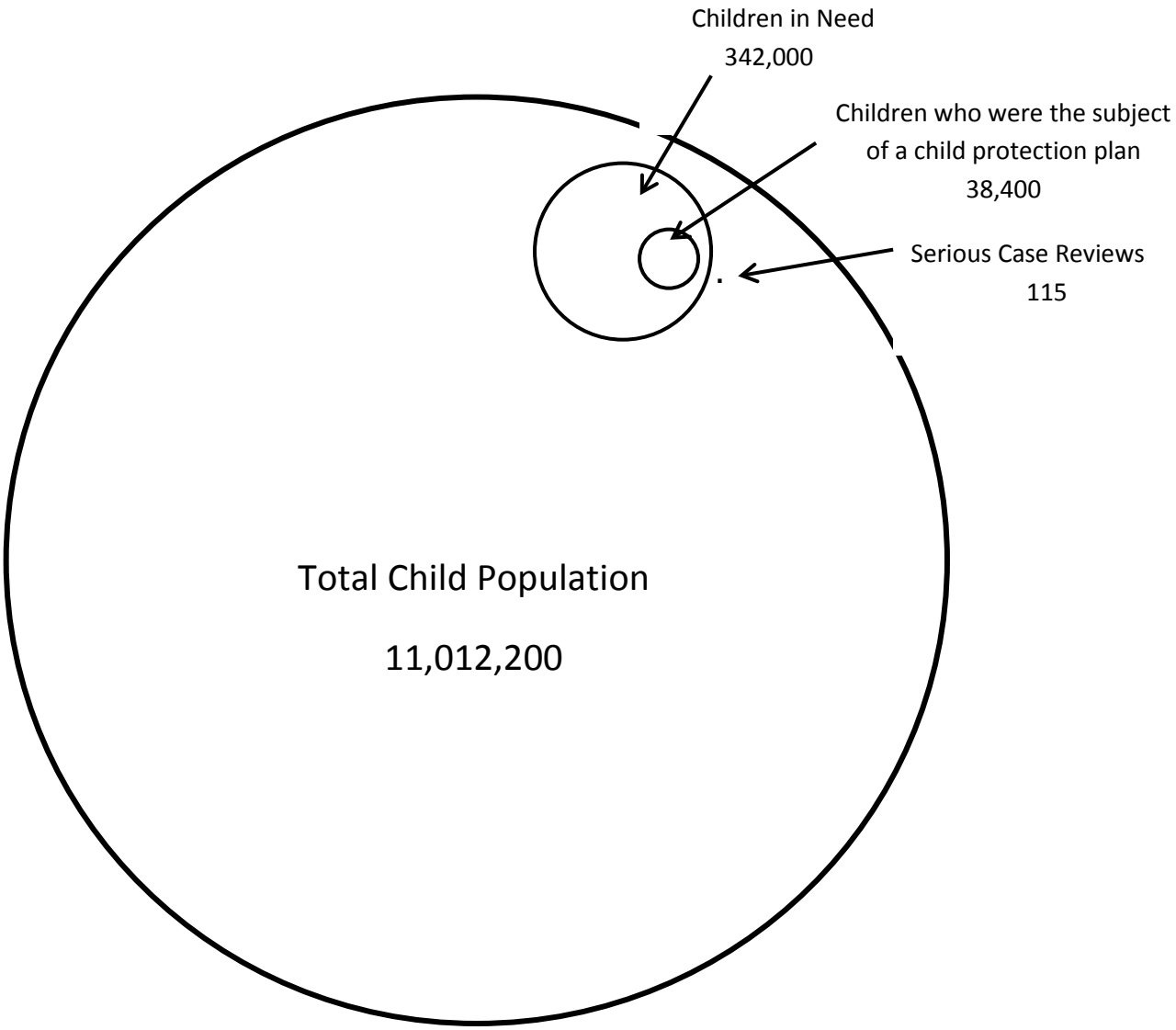
Table 2.9: Children who became the subject of a child protection plan and serious case review

Age at start of child protection plan	**Children who became the subject of a child protection plan 2009-10**			**Serious case reviews 2009-10**		
	N	(% in age group)	Rate per 100,000	N	(% in age group)	Rate per 100,000
Unborn	600		N/A			
<1	9,000	(21)	94	44	(39)	6.63
1-4	12,600	(29)	357	28	(25)	1.11
5-9	11,300	(26)	441	13	(11)	0.45
10-14	9,000	(21)	373	16	(14)	0.53
15-17	1,700	(4)	465	13	(11)	0.67
Total	**43,600[1]**	**(100)**	**392[1]**	**114**	**(100)**	**1.04**

[1] Excluding unborn/unknown gender children

Compared to the numbers of Children in Need, and to those children who are the subjects of child protection plans, the numbers of children who were the subject of serious case reviews following serious and fatal maltreatment are low. Just over 1 in 100,000 children aged 0-17 were the subjects of serious case reviews during 2009-10, compared to 400 in 100,000 becoming the subject of a child protection plan, and over 3,000 per 100,000 being deemed Children in Need. This can be illustrated by a series of circles, the volume of each representing the number of children in different categories (Figure 2.2). Although this gives us a visual representation of officially recognised need, it must be interpreted with caution in the light of the acknowledged under-recognition of child maltreatment. Indeed, drawing on the estimates from the published literature of the proportion of children experiencing abuse or neglect who do not come to the notice of professionals, one could draw a further circle, half as wide again as that for Children in Need, to represent those children who are currently experiencing abuse or neglect.

Figure 2.2 The numbers of Children in Need and child protection in England, 2009-10



Extrapolating from these figures, a typical Local Authority with a population of 500,000 would have just over 100,000 children aged 0-17. They could expect to have around 3,500 Children in Need at any one time. In a typical year, they could expect around 420 children to become the subject of a child protection plan, while on average one child might suffer serious or fatal maltreatment each year resulting in a serious case review. This latter figure, being so small, is subject to considerable year-on-year variation. A single serious incident involving a large family could skew the figures for a single year. Thus at a local or even at a regional level, single-year figures for serious case reviews need to be treated with some caution. Rates of serious case reviews will vary geographically and over time in relation to a combination of the actual levels of serious and fatal maltreatment, and to the thresholds applied in the decision to undertake a serious case review. This may particularly apply to the numbers of non-fatal cases, where there is a degree of independent judgement as to

whether or not to initiate a serious case review, in contrast to the obligation to undertake one in every fatal case where abuse or neglect is suspected.

Violent Child Deaths: a comparison of different data sets

A comparison of the DfE, ONS and Home Office data on child deaths shows some apparent slight discrepancies in the figures for the numbers of children dying as a result of violence or abuse, particularly in relation to infants and adolescents (Table 2.10). These differences largely reflect the different entities that are being measured in the different datasets, along with some differences in the manner in which data are collected. The figure of 47 deaths attributed to deliberately inflicted injury, abuse or neglect from the CDOP returns is comparable to the 54 deaths recorded as homicide and injury purposely inflicted by ONS, and the 52 police recorded homicides. CDOP data on category by age are not available, and as the data relate to deaths reviewed in 2010-11, rather than to the date of death, the overall figure is given for comparison purposes only.

Table 2.10: Violent child deaths, 2009-10. Numbers (rates per 100,000)

Age	SCR Data		ONS Data		Home Office Data		CDOP Data
	N	(Rate)	N	(Rate)	N	(Rate)	N
<1	31	(4.67)	10	(1.51)	16	(2.41)	
1-4	19	(0.75)	14	(0.55)	13	(0.51)	
5-9	7	(0.24)	6	(0.21)	4	(0.14)	
10-14	10	(0.33)	6	(0.20)	4	(0.13)	
15-17	6	(0.31)	18	(0.93)	15	(0.77)	
Total	**73**	**(0.66)**	**54**	**(0.49)**	**52**	**(0.47)**	**47**

The serious case review data relate to all cases of children dying during 2009-10 where abuse or neglect was known or suspected to be a factor in their death. Thus these data should include all deaths occurring as a direct result of abuse or neglect, but will also include children dying of other causes, for whom abuse or neglect was a factor, but not the direct cause of death. An analysis of previous serious case reviews found that in 50% of fatal cases, maltreatment was the direct cause of death, including severe physical assaults, overt and covert homicide and extreme neglect (Sidebotham et al. 2011(a)). In the remaining 50% abuse or neglect was a contributory factor but not the primary cause of death. These cases included infants dying suddenly and unexpectedly, teenage suicides, and other deaths from accidents or natural causes. Thus not all child fatalities which become the subject of a serious case review will be recorded as homicides, either for the purposes of death registrations, or from the perspective of police investigations. This may explain why the SCR data in infancy are higher than those from the ONS and Home Office.

The Home Office data include all cases which the police, at a specific point in time, are recording as homicide. This will include some cases which are currently under investigation but which subsequently turn out not to be homicides. It is possible that a small number of cases will be reclassified and the final numbers may be marginally lower. The Home Office figures include all police recorded homicides, regardless of perpetrator. Some of these, particularly in the older age groups, will be perpetrated by persons outside the family, including peers, gang violence and unrelated homicides. Many of these would not be considered child maltreatment-related, and so may not result in a serious case review. Conversely the Home Office figures will not include deaths where abuse or neglect may have played a part, but which are not recorded by the police as homicides. Many of the broader category of maltreatment-related deaths, included in the serious case review data, will not feature in the Home Office data.

The ONS data are based on death registrations, and for most of the categories of interest these will be based on coroners' verdicts as to the cause of death. Coroners are likely to record a death as homicide only when they are certain that is the case. Thus the ONS figures for homicide would be expected to be lower than those from the Home Office. The inclusion of deaths from injury, undetermined whether accidentally or purposely inflicted, gives a higher estimate of the number of homicides (70 deaths, 0.64 per 100,000 children aged 0-17), including those which the coroner is unable to conclusively label as such. However, these figures will also include some deaths which are truly accidents. Nevertheless, it is our view that the data for combined homicide and undetermined cause give a more accurate estimate of the true numbers of homicides (Sidebotham et al. 2011a). As with the Home Office data, the ONS data do not include those deaths related to but not directly caused by maltreatment, so would be anticipated to provide lower figures than those from serious case reviews, particularly in infancy. They will however include homicides perpetrated by persons outside the family, a category which becomes increasingly important with increasing age, hence the higher figures in adolescence.

All three data sources are likely to miss some violent deaths or deaths due to maltreatment. Thus there will be some covert homicides which are not detected by any agency and thus get recorded as deaths from other causes, and not investigated as homicides or maltreatment-related. Other deaths may initially be investigated as potentially suspicious, but subsequently concluded not to be. Most notable are the sudden unexpected deaths in infancy (SUDI). In at least 50% of these deaths, no cause of death is found after a thorough investigation, and the deaths are correctly recorded as sudden infant death syndrome (SIDS), or an equivalent term. It is well recognised that a small, but nevertheless significant proportion of these will be covert homicides. Most researchers and practitioners estimate that up to 5-10% of SIDS may be covert homicides, thus of the 250 cases of SIDS annually, up to 25 could in fact be homicides. Many of these are already the subject of serious case reviews, but it is possible that others will not be.

With those caveats in mind, the combined data provide a reasonable estimate of the total number of violent and maltreatment-related child deaths for 2009-10. The total number of homicides in children and young people aged 0-17 in England is around 50-55 based on the ONS and Home Office data (approximately 0.48 per 100,000 children aged 0-17). Rates are highest in infancy (1.51-2.41 per 100,000 children aged 0-17) dropping to just over 0.5 per 100,000 in the preschool years, less than 0.2 per 100,000 in the school-age years, and rising again in late adolescence to just under 1 per 100,000. The numbers and rates of serious

case reviews are similar in the middle childhood years. There is a higher rate in infancy, reflecting the inclusion of unexpected infant deaths where maltreatment may have played a part but was not the direct cause of the child's death, and a lower rate in adolescence, reflecting that many violent deaths in this age group are not perpetrated by family members. Taking the highest figure for each age group (i.e. the SCR data for children aged under 15 years and the ONS data for children aged 15-17 years), we estimate the total number of violent and maltreatment-related child deaths (0-17 years) to be around 85 (0.77 per 100,000).

The report which forms the basis of the chapter was published by the DfE in autumn 2011 (Sidebotham, 2011b), and included a preliminary consideration of the numbers of serious case reviews over time, from 2005-10. The data have been updated here to include a further 10 cases notified after 31 March 2010, but relating to incidents before that date. This analysis has now been taken forward and full statistics are given in the following chapter (chapter 3), with an update to include the second year of the biennial period, and comparisons of data from 2003-11 inclusive.

Chapter 2: Summary

- Drawing on the serious case review notifications from 1 April 2009 to 31 March 2010 and comparator data from other sources, we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death.

- While there is considerable year-on-year fluctuation in the total number of serious case reviews, most of this relates to non-fatal cases where there is some discretion for LSCBs in deciding whether or not to carry out a SCR. The overall rates of SCRs relating to fatal cases have remained relatively stable over the past 5 years.

- We have previously reported that overall rates of violent deaths in infants and children have fallen over the past 30 years (Sidebotham, Atkins et al., 2012), although rates in adolescents have not fallen. The highest risks remain in infancy, although a second peak is seen in adolescence. The patterns and nature of these deaths are likely to vary and any further efforts to reduce these rates should be based on a good understanding of the different patterns.

- It is clear from this analysis that no one data source is robust enough to capture all violent and maltreatment-related deaths. It is hoped that by comparing annual data from a range of sources, it will be possible to gain a reasonably accurate profile of these deaths, and to show any trends over time, allowing for the fluctuations caused by small numbers.

- An earlier version of this chapter was published in 2011 as DFE-RR167 and can be downloaded from the Department for Education website: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR167.pdf

Chapter 3: Background characteristics of the children and families, and agency involvement

This chapter provides an update of the background characteristics of the children and their families, and a comparison with patterns and trends found in our previous three biennial analyses (Brandon et al., 2008, 2009 and 2010). While it is important to acknowledge the individual, and often harrowing, stories of each child or young person at the centre of the reviews, it is also important to be able to consider each case objectively and systematically as part of the whole set of reviews, and to be able to manage and make sense of the information they contain, and the common themes which often link them.

The chapter incorporates an extended examination of the incident or harm that prompted the review. Since this is the fourth biennial review using the same methodology, we now have eight years of comparable data, covering 802 cases – of which 502 (63%) were fatal. In the following tables we have presented, whenever possible, data from all four biennial periods, to cover the years from 2003 to 2011. This has resulted in robust baseline data on the children and young people and their families, and agency responses and involvement with them. Importantly it has provided continuity of analysis.

The number of serious case reviews undertaken

Using the information from the child protection database (CPD), we conducted a repeat, updated analysis of the information. Over the two-year period 2009-11 there were 184 notifications relating to incidents which led to a serious case review. There is an overall reduction in the number of reviews in comparison with the last biennial analysis (2007-09), when 280 serious case reviews[2] were undertaken, and a return to the earlier pattern of somewhat fewer reviews (for example 189 reviews during 2005-07 and 161 during 2003-05). There also appears to be a return to the earlier overall balance of two thirds fatality cases and a third non fatal cases. However, if the two years are considered separately, some differences emerge.

In the year April 2009 – end March 2010 there were 115 serious case reviews and in the following year April 2010 – March 2011 there were 69. This pattern of more cases in the first than second year is typical, although more pronounced here than in previous years. In the first year approximately two thirds of the cases involved a child death (73) and one third were non fatal, serious injury cases (42), whereas in the second year there were proportionately fewer serious injury cases (21 of the 69) showing a 70/30% division between fatal and non-fatal cases. The apparently smaller number of reviews in the second year may reflect, in part, a delayed decision about undertaking a serious case review, although this would be unlikely to account for more than a half a dozen additional cases. Another explanation for the drop in the number of reviews in this second year, and particularly a drop in the number of serious injury cases where there is more discretion about undertaking a review, could be a reticence among Local Safeguarding Children Boards to carry out a

[2] The 2007-09 total has been revised upwards to 280, from the figure of 268 published in the original review of these cases. We have been able to incorporate late notifications into the analysis, and thus present more accurate statistics.

serious case review. This could be driven by a number of factors, not least the Ofsted serious case review evaluation process and the requirement to publish serious case reviews initiated on or after 10 June 2010 (Loughton, 2010). Feedback at conferences and in a forthcoming study of family involvement in serious case reviews has suggested that publication is limiting the number of reviews undertaken (Morris et al, forthcoming).

Over time there has been a fairly consistent pattern in the number and rates of serious case reviews, particularly for the fatal cases, from 2003-11. The exception to this is the peak in the numbers of serious case reviews, particularly serious injury cases, between 2007-09. This largely pre-dated the spotlight on reviews following the widespread debate, which began in the autumn of 2008, surrounding the circumstances of the death of Peter Connelly and a shift in expectations of reviews from Ofsted at a similar time. It is also important to note, however, that this spike in the number of reviews did not represent a real difference in the incidence of severe and fatal maltreatment (as we have shown in Chapter 2) and might have reflected a greater willingness to undertake reviews in order to learn from these cases. Further comparisons between fatal and non-fatal cases are considered later in the chapter (p.36).

As previous reports have highlighted, information is sometimes limited at the point of notification. In an attempt to fill in some of the 'gaps' missing from previous biennial reviews this report offers a more in-depth analysis by supplementing the child protection database (CPD) data, using the detailed information contained in 139 overview reports or executive summaries available to us (representing 78% of the full sample). This has been a valuable exercise – enabling us to report results with more confidence. The particular areas which were selected for more detailed and intensive scrutiny were:

- **Cause of death or serious injury**
  For the first time we are presenting analysis of both the classification system for children who die (developed by Sidebotham et al., 2011a) as well as for those who are seriously injured (Brandon et al., 2010) in the one biennial review. These new frameworks enable us to build on our knowledge of the possible causes of these incidents, and the frequency of their occurrence.

- **Inter-relationship between domestic violence, mental ill health and substance misuse**
  At least one of these characteristics was evident in the lives of the families at the centre of serious case reviews in 86% of the cases. Almost two thirds of the cases featured domestic violence, and parental mental ill health was identified in 60% of cases. Parental substance misuse was evident in 42% of cases. All three factors were present in just over a fifth of the cases and, as in our previous biennial reviews, we argue that it is the combination of these factors which is particularly 'toxic'.

- **The extent of neglect**
  The extent of neglect as an underlying feature of these cases can easily go unrecognised. We found that neglect was a feature in at least 60% of the serious case reviews. Past neglect was a factor in eleven out of fourteen reviews conducted following a young person having been believed to have committed suicide.

- **Maternal age at birth of first child**
  For the first time we have collected information on the age of the mother when her first child was born, although the incident to the index child may have happened some years later. We found that nearly 60% of the mothers were under 21 years of age at the time of their first confinement. In the general population the mean age of mothers at the time of the birth of their first child in 2010 was 27.8 years (ONS 2011b).

- **Children's social care involvement**
  The number of children and families receiving any service from children's social care at the time the child died or was seriously injured or harmed was 42%. A further 23% of cases had been closed, and for 14% of the children referrals had been made but did not reach the threshold for an initial assessment and were therefore not accepted. A significant minority of just over a fifth of the children (21%) had never been referred to children's social care.

3.1 Characteristics of the children and their families

The remainder of this chapter concentrates on the 178 cases originally notified within the 2009-11 timeframe, since six of the cases referred to incidents which had occurred in 2009-11, but were notified to the Department for Education in the subsequent year, 2011-12 (too late for inclusion in most of our analysis).

Age of child

As in the three earlier biennial studies, the largest proportion of incidents related to the youngest children, who were aged under one year. There were 64 children in this age group, and as a proportion of all children at the centre of reviews, the percentage had declined to 36% from an average of 46% (Table 3.1). Forty-seven (73%) of the 64 reviews for this age group related to a fatality, a smaller number than in previous years. Sudden unexpected deaths in infancy which led to a review fell from 20 and 28 in 2005-07 and 2007-09 respectively to 15 in 2009-11. In addition there was a marked reduction in the number of serious case reviews undertaken for non-fatal incidents in the under-one age group, from 55 in the period 2007-09 to just 17 in the period 2009-11. This reduction may reflect a change over time in local decision-making as to when to undertake serious case reviews, and perhaps may be related to the CDOP processes becoming statutory from 1 April 2008. However, the smaller number of reviews which concern infants might also be attributable to the efforts to spread awareness among practitioners and community groups of the vulnerability of babies and the risks of harm they face.

Table 3.1: Age of child at time of incident

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)
<1yr	76 (47%)	86 (46%)	123 (44%)	64 (36%)
1-5yrs	33 (21%)	44 (23%)	60 (22%)	51 (29%)
6-10yrs	11 (7%)	18 (10%)	26 (9%)	21 (12%)
11-15yrs	26 (16%)	20 (11%)	40 (14%)	27 (15%)

16-17yrs	15 (9%)	21 (11%)	31 (11%)	15 (8%)

Of the 64 children aged under one year, 26 (41%) were under three months of age, 24 (38%) were aged three to five months, 9 (14%) were aged six to eight months, and the remaining 5 children (8%) were between nine months and one year. Although smaller in number, the proportions of babies in each of these age bands remain similar to that in previous biennial studies.

The proportion of children aged between one and five years has increased to 29% in this two year period, from an average of 22% in the three previous biennial periods. Similarly there has been some increase in the proportion of six to ten year olds who were the focus of a review, although this remains one of the smallest groups. These have been the 'hidden' children in serious case reviews and themes relating to this group of middle years children are examined in depth later in Chapter 4 of this report.

Gender of child

As in our previous studies, a slightly higher proportion of boys than girls were the subject of a serious case review. Although this proportion had been lower in the set of 2007-09 cases, it has otherwise been remarkably stable since 2003 at around 56%.

Table 3.2: Gender of child

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=177)
Male	88 (55%)	106 (56%)	142 (51%)	100 (56%)
Female	73 (45%)	83 (44%)	138 (49%)	77 (44%)

Boys are still over-represented in the younger age groups (0-5 years), and in the age category of under one year, 39 of the 64 (61%) babies were boys compared to 25 girls (39%). There appears to be a pattern over all three studies of boy babies being particularly vulnerable (see Table 3.3). There were also more boys than girls in the 11-15 age band over the current two year period. However there is no pattern for gender distribution among this age group with all three studies showing different gender balances for the young people aged 11-15 years.

Table 3.3: Age at time of incident by gender

Age group	Gender 2005-07 (n=189)		Gender 2007-09 (n=280)		Gender 2009-11 (n=177)	
	Female (n=83)	Male (n=106)	Female (n=138)	Male (n=142)	Female (n=77)	Male (n=100)
<1yr	34 (40%)	52 (60%)	55 (45%)	68 (55%)	25 (39%)	39 (61%)
1-5yrs	17 (39%)	27 (61%)	23 (38%)	37 (62%)	24 (48%)	26 (52%)
6-10yrs	11 (61%)	7 (39%)	14 (54%)	12 (46%)	11 (52%)	10 (48%)
11-15yrs	10 (50%)	10 (50%)	26 (65%)	14 (35%)	10 (37%)	17 (63%)

16 + yrs	11 (52%)	10 (48%)	20 (65%)	11 (35%)	7 (47%)	8 (53%)

Ethnicity

Data for ethnicity are displayed in Table 3.4. Over time these data on ethnicity have steadily become more comprehensive, and in only six reports (3%) was ethnicity not stated. By contrast, ethnicity data were missing in 5%, 8% and 16% of the reports pertaining to incidents occurring during 2007-09, 2005-07 and 2003-05 respectively.

The final columns of Table 3.4 provide a context for considering the ethnicity of the children and young people who were the subjects of reviews, and shows the ethnic distribution of the children who were looked after in March 2011 in England, alongside the estimated ethnic distribution of all children aged 0-15 in England in 2007. There is a tendency for children of black/black British ethnicity to be over-represented in serious case reviews, as they are in the population of looked after children. One can also note that a slightly higher percentage of serious case reviews concern white children in 2009-11 than in the earlier biennial studies.

Table 3.4: Ethnicity

	Frequency 2003-05 (n=136)	Frequency 2005-07 (n=173)	Frequency 2007-09 (n=267)	Frequency 2009-11 (n=172)	Children Looked After 31st March 2011 *	Children aged 0-15 years England 2007 **
White	101 (74%)	125 (72%)	204 (76%)	137 (80%)	77%	84%
Mixed	8 (6%)	23 (13%)	25 (9%)	11 (6%)	9%	4%
Black/Black British	17 (13%)	13 (8%)	24 (9%)	14 (8%)	7%	3%
Asian/Asian British	8 (6%)	8 (5%)	12 (4%)	7 (4%)	5%	7%
Other Ethnic Group	2 (1%)	4 (2%)	2 (1%)	3 (2%)	3%	1%

* DfE (2011a) Children Looked After by Local Authorities in England - year ending 31 March 2011. Table LAA8
** ONS (2010a) Population Estimates by Ethnic Group mid-2007. Table EE3

Siblings

Full information on siblings was not always available. In particular it was difficult, in some instances, to determine whether there were no siblings or whether this information was simply missing (Table 3.5).

Table 3.5: Number of Siblings

Number of siblings	Frequency 2003-05 (n=152)	Frequency 2005-07 (n=177)	Frequency 2007-09 (n=250)	Frequency 2009-11 (n=175)
0	41 (27%)	42 (24%)	52 (21%)	53 (30%)
1	50 (33%)	54 (31%)	90 (36%)	52 (30%)
2	28 (18%)	42 (24%)	59 (24%)	32 (18%)
3	13 (9%)	20 (11%)	30 (12%)	21 (12%)
4	7 (5%)	11 (6%)	9 (4%)	9 (5%)

5	7 (5%)	4 (2%)	7 (3%)	4 (2%)
6 and over	6 (4%)	4 (2%)	3 (1%)	4 (2%)

One in five reviews relate to large families with four or more children (i.e. three siblings and the index child), and this pattern has remained constant throughout the eight year period of our four biennial reports.

The sample included four index children who were a twin, representing 2%. Nationally 1.57% of all deliveries are multiple births (ONS, 2011a). It is worth noting that in three of the four cases involving a twin, the baby was under 6 months at the time of the incident, that the twins were their mothers only children at that time, and that two of the mothers were aged 16 and 17 at the time of the incident.

Birth Order

Birth order was not specifically given on the notification report but, in many cases, could be deduced from information provided on the date of birth of siblings. Where there were siblings, and birth order could be determined, around two thirds of cases concerned the youngest child (see Table 3.6).

Table 3.6: Birth Order (for children who had siblings)

	Frequency 2005-07 (n=127)	Frequency 2007-09 (n=177)	Frequency 2009-11 (n=94)
Oldest Child	22 (17%)	36 (20%)	12 (13%)
Youngest child	75 (59%)	115 (65%)	63 (67%)
Both Older and Younger Siblings	27 (21%)	22 (12%)	16 (17%)
Twin of single pregnancy	3 (2%)	4 (2%)	3 (3%)

However, given that over a third of all the cases concerned babies under 1 year of age, many were by definition the youngest child. The heightened vulnerability of the youngest child appears to be a recurring theme in the biennial reviews.

Child Disability

A total of 21 children (12%) were identified as being disabled (Table 3.7). Previously we have just relied on CPD data to inform our analysis, but our thorough scrutiny of a much larger number of overview reports than in previous years has revealed a greater prevalence of disability than previously indicated. The extent of disability is still less than might be expected perhaps because of the young age of most of the sample and the possibility that disability had not yet been recognised.

There is a growing body of knowledge about the enhanced vulnerability to abuse of disabled children, and this appeared to be reflected in our sample. There was evidence from a number of cases involving children with a disability that the risk of significant harm went

unrecognised, including in some cases where the family presented as loving and cooperative.

Table 3.7: Disability (prior to incident)

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n= 187)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)
No	153 (95%)	173 (93%)	256 (91%)	157 (88%)
Yes	8 (5%)	14 (7%)	24 (9%)	21 (12%)

Child Protection Plans

Despite a national increase in the number of children who are the subject of a child protection plan (from 25,900 at 31.03.2005 to 42,700 at 31.03.2011: Department for Children Schools and Families, 2007; DfE, 2011), this does not appear to be reflected in a parallel rise in SCRs for children who had a plan in place. Table 3.8 shows that at the time of the incident, 18 (10%) of the children were the subject of a child protection plan, which is a marked fall in the number and proportion when compared with the cases covered in the previous two biennial reviews. It would be encouraging if this fall implied that child protection plans were effectively protecting children. This is a reasonable interpretation which suggests that professionals may be doing better in preventing the death or serious injury of those children known to be suffering or likely to suffer significant harm. On the other hand, child protection plans may be being ended prematurely.

A further 23 children (13%) had been the subject of a plan in the past. This proportion has remained constant over time, and shows that risks of serious harm can be enduring.

Table 3.8: Index child with a child protection plan

	Frequency 2005-07 (n=175)	Frequency 2007-09 (n=276)	Frequency 2009-11 (n=177)
No	127 (73%)	198 (72%)	136 (77%)
Yes*	29 (17%)	43 (16%)	18 (10%)
Has been	19 (11%)	35 (13%)	23 (13%)

* A small number of cases were removed where the plan was highly likely to be post incident. This applied to 4 cases in 2005-07 and 4 cases in 2007-09.

The category of child abuse or neglect suffered by the child is explored in Table 3.9. While neglect remains the most frequent category recorded, as a proportion it has declined (although the numbers of children with a child protection plan in the category of neglect has increased nationally). Conversely, the proportion of children with a plan under the category of physical abuse has risen, from 35% to 41%, although it should be reiterated that this is a smaller number in absolute terms, when compared to 2007-09.

Table 3.9: Index child with a child protection plan (current or past) - category of plan

	Frequency 2005-07 (n=46*)	Frequency 2007-09 (n=78)	Frequency 2009-11 (n=41)
Neglect	30 (65%)	46 (59%)	21 (51%)
Physical abuse	11 (24%)	27 (35%)	17 (41%)
Emotional abuse	7 (15%)	21 (27%)	10 (24%)
Sexual abuse	7 (15%)	10 (13%)	5 (12%)

*Category of plan missing for two children. Children may be named in more than one category, and the columns therefore sum to more than the total number of children.

Where were the children living?

Information about where the child was living at the time of the incident is displayed in Table 3.10. This shows that, at the time of the incident, most of the children (87%) were living at home or with relatives but, as in earlier years, that death and serious injury can also occur for children living in supervised settings.

Table 3.10: Where living at time of incident

	Frequency 2005-07 (n=187)	Frequency 2007-09 (n=278)	Frequency 2009-11 (n=177)
Living at home	148 (79%)	229 (82%)	145 (82%)
Living with relatives	10 (5%)	11 (4%)	8 (5%)
With foster carers (short term, long term or short break)	7 (4%)	8 (3%)	4 (2%)
Hospital, mother and baby unit and residential children's home	7 (4%)	15 (5%)	8 (5%)
Semi-independence unit	5 (3%)	3 (1%)	1 (1%)
Other, including YOI	10 (5%)	12 (4%)	11 (6%)

Domestic violence, substance misuse and parental mental health problems

Previous biennial reviews have noted the prevalence of domestic violence, misuse of alcohol and/or drugs, and parental mental health problems in the lives of the families at the centre of serious case reviews. Fuller information, drawn from 139 overview reports, allows us to get a clearer understanding of the extent to which these factors feature and overlap. Table 3.11 displays the frequency with which each factor was mentioned in the reviews as being significant for the family. There was evidence that about two-thirds of cases featured domestic violence, and mental ill health of one or both parents was identified in nearly 60%

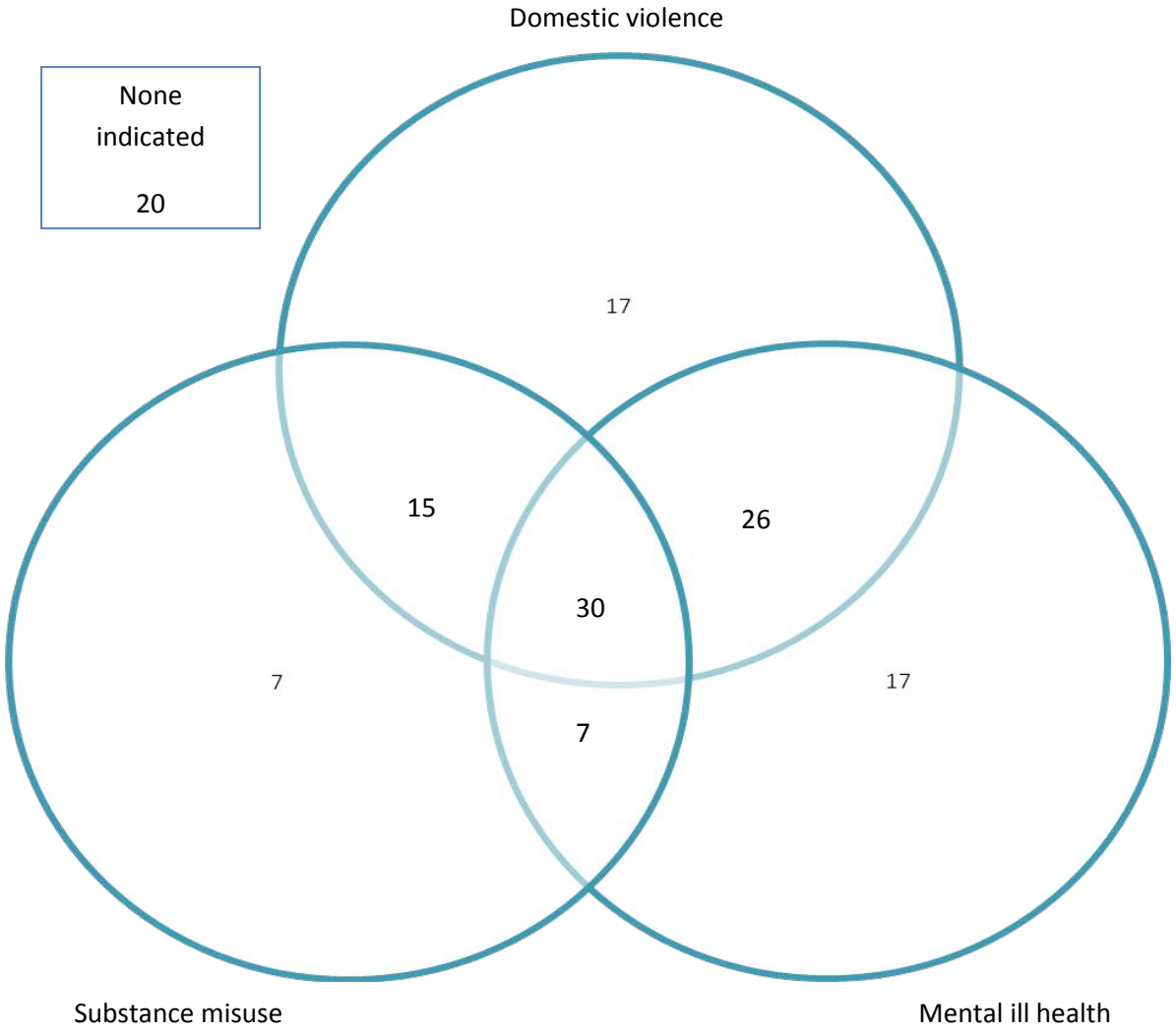
of the families. Parental substance misuse was mentioned for 42% of families, with a context of drug misuse in 29% of families, and alcohol misuse in 27% of the cases. In some families there was misuse of both substances.

Table 3.11: Frequency of occurrence of key factors within the family

	Frequency of occurrence (n=139)
Domestic Violence	88 (63%)
Mental ill health	80 (58%)
Substance misuse	59 (42%)
Alcohol	38 (27%)
Drugs	41 (29%)
None of the above factors	20 (14%)

In many families it appears that it is the presence of more than one of these factors which poses a particular risk to the child's safety. Our analysis shows that it is more common for these features to exist in combination than singly, which is well illustrated by the Venn diagram (Figure 3.1) below.

Figure 3.1: Intersection of adverse parental circumstances (n=139)



It is striking that 86% of the children lived in an environment where one or more of these factors was present, and for 30 children (22%) all three factors co-existed, as shown in the central segment of the diagram where the three circles intersect, and in Table 3.12. Any two of the three characteristics were present in 48 families (35%) and a single characteristic in 41 families (29%). While, singly, parental substance misuse, domestic violence and parental mental ill health may pose risks of harm to the child, this analysis reinforces findings from our previous biennial reviews that it is the combination of these factors which is particularly 'toxic'. The existence of these characteristics is not a given in all cases, and it is interesting that in twenty reviews none of these features were indicated.

Table 3.12: Co-existence of case characteristic

	Frequency of occurrence (n=139)
All 3 characteristics present in case	30 (22%)
Any 2 characteristics present in case	48 (35%)
One characteristic present in case	41 (29%)

No characteristics evident in case	20 (14%)

Whether the death or harm occurred in a family or community context

As part of our previous biennial report we developed a categorisation of incidents in terms of whether they occurred in a family or community context (Brandon et al. 2010), which we defined as:

1) ***Incidents occurring within a household/family setting*****.** These incidents mostly involved the mother, father, or another member of the household as the probable or known perpetrator of harm to the child. If the parents were separated, and the child was in contact with both parents, this was considered a household/ family case. Suicide of a young person within a family setting was also included.

2) Incidents occurring within a 'community context' involving non-household/family members. These incidents included those perpetrated by non-household members and gang/street related violence. They included harm from childminders, foster carers, and harm which occurred in supervised settings such as hospitals, school or residential care. The suicide of a young person outside of a family setting was also included in this category.

We applied this framework to the current sample, restricting the analysis to those 139 cases for which we had an overview report or an executive summary. Again, the majority of cases relate to incidents occurring within a 'family setting' (Table 3.13).

Table 3.13: Family or community context

	2007-09 (n=268)	2009-11 (n=139)
Family context	213 (79%)	117 (84%)
Community context	55 (21%)	22 (16%)

Our previous biennial study (Brandon et al., 2010) provides an examination of themes and issues which emerged in the cases of children who were harmed outside of the family context including community based violence.

3.2 The incident of death or serious harm

Comparisons of cases of death and serious injury through time, and by region

The number of serious case reviews undertaken (178) and the proportion of deaths (two-thirds) as against non-fatal cases (one-third) has returned to the pattern found *prior* to April 2007 suggesting an atypical increase in the two year period 2007-09. Our previous analysis for the period 2007-09 (Brandon et al., 2010) speculated that there may have been a lower threshold for holding a serious case review during this period, and a consequent increase in the number and proportion of non-fatal serious injury cases. The pattern appears to have reverted to that found in our first two biennial reviews.

Table 3.14: Death / Serious injury

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=280)	Frequency 2009-11 (n=178)
Death	106 (66%)	123 (65%)	158 (56%)	118 (66%)
Serious injury	55 (34%)	66 (35%)	122 (44%)	60 (34%)

Table 3.15 shows whether the maltreatment was fatal or non-fatal for children of different ages, and highlights in particular that the number of SCRs undertaken in relation to serious injury to babies has fallen markedly when compared to 2007-09.

Table 3.15: Death / serious injury by age group

	Frequency 2005-07 (n=189)		Frequency 2007-09 (n=280)		Frequency 2009-11 (n=178)	
	Death	Serious Injury	Death	Serious Injury	Death	Serious Injury
<1yr	62 (72%)	24 (28%)	68 (55%)	55 (45%)	47 (73%)	17 (27%)
1-5yrs	24 (55%)	20 (46%)	38 (63%)	22 (37%)	36 (71%)	15 (29%)
6-10yrs	9 (50%)	9 (50%)	12 (46%)	14 (54%)	10 (48%)	11 (52%)
11-15yrs	12 (60%)	8 (40%)	17 (43%)	23 (57%)	15 (56%)	12 (44%)
16 + yrs	17 (81%)	<6	23 (74%)	8 (26%)	10 (67%)	5 (33%)

The notification database is ordered chronologically according to the date of notification. We have however considered cases by the date of the incident, to keep the cases in the appropriate two year time period, and particularly to preserve comparability with the three previous reports covering the six years from 2003-09. In a few instances of non-fatal long-term abuse or neglect, or where a number of children were abused at different points in time, the date of notification was used as the incident date.

Table 3.16: Number of reported incidents occurring in each quarter

Quarter	Fatal incidents (n=118)	Incidents leading to serious injury (n=60)	Total number of incidents which led to SCR (n=178)
April 2009 – June 2009	20	12	32
July 2009 – September 2009	13	12	25
October 2009 – December 2009	15	10	25
January 2010 – March 2010	25	8	33

April 2010 – June 2010	9	3	12
July 2010 – September 2010	13	5	18
October 2010 – December 2010	10	4	14
January 2011 – March 2011	13	6	19

The number of incidents in each quarter is given in Table 3.16 above, while the numbers of incidents in the Ofsted and former Government Office regions are presented in Tables 3.17 and 3.18. It is important to note that our data will differ from Ofsted figures for the equivalent time periods, which relate to the notification date, rather than the incident date.

Table 3.17: Number of incidents which occurred in each Ofsted region 2009-11

Ofsted Region	Fatal incidents (n=118)	Incidents leading to serious injury (n=60)	Total number of incidents which led to SCR (n=178)
South	43 (64%)	24 (36%)	67 (38%)
North	42 (65%)	23 (35%)	65 (37%)
Midlands	33 (72%)	13 (28%)	46 (26%)

The Southern region initiated 67 serious case reviews, i.e. 38% of the total number, a similar proportion to the 41% of the total English population residing in this region in 2008 (ONS, 2010). The Northern Ofsted region initiated 65 (37%) of reviews, but includes only 28% of the population, whilst the Midlands Ofsted region initiated 46 (26%) of reviews and has 30% of the population. At the more micro-level, there is some variation, with nearly all reviews in Yorkshire and Humberside and the East Midlands relating to fatal incidents, while less than half in the North East relate to fatal incidents (Table 3.18).

The figure in brackets in the final column illustrates the extent to which fewer SCRs were undertaken across all regions. The most marked decrease was in Yorkshire and Humberside, with only twelve reviews compared to 36 in 2007-09, a fall of 24 (or two thirds).

Table 3.18: Number of incidents which occurred in each region in 2009-11

Region	Fatal incidents (n=118)	Incidents leading to serious injury (n=60)	Total number of incidents which led to SCR (decrease from 2007-09)
North West	23 (66%)	12 (34%)	35 (-8)
North East	7 (44%)	9 (56%)	16 (0)
Yorkshire and Humberside	10 (83%)	2 (17%)	12 (-24)
East Midlands	10 (83%)	2 (17%)	12 (-7)

West Midlands	18 (75%)	6 (25%)	24 (-4)
Eastern	6 (55%)	5 (45%)	11 (-9)
London	19 (68%)	9 (32%)	28 (-20)
South East	11 (58%)	8 (42%)	19 (-15)
South West	14 (67%)	7 (33%)	21 (-3)

The cause of the incident

In our recent biennial reviews we have sought to develop a clearer classification system for both fatalities (Sidebotham et al., 2011a) and non-fatal incidents (Brandon et al., 2010). We have applied this framework to the 2009-11 incidents, making notes on each case, assigning a category, and checking discrepancies between researchers to ensure a consensus opinion. Table 3.19 presents the analysis for the 118 fatal cases, and enables a comparison to be made with the 158 fatal cases in 2007-09 and the 123 fatal cases between 2005-07.

The overall pattern is largely consistent, although there is a fall in the number of 'sudden unexpected deaths in infancy', and a reduction in 'deaths related to maltreatment', which revert to earlier levels, with the 2007-09 numbers appearing to be the exception.

'Severe physical assaults' typically feature an inflicted head injury, including shaking and shaking-impact injuries, and also multiple limb injuries and abdominal injuries. When this category is combined with 'homicides' and 'infanticides', where there is an apparent intent to kill the child, nearly half (48%) of the fatal cases which led to a serious case review between 2009-11 can be included in a category of fatal physical assault.

Table 3.19: Categorisation of fatal cases

Incident cause	Number of fatal incidents 2005-07 (n=123)	Number of fatal incidents 2007-09 (n=158)	Number of fatal incidents 2009-11 (n=118)
Severe physical assault	27 (22%)	33 (21%)	30 (25%)
Deliberate – overt homicide	9 (7%)	22 (14%)	20 (17%)
Infanticide and covert homicide	7 (6%)	6 (4%)	7 (6%)
Extreme neglect, deprivational abuse	2 (2%)	2 (1%)	2 (2%)
Deaths related to maltreatment	57 (46%)	81 (51%)	50 (42%)
Sudden unexpected death in infancy	*20 (16%)*	*28 (18%)*	*15 (13%)*
Suicide	*20 (16%)*	*21 (14%)*	*17 (14%)*
Other death related to but not directly caused by maltreatment	*17 (14%)*	*32 (20%)*	*18 (15%)*
Other death, category not clear	21 (17%)	14 (9%)	9 (8%)

There was some increase in 'deliberate homicides', which rose from 7% in 2005-07 to 17% of fatal incidents leading to a review during 2009-11. This can to some extent be linked to the rise in the number of filicide-suicides, sometimes referred to as extended suicides (killings of a child in the family with the subsequent suicide or attempted suicide of the perpetrator) which led to a serious case review. Ten of the 20 homicides fit this category; half of which involved the father killing the child or children, and the other five cases involved the mother as perpetrator. There is, perhaps, a greater visibility of this type of case with the introduction by the Home Office of Domestic Violence Reviews (section 9, Domestic Violence, Crime and Victims Act, 2004). A discussion of filicide-suicides forms part of Chapter 4 which considers in depth those cases which concerned children aged 5-10 years. The significant differences in the characteristics of those cases where the mother was the suspected perpetrator, compared to those where the father was suspected, are also discussed in that chapter.

As in previous biennial reviews we have included 'case vignettes' at various points in the report to illustrate particular themes. It is worth noting that all the vignettes in this chapter are anonymous and composite, being based on a number of cases which shared similar features. Each vignette follows the same basic structure, first providing a background to the case, and followed by learning and key messages. Some learning points are drawn directly from the reviews, and refer to salient comments written by the overview report authors, generally in the analysis or conclusions sections of the serious case review; others arise from our own analysis of multiple cases.

The first vignette presents a 'composite' case of extended family suicide, and explores the way that professionals' perceptions of the risks of harm to a child can be minimised if one parent is functioning well.

Case Vignette – extended family suicide

The mother was in her mid thirties when the baby was born, and she received universal services from midwifery, health visiting and her GP. Her husband was receiving services to address his alcohol consumption, although his wife considered that the underlying problem was his mental health. There had been a referral from a voluntary alcohol organisation to children's social care, but following a phone conversation with the mother no further action was taken, nor service provided in respect of the young child's safety. The couple separated and the father maintained contact with his child. Subsequently the mother became pregnant with the baby of her new partner. When the ex-husband became aware of the pregnancy he was fearful that he would lose touch with his child, and made a number of threats to his estranged wife. The police were contacted but the father denied making any threats, and the officers concluded that there was no indication that he intended to harm himself or anyone else. Soon after this incident the father killed his child, before committing suicide himself.

Learning:

During the marriage, the mother was seen as articulate and resourceful in the way she sought help for her husband's alcohol problem, and this may have prevented agencies from recognising the extent of her concern, and in turn limited their response. For example her increasing concerns about his mental health were not acknowledged, nor help provided. The father also presented as articulate, and plausible in his response when questioned by the police about his threatening behaviour. The risk of harm posed to the child by the parent's alcohol use, unacknowledged mental health problems, and anger at a new partner and pregnancy were not seen in context, nor as factors which jeopardized the safety of the child.

One overview author notes the rarity of filicide-suicides and suggests that it would make it almost impossible to identify the children most at risk of harm in this way, or predict whether any one particular 'threat to kill' will in actuality lead to the death and suicide of the family members. Chapter 4 illustrates however that parental separation may be an additional risk factor that was not taken into account in this case.

Serious Injury Cases

Most international studies of serious child abuse focus on child fatality. The four nations of the United Kingdom are unusual in combining the process of reviewing cases where children are seriously injured through maltreatment with cases where children die. In England there were 60 non fatal cases during 2009-11, which can be disaggregated into a number of categories, although it should be noted that frequently more than one type of abuse is suffered by the child.

The serious injury categories can to some extent be compared with the fatal categories presented in Table 3.19, although the classification we have used for serious injury is somewhat broader. For example non-fatal physical assault is not further broken down, unlike the fatalities categories where deliberate homicide and infanticide could be considered a sub-division of severe physical assault. Non-fatal neglect is a broad category too,

encompassing a range of severity and accidents linked to poor supervision. Sexual assault very rarely features as a primary cause of death, and did not feature in the fatal classification. In the fatality classification suicides are a category of their own, whereas non-fatal self harm and suicide attempts are included in the category of 'risk-taking' or violent behaviour by the young person, which also incorporates those cases where the young person was the perpetrator of a physical or sexual attack.

The number of serious injury cases in 2009-11 which led to a review fell sharply from the number in 2007-09, to approximately half the previous total. However the proportions within each type of harm remained broadly similar (Table 3.20). Only the prime cause of harm to the child is given in this table.

Table 3.20: Categorisation of serious injury cases

Incident cause	Number of incidents 2007-09 (n=122)	Number of incidents 2009-11 (n=60)
Physical assault	66 (54%)	31 (52%)
Sexual assault	20 (16%)	12 (20%)
Neglect	14 (12%)	6 (10%)
Risk taking or violent behaviour by YP	9 (7%)	8 (13%)
Other	7 (5%)	3 (5%)
Not known	6 (5%)	

In half (52%) of all non-fatal cases the child suffered a physical assault. This proportion is broadly comparable with the 48% of deaths resulting from homicide, infanticide or a fatal physical injury.

Sexual assault and neglect account between them for nearly a third of the non-fatal cases where a serious case review was undertaken. However, these types of harm are rarely fatal, as is shown in Table 3.19. Neglect is, though, often a feature of deaths which are related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death; for example fatal accidents where there are issues of parental supervision – ingestion of drugs, falls, drowning, electrocution and fires.

Risk taking behaviour / violence by the young person accounted for 13% of the non-fatal reviews undertaken in 2009-11, while approximately 15% of fatal serious case reviews relate to the suicide of a young person.

The classification of non-fatal harm that we have developed is useful since, as explored in greater depth in the previous Biennial Review for 2007-09 (Brandon et al., 2010), different child characteristics and family circumstances are evident between the different groups.

- Severe but non-fatal physical assault is most likely to be inflicted on babies aged under one year (over half of all cases), to take place in a family setting (over 90% of cases), and in two-thirds of the cases to be inflicted on boys rather than girls.

- By contrast, sexual assault is generally inflicted on older girls (10 of the 12 victims were girls, with an average age of 11 years), and is the form of harm most likely to occur outside of the family setting.

- In this biennial period there were fewer cases than in 2007-09 where neglect was the primary cause, and which led to a serious case review. The average age of these six children was 5 years, and they were generally already known to children's social care at the time of the incident which prompted the review.

- The eight young people included in the category of risky or violent behaviour were, in this latest biennial review, all young men, with an average age of 16 years. Their actions were taking place in a community setting, rather than within the home, and seven of the eight young men were already known to children's social care. Interestingly, in the previous biennial study, a number of the reviews involved girls' high risk behaviour.

3.3 Additional Themes

Neglect

The extent of neglect as an underlying feature of these cases can easily go unrecognised and unreported. Information about neglect is rarely available from the notification information in the child protection database (CPD) unless there is/has been a child protection plan under the category of neglect, or the recent or long-term neglect was stated as a 'case characteristic'. To explore this issue further, we attempted to identify the presence of neglect in the sample by searching overview reports for indicators, identifying neglect using the protocol outlined below. Identifying neglect was sometimes constrained by the varying form and detail of information available to us, and inherent difficulties surrounding precise definitions of neglect. While some of the information sources did mention what may be considered risk factors for neglect (for example parental substance misuse, mental health problems, domestic abuse) from this evidence alone it could not be clearly ascertained whether the child had been being neglected. These constraints should be borne in mind when interpreting the results below.

Study protocol for identifying indicators of neglect

1. Current Child Protection plan (CP plan) or past CP plan for index child in the category of neglect.
2. Child protection database (CPD) states that long term or recent neglect was a 'case characteristic'.
3. Indications of neglect drawn from further sources of information (including the case narrative section of CPD notification, SCR executive summaries, overview reports) from a combination of the following factors:

- 'Neglect' directly referred to as a feature of the case
- Child poorly nourished
- Poor living conditions
- Drug/alcohol misuse in pregnancy
- Persistently not accessing health care for child/ante-natal care/not acting on medical advice/untreated ailments, (including concealed pregnancy/birth)
- Repeated missed appointments, or sustained reluctance to engage with services
- Inappropriate supervision of a child, including inappropriate babysitter, supervision while under the influence of alcohol or drugs
- Inadequate clothing/hygiene
- Serious school/nursery attendance concerns
- Child accessing firearm or ingesting a harmful substance (associated with lack of supervision).

As a result of this exercise we determined that neglect was a feature of 60% of the 139 serious case reviews for which the overview report or executive summary was available.

Table 3.21: Incidence of neglect

	Frequency mentioned 2009-11 (n=139)
Indicators of neglect a feature of the case	83 (60%)
No mention of indicators of neglect	56 (40%)

In contrast with other studies we did not find that the younger children were more likely to be experiencing neglect. Our analysis shows that neglect was likely to be a feature in approximately half of all the cases irrespective of age, apart from the 11-15 year old where neglect is a much more common feature in the child's history. Ward's recent longitudinal study of infants and significant harm found that children's social care become less involved with children as they go to school or nursery (Ward et al., 2012), which may mask the extent of neglect among older children. A better awareness of the widespread existence of neglect in the history of vulnerable adolescents has been an important consequence of Rees and colleagues' study of adolescent neglect (Rees et al., 2011).

Table 3.22: Incidence of neglect by age group

Age group	Incidence of neglect	
	Neglect a feature of case (n=83)	No mention of neglect (n=56)
<1yr	27 (56%)	21 (44%)
1-5yrs	20 (54%)	17 (46%)
6-10yrs	10 (53%)	9 (47%)
11-15yrs	20 (87%)	3 (13%)
16 + yrs	6 (50%)	6 (50%)

Next we considered the incidence of neglect within certain types of maltreatment and abuse, distinguishing between those cases which had a fatal outcome (n=96), and those where the child was seriously injured (n=43). Table 3.23 shows that in the fatal cases, current or past neglect was evident in almost all of the deaths related to but not directly caused by maltreatment, where accidents were often a feature. It was also very common in the Sudden Unexpected Deaths in Infancy (SUDI) group which is perhaps not surprising since concerns about neglect are likely to trigger a serious case review in these cases. There was evidence of past neglect from eleven of the fourteen suicide serious case reviews. Neglect was also a feature in a quarter of the physical assault and in a similar proportion of the deliberate homicide cases.

Table 3.23: Incidence of neglect by type of fatal injury

Incident category	Incidence of neglect (n=96)	
	Neglect a feature of case (n=56)	No mention of neglect (n=40)
Infanticide and covert homicide	3 (50%)	3 (50%)
Fatal physical assault	5 (25%)	15 (75%)
Extreme neglect, deprivational abuse	2 (100%)	0
Deliberate / overt homicide	5 (26%)	14 (74%)
Deaths related to but not directly caused by maltreatment	14 (88%)	2 (12%)
SUDI	12 (80%)	3 (20%)
Suicide	11 (79%)	3 (21%)

Twenty seven of the 43 non-fatal injury cases showed indications of neglect (Table 3.24). In five out of the seven cases relating to serious sexual abuse, the children had also been living with neglect. Neglect was also apparent for almost two thirds of the children who suffered non-fatal physical assault. There was little evidence of neglect in the risk-taking young people's cases although it may be that family backgrounds are less to the fore here, and that a fuller picture, going further back in time, would reveal more neglect than is suggested here.

Table 3.24: Incidence of neglect by type of non-fatal injury

Incident category	Incidence of neglect (n=43)	
	Neglect a feature of case (n=27)	No mention of neglect (n=16)
Physical assault	14 (61%)	9 (39%)
Sexual assault	5 (71%)	2 (29%)
Neglect	5 (100%)	0
Risk taking or violent behaviour by YP	3 (43%)	4 (57%)
Other e.g. extended suicide attempt	0	1

There is increasing recognition of the long-term harm that stems from living with neglect during childhood (Gilbert et al., 2009; Davies and Ward, 2012). Although the analysis of neglect cases has been a feature of recent biennial analyses of serious case reviews, we now also have a clearer understanding of the *extent* to which neglect features in these cases. This sets a good foundation for further exploration of the learning about neglect in serious case reviews.

Maternal age at birth of first child

For the first time we considered the age of the mother when her child was born. Not all notifications or overview reports gave either the mother's date of birth or her age in years at the time of the incident, however using genograms and other information within the report, maternal age at her child's birth was available/deducible in 124 of the cases. As of yet an equivalent analysis has not been undertaken of the age of fathers or partners in the household, and this would be a much more complex task with less complete information available. We have not analysed the mother's age at the time of the incident itself, since the older children who are the subjects of the reviews will, by definition, have older mothers.

Initially we focused our analysis on just those mothers where the *index child was her only child* (Table 3.25). For this group the average age of the mother at the time of the birth of her first (and only) child was 23.8 years, which can be directly compared with the average age of all first-time mothers in England and Wales in 2010 of 27.8 years (ONS, 2011b). The average is slightly skewed by a number of first time mothers who were aged 30 or over; the most frequent (modal) age at which first time mothers in our sample (where there was only one child) gave birth was 18 years, and 36% were under the age of twenty.

Table 3.25: Age of the mother at the time of birth of her first (and only) child

	Frequency 2009-11 (n=31)
16 years and under	3 (10%)
17 – 19 years	8 (26%)
20 – 24	8 (26%)
25 – 29	6 (19%)
30 years and over	6 (19%)

For families where there was more than one child, we analysed the mother's age when she became a parent for the first time, rather than her age when the 'index' child was born. We were interested in the wider family picture, and in particular exploring any effects that young motherhood might be having, or have had, on the ability of these families to cope.

Table 3.26 looks at the age of all the mothers (whatever their family size) at the birth of their first child, irrespective of which child in their family was the index child. For this group of 124 mothers, maternal age at first birth ranged from under 16 years to over forty, with an average age of 21.2 years. Again the mean age of the SCR sample of mothers is somewhat skewed by a small number of very much older mothers. In this instance the modal age is perhaps the most revealing; the most frequently occurring age for first-time motherhood was 17 (20 women) followed by 18 years (14 women) and 19 years (12 women). A half of mothers were still in their 'teens', and 58% of women were aged under 21 at the time of their first baby.

Table 3.26: Age of the mother at the time of birth of her first child

	Frequency 2009-11 (n=124)
16 years and under	16 (13%)
17 – 19 years	46 (37%)
20 – 24	36 (29%)
25 – 29	14 (11%)
30 years and over	12 (10%)

Drawing from our reading of many reports, we have noted a number of relevant themes and have identified different groups of mothers and their partners, who appear to be subject to different pressures. These themes are presented in the form of composite case vignettes. The following example illustrates, among other issues, that wider family involvement is not always a positive and protective factor.

Case Vignette - Young mother living with extended family

This example concerned the death of a baby from asphyxia. The death occurred while the baby was co-sleeping with his mother, who had been drinking that night. The baby lived with his mother, who was 17, and her maternal family (her own mother and two siblings). The family situation was described as chaotic, featuring a long history of persistent neglect, poor parenting skills, poor living conditions, alcohol and substance misuse and aggression. The mother and grandmother both had learning disabilities. Historically there had been varying levels of agency involvement with the family, including periods when children in the household were the subject of child protection plans, but as the children became older there was less recognition of their safeguarding needs. After the mother left school she had little contact with any agencies and she presented to health professionals as having the support of her family. No concerns were raised by midwifery, health visitors or GPs about the pregnancy or welfare of the child, and there was no referral to any other service.

Learning:

What we have previously described as the 'start again syndrome' whereby a new baby is seen as presenting a fresh start for a family, was in evidence - but in this case applying to a further generation within the same family. Given her history, a lack of consideration was given to the abilities of the mother to parent her child and the types of support she would need. The youth of the mother made her a child in her own right, as well as the mother of a dependent infant. While remaining within the same family home, it was likely that her child would also be exposed to the same environment and care that she herself had experienced. Despite the history of multi-agency involvement with the family, at no stage following the mother's pregnancy was a Common Assessment Framework undertaken, which would have led to the identification of additional needs. The presence of the grandmother was perceived as a support, rather than a potential risk factor.

This next vignette reveals the need for continuing support for vulnerable adolescent mothers in the transition to adulthood.

Case Vignette: Young person estranged from wider family, little support.

This review related to the death of an 18 month old child, following a severe physical assault (for which the mother's partner was subsequently arrested). The mother had become pregnant at 17, when she was still a troubled adolescent herself. She was described in the review as even younger than her years, with a history of substance misuse and self harm. A number of agencies, including children's social care, had been involved with her as a younger child but professional support dwindled and became inconsistent as she grew older. By the time she was pregnant, her relationship with her parents had broken down completely as had her relationship with the child's father, and she was living in a hostel for homeless families. Following the birth of her child, she became emotionally dependent on a new, older partner - a dominant personality who was physically abusive and supplied her with drugs.

Learning:

This case highlighted a number of issues surrounding agency responses to teenage pregnancy and the need for ongoing support in the transition to adulthood and parenthood. The young person was very isolated, without any parental support or control. There was a failure of agencies to demonstrate a commitment to the mother and the extent of her vulnerability was not fully recognised or assessed, resulting in inappropriate accommodation placements. The review also noted that information from community child health records did not follow the patient into her adult health record - had this information been available health professionals would have been better informed about the mother's troubled history and the concerns about her own experiences as a child. Issues of domestic violence had been raised by a health visitor – but denied by the young mother, who may not have recognised she was a victim at that time, and felt her partner's behaviour towards her was an acceptable part of the relationship.

A further vignette shows the impact of cumulative adversities for young parents compounded by having three young children under the age of five.

Case Vignette: Mother and father under 21 years of age with three pre-school children

This review concerns the sudden death of a baby, where co-sleeping was thought to be a factor, and whose post mortem examination revealed rib fractures which were likely to have been non accidental injuries and sustained some weeks prior to the baby's death. Criminal proceedings against the father remained a possibility.

The mother had been looked after in her childhood, and both the mother and the father were still teenagers when their first child was born, with the mother receiving services from the teenage pregnancy midwife. By the time they reached 21 years of age they had three young children under school age. The mother had experienced multiple moves between bed and breakfast accommodation and supported lodgings, and when the couple were later housed

together in rented accommodation they built up rent arrears and were evicted from one of their homes. In addition there were relationship difficulties leading to periods of separation, domestic disputes and domestic abuse incidents, and alcohol and occasional drug misuse by the father. The parents received very limited support from their own families, and were relatively isolated in terms of any support network for their roles as parents.

Although disadvantaged by her circumstances and experiences in her teenage years, the mother managed a high level of contact with the leaving care service, and the Connexions service noted a good level of motivation on her part in seeking training and employment (she held some part time, although low-paid, employment). The mother was considered to be pro-active in accessing universal health and community services for herself and her children, and attended some courses at the local Sure Start children's centre. The father was noted to be in intermittent employment, and cared for his children when his partner was at work.

Learning:

Leaving care services ceased when the mother reached the age of 21 years, but she still remained a young parent with three children who needed support. Professionals were keen to recognise the mother's achievements, and perceived her to be a capable parent, but they may have been less able to see the wider picture which was impacting on the welfare of the children, and particularly on the new baby who was particularly vulnerable. Although the father was known to be significantly involved in the care of his children, there were few attempts made to engage with him, to assess his parenting capabilities, or to understand how he could be supported in his role as father.

The extent of children's social care involvement

The notification report from which the child protection database is compiled includes a mandatory question on the child protection plan status of the child but does not include wider information on whether the child was known to children's social care, at the time of the incident which prompted the SCR, or in the past, and if so at what level of referral, assessment or service provision. A research tool, incorporating a diagrammatic flow chart, was developed to be able to capture this useful information from overview reports.

These are important questions since it is often asked by the media and LSCBs:

- If the child was already known to children's social care, why were the risks of harm not picked up? and,
- If the child was unknown to children's social care, why was this so, and should the child or family perhaps have been receiving a service?

Although this analysis cannot provide clear answers to these questions, it can demonstrate the patterns of involvement with children's social care and the way these might have had an impact on risks of harm being missed and which agencies and group of practitioners are best placed to recognise risks of harm. Our previous biennial analyses have shown that some 'below the threshold' for children's social care cases included children who needed protection while others had no clearly evident risks of harm.

Our previous biennial reviews, working with a smaller subset of overview reports, have suggested that just over half of the children and families were seeing a social worker at the time of the incident which led to the review. In this report we are exploring the extent of children's social care involvement for the *index child* with a much greater number of cases (138) where we had fuller information (one overview report relating to multiple children could not be included in this analysis).

Table 3.27: Child's case open or closed to children's social care at time of incident

	Number of children / young people (n=138)
Open case to CSC	58 (42%)
Closed case to CSC	32 (23%)
Referred but did not reach threshold	19 (14%)
Child's case never been known to CSC	29 (21%)

A total of 58 children were receiving a service from children's social care at the time s/he died or was seriously injured or harmed, representing 42% of the sample. Just over a fifth of children (23%) had been known previously to children's social care, which may suggest that some cases were being closed prematurely. Another worrying group of cases are those 14%

where referrals were received but not accepted for an initial assessment. The extent and severity of problems in these cases suggests that (from what was known in retrospect) thresholds to children's social care were set too high. Other studies reinforce this suggestion showing that children may not get help from children's social care because health and other professionals' experience is that children's social care may be slow to act or offer too little support in relation to referrals (Davies and Ward, 2012:124).

Pattern of services received

Table 3.28 shows the highest level of involvement reached either at the time of the incident or in the past, and that one in five children were never known to children's social care services.

Table 3.28: Highest level of involvement of children's social care (current or past)

	Number of children / young people (n=138)
No involvement with the child	29 (21%)
Referral – not accepted or not processed at the time of the incident	19 (14%)
Referral - accepted	1 (1%)
Initial assessment completed	33 (24%)
Strategy discussion	5 (4%)
Core Assessment completed	11 (8%)
Child Protection conference convened	3 (2%)
Subject to CP plan – current	12 (9%)
Subject to CP plan – in the past	13 (9%)
Accommodated – Section 20	12 (9%)

Further analysis of the pattern of services sheds more light on the reasons why a referral progressed or a child's case was closed, and why the case progressed in one direction rather than another. It is interesting to note that, as suggested in the Munro Review of Child Protection (2010, 2011, and Cm 8062) many of these issues are systemic and reflect aspects of agency and multi-agency functioning.

There was evidence that referrals either were not accepted or not processed in nineteen cases. Over time this could involve a dialogue about numerous referrals in the same case. In one case, four of the fourteen referrals made were accepted for initial assessment but only two of these assessments were completed, and in another case eight initial assessments failed to result in any services. The following composite case vignette illustrates one such scenario.

Multiple referrals for an initial assessment – but referrals not accepted

The mother and father's relationship had ended, following episodes of domestic abuse and alcohol misuse. However the care provided to the pre-school child had been good, and there were no concerns about her development, with the child receiving only universal health and nursery services. There was a protracted custody dispute over the care of the child. The mother formed a new relationship, with her partner moving into the household. Both the girl's father and, on one occasion, the paternal grand-mother made a number of referrals to children's social care, but no action was taken. An incident occurred at the girl's home and the child received a serious injury at the hands of the mother's new partner.

Learning:

The father was to some extent considered to be a 'bad' father (due to previous alcohol and domestic abuse allegations). In addition there was no consideration of what the risk of harm to the child might be if the allegations were true. There was evidence of fixed views about the child's father by the professionals involved with the family, and his legitimate concerns about his child's care were not given due weight or credence. There is a wider issue, which this case illustrates, about the lack of involvement by professionals with men who are playing a significant part in children's day-to-day lives, or indeed of the professionals' knowledge of, or curiosity about, who is actually living in the household.

Similar issues arose when multiple referrals led to an initial assessment, but subsequently no services were offered and the case was closed.

Multiple initial assessments – but cases judged not to reach the children's social care threshold

The mother of the toddler had suffered domestic violence from a succession of male partners. She tended to minimise the incidents, or on occasions deny that they had happened, and similarly claimed that she did not have a problem with alcohol, although she was alcohol dependent. Attendance of the older children at school was consistently poor, but this was not satisfactorily recognised nor addressed by the schools, nor the attendance and welfare service. The mother engaged with and was supported by her health visitor, but refused other help offered.

A total of seven initial assessments had been completed, following referrals from the police, a former partner, health services, and from anonymous sources – the latter being deemed to be malicious. On each occasion the case was closed as it was judged there was no evidence to substantiate the concerns expressed, and no targeted support being offered. Despite such a large number of initial assessments, no core assessment was undertaken which would have uncovered the alcohol, domestic violence, and health pressures faced by the mother, and their impact on her children. Children's social care concluded that there were no concerns for the children and no role for them.

Learning:

The mother's denials about domestic violence and her alcohol use, together with her positive and articulate manner, led to the conclusion that the children were not in need. Victims of domestic violence are, on occasions, likely to deny or minimise the abuse, for complex reasons. The impact of domestic violence on children can be overlooked, due to the lack of any physical injuries to them, and a perception that the mother is a 'good mother' and able to protect her children from harm. Various professionals were unduly optimistic about the mother's parenting ability, and did not respectfully challenge her story. On at least two occasions one of the older children identified safeguarding issues, but was not listened to, and no professional actively sought the children's views.

Failure to progress to a core assessment was sometimes attributed to the inexperience of the social worker, to gaps in information or an inability to understand information about the family in a historical context. One report commented that the lack of a properly completed core assessment tended to shift the focus of the work in the direction of practical support and that this kind of short-term, task oriented work did not provide a good basis for sound long-term judgements about the child's welfare.

Professional challenge was an issue in the progress of a number of cases and in particular over the decision about whether to manage the case as child in need or child protection. In one instance children's social care overrode police recommendations to hold a child protection conference and instead convened child in need meetings to discuss the family. In another case a newly qualified social worker did not feel sufficiently confident to insist that a case be assessed under section 47 (child protection enquiry) of the Children Act 1989 in accordance with the LSCB procedures.

Some cases were closed because parents refused offers of support. Services cannot be imposed on a family unless a child is deemed to be in need of protection, yet a number of cases were closed because parents would not cooperate, before it was clear whether or not the child was suffering harm. One reviewer commented that lack of cooperation should trigger a reconsideration of more robust or different ways of managing the case. Similarly, Common Assessment Framework and Team Around the Child (or Team Around the Family) approaches are suitable where there is cooperation, but where parents are resistant to services it may be necessary to re-involve children's social care. As in previous analyses it was clear in these and other examples that many cases lacked rigorous assessment following referral to children's social care.

Case closed through lack of co-operation by parents

Young person 'A' is one of a large family, with both full and half siblings living in the household. There were numerous incidents of domestic violence, drug and alcohol misuse, financial problems, and reported anti-social behaviour by the parents. When A was young, A's father spent time in prison, for assault, and the two oldest children were placed on the child protection register following his release from prison. Their names were removed when the mother stated that she was no longer in a relationship with A's father, and that he no longer resided in, or visited, the family home, although in fact this was not the case. The case was closed to children's social care.

The mother's second partner, father to A's half-siblings, was also known to misuse drugs and alcohol, and various domestic abuse incidents were reported to the police, with the mother subsequently withdrawing her statement and failing to support a prosecution. The children's schools reported numerous concerns regarding the appearance, mental wellbeing and behaviour of the children. Children's social care (CSC) recommenced involvement with the family, and two core assessments were completed. As a teenager, Child A displayed increasingly risky behaviour (shoplifting, drug and alcohol use, early sexual activity, aggression at school and at home toward siblings and mother/step-father, self harming and running way) and was referred to CAMHS, although there was delay in providing a service. However, subsequently, both CAMHS and children's social care agreed that they would close the case, due to the non co-operation of the parents. CSC professionals had judged that the case did not meet the threshold for a service, as the teenager was at risk from herself, and not from her parents. Child A attempted to commit suicide.

Learning:

Too much credence was given to the mother's version of events, in particular her claim that A's father was not part of the household, when in fact he still had significant contact. The mother's retractions of her allegations of domestic violence was accepted without due weight being given to the level of fear and intimidation that she felt, which had led her into withdrawing the allegations.

Agency responses tended to lack coordination or focus, and to concentrate on quick solutions, rather than a comprehensive assessment of the potential for long term change. Each child in the family and referral was considered in isolation, without adequate consideration of the past history of the family, and the 'whole picture'. While the risk of harm was significant, it was not recognised or responded to in accordance with Section 47 child protection procedures. Non-cooperation should have been an indicator of increasing concern, rather than a reason for case closure, and closing the case was both inappropriate and premature.

Chapter 3: Summary

- Over the period 2009-11 there were 184 serious case reviews (121 (66%) were fatal cases). There were 115 reviews in the year April 2009 – end March 2010, and 69 in the following year. There is a drop in the number of SCRs in comparison with the last biennial review (2007-09), when there were 280 SCRs, and a return to the earlier pattern of fewer reviews (189 reviews during 2005-07 and 161 during 2003-05). In the last year (2010-11) numbers of non fatal serious case reviews seem to be falling but this should not restrict learning from this study because the same types of harm are represented as in previous years.

- Just over a third (36%) of all serious case reviews concerned a baby under one year of age – a somewhat lower proportion than the almost half of cases in earlier years. This decline may reflect a change over time in local decision-making about when to undertake a SCR. However, it might also be attributable to the successful efforts to promote awareness among practitioners and community groups of the vulnerability of babies and the risks of harm they face.

- As previously, a slightly higher proportion of boys than girls were the subject of a serious case review. This figure has generally held stable since 2003 at around 56%. A higher proportion of the children than before were identified as having a disability (12%). At the time of the incident, 18 (10%) of the children had a child protection plan - a marked drop since the previous two biennial reviews, in a period when the number of children with a child protection plan has been steadily rising.

- In total, 48% of deaths resulted from fatal physical injury. A similar proportion (52%) of non-fatal cases involved a physical assault to the child. Sexual assault and neglect account for nearly a third of the non-fatal cases but these types of harm are rarely the direct cause of a fatality. The only category of fatality or harm showing much change was a rise in the number of deliberate homicides from 7% of SCRs in 2005-07 to 17% in 2009-11. This was prompted by the increased number of filicide suicides.

- Almost two thirds of the reviews featured domestic violence, nearly 60% featured parental mental ill health, and parental substance misuse was evident in 42% of cases. At least one of these characteristics was evident in 86% of the cases while all three factors were present in just over a fifth of the cases.

- Neglect was a feature in at least 60% of the serious case reviews. Past neglect was a factor in eleven out of fourteen reviews relating to the suicide of a young person.

- Almost 60% of the mothers were under 21 years of age when they had their first child. The vulnerability of these young mothers may be long lasting.

- The number of children and families receiving a service from children's social care at the time of the incident was 42%. A further 23% of cases had been closed, sometimes because of non-cooperation. In 14% of cases a referral had been made but not accepted, implying that thresholds to children's social care were set too high. Only 21% of the children had never been referred to children's social care.

Chapter 4: Thematic analysis of serious case reviews involving children aged 5-10

4.1 Introduction

The primary school years are generally perceived to be a very positive time in children's lives. Rates of serious and fatal maltreatment are low. The data presented in the earlier chapters show that children in this age group have the lowest rates for serious case reviews (0.42 per 100,000) and for child fatality cases (0.21 per 100,000 fatal cases). However, this may mask a significant burden of lower level maltreatment, with 10,900 (381/100,000) children aged 5-10 years being the subject of a child protection plan, and 88,000 (3,000/100,000) being a child in need (Table 2.8, Chapter 2; Department for Education, 2010).

Previously, most work on serious and fatal maltreatment has focused on very young infants and on adolescents (Brandon et al., 2008, 2009 & 2010; Ofsted, 2011). This is entirely appropriate as these are two of the most vulnerable periods of children's lives. The middle childhood years, and particularly the primary school years, have been subject to less research. In this chapter, we report on an in-depth analysis of serious and fatal maltreatment involving 5-10 year old children.

This review contains the highest number of cases of children in the 5-10 year age group compared to previous biennial analyses. Many of the themes emerging are similar to those identified in previous reports, however, there is significant heterogeneity of cases within this age group.

As in other age groups, domestic violence and parental mental health issues were prevalent. One issue which was raised in several cases was that of marital or partnership breakdown. ONS statistics indicate that, of the nearly 120,000 couples who divorced in 2010, 50% had children aged under 16 living with them (Office for National Statistics, 2011c). That represented 104,364 children in 59,309 families. Of those, 43% (44,635 children) were aged between 5 and 10 years. In several cases within our 5–10 year age group, the death of or serious harm to a child was the result of an acrimonious marital/partnership breakdown. The role of the courts in safeguarding children whose parents are involved in divorce or separation proceedings will be discussed in this chapter.

An important feature of many of these cases was that the children's schools often appeared completely unaware of the circumstances in which these children were living outside of the school environment. While many children appear to enjoy and achieve at school, that may not reflect the reality of their lives beyond the school gates. What was evident from the cases were the many opportunities for early interagency collaboration to address some of the multiple and complex issues these children and families experienced. The Common Assessment Framework could have been used in many of these cases to support these children, to find routes to safeguarding and promoting their welfare, especially where issues for one or both parents were the focus of professional contact and service provision. The roles of health and social care professionals and teachers in detecting and responding to indicators of harm are discussed later in this chapter.

Some of the cases in this review document the sequential results of maltreatment as young children. Abuse and neglect in the early years may lead to challenging behaviours and mal-adaption becoming manifest during the primary school years. In some of these children underlying home stresses may be exacerbated by the transition to school. Without appropriate identification and intervention these children are at risk of going on to develop more complex and challenging problems as they grow older.

The remainder of this chapter is structured into a discussion of the methods used; a summary of all cases within the 5–10 year age group; and a thematic analysis of emerging issues sub-divided into child issues; parent and environmental issues; and systemic and service issues.

4.2 Methods

A triple-layered reading process was carried out for each case relating to a child within the 5 to 10 year old age group. First, the redacted overview report was read and summarised to identify key points, then a structured summary sheet was completed for each case, whereby data were collected on case characteristics, main findings and main recommendations of the serious case review. Secondly, the overview report was read again and data were coded to the most appropriate nodes within a thematic coding framework which combines transactional/developmental, ecological, and systemic models. A copy of the thematic coding framework is reproduced in Appendix 1. Thirdly, the data were analysed thematically within three core domains: the child; family and environment, including parenting capacity; systemic and service issues. Three researchers were involved in reading, coding and analysis, and the team used a constant comparative approach to analysing data, looking for emerging themes and outliers. Team discussions were held to identify common emerging themes.

4.3 Case characteristics 5-10 year olds

A total of twenty four cases involving 5-10 year olds were notified to the Department for Education during the period 2009-11. Of these, 15 related to incidents occurring between 1 April 2009 and 31 March 2010 and nine to incidents between 1 April 2010 and 31 March 2011. There were twelve serious case reviews relating to fatal incidents involving 5-10 year olds.

Overview reports were available for 21 cases (12 fatal) where the primary victim was aged between 5 and 10 years. These cases represented a variety of incidents:

Twelve Fatal Cases

Two cases of disabled children where neglect was considered a factor.

Three cases of arson involving a total of five children.

Three cases involving children killed by their father following an acrimonious separation from the mother.

One child killed by a sibling with known mental health problems.

One child who took his own life following a history of bullying and emotional abuse.

Two children killed by their mothers' partners.

Nine Non-Fatal Cases

Three cases of serious assault/attempted murder of three children.

Two cases involving a total of four children subject to long-standing neglect.

Two cases of sexual and physical abuse involving a total of five children; perpetrators were father/mother's partner.

One case of long-standing physical and emotional abuse involving 3 adopted children.

One case of a severely traumatised child who witnessed the murder of a parent.

4.4 The Child

Children in this age group may be seen as less vulnerable. Typically they spend a portion of each day in the safe, supervised environment of the school: they are seen regularly by professionals and they are generally not yet independent enough to engage purposefully in risky behaviours. It is a time when the positive outcomes set out in section 10 of the Children Act 2004 of being healthy, staying safe, and enjoying and achieving come to the fore (Department for Education and Skills, 2003, HM Government, 2004). Children at this age rapidly develop new relationships with peers and other adults, and their relationships become more complex and selective (Cleaver et al., 2011). There is possibly an expectation that these children would be able to communicate with a trusted adult if something were wrong.

However, this perspective is far from universal, as indicated in the cases studied. There are children who equally spend portions of their day in very unsafe and unsupervised environments; children who are hidden from view, either because they just do not come into contact with professionals, or because they do not stand out as different from their peers; children who, through choice or coercion, do engage in risky behaviours; children whose relationships become harmful rather than protective; and children who, for various reasons,

are unable to turn to trusted adults. Three core themes were identified in relation to the children themselves. These are summarised in Table 4.1.

Table 4.1: Child themes

Core Theme	Issues Identified
The invisible child / hidden adversity	Children may appear to thrive in the positive school environment Children may present as healthy, clean and well cared for, masking underlying distress Children may be resilient, hiding the trauma they are experiencing Focus on a single 'problem child' in a family may leave other children in that family more vulnerable Focus on parental issues, without considering the impact on the child Children are not seen or spoken to
Behavioural indicators of distress	Severe, persistent behaviour difficulties Sudden change in behaviour Truanting or running away Stealing food Enuresis and soiling Self-harm
Underlying health issues	Neglect of the child's health needs Repeated minor injuries The increased vulnerability of disabled children

The invisible child

As with most serious case reviews, there was little in these reviews to portray a picture of these children's lives. Where information was present, what came across was that these children do not tend to stand out: in the majority of cases there is little to distinguish them from other children of their age, or to suggest that they were in some way vulnerable.

Many of these children may appear to be doing well at school, which is experienced as a positive, safe environment. They may continue to play and engage with other children, and to outward appearances may be thriving. In contrast, their home circumstances may be very

different and may be far from being a positive environment. In several of the cases, this contrast only became obvious after the incident, or once information from a range of sources was brought together in the serious case review. In some of the cases it seemed that the schools were totally unaware of the negative experiences these children had outside the confines of the school environment.

In some cases it appeared that the children themselves took steps to hide their negative experiences. This may have been because of perceptions of being stigmatised, for example because of having a parent with a mental health, drug or alcohol problem, or through a sense of loyalty to the family. Similarly parents themselves may hide issues that they themselves or a partner are facing. Other professionals may be aware of some of the issues for these children, but not share this information with the school. This was particularly the case in relation to domestic violence; or in relation to parental physical or mental health issues (particularly where the child may be acting as a carer for his or her parent), where practitioners within health had knowledge of background adverse incidents but again had not shared these with the schools, focusing on the adult issues rather than considering the impact of the situation on the children. These issues are dealt with in more detail in the sections on family issues and agency working.

Case Vignette: Resilient children, hidden adversity

This five year old boy who was killed by his father was one of two siblings who came across as well adjusted and settled with no indicators of concern. They were described by their school as '*two well behaved children who were observed to be settled at school. They had both grown in confidence and learning at school and had groups of friends. They were observed to be happy to be collected by either parent after school and on the day before the event were seen with their father in the local shopping area interacting quite happily. Both parents attended Parent's Evenings and specific events but were not otherwise proactively involved in school life. Both children were described as healthy, rarely having time off and always well presented, smart and clean*.'

This was in spite of a very disturbed family environment. The mother had a history of depression and anxiety, and both alcohol and drug misuse. The father similarly had mental health problems and a history of alcohol misuse. There was a history of domestic violence and arguments, the parents had separated, and there were ongoing issues around contact arrangements with the father. There were financial difficulties and housing problems and the mother and children had been evicted from their home.

Learning:

Positive presentations in children may mask underlying adversity and distress making it difficult for the school to identify any issues. In this age group, the school is typically the key point of stable and ongoing professional engagement with the child. Any agency that identifies a concern must therefore share this appropriately with the child's school. When children are known by the school to be in a risky home situation, apparent well-being in school should not be taken as a reason not to fully assess their needs and to take action to protect them.

While, in some cases, children displayed behavioural indicators that pointed towards the distress they were feeling, such pointers were often subtle. Picking up on these depended on teachers and other professionals being alert to minor indicators of distress, a gradual deterioration in the child's performance, or deteriorating school attendance, any of which may be symptoms of underlying difficulties in the home environment. In some cases, professionals may be aware of the negative home environment in which these children are living and of the potential impact of this on the children, but perceive the children as resilient, and therefore treat this with a lower level of concern.

As with many serious case reviews, a common finding in these cases was a failure of practitioners to adequately engage with the children, and to see things from their perspective (Aldgate and Seden, 2006). Two thirds of the cases refer to the 'voice of the child' not being heard or taken account of.

Another feature present in some of the reviews, which perpetuates the impact of hidden adversity, is the failure to act on or take seriously direct disclosures by the child to professionals about what is happening to them, or giving significant clues to the life they are experiencing at home. One aspect of this is the failure of the professional to explore the issue further with the child, or to allow the parents voice to dominate. In several of these reviews children were giving information to the professionals, or said that they would have told professionals what was happening if they had been asked. Children in this age group are well able to communicate to professionals what life is like for them and express their wishes and feelings, even children with communication difficulties can be supported by experts to provide information about their life experiences; however, they need support and encouragement to do so.

Behavioural indicators of distress

One child characteristic which arose in a number of cases was the significance of severe and persistent behaviour problems. This was also a feature in most of the reviews involving older children. In many cases the child, or a sibling, presented with severe challenging behaviour at a very early age. Typically it would appear that these were managed on a single-agency basis, with a focus on behaviour management, rather than taking an holistic approach to the child and family and attempting to understand the context and cause of the behaviour. The important point here is that when a child is presenting with extreme behaviours at an early stage, or where challenging behaviour (particularly behaviour involving violence towards others) persists over a long period, this should prompt a deeper analysis of what underlies the behaviour, along with a recognition of the risk of harm both to the child and to the family as a whole. This argues for a holistic, multi-agency approach to engaging with the child and family. Management of cases needs to be geared towards addressing the causes and not just the symptoms. It may not always be clear when such behaviour is indicative of the child being a child in need of protection; however the fact that it may be a child protection issue is reflected in the definition of significant harm as including children who are beyond parental control (Section 31, Children Act 1989).

As well as severe and persistent behaviour problems, another indicator of concern is the child in whom there is a significant or sudden deterioration in behaviour. This should be

readily identifiable by professionals in regular contact with these children. It appears that professionals are well able to identify and record these behaviour changes but that there is often a period of 'monitoring' which follows rather than any direct action.

Case Vignette: Significant behaviour change

This ten year old boy lived with his mother who had serious mental health problems, including suicidal behaviour and deliberate self-harm. A serious case review was instigated after the boy suffered a serious physical assault by his mother. The child intermittently presented with behaviour problems, including bed wetting (enuresis) and soiling. Three years before the incident, there was an incident of the child presenting in school with extreme distress:

'*The class teacher had stated being alarmed by the child's sudden change of behaviour and outpouring of emotion and distress. The teacher said that her feeling was that the child had wanted to tell her something, but was too worried to do so.'*

Learning:

In this case, the school responded appropriately, reporting the case to children's social care. A child protection plan was put in place, with the child remaining at home with extra support and monitoring. The review author commented that '*the child's outpouring of emotion at school is particularly noteworthy and clearly alarmed the school. At this point there appears to be a real insight into his world.*' Unfortunately, the case was subsequently allowed to drift, and this insight was not given sufficient weight in subsequent planning and court processes, so that the child was left at risk and ultimately suffered serious physical harm.

Children at this age truanting or running away from home may be using this behaviour to express the underlying distress they are feeling. Children run away from home in response to being unhappy, feeling isolated, family conflict, being in danger and from neglectful parenting. Children in this age group are becoming more independent and physically able to run away, but developmentally they remain young children and extremely vulnerable. In a survey of older children who had run away more than once, they were more than twice as likely to have first run away under the age of 13 years, more likely to have been harmed or had a risky experience whilst away from home, and were less likely to have access to informal support sources (Rees, 2011). These children are placing themselves at greater risk of suffering harm and running away should be viewed by professionals as a desperate measure used by these children. Many children who run away are not reported as missing. In these cases several children repeatedly ran away, some episodes were reported, but many were not.

When children are located they may be reluctant to disclose the reasons why they ran away. This may be due to lack of trust in the authorities, concern about being returned home and the consequences of telling professionals what is happening to them. The child's response to professionals may be based on previous experience, for example, a child who is

continuously returned home without further investigation of the situation is unlikely to trust that another course of action is possible.

Other behaviours observed in school may point towards home environments that are neglectful, controlling or violent. These include children who are aggressive towards other children or who steal food.

Case Vignette: Behavioural indicators in school

In one review of three children suffering serious harm through neglect and abuse, the children were observed over a number of years in different schools to be thin and small, and suspected of or caught stealing food. On occasions the school fed the children due to the paltry content of their lunch boxes:

'Several teachers had concerns about the small amount of food that the children had in their lunch boxes – often consisting of a folded piece of bread, and a single piece of fruit. This had been picked up because it was suspected that the children were regularly stealing food from the lunch boxes of other children.'

The eldest of these children demonstrated a marked behaviour change when he moved to secondary school:

'*Shortly after he started High School his behaviour worsened and, in contrast to being a polite and well behaved boy in Primary School he began truanting... He ran away from school over 20 times and received exclusions. At this time he also ran away from home and went missing overnight on several occasions, each time being brought back home despite protestations that he did not wish to return home. He also began to smoke and hang around with gangs.'*

It later transpired that the children were living with a very controlling mother who used excessive physical punishment and also withheld food as a means of punishment and control.

Learning:

When children display behaviours such as truanting, running away or stealing food, attempts should be made to understand the child's context and to listen to them, not merely to return them home. Although the transition to secondary school occurs just outside the age range considered in this chapter, it is important to highlight that this is a critical stage and any manifestation of challenging behaviours are likely to have their foundation in the preceding middle childhood years. It is vital to understand and address the source of the behaviour rather than to focus on the behaviour as the problem.

Normally developing children in this age group have bladder and bowel control unless there is a physical condition or temporary condition which prevents or interferes with this. Although there are reasons why a child may have a temporary regression, an ongoing or deteriorating problem in any child who has previously had bladder and bowel control should be thoroughly

and sensitively investigated with a multi-agency approach. Secondary bedwetting and soiling was a feature in a number of these children.

Suicide and deliberate self-harm feature in a number of serious case reviews in older teenagers. In the 5-10 year age group such behaviours are fortunately rare. However, both in this series and in previous analyses, small numbers of children dying as a result of apparent suicide are seen. Given its rarity, any suicidal ideation or attempts at suicide or deliberate self-harm in this age group need to be taken seriously: even in this age group it would appear that children may feel and act on genuine suicidal thoughts.

Case Vignette: Suicide and deliberate self-harm

This ten year old boy was found dead apparently having committed suicide. He had two previous episodes of suicidal behaviour, the first at the age of 7. On both previous occasions he had expressed clearly that he wanted to kill himself. He had previous behaviour problems with self-harming behaviour and soiling.

The overview report on this case concluded that:

'*This child was a very sad, lonely boy with low resilience, who embarked upon a course of self-harming behaviour when he was very young to communicate his distress to the world. Because he never received the help and support he needed, as he got older, and his distress remained unrelieved, his behaviour became more dangerous and his stated intention to kill himself more strident.*

It was the view of the Panel, given this child's words and actions over the years, and in the absence of anything to relieve his pain and distress, there was a high degree of predictability that he would continue to put himself in harm's way and that on one of these occasions he could kill himself.'

Health Issues

The children in this sample of cases had a number of health needs reported in the serious case reviews, including problems with growth and development, hygiene, recurrent and chronic illness, eyesight, hearing and speech issues, and underlying disability. In many cases there was evidence that identified health issues were not viewed as a priority either by the parent or, in some circumstances, by a range of professionals with whom the child had contact. Often health issues were identified by health professionals then followed by a period of intermittent referral, monitoring and follow up, with little coordinated action to fully assess and manage the child's needs. The number of different health professionals involved and the nature of communication and feedback between professionals was sometimes problematic. In several of these cases the high number of health and other professionals involved in the case seemed to 'paralyse' the ability of individual workers to respond to the problem, each professional 'assuming' that someone else was taking the required action. These children often fell through the net.

Case Vignette: Unmet health needs

Two boys, aged 5 and 6, were looked after by the local authority one child presented at school with non-accidental injuries allegedly caused by the father. A medical assessment raised concerns that they had been seriously neglected and had suffered considerable damage as a result.

These boys had been known to health professionals throughout their pre-school years, with a range of problems related to faltering growth, mild developmental delay, poor hygiene, and repeated emergency department attendances with minor injuries. None of these issues had been sufficiently concerning to trigger child protection procedures. The parents had intermittently engaged with medical care, and compliance with treatment was irregular. There was a pattern of repeated non-attendance at health appointments. A lack of follow-up, and the perceived 'willingness' by parents to engage meant that these children's health needs were not being consistently met by the parents and this situation was allowed to continue for over 2 years.

Learning:

This inadvertent neglect of health issues does not keep the welfare of the child at the centre of professional practice. Although there was a lot of activity, professionals did not appear to consider the implications for the children and were too readily 'reassured' that the parents were trying to improve their care of the children. While these issues had begun in the pre-school years, their persistence once the children started attending school gave an opportunity to reassess the ongoing nature of the concerns.

Opportunities for health staff to identify non accidental injuries, to talk to children about their injuries and to believe what children were telling them were missed in several of the cases reviewed. As in the pre-school group, children in this age group tend to get a lot of minor bruises and injuries; they are very mobile, adventurous and curious. However bruising will have a particular pattern or be on expected parts of the body, particularly bony parts such as arms and legs (Maguire et al., 2005). This issue is also highlighted in the following chapter on development. Frequent attendance with repeated accidental injuries and bruising should be explored as it may be a sign that the child is in a dangerous environment and not being properly and safely supervised. In contrast to infants and younger children, those in this age group are generally able to give a clear account of any injuries they receive. In some of the cases reviewed, there was little evidence that the child's account of the injuries was ever sought or taken heed of.

Case Vignette: Repeated injuries

This five year old boy died as a result of multiple abdominal and head injuries. In the few months prior to this fatal assault, he had presented a number of times with minor injuries. There had been some earlier injuries when he was aged 2, which in retrospect should have triggered concerns, but at the time were not felt to reflect any parenting concern.

Nine months before the assault, he had presented at pre-school with a bump to the back of his head. The mother was advised to seek medical advice, but no further action was taken.

A few weeks later he was taken to A&E with a painful right leg after allegedly falling up the stairs the previous evening. He was found to have a fracture and numerous bruises. The child presented again 6 months prior to the assault with an injury to his penis. Different accidental accounts were given to explain this.

A month before he died, the child was seen at school with a sore foot which was weeping and bleeding. He said he had burnt himself on a radiator. It seemed that little consideration was given to the delay in presentation and the failure to obtain adequate treatment.

Learning:

Each of these incidents raised potential concerns about the mechanism and patterns of injury, changing explanations, and delays in presentation. On all these occasions, there would have been opportunities to obtain a clear account from the child; apart from the burn to the foot, there was little indication that this was done.

Two of the fatal cases in this series involved disabled children who died as a consequence of neglect. In both cases there were indicators that their underlying needs were not being met. In both cases, there were issues around communication with the child; for a variety of reasons professionals assumed they could not communicate directly with these children. The issue of disability and communication is explored more fully in Chapter 5 on development. In these cases there was an over-reliance on communication with the parent, and a failure to consider the child's capabilities or understand what life was like for these children. If these issues had been addressed, this may have altered the outcome of each case.

Case Vignette: Disability and communication difficulties

This 7 year old child who died while in her mother's care had a diagnosis of a neurological condition with both learning and communication difficulties. This diagnosis was made when the child was less than one year old and was not subject to review or updated in professionals' records even though the child had received speech and language assistance, was now at school and able to communicate quite effectively with the right help. Shortly before her death, she underwent a medical procedure in hospital. A failure of hospital staff to communicate directly with the child was flagged up as a potentially contributory factor in the combination of events that led to her death.

'There is no indication that any of the hospital staff attempted to communicate directly with the child about how she was feeling or explain the need for her to eat and drink in spite of the pain she was most likely suffering. It would be difficult for a young child with limited comprehension and communication skills to understand the processes involved and the need to eat solid foods.'

Learning:

It is important to seek out experts who can provide an accurate assessment of what is required to communicate effectively with a disabled child. It is important to keep records about the progress of the child up to date and ensure this information is appropriately disseminated.

Every effort must be made to communicate directly with the child, using an expert third party where appropriate, remembering that the parent may not be in a position to represent the child's best interests at that time.

4.5 The family and environment, including parenting

A number of issues were identified in these reviews in relation to the child's family and environment. These were grouped into 6 core themes (Table 4.2). Many of these issues, particularly in relation to parental characteristics, were not unique to this age group, but have been identified in previous research. However, this focus on 5-10 year olds did reveal new insights into family functioning and its impact on children of this age.

Table 4.2: Family and environment themes

Core Theme	Issues Identified
Parental mental health problems	Suicide and deliberate self-harm Depression and other mental health problems Alcohol and substance misuse
Family functioning and the parental relationship	Domestic violence Parental separation
Filicide and filicide-suicide	Differences between maternal- and paternal-perpetrated filicide
Parental hostility	Overt hostility Disguised compliance Authoritarian parenting styles
Sibling behaviour and relationships	Impact of siblings with behavioural problems
Home environments	Poor living standards Unprotective neighbourhoods

Parental mental health and suicidal/self-harming behaviour

Parental, particularly maternal, mental health problems featured in a majority of cases, with reported depression in 10 mothers and 5 fathers/father figures, along with other mental health disorders, and alcohol and drug misuse reported in many cases. One particular issue that stood out was that of parental suicidal or self-harming behaviour (9 cases). Being a parent is generally perceived to be a protective factor in relation to suicide, particularly among women (Hawton, 2000, McLean et al., 2008, Qin et al., 2000). In several cases,

notably those that ended in maternal-perpetrated filicide (see below), mothers had presented within health services with deliberate self-harm, or attempted or threatened suicide. In these situations it would appear that the fact of being a parent was not proving the protective factor it is generally perceived to be. This suggests that if a parent presents with self-harming or suicidal ideation or behaviour, the risks of harm to both the parent and the children should be taken very seriously indeed.

In some cases, parents' attempts to seek help for their mental health problems did not appear to be taken seriously. This included at least one case where a partner had informed the relevant agencies of their concerns about their partner's suicidal ideation and yet no urgent action was taken. In other cases, the parents were treated in isolation, without considering the broader family context, or the potential impact of their mental health problems on the children. The response within health seemed often to be one of treating the symptoms, or addressing single issues or individual incidents, rather than taking a broader view of the context.

Case Vignette: Parental suicidal behaviour

Two children in this family died following a house fire. The home environment for these children was unstable with a parental relationship that was marked by alcohol misuse and domestic arguments, separation and reconciliation. The mother had a history of depression and had been on and off treatment for this. Two years prior to the fire, she had presented twice in quick succession with serious suicide attempts while the children were in her care. There had also been at least one previous threatened suicide. The health and social care staff appeared to recognise the seriousness of these incidents at the time:

'Mother stated that she has taken two recent overdoses when the children were present and although she informed people of her actions, she feels they were intentional acts of attempting suicide at the time. Mother made cuts to her arms during these incidents also. This is a clear indication of her intentions to take her own life at the time of the overdoses, and telling people she was going to do so was not an idle threat or attention seeking behaviour.'

The overview author reported that:

'*This was a critical period in the life of this family; it included significant self-harming behaviour by the mother and evidence of her vulnerability and the complexities of her relationship with the children's father. For the children this must have been a difficult time… it is remarkable that they appeared to cope with all of this, with no recorded evidence of distress.'*

In spite of these concerns, the children were eventually returned to the mother's care where they were at the time of the house fire.

Learning:

In this case, it would seem that the mother's self-harming behaviour was sufficiently concerning to have raised alarms (and indeed did at the time), which, coupled with the fluctuating family structure, meant these children were at risk of harm.

Family functioning and the parental relationship

Domestic violence was a feature in 14 of the cases in this age group. In most cases it was the father, or father figure, who was identified as the perpetrator, although in at least two cases both parents alleged that the other was abusive towards them. All forms of domestic violence were seen, including physical, emotional/verbal, financial and sexual abuse. The cases highlight both the potential risks for children to suffer direct, severe harm, including homicide, and the emotional harm suffered by children living in situations of ongoing domestic violence. In some cases, one or other of the parents had grown up with domestic violence between their own parents, and thus it became seen as normal marital behaviour.

Several issues arise in relation to the management of domestic violence. Although there has been a major shift in recognising the impact of domestic violence on children, and including it within the Children Act 1989 definition of significant harm (HM Government, 1989), these cases suggest that this has not necessarily filtered through to the level of professional responses to domestic violence. In most cases, where domestic violence was identified, there appeared to be some awareness among the police that the presence of children in the home constituted a risk to those children, and the incidents would therefore be notified to children's social care. Procedures appear to be appropriately in place to do so. However, the manner in which this was done, and the subsequent response by children's social care, varied. In many instances, the notification appeared to be treated as information only, to be stored away but not acted on. In other cases, it initiated a low-level single agency response by children's social care. Occasionally, the information was forwarded to other professionals, particularly health visitors (though rarely to schools or GPs).

It was striking, however, how rarely this information triggered a multi-agency response to consider the risks to and needs of the children. This suggests that domestic violence is still not being treated with the same degree of concern as other incidents of perceived maltreatment. There was no evidence that information about domestic violence ever triggered a multi-agency strategy discussion or a section 47 enquiry. In some cases, children's social care simply wrote to the mother, providing sources of advice and support, but apparently not considering the impact on the mother or the children, or how the mother might access support. Several of the overview reports suggested that once the police had notified children's social care of the case, they considered that their responsibilities to the children had ended. In most cases, it appeared that the police child protection teams did not become involved. As with other reviews, there seemed to be an expectation in some cases that protection of the children was the mother's responsibility, with little thought as to whether or how she would be able to achieve this.

This suggests that there is a need to take domestic violence much more seriously, and to address it as a multi-agency child protection issue, requiring a strategy discussion and a thorough assessment. This could have major resource implications and careful consideration needs to be given to the feasibility of doing so, and how this might tie in with other processes for managing risk to children, including the work of multi-agency risk assessment conferences (MARAC) regarding victims of domestic violence.

One factor which came across very clearly was that domestic violence, and its effect on children, does not stop when parents separate. This may be particularly marked with very

controlling fathers who move out of the family home, but continue to exert a strong negative effect on the mother and family. As indicated earlier, parental separation affects large numbers of children in this age group and these children could be particularly vulnerable if the parental separation is seen as protective without considering the potential ongoing risks from excluded violent partners. As pointed out in one report:

'It is well established that domestic violence often does not cease on the separation of perpetrator and victim. Because the desire for control of other members of the family is a common feature of the behaviour of perpetrators, contact with violent fathers is recognised as a point in the case history when children may be particularly at risk.'

Parental separation, whether linked to domestic violence or not, was a significant issue in at least eight of the 21 cases in this series. There was evidence of acrimonious separation and contested residency and contact arrangements in several reviews. These issues were typically dealt with through the family courts, particularly in private law cases, with little, if any, reference to inter-agency working. In most of these cases, there seemed to be little consideration of the needs of the children, or the impact on the children of the proceedings. These cases highlighted that acrimonious separations can present direct risks to children's safety and welfare, specifically risks of homicide as highlighted below. Even where the cases do not progress to such extremes however, there is evidence that children suffer emotional harm, potentially being used by parents to get at each other, or being caught in the middle of ongoing conflict.

There was evidence however that the impact on children was downplayed by professionals, seeing these cases as private law issues revolving around parental arrangements, rather than as situations posing harm to children. One review reported that *'the social worker recommended that the case could be closed as this was "a private law dispute and the children were being caught in the middle" '.* In another review, the author commented that *'it would appear that the response by agencies to the contacts with the parents was to view them as being part of an on-going marital dispute and therefore to downgrade the level of the concerns being raised'.*

The severity of these risks is such that where children are caught in the middle of an acrimonious parental separation, consideration is always given to the emotional harm that the children are suffering, and that such cases are treated as child protection issues, triggering a strategy discussion and consideration of a multi-agency section 47 enquiry. This however could have significant resource implications. This is probably an area where more research is needed on the impact on children of parental separation, how we identify which cases are concerning, and what tips the balance between a 'normal' separation and a high-risk situation.

Filicide and filicide-suicide

There were seven cases, involving ten children, in which a parent was apparently responsible for the murder of his or her child, along with a further two cases of apparent attempted filicide. In five cases more than one family member was targeted, and in two cases the perpetrator took, or attempted to take, his own life. The literature suggests that in

young children aged less than one year mothers are more likely than fathers to kill their children (Wilczynski, 1997); in older children, however, the reverse is true (Bourget et al., 2007). In keeping with this, in our case series there were more filicides perpetrated by the father or male partner than the mother.

There appear to be significant differences in the characteristics of those cases where the mother was the suspected perpetrator, compared to those where the father was the suspect. In cases of maternal filicide, the mothers invariably were reported to have severe mental health problems, and it would appear to be those problems that led to the filicide. Those cases perpetrated by fathers were primarily linked to violent behaviour and domestic violence. In some cases there were additional mental health problems and/or alcohol or drug use. Issues around separation and contact, and particularly ongoing court proceedings, seemed to feature in many of the paternally-perpetrated cases. In some cases there was direct evidence that the filicide was being used in a desire to exact revenge on the mother. This behaviour has been noted by previous researchers. Resnick (1969) coined the term 'spouse revenge', and subsequent authors found that men were more likely to commit retaliatory killings than mothers (Wilczynski, 1997, Daly and Wilson, 1988).

Case Vignette: Paternal-perpetrated filicide

A five year old girl was killed by her father during a weekend contact visit. The father also attempted to take his own life and that of the older sibling. The parents both had histories of mental health problems and alcohol abuse. There was a history of domestic violence, and the parents went through a difficult separation 2 years earlier. Three months before the fatal incident, there had been a specific threat made by the father:

'*A referral was made to the police when mother had gone to father's flat to collect children's clothes. Mother stated that father had said that "If I can't have the children, you can't. I will kill them and myself". Mother was described as "clear and matter of fact" by the uniformed police officer and she confirmed that this was the second time father had made this statement. Mother also explained that father had an alcohol problem and was taking antidepressants and although he was verbally abusive to her, he had not physically attacked her. Father was seen and interviewed under caution as he was due to have the children for weekend contact after collecting them from school.'*

Learning:

Filicide threats need to be taken seriously. In the context of parental separation this can sometimes be seen as 'just' controlling behaviour on the part of one partner. The controlling behaviour should be seen as further evidence of ongoing domestic violence; the potential risks of harm to the children need to be thoroughly assessed.

Parental hostility

In some cases, the parents were noted as hostile to professionals and as a consequence either rejected or were denied services. The serious case reviews concluded that professionals should have persisted with their efforts in these cases. In at least one case, professionals closed the case when the parents refused support.

There were several cases where one of the parents was seen by professionals to engage particularly well with services. In at least three of the cases a male parent, or male taking the parental role, managed to convince professionals that he was the caring parent and that the mother was not to be trusted. This phenomenon has been described as 'disguised compliance' (Reder et al., 1993). In these cases, the male partner was the perpetrator of the offence, yet professionals 'believed his story' and often discounted the mother. Previous biennial analyses have highlighted the issue of disguised compliance whereby professionals are influenced by a seemingly engaging family member. Working with some families is clearly challenging and may be confrontational, so professionals find a compliant parent/parental figure easier to work with. However, it is important that professionals do not allow themselves to be blinkered to the views of other family members.

Parental hostility towards professionals, or deliberate non-engagement with professionals, may reflect an underlying controlling or authoritarian manner which may also affect the parenting the children receive.

Case Vignette: Parental hostility and authoritarian parenting

Three children in this family were subjected to prolonged physical and emotional abuse and neglect, persisting throughout their pre-school and primary school years, culminating in a series of allegations by the eldest child. This eventually led to child protection enquiries and a serious case review once the extent of the maltreatment became clear. Their mother was described as having an authoritarian parenting style, unrealistic expectations and to be very controlling. Over a period of many years teachers at a succession of nursery and school placements became concerned about the mother's treatment and punishment of the children. However, no effective action was taken. In this case the mother was articulate, well-educated and described as intimidating:

'*The fact that some teachers, who were adults, were so distressed by the mother's behaviour should have given them greater insight as to the implications for the children, and how much more distress they were likely to be experiencing as children as a result of the mother's harsh parenting and aggressive behaviour*.'

'The mother was hostile and aggressive in her dealings with professionals when she arrived on the ward to collect the child and her level of anger and abusive language was such that a Staff Nurse felt very intimidated.'

Learning:

In this case the mother's hostile behaviour to staff actually prevented them taking action to protect the children, rather than prompting a consideration of what the home environment must be like for those children. There were plenty of opportunities for both health and education staff to have escalated their concerns and trigger a child protection response.

Sibling behaviour

In three cases, a sibling or half-sibling of the subject child had known mental health issues and/or offending behaviour. In one of these cases an older sibling was the perpetrator of a

homicide. Complex family situations with severe behaviour problems can be directly harmful to other children in the family, and there is a significant risk that the needs of other children can become lost because of a focus on the index child.

Case Vignette: Child lost within the family

This family consisted of 4 children aged 9 upwards at the time of the incident involving the youngest child. Several of his older siblings had problems in relation to their behaviour and education. These were dealt with in isolation, resulting in a variety of professionals being involved with the family over a long period of time. The oldest child had significant mental health problems which were described as 'dominating professional attention'. The review commented, 'this meant that professionals paid insufficient attention to the needs of other children in this family who had experienced the same quality of parenting and adverse family circumstances'. The youngest child in particular seemed hidden from professional view. He was described as 'mischievous and lovable' and as 'a person who was caught up in his family's difficulties but who nonetheless attracted relatively little attention from agencies and professionals'. In the year before his death however, his behaviour and well-being started to deteriorate. It was as though he had been coping with his adverse home environment until it reached a crisis point:

'*The Learning Services chronology reports the child telling his teacher on one occasion that he was late because his mother was drunk and on another that he was tired because his father had been drunk and was shouting… he attended school looking dishevelled and [3 months later] records indicate his disruptive classroom behaviour and problematic behaviour in the playground. A [subsequent] SEN review recorded that the child was often lethargic and tired and had recently shown a more aggressive side to his personality.'*

Learning:

This child was seen by professionals as a product of the local community and a family in chaos. There was no expectation that he would turn out any differently to the other children in the family or neighbourhood. Where professionals are involved in working with one child in a family, they need to consider the safety and welfare of the other siblings in the same family. Children may well mask the adversity they are experiencing at home, and professionals need to be alert to possible indicators of distress. A multi-agency meeting or CAF could have helped to co-ordinate the complex nature of multiple professional involvement and to assess the needs of the individual child and family.

The home environment

Very few of the families in our cohort owned their own home; more commonly, families lived in privately rented or council housing which was often cramped or unsuitable. Where the home environment was described, it was often of a poor quality, particularly in cases where there was evidence of neglect. In younger children, issues of neglect may be more apparent, through their impact on growth, hygiene and development. In school-age children, these impacts may be less prominent. Professionals have fewer opportunities to visit and

assess the home environment within which children are living. Some of the home environments described in these reviews appeared totally unsuitable for children.

Case Vignette: An unsuitable home environment

In this case, involving two children who suffered long standing neglect, the school had ongoing concerns about their welfare. There had been previous involvement from children's social care. A number of referrals eventually led to a section 47 enquiry which highlighted the extent of neglect these children were facing.

'*These two children were removed from their home because of the filthy and insanitary conditions in which they were living. Their home had no working toilet, only a basic supply of cold running water and only one working electrical socket. Large numbers of pets and small farm animals shared the accommodation with two children and two adults. The floor and fittings in the bathroom were covered in human and animal excrement and other rooms were in a foul state cluttered with furniture and numerous possessions..... None of the professionals who were working with the children knew they were living like this. The simple reason for this is that for several years no professional had seen the inside of their home.*'

Learning:

Cases such as this raise the question of how professionals involved with the family did not visit the family home to assess the conditions under which the children were living. The children in this case had no possessions or clean clothes to wear, and they rarely washed. Two girls lived in this house and attended different schools. Eventually, both schools started to launder the children's clothes so that they had decent clothes to wear during school time and offered the children an opportunity to shower. Instead of merely treating the effects of unsanitary housing, agencies should have carried out an assessment of why the children were unclean.

In some cases the wider community in which the family lived had a culture of anti-social behaviour and substance misuse, thus making the subject family unremarkable. The wider community can be a protective factor whereby concerned neighbours will alert the police or other agencies if they witness or suspect child maltreatment. However, in a case of long-standing neglect, where the children were living in squalid and unhygienic conditions within a rural location for several years, the serious case review reported that none of the neighbours had taken any action to alert the authorities on the living conditions of the children, adding that the local police were aware of the house, but did not refer the case to children's social care. In these situations, far from being a protective influence, the neighbourhood and community can perhaps mask the reality of the squalor in which the family are living.

4.6 Systemic and service issues

This subset of serious case reviews identified many of the common themes found in previous serious case reviews in relation to services, professional attitudes, knowledge and behaviours, and the systems and structures that underpin safeguarding. These common

themes are explored in the next section, along with a major theme related to professionalism in safeguarding practice; issues in relation to child protection systems; and some issues identified in relation to the interaction between inter-agency working and court processes (Table 4.3).

Table 4.3: Systemic and service themes

Core Theme	**Issues Identified**
Common, previously identified themes	Incident-driven practice Rule of optimism Silo practice and professional isolation
Professionalism	Taking responsibility Critical thinking Engaging child and family Inexperienced workers Supervision Time
Child protection systems	Distinction between child in need and child protection Strategy discussions
Inter-agency working and the courts	Court proceedings seen as separate from inter-agency working Court decisions affecting ability of professionals to continue safeguarding work Barriers to involvement of the courts in learning from serious case reviews

Common, previously identified themes

Incident-driven practice and a failure to recognise the big picture or context of the case was commonly reported, with practitioners criticised for failing to take account of accumulating concerns, or ignoring the previous history of the child and family. This seems to reflect a problem-based approach to practice, rather than a broader holistic approach. There were often multiple assessments of specific problems, and a focus on the adults' needs, rather than considering the ongoing impact on the child's health and development.

The contrasting perspectives of the 'rule of optimism', with professionals unrealistically anticipating improvements in families, and, conversely, professionals withdrawing as they become overwhelmed by the multitude of problems in chaotic families, were both identified as features which led to a failure to focus on the child, or to effectively intervene to safeguard the children's welfare. In other complex families, there was tolerance of unacceptable levels of care, particularly if this was seen to be normative for the community in question. These issues were summed up in the words of one report author:

'There is little evidence of staff from any agency trying to work directly with the children, and understand from them the reality of their daily lives. The case review presents a familiar picture of parents presenting such a multitude of problems – school attendance, housing, finance, chronic illness, historical sexual abuse and more - that agencies lose their focus on the child.'

The issues of 'silo practice' and sidelining/exclusion of different professionals were apparent in a few of the cases. This may have arisen because of professionals focusing exclusively on their own areas of practice, again taking a narrow, problem-based approach to working with children and families; or because of different understandings of criteria and thresholds for provision. There was evidence in some cases of fragmentation of adult services, for example between alcohol services and other mental health services.

Many of these issues, and others reflected elsewhere in the report, are perceived as common and repeated failures in professional's working to safeguard and promote the welfare of children. They typically raise the question, 'Why aren't the lessons being learnt?' Sidebotham (2012) has argued that some of these lessons are so important that they need to be repeatedly learned, and their frequent occurrence reflects the fact that individuals and organisations change, and new staff come in who may not have the experience and 'memory' of previous learning. An awareness of these issues among professionals for whom safeguarding children is a key part of their role is likely to mean that they are alert to the issues, and quick to identify them when they are present. The impression gained from reading these reports is that individual practitioners and professional teams continue to make a range of mistakes in their day to day practice. However, in many of the reports, examples of good practice were noted as well.

This should not prompt any complacency. The fact is, as highlighted throughout this report, that children continue to get seriously harmed as a result of maltreatment, and that the professionals and agencies charged with a duty to safeguard and promote the welfare of children are therefore somehow failing these children. On the whole, in these cases, there were indications that the systems and structures in place for safeguarding are perceived to be appropriate, but that mistakes are made when individuals work outside the procedures, or do not follow them adequately; this perspective however does not address the deeper question of why such mistakes could continue to happen. In spite of the emphasis in *Working Together to Safeguard Children* and in the many reviews of safeguarding services, there is a disappointing lack of any deep, systemic analysis of these cases. The serious case reviews we reviewed were very good at identifying *what* went wrong, but rarely moved beyond that to seriously consider *why*.

It was notable that resource issues were rarely mentioned in any of these reviews. This seems surprising in a time of austerity and widespread cuts in welfare budgets. It is possible that both the professionals involved and those conducting the serious case review are blind to the impact of resource, staffing and finance on working practices, that they accept this as the status quo and an issue that cannot be changed, or that, in the absence of a direct link with the outcomes, they do not make a connection between the two. Another interpretation is that those conducting the review judge it to be politically unacceptable and unwise to mention resource constraints. However, it is our impression, in collating data from a large

number of serious case reviews, that there are significant resource implications of our failure to protect these children.

Professionalism

Lying beneath the mistakes made by individual practitioners, there would appear to be a lack of professionalism and critical thinking. In many cases, practitioners did not appear to be taking their safeguarding roles seriously. This could lead to individuals passing the buck, or relinquishing their responsibility once they had referred the case on to others. This was often accompanied by practitioners making assumptions about the actions that others will take. Thus, individual practitioners would often not take responsibility for following through on cases and ensuring that actions did take place. This was reflected in the issues around incident-driven practice, the rule of optimism and failure to consider the child's perspective referred to above.

Case Vignette: Lack of professional curiosity

In this case of a 5 year old, who died of multiple inflicted injuries, there was evidence throughout the report of a lack of critical thinking and of professionals failing to take their safeguarding roles seriously. In the years preceding his death, there had been a number of presentations with concerning injuries, parental mental health problems, and domestic violence, but the lack of any clear indicators of non-accidental injury meant that there had been no adequate assessment. This lack of professionalism was highlighted in the contributory individual management reports:

'The Children's Social Care IMR identified the "lack of professional curiosity" displayed in this case, although this did not only apply to social work staff. Lord Laming helpfully identified that there was a greater need for "respectful uncertainty" to be displayed by child care professionals, and this could be said to be relevant within this case. Overall, concerns and incidents were seen in isolation, with minimal attempts to link concerning patterns of injuries, to enquire in more detail about their cause and nature, and to gain a collective view of family life.'

'*It was apparent that the investigation went no further than the interviews in the hospital, (other than a telephone call by the Police to the GP), in that there was no record of the need to at least meet with the mother's partner and to visit the home and perhaps see where and how these unusual injuries occurred. To have extended the enquiries in this way would have been appropriate in these circumstances and the Police IMR recognised that this reflected a missed opportunity for a "more incisive investigation into the injuries".'*

Learning:

There had been plenty of opportunities to intervene in this child's life, but this required the professionals involved to challenge the actions and decisions of other professionals, not to make assumptions about what others would do, and to take personal responsibility for following through on concerns about children's safety and welfare.

A lack of critical thought and professionalism was also often reflected in the attitudes and behaviours of professionals towards parents, particularly where there were difficulties of engagement, non-compliance or disguised compliance. In some cases this resulted in professionals relying on written or telephone contact with a mother to highlight concerns, rather than face to face meetings backed up in writing; relying on the mother to take action in response to concerns, rather than referring into the multi-agency system; and in a lack of challenge to non-cooperative parents.

This lack of professionalism could extend to the underlying culture of whole teams, resulting in inadequate assessments, or a failure to follow cases through from assessment to actions and outcomes. A culture of procedure-driven, uncritical practice in teams can contribute to the 'silo practice' and sidelining of professionals highlighted above. A lack of professional approach and critical challenge within teams can also extend to supervision, and this was observed in both front-line practitioners and in their managers in some of these cases.

Case Vignette: Ineffective supervision

This case involved a 10 year old boy who was seriously injured in a severe physical assault by his mother. There had been a number of previous concerns regarding the child's welfare, and the Local Authority had sought to place the child in foster care. The ongoing management of the case was characterised by polarised positions between different professionals working in the case. This polarisation of views in turn contributed to ineffective joint working. The lack of effective supervision was perceived to be a critical factor in the outcome of this case:

'There was evidence that supervision took place in respect of social workers, the health visitor and the guardian. However, what is less evident is the impact that this had on outcomes in this case. Health visitor records show that the case was notified to senior nurses with clear action plans agreed, although it still appears that there were misunderstandings between the professional interpretations of information shared at this point. The issue of professional relationships has been explored in this review and there is little evidence that supervision processes effectively tackled this matter, with the supervision of the guardian and the social worker apparently making little difference to the polarised positions between the guardian and the social care professionals. There remains a question as to whether supervision was sufficiently probing or challenging in either organisation.'

Learning:

This serious case review went further than many in attempting to probe deeper into the reasons why such failings could have occurred. It identified the need for effective supervision and support of supervisors as one of the key factors:

'This lack of challenge within supervision may indicate that the supervision and support for the supervisors themselves in recognising and working with the complex dynamics in this case was insufficient. The quality of supervision practice will be affected by the quality of the supervision that managers themselves receive.'

In her recent review of child protection, Professor Munro highlighted the importance of professionalism and critical thinking within all agencies (Munro, 2010, 2011a). This is strongly reflected in the findings of this analysis. While the systems, structures and procedures can bring standardisation, and are valid and useful components of our approach to safeguarding, there is some suggestion that practitioners end up being bound by these procedures, with an over-reliance on electronic recording systems and pro-formas, and working strictly to criteria rather than critically thinking about cases. This was highlighted specifically in one case:

'An over-reliance on electronic recording systems, protocols and pro-forma requirements that direct professionals' attention to the characteristics of individual service users and indicate algorithmic relationships between prior conditions and specific interventions. These divert professionals' attention from logic and initiative.'

Professionalism and critical approaches to practice do not come automatically. They require both training and experience, and systems that support such approaches. One feature that came out in a number of cases, particularly in relation to children's social care, but also to some extent in relation to the police and some other agencies, was the inexperience of those practitioners who are dealing with complex cases. In many cases, the front-line worker was a newly qualified or agency worker. It would seem that in social care, those professionals with the most experience tend to be in managerial/supervision roles and have very little direct contact with children and families. This is in contrast to the model of clinical care within health, where services are both led and, to a large extent, delivered by experienced practitioners, including consultants, GPs, health visitors and school nurses. This is reinforced by extended periods of time in training posts, and by newly qualified practitioners joining teams in which the more experienced practitioners have ongoing direct clinical contact with clients. These findings support the current emphasis on increasing professionalism within social care and Professor Munro's recommendations around developing social work expertise and supporting effective social work practice.

One specific model of practice that could support more professionalism and critical thinking within and between teams would be to further develop systems of peer supervision. These are currently widely in use within paediatrics for child sexual abuse, but the principles could be extended to other areas of child protection, to teams in other agencies, and to inter-agency teams.

It was clear, from reading these cases, that providing this level of professional, critical reflective practice takes time. Many of these cases were staggering in their complexity, a finding that is reflected across the serious case reviews and in the day to day practice of all professionals involved in safeguarding children. Assessment processes must not be rushed if they are going to be effective. Similarly, inter-agency working takes time in liaising with others, following through on actions, and challenging and escalating when necessary. And critical reflection, peer review and supervision all require adequate time set aside if they are to be effective. Professor Munro has highlighted the issues around sacrificing quality in favour of timeliness, and there clearly needs to be a balance, but it seems clear that, at present, too often professionals are driven by the needs of the system, and do not take the time to stop and think. This has important implications, as practitioners and managers need

adequate time allocated within their jobs for such critical reflection, and caseloads need to reflect this.

Inherent to this is also recognition that this is demanding work that takes its toll on practitioners, and therefore there needs to be structures for support of front-line workers. The impact of this work and the need for appropriate support was powerfully expressed in one overview report:

'An important aspect of this review has been an affirmation of the need to support all front line practitioners in working with complexity. Child protection is rarely straightforward and this case has challenged many experienced professionals over a number of years.'

'A final fundamental lesson is the importance of recognising the emotional toll that working with child protection can take and the effect that this can have on relationships, judgements and decisions and capacity to remain in the job. Effective supervision is key in recognising and working with the impact of emotions on practice yet there is little evidence that supervision in any agency provided a forum where this could happen. The result was that in some instances there was a failure to see the significance of information or to challenge biases and beliefs affecting the way information was interpreted. On other occasions the overwhelming feelings of frustration and despair appear to have resulted in an organisational response which did not provide the emotional support and effective challenge that front line managers need. A whole system approach is needed to supervision which ensures that everyone involved in child protection work has available, and makes use of, effective supervision that:

- *Enables critical thinking*
- *Provides emotional support*
- *Facilitates effective inter agency working.'*

Child protection systems

While Lord Laming found that the basic systems and structures of inter-agency safeguarding are sound , Professor Munro identified system failings that compromised the safe working of these child protection structures (HC 330; Cm 8062). The cases reviewed in this analysis highlight both that overall structures are sound but also that there are a few weaknesses in these systems.

First, there appears to be some confusion engendered by the perceived distinction between 'child in need' procedures and 'child protection' procedures. Indeed, rather than being seen as a continuum, this distinction leads to a substantial gulf in practitioners' approaches. In several cases there was apparent confusion over the terminology used for multi-agency meetings, including 'child in need', 'common assessment framework', and 'team around the child' meetings. This was often compounded by a lack of clarity in terms of who takes responsibility for such meetings, lack of clear arrangements for chairing and taking minutes, and a lack of structure for the meetings. This in turn led to many meetings being very

unclear in their focus, with a lack of any definitive action plan or accountability for following through on agreements.

Within children's social care, and among professionals in other agencies, there often seemed to be confusion over the remit of 'initial' and 'core' assessments, and between single agency and multi-agency assessments. This led, in some cases, to inadequate assessments being undertaken or repeated partial assessments which never fully appraised the situation of the children. Similarly, cases could end up being closed without adequate analysis of the context, leaving children at ongoing risk of suffering harm.

Case Vignette: Lack of clarity in inter-agency working

One particular fatal case involving a 9 year old boy highlighted a number of issues in relation to inter-agency working. In the years preceding his death, there had been a large amount of activity from different professionals and agencies. Much of this had focused on the older brother's behaviour problems. There had been a number of assessments, many of which were deemed to be inadequate, and little follow-through on actions. There seemed to be particular confusion in the status of different meetings and assessments. The overview report highlighted the failure to proceed with appropriate child protection procedures.

'It seems remarkable that twelve years after a strategy meeting and ten years after a multi-agency meeting regarding this family and the children's wellbeing, no agency had taken the initiative to convene a multi-agency meeting by way of a core assessment or a CAF assessment, or simply because they thought this would have been useful. By this time CSC had completed four initial assessments.'

'At no point over fifteen years did Children's Social Care initiate child protection enquiries, a Child Protection Conference, or a core assessment.'

'The lack of an effective pre-birth assessment, despite compelling evidence that the mother may have difficulties parenting, laid the foundations for a lack of rigour in assessment practice across all agencies throughout the period covered by this review. Although a parenting assessment took place there was no core assessment and importantly at no time did any assessment include an analysis of relevant historical information regarding the parents' previous experience of parenting.'

Learning:

In this case, the meetings that were held did not carry the status of formal child protection procedures. Although other meetings were held, these were not designed to focus on the children's needs. It is essential that when meetings are held in relation to vulnerable children and families, they should have a clear structure, chairing and recording arrangements, and should conclude with a focused outcome-based plan.

One of the pivotal points of inter-agency child protection work is the strategy discussion. This should be the starting point for every section 47 enquiry. *Working Together to*

Safeguard Children (2010) emphasises the importance of a strategy discussion in every case:

'Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies as appropriate (for example, children's centre/school or family intervention projects), in particular any referring agency.' (HM Government, 2010; paragraph 5.56, page 152)

Given their centrality to the process, strategy discussions were conspicuously absent from the SCR reports we reviewed. Where they were mentioned, it was often to highlight inconsistencies in the conduct of these discussions, delays in holding the discussions, inadequate representation, or poor decision making. This suggests that strategy discussions may not be being given the priority they deserve and therefore do not feature as a central point in critical thinking about the case and appropriate planning. This would seem to be an area where further research and consultation could be beneficial.

Inter-agency working and involvement of the courts

In several of the cases in this age group, there was involvement of the family courts, either in the form of private law proceedings, or through public law cases brought by the Local Authority. A number of overview reports highlighted significant difficulties raised by the interaction between court processes and inter-agency working to safeguard children. Indeed, in at least two cases, decision making by the courts, and apparent difficulties in the interaction between court processes and wider inter-agency safeguarding activities, were directly linked to the deaths of children.

There is an inherent difficulty in this, with the principle of judicial independence being central to the impartiality of the law, and with this requiring separation of the courts from other aspects of inter-agency working. In some cases, the entire court process, including the involvement of Cafcass and probation, was sidelined and excluded from inter-agency working. In other cases there appeared to be a perception among practitioners that if a case was being dealt with by the courts, there was little role for inter-agency safeguarding, or even that it was not possible to pursue safeguarding procedures at the same time. In yet other cases (both public and private law), there appeared to be little follow-through on cases once they had been dealt with in the courts, even if professionals perceived there to be ongoing risks of harm to the children.

Such issues are not new and were highlighted in a 2004 Women's Aid report on 29 children in 13 families who were killed between 1994 and 2004 as a result of contact arrangements in England and Wales (Saunders, 2004). Domestic violence or obsessively controlling behaviour was a feature in 12 of the 13 families; parental mental health problems, including suicide threats or attempts were common. In many cases it seemed that the professionals did not appreciate the significance of the power and control dynamics inherent in domestic violence, or the risks posed to the children, even following separation. The report concluded that '*in three of the cases it is clear that not only did the court grant orders for unsupervised contact or residence to very violent fathers but that these decisions were made against*

professional advice, without waiting for professional advice or without requesting professional advice.'

Case Vignette: Confusion in the roles of the court and wider inter-agency safeguarding

This case involved a ten year old boy admitted to hospital with serious injuries inflicted by his mother. Throughout his life, this child had lived in an unsettled home environment, characterised by parental conflict and domestic violence; maternal mental health problems, including depression and deliberate self-harm; and repeated episodes of physical and emotional abuse. The child had more than once been made the subject of a child protection plan, and there had been numerous strategy meetings, core assessments and child protection conferences. Two years prior to this incident, an application for a care order by the Local Authority was turned down and the child returned home under a written agreement. There followed a pattern of further court hearings; ongoing risks of harm to the child were recognised by the professionals working with the family, but not accepted by the courts, and the child remained with his mother. A review conference some months before the incident concluded that in the light of the court order the child should remain at home and that the Local Authority should only be involved in serious child protection issues, that there was no role for the Local Authority and that the child should no longer be the subject of a child protection plan. The child was in fact removed under police powers of protection 3 months later, following an incident in which the mother appeared suicidal and was threatening to harm the child. Once again, the court ordered that the child be returned to his mother, where he was at the time of the final assault.

Learning:

The overview report author commented on the significance of the court rulings in this case:

*'The comment in the final judgement that the Local Authority should only be involved in **serious** [OR report author's emphasis] child protection issues is surprising, since it can be interpreted as preventing the Local Authority from carrying out their duties under s47 Children Act 1989 and fulfilling the requirement of the statutory guidance… In fact, the wording in the judgement is ambiguous regarding the role of the Local Authority where there are child protection concerns and seems to have resulted in some confusion within the professional network about how to respond when further concerns emerged. The judgement states that "more serious child protection issues should of course be communicated to the Local Authority" and there should be an inter-disciplinary meeting before untoward action was taken. This did not necessarily preclude conducting enquires under section 47 via an interdisciplinary strategy meeting and this course of action could have been taken following the concerns of the (day care) worker.'*

This serious case review recommended developing a process for structured de-briefing following court hearings where the Local Authority has had an application refused in court. Such a process could help to identify appropriate ways for children's services to continue to work to safeguard a child, even when it has not been possible to remove the child from the parent's care.

The issues around the involvement of the courts in wider aspects of inter-agency working extend to their involvement in learning from serious case reviews. In three of the reviews, attempts had been made to involve the courts in the process, but in each case had been unable to do so as there are no current mechanisms for involving the courts in the serious case review process, and to do so was perceived as compromising judicial independence.

This highlights some of the difficulties inherent in the interaction between court processes to protect children and wider inter-agency working to safeguard and promote their welfare. The principles of judicial independence and due process of law are inherent to a just system and provide important safeguards to all involved. This can, however, lead to frustrations among practitioners in the multi-agency arena. Misunderstandings of these processes and breakdowns in communication may at times lead to children being put at further risk of harm. These cases highlight the need for further research and consultation into how the courts and other agencies work together to effectively safeguard and promote the welfare of children, while maintaining these important principles.

Chapter 4: Summary

- This chapter analyses themes which emerged from the 21 serious case review overview reports pertaining to children aged between 5 and 10 years. These themes are considered in relation to three interconnecting domains of the child; the family and environment, including parenting capacity; and systemic and service issues. Many of the themes are similar to those seen in other age groups, yet there is significant diversity of the type of cases in the 5–10 year old age group. Such heterogeneity has particular challenges for understanding and practice.

- The primary school years are generally perceived to be a positive time for children; rates of serious harm are low. Nevertheless substantial numbers of children do suffer significant harm.

- There may be particular issues in this age group around hidden adversity. Most of these children will be seen regularly in school, and when they present well, professionals may be unaware of underlying concerns. In contrast to the pre-school years, there tends to be little direct professional engagement with the parents or the home environment. School staff may be unaware of the circumstances of these children outside of the school environment.

- Indicators of physical and emotional harm may be harder to detect in this age group. Often this will rely on behavioural issues, which may be subtle, or may be tackled solely by focusing on the behaviour, rather than considering what may underlie that behaviour.

- Parental suicidal or self-harming behaviour needs to be taken very seriously, and the potential risks to the children thoroughly assessed. Being a parent is generally perceived to be a protective factor in relation to adult suicide or self-harm; thus when a parent is threatening or actually carrying out suicidal or self-harming behaviour, this protective element may have been lost.

- Many children in this age group are affected by parental separation. This may be a context within which children are at risk of significant harm. This may be particularly so where the separation is coupled with ongoing domestic violence or controlling behaviour; where there are conflicts around contact arrangements; or where children are caught in the midst of acrimonious separations.

- These cases highlight a number of systemic and service issues that are found across the age spectrum. These include the importance of professionalism and critical thinking in safeguarding, both for individuals and for whole teams. Supervision is an important component of this, but to be effective needs to be both challenging and supportive.

- There is a need for further research into the ways in which the courts can work to support other agencies to effectively safeguard children.

Chapter 5: Child and family practitioners' understanding of child development

5.1 Introduction

This chapter provides an in-depth exploration of a small number of serious case reviews to consider how the knowledge that practitioners have on child development might have had an impact on the case and on outcomes for the children.

Six serious case reviews were selected from among the earliest reviews which had been completed in 2009-10. These six were purposively selected to include a wide age range with proportionately more younger children to reflect the expected age balance in the full cohort of serious case reviews. Three children died, and three were seriously injured. The issues raised by these six cases included bruising to babies, problems with feeding and growth, disability, complex health needs, self-harm, disguised parental compliance, and disputed and differing judgements made by health and social care professionals. The six children were all from white British families. These children's cases were also specifically selected, for the purposes of learning, in order to have a greater degree of social care involvement than is known to be found in serious case reviews as a whole. Two of the cases included children with a current child protection plan and two children were living in supervised settings as a looked after child one of whom was the subject of a care order. Two families were most recently getting help as 'children in need' cases.

There are limitations to any study and there are particular issues with regard to lessons drawn from these six cases which were purposively selected to illustrate learning about child development and social work. These cases, like all serious case reviews, are also not necessarily representative of everyday practice: children in similar situations very rarely die or are seriously harmed and even when there is good practice, the child can still die. Nevertheless, findings from individual case studies provide powerful illustrations and learning from the way that events can play out. Although there are similarities, patterns and themes within these six cases, it is important to note that there are more individual differences and nuances than similarities, not only in these six very complex cases but in all serious case reviews. However, certain core principles regarding child development can be established.

The transactional ecological perspective

Since development takes place in the context of a series of complex interactions between the child and the changing and evolving environment he or she is in, it is fitting that a transactional ecological perspective is used to analyse the six cases, as in our previous analyses of serious case reviews (Brandon et al., 2008, 2009, 2010). Attachment is the principal theoretical foundation for the analysis of the child's development in the context of their environment. A transactional model using an attachment perspective in this way recognises the complex interaction of both parental and child vulnerability factors (Howe, 2006).

Child development knowledge

Knowledge of child development is essential for all workers who come into contact with children and for their managers. The Children Act 2004 provides a mandate for all these practitioners to be concerned about children's safety and wellbeing. Understanding development is an important step towards being clear about what constitutes children's safety and wellbeing and promoting and preserving wellbeing. For social workers a good working knowledge of child development is a crucial component in family support and child protection and in assessment and planning interventions. The Children Act 1989 defines 'development' as physical, intellectual, emotional, social or behavioural development and 'health' as physical or mental health. In determining and defining which children are in need of services the Children Act 1989 has at its heart (in section 17) the child's right to achieve and maintain a reasonable standard of health or development. A child's development must also be taken into account when a family court considers making a care or supervision order where the child's development is 'compared with that which could reasonably be expected of a similar child'. This comparison with a 'similar child' requires familiarity with the range of development any child might demonstrate. It also requires balancing the norms of development with the needs of the individual child (Daniel et al., 2010).

5.2 Findings

Introduction to the children, their experiences and their development

The learning about the way these children's development interacts with maltreatment is presented in themes linked to age-related stages, starting with the babies and toddlers and moving to the older children. The early parts of this section concentrate on professional responses to physical and emotional development in infants and young children in the context of bruising and faltering weight. Later parts of this section widen out to consider older children and professional responses to social and behavioural and other aspects of development, focusing on behavioural distress among young people, including among children with disabilities. After discussing children in age related stages, the findings are analysed further by addressing crucial questions which help social workers and other professionals to think about and understand children's evolving development, namely, what does the child mean to the parent, and what does the parent mean to the child? The final part of the findings section summarises what has been learnt from these six cases about acting on maltreatment and development.

Each of the six children's lives and experiences were unique and different. However, there are some recurring themes in agencies' faltering responses to potential warning signs of abuse and neglect that could be seen to link to the child's development, or to an understanding of the child's likely developmental capacity. A central aim in presenting these findings is to highlight the messages from these individual cases for both practitioners and for Local Safeguarding Children Boards. Where possible the findings are illustrated with examples from the six serious case reviews. However, to respect confidentiality, only limited aspects of each child's story can be used.

Themes arising from the cases which link development and abuse and neglect

Younger children - Bruising and minor injuries

Understanding the meaning and origin of bruising and minor injuries in pre-mobile babies and toddlers emerged as a theme from the analysis of two of the cases. Bruising and minor injury tended not to be considered in the context of the child's own development and capabilities nor in the context of a good understanding of the care they were receiving.

The reasons that explanations for bruising were accepted by practitioners without sufficient scrutiny appeared to be because:

- Children had complex health needs or disabilities and the bruising was somehow (but implausibly) connected with this; or
- The child's development was otherwise good; or
- The person who posed a perceived risk of harm to the child (e.g. a dangerous male figure) was believed to be out of the picture; or
- The parents were hostile or difficult and somehow stopped the practitioner from seeing clearly.

The Welsh systematic review group provide a clear research evidence base for having child protection concerns when there is any bruising on any pre-mobile baby. In their review of patterns of bruising in childhood, they conclude that the prevalence, number and location of bruises in children are directly linked to motor developmental ability (Maguire et al., 2005). They highlight that bruising in babies who are not independently mobile is very uncommon, whereas around 17% of infants who are crawling or cruising have bruises, and the majority of preschool and school children have accidental bruises. They also point out that a child with impaired motor development would not be expected to have the same bruising patterns as other children of the same age, but different developmental abilities. Thus an understanding of normal motor development in childhood is essential for evaluating the significance of bruising and for distinguishing potentially abusive from non-abusive injuries. Further information for practitioners about children's developmental capabilities and accidents is available through guidelines for practitioners on accidents and child development (CAPT, 2009).

What should professionals know and do?

The need for heightened concern about any bruising in any pre-mobile baby (up to the age of around six months) is explained through an understanding of the child's physical development. Because physical self control and independent movement is very limited in young babies, it is extremely difficult for them to bruise themselves. Any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused. The explanation, for example, as in the case of Sally, that a pre-mobile baby hurt herself while in her cot needs to be scrutinised very carefully and treated with suspicion.

Vignette – Sally

Sally was five months old when both the social worker and health visitor noticed a bruise on her face but they did not consider this to be a child protection concern. The fact that Sally was meeting developmental milestones (well enough) and her mother was thought to be cooperating with the contact arrangements for Sally with her father (who had limited and supervised contact because of domestic violence) should not have stopped these workers extending their curiosity about what might be happening in Sally's life. They needed to see things not just from Sally's perspective but also from the perspective of her young mother – who was a child herself. The serious case review revealed that Sally's mother had been feigning cooperation and was continuing her relationship with Sally's father. Since there were already concerns about Sally suffering harm (she was the subject of a child protection plan) this bruise should have put practitioners on high alert. The cause of this bruise should have been considered to be suspicious and urgent and robust enquiries should have been made. Sally's mother's supportive family and relatively problem free background are protective factors but they do not mean that the possibility of abuse can be disregarded.

Bruising in pre-school aged children

It is not surprising that bruising is more common in toddlers and especially in older pre-school age children. At this age children regularly have tumbles and accidents as they develop their gross motor skills and are exploring the world around them. However, any bruising will usually have a pattern and be on particular parts of the body, like the bony surfaces of the legs, arms and face which take the knocks in everyday falls (Maguire et al., 2005). Frequent, repeated bruising in children of pre-school age might also signal that the child is not being kept safe and is not being appropriately supervised. There needs to be a sense of curiosity about how and why the bruising is occurring and how well the child is being kept safe and supervised.

Bruising in the context of complex health needs and disability

Vignette - Ben

Another young child, Ben, had numerous episodes of bruising prior to the incident of physical assault which ultimately triggered the serious case review. He also had complex health needs, but these did not restrict his mobility. The prevailing view of the multi-agency team was that the bruising was linked to his being a lively toddler and also to the demands made by his health care and health problems. The unusual pattern and site of Ben's bruising (which was not compatible with what would be expected in a lively toddler) did not provoke curiosity or questioning. Again, the fact that Ben was the subject of a child protection plan should have put practitioners on high alert. The pattern of Ben's bruising should have been considered in the context of his development with specific care taken not to explain away the bruises because of his health needs or disability without careful checking. In this case repeated bruising did not cause the social worker or others in the multi-agency team to think more broadly about whether these might be non-accidental injuries, '*some (professionals) had difficulty in believing such a sick child could be harmed deliberately*'.

These cases also show that the category and primary reason for the child protection plan is not always an indicator of where the risk of further harm or recurrence of harm is coming from. In Ben's case, although the child protection plan was linked to domestic violence, it was his mother not his violent step-father who was inflicting the bruising.

In these two cases involving pre-school aged children, the following questions were not sufficiently attended to:

- Does the explanation for the bruise match the child's developmental capability and likely behaviour? Was the child developmentally capable of causing these injuries to him or herself?
- Does this pattern of bruising match the particular developmental capabilities of a child of this age with these particular developmental needs?
- For a child who is otherwise meeting developmental milestones, might a parental explanation for injuries be too readily accepted?
- Is there a full understanding of the caregiving the child receives?

Who provides developmental advice?

When making judgements about babies and children, social workers need access to both formal and informal advice and developmental expertise. Good relationships with health visitors and paediatricians will enable social workers to check out concerns, or to have a sounding board for discussing babies' and young children's development. A good paediatrician should be happy to talk through concerns about bruising or minor injuries in a baby or child. We have argued elsewhere that skilled use of expertise and consultation in a coordinated manner could result in more rigorous assessments and promote greater professional trust and confidence (Brandon et al., 2005). These routes through to advice and developmental expertise are important for social workers working with children of all ages. As children grow older the range of possible developmental experts with whom to consult expands. Sidebotham and Weeks (2010) have summarised the likely child development contributions made by different professionals in the multi-agency context.

Emotional development and faltering weight in young children

Poor or faltering weight gain for babies and toddlers was an issue in three of these reviews. In all of these six cases, not just the three concerning faltering weight, there was little evidence of knowledge about or sufficient interest in the child's emotional development. This rarely featured in the individual management reviews or the chronologies and, in line with the findings from Ward's study of infants suffering harm (Ward et al., 2012), was perhaps also often absent in practice. There were complex and differing reasons why parents appeared not to be nurturing their child. There was, however, a pattern in professionals' failure to recognise problems in the children's relationship with their caregivers and their emotional development as a key part of their faltering growth. The different issues presented in the cases and the professional responses are summarised as follows:

- Early difficulties in feeding could be linked, initially, with the baby's prematurity and subsequent complex health needs;
- In another case the baby was healthy at birth and the weight gain problems were not prompted by any easily recognised innate problems in the child; and

- Barriers to understanding development in cases of faltering growth included treating the issue as a mechanical feeding problem rather than raising questions about emotional development, attachment and the parent-child relationship.

What should professionals know and do?

Practitioners need to be aware of the parents' reactions to their child, and to specifically observe and reflect on the child's responses to his or her caregivers. These are the foundations of emotional development and of attachment behaviour. What happens during feeding provides powerful clues to emotional development.

In each of these examples there was an emphasis in the professional response on the single issue of feeding and the mechanics of feeding rather than any concerted attempt to try to understand the child in the context of their caregiving environment and the different possible explanations for why the child was not gaining weight.

Usually, concerns about feeding and poor weight gain did prompt the social worker to request an additional or an enhanced developmental assessment for the child if this was not already taking place. This is good practice. However, in one instance the developmental assessment used by health staff, the NFER assessment, did not take account of faltering weight which was the particular problem highlighted. The serious case review noted that developmental assessments need to be global if they are to pick up the full range of developmental issues.

Vignette – Joe

Joe was born at term, healthy and within the normal weight range. Within a month of his birth, Joe had not regained his birth weight. Instead he had slipped rapidly down the weight percentile chart. Although his mother was perturbed by Joe's lack of weight gain, her rough handling of her newborn baby was not congruent with this and he was often prop-fed. When Joe was two months old he died of unexplained causes, however a post mortem report concluded that his growth problem made him more vulnerable to stress thus contributing to his death. The rough handling and prop-feeding are clues that point, not least, to the possibility of a lack of emotional warmth. There was also a pattern of faltering weight in his siblings.

Vignette - Melissa

Melissa was born prematurely with associated complex health needs, which meant that she was more difficult to feed and care for than a healthy baby born at term. There were concerns about her care from birth and these persisted. Melissa's mother continued to need to be prompted to feed her baby and it was noted that she was using her mobile phone almost constantly and not interacting or engaging with her baby. Melissa's lack of weight gain and her poor emotional development was assessed as non-organic failure to thrive when she was a toddler, at which point she was made the subject of a child protection plan. This baby's failure to gain weight should have been assessed holistically in the context of her emotional need to be and feel connected with her mother as well as her physical need to be properly fed and well cared for. Poor care in this case was tolerated for a long period when evidence of impaired development had been apparent for many months.

Older Children

For the older children it was clear that to obtain a good picture of their current developmental state, professionals needed to get a sense of their developmental pathway over time. It was apparent in these cases that children who felt that their needs were repeatedly unrecognised, ignored or misunderstood were likely to become distressed, angry and desperate. Issues that prevented practitioners paying sufficient attention to the impact of maltreatment on young people's development were as follows:

- Not making a relationship or getting to know the young person;
- Not taking account of what the young person has to say to make sense of them as a person, nor to make sense of the impact that their experiences (especially of care and nurture) had on their sense of themselves and on how they behaved;
- Not speaking to the child. In one case the only consistent efforts to gain the child's view were at school (he had disabilities and global developmental delay) and the child was not spoken to during an assessment: '*This assessment fulfils the function of confirming the developmental delay … it fails to analyse what that means to (the child) in terms of care, safety and welfare needs*' (IMR Health);
- Allowing the parents' voice to dominate (especially if they are volatile and difficult to confront);
- Seeing the disability not the child and viewing a case essentially as supporting disability rather than supporting or protecting the child (including identifying and responding to signs and symptoms of harm);
- Accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child. A secondary health service acknowledged that they had different expectations of care for disabled than non-disabled children when they confirmed that in high risk disability cases locking children in their bedrooms was an acceptable strategy;
- Pockets of good development in maltreated young people do not necessarily signal resilience.

What should professionals know and do?

One young person's good intellectual development, and his capacity to make relationships and confide in professionals, showed that not all aspects of his development were negative. Yet it would be a substantial leap from here to say that he was resilient. Rees and colleagues (2010) have found that professionals can be prone to misinterpreting positive aspects of a young person's demeanour or development as resilience (good development in adverse circumstances) and that this can blunt their capacity to appreciate the impact that maltreatment has on the young person's overall development and sense of self.

The overview report author in one case suggested that things might have been better for the young person if he had been assigned inquisitive social workers who wanted to know why his behaviour was so difficult at this point in his life, and who were curious about the research behind neglect, attachment and child development.

It is important that social workers in particular work hard to develop a relationship with children and young people, getting to know and understand them as individuals. This

includes taking notice of what they have to say, considering what it means - and where it meets with their best interests - acting on what they have to say. The social worker should act as an advocate for young people who are being looked after or have child protection plans, or find them an independent advocate. They should make sure that specialist assessments are completed (in one case a full mental health assessment requested from CAMHS was never followed through). Clear plans for the future should be set out based on an understanding of the young person's developmental needs and young people should be involved in these plans and understand them.

All of these activities are legitimately within the social worker's role and sphere of expertise. If the social worker is not able to carry out all aspects of this role they should make sure that someone else does.

Signs of distress in older children

Vignette-Shelley

Shelley took her own life, as a young adolescent, while in a therapeutic unit. Shelley's care order and placement protected her, to an extent, from harm at home (where she no longer wanted to be) providing her, in many respects, with safety and security. However, the meaning for her of living for years with significant harm was not wholly taken into account when a standard strategy for managing challenging behaviour was imposed, and when she perceived that contact with her family was dependent on her behaving well.

Shelley's behavioural and emotional development marked her out as different to other children from a young age. She had began to behave like a distressed, much older teenager when she was many years away from puberty engaging in defiant and risky behaviour, and also expressing suicidal thoughts and beginning to self-harm. Shelley's exposure to years of neglect, physical and emotional harm at home had affected almost all aspects of her development, although her intellectual development was good. At all of her schools she was perceived as 'bright and able'. When tested, her reading age was well ahead of her chronological age.

Shelley's parents admitted that they had given up trying to control their children. Shelley's parents had never been able to see their daughter's distressed mental state. When she was very young and needed to have her distress and dysregulation recognised and contained, this parental sensitivity was missing. Instead, Shelley's parents either ignored her or lashed out at her. Because Shelley's parents were unable to take control of her safety and her needs, Shelley began to take these on for herself, a pattern commonly noted for children who develop a disorganised attachment (Howe, 2005). Part of the controlling strategy that Shelley adopted included compulsive caregiving of her siblings and to a lesser extent of her parents.

The strategy children evolve to survive life at home is deeply ingrained and will be transported with them to any new environment. When she was away from home, in care, Shelley was consumed with anxiety about what was happening at home.

Vignette: Adam

Adam's disabilities were connected with a congenital neurological condition. Adam told teachers about being locked in his bedroom each night and how he tried to get out. Trapped in his room, isolated, and unable to get to the bathroom, Adam soiled and smeared faeces in his room which was described as being 'in a terrible state'. The condition of his bare and filthy room contrasted with the rest of the house. Adam's parents spoke to the social worker and others in the multi-agency team about locking him in his room as a way of managing his sleep disturbance, sleep walking problems and to stop him hurting himself. Despite many years of involvement, social workers had only seen Adam's bedroom four times. There is no evidence that any professional had considered the impact that spending a considerable amount of time isolated and locked away in this bare room was having on this young person.

Adam's distressed behaviour (smearing) escalated frustration in his parents who, largely because of their own childhood experiences of rejection and abuse, had a heightened sensitivity to their child's behaviour and disability which they interpreted as dependent, difficult and demanding. This triggered more coercive, rigid and insensitive care. In this example it was easy to see that the interaction of the vulnerabilities possessed by both child and parent played out to increase the risk of insensitive dangerous care and harm to the child (Howe, 2006).

What does the child mean to the parent and the parent mean to the child?

The learning about bruising and faltering growth in the younger children, and about behavioural distress in the older children, suggest that there are linked questions that practitioners need to be curious about:

- What does each parent or parent figure bring, psychologically, to the relationship with their child;
- What does the child mean to the parent; and
- What does the parent mean to the child?

Questioning the meaning of the child for the parent seems a good way for social workers, and for other professionals, to make sense of children's development and of their care and nurture. Grappling with these questions will help the social worker to understand the child in the context of their caregiving environment so that they can build a clear plan for help, support and protection together with the child, the parent(s) and other professionals.

The child's caregiving environment

The child's development is best understood in the context of the care they receive at home, or received at home pre-placement. In these cases there are examples or reports of specific parental behaviour that is incongruent with the child's developmental needs. This potentially developmentally harmful parental behaviour included:

- Not being emotionally available or attuned to the child's needs (for example being constantly on the phone);
- Handling young babies roughly;
- Not giving babies or children adequate food or 'forgetting' to feed them;
- Making the new born baby's regular night-time sleeping place a long way from the parents' bedroom (with no baby alarm);
- Reports of hitting a very young baby;
- Locking children in their rooms for long periods or keeping them out of sight;
- Opting out of responsibility or giving up trying to control a pre-pubescent child;
- Expecting children to be carers for siblings and to protect siblings from harmful parental behaviour like violence (including domestic violence).

Studying these cases in depth has emphasised the importance of puzzling over the meaning that each child has for his or her parents (or parent and step-parent) and the way each child makes their parent(s) feel. In some of these families one child is singled out for particularly harsh or rejecting treatment, in others all the children in the family seem to be treated in a similar way. But even in families where the parenting seems to follow the same pattern for all children, each child's experiences will in reality be different (as studies of birth order have shown). In one family where weight loss was the key professional concern, one particular child provoked more anger in his mother than did his siblings. The mother called him a 'devil child,' but it was a younger sibling and not this child who died.

Four of the six children who were the focus of this study began their childhood in an environment where they experienced both unpredictable danger (being hit as infants, living with violence or in other frightening environments) and/ or emotional abandonment experiences (not being tended to when distressed or ill, not being fed when hungry or not being held close when fed). These early patterns of experience, repeated over time, would be likely to set the scene for a developmentally damaging, disorganised attachment. There is evidence from the serious case review that their carer or carers were during their early months and years likely to cause them distress and/ or fear for much or part of the time. Their parents' behaviour seemed to fit into the typologies of parents who were hostile, helpless or intermittently hostile and helpless (Howe, 2006). These carers *frighten* their infants or behave in a *frightened* way when they are faced with their child's basic needs for care and nurture. Howe describes how this plays out in the developing relationship between the parents and child: *'Parent and child find themselves in a loop of catastrophic feedback, leading in each case to a state of emotional hyper-arousal and behaviour that becomes hopelessly out of control (hostile, helpless, or rapid switches between the two)'* (Howe, 2005:40).

The relationship histories of almost all of these carers revealed abuse, neglect, loss, rejection and trauma which increased the likelihood that they would be emotionally and psychologically unavailable when their babies needed them most. These parents were also living in a high stress environment, where most had debt problems or faced eviction, and struggled with mental ill health and substance misuse. Four sets of parents were caught up in volatile relationships where there was domestic violence, and two children were the subject of a child protection plan because of domestic violence. These parents were highly

likely to have felt overwhelmed by their own unresolved feelings of fear, abandonment and powerlessness.

In retrospect it is easier to recognise that some of these parents were finding ways to switch off from their children. There were examples of parents who did not feed babies or restricted their young child's intake of food, or made feeding a distressing experience. Other parents appeared to be too emotionally preoccupied and overwhelmed, or perhaps not intellectually able to keep in mind their child's need for regular food. Young children and especially babies are wholly dependent on their carers for nurture and for survival – by denying these children's most basic needs for survival, parents are in effect denying their child's existence. The child's demands appear to make these parents feel so distressed or angry that it feels better or safer not to connect with the child. Locking a child away each night behind a door is a similar demonstration that the parent cannot bear to see or hear that child.

In one case the meaning of the child to his mother was especially confusing. The pattern of this mother's complex behaviour (making regular emergency calls for medical help and not following through with advice or appointments) suggested that she was using the child as a way of meeting her own needs for life to contain high drama. This case showed that what appeared to be compulsive help-seeking behaviour was instead a means to meet the mother's own complex narcissistic needs. When the mother's behaviour was eventually recognised as a serious mental health problem, it was not immediately acknowledged as affecting the safety and welfare of her children. In addition to a high level of health care use this mother also insisted to the social worker that her young baby had a bruise on her face even though when checked there was no bruise visible on the child and no other sign of injury. There were features of this mother's history and her current difficult and hostile behaviour which had similarities with cases of fabricated or induced illness (HM Government, 2008). This type and pattern of behaviour needs to be recognised as it can result in children being harmed and in some cases dying as a consequence of the harm.

Further issues which connected the child's development to their meaning to their parent or carer were the meaning of the pregnancy to the mother (for example ambivalence) and differences in the meaning of the child to the mother and to the father (or unrelated male).

Being curious about the meaning of the pregnancy to the mother and noting any ambivalence gives a helpful context to the developing relationship between the mother and her baby. Cases where there is late ante-natal booking and poor ante-natal care provide an ambivalent backdrop to the mother–child relationship. In one of the cases the pregnancy was concealed and the mother gave birth alone and unattended. Little attention was paid to the mother's history, her own experiences of sexual abuse and the impact these had on her sense of self and her identity as a mother. In another the mother had suffered multiple miscarriages. In two cases where the pregnancy was unplanned the mothers were children themselves when they gave birth.

There were interesting examples about the different meaning of the child to mothers and fathers, or unrelated males in the household. Our other studies of serious case reviews have emphasised how important it is to have a full understanding of the role that men – whether or not they are related to the child - play in the child's life (Brandon et al., 2008, 2009) and the risk and protective factors that they represent for each separate child in the family. These findings are borne out in the examination of these six cases which show that assumptions cannot be made for example about the child having a more negative meaning to the male than the female in the household.

In three of the cases, damaging developmental influences came from both the child's mother and father (or in one case the step-father). In another case the father was apparently a more sensitive carer than the mother and professionals' concerns about the mother's care were lessened while he was a significant caregiver. However in both this case and in another example where the mother was the better carer, professionals over-estimated the ability of the apparently more attuned carer to protect the child and promote their healthy development.

In one case where the mother was believed to be the better carer, professionals were most concerned by the child's father who had a history of offences against children. When he lost contact with his child, they were falsely reassured about the child's safety and attention was deflected away from the mother's care, which was not only neglectful, but posed a physical risk to the young child's life.

Acting on the understanding of the relationship between maltreatment and child development

A number of themes emerged in relation to practitioner and agency involvement and decision making in these cases.

Continuity and flux

In many serious case reviews we know that there is a high level of family mobility and a high level of staff turnover creating a system of almost constant flux. In these six cases there was less mobility among families and, when they did move, professionals were usually aware of these moves and usually kept in touch with the families. This does not mean, however, that there was continuity of staff seeing families, or continuity of staff support. Most cases had a strikingly large number of practitioners involved with the family, both over time and in the build up to the incident which prompted the serious case review. This was particularly true in the cases of children with disabilities and complex needs. However, even in one case concerning a physically healthy child, over 200 professionals had been involved with the family over a ten year period. Lack of supervision, lack of oversight or long gaps without oversight were a feature of many of these cases. Gaps in support and supervision are very worrying at a time when the need for good staff support in child protection is well recognised (Munro, 2010, 2011).

Downgrading concern

A theme running through most of the reviews was the downgrading of concern about the child. Some cases, particularly where the key concern was faltering growth, tended to be dealt with as a child in need case, with little or no recognition that the child may have been or was suffering significant harm. In one instance this was in spite of the health visitor's recorded concerns about the child's development (faltering growth) and her opinion that this was a child protection issue. Because children's social care did not consider that the children should have been the subject of section 47 enquiries and perhaps further statutory

intervention to protect them from harm, it was deemed appropriate in two cases to allocate the work to less experienced and unqualified staff.

In one case an unqualified social care worker who made the assessment visited the family without adequate preparation including not reading the files. Therefore the worker did not discover that there had been a pattern of faltering growth for three successive babies in this family. The health service also used unqualified staff in one of these complex cases where an unqualified health visitor carried out a developmental assessment which had been requested specifically because of developmental concerns about the child.

In another worrying example, an unqualified social care worker had been allocated the case even though a section 47 enquiry was being undertaken. The enquiry was not handled with the appropriate urgency: 'there may have been less drift in this case once a decision to commence a s47 enquiry had been taken … if the case had actually been allocated to a social worker rather than a (unqualified) duty social worker who may not have had the same capacity as an allocated worker' (Overview report).

Sometimes the downgrading stemmed from an inadequate social work assessment, for example where a 'wait and see' approach was adopted for a neglect case and the available evidence from other professionals about poor development was not properly marshalled. Another review suggested that had the common assessment framework (CAF) been used during pregnancy for the young parents it would have acted as a mechanism for getting people together and synthesising developmental information about these parents as children, as well as about the needs of the unborn child. In this way the parents' vulnerabilities (especially the father's) could have been recognised and support could have been offered earlier.

Downgrading also occurred when one area decided to use a 'single agency protocol' for responding to allegations of sexual abuse. In this case the GP examined a very young child, where sexual abuse had been alleged, and decided that there were no signs of sexual abuse. The telephone discussion between children's social care and the police decided that since there was 'little to go on' only a single agency enquiry would be pursued. This precluded both an expert paediatric examination and a wider discussion and sharing of information about the child and family as a whole.

It was difficult in these cases, as in other serious case reviews (Brandon et al., 2008), for social workers and other multi-agency colleagues to recognise and perhaps accept that children with complex health needs and disabilities could be being maltreated. Not only were these children's needs for protection being overlooked, their needs were also often assessed as not meeting the criteria for a social work service at all. Whether the ill or disabled child (and therefore their family) was judged to meet the threshold for social work services varied over time in the same cases. Sometimes the child would have a social work service, sometimes they would not, in spite of the fact that their needs had not diminished and indeed the risks of them suffering harm had increased.

The role of specialists in child development

It was clear that the social worker should have been part of the group of experts in child development bringing their own knowledge about the child's overall development to the multi-agency grouping when making decisions about children's safety and welfare. However in these cases this expertise was not often apparent. In most of these six cases however, there was at least one professional who had a good understanding of the child's development (usually the health visitor, paediatrician, teacher or, to a lesser extent, the GP). If their information about developmental concerns had been known and understood by the social worker, it could have helped prompt the social worker into taking action to protect the child sooner or better.

Yet even when this information was forthcoming from other professionals, the social worker did not always agree with their opinion. In one instance where concerns were clearly communicated the social worker chose not to accept the health professional's view. However in other examples, child health specialists did not make their concerns about development and the implications of these concerns for the child explicit. For young children this often concerned emotional development linked to attachment, for example, bonding problems, feeding, nurturing, and emotional warmth. Any professional involved with the child (including the social worker) should make developmental concerns explicit and relate them to the age of the child. Ideally, they should provide a benchmark of what the norm might be for a 'similar child'. This would provide a clear statement about what the child should or could be doing or achieving.

Children and their families as experts in child development

Other specialists in child development are the child and family themselves: they are experts in their own experiences. Failure to understand the impact of what is happening from the child's perspective means that the child's development cannot be wholly understood. Gaining this understanding involves talking to the child and observing the child and thinking about what is happening to them in the context of their particular family and environment.

Parents' perspectives are crucial to understanding the child's development. Parents' contributions to the serious case review itself provided important learning about the child and their development in ways that were not revealed in any other reports in the serious case review.

In reviews concerning disabled children a finding was that the onus appeared to be on the child's capacity to communicate well enough, rather than the professionals' responsibility to find ways of communicating with the child. Even when disabled children did communicate well they were not listened to, and key learning about their development and their experiences was missed.

Missing developmental clues and professional challenge

Clues in the child's development which gave a good indication that things were not right were being missed, even at times, by developmental specialists who misread developmental information. Health visitor records in one case noted that the baby was weighed and was 'fine' since her weight was up. What had not been checked was the position of the baby's

weight on the centile scale which was continuing to drop to a dangerously low point. The health visitor said she had felt 'overwhelmed' by this case and by the difficult and hostile behaviour of the mother. The impact of difficult and hostile families on the worker and the way that dealing with this hostility can overwhelm and paralyse the worker has been considered in our other studies of serious case reviews (Brandon et al., 2008, 2009). As in this case, family hostility can impinge on the worker's capacity to think clearly and systematically and use their professional knowledge and expertise.

In two instances sustained weight loss for the child should, arguably, have triggered court proceedings. In one example this could have occurred as much as a year ahead of the incident which prompted the serious case review. Instead, a lack of professional urgency prevailed and the developmental information was not properly gathered or used. Gaps in support and supervision that have been noted in these cases thwart robust decision making to support families in protecting their children and militate against intervening with urgency when danger is evident.

In these cases professionals were rarely analysing the situation fully or challenging each others' or the parents' views robustly. There were some examples of good practice where professionals picked up on developmental information and challenged each other, for example a health visitor challenged a decision not to act on neglect and a youth offending worker insisted that what a child said about parental abuse must be acted upon. In another case a social worker who was new to the case started questioning and probing the family and challenging the mother. 'This level of challenge had not taken place prior to this and had allowed the mother to manipulate the situation. (This social worker's) action eventually led to the removal of the surviving children' (Overview Report).

However, more often developmental clues were missed. Parents' apparent compliance or hostility, or their implausible and insistent explanations for developmental harm, suppressed the professional curiosity that was needed. In one example a child's mother insisted to her GP that her young baby was lactose intolerant. The GP took the mother's word instead of checking and hypothesising that this might be part of an elaborate pattern of difficulties that the mother was having in feeding the child rather than the child having an underlying medical condition.

Recording

Difficulties in recording are a perennial problem in serious case reviews and these six cases were no exception. Clarification about how developmental information is recorded and shared between health and social care professionals might be useful here. One potentially helpful approach from health is the type of recording used by midwives who complete concise, succinct notes giving a picture of the mother and baby and the father (where they are present). Midwives are individually professionally liable, so take care over their recording. They are also pressed for time so are not verbose.

5.3 Discussion

To widen the learning, the findings from the six cases are set against a wider literature review about maltreatment in the context of the developing child, and the expertise and training of key child protection professionals as well as the contribution of families. The section concludes with a consideration of how outcomes for children might have been improved with a better understanding of child development, and what type of practice conditions would foster the ability to exercise professional judgment in relation to this knowledge.

Understanding maltreatment in the context of the developing child: concepts of childhood vulnerability – learning from the literature

The very nature of childhood involves the child as an active, changing (growing and developing) individual who interacts with his or her world and in turn both influences and is influenced by his or her environment (Aldgate et al., 2006, Margolin and Gordis, 2000). Within this context, children may be vulnerable to maltreatment and its effects, but this vulnerability varies between children and over time, and needs to be understood in the light of (a) characteristics of the children themselves, both their vulnerability as targets and their ability to protect themselves, (b) characteristics of the environments they inhabit and c) the interaction between the child and his or her environment (Finkelhor, 1995, English et al., 2005).

Certain key developmental stages can be identified which have implications for understanding child maltreatment. In infancy, the child is particularly vulnerable to both physical abuse and neglect, because of rapidly developing skills in all areas, the formation of multiple neural connections in the brain, the importance of perceptual input, and the development of attachment relationships (Finkelhor, 1995; Harden, 2004). A lack of, or inappropriate, stimulation during this phase lays patterns that may affect the acquisition of future developmental milestones (Cicchetti and Howes, 1991; Hildyard and Wolfe, 2002). Failure to develop appropriate language skills due to neglect in this stage may lead on to wider cognitive and social impairments, whilst disorders of attachment can give rise to future emotional and social difficulties. During the pre-school years, there is a strong emphasis on social development. Early maltreatment may lead to difficulties in emotion regulation, initiating social interactions, and learning to respond appropriately to others (Cicchetti and Howes, 1991). During the school years, the effects of early adversity may be seen in poorer academic achievement and further social difficulties, whilst early attachment disorders can result in persistent negative concepts of self and others (Cicchetti and Howes, 1991; Harden, 2004). In adolescence, these negative self-concepts can lead to personality disorders, anxiety, depression, and problem behaviours. Recognition of these different stages and of what constitutes normal development is crucial to understanding what is going on in the maltreated child's life, the likely impact of any maltreatment, and how it might manifest through disordered development or behaviour.

It is important to recognise that many maltreated children will also be exposed to a range of other adversities, including the effects of poverty, poor housing, parental mental health issues or low educational achievement and poor nutrition. All of these are potentially related to poor development per se, and it may be the interaction of multiple adversities, including

maltreatment that has the biggest impact on development (Margolin and Gordis, 2000). Extrapolating from this, the context within which children are growing will impact on their development. Issues such as good nutrition, maintaining good health, hygiene, physical and economic security, the physical environment, opportunities for social interaction and play, and aspects of parenting such as stability, availability, affection, and setting boundaries are all important for healthy development.

It is recognised that some disabled children may be at higher risk of being maltreated (Goldson, 1998; Sullivan and Knutson, 2000). The prolonged and heightened dependence of disabled children on their parents and carers may make them more susceptible to neglect, and may also increase the stress on parents as triggers for physical and emotional abuse (Murray and Osborne, 2009, Goldson, 1998). Because of their greater dependency, disabled children may be less able to protect themselves. Disabled children, particularly those with language disability, may be less able to express any maltreatment they are experiencing. It is important, however, to recognise that disabled children do not form a heterogeneous group, either in severity or type of disability, so an understanding of the particular nature of any underlying disability and how the child's development is affected is essential to appreciating the nature and impact of any maltreatment a child may be experiencing.

The practice context: what child development expertise can social workers and other professionals offer?

What should social workers know?

Social workers should have a good working knowledge of the key developmental processes for the child from infancy through to adolescence and maturity (Aldgate et al., 2006). In addition, they need to be aware of what they don't know, acknowledging that they are not the experts in child development. Therefore they should work closely with colleagues in other agencies to consider the child's developmental progress. They should be able however to recognise patterns of overall development, to promote optimal child development and to detect when such development may be going off track. In a recent study, Ward and colleagues found that many social workers did not think that child development had been a major part of their professional training and also that some professionals showed 'little understanding of infant attachments; the impact of maltreatment on long-term well being; of how delayed decisions can undermine life chances' (Ward et al., 2012:6).

Different professional groups have particular expertise to offer in different aspects of child development, although there is obviously considerable variation in individuals' knowledge and experience. Sidebotham and Weeks (2010) have summarised the likely child development contributions made by different professionals in the multi-agency context:

Nursing and midwifery staff, including health visitors and school nurses: Chronology of child's history- infancy, pre-school, school years; child's physical development, behaviour and temperament; health needs, hygiene, feeding, growth parameters; observations of parent-child interaction (positive and negative); evaluation of parents' understanding of and capacity to respond to the child's needs at different developmental stages; growth and development of other children; child health surveillance.

General Practitioners: Chronology of child's medical history; identified health problems, past and current treatment and referrals; parents' background history.

Secondary Health Care Providers (paediatricians, specialist consultants, hospital staff, therapists): Specific assessments of child's physical and mental health, growth or development; identified health needs; specific assessments of parents' health; evaluation of parents' understanding of and capacity to respond to the child's needs at different developmental stages.

Adult Mental Health Care (psychiatrists, psychologists, community psychiatric nurses, drug and alcohol support teams): Identified mental health issues in parents, including learning disabilities, mental illness, alcohol and substance misuse; specific assessments of parents' learning abilities and parenting capacity.

Education staff (Sure Start children's centres, and early years providers, teachers, head teachers, SENCOs, Connexions, Educational Psychologists): Educational history of child; past and current educational attainment; assessment of any learning disabilities; presentation and behaviour in school or pre-school; interaction with others, aspirations and plans of young person (adapted from Sidebotham and Weeks, 2010).

What training in child development do professionals working with children receive?

The Munro Interim Report notes that child development is not covered thoroughly in all social work qualifying courses (Cm 8062). Most social work programmes fit child development within the broader curriculum of lifespan development (sometimes called human growth and behaviour). Since the remit of basic social work training is to provide a generic qualification covering all social work service user specialisms, including work with children and families, it is likely that constraints of time will limit child development coverage. It is only at the post-qualifying level that social workers are expected to develop specialist knowledge. Beginning specialist learning for social workers and all those working with children, young people and their families was set out in 2005 in a 'common core' of knowledge and skills (HM Government, 2005, CWDC, 2010). Child development was pivotal to this 'common core' in its original, and in its revised form. For safeguarding and child protection it currently includes:

'Being able to recognise when a child or young person is not achieving their developmental potential, or when a child is displaying risky or harmful behaviour, or when their physical or mental health is impaired' (CWDC, 2010:13).

There has been no consistency in the reach of common core training, nor in the level or standard of its delivery. This training gap was recognised some years ago by the then Department for Education and Skills who commissioned the *Developing World of the Child* book (Aldgate et al., 2006) and training pack to assist with multi-disciplinary and multi-agency training (DCSF, 2008). There has also been considerable investment, since 2008, in early career development support for child care social workers. However, neither the Newly Qualified Social Worker Programme nor the follow on Early Professional Development Programme lay any emphasis on child development (CWDC, 2008). Given the limitations of child development input in basic social work training, this absence in follow up specialist development is a missed opportunity.

Professional standards for qualified teacher status include the following:

'*know how to identify and support children and young people whose progress, development or well-being is affected by changes or difficulties in their personal circumstances, and when to refer them to colleagues for specialist support'* (Training and Development Agency for Schools 2008:8).

These criteria require that providers design their provision to enable trainees to meet these requirements, but there is no clear expectation that child development training will be included in the curriculum. Discussions with Higher Education Institutions providing qualifying training indicated that primary school teachers will receive very limited child development input but secondary school teachers will typically get none. Patchy child development training is also apparent among other professional sectors. In health, training in paediatrics (and child development) for General Practitioners, is desirable but not a mandatory part of GP training, which is a cause for concern for the Royal College of General Practitioners (Harnden, 2010). Having consistently available, high quality child development training which reaches out to all health visitors and paediatricians is also a problem. For health visitors there is also a danger that in order to meet the recruitment targets, nurses and midwives with little practice knowledge or experience will be recruited onto health visitor trainee schemes. In addition the 'branch system' of pre-registration nursing education results in the majority of registered nurses being 'adult trained' and that even those who elect to take the children's option major on the 'sick child' and miss out on a thorough grounding in child development.

Overall, it would appear that there is scope for improvement in child development training for all professionals working with children. A good in-depth knowledge of normal development is essential if practitioners are to grasp the nuanced understanding that meeting developmental milestones is not a sufficient guide to good development or to safety. One of the key findings from Davies and Ward's analysis of a number of safeguarding studies was that there was abundant evidence that improved training in child development would benefit social work practice and enhance outcomes for the children they are working with (Davies and Ward, 2012).

How might a better knowledge of child development have affected the outcomes for these children?

It is, of course, impossible to be clear whether better knowledge of child development among social workers and other practitioners would have made a difference to the outcomes for the children at the centre of the six reviews. A number of examples in the six case studies suggest that acting on child development knowledge with more confidence, and a greater degree of urgency, might have protected children sooner or better.

There were different developmental concerns but also some facets of the child's development that were positive for children of different ages in the six case studies. Overall these tally with MacMillan's summary of the adverse effects of maltreatment on children's development and wellbeing in three age bands (MacMillan, 2009). In infancy she found injury, affect regulation, attachment, growth and developmental delay; in childhood there were anxiety disorders, mood disorders, disruptive behaviour, academic failure and poor peer relations; in adolescence likely effects included conduct disorder, alcohol abuse, drug abuse, other risk taking behaviours and recurrent victimisation.

Evidence from the six cases has underlined the importance of relationships. These include relationships between parents and children, between children and professionals, such as social workers or teachers, and relationships between professionals. Good relationships are important not only in terms of understanding but also for the success of therapeutic work with parents who abuse their children (Barlow and Scott, 2010) and with children who have suffered trauma through maltreatment (Perry and Szalavitz, 2008). Learning from emotional development in babies can help practitioners to be more attuned not only to the children and families they are working with, but also to each other. This also includes a relational approach to organisational functioning:

'(Concepts) *that have been developed to make sense of the inner world of infants, and the ways in which such early development can be seriously derailed by non-optimal parenting, can also be applied in terms of the wider professional system and organisations'* (Mandin, 2007 in Barlow and Scott, 2010:24).

Understanding the child's development, and making good use of that understanding in exercising judgements and making decisions, clearly requires good relationship skills.

Developing good relationships and exercising judgements about child development require the kind of 'containing' practice conditions that encourage practitioners to be both thoughtful and confident (Ruch, 2006). Practitioners need regular and challenging supervision, opportunities to enhance and extend their knowledge of child development and the time and opportunity to reflect on what they see and what they know. They also need the time and confidence to check out what they see and know with colleagues from other agencies. Fortunately, these practice conditions chime well with what is being recommended by the Social Work Reform Board and the tenor of the two early reports from the Munro Review (Munro, 2010, 2011), but they are not cost neutral.

Chapter 5 Summary

- Since physical self control and independent movement is very limited in young babies, it is extremely difficult for them to bruise themselves. An understanding of normal motor development in childhood is essential for evaluating the significance of bruising, and for distinguishing potentially abusive from non-abusive injuries, and the need for heightened concern about any bruising in any pre-mobile baby (up to the age of around six months) is explained through an understanding of the child's physical development.
- Bruising in toddlers and pre-school children will usually be on particular parts of the body which take the knocks in everyday falls. An unusual pattern or site of bruising should provoke curiosity about how and why the bruising is occurring, and how well the child is being kept safe and supervised.
- Poor or faltering weight gain for babies and toddlers should not be treated as a mechanical feeding problem, without a contextual understanding of the differing reasons why the parents appear not to be nurturing their child. Questions about the emotional development, attachment and the parent-child relationship need to be raised.
- Getting a sense of older children's developmental state needs professionals to understand their developmental pathway over time. When practitioners did not know or make a relationship with the young person they tended to pay insufficient attention to the impact of maltreatment on the young person's development.
- For disabled children there was a tendency to see the disability rather than the child. This can mean accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child.
- Pockets of good development in maltreated young people do not necessarily signal resilience.
- Questioning the meaning of the child for the parent helps social workers, and other professionals, to make sense of children's development and to understand the child in the context of their caregiving environment.
- There is scope for improvement in child development training for all professionals working with children. A good in-depth knowledge of normal development is essential if practitioners are to grasp the nuanced understanding that meeting developmental milestones is not a sufficient guide to good development or to safety.
- The full version of this chapter was published in 2011 as DFE-RR110 and can be downloaded from the Department for Education website: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR110.pdf

Chapter 6: A study of recommendations arising from serious case reviews

6.1 Introduction

This chapter presents a thematic and critical analysis of recommendations from the overview reports of a sample of 33 serious case reviews from the year 2009-10. We considered what part recommendations might play in aiding 'agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children' (HM Government, 2010).

The following research questions were identified:

- How many recommendations are there, and to which agencies do they relate?
- What kind of recommendations are they, in terms of themes addressed?
- On an individual case basis, do the recommendations match the issues the case raises? Are they the 'right' recommendations for the case?
- Are recommendations focused, specific, and capable of being implemented in a timely way?
- Can recommendations easily translate into improving practice?
- Is there, on the other hand, learning from (some of) the cases which doesn't necessarily translate into recommendations?

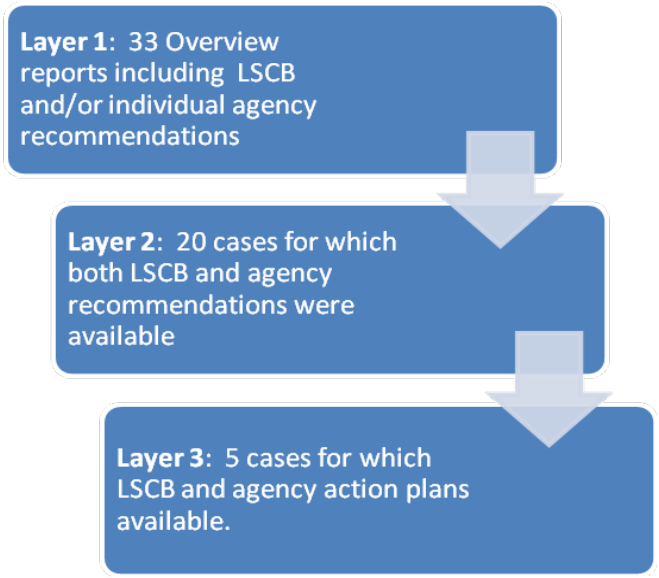
Overarching Local Safeguarding Children Board (LSCB) recommendations were available for these 33 reviews, and accompanying individual agency recommendations were available for 20 of these, five of which also contained LSCB (agency) action plans. Key characteristics of the child and family, and details of the incident and agency involvement were ascertained from the 33 reviews, and qualitative analysis focusing on the recommendations sections was then undertaken using Nvivo9. The overall characteristics of these 33 cases (21 of which were fatal) were similar to the total sample of 184 cases from which they were drawn.

For some elements of the work, it was appropriate to consider only those 20 reports where individual agency recommendations were provided, in addition to the broader LSCB recommendations. This sub-sample was utilised to assess:

- Total numbers of recommendations and to which agency they related;
- The frequency of major themes arising in the recommendations;
- The extent to which recommendations reflected the themes of the case.

The recommendations and action plans for the five cases for which full information was available were scrutinised in more detail, with a view to providing a critical appraisal of the extent to which recommendations were 'SMART' (Specific, Measurable, Achievable, Relevant and Timely). Figure 1, below, illustrates the 'layered' approach to our analysis.

Figure 6.1: Numbers of overview reports included in each stage of analysis



The initial section of these findings considers recommendations from two different viewpoints; firstly which agency they relate to (irrespective of the subject matter of the recommendation) and, secondly, the subject matter or theme they were addressing (irrespective of the agency concerned). Later sections try to assess whether the themes of the case were translated into relevant and achievable recommendations, and whether the recommendations might reasonably be expected to lead to better practice in safeguarding children.

6.2 Literature context

The national study of learning from serious case reviews (Sidebotham et al., 2010) revealed mixed views about the value of recommendations. Some respondents indicated that the analysis of outcomes of recommendations and action plans is the only way of knowing the impact on practice; others were concerned that emphasising recommendations and action plans was too simplistic, casting doubt on the fact that the impact on practice was necessarily measurable. These contrasting views reflect the tension that exists between, on the one hand, finding ways to act quickly on easy to audit learning before the impetus dissipates, and, on the other hand, wanting slower, more considered responses and deeper learning to overcome the perennial obstacles to good practice (Sidebotham et al., 2010, Cm 8062).

Earlier studies of cases from Wales (Brandon et al., 1999, 2002) and England, (Sinclair and Bullock, 2002, Rose and Barnes, 2008) found that recommendations tended to focus primarily on procedures and compliance with procedures. There was some suggestion from Rose and Barnes' study of cases from 2001-03, that increasing the number and scope of procedures might serve to provide a sense of security to managers and agencies and

perhaps offer the illusion of a degree of control over unexpected future circumstances (Rose and Barnes, 2008). The criticism of procedurally driven recommendations and the emphasis on compliance rather than professional judgement has been echoed by later studies (for example Hyland and Holme, 2009; Ofsted, 2008; Sidebotham et al., 2010) and particularly by the three reports that make up the Munro Review of Child Protection (2010, 2011 and 2012). Rose and Barnes noted that beyond procedural matters, other recommendations grouped around improving communication, assessment of practice and training needs – findings replicated, to a large degree, by most other published studies. Far fewer recommendations concerned organisational issues of management including supervision and staffing (Rose and Barnes, 2008, Devaney et al., 2011, Hyland and Holme, 2009).

Most analyses have focused on grouping and classifying types of recommendations and assessing whether they are, or can become, Specific, Measurable, Achievable, Relevant and Timely (SMART) (Handley and Green, 2004, Hyland and Holme, 2009; Johnston et al., 2011; Wirtz et al., 2011; Douglas and Cunningham, 2008; Devaney et al., 2011). Recommendations which have come to be expected from serious case reviews are those where solutions are clear cut and straightforward and can be implemented at a local level in this kind of way (Fish et al., 2008). Devaney and colleagues note from their Delphi study of the process of serious case reviews in Northern Ireland (carried out in 2008) that recommendations did not always flow clearly from the review, could be repetitive, and concern matters already being addressed (Devaney et al., 2011). Lack of relevance of recommendations or missed recommendations were also found in Ofsted's 2008 report of English serious case reviews.

It appears that some types of recommendations do not always readily fit into a SMART type of framework. For child death review teams they include prevention strategies (Johnston et al., 2011). For serious case reviews, they tend to cluster around actions linked to professional knowledge and skills (Handley and Green, 2004) and wider issues that require further thought and enquiry and perhaps a longer time scale to find national level solutions (Fish et al., 2008). Handley and Green suggest that 'difficult to audit' recommendations should be made sparingly even though they claim they could make the most difference to children (2004). Overall, Fish and colleagues criticise the current system for focusing too heavily on factors at an individual level (Fish et al., 2008), a point which is taken up in the final report of the Munro Review (Cm 8062).

In relation to deriving benefit from recommendations in particular, the national study of learning from serious case reviews (Sidebotham et al., 2010) noted that there had been relatively little focus on recommendations in the biennial analyses of serious case reviews in England. This small, document-based study is an attempt to redress this imbalance.

6.3 The number of recommendations made and agencies concerned

To enable the lessons to be disseminated and implemented effectively, *Working Together to Safeguard Children* (HM Government, 2010) advises that recommendations should be few in number, focused and specific. Indeed one LSCB commented on 'agencies swimming in a sea of recommendations' and made efforts to restrict the number and nature of recommendations it made to critical areas that it thought would help agencies to make significant changes.

The first research task was therefore to consider the total number of recommendations made in each overview report. In the twenty SCRs we examined, where LSCB and specific individual agency recommendations were included, there was considerable variation in the total number of recommendations in each overview report, ranging from 10 to 94, with an average of 47 per review (Table 1). In total, across the twenty reviews, there were 932 recommendations. The majority of these were targeted at children's social care (179), community health services (161), hospital trusts (92) or the police (85). Given the repeated exhortations to produce only a small number of recommendations, it begs the question as to why some reports contain not far short of one hundred.

There were a number of possible explanations for the profusion of recommendations, with some of the variation in number being accounted for by stylistic differences between report authors. Some writers group a number of related recommendations into a single one, whilst others make each separate required action into different recommendations. Of more significance is the fact that there are often a large number of agencies contributing to a review, and this generates many recommendations. We also noted that the ten reviews relating to the death of a child tended to contain more recommendations (mean=55) than those ten concerning a non-fatal injury (mean=38).

Many of these cases were complex, which contributed to the high numbers of recommendations. The tendency towards these high numbers may also be linked to LSCBs wanting to be seen to be taking the learning forward from the review very thoroughly. Additionally, the pressure to be more focused and more specific may encourage the practice of breaking down each recommendation into actionable parts. This causes a proliferation not only of recommendations but also of actions.

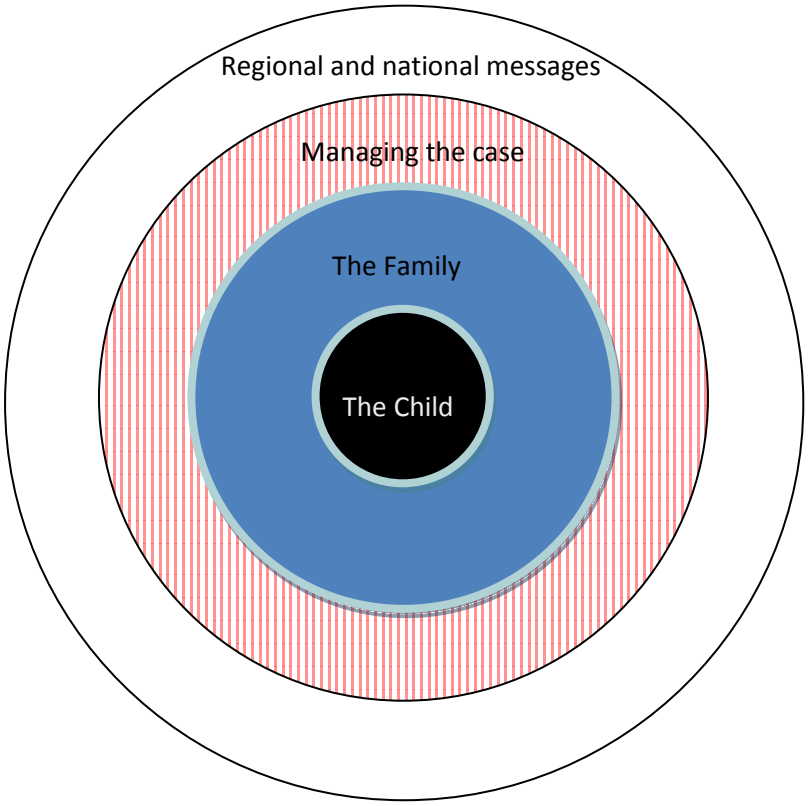
Table 6.1: Number of recommendations made in each of 20 SCRs, together with the agencies addressed (shaded cases represent serious injury)

Serious Case Review our reference number	LSCB / applicable to all agencies involved	Children's Social Care	Early years and nursery	LA or private housing	Health overview	Hospital trusts and Ambulance trusts	Community health, HVs, School Nurses, CAMHS	Adult mental health, drug & alcohol team	Education	Connexions	Youth Offending	Police	Probation	Voluntary provider	Miscellaneous: e.g. Cafcass, employer	Regional or national recommendations	**Total**
1	8	17		3	1	4	8					12					**53**
2	11	5				5	6	4	2	4	3	3					**43**
4	9	4															**13**
8	2	5			8	4	1	3	6		2	3		5	8		**47**
10	4	18		1	3	15	22	7				3	5	6			**84**
12	6	11	7			7	23	5	5			1	4	4			**73**
13	5	12	2	9		3	2		6	6		4					**49**
16	4	2				1							2			1	**10**
17	1	3		1		2	1					2					**10**
21	9	11			4	14	10					4					**52**
22	9	7	5				9					3		2	2		**37**
23	7	11		5	9	13	9			3	4	3	4				**68**
24	7	16			3	3	5				12	7			1		**54**
25	7	2	2			1	2		3								**17**
26	4	9	3	2	2	1	7	6				4			5	3	**46**
29	9	12		9	12	11	22					4		5	4	3	**91**
30	8	2	3	1			4		3			7	3		2	1	**34**
31	13	18			8	4	17		6	4	5	14		3		2	**94**
32	8	6					1					1					**16**
33	4	8				4	12					10		3			**41**
Total	**135**	**179**	**22**	**31**	**50**	**92**	**161**	**25**	**31**	**17**	**26**	**85**	**18**	**28**	**22**	**10**	**932**

6.4: Thematic analysis of recommendations

In exploring thematically the recommendations made, we developed a framework which focused on the child at the centre of the serious case review. The framework then worked outwards through to a consideration of the child's family and environment and subsequently to managing the case and the services which were (or were not) put in place to meet the child's needs. Finally those recommendations which addressed wider issues, or were deemed to have regional and national implications for practice and/or policy, are considered.

Figure 6.2: A layered approach to a consideration of recommendation themes



In Figure 6.2, the recommendations are grouped as to whether they concern:

- The child as the primary focus;
- Working with the family, to ascertain the whole picture of the family's circumstances and environment;
- The management of the case, including referral, assessment, procedures, recording, multi-agency working together and sharing of information, staffing levels, staff skills and training;
- Regional and national messages.

When analysing those overview reports where individual agency recommendations were available, it became apparent that some themes occurred with great regularity irrespective of the precise context and the specific agency concerned. These themes are set out in Table 6.2, alongside the frequency with which they were addressed in the twenty reports studied.

Table 6.2: The number of overview reports addressing specific themes in the recommendations (maximum=20)

Theme	Number of reports
Training and awareness raising	20
Information sharing between and within agencies	19
Quality of recording	18
Management and supervision	18
Clarification of staff roles	16
Ascertaining the 'whole picture' regarding the child/family	16
Referral process	16
Audit	15
Responsibility for case or avoiding case 'drift'	14
Use of Common Assessment Framework	13
Ensuring adequate professional representation at meetings	13
Maintaining a focus on the child	12
Need to keep to timescales	12
Hard-to-engage families and non-attendance procedures	11

When compared with previous analyses of recommendations, for example Rose and Barnes' 2008 study of reviews in England from 2001-03 and Devaney et al's 2008 Delphi study of the review process in Northern Ireland (Rose and Barnes, 2008, Devaney et al., 2011), it appears that more attention is now being paid to management, staffing and organisational issues. The recommendations in the serious case reviews we examined were much more wide-ranging and encapsulated these previously under-explored areas.

There were additional themes, pertinent to fewer cases, which will be discussed later in this chapter. The list of themes is not exhaustive, but topics have been selected which are of particular interest or which may introduce a new slant to the discussion. Topics include the importance of challenge to both colleagues and parents, a number of issues around staffing levels and competency, out of hours and weekend/school holiday provision and issues which contain a 'public health' message or have particular regional or national resonance. In the following sections a number of recommendations from the SCR overview reports are quoted to illustrate the points being made, and to give examples not only of the themes covered in the recommendation sections but also the means by which the concern is translated into, for example, training, documentation and practice.

Focus on the child

Many sets of recommendations stressed the importance of practitioners, across many different professions, employing a focused, child-centred approach which demonstrated '*an understanding of the child's experience*' and the ability to undertake a holistic assessment of the child's needs.

Maintaining a focus on the child was specifically mentioned with regard to:

- Occasions when the child went missing from home;
- The child was being educated at home;
- The importance of separate communication with children to ascertain their wishes and feelings;
- The added importance/challenge of ascertaining wishes and feelings when the child is very young, or when disability hinders him or her from communicating clearly;
- Keeping the unborn child in mind (especially when services are addressing the parents' needs).

The child's family and environment

Many sets of recommendations explicitly mention the importance of considering the 'whole picture'. One LSCB notes the need to ensure that: 'a broad view of the family's circumstances is taken into account'. Among the recommendations the following sub-themes concerned aspects of the family and their environment:

- Addressing cumulative concerns and not treating incidents in isolation;
- Understanding the family history;
- Awareness of the composition and role of wider family networks;
- Awareness of significant males in the household;
- Siblings groups to be managed by the same practitioner where possible;
- Home environment, poverty and multiple house moves (although these factors were rarely explicitly mentioned in the sets of recommendations);
- Formal observation of the child and family in different environments, especially the home;
- Consideration of the family dynamics and avoidance of undue optimism.

Recommendations arising from various aspects of the family's circumstances and environment could often be divided into two main groups. Firstly there were recommendations which addressed awareness raising within agencies and training of staff around issues such as domestic violence, substance abuse, 'hidden men' and cultural considerations. Secondly, and numerically greater, were the recommendations around managing the case, where these family characteristics were present. These included referral and threshold procedures, assessments, protocols and audits, case management and supervision of practitioners, the quality of recording and information sharing both within and between agencies.

Managing the case

This section discusses selected aspects of recommendations related to managing cases, including dominant themes such as referral, assessment, procedures, recording, multi-agency working, sharing information, staffing levels, staff skills and training. In addition we have considered some more specific issues pertinent to this sample of twenty cases.

Referral and assessment

- ***Timeframes and feedback***

The issue of a timely response to children in need or child protection referrals was raised in a number of the recommendations, with a need to ensure that: '*referrals are processed, prioritised and reviewed as efficiently as possible*', and *'completed within timescales and in line with procedures'*. Other recommendations included a reminder that referrals from one agency to another, initially made by telephone, must subsequently be confirmed in writing and the relevant forms completed. It was advocated that one route to verify that referrals were being made and handled appropriately was by way of a routine audit of case files.

- ***Which assessment?***

Of some concern in a number of overview reports was the decision making around the thresholds for undertaking a pre-birth, initial or core assessment by children's social care and the common assessment framework (CAF) by other agencies. Use of the CAF had not been a significant feature of practice when our earlier biennial reviews of serious cases were undertaken. However there was evidence in overview reports that, in some parts of the country, there had been significant recent investment in and promotion of the use of the CAF as a means of holistic assessment, earlier identification of need and a basis for intervention. Questions were however raised about staff awareness of the framework, clarity of roles and responsibilities of the CAF team, how the assessment fitted with the referral process to children's social care, the CAF process where a child protection plan was being discontinued and the means by which the effectiveness of the CAF assessment could be evaluated.

Particularly in neglect cases it appeared that thresholds for referral to children's social care were not being met, and referrals were less likely to be accepted or did not progress. Cases might have been 'drifting' for years – and as one overview report writer notes: '*at what stage did the level of neglect suggest child protection procedures should have been invoked*?'

Professional challenge and curiosity

As highlighted by Lord Laming (2009), the importance of 'respectful challenge' of parents, colleagues and professionals in other agencies, needs to be an integral part of professional practice. A number of the overview reports make reference to this concept, and indeed to Lord Laming, and around half of the recommendation sections address this at some point:

'Health professionals will be reminded of their responsibilities to question and challenge other agencies, as well as health professionals, if they have reason to believe that the child protection process is not robustly safeguarding a child.'

This responsibility to challenge is reinforced through recommendations about training, through both supervision and procedures on thresholds, assessments, decision making and rigorous follow up where there is a lack of response. In addition, professionals should recognise the limits to their own knowledge, and know when to refer for a more specialist opinion, and to whom to refer in those circumstances. This could occur, for example, in relation to unexplained injuries in young children.

Challenging parents, not just colleagues or other professionals, was alluded to in a small number of recommendations, as in a case of bruising to a pre-mobile baby where it was recommended that *'the health visitor must gain a full history of how the bruise occurred and record the reaction of the care giver'.*

Hard to engage families

The majority of cases in this sample featured at least some degree of poor family and child engagement with services, and eleven of the reports contained recommendations relating to this theme. Various strategies were proposed to improve practitioners' ability to respond to the challenges associated with working with hard-to-engage families. A number of reviews proposed further training and guidance to develop professionals' ability to work with hostile or hard to engage families. Recourse to revision of procedures was again apparent in relation to this issue and included the need for clear contingency plans and protocols relating to follow-up of non-attendance of appointments and refusal of services.

'Staff must consider which engagement strategies would best enable a young adult (aged over 16) to attend appointments following a referral to the service and ensure that these are clearly recorded within the young person's records.'

The need for prompt action was stressed, so that cases were not allowed to drift. Other recommended responses to non-attendance at appointments, were supervision (including for health professionals) and the perennial exhortation for effective and timely communication between professionals, with clear recording of these discussions.

A further step recommended in one report was an audit of cases where poor engagement had been identified, to ensure compliance with procedures. Another review drew attention to the related, but separate, issue of obtaining more information about migrant families living in the local area who are hard to reach simply by not being visible to agencies, and remaining 'below the radar'.

'Gaps' in continuity of service provision

A number of recommendations addressed times of heightened vulnerability of children for whom services were either not available (weekends, bank holidays, school holidays) or not accessed because of lack of clarity about the provision of out of hours services.

Training for schools and school-based services about managing safeguarding processes in holiday times, as well as the implementation of new mechanisms to ensure school representation at all child protection meetings during school holidays were recommended. Improved provision and awareness-raising about availability of 'out of hours' services also featured in the recommendations, including ensuring that all [Police] front-line staff and supervisors were aware of the provision of 'out of hours – at risk' intelligence checks. The process by which children's social care accessed Magistrates' Court Clerks outside of normal office hours when seeking Emergency Protection Orders was also addressed.

Gaps in services could also arise at the point of transition between agencies. This issue was well illustrated in one review, concerning a young baby, which drew attention to an 11 day gap between midwifery discharge and the subsequent initial health visitor visit. A review of the arrangements between health visiting and midwives was therefore recommended, with the aim of providing a continuity of support for families, and ensuring: *'that there is professional health advice and support available at key transition times when mothers are vulnerable to developing post-natal depression and need support to establish breast-feeding. It is necessary to reinforce safer sleeping messages and help to reduce the incidence of SUDI (Sudden Unexpected Death in Infancy)'.*

Record keeping and information sharing

Many recommendations focused on upgrading systems or changes to forms to be made in the light of the learning from the SCR. Most usually, these advised the gathering of particular additional details, to better inform the assessment process, for instance to *'amend records to include specific question on ethnicity, religion and first language'.* Other recommendations surrounded the recording of information on adults involved with the child, for example guidance to GPs to highlight documentation on parents/carers suspected or convicted of child abuse within the medical record, or in another case to record the identity of the adult accompanying a child to the Emergency Department.

Some SCR recommendations also stressed the need for children's social care to comply with the requirement to include, and keep updated, a chronology of events in the top sheet of records. If the serious case review is not able to answer the question of *why* there was not compliance with procedures, a recommendation reinforcing that this should be done may not be successful. Furthermore, it can only be checked if all records are regularly scrutinised.

In some cases, a recommendation was made to introduce an entirely new form of record, for instance a 'social risk assessment form' for midwives to complete with all antenatal patients, or, in another review of a case featuring neglect, the devising of a tool: '*that can be used by professionals to identify and record signs and symptoms of the neglect of children in an objective way, including the physical conditions in which children are living where this is the subject of concern. Individual agencies should modify the agreed template so as to make it available to staff in a convenient format, linking to their own recording systems'.*

The importance of full, accurate, up-to-date and accessible information was a frequent theme, across all agencies. More specifically, one recommendation drew attention to the difficulties arising from inaccurate spelling of names when inputting information. The need to

ensure good use of information that was already available was noted, with one LSCB recommending a review of arrangements for collating information on children who go missing, to ensure that this information is seen as a whole rather than as a series of separate incidents. Issues surrounding the disposal of records were also addressed.

The need for better information sharing, both between and within agencies, was central to many of the recommendations made, and was addressed in some respect in 19 out of the 20 reports. This included a plea for a shared record for children who are receiving service from a variety of agencies:

'The IMR author considers that the use of a shared record…would enhance communication and improve care afforded to the child. The shared record could contain a basic log of actions and interventions that have been carried out so that the family and the professionals are aware of each other's action .... providing greater continuity of care for the child / family.'

The need for better sharing of information within an agency was often cited regarding a specialist group or team in respect of the organisation as a whole; for example between the leaving care team or the emergency duty team within the same service, between Education Welfare Officers and the Education Service and between the Child Abuse Investigation Unit and the police force of which it was part. Of particular concern was the transfer of information when the patient/client/user moved; for example the transfer of children's records between schools, patients' records when changing GP practice or between the out of hours GP service and the family GP. The handover between shifts in Accident and Emergency could be a key point at which information was not adequately passed on. One issue raised was how to ensure that relevant information was shared '*when the young person had expressed a desire for the information not to be shared at meetings'.*

A further issue which arose, and in relation to a number of organisations, was cross-boundary information sharing, for example between police forces in neighbouring areas, ambulance trusts in neighbouring areas, and children's social care provision in nearby authorities or when an out-of-area provision was being used.

Linked to the concern around information sharing between agencies was an issue of attendance at meetings, to ensure that *'all those who should be invited are invited'*, and that the key people do indeed attend so that participants can contribute to meetings and '*share information first hand'*. In one of the reports, a police recommendation reminded staff in the Public Protection Unit that attendance at all child protection conferences is mandatory. In another locality the recommendation noted that *'technology permits video conferring and multi-person telephone conference'* and required attendance, even if remote attendance, to become the accepted norm.

Staffing

Recommendations were made with regard to staff in various contexts, including general staffing levels, the desirability of a new post or service, caseloads, delegation and the use of unqualified staff, clarity of staff roles and staff competencies.

- ***Workforce capacity***

Overview Report writers note that agencies have a duty to ensure that they have sufficient capacity and resources to safeguard children. Agencies need to be mindful both of their statutory responsibilities and constrained budgets, and: '*fully cognisant of areas of pressure that may affect their ability to safeguard children i.e. staffing levels, workloads, and the provision of supervision, and have in place systems to address any concerns'*. Moreover the report authors are aware that many recommendations have '*significant implications for resources for the designated and named child protection professionals*' and, particularly at a time when budget reductions are in force, that recommendations need to be realistic and achievable. No doubt with financial constraints in mind, recommendations were not often made about the desirability of new posts.

- ***Caseloads***

Recommendations, on occasions, addressed caseloads, particularly with children's social care, where it was important to ensure that they were 'within reasonable limits'. A specific recommendation was: *'to review the health visitor caseload weighting tool, which should reflect vulnerability and disadvantage not numbers of children…This should help to reduce staff stress levels in areas of high deprivation and need'.*

- ***Use of unqualified staff***

Delegation and the use of unqualified staff were addressed in a small number of serious case reviews: *'Children's social care's children with complex health and disabilities team should re-examine their use of unqualified workers*'.

- ***Clarity of roles and responsibilities***

There were a number of recommendations, addressed to a variety of agencies and organisations in both the statutory and voluntary sectors, which called for greater clarity about staff roles and responsibilities within and across agencies. Overall, this issue was to be improved through the usual recourse to the establishment of guidelines and procedures, and more training: *'The Education Support Team to develop a protocol with the Leaving Care team and relevant educations establishments (e.g. schools) to allow a greater understanding of each others' roles and responsibilities'.*

- ***Knowledge and skills of staff***

There was emphasis on the need to ensure that staff were appropriately qualified and experienced, that competencies for each role were clearly identified, and that the post-holder had the knowledge and skills to carry out their role in safeguarding vulnerable children: *'The LSCB should examine the duties of the Named Doctors and Named Nurses for Safeguarding to ensure that the post holder has the mandate and capacity and systems to carry out the full role as envisaged by the Royal College of Paediatrics and Child Health*'.

Training and Awareness Raising

Recommendations about training and awareness raising were identified in all 20 reports resulting in some one hundred and twenty recommendations between them. Many of these related to general awareness raising regarding safeguarding and case management.

However, other recommendations suggested training about single issues which had been relevant to the particular case, such as substance abuse, mental health, cultural issues, 'hidden males' and the identification of physical signs of abuse. Recommended approaches to training and awareness identified within the reports included:

- Implementation of new training programmes, or a review of existing training programmes to incorporate the learning from the SCR, or ensuring attendance of professionals at existing training programmes;
- Induction training for newly appointed staff;
- Leaflets and bulletins to provide guidance and reminders;
- Creation of a web-based training resource accessible to all staff 24 hours a day and containing practical case examples;
- LSCBs to develop systems or tools to monitor types of training offered, uptake and impact of training;
- Refresher training/ regular training (as recommended 'at least every 3 years' in Working Together 2010), to provide an opportunity for professionals to renew their own learning in the light of their own practical experience;
- Ensuring that Safeguarding Awareness training is tailored to meet the specific needs of staff depending on their roles and responsibilities, or for example whether they have face to face contact with clients, or only telephone or postal contact;
- Staff briefings and meetings regarding specific issues such as completion of a CAF or Risk Management planning.

No recommendations were found, including those about training, which specifically addressed the meaning or application of professional judgement. This was implicit, however, in a recommendation which required multi-agency safeguarding training to emphasise that procedures alone will not protect children and that professionals need to consider the wider implications of each situation.

Public Health messages

A number of recommendations included what could be called 'public health' or more general messages. These related to how parents, carers and the community in general could be made more aware of:

- 'safer sleeping' messages, particularly regarding co-sleeping where there are concerns about alcohol and drug use;
- the 'hidden harm' to children of any age arising from parental drug or alcohol misuse;
- the danger to babies from being shaken;
- dangers arising from inappropriate babysitting and child care arrangements.

To achieve this awareness raising, mention was made of targeted communication and advice, written guidance for professionals and commissioning of publicity material for the public, including information on the internet. One LSCB raised the particular issue of running such campaigns in a largely rural county.

Recommendations for a wider regional or national audience

Some report authors take the opportunity to use the recommendation section to suggest imaginative ways of extending the learning beyond the local setting, directing some of their recommendations at a wider audience than the LSCB or any of the agencies involved in their specific local serious case review. This audience divides between government departments, professional bodies and other organisations. The government departments referred to include the then Department for Children, Schools and Families, including Government Offices (at time of serious case review), the Department of Health, the Home Office and the Crown Prosecution Service and the Ministry of Justice; the professional bodies were for example two Royal Colleges (of General Practitioners, and of Paediatrics and Child Health), and other organisations were Ofsted and C4EO.

While they are a rather disparate group of recommendations, there are some elements among them which are common to a number of LSCBs. The need for further research was addressed by two LSCBs, one requesting a national review of adolescent suicide and para-suicide in 'looked after children', and the second requesting (through C4EO) further research in working with young people who are hard to engage.

- ***Incorporating messages into government thinking or policy***

Some LSCBs considered that issues they had raised required cross-departmental discussion within Government, or that a particular message needed to be relayed to a specific forum. Topics addressed, which were considered to merit consideration within a Government department, included increased participation of the armed forces in safeguarding processes, the need for the then Department for Children, Schools and Families (now Department for Education) to issue guidance and direction on the coordination and delivery of services to children with a disability and the lack of guidance on the safeguarding of vulnerable migrant children. Two LSCBs recommended making representations to the Munro review, one concerning the need to reflect 'Think Family' in the re-write of Working Together and the other to clarify information sharing between adult mental health services and additional support children's services:

'….what information adult mental health services can provide to children's services where there are safeguarding concerns, rather than child protection concerns, and they do not have parental consent to share information.'

Other specific recommendations included the need for discussion with the Crown Prosecution Service around the subject of plea bargaining and the subsequent sentence, and the impact of this on safeguarding children issues, and the promotion of the CALM offending behaviour programme offered by HM Prison Service. The latter aims to assist offenders to control and manage anger in situations relating to relationships, and when dealing with the demands of children in their care**.**

- ***Recommendations directed at regional bodies and the Royal Colleges***

There were a number of specific issues which various LSCBs thought should have a higher profile at the regional level, or should be drawn to the attention of one of the Royal Colleges:

'The Strategic Health Authority clinical lead for safeguarding should use the existing regional health networks to ensure that awareness is raised regarding the effects of drug ingestion in infants and children presenting with acute symptoms / illnesses particularly where abuse or neglect could be factors.'

In one serious case review, the LSCB considered that valuable information that the GP held about a child and his family had not been adequately utilised nor adequately shared. They recommended that the overview report, with its recommendations, be sent to the Royal College of General Practitioners, and that the College should be asked to address issues of information sharing by GPs.

A different LSCB proposed that the learning from the SCR be shared: *'with the Officer for Child Protection at the Royal College of Paediatrics and Child Health in order to consider how the effects of adult substance abuse on children can be included in training for medical staff of all grades through national health networks'.*

- ***The development of guidance and protocols***

The Munro Review (2011b) has challenged the culture of procedural, compliance driven practice. As in previous studies, it was apparent here that a number of the recommendations sought the development of guidance or protocols (at a regional or national level) to cover specific circumstances. These included, for example, the prescribing and safe storage of methadone, the managing of CAF and child protection procedures in holiday times – particularly with regard to schools and school-based services, and a need for protocols regarding young sex offenders, or alleged sex offenders, if they moved between different geographic and administrative areas.

The development of a national template was recommended to assist those conducting regulation visits to children's homes. This same review recommended that Ofsted inspectors should interview children in a residential setting not only when children themselves make a complaint, but also when a representative makes a complaint on behalf of that child. Another recommendation addressed national minimum standards in residential homes for children:

'That the redrafting of national minimum standards for residential homes, which has been delayed over the past two years, be accelerated and contain learning from this review. That these national minimum standards state that where there are two sets of standards (school and care for example) in a unit which provides both services, that the higher set of standards be applied for children.'

A very different template was suggested in one report, which recommended that the then Department for Children, Schools and Families be invited to prepare a standard template to assist agencies in preparing individual agency reports for the purposes of serious case reviews.

6.5 Matching the themes of the cases to the recommendations made

Recommendations are an important conduit for lessons from the serious case review flowing into the practice community. Rose and Barnes (2008), Devaney et al (2011) and Ofsted (2008) found in their analyses of serious case reviews that recommendations did not always link clearly to the review's findings. If recommendations are not capturing the essence of the learning from the case then opportunities are being missed. This part of the chapter is therefore an attempt to gauge whether, on an individual basis, the recommendations did appear to match the issues raised by the case.

We already know from our previous biennial reviews that domestic violence and drug and/or alcohol misuse feature frequently in the lives of the families where fatal or serious incidents have occurred. It is the combination of these factors and practitioners' ability to judge the impact that they have on parenting capacity, which is particularly challenging to child protection practice and to children's welfare and safety. These were again recurrent themes, and led to a number of recommendations.

A close study of the twenty cases where full recommendations were available has enabled us to consider some other factors which feature, with varying degrees of frequency in the lives and circumstances of the families at the centre of the reviews. Table 6.3 analyses the extent to which these themes are addressed by recommendations in the respective reports, with the twenty cases being grouped according to the age of the child at the centre of the review.

The sub set of factors selected for closer consideration were teenage parenthood, prematurity and/or low birth weight, mental health problems or learning disability of one or both parents, the issue of men in the household, the parents' engagement with services and professionals' need to challenge both parents and their fellow colleagues. These factors mostly encompassed the interaction between family characteristics and practitioner working. Each of these factors is tracked across the 20 cases, with the first of the two columns recording whether the theme was noted in the overview report, while the second, shaded column records whether there was a recommendation related to the theme. The totals at the bottom of the table illustrate the extent to which the recommendations address the theme in question. Thus, for example, when parental (or the young person's own) mental health problems were an important factor in the case, there were, in nearly all cases, recommendations made which related to that issue. The one exception was an instance of post-natal depression, which had no 'matching' recommendation.

The issue of the 'hidden man' in the household, and who was living in the home and acting as care-giver to the children, to whom he may or may not have been related, seems to have been taken on board by many agencies. It emerged as a theme in eleven of the twenty cases, and led in all these eleven cases to recommendations, often around raising awareness of the issue, and of accurate recording of the man's presence, and sharing of this information appropriately. Sharing of information was of real concern when the man had a history of violent offending or had assaulted a child in the past.

Table 6.3: Extent to which themes in 20 cases are reflected in the recommendations

Serious Case Reviews (banded by age of the child)	Prematurity and/or low birth weight (<2.5kg)		Young mother (or at time of 1st baby's birth) or highly vulnerable		Learning disability – mother or father		Mental ill health of parent (**or older child if CAMHS involvement)		Fathers or significant male in household – including 'Hidden Male'		Hard to engage		Disguised compliance		Professional challenge of parent / colleague	
		Rec		Rec		Rec		Rec		Rec		Rec		Rec		Rec
Age < 1																
			✓				✓								✓	✓
	✓		✓	✓					✓	✓	✓	✓				
									✓	✓	✓		✓		✓	
							✓	✓								
	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓
			✓		✓	✓			✓	✓	✓	✓			✓	✓
							✓	✓	✓	✓						
			✓		✓		✓	✓					✓			
Age 1–5																
	✓*	✓			✓	✓					✓	✓				
									✓	✓	✓	✓			✓	✓
			✓	✓					✓	✓	✓	✓			✓	
			✓						✓	✓			✓	✓	✓	✓
	*	✓	✓		✓						✓	✓	✓		✓	✓
									✓	✓						
									✓	✓	✓	✓	✓	✓		
Age 6–10																
	✓*								✓	✓	✓	✓				
							**	**			✓					
	✓*										✓				✓	
Age 11 +																
							**	**			✓	✓				
							**	**			✓	✓				
All cases	**6**	**2**	**8**	**3**	**4**	**2**	**8**	**7**	**11**	**11**	**14**	**11**	**6**	**2**	**9**	**6**

*No ante-natal care, or very late presentation for ante-natal care

** Child and Adolescent Mental Health Service for the young person, rather than adult mental health service for the parent(s)

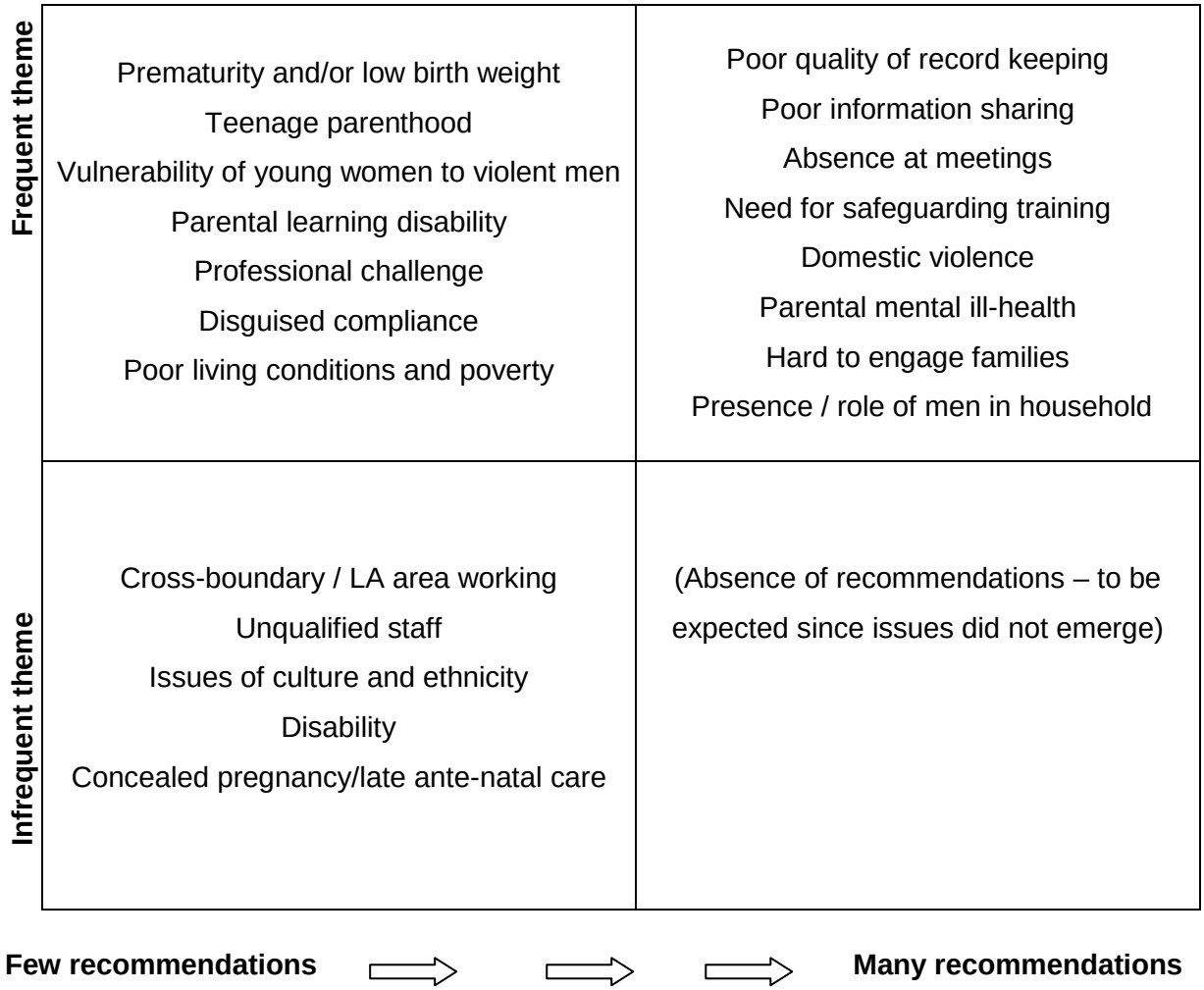
An example of a theme which appeared not to lead to many recommendations was that of pre-maturity and/or low birth weight, evident in six cases. Previous biennial reviews of SCRs have discussed the impact that the needs of an extra demanding pre-term baby place on the parents, often compounded by time spent apart from the new baby who is in a special care baby unit (Brandon et al., 2009). Worth noting is the fact that there were four instances of the mother presenting either very late during the pregnancy for ante-natal care (for example at 24 or 32 weeks) or in one case reporting that she had been unaware of her pregnancy, had received no ante-natal care and gave birth at home with no medical assistance. Another theme which arose is that of teenage parenthood, which has been explored in chapter 3 of this biennial review.

Young parenthood was a factor in seven of the twenty cases (the age of the parents was not always given, so the proportion may have been higher). In some cases the young mother's vulnerability had been compounded by her background of special educational needs (SEN), a troubled childhood including time spent in care, and a succession of volatile, violent and often exploitative adult relationships. However, the needs of young teenage parents and the challenges that they may face rarely lead to any specific recommendations. One overview report author noted: '*a lack of recognition by professionals of the fact that the parents were young, the mother a teenager and father barely an adult, who were having an unplanned pregnancy. Professionals need to recognise and have a multi-agency service approach to try and engage with young parents who may be a Child in Need themselves'*. In this report the development of a comprehensive, multi-agency teenage pregnancy strategy was advocated.

The issue of 'disguised compliance', discernible in a number of reviews, was rarely specifically addressed in terms of recommendations (unlike the similar theme of 'hard to engage' families). This was perhaps surprising since all these SCRs were completed after the issue of disguised compliance was given prominence in the debate about the Peter Connelly case. However, one report did note the mother *'actively colluding with (father) to distract and divert professionals from investigating concerns about the children'*. Likewise the need for respectful professional challenge, of colleagues and also of parents, was often noted in the analysis and concluding sections of the overview reports, but appeared much more difficult to translate into actual recommendations.

The information in Table 6.3 is extended to include issues of intra and inter-agency working and is represented in a grid format in Figure 6.3.

Figure 6.3: Frequency of Recommendations and Serious Case Review Themes



The number of recommendations made on a topic is plotted on the horizontal axis, from few recommendations at the left hand side of the diagram, to many on the right hand side. The vertical axis plots whether the theme is one which occurs frequently or, while still being important, arises in relatively fewer cases.

Taking all the twenty reports together, one would expect, intuitively, there to be many recommendations made around topics which arose frequently (top right hand quadrant). Similarly themes only pertinent to a few cases would be expected to lead to fewer recommendations (bottom left hand quadrant). It is encouraging that there are no themes in the lower right-hand quadrant as that would indicate many recommendations being made about topics rarely arising out of the reviews.

Of particular interest, however, is the upper left-hand quadrant, where themes occur frequently, but few recommendations are made. This contains 'within family' themes like premature births, teenage parents, parental learning disability and some wider themes such as poverty, inadequate housing and poor living environment. It is, in many respects, appropriate to be cautious when making specific case-based recommendations about 'within

family' issues since they may have little relevance for most other vulnerable families. If, for example, issues such as teenage parents are used as 'risk factors' for abuse or neglect they are likely to prompt false alarms and false positives.

The impact of such potential vulnerabilities on child safety, especially in combination, need to be understood on a case-by-case basis and require careful professional judgement. The kind of recommendations most likely to bring this about would be those addressing staffing levels and supervision which would help practitioners to make sense of complex cases. Robust supervision should also help practitioners to recognise disguised compliance and prompt professional challenge (also in this quadrant of few recommendations) provided workers are able to see families often enough to get to know them and make relationships with them. Wider societal issues like poverty and poor environments do have a clear impact on deepening vulnerability and hence threatening child safety, beyond the level of the individual case. These factors require a more strategic national level response, beyond what is achievable locally through the LSCB.

The top right hand quadrant in contrast, where there are many themes and many recommendations, includes primarily professional issues, particularly concerning training and aspects of communication but also some 'within family' themes such as domestic violence, and mental ill-health (for which the earlier caveat about use as a wide ranging risk factor also applies). These professional issues lend themselves more readily to crisp and measurable recommendations but often include repetitive messages. This may be appropriate if messages need to be repeated and reinforced or it may mean that the imperative to fix everything results in little action or nothing getting fixed.

It would seem therefore that there are some lessons which emerge from SCRs which rarely lead to specific recommendations. The introductory paragraph to the recommendations section in one of the overview reports explicitly states 'the review does *not* make a recommendation for every point of learning that has been identified'. Indeed, this would seem to be the only reasonable approach to take if reviews are to make few recommendations.

The extent to which recommendations match the themes raised in their respective overview reports is further explored in the discussion on 'relevance' which forms part of the next section on whether recommendations are 'SMART' .

6.6 A critique of the 'SMART' approach to recommendations and action plans

This brief section offers an analysis and critique of the Specific, Measurable, Achievable, Relevant and Timely (SMART) approach of translating recommendations into learning, which is illustrated from the overall findings on recommendations and in particular from an examination of five available action plans. Overall, our impression of reading recommendations from the 33 cases has been that they are indeed becoming tighter and more clearly focused, although rarely are they few in number. The Rose and Barnes report of reviews from 2001-2003 (Rose and Barnes, 2008) and Devaney and colleagues' 2008 Delphi study of reviews from Northern Ireland (Devaney et al., 2011) found that many action plans had been completed in a rush. These few action plans appeared, in contrast, to be thoughtful, well considered documents.

The brief literature review pointed to the now well established view, that recommendations should be produced which can be easily translated into action and learning. Working Together states that to learn lessons locally, recommendations should focus on a small number of key areas, with 'Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes' (HM Government, 2010:245). Handley and Green's audit tool was produced to help LSCBs apply a SMART analysis to assess serious case review recommendations (Handley and Green, 2004). We have summarised these authors' definition of SMART as follows:

- **Specific** (exactly what should be done, best limited to single action);
- **Measurable** (how much, how many, how well);
- **Achievable** (can it be done, can the person identified do it);
- **Realistic** (what is possible in the real world);
- **Timely** (what is a realistic timescale).

Their interpretation of the 'R' in 'SMART' as 'realistic' differs from the *Working Together* (HM Government, 2010) interpretation as 'relevant'. Here we have adopted the term 'relevant' particularly since 'realistic' can be subsumed in 'achievable'.

Action plans are the means by which recommendations are translated into workable actions and followed through. *Working Together* states that the action plan should highlight which recommendations are relevant to which agencies, the agency/ies responsible for taking forward specific recommendations, how action will be monitored and by whom. The action plan should also set out the progress that has already been made in implementing or completing recommendations and plans to evaluate the impact of these changes (HM, Government 2010).

The five action plans all had a range of transparent methods for making sure that progress could be tracked. All were constructed in similar ways, setting separate recommendations against actions, evidence, outcomes and progress, in varying degrees of detail and specificity. Where there were high numbers of recommendations, the action plans were

accordingly long and detailed (they ranged in length from 10-40 pages). The action plans are analysed, here, briefly, in the five SMART domains.

Specific

There were varying degrees of clarity and specificity in the recommendations as listed in the action plans. On the one hand, things could become blurred and confusing when one recommendation had multiple threads. On the other hand, very complex recommendations could be divided into numerous very specific aspects. Although this sub-division produced greater clarity, it also encouraged a proliferation of tasks to be achieved. These numerous, highly focused recommendations appeared to leave little room for professional judgement by adding new layers of prescriptive activity to follow.

Measurable

Easily measurable actions tended to be concrete activities like training events and changes to procedures or demands for information, for example:

- Change in wording of a protocol; letter to be sent; sending an *'email about procedures for child protection checks'; 'leaflets updated';*
- Numbers attending courses: *'the PCTs to provide updates as to the number of GPs attending training and awareness events'.*

Merely tracking the numbers of GPs attending courses, however, is unlikely to promote a higher level of attendance and disregards the need for action when GPs do not attend. 'Evidence' of action and/or outcome was interpreted somewhat differently in the action plans. There were also some gaps in the 'evidence' sections and sometimes the 'evidence' listed was just a name or title, for example *'Designated Nurse and Doctor'* suggesting perhaps that finding and specifying a measurable outcome was just too hard.

Moving recommendations beyond the concrete appeared to be difficult, for example gauging *how* the quality and impact of awareness raising/training sessions will be measured. One plan noted that lessons learned from the serious case review were: *'to be presented to all the teams in Social Care through the Children and Families Team and cascaded down by Heads of Service'* with the evidence of outcome being: '*Staff able to recall lessons and how practice will change'.* This still leaves the question of how staff recall would be measured let alone discerning its trickle-down effect on practice. While it is clear that some tasks are easier to tick off as done, these easily achievable tasks, as other studies have noted, are not necessarily those that make most difference to practice (Handley and Green, 2004).

Achievable

Within each plan it was possible to discern delegated responsibility for ensuring that actions were completed, suggesting that earlier criticisms in this respect (Rose and Barnes, 2008) had been taken on board. This was done through either naming an accountable individual or specifying a named role to check the follow through, for example a designated nurse or a training manager. Handley and Green (2004) and Hyland and Holme (2009) make the point that the named individual must have sufficient authority to be able to implement the recommended action.

There are other parameters surrounding what is achievable and realistic – not least the thorny issues of resources and capacity. Passing responsibility for achieving results higher

up the chain to national bodies was rarely seen in action plans and recommendations but extends the achievability of a recommendation beyond the remit of individual agencies or LSCBs. This is a valid activity and *Working Together* (HM Government, 2010) states that *'national implications should be highlighted and the information sent to the relevant government department'*. It also addresses the suggestion in the study by Fish and colleagues (2008) that complex national level issues are pursued and given further thought.

Relevant

Although, on the whole the recommendations did connect clearly to the case (and were therefore relevant), there were a number of regularly occurring themes from cases which rarely translated into recommendations. Overall, recommendations rarely drew explicitly on wider research-based evidence to substantiate their validity. Where research was referred to, this was mostly in the 'Lessons Learned' or 'Analysis' sections of the Overview Report but there was not a clear link from here to the later recommendations, nor was there any evaluation of whether the recommendation would be likely to lead to improved outcomes.

Perhaps in some instances LSCBs shied away from making recommendations because they were unsure about the evidence base or doubted the usefulness of a recommendation. For example, perhaps few recommendations were made about the common theme of teenage parenthood because LSCBs were aware of the evidence that the age at which pregnancy occurs has little effect on social outcomes (Duncan, 2007, Alexander et al., 2010). While this issue had a significant impact on a single case it might have had limited transferable learning to the general population. On the other hand, the combination of adversities usually suffered by teenage parents who feature in serious case reviews increases their vulnerability and agencies need to be alert to this.

From the five action plans studied here, the key point to emerge was the degree to which the learning from a recommendation from a particular case was transferable and could be generalised to other circumstances. Some recommendations were relevant to a single case only, others had meaning solely to the particular LSCB, while others had much wider, far reaching messages and applicability. Earlier studies of serious case reviews pointed out that the narrower the applicability of the recommendation, the greater the risk of making potentially inappropriate or irrelevant decisions or procedures on the basis of a single case (Sinclair and Bullock, 2002, Brandon et al., 1999, 2002).

Timely

Most of the recommendations contained within the sub-sample of five action plans were accompanied by a timescale for implementation. Sometimes these actions had already been completed, and most actions were expected to be implemented within less than six months. Some longer-term recommendations, for example concerning the audit of safeguarding training, had a timescale which extended a year ahead. When the timescale becomes drawn out, both the momentum and the learning risk getting lost. This point was made strongly by respondents in the recent study of the learning from serious case reviews (Sidebotham et al., 2010). The few action plans that we saw did not give themselves a time frame beyond one year.

Two reports had assigned recommendations a level of urgency - low, medium or high. However, the definitions in each differed somewhat, serving to illustrate how expected

timescales for development and implementation of recommendations may vary between LSCBs. The range was as follows:

- 'Low' priority: 6-12 months;
- 'Medium' priority: 3-6 months;
- 'High' priority: 0-3 months indicating 'urgent and immediate action'.

What next for recommendations?

Recommendations have become more 'specific, measurable, achievable, relevant and timely' but this has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity appears to leave little room for professional judgement. However, it is easier to be critical of the SMART approach than to create an alternative. Where recommendations need to be made there is still value in this structured, methodical model but LSCBs should free themselves to construct a proportion of recommendations that are not easy to audit or make SMART that might encourage deeper learning and take longer to embed. Perhaps more importantly, LSCBs should be less reliant on recommendations being the central plank of the learning process in serious case reviews.

6.7 Conclusions

The most startling findings to emerge from the Recommendations Study have been not only the sheer volume of recommendations to emerge from reviews, but also that the endeavour to make them specific, achievable and measurable has resulted in a further proliferation of tasks to be followed through. Carrying through these, often repetitive, recommendations consumes considerable time, effort and resources – but there appears to be growing evidence that the type of recommendations which are the easiest to translate into actions and implement may not be the ones which are most likely to foster safer, reflective practice.

A number of studies have similarly found that action plans which are easy to implement tend to be ones that address superficial aspects of procedures and concrete tasks. This focus on creating or adapting local procedures, or arranging training for which the LSCB has the responsibility and capability to monitor and implement via the action plan, can mean that the deeper and wider issues get sidelined or diluted. An interviewee in Sinclair and Bullock's much earlier study of serious case reviews from 1999-2001, made a comment which in some respects resonates with this study ten years later: 'There's a tendency to translate a rather big issue (*parents who are hostile and lie*) into something that can be measured and ticked …(*like)*...awareness training' (Sinclair and Bullock, 2002:43).

The interface between societal issues like deprivation and maltreatment is rarely reflected in recommendations or action plans. These big issues, such as poor environment and bad housing, tend to be thought of as beyond the scope of the review. LSCBs may consider that these are issues over which they have little influence even though the potential for a single serious case review to prompt wide-ranging change should by now be understood.

Rarely was a research evidence base cited for the recommendations made. This begs the question of the extent to which recommendations were thought to be likely to deliver change, and whether there were clear rationales for making, or not making, recommendations. The

Munro Review has recommended a ‘fundamental rethink’ of the way to learn about professional practice from serious case reviews and pointed out, as we have argued before, that serious case reviews have their limitations and are not necessarily the best sources of learning. The Munro Review emphasises the advantages of a systems approach and learning from deeper underlying issues and local rationalities (Cm 8062). A systems approach does address the important organisational context and support structure for the staff of agencies working together to safeguard children and support families, but learning from the story of individual children and their families can get lost.

Sinclair and Bullock have stressed the importance of accurate epidemiological data to help to identify children vulnerable to abuse and predicting those at risk of violent death or injury (Sinclair and Bullock, 2002). Attempts are being made in the development of an observatory function of serious case reviews to combine what is known about serious case reviews with whole population studies. This, like the systems approach, will help us to learn more but may still leave gaps in understanding individual family/practitioner level factors which will defy predictability. Practitioners will still need help in making difficult professional judgments about individual cases. Reflecting on and learning from deeper issues in the systems, attitudes and practices of the organisation and individuals takes time (Sidebotham et al., 2010). These deeper issues can prompt more questions than solutions and so cannot fit comfortably within a SMART framework.

Chapter 6: Summary

- This chapter presents a critical, thematic analysis of recommendations from 33 serious case reviews completed in 2009-10.
- Overall, our impression of reading recommendations from the 33 cases is that they are indeed becoming tighter and more clearly focused, although rarely are they few in number.
- In the 20 serious case reviews examined in depth, there were a total of 932 recommendations with an average of 47 per review. This is in spite of repeated calls to make recommendations few in number. The majority were targeted at children's social care services (179), community health services (161), hospital trusts (92) or the police (85).
- Breaking down recommendations into achievable actions has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity leaves little room for professional judgement.
- Most recommendations concerned procedures and training. The route to grappling with practice complexities like engaging hard to reach families, was usually more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.
- There was rarely a research evidence base cited for the recommendation made: they tended, instead, to be based on learning from the single case which was assumed to have wider implications.
- Action plans were thoughtful, well considered documents that tracked the implementation of recommendations carefully. However, those recommendations that were easy to implement rarely addressed complex matters of professional judgement.
- The interface between societal issues like deprivation and maltreatment rarely featured in recommendations or action plans. Wider issues tended to be thought of as beyond the scope of the review despite *Working Together to Safeguard Children* (HM Government, 2010:248) inviting consideration of national policy and practice issues.
- Local Safeguarding Children Boards need to take responsibility for curbing this self-perpetuating cycle of a proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews. Recommendations may not be the best way to learn from these cases.
- The full version of this chapter was published in 2011 as DFE-RR157 and can be downloaded from the Department for Education website: https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR157.pdf

Chapter 7: What's new in these serious case reviews?

Although the learning from serious case reviews is acknowledged to be important, there can also be a degree of weariness about the translation of messages from reviews into practice. This may be because serious case reviews rarely identify good practice and also because they tend to produce apparently similar findings concentrating on practitioner failings rather than systems failings. Several discussion points emerge from this however. Firstly, as we noted in Chapter 5 and elsewhere (Sidebotham et al., 2010) some of these lessons are so important that they need to be repeatedly learnt and staff need to be regularly reminded of issues that individuals and agencies can lose sight of; secondly the question of why the same mistakes are repeated and why the same failure to see what might be obvious in hindsight should be a source of intrigue and curiosity rather than exasperation; thirdly, each two yearly review produces a number of new insights and new knowledge alongside the recurring messages; and finally, building on our research knowledge about reviews over the years helps to clarify patterns and deviations from patterns.

What is new from the analyses of the serious case reviews from 2009-11?

We have always been aware that serious case reviews represent a very small portion of the child population. The analysis reported in Chapter 2, which brings together data from different national databases, has helped us to quantify this more clearly. It has been able to provide a reasonable estimate of the number of violent and maltreatment related child deaths for the single year 2009-10 as approximately 0.48 per 100,000 children, or 50-55 per year (or up to 85 if undetermined SUDI cases are included). The complexities of matching national level data from different sources has also underlined the difficulty of interpretation and prediction so that tracking the extent to which this estimate rises or falls will never be exact.

Information from the analysis in Chapter 3 adds to our understanding over time (since 2003) about the families in which children live and the context of professional practice and decision making which surrounds them. For the first time we know, with some accuracy, that neglect is a background factor in the majority of cases (60%) which become the subject of a serious case review, and for children of all ages not just the younger children. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including SUDI and suicide, and in over a quarter of homicides and fatal physical assaults. Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non fatal cases, including physical abuse and sexual abuse. This information adds to the climate of urgency and the greater willingness to acknowledge the harm that stems from neglect as an immediate concern and especially over time, even though it is seldom identified as the key factor in the child's death.

We also know that in the reviews from 2009-11 only 42% of children were getting services from children's social care at the time of the child's death or the incident which prompted the review, but also that a significant minority of 21% of children had never been known to this agency. The remaining 37% of cases were either closed or had not been accepted at the

point of referral. This reinforces the importance of staff in universal services sharing responsibility for protecting children. This may be particularly pertinent for education staff in relation to primary school aged children, many of whom will have limited contact with other agencies. For these children, their world outside the secure environment of the school may be one of quite extreme hidden adversity. These are important elements of system level learning.

A drop in the number of cases known to children's social care could suggest an improvement in this lead agency's protection of children or could instead imply that thresholds for eligibility to the service are rising. Clearer signs of improvement however are the fall in the number of children at the centre of a review with a child protection plan in place - declining from 16% in 2007-09 to 10% for the latest two year period, at a time when overall numbers of children with a child protection plan are rising. Other possible pointers to improvement are a reduction in the proportion of infant cases from a pattern over time of almost half of all reviews to just over a third (36%) this time. Perhaps this offers some hope that the practitioner and wider public health messages about safer care and protection of babies are being heeded.

Other studies have also noted that children aged 5-10 are an overlooked group (Cleaver et al., 2011, Ward et al., 2012). The in-depth analysis of this hitherto 'hidden' group of children at the centre of a serious case review (reported in Chapter 4) therefore raises some important new learning. The primary school years are generally perceived to be a very positive time in children's lives and rates of serious maltreatment for this age group are low. However, this may mask a burden of lower level maltreatment. Many of the 21 cases studied revealed that there had been opportunities to address low level needs which could have prevented the escalation of problems and maltreatment, particularly through the use of the Common Assessment Framework in schools. There was however little homogeneity among this group of children's cases and while some had only low level problems prior to the incident which sparked the review, other children were suffering serious and severe harm.

A number of the 21 cases of children aged 5-10 illustrate the danger that can occur to children when parents separate. The chapter also offered examples of the risks to children from filicide/suicide, (where a parent kills a child and either the other parent or themselves). In these cases, mental illness was a common finding in maternally perpetrated filicide; where the child was killed by the father or male figure, domestic violence and control was a common feature. It would be wrong to draw strong conclusions from this small sample, and the context of all these cases was far more complex than a simple distinction such as this allows. However, this in-depth study raises important questions about the risks of harm to children where parents separate and the risks of harm from the growing number of filicide/suicide not just among middle years children, but across all age groups. These issues are worthy of wider study.

Implications for practitioner knowledge and practice

The study of practitioners' knowledge about child development (Chapter 5) provides insights into the traps that professionals can find themselves in. Professionals working with children should be aware that pre-mobile babies cannot bruise themselves but, the cases studied here, showed how and perhaps why, practitioners found reasons to believe that the

explanations for such bruises were plausible. This raises interesting questions about why professionals don't believe what they *know* to be right but perhaps act instead on what they *feel* to be right. Testing out instinct is an important part of professional expertise but the practitioners in these cases didn't ask additional questions of themselves or others or act with sufficient curiosity. As in the children aged 5-10 study, there was a sense of disconnection from the children themselves; not paying attention to children's emotional development and not thinking about what it's like to be a child living in that family or that residential setting; seeing the disability not the child; and, most powerfully, holding back from knowing the child as a person. All of these issues point up the emotional toll that working with children, from any discipline and especially social work, takes on the practitioner.

Each of our two yearly national analyses has highlighted the importance of challenging and reflective supervision that goes beyond procedures and processes. The same is true of this report, which similarly illustrates the need for good supervision (including peer supervision) that should pay attention to the impact of the case and the work on the practitioner. Supervision also has an important role to play in fostering professional development and encouraging practitioners to keep their knowledge up to date. Supervision, particularly of newly qualified social workers, can help practitioners prioritise the time needed to get to know the children and families they are working with. However such support and constructive challenge of front line practitioners will not be possible if the agency context is one of overwhelming bureaucratic demands, with a limited capacity to invest in relationship building or critical reflection. The latest progress report from the Munro Review has indicated that the reforms required to redress these systemic problems are slow to materialise, not least because of funding cuts to all services (Munro, 2012). To survive and thrive in this difficult climate, workers need to be able to attend to their coping and thinking skills as part of their continuing professional development, and in training.

Implications for strategic manager knowledge and practice

The recommendations study (Chapter 6) showed that recommendations were becoming tighter and more clearly focused. There were also improvements in Action Plans which were found to be thoughtful, well considered documents that tracked the implementation of recommendations carefully. However, those recommendations that were easy to implement rarely addressed complex matters of professional judgement. This study questioned the orthodoxy that sharpening and refining recommendations is the key way to improve learning from serious case reviews. Findings showed that breaking down recommendations into achievable actions appears, instead, to result in a further proliferation of tasks to be followed through and the dangers that Professor Munro and others have emphasised in procedure driven practice. Focusing on the types of concrete recommendations which translate readily into actions can sideline important deeper issues that are not easily measureable and evade ready answers. A better approach might be for LSCBs to be less reliant on recommendations as the key route to learning from serious case reviews. Shared and more immediate learning through the process of carrying out the review, including learning from family members (Morris et al., forthcoming), may be a more positive and fruitful way to embed the lessons into practice and agency culture.

Implications for Policy

The Munro Review has recommended that serious case reviews be undertaken using a systems methodology that moves away from a focus on the specifics of the particular case to identify underlying, often local, issues that influence practice more generally. The focus that this could bring on gathering together relevant practitioners to be closely involved in exploring how people saw things at the time, and analysing how and why things unfolded as they did, would deliver a sense of immediacy to the learning. It would also involve practitioners (and should involve family members) more closely in understanding the local context, avoiding the feeling of exclusion that can come with the more traditional, primarily paper-based, approach to undertaking a SCR. This shared learning could also offer a sense of catharsis to help to restore workers' confidence.

The Munro review recommends that national learning will be improved if findings are presented through the development of a consistent typology (Cm 8062, 2011:64). The typology being piloted by the Social Care Institute for Excellence (Fish et al., 2008, Cm 8062, 2011) points out that although in three quarters of cases the outcome is attributed to human error, this emphasis on individual blame is unhelpful. The systems framework being developed assumes a significant amount of professional interaction with the families which is not always the case in serious case reviews. There are a substantial minority of serious case reviews where there was either little or minimal agency involvement and it is yet to be seen how these cases will fit into the proposed typology of error causation.

There are perhaps distinctions, however, to be drawn between doing the review and the recording that will result from the serious case review. The systems typology being developed is not intended to address or include any characteristics of the child or family. There are some potential problems if this framework is also intended as a format for providing data in individual cases which can be aggregated at a national level. It will not be possible to continue to build the current research database (which dates back to 2003) about the characteristics of the children and families as well as the agency response within each review. Being able to understand differences and similarities between individual cases and the whole cohort of serious case reviews has provided learning with policy implications.

It has been possible, for example, to highlight not just the preponderance of babies at the centre of the review but their very young age and the importance of specialist health staff (like midwives and health visitors) in safeguarding these most vulnerable infants. In the current report it has been possible to identify an encouraging drop in the proportion of infants in serious case reviews. We have also been able to show that older adolescents are vulnerable to death and serious harm but that agencies can pull back from providing services at the point of the young person's greatest need. It is important to understand the cases individually but also to continue to build a picture of their totality so that misinformation is not perpetuated. Because one individual case review can be so powerful it is very easy to inflate or misinterpret the extent of, for example, parental mental ill health or domestic violence or substance misuse and believe that what is apparent in one case is true of the whole serious case review population. Most importantly, having a national sense of the profile of the children and their families puts the children as real people back at the centre of the review.

Too often in the current format of serious case reviews the children themselves can seem tangential and scarcely visible. If we focus solely on systems issues, ignoring the child's story, we could perpetuate their marginality. Children who are seriously harmed through abuse and neglect have a story to tell, and one that needs to be heard. Through this and our other national reports, by using case studies and vignettes, we have tried to give more voice to these children and young people. Indeed the contribution that surviving young people can make to reviews is an underexplored area worthy of further study (Morris et al., forthcoming).

If the systems typology under consideration is to exclude details about the child and family, one way of making it possible to continue to collect anonymous data about them, as well as key information about service use, would be for the submitted serious case review to include a 'front sheet' template where this basic anonymised information could be provided. This information could then feed into the ongoing research database (see Appendix 2).

Implications for Research

The new approach of publishing smaller focused studies, as well as the overview report at the end of the two years, has shown the value of combining the regular relaying of messages to policy makers and practitioners, with final reporting and taking stock of what has been learnt from the totality of serious case reviews over the two year period.

From the experience of the study reported in Chapter 2, future research could now usefully combine learning from serious case reviews and child death overview panels (CDOP). Bringing together data from these and other national sources has been complex but has produced useful results, not least the possibility of establishing a cautious estimate of any rise or fall in child deaths through maltreatment. A similar exercise can be replicated on an annual or a two yearly basis, with attempts to refine the way that the various data (including about serious harm as well as death) can link. Account will need to be made for the long time lag in the availability of data from different government sources. The experience of undertaking the exercise this time showed that it could take fourteen months for the data to be available and brought together.

The experiment to test the feasibility of a national observatory function has also been largely successful. We found that the complexity of these serious case reviews and the lack of standardisation in the way they are written militated against any system for automatic coding of the data within them. However it would be possible to produce a framework for national analysis of serious case reviews that could also be used for regional or national analysis of CDOP data. This would be easier if the reporting structure for serious case reviews shared similarities with the reporting of unexpected child death through the CDOPs. Depending on the final structure of the serious case review report, the framework could include four primary analysis domains: circumstances of the event; ecological-transactional (including child factors, parenting capacity, family and environment, and service provision); systemic; and process. These domains would allow qualitative analysis to take place on a number of different levels and provide scope for different thematic analyses to be undertaken (see Appendix 1).

The combination of the quantitative analysis of national data sources with detailed qualitative analyses linked to a clear framework, provides a flexible and responsive way of storing,

analysing and reporting learning. A national observatory function could work in the following way:

- Each SCR to be coded according to an established framework as it is submitted to the Observatory, with information from the 'front sheet' added to the ongoing database. The analysis and learning from each individual SCR would be reported to both policy makers and the practice community (for example via an anonymised single page summary posted on the Department for Education or Observatory website);

- The production of six monthly critical analyses of a separate theme (for example- filicide suicide or separated parents or child disability). The thematic analysis could compare current reviews with past findings, and ground the findings within the context of wider research and evidence;

- Annual or two yearly reporting of national data linkage from CDOP, SCR and other national sources, replicating and refining the work reported in Chapter 2;

- Two year reports of cumulative learning from SCR and CDOP findings.

Endpoint

A measure of success of serious case reviews may be finding in these research studies a large number of what the Munro review has termed 'low probability' cases, not known to children's social care or other specialist agencies. By definition it will be harder to predict and prevent death or catastrophic harm to these children because there are lower levels of known risk of harm. Paradoxically, the better we get at this work the more we reveal hitherto unrecognised maltreatment.

These finer points of prevention or predictability do not lessen the pain that surrounds the death or harm of each child. In whatever way the new serious case review system is configured, it is essential to remember that each review is about an individual child and not just a system.

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Appendix 1: Serious Case Reviews Coding Framework

This document sets out a draft approach to a framework analysis for Serious Case Reviews (SCRs). This framework (Draft 4 at 30.3.11) was developed in the light of previous work on biennial analyses of Serious Case Reviews and consideration of Child Death Overview Panel (CDOP) data, along with an understanding and review of different approaches to critical incident analysis. It is envisaged that this could provide a framework for national analysis of Serious Case Reviews, and also that the same framework could be used for regional or national analysis of CDOP data, and for other case-based analysis. Thus it could be applied to a comparative analysis of children subject to child protection plans.

The documents (sources) are those submitted reports which we drew on for the analysis. These include database notifications and reports, and submitted SCR executive summaries and overview reports. Additional data could be obtained from IMRs, chronologies, and action plans, although this did not form part of the data used for this study. Currently CDOP data only consist of aggregated data submitted annually. Individual anonymised case data (forms B and C) would enable a much richer analysis using the case characteristics and analysis domains listed below.

Case characteristics include data on the incident (classification, date, region), victim(s), and perpetrator(s). These data allow quantitative analysis and comparison across different data sets. They also provide the case characteristics to interpret the analysis, and allow analysis by different subgroups.

There are four primary analysis domains: circumstances of the event; ecological-transactional; systemic; and process. These allow qualitative analysis to take place on a number of different levels. The source data are reviewed by a researcher and coded within these four domains, using the framework below. Within each domain, data are coded at different levels, using an hierarchical framework. Any item of data (for example a paragraph in the overview report, or a particular quote) may be coded within more than one domain. Once data are coded, the data within each domain are analysed separately, looking for consistent themes within that domain, as well as any outlying or discrepant data. Emerging themes are then explored further in the context of the overall data and with reference to other research.

1. Documents (Sources)

Database notifications/reports
Executive summary
Overview report
IMRs
Chronologies
Action plans
CDOP agency reports
CDOP analysis proforma
Others, e.g.
    Case conference minutes
    Transcribed interview data

2. Case Characteristics

Level 1	***Level 2***	Level 3	*Level 4*
Incident	***Year***	Month	
	Region	LSCB	
	Classification	Death	*infanticide/covert homicide*
			severe physical assault
			extreme neglect/deprivational abuse
			deliberate/overt homicide
			deaths related to but not directly caused by maltreatment
			death, category not clear
			CDOP classification
		Serious Incident	*physical abuse*
			neglect
			sexual abuse
			emotional abuse
			other incidents
Victim(s)	***Number of victims***		
	Primary victim		*Age*
			Gender
			Ethnicity
	Secondary victims		*Age*
			Gender
Perpetrator(s)			*Relationship to victim*
			Age
			Gender

3. Analysis Domains

Include both strengths and difficulties/gaps/weaknesses

Level 1	***Level 2***	Level 3	*Level 4*
Transactional	***Pre-incident***	Child Chronology	*Pregnancy and birth*
			Infancy
			Pre-school
			School age
			Adolescence
		Family Chronology	*Early family history*
	Incident	Cause of death/injury	*e.g. hypoxic brain damage; severe infection (as per coroner's verdict/ death registration / CDOP categories)*
		Location	
		Chronology	*Events leading to incident*
		Perpetrator characteristics	*Relationship to victim*
			Age
			Gender
			Criminal history
			Mental health
	Post incident	Management	
		Outcomes	*Survivor outcomes*
			Surviving siblings
			Family
			Legal outcomes

Level 1	***Level 2***	Level 3	*Level 4*
Ecological	***Child***	Child characteristics	*Age*
			Gender
			Ethnicity
		Development	*Development*
			Education
			Behaviour
			Social relationships
			Identity
			Independence
		Health	*Growth*
			Disability
			Illness
	Family / Environment	Family structure	*Genogram*
			Mother
			Father
			Other adults
			Siblings
			Other children
		Parental characteristics	*Parental age*
			Domestic violence
			Drugs and alcohol

			Mental health
			Disability
			Convictions
		Family functioning	*Wider family relationships*
			Employment and income
			Social integration and support
			Stability
		Physical environment	*Housing*
		Immigration status	
		Community	
		Culture	*Faith*
	Parenting	Parental responsibility	
		Supervision	
		Child protection	*CPP index child*
			CPP siblings
			Court orders index child
			Court orders siblings
		Parenting capacity	*Basic care*
			Health
			Safety
			Emotional warmth
			Stimulation
			Guidance & boundaries
			Stability
		Factors affecting parental provision	
		Family engagement with services	
	Services	Agencies involved	*At the time*
			Previously
		Unmet needs	
		Family engagement	*Cooperation*
			Hostility
		Health	
		Police	
		Social care	
		Education	
		Other statutory	
		Voluntary / third sector	

Level 1	***Level 2***	Level 3	*Level 4*
Systemic	*Individual*	Practitioner issues	*Knowledge*
			Training
			Performance
			Decision making
	Single agency	Culture	*Equality and diversity*
			Communication
			Supervision and support
			Continuity / consistency
		Systems and structures	*Policy, regulatory context, protocols*
			Structures
			Working environment
		Resources	*Staffing and workload*
			Financial
	Interagency	Culture	*Communication*
		Systems and structures	*Policy, regulatory context, protocols*
	National	Culture	*Communication*
		Systems and structures	*Policy, regulatory context, protocols*

Level 1	***Level 2***	Level 3	*Level 4*
Process		Scoping	*Terms of reference/ scope*
		Methodology	*Contributors*
			Family involvement
			Analysis
			Parallel processes
			Time scale
		Outputs	*Conclusions, including preventability, contributory factors*
			Learning points
			Recommendations
			Action plans

Appendix 2

Proposed Information Sheets for Serious Case Review

Child identifier (or initials) as used in the SCR .....

Local authority..... Region .....

Gender: Male ❑ Female ❑

Date of birth ..... Date of death .....

Nature of incident: Death ❑ Serious injury ❑

Date of incident (death or serious injury) .....

Age at time of death or serious injury .....

Known or likely perpetrator ..... or not known ❑ not applicable ❑

The child (for all ages):

Low birth weight? (less than 2.5 kg) Yes❑ No ❑ Not known ❑

Premature? (prior to 37 weeks gestation) Yes❑ No ❑ Not known ❑

Ethnicity

White ❑ Mixed ❑ Asian/Asian British ❑ Black/Black British ❑ Other ❑

Any known developmental impairment / disability at the time of the death/injury

Yes ❑ No ❑ Not known ❑

Any known substance misuse at the time of the death/injury

Yes ❑ No ❑ Not known ❑

Where living at time of the incident (which led to death or resulted in serious injury)

Parental home ❑ Other relatives ❑ Foster carers ❑ Children's home ❑

Mother and baby unit ❑ Hospital ❑ Semi-independence unit ❑ YOI ❑

Friends ❑ Homelessl ❑ Semi-independence unit ❑ YOI ❑

Child the subject of a child protection plan?

At the time of death / injury ❑ Previously ❑ Not at all ❑

Category of child protection plan

Physical injury ❑ Emotional Abuse ❑ Sexual Abuse ❑ Neglect ❑

Sibling(s) subject of a **child protection plan**?

At the time of death / injury ❑ Previously ❑ Not at all ❑

Category of child protection plan

Physical injury ❑ Emotional Abuse ❑ Sexual Abuse ❑ Neglect ❑

Child assessed as a **child in need** under section 17 of the Children Act 1989?

At the time of death / injury ❑ Previously ❑ Not at all ❑

Legal Status

Was the child subject of any statutory order?

At the time of death / injury ❑ Previously ❑ Not at all ❑

Category of most recent statutory order:

Interim Care Order ❑ Care Order ❑

Police Powers of Protection ❑ Emergency Protection Order ❑

Supervision Order ❑ Residence Order ❑

Section 20 (Children Act 1989) ❑ Antisocial behaviour order ❑

Other court order ❑

The Child's Family

	Age or d.o.b.	Gender	Relationship	Occupation	Living in primary household? (circle)
Mother		F	Mother		Y N NK
Father		M	Father		Y N NK
Significant others - adults (e.g. mother's partner, significant carer, please specify)					
1					Y N NK
2					Y N NK
3					Y N NK
Siblings – please complete any information known and include step and half siblings					
1					Y N NK
2					Y N NK
3					Y N NK
4					Y N NK
5					Y N NK

Further family information (circle as appropriate: Y=yes N=no NK=not known

Any known?	Child	Mother	Father	Other adult 1
Disability, including learning disability	Y N NK	Y N NK	Y N NK	Y N NK
Physical health issues	Y N NK	Y N NK	Y N NK	Y N NK
Substance misuse	Y N NK	Y N NK	Y N NK	Y N NK
Alcohol misuse	Y N NK	Y N NK	Y N NK	Y N NK
Criminal conviction	Y N NK	Y N NK	Y N NK	Y N NK

Any known domestic violence in the household? Y ❑ N ❑ Not Known ❑

Ref: DFE-RR226

ISBN: 978-1-78105-123-8

July 2012