

Analysing child deaths and serious injury through abuse and neglect: what can we learn?

A biennial analysis of serious case
reviews 2003-2005

*Marian Brandon, Pippa Belderson,
Catherine Warren, David Howe, Ruth Gardner,
Jane Dodsworth and Jane Black*

Research Report No
DCSF-RR023

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

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ISBN 978 1 84775 096 9

Acknowledgements

The research team wish to thank the Department for Children, Schools and Families steering group members for their expert advice and for generously donating their time to overseeing this study. The group members are:

Isabella Craig; Nigel Gee; Jenny Gray and Rajvinder Heer (Department for Children Schools and Families); Christine Humphrey and Sian Rees (Department of Health); Suzelle Dickson (Home Office); David Monk (Youth Justice Board); Dr Arnon Bentovim (Consultant Child and Adolescent Psychiatrist); Christine Christie (London Child Protection Committee); Emeritus Professor Hedy Cleaver (Royal Holloway, University of London); Kate Hart (Hampshire County Council/ADCS); Professor Jan Horwath (University of Sheffield); Dr David Jones (Consultant Child and Family Psychiatrist, Park Hospital for Children, Oxford) and Wendy Rose (Open University).

Expert advice and feedback was also given to the research team by a group of local experts, to whom the team are also extremely grateful. The group members are;

Dr Caroline Ball (Chair of the Local Safeguarding Children Board, Norfolk); Helen Jackson (Service Development Manager, Norfolk Children's Services); David Lambert (Chair of the Serious Case Review Panel, Norfolk LSCB); Dr Rosalyn Proops (Clinical Lead, Children's Services, Norwich PCT); Dr Daphne Rumball (Consultant Psychiatrist, Substance Misuse, Norwich PCT) and Dr Sue Zeitlin (Consultant Community Paediatrician and Designated Doctor, Norwich PCT).

We are most grateful to Dr Fiona Colquhoun and the NSPCC for allowing us to include their model of suicide prevention. We also wish to thank all those who provided feedback at the regional seminars, including Dr Vic Tuck (Warwickshire LSCB), for giving us sight of his risk assessment model.

A particular thank you is also extended to Sue Bailey (Centre for Research on the Child and Family in the School of Social Work and Psychosocial Sciences, UEA) for statistical and analytical advice.

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Disclaimer

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EXECUTIVE SUMMARY

Serious case reviews are carried out when abuse and neglect are known or suspected factors when a child dies (or is seriously injured or harmed), and there are lessons to be learnt about inter-agency working to protect children (HM Government 2006a). The review should establish what improvements can be made to the way in which professionals and agencies work together to safeguard children and identify how these will be acted upon.

At least every two years, an overview analysis of serious case reviews in England is commissioned to draw out themes and trends, so that lessons learnt from these cases as a whole can inform both policy and practice. This is the third such overview analysis. The 161 reviews studied were notified during the period April 2003 - March 2005.

KEY FINDINGS AND LEARNING POINTS:

- Two thirds of the 161 children died and a third were seriously injured.
- A total of 47% of the children were aged under 1, but 25% were over 11 years, including 9% who were over 16. Many older children were *'hard to help'* and failed by agencies.
- A total of 12% of children were named on the child protection register, and 55% of children were known to children's social care at the time of the incident.
- The families of very young children who were physically assaulted (including those with head injuries) tended to be in contact with universal services or adult services rather than children's social care.
- In families where children suffered long term neglect, children's social care often failed to take account of past history and adopted the *'start again syndrome'*.
- In the cases where the information was available, well over half of the children had been living with domestic violence, or parental mental ill health, or parental substance misuse. These three problems often co-existed.

The findings about the children and their circumstances make powerful and painful reading. Prevention of child death or injury through abuse or neglect is uppermost in the minds of practitioners and managers working with children and families. However, the complexity of family circumstances means that even if the 'whole picture' of family circumstances had been known, it would not always have been possible to predict an outcome for most of the children. Although the majority of these cases may be essentially unpredictable, and working with uncertainty and risk is at the core of work with children and families, in most reviews there were numerous childhood adversities that were not known to practitioners. Awareness of these difficulties and the way in which they had an impact on family life would have aided professionals' understanding of the children's circumstances.

To have a better chance of understanding the risks of harm that children face, practitioners should be encouraged to be curious and to think critically and systematically. Being aware of the way in which separate factors can interact to protect from harm or cause increased risks of harm to the child is a vital step in this process. Since in many of the cases families were known to adult services and not just to children's services, the well being of children and whole families must also be a priority for those working in services for adults.

The reviews identified not only confusion and misunderstanding of thresholds, but also a preoccupation among agencies with eligibility criteria for services rather than a primary concern about the child or children with whom they were working. A key test of the effectiveness of Local Safeguarding Children Boards will be the extent to which they are able to rectify the long standing problems with thresholds.

Attempts to learn from these cases and a determination to prevent or avoid their reoccurrence can lead individuals to misinterpret and misapply information. Although domestic violence, parental mental ill health and substance misuse were common, it is important to stress that, in this study, there are no clear causal relationships between these potentially problematic parental behaviours and child death or serious injury.

In *Working Together to Safeguard Children (2006)* there is a government commitment to serious case reviews being analysed periodically. To optimise the learning from the deaths and serious injury of these children, there is a need for consistently reported minimum information. This will help build a more rigorous knowledge base to provide better pointers to prevention of injury or death where abuse or neglect is a factor.

BACKGROUND

The study offers an analysis, for the first time, of a near total sample of 161 serious case reviews undertaken during the two year period from April 2003 to March 2005. The '*full sample*' of 161 cases includes all of the available incidents of child fatality or serious injury through abuse or neglect, notified to CSCI (Commission for Social Care Inspection), which were the subject of a serious case review. Only basic information recorded at the time the incident was notified to CSCI, was available which means that some of this information is sparse or subsequently proved to be incorrect. The '*intensive sample*' is a sub-sample of 47 reviews drawn from the 161 cases where fuller, more detailed information is available from the serious case reviews' overview reports and chronologies.

The overall aim of the study was to use the learning from serious case reviews to improve multi-agency practice at all levels of intervention including universal services and early intervention. It also aimed to analyse the ecological-transactional factors (which we also refer to as inter-acting risk factors) for children who became the subject of serious case reviews.

The ecological-transactional perspective (Cicchetti and Valentino 2006) requires a dynamic, not a static understanding and assessment of children and their families. It is wholly compatible with the ecological roots of the Assessment Framework (2000).

Carers' experiences of being parented themselves and the history of their own relationships with family, peers, partners and professionals influences their sense of themselves and others. These emotional histories, cognitive models and current life stressors will affect carers' states of mind and the way they understand and interpret the needs and behaviour of their children. A dynamic ecological explanatory view of parent-child interaction should allow practitioners to spot warning signs at an earlier stage, based on less information.

Practice note:

It is what is done with information, rather than its simple accumulation, that leads to more analytic assessments and safer practice.

THE FINDINGS

The children

In two thirds of the reviews the children died and in a third the children were seriously injured. As in other studies of serious case reviews, almost half of the children were under the age of one year. Many of these babies had non fatal injuries (often head injuries).

Practice note:

Staff working with young babies and their families, particularly midwives, health visitors and GPs, have a key role in safeguarding children.

A quarter of the children were aged between one and five years, and a further quarter were over eleven years old, including a significant minority who were aged over sixteen. This shows that older adolescents are being significantly harmed or dying (many committed suicide).

Practice note:

Some older adolescents are beyond the reach of existing services and their vulnerability is not being recognised or taken sufficiently seriously by professionals.

The parents and carers

Using information from the detailed sub-sample of 47 cases, there was evidence of house moves for about one third of parents and carers and a similar proportion were living in poor conditions. Only a small minority had supportive family links. There was evidence of domestic violence in two thirds of families, and mental health problems or substance misuse among well over half of the parents or carers. The coexistence of all three potentially problematic parental behaviours was evident in a third of these families.

Practice note:

The added impact of parental mental ill health, to the known risks of harm to children when domestic violence and parental drug or alcohol misuse coexist, is a potential risk factor which should inform both assessment and intervention.

Which agencies were working with these families?

Although 83% of the families had been previously known to children's social care, little more than half of the children were recorded as receiving services from children's social care at the time of the incident which resulted in the serious case review. A number of cases, however, had been 'closed' by specialist services days or weeks before the incident. As in other studies of serious case reviews, few of the children's names were listed on the child protection register (12%). This is a reminder that children living with the serious risks of harm reflected in these case reviews are rarely within the ambit of formal safeguarding procedures.

Practice note:

All practitioners working with children and in services for adults need to be aware of the risks of significant harm across *all* levels of need and intervention.

All practitioners, and particularly those working with the Common Assessment Framework (2006) and adopting lead professional roles, need a holistic understanding of children and families. They should be alert to the way in which separate factors can interact to cause increased risks of harm to the child. Practitioners identifying additional needs for children should be supported in understanding when it is safe to work with early, low level safeguarding concerns, and when to adopt local safeguarding children procedures without delay.

Practice note:

Working with early needs means working within, not outside of, the safeguarding continuum.

How did families and practitioners work together?

In many cases parents were hostile to helping agencies and workers were often frightened to visit family homes. These circumstances could have a paralysing effect on practitioners, hampering their ability to reflect, make judgments, act clearly, and to follow through with referrals, assessments or plans. Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents made it difficult for professionals to see children or engineered the focus away from allegations of harm, children went unseen and unheard.

When reluctant family engagement was coupled with frequent moves of home, records were often sketchy or inaccurate and practitioners would not be aware of the sequences of events or behaviours which might be indicative of serious risks of harm to the child or children.

How did agencies work together, share information and challenge each other?

As in all other studies of serious case reviews, communication problems among agencies and professionals were common. However, there was some evidence that direct verbal communication provided a more immediate and effective way to share concerns.

There was hesitancy in challenging the opinion of other professionals which appeared to stem from a lack of confidence, knowledge, experience or status. Although there were some good examples of incidents of confident professional challenge, sustained challenge was difficult, and differences of opinion or judgment were rarely pursued to a satisfactory conclusion.

Practice note:

Since there is considerable emphasis currently on electronic information sharing, it is very important to remember the power of personal contact.

Typology of cases

In-depth analysis of the intensive sample of 47 cases revealed an even clustering into the following broad but overlapping themes:

- Neglect
- Physical assault
- ‘Hard to help’ older children (aged over 13 years) who experienced ‘agency neglect’.

Neglect:

Many families where children were severely neglected were well known to children’s social care over many years, often over generations. Family histories were complex, confusing, and often overwhelming for practitioners. One common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present, adopting what we refer to as the ‘**start again syndrome**’. In cases where children had already been removed because of neglect, parental history was not fully analysed to consider their current capacity to care for this child. Instead agencies supported the mother and family to ‘start again’. The ‘start again syndrome’ prevents practitioners and managers having a clear and systematic understanding of a case informed by past history.

Engagement with agencies

Families tended to be ambivalent or hostile towards helping agencies, and staff were often fearful of violent and hostile men. Although parents tended to avoid agencies, agencies also avoided or rebuffed parents by offering a succession of workers, closing the case, losing files or key information, by re-assessing, referring on, or through initiating and then dropping court proceedings. There was systemic failure to engage with the parents’ fundamental problems in parenting and the child’s experience of direct or indirect harm. These problems were exacerbated by the lack of a shared understanding of definitions and thresholds for neglect, leading to confusion and delay of key decisions (see also Gardner forthcoming).

Practice note:

The 'start again syndrome' prevents practitioners thinking and acting systematically in cases of long standing neglect.

Physical assault in young children

Although there were some similarities to the family profiles in the 'neglect' cases the key difference was the presence of 'volatility', which tended to erupt into violence. In addition there was often a history of previous injury, illness or admission to Accident and Emergency for the baby or child. In these cases, there was less contact with children's social care, or involvement for briefer periods of time and greater involvement with services for early needs or universal services in these cases. Domestic violence was present in almost all these families.

Engagement with agencies

The police tended to be the agency most involved with these families, often containing domestic or community conflict or violence. Some parents had mental health difficulties and past, but rarely current, involvement with children's social care. Links with probation and mental health agencies were more frequent than links with children's social care. Many, but not all, families were 'difficult to engage' with many missed appointments. There was sometimes a lack of awareness on the part of health staff and some branches of the police force to the link between domestic violence and the risk of harm to the child.

Practice note:

Family 'volatility' and a history of previous injury or admission to A&E for the child present warning signs of abuse. Moreover, community and hospital based practitioners need a greater awareness of the dangers of domestic violence to children's safety.

'Hard to help' older children

The theme of older adolescent children who were very difficult to help emerged powerfully. Almost all of these 'hard to help' older young people (over the age of 13) had a long history of high level involvement from children's social care and other specialist agencies, including periods of state care. Latterly, agencies had 'neglected' these young people's needs.

Profile

Most children who had experienced extensive contact with agencies shared elements of the following profile:

- A history of rejection and loss and usually severe maltreatment over many years.
- Parents or carers with their own history of abuse and rejection, most of whom misused substances and had mental health difficulties.
- By adolescence most were typically harming themselves, neglecting themselves, and misusing substances.
- It was difficult to contain these young people in school and in placement. There were numerous placement breakdowns featuring running away. Going missing increased the risk of sexual exploitation and risky sexual activity. The causes of running away were not properly addressed.

- Persistent running away sometimes led to discharge home, so that at the time of the incident which prompted the serious case review, the young person may have been receiving low level services only.

This catalogue of risk factors reinforces the view that it is the cumulative interaction between these difficulties that produces the most harmful effects (Rutter 1979). The reviews showed that state care did not always support these young people fully.

Engagement with agencies

Agencies appeared to have run out of helping strategies and were sometimes reluctant to assess these young people as mentally ill and /or with suicidal intent. Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the provision of services that the young people needed. There was a lack of coordination of services for these young people 'in transition' and failures to respond in a sustained way to their extreme distress which occurred in parallel to their very risky behaviour.

Practice note:

'Agency neglect' of these 'hard to reach' young people should be acknowledged. More creative, more responsive services are required that address the young people's trauma and the root causes of their problems. Better join up with adult services is essential.

Chapter 1

Introduction

1.1 THE PROCESS OF BIENNIAL ANALYSIS

Serious case reviews are carried out in England when abuse and neglect are known or suspected factors when a child dies (or is seriously injured or harmed), and there are lessons to be learnt about inter-agency working to protect children (HM Government 2006a). The purpose of the review is to establish what improvements can be made to the way in which professionals and agencies work together to safeguard children and to identify how these will be acted upon.

Recent editions of *Working Together* (HM Government 1999, 2006a) have documented central government's requirement for a two yearly overview analysis of serious case reviews in England to be commissioned to draw out themes and trends so that lessons learnt from the cases as a whole can inform both policy and practice.

The latest edition of *Working Together*, published in 2006, reflected learning from the circumstances of the death of Victoria Climbié which highlighted the continued failings of services for children and illustrated, chillingly, how children can remain invisible, in spite of being known to many separate agencies. Indeed Victoria Climbié's death prompted the widespread re-examination of the systems intended to safeguard children's welfare and culminated in the government's Every Child Matters: Change for Children Programme, backed by the legislative spine of the Children Act 2004. Chapter 8 of *Working Together to Safeguard Children* (HM Government 2006a) included some changes to the process of review for serious child abuse cases, now termed serious case reviews.

A significant change is the shift of responsibility for *monitoring* this process from Area Child Protection Committees to serious case reviews becoming a *function* of Local Safeguarding Children Boards. In conceptual terms there is also a broadening of the use of the term 'safeguarding' rather than 'child protection' which gives more prominence to promoting children's welfare. The criteria for determining when a serious case review should be undertaken are also broader and include the death of a parent through domestic violence, the death of a child by a parent with a mental illness and, among other circumstances, a child's death through suicide. In terms of official notification of the review process, from 1 April 2008, notification is to the Office for Standards in Education (OFSTED) rather than to the Commission for Social Care Inspection (CSCI).

The effectiveness of serious child abuse reviews in altering practice has been debated many times (e.g. Dingwall 1989). In response to the Climbié Inquiry, Parton (2002), amongst others, has commented that it is ill advised to change policy on the basis of the worst cases (child deaths) and that the old adage 'hard cases make bad laws' still applies. It is generally acknowledged that many themes recur repeatedly in reviews and Inquiries and studies of reviews. But even if the learning and change from analyses of these worst cases is likely to be limited, there is a heavy responsibility to try to understand more about the circumstances which might trigger these occurrences

and the factors which influence the behaviour of practitioners who are working with the children and families.

Sinclair and Bullock's biennial analysis of serious case reviews in England, published in 2002, identified recurring failings in elements of inter-agency working, in collecting and interpreting information, in decision making and in aspects of relations with families. The findings from Sinclair and Bullock confirm that '*child abuse is rarely related to a single cause but rather to the interplay of several factors in particular circumstances*' (Sinclair and Bullock 2002 p26). The three domain approach of the *Framework for the Assessment of Children in Need and their Families* (DH et al 2000) provides a good structure for making sense of these interrelated factors, but early evaluations have suggested it is not always used to full analytical effect (Horwath 2002, Cleaver and Walker 2004a). A key objective of the current analysis is to consider how interacting risk factors present themselves in this new cohort of cases.

This biennial review considers those serious child abuse cases (serious case reviews) which were notified to either the Commission for Social Care Inspection (CSCI) or the then Department for Education and Skills (DfES) between the two year period of 1 April 2003 to 31 March 2005. The study was carried out over twelve months (June 06 to May 07) by a team based in the School of Social Work and Psychosocial Sciences at the University of East Anglia, working in conjunction with the National Society for the Prevention of Cruelty to Children (NSPCC). The large research team included academics, researchers and practitioners, some of whom had recent or current experience of working in health and social care and with Area Child Protection Committees and Local Safeguarding Children Boards. The team was chosen, in some respects, to model the different knowledge base and perspectives of multi-agency groupings working with children and families.

A central aim of the study was to learn from the analysis of interacting risk factors present in the cases under review and to transfer this learning to both everyday practice and to the process of serious case reviews. It was hoped that the learning from this analysis would help to change the way that practitioners, clinicians and decision makers think about and approach the work with children and their families at different levels of intervention. In order to assist with this, a central steering group was established at the (then) Department of Education and Skills comprising policy makers, researchers, academics and practitioners who acted as a sounding board for work in progress. A local consultation group of expert practitioners with expertise in paediatrics, mental health, substance misuse and operational facets of Local Safeguarding Children Boards also provided useful feedback in earlier stages of the study. Regional seminars were also conducted by the (then) Department for Education and Skills in February and March of 2007 to disseminate early findings from this analysis (and from the study being conducted by Wendy Rose and Julie Barnes of serious case reviews from 2001-3). The regional seminars also presented early work from the national evaluation of the child death review teams by Dr Peter Sidebotham and colleagues. Comments from seminar participants and presenters have helped to shape this report and to keep it focused on practice.

1.2 AIMS AND OBJECTIVES OF THE STUDY

The overall aim of this biennial review is to use the learning from serious case reviews to improve multi-agency practice at all levels of intervention. This can be considered on three different levels. Firstly, at the level of universal services and early identification of needs, this includes a better understanding of risks of harm and thresholds for early intervention; secondly at the later stages of intervention the hope is to improve joint practice in safeguarding children. Finally where joint practice has to be examined (when serious case reviews take place) the aim is that lessons are implemented more effectively, learning where possible from good practice.

The study offers an examination of the total sample of available serious case reviews undertaken during the specified two year period between 2003 and 2005, and further scrutinises a sub sample of these reviews. The two samples are explained below:

- ***The ‘full sample’***: 161 cases for which minimal, notification information was available (Commission for Social Care Inspection database of notification of Critical Child Care Incidents [2005]).
- ***The ‘intensive sample’***: a sub-sample of 47 cases, drawn from the full sample, for whom fuller, more detailed information was available (overview reports and chronologies).

The objectives set at the outset of the study are outlined below:

- i. To provide descriptive statistics from the agreed full sample (i.e. 161 cases), illustrated by some examples from the reviews. This is reported in Chapter 3.
- ii. To scrutinise a sub sample of cases (i.e. 47) to chart thresholds of multi-agency intervention at the levels specified in *Every Child Matters* (Cm 5860 2003). These findings and a discussion of other themes which emerged are offered in Chapter 5.
- iii. Building on the learning from the first two objectives, to seek a meaningful analysis by identifying some ecological-transactional factors within the sub-sample of reviews. This model of understanding is explained in Chapter 4 of the report.
- iv. To provide practice tools for use by Local Safeguarding Children Boards and practitioners and to identify any lessons for policy and practice, including examples of good practice. Implications for safer practice are discussed in Chapter 6 and practice tools are discussed in Appendix 4-7.

1.3 LEARNING FROM THE DATA COLLECTION PROCESS

A mixed methods approach was used to collect the data and carry out the study. Primarily quantitative methods were used to describe and chart the background characteristics of the children, their families and multi-agency practice in all 161 case reviews studied (the full sample). Qualitative methods, drawing on fuller information from the reviews and the stories of the cases, were used to identify and analyse themes

which emerged from the intensive sample of 47 cases. More details about the data collection process and the methodology for the study are outlined in Appendix 1.

In order to manage and make sense of the relatively large number of reviews in the study, a 'layered reading' approach was adopted. This involved building information about both the full sample of 161 cases and the intensive sample of 47 cases from layers of initially minimal, and later more detailed information as it became available. The story of each child's death or serious injury makes very powerful reading. As a result one feature or theme can take on a disproportionate significance. While it was important to acknowledge the individual differences of each child or young person, it was also essential to consider each case objectively as part of a larger whole of 161 or 47 reviews. The layered reading approach allowed the children and their circumstances to be studied respectfully, but systematically. Initially, minimal notification, information from each review was studied as a constituent part of the 161 cases rather than allowing particular reviews to dominate the thinking and the learning. The later stages of the study allowed individual cases and individual children's circumstances to be studied in more depth. This approach also helped the research team not to be overwhelmed, emotionally, by the material at the outset of the study.

Moving from the individual children's circumstances, a number of learning points emerged about the serious case review process and about researching serious case reviews.

The early data collection phase of the study (outlined in full in Appendix 1) attempted to gather information about the full cohort of reviews for the two year period under scrutiny and this study presents findings from the first near full cohort of reviews for England. Some cases may have been missed however, and inaccuracies and inconsistencies were apparent in some of the reporting, recording and data storage of reviews. Similar points were also raised by Sinclair and Bullock (2002), Reder and Duncan (1999) and Rose and Barnes (2008) who were unable to report on full sets of these serious child abuse cases. Previous similar studies have examined up to approximately 50 cases per cohort only and this is the first analysis of a large number of reviews reported over a two year period.

The opportunity to analyse data obtained at the point of notification of a near full cohort of English serious case reviews presents new challenges in identifying patterns and trends. To make sense of patterns and themes emerging it is helpful to make comparisons with other, similar studies of death and serious injury or harm through abuse and Chapter 2 charts some comparisons with earlier studies. Opportunities also present themselves to compare data from this study with findings from research into larger populations for example of 'near miss' child protection cases (Bostock et al 2005) or with the growing body of knowledge about unexpected child deaths. This latter category will include, in time, findings from the child death review teams being established in line with guidance in Chapter 7 of *Working Together* (HM Government 2006a). Although child deaths through abuse are a sub-set of all of unexpected child deaths, it needs to be remembered that serious case reviews also include many children who do not die but are seriously injured and harmed (one third of the cases in this study). It is important that research as well as practice in these two separate but interlinking elements remain connected, even though the learning from serious case

reviews cannot be joined up straightforwardly with that from the unexpected child death data.

1.4 THE PROCESS OF SERIOUS CASE REVIEWS

Learning from executive summaries

Chapter 8 of *Working Together* (HM Government 2006a) highlights the following about executive summaries:

- They will be made public.
- They should include, as a minimum, information about the review process, key issues arising from the case and the recommendations which have been made.
- The publication of the executive summary will need to be timed in accordance with the conclusion of any related court proceedings.
- The content needs to be suitably anonymised in order to protect the confidentiality of relevant family members and others (para 8.33 p179).

The data collection process for the study revealed that there were two problems that compromised the national learning that could come from the reviews' executive summaries. The first related to the extent to which they are available publicly or to the practitioner community, and the second to the way in which the bulk of them were written, focusing narrowly on recommendations.

Seventeen executive summaries from the 161 reviews were available on LSCB/ACPC websites making them fully accessible, but the availability of others was more restricted. There are clearly problems of confidentiality for Local Safeguarding Children Boards, both for the family concerned and staff involved, in making these reports available to the public, but since some areas are able to overcome this difficulty the problem may not be insurmountable. If executive summaries were more readily available, as intended, these could add pertinent information for the dissemination of learning. Easier access to summaries from other regions would also help LSCBs to look at the extent and type of serious case reviews in their own area. A number of difficulties have transpired to limit the availability of these summaries, for example the Pan London agreement not to make them public. The sensitivity of these cases and the ensuing media interest is undoubtedly a barrier but this also becomes a barrier to learning which is limited to local geographical area only.

In terms of the way in which these summaries were written, a key issue is that they need to provide enough background information about the case and the dynamics of the abuse for the reader to be able to interpret the recommendations and understand the lessons learned. If summaries are very bland or focus exclusively on recommendations and procedures, the learning will be very limited. There is also a wide variation in the way executive summaries are written; in the length, structure and detail included. Greater consistency in the format and structure of these summaries could be helpful.

Reder and Duncan sum up the problem that arises in the reliance on bland summaries or the focus on recommendations.

Since the majority of local agencies and Area Child Protection Committees have tended to concentrate their attention on the final list of recommendations, the reductionist style made it less likely that the required behaviour would be implemented successfully. (Reder and Duncan 2004a p98)

Proposed structure for executive summaries

If the following items were included in executive summaries, a greater depth of learning could potentially be achieved:

- Anonymised name or initials of the child, and age at the time of the incident;
- The serious case review process - brief outline of the purpose and scope of the review and terms of reference;
- Reasons for conducting the review and what SCR criteria were met (or if the criteria were not met the reason for conducting the review);
- Brief case summary to include details of incident, kind of maltreatment, who was believed to be responsible for the abuse;
- Family background (including anonymised details of members of the household in which the child was living, or otherwise relevant persons with ages if possible). Potentially identifying details need to be restricted to the overview report;
- Context of agencies involved and resourcing (e.g. staff absences, vacancies etc);
- Key recommendations indicating the resource implications (time/human resources, services) or action plan;
- Key themes and lessons learnt.

Family involvement in serious case reviews

Sinclair and Bullock made the criticism that families were excluded from the serious case review process (Sinclair and Bullock 2002). Efforts have been made to redress this and the new edition of *Working Together* (HM Government 2006a) requires agencies to consider not just whether, but how family members should be involved in serious case reviews. In the reviews studied here (from 2003-5) it was apparent that families were sometimes involved. In 21 of the 47 cases studied (almost half) some mention was made of *the consideration* of family involvement. In the remainder no reference was made to this at all. In a small number of cases the review panel appeared to give tentative thought to involving family members:

The Panel did not establish any intention to involve family members in the review - a matter which remained under consideration.

Family members' participation was not always actively encouraged, for example the onus could be left with the parents to contact a named person connected with the serious case review if they wished to contribute to the review. In some cases family members were invited to participate and they chose not to do so. In some instances

their choice to decline was thought to be detrimental to the final report '*there are areas where clarification from them could have assisted.*'

In nine of the 47 cases studied in depth, however, families were involved in the serious case review process. Family members were usually visited in their own homes, often with a supportive person present, by the Chair of the review or the overview report writer, or by an independent social worker or child protection coordinator, who subsequently presented their views to the review panel. Family members who were listed as taking part included the child's parents, a parent's partner, grandparents, and siblings. In a small number of cases the child (him or herself) also contributed to the review, being visited similarly by the Chair of the review, usually with a supportive family member or other supporter present. Advice was sometimes offered (for example by a Children's Guardian) that it would not be in the child's best interests to be interviewed for the purposes of the review by an unknown person. However, in these circumstances the child's views could be presented, for example through the involvement of a social worker who was already undertaking direct work with the child.

In some instances the child or family member met initially with the Chair of the review and was then visited for a follow up meeting by an independent social worker:

The Chair of the Review Panel visited the child's parents who both expressed a desire to take part in the review. An independent social worker visited the mother and obtained her views which were expressed in a report. The mother saw and agreed to the contents of this report. The father was visited by a different independent social worker. A written report of this meeting was seen and agreed to by him.

Where parents who were part of criminal proceedings contributed to the review this could lead to the review timescale being extended so that it did not conflict with the prosecution: '*it would not be ethical to invite parents to contribute to the review before their trial as evidence may be contaminated, they would be under caution*'. In some other cases when criminal prosecutions were ongoing this was seen to preclude parental involvement, although grandparents or other family members were sometimes invited to participate.

From the limited information available it appeared that family members were asked to contribute to the review for the purposes of checking the accuracy of information and history and to ask their views about services provided. These contributions were usually valued and seen to have a worthwhile place in the review. There was limited evidence of a less useful contribution where family members were asked to absolve professionals of blame by confirming that they could not have known about the extent of, for example, domestic violence or substance misuse in the family:

[The parents acknowledged] that their heavy drug use was persistent and that they were not open about this with professionals.

Summary of learning about the serious case review process

A number of points have emerged from the study which could be used to provide both a better base line of information for biennial reviews of these cases and a better overview of the quality of the serious case review process.

- If serious case reviews are to be analysed every two years, there is a need for consistently reported minimum information to provide a better understanding of the total cohort. This could be provided through continuing the improvements in the recording of the original notification (now to OFSTED) of a critical incident which might lead to a serious case review. This information could be matched to the child death data and to other information on serious harm and injury.
- Improving the quality, accessibility and comparability of reviews, or parts of reviews (for example executive summaries) would encourage shared local and national learning.

This study has not considered the format of serious case reviews in any depth but some feedback from the (then) Department for Education and Skills Regional seminars held in February and March 07 suggested a desire to consider ways of streamlining the process by reducing the volume of paperwork, but increasing the learning locally.

Chapter 2

Literature review

2.1 INTRODUCTION

This brief review provides a summary of selected literature and research in three areas which link directly to the study:

- 1) Thresholds of intervention in child welfare practice
- 2) Serious case reviews
- 3) Interacting factors linked to risks of harm

These themes were pursued to inform the research process and to provide a literature and research base to elaborate the aims of the study.

The parameters of the review were as follows: in relation to thresholds, literature since 1991 was considered to include studies examining the working of the Children Act 1989 in England and Wales, the key legislation which informs the safeguarding of children, although emphasis was given to more recent studies. For serious case reviews, an overview of the literature since 2000 was undertaken, as Sinclair and Bullock's 2002 study had provided a review of earlier literature. Literature and research pertinent to the theme of interacting risk factors was examined, for the most part, since 2000 as a means of limiting this potentially expansive area.

Empirical studies and peer reviewed articles were prioritised over commentaries, books, chapters and reports. A broad overview is provided rather than a systematic analysis. The literature was identified using electronic databases and by hand searching electronic and paper journals and following up key references.

2.2 PROFESSIONAL PRACTICE -THRESHOLDS

Introduction to thresholds

The debate concerning levels of intervention and thresholds into and between services has been part of the long standing drive to encourage prevention within child welfare services. Within the Children Act 1989 this included the promotion, development and delivery of more effective services for a broader group of children and families (Parker in Frost 1997, Hardiker et al 1991). Hardiker's work (1991) helped to disseminate the idea, already apparent within health services, of a tiered model of services. Hardiker's model of prevention, using four levels, was later appended to the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al, 2000). It was adapted into a 'pyramid' of levels of need in *Every Child Matters* (Cm 5860 2003) and as a 'windscreen' continuum of services in the guidance for the Common Assessment Framework (HM Government 2006b). Mesie, Gardner and Radford adapt Hardiker's description of the four separate levels in their work on Public Service Agreements in Safeguarding Children as follows:

- Primary Prevention - taking universal action to promote conditions so that problems do not arise and families are strengthened
- Secondary Prevention - focusing on individuals or families who are vulnerable, but may not yet have problems, or with early difficulties where the risks of breakdown are low;
- Tertiary prevention - targeting individuals or families who have more entrenched problems to minimise their adverse effects; and
- Quaternary prevention - optimising the prospects for children where family problems have resulted in their placement in public care
(Mesie et al 2007 p20)

The impact of thresholds

The Children Act 1989 introduced new criteria for children's social care involvement in the lives of children and their families in both a voluntary and a compulsory basis. A continuum of involvement and intervention from the more voluntary 'children in need' to the more coercive 'children in need of protection' was presented in early and later studies into the workings of the Children Act 1989 as thresholds into and through services (Department of Health 1995, 2001). The bulk of these studies found that access to services were often limited to children deemed to be in need of protection and high thresholds were limiting or preventing services reaching families where problems were at the early stages (Department of Health 1995, 2001).

Later studies uncovered similar findings. The first Joint Chief Inspectors' Report into the work of 8 Area Child Protection Committees in England in 2002 '*Safeguarding Children*' (Joint Chief Inspectors 2002) found that pressures on resources in children's social care had led to a tightening of the threshold for services for children where there were concerns about their welfare. Many referring agencies considered that children's social care were not providing an adequate response to safeguarding children. The follow up report in 2005 (Joint Chief Inspectors 2005) reiterated concerns about thresholds, '*there remain significant issues about how thresholds are applied by social services in their child protection and family support work*' (p7). The 2005 study also found that agencies other than children's social care were often unclear about how to recognise the signs of abuse or neglect and about how to refer on concerns about a child.

Recent policy changes and the impact on thresholds

Policy changes in recent years are likely to have an impact on thresholds. In September 2003 the government published a detailed response to Lord Laming's Report on the Victoria Climbié Inquiry (Cm 5730, 2003) alongside the Green Paper '*Every Child Matters*' (Cm 5860, 2003) which proposed an overhaul of children's services in England supported by new legislation, the Children Act 2004. Laming's view was that children are best protected by preventative and supportive services in the community that are sensitised to safeguarding children. This is exemplified by the practice guidance '*What To Do If You're Worried A Child Is Being Abused*' (HM Government 2006c) which is aimed at 'everyone' working with children and families. Thus the widespread changes represented another shift towards prevention. Other changes which will have an impact on thresholds include the appointment of a

Director of Children's Services, presiding over education and children's social care in each local authority, pooled budgets within new children's trusts arrangements, the replacement of Area Child Protection Committees with Local Safeguarding Children Boards (LSCB) and the introduction of the Common Assessment Framework (CAF) and Lead Professional (LP) Working.

Working Together (HM Government 2006a) sets out the new LSCB functions which include specifying:

the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention (p50) clear thresholds and processes and a common understanding of them across local partners may help to reduce the number of inappropriate referrals and to improve the effectiveness of joint work, leading to a more efficient use of resources (p51).

Thresholds in early intervention and working with additional needs

Common Assessment Framework (CAF) and Lead Professional (LP) working provide a framework for early intervention so that agencies can become involved with children who are considered to have 'additional needs.' This avoids the problem of waiting for problems to worsen to meet the higher thresholds for specialist services like children's social care. The CAF is intended to shift thresholds downwards and move the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place (HM Government 2006b). The LP role is intended to avoid duplication so that more services can be offered at a lower level. *Working Together* 2006 states that the CAF, where it is undertaken, can provide the structure for a written referral to children's social care and that, where a common assessment has been completed on a child, this information will be used to inform the initial assessment led by children's social care.

Brandon et al's study (2006a; 2006b) of the early stages of CAF/LP working found examples in practice of thresholds of intervention going both up and down. Thresholds went up when other agencies experienced that under these new working practices children's social care were pitching their intervention at an even higher level and not working with the lower levels of children in need (i.e. s17 of the Children Act 1989) at all. Thresholds were also perceived to be going up when work previously undertaken by children's social care staff was being carried out by personnel from universal services as part of the early intervention strategy to prevent problems becoming entrenched. Thresholds into children's social care were found to go down, however, where clearer referrals (via CAF) were presented, making it easier for children's social care to justify taking on work which would previously have been rebuffed. As this evaluation was undertaken in the early stages of implementation, it will take some time before the impact of these new working practices on thresholds and levels of intervention becomes apparent.

The thresholds in complex needs, including the involvement of children's social care

One of the objectives of the Quality Protects Programme launched in 1998 was *'To ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response'* (Department of Health 1999 p20 in Rose, Gray and McAuley 2006 p26). New assessment guidance was issued in 2000 launching the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000) as statutory guidance for social workers and colleagues in other agencies to use with all children in need, including those deemed 'at risk of harm' under s47 of the Children Act 1989. More discussion of assessment is to be found in Chapter 4 which considers an ecological-transactional perspective.

Corby et al's (2002) small scale study of parental perspectives of the Assessment Framework in one local authority found that parents viewed the assessment process positively and felt they did receive a speedier response than before the implementation of the Assessment Framework. The study found that when assessments were carried out with skill and sensitivity, some parents changed their attitudes towards social workers and towards their own strengths and difficulties as carers. Cleaver and Walker's (2004b) much larger scale study evaluated the use of the Assessment Framework in 24 English local authorities and found that there was an improvement in the quality of assessments and in interagency collaboration over assessments. However analysis, judgement and decision making were causing problems for practitioners who lacked confidence in these areas. The National Children's Bureau are in the process of producing work in this area entitled 'Putting Analysis into Assessment' (see Dalzell and Sawyer 2007).

These evaluations focused on attitudes towards the assessment process rather than an evaluation of the impact of the Assessment Framework on particular children and families in meeting their needs. Calder (2003) expresses concern that the resources have not been provided to implement this way of working. Reder and Duncan (2004b), in examining the Victoria Climbié Inquiry Report, suggest that improvements to assessments will come about when practitioners adopt an assessment mindset when responding to referrals and emphasise the need to regularly review their opinions as they gain new information. Cooper et al (2003) go a step further and recommend considerable changes to the child welfare system which would negate the need for thresholds altogether. These changes include relocating social workers to multidisciplinary teams based in accessible places for families, such as schools, health centres and community organisations. They suggest this will change families' perception of social workers and allow practitioners to reach out to the community and *'increase the possibilities for trust, authority and negotiation.'* (p90).

The threshold to child protection and children looked after, or compulsorily detained

A study of children whose names are on the child protection register in 8 local authorities (Commission for Social Care Inspection 2006) examined the threshold criteria applied by both adult and children's services and found that professionals considered that high thresholds created tensions between agencies and prevented help

getting to parents when they need it. As in earlier studies from the 1990s (Department of Health 2001), adherence to high thresholds was found to lead to services being withdrawn too quickly, for example when a child's name is no longer on the child protection register. Thresholds were also thought by professionals to have an impact on the nature of assessments, with the emphasis placed on risks of harm rather than needs. Most parents interviewed felt that the assessment of their own needs was inadequate, that services came too late and were not always relevant.

Spratt's study (2000; 2001) of how 200 child protection referrals in Northern Ireland were acted upon considered whether it might be possible to treat more initial referrals as 'child-care problem enquiries' as opposed to 'child protection investigations'. He states that responding to referrals only as an 'investigative response' resulted in '*families being traumatized and children's needs left unmet*' (p597), as cases were closed once risks had been checked and calculated, with no ongoing work. This echoed the findings of Gibbons et al's study of nearly 2,000 referrals in 1995.

Corby (2003) studied social work decisions made on 400 child protection/children in need cases and noted concern about how a move to assessment first, and then to safeguarding measures after this, could lead to some children not being adequately safeguarded. This study revealed that practitioners were struggling to combine safeguarding children with the promotion of their welfare as required by both the Assessment Framework and the Children Act 1989. This theme is considered further by Cleaver and Walker's (2004b) study of early implementation of the Assessment Framework. They discovered an absence of in depth assessment for up to a quarter of the most needy cases studied and suggested that this reflected an organisation-led approach to decision making dictated by the availability of resources rather than the needs of the children.

Child protection thresholds in emotional abuse and neglect

Identifying and working successfully with emotional harm and neglect are known to pose problems. Operational difficulty may result from the way in which emotional abuse and neglect are described, which for the purpose of considering child protection registration, are by their most acute manifestations (in both the 1999 and the 2006 editions of *Working Together*):

emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development and severe neglect is associated with major impairment of health and development (Department of Health et al 1999; HM Government 2006a).

Because these descriptions do not include early signs and symptoms, there may be tendencies both to delay recognition and /or to over-identify behaviour as abusive in order to reach a threshold to attract services. Thoburn and colleague's large-scale study of emotional harm and neglect found evidence to support this hypothesis (Thoburn et al 2000). Nearly a quarter (23%) of 337 referrals to children's social care included concerns about emotional abuse and neglect. On examination this was found to mask an over estimate of the extent of neglectful or emotionally abusive parental behaviour but was an underestimate of the proportion of children whose emotional development was being or was likely to be impaired if services were not provided.

Platt's study also echoes this concern about the identification of emotional harm and neglect, finding that investigations were more likely to be initiated where there was an observable event or injury to respond to, and that referrals indicating neglect were less likely to be pursued (Platt 2006). Buckley also concluded that these cases were most likely to be closed without any services being offered and recommended an approach to assessment that focused more on children's welfare than parental culpability (Buckley 2000).

Because of these areas of concern, the Department of Health /Department for Children Schools and Families Research Programme 'Safeguarding Children' is focusing on both emotional abuse and neglect and in particular 'effective interventions.'

Relevance of thresholds to the current study

This study is being carried out in the midst of the bedding in of wholesale changes to the system of children's services in England including the establishment of Local Safeguarding Children Boards. It is important that learning from the reviews is pertinent to the work of these Boards and helps them to be confident in their work, not just with serious case reviews but with the whole spectrum of safeguarding and promoting welfare from early intervention thresholds to emergency protection. It is crucial that the children's workforce is helped to be more confident in recognising and responding both to early needs and to signs of maltreatment as early as possible.

A central aim of the Government's Change for Children Programme is that children needing help at all levels, from early intervention to safeguarding their welfare, are not overlooked. We know from studies of serious child abuse that most children who die from abuse or are seriously injured are not child protection cases but children known to have additional needs (Reder and Duncan 1999, Sinclair and Bullock 2002, Brandon et al 2002). As Lord Laming said '*child protection cases do not always come labelled as such*' (para 17.106 Cm 5730 2003). Increasingly, lead professionals and common assessment framework workers will work alongside these children and their families. The national evaluation of CAF/LP work however (Brandon et al 2006a), found that there is not always a good join up between services for early intervention and safeguarding, so that children's need for protection may continue to go unnoticed. This evaluation also found that practitioners welcomed clear structures and processes and explanations of 'levels of intervention'. For this reason understanding and communicating thresholds along the safeguarding continuum from early signs of maltreatment to later indications of significant harm is a key strand of this project.

In this study an intensive sub-sample of 47 cases was examined to chart thresholds for action and intervention as follows:

1. A threshold for recognition (i.e. when might abuse or neglect have first been a concern).
2. A threshold for early intervention in partnership with parents.
3. A threshold for safeguarding actions.

4. A threshold for compulsory safeguarding actions (e.g. court actions) or voluntary placement/arrangements (i.e. s20 Children Act 1989) or safe placement of a child away from the parent or carer.

This is reported in Chapter 5 and in Appendices 4 and 6. The threshold mapping activity draws on learning from developmental studies of interacting risk factors to interrogate each case. The cases and threshold patterns were then examined and grouped against common themes in the cases and key features in the child, the parents/carers and the community/environment of the family.

2.3 SERIOUS CASE REVIEWS

Learning from serious case reviews

After more than thirty years of debate about the purposes of reviews into serious child abuse cases, many of the same mistakes are still occurring. Munro (2005b) suggests, like Bostock et al (2005) and Brandon et al (1999a; 2002), that serious case reviews need to focus less on who is to blame and whether procedures have been followed and more on wider factors which could explain why these incidents are continuing to occur after decades of new procedures and policies. Stanley and Manthorpe (2004) point out that inquiries have led to defensive practice, a higher number of child protection referrals, greater emphasis on audit in practice, and the recruitment of fewer social workers.

A major recurring theme emerging from serious case reviews is communication. As well as a reluctance to share information, failings in this area have included a lack of clarity of information, problems in interpreting information and the lack of clear agreements between workers. As Reder and Duncan (2003 p82) point out:

Since the 1970s, virtually all reviews of fatal child abuse cases in the UK report that there was evidence of communication failures between professionals (Reder et al 1993, Falkov 1996, Brandon et al 1999, Dale et al 2002, Sinclair and Bullock 2002, Lord Laming 2003).

The government has sought to address this by planning better IT solutions, such as the information sharing system, ContactPoint, which can be used by all agencies. Stanley (2003) and Munro (2005a) criticise this as a solution to the problem of inter-professional communication, and both state that technology is only a tool, not an answer in itself. Munro (2005a) argues further that it is not sharing the information that is the problem for practitioners, but assessing the information. The Integrated Children's System, about children in need, is intended to help not only with the collection, but also with the collation and analysis of key information.

Reder and Duncan (2003) and Brandon et al (2002) also make this point adding that assessment is not merely about collecting information but attributing meaning to the information. Assessments tend not to be holistic (Cleaver and Walker 2004a), but to focus on single domains of the assessment triangle rather than an understanding of all three areas (Horwath 2002, Munro 2005a). Practitioners also tend not to move on from an initial, often optimistic, judgement despite new information emerging (Munro

1999, Munro 2004b, Munro 2005a, Brandon et al 2002). Further difficulties highlighted in inquiry reports have included ineffective decision making, lack of inter-agency working and poor recording of information (Sinclair and Bullock 2002).

Many studies allude to the influence of wider factors. These include the impact of managerialism and the audit culture on present day social work (Reder and Duncan 2004b, Parton 2004), the complexities of current social work (Parton 2004), the use of coping mechanisms by practitioners in this immensely difficult area of work such as avoiding the truth of the situation, and over-identifying with a parent (Reder and Duncan 2004b, Rustin 2005, Cooper 2005), the practitioners' working environment, including workload, resources, the working atmosphere, the provision of supervision, and confidence in one's ability as a worker (Reder and Duncan 2004b, Rushton and Nathan 1996, Munro 2005a).

Suggestions for improvement include providing practitioners with tools to conduct better assessments (which includes their communication with other professionals and with children and parents, and also the need to consider the history of a case). Improvements could also be achieved if practitioners were helped to analyse information gathered in an assessment, and were able to change their view, and to scrutinise both their own and others' practice (Reder and Duncan 2004b, Horwath 2002, Munro 1999, 2004b, 2005a, White and Featherstone 2005). Recommendations have also been made that practitioners be given tools to undertake risk assessments. Tools for this are very common in the US but less popular in the UK. Hughes and Rycus' review article summarises findings on the US risk assessment literature and concludes that many risk assessment protocols and tools in use do not improve either the consistency or the accuracy of protective decisions for maltreated children (Hughes and Rycus 2007). Assessment tools are clearly not a substitute for sound professional judgement.

A number of practice tools do exist which aim to help with the analysis element of assessment and professional judgement, for example NCB's '*Putting Analysis into Assessment*' (Dalzell and Sawyer 2007) and Core Assessment Toolboxes (Cleaver and Walker 2004b). A model of assessment intended to analyse interacting risk factors was devised and introduced in Warwickshire (Tuck 2004) and is being adopted elsewhere in England. It should also be noted that Chapter 4 in the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000) considers analysis, judgements and decision making and refers to questionnaires and scales which are intended to help practitioners by providing evidence on which to make these judgements.

There is some concern that used in isolation, tools could minimise scope for individual professional judgement (Munro 2004a) and that other resources are needed such as supervision (Brandon et al 2005) and professional skill (Munro 2004a). Jones and colleagues have similarly queried the validity of actuarial approaches, and drawn attention to the limitations and imprecision of the evidence base for decision making (Jones et al 2006 p281). They also endorse the need to exercise careful and systematic professional judgement.

A recent study of serious case reviews undertaken between 1998 and 2001 was carried out by Sinclair and Bullock and published in 2002 (Sinclair and Bullock 2002). Their

overview focused on learning from the profile of the children who died or were seriously injured. They also aimed to identify what helps and what hinders the serious case review process in the 1999 edition of *Working Together*, to ascertain whether the revised serious case review process had led to any changes in policy or practice at a local level and to identify from the reviews any lessons for policy and practice at a national level. Their recommendations for future study of serious case reviews included the need for better identification of children vulnerable to abuse, improved understanding of the process of change in public services and the development of practice tools.

The biennial review of serious case reviews from England from 2001-3 is being undertaken by Rose and Barnes and is due to report at the same time as this study.

Recent changes to serious case reviews

The Children Act 2004 and its accompanying Regulations placed serious case reviews on a statutory footing. With the demise of Area Child Protection Committees, serious case reviews became a function of the Local Safeguarding Children Boards (LSCBs) which were to be in place by 1 April 2006. Some other changes required in *Working Together 2006* were to be implemented by 1 April 2008. These included the introduction of a new process to review the deaths of all children and a

rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child' and 'an overview of all child deaths in the LSCB area undertaken by a panel (HM Government 2006a p128).

This means that LSCBs will review information on all deaths, including unexpected deaths of *all* children in the local authority area, not just those in contact with organisations responsible for safeguarding their welfare. LSCBs will be required to draw conclusions on what can be learned to prevent or avoid the deaths of all children in the future.

This change is welcomed by Bunting and Reid (2005) who commented on the multidisciplinary child death review teams (CDRTs) in America, and were mindful of the proposals recommended in *Every Child Matters* (Cm 5860, 2003) for such a system in England. They found that benefits in America from CDRTs included improved multi-agency working and communication, more effective identification of suspicious cases, a decrease in inadequate death certification and a broader and more in-depth understanding of the causes of child deaths through systematic collection and analysis of data. They add that this can promote preventative, rather than reactive, work;

The findings and risk factors identified during the review process have enabled the team to propose and implement a wide variety of prevention initiatives such as reducing the risk of sudden infant death syndrome (SIDS) and suffocation deaths as well as preventing deaths by suicide, drowning and abuse and neglect. (Bunting and Reid 2005 p89)

A similar example can be found in Schnitzer and Ewigman's (2005) study of the deaths of all children under five years of age in Missouri, US between 1992 and 1999. A sub sample of 149 inflicted-injury deaths by a parent or caregiver were identified during the eight year period. It was found that children residing in households with unrelated adults were nearly 50 times more likely to die of inflicted injuries than children living with two biological parents. Children in households with a single parent and no other adults in residence had no increased risk of inflicted-injury death. The majority of known perpetrators were male and most were the child's father (34.9%) or the boyfriend of the child's mother (24.2%). Seventy three per cent of the injuries were inflicted by shaking or striking the child.

Schnitzer and Ewigman claim that the study has important implications for educational strategies to prevent fatalities caused by inflicted injuries and for child care policy. They point out that educational campaigns regarding shaken babies are wrongly aimed mostly at mothers, rather than fathers. The introduction of Child Death Review Panels in England could similarly contribute to understanding the risk factors in child fatality, and add to learning about interacting risk factors.

Suggested changes to serious case reviews

It has been disputed that learning from deaths and serious injuries is the best way to inform practice (Powell 2003). Bostock et al's (2005) study of 'near miss' cases in 8 local authorities in England and Wales proposed an alternative to serious case reviews. 'Near misses' are defined as incidents in child care cases where something which could have gone wrong was prevented, or as something which did go wrong but no serious harm was caused. Such incidents were found to be frequent, and were described by practitioners as 'part and parcel of the job'. They could provide an opportunity to identify weaknesses within safeguarding systems before children are harmed. In health professions, staff are obliged to report such 'near miss' incidents, and learn from latent failures within the organisations rather than focusing purely on active failures by the staff members.

This way of learning, based on 'root cause analysis,' involves the analysis of a child death considering not who made the mistakes but why. It takes human error as the starting point, not the conclusion, of the investigation and is relevant to cases of serious injury or harm as well as child death. Bostock and colleagues recommended that LSCBs should include 'safeguarding incidents' (near misses) alongside unexpected child deaths and serious injuries and also that children's services should introduce reporting systems for such incidents, using root cause analysis to understand why these incidents happened. However, since root cause analysis is incident driven it is not a good methodology for considering cases of neglect or most cases of sexual abuse. The introduction of 'Child Death Overview Panels' (CDOP) could, in principle, provide an opportunity to apply root cause analysis (RCA) techniques to unexpected child death on a larger scale.

Corby's criticism of the lack of external scrutiny in the serious case review process has been addressed by the requirement in the new edition of *Working Together*, for the overview report to be commissioned from a person independent of the agencies /professionals involved (HM Government 2006a p174, Corby 2003). Corby is of the

opinion that the findings of reviews should be more accessible and recommends a permanent body to carry out inquiries, preferably at a regional level.

Links with the current study

Themes emerging from the current cohort of 161 cases will be contrasted with findings from previous studies of serious case reviews. Data has been collected from the 161 cases using themes drawn primarily from Sinclair and Bullock's 2002 study, although additional factors prompted by this literature review, for example from the ALSPAC study (Sidebotham et al 2003) (e.g. low birthweight, parental attitude to child, overcrowding etc) have also been added.

Sinclair and Bullock suggest that there is limited value in looking at common factors alone. They recommend that studies of serious case reviews need to look at improving processes for managing risk of harm, improving identification of children vulnerable to abuse and developing practice tools.

Comparisons are made in this study of the way in which executive summaries are written. From this comparison, it may be possible to determine what might be the most useful information to record in these summaries.

2.4 INTERACTING RISK AND PROTECTIVE FACTORS

Working Together (HM Government 2006a) highlights the importance of considering how a combination of different factors can impact on the risk of significant harm to a child; 'often it is the interaction between a number of factors which serve to increase the likelihood or level of significant harm' (p156).

Little, Axford and Morpeth (2003) stress the need for more research in this area since: 'social and health research is littered with examples of single variables that correlate with childhood development problems' (p6). They quote Rutter's (1979) view that it is rare for a single risk factor to be identified in relation to a single deficiency state:

More commonly risk factors interact to produce a particular outcome at a specified stage in a child's development. To complicate matters further, the same combination of risks can often produce different deficiency states in different children...the same risks may produce different manifestations at successive stages of the child's development and in different contexts (Rutter, 1989 p6).

Hindley et al's recent systematic review examines the most significant individual risk factors for the *recurrence* of maltreatment. These were the number of previous episodes of maltreatment, neglect as opposed to other types of maltreatment; parental conflict and parental mental health problems. Those factors with some suggestion of further maltreatment were parental substance misuse; 'family stress'; a lack of social support; families with younger children; parental history of abuse; and already being in contact with child protection services (Hindley et al 2006 p751). This review is not a useful measure of risk factors in the general population, but provides valuable findings about cases where child maltreatment or neglect has already occurred.

The UK Avon longitudinal study (ALSPAC) also considered interacting risk factors for 115 out of their cohort of 14,138 children who were named on local child protection registers prior to their 6th birthday. Risk factors were reported in relation to the interacting characteristics of the child, the parents and socio-economic environment (Sidebotham et al 2003, 2001 and 2002). For the child, the key markers for poor health and developmental problems in infancy and subsequent maltreatment were low birthweight and unintended pregnancies (Sidebotham et al 2003). They also found that mothers of children listed on the child protection register were less likely to report positive attributes in their four week old infant. The authors concluded that:

while child factors are significant, they are only a small part of the overall complex set of circumstances and conditions that ultimately lead to abuse or neglect. Parental attitudes towards the child may be more significant than the actual characteristics of the child (p337).

Maternal background factors linked to the risk of child maltreatment were: age under 20, lower educational achievement, history of sexual abuse, use of child guidance or adolescent psychiatric services, absence of her father during childhood, and a previous history of psychiatric illness (Sidebotham et al 2001). Significant factors in the fathers' backgrounds were: age under 20, lower educational achievement, having been in care during childhood and a history of psychiatric illness. The commonly replicated findings from this study which link to an understanding of child maltreatment are parental age, educational achievement and a history of psychiatric illness. Unlike other research, the ALSPAC study did not find that a parental history of childhood abuse emerged as a strong predictor of subsequent maltreatment: 'the only indicator of previous abuse found to be significant, after controlling for other variables, was a maternal history of sexual abuse' (Sidebotham et al 2001 p1191). This study is significant in its inclusion of fathers, although response rates were still generally low and more needs to be known about the role of fathers in child maltreatment.

Sidebotham et al (2002) suggest that psychodynamic models are inadequate to explain child maltreatment, claiming that wider models incorporating other ecological domains within the socio-economic environment are needed:

Social deprivation is an important determinant of child maltreatment, and encompasses a number of different aspects, including financial security, housing situation and material benefits; in addition, the job situation of the parents and the stability and richness of their social networks all have a significant impact on risk of maltreatment. (Sidebotham et al 2002 p1243).

The US longitudinal Minnesota Study followed 180 children born into poverty over three decades. Factors found to protect parents from repeating cycles of abuse were emotional support from an alternative, non-abusive adult during childhood, a therapy experience of at least 6 months duration, and an emotionally supportive and satisfying relationship with a male as an adult. The study also found that:

for some mothers, such difficulties understanding their infants and their own feelings, in combination with stressful, unsupportive living situations, a history of abuse in their own childhoods and personality characteristics of hostility and suspiciousness, all converged to predict abusive care. (Sroufe et al 2005).

This lack of understanding of the ‘psychological complexity’ of the infant was a major predictor of poor-quality parenting in this study.

A US qualitative exploratory study (Ryan et al 2005) brought together 22 child protection researchers and professionals to identify items that they believed should be included in a child welfare risk assessment. Most factors concerned parents, with only one, behavioural issues, which linked specifically to the child. The factors they drew up were: a history of child protection referrals, domestic violence, history of significant trauma in the family, financial strain or unemployment, absence of social supports, parental psychological diagnosis, substance abuse, terminal illness, acceptance of role as parent, marital/partner discord, quality of caregiver interactions, single parent household and multiple caregivers in and out of the home. This study did not really reveal any significantly new areas, apart from terminal illness and did not intend to identify those factors which, when interacting, cause greater concern.

Earlier analyses of serious child abuse reviews have also identified findings in relation to interacting risk factors. The 1993 and 1999 studies by Reder and Duncan argued for better assessments of the relationship between accumulating risks and for the need for assessments to be theoretically informed by an inter-actional framework. Sinclair and Bullock also noted that the three domain approach of the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 1999) should enable a more dynamic, less static account to be taken of the interaction between the characteristics of the child, the attributes of family members and situational factors such as poverty (2002 p26). These themes are explored further in Chapter 4 in the more detailed examination of the 47 cases in our argument for an ecological transactional perspective. This builds on the ecological approach initiated by Bronfenbrenner (1979) and elaborated by Cicchetti and Valentino (2006), Sroufe (2005 et al) among many others.

Interacting risk factors and neglect

A high number of serious case reviews include elements of neglect. An approach to understanding neglect is to consider the interacting risk factors in the parent-child relationship. Glaser argues that emotional abuse and neglect describe a relationship between the parent and the child (rather than the event or series of repeated events occurring within the parent-child relationship), and that the interactions of concern pervade or characterise the relationship and often result in impairment of the child’s emotional and psychological development (2002 pp697-714). Glaser lists parental attributions in this context which include: emotional unavailability and unresponsiveness, negative attributions and misattributions to the child, developmentally inappropriate or inconsistent interactions with the child and failure to promote the child’s social adaptation. Lyons-Ruth et al (1999) also recognise that ‘out-of-control’ parents who switch unpredictably between hostile (abusive) and helpless (neglectful) care-giving pose a particularly serious developmental risk for their children.

The background context of a child’s experience is essential to a dynamic understanding of risks and protective factors. Without this professionals can be distracted from maintaining a focus on the child’s welfare. For instance Kantor and

Little (2003) point out that domestic violence may or may not include elements of neglect ('failure to protect'), or indeed, of emotional harm. Certain aspects of poverty appear to prolong neglect (Slack et al 2004). Emotional harm has been linked to a number of parental behaviours including domestic violence, adult mental ill-health and substance misuse including alcoholism (Chaffin 1996, cited in Tomison and Tucci 1997; Glaser 2002). The advantage of this approach is that the family's resources as well as its challenges are reviewed and appropriate support can be identified.

Protective parenting factors

Some disadvantaged families facing multiple adversities manage to break the cycle of disadvantage. Their ability to adapt to challenges and to succeed in spite of difficulties and stresses earns them the label 'resilient' (Morris et al [forthcoming] in Cabinet Office 2007). In relation to breaking a cycle of abuse, the US Minnesota Study found that protective factors for children included emotional support from an alternative, non-abusive adult during childhood, a therapy experience of at least 6 months duration, and an emotionally supportive and satisfying relationship with a male as an adult (Sroufe et al 2005).

An ecological understanding of parenting (Quinton 2004) reminds us that parenting capacity does not operate in a vacuum but in communal, socio-economic and domestic contexts (Jones 2001 p257). Rutter (2000) and Jones (2001) both emphasise the essentially unknown and variable relationship between positive factors and deficits in consideration of parenting and of children's resilience. Successful parenting however, tends to be associated with a combination of a warm, affectionate bond of attachment between child and parents combined with authoritative parenting. This type of parenting tends to be high in both control and warmth and involves setting clear boundaries at the same time as being aware of children's needs (Maccoby and Martin 1983 in Cabinet Office 2007 p13). The *Families at Risk Review* sums up the benefits of a protective family life:

Good parenting and strong family relationships can help to build social and emotional skills which are themselves protective factors. They allow children to create their own friendships and support networks and to develop greater resilience in coping with negative situations. (Cabinet Office 2007 p14)

Links with the current study

The closer examination of the 47 cases mentioned above enables a more detailed examination and analysis of interacting risk and protective factors in children who become the subject of serious case reviews. This analysis helps to identify the constellations of factors which all practitioners need to be aware of when working with children and their families. Because of the nature of these reviews there may be scant evidence of protective factors.

Chapter 3

Findings and descriptive statistics

3.1 INTRODUCTION

This chapter considers the characteristics of children and families who are the subjects of serious case reviews. It also examines what is known about intervention from agencies. The results presented relate to:

- *The ‘full sample’*: the 161 cases for whom only minimal information was available (from CSCI child protection database including notification of Critical Child Care Incidents, [CSCI 2005] and some executive summaries).
- *The ‘intensive sample’*: a sub-sample of 47 cases, drawn from the full sample, about whom fuller, more detailed information was available (from overview reports, chronologies, and sometimes other information, from the serious case reviews).

Further information on sources of data used is contained in the Methodology section, in Appendix 1. Appendix 1 also explains the way in which the statistics are analysed and presented and the high degree of comparability between the full and the intensive sample.

In the tables that follow, the full and intensive samples are presented together. Since the information sources for the full sample were often minimal and there were many missing values, the intensive sample could be said to be a better reflection of what is known about the cases and the family profiles. Seeing the two samples side by side provides an indication of what can be learnt from minimal data sets and also highlights where gaps in the information exist. Previous studies of English serious case reviews have not analysed child protection database notifications (CSCI 2005) (our key source of information for the sample of 161 cases) in the belief that they were too limited to be of use. This study examines whether they do yield important information. We have gone a step beyond previous analyses to discern which data in the minimal dataset are robust and which are less reliable. We explain as the data are presented whether the information appears to be consistently and reliably reported or whether there are gaps and flaws in the recording in the minimal information sources. Notes of caution in the interpretation of the statistical findings are given overleaf.

Statistical findings are illustrated by researcher notes about individual children and their families, some of which have been changed to preserve the child and family’s anonymity. These notes were derived from the scrutiny of the minimal information sources.

Some degree of caution is required in the interpretation of these results, for reasons discussed below:

1. Generalisation

These results are not necessarily representative of all serious occurrences of child injury or death. The sample includes only those cases where local Area Child Protection Committees deemed it was appropriate and/or necessary to hold a serious case review. This is a decision which may vary between regions for a number of reasons.

2. Accuracy

Information sources for the full sample of 161 were minimal since they rely on what was known by the local authority at the point of notification. For this reason information was limited, and sometimes inaccurate or confusing. Although robust attempts were made to verify the information, at times these ambiguities introduced an element of researcher subjectivity when coding the material. With this in mind, the following chapter attempts to highlight carefully which data can be more confidently interpreted.

3. Under-reporting

The gaps in the information for the reasons stated above mean there is the potential for under-reporting of certain child and family characteristics and other relevant factors. Absence of information does not indicate a lack of any particular feature, simply that it is not recorded.

This is also true for all of the cases studied, including the intensive sample of 47 cases.

3.2 CHARACTERISTICS OF THE CHILDREN

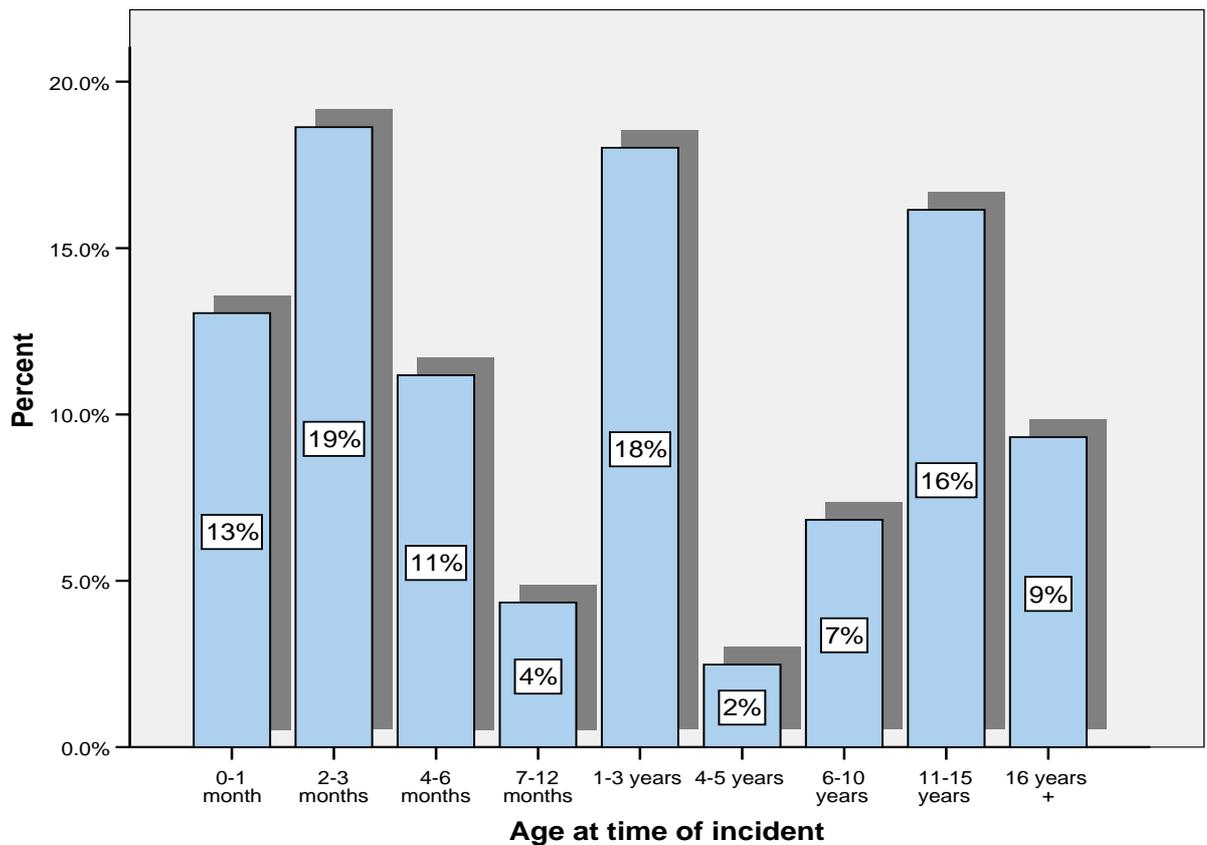
Age

Data for age are presented in Figures 1 and 2. In keeping with previous serious case review studies (Reder and Duncan 1999; Sinclair and Bullock 2002; and Brandon et al 2002) we found that almost half of the children in this study (76) were less than a year old. All but seven of these infants were under six months of age and the very young age of some children is underlined, with 21 being less than four weeks old:

A six week old baby was admitted into hospital with injuries consistent with shaking. It was discovered that he also had week old fractures and bruises. The baby's father spent a considerable amount of his childhood in care. The baby, his mother, and sibling were not known to Social Services.

Almost half of the children in the sample were under one year of age. This has important implications for all staff working with young babies and their families (primarily midwives and health visitors).

Figure 1: Age at time of incident

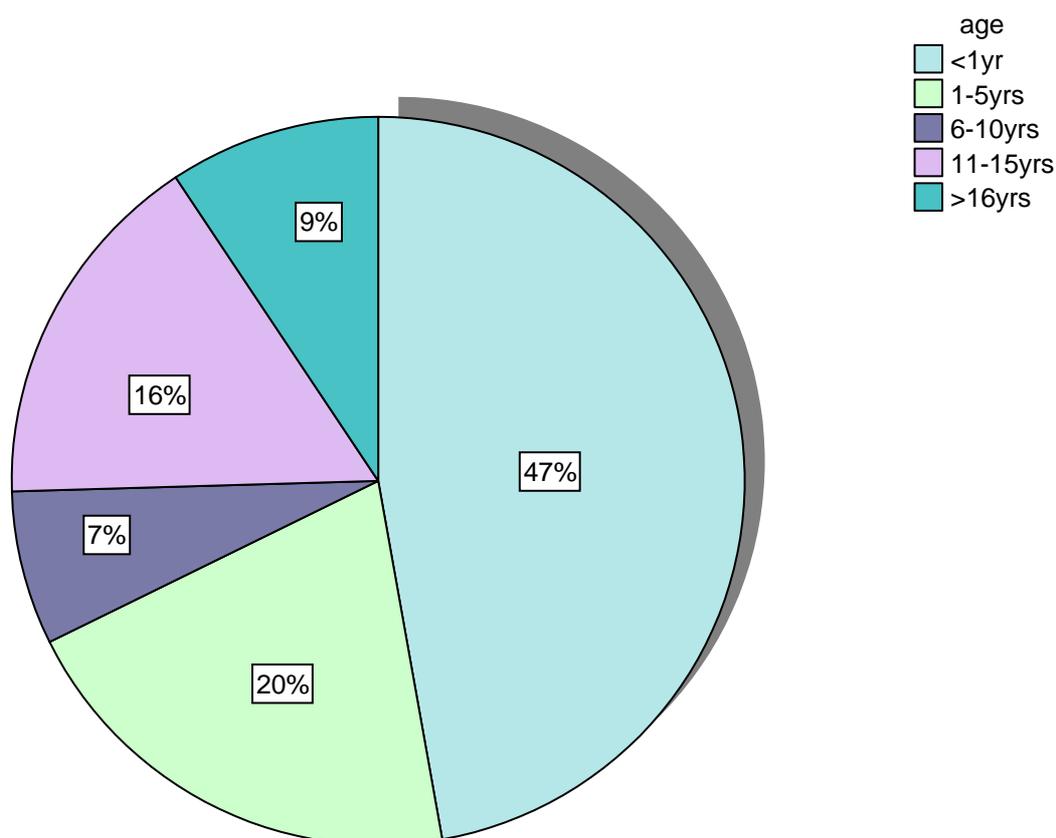


A further 33 children clustered between the ages of one and five years, while a smaller grouping of 11 children were between six and ten years of age:

An 8 year old child had extensive injuries over his body and face. The child and family were known to children’s social care and proceedings were ongoing in relation to a sibling but not this child. There was known domestic violence in the family.

A quarter of the children (41) were aged over eleven. Although this sample contained a similar proportion of children in the 11-15 age band to those in the Sinclair and Bullock study, unlike any other comparable studies, our sample included a number of much older teenagers over the age of sixteen. The Rose and Barnes study, due to report in 2008, revealed that their sample of 40 cases also included a small number of older teenagers.

Figure 2: Age categories



The appearance of older adolescents in serious case reviews shows that much older children are also dying or being harmed through maltreatment or neglect, and it reflects the increase in Area Child Protection Committees' willingness to notify and learn from these cases. As such it represents a greater acknowledgement among safeguarding organisations (ACPCs and potentially LSCBs) that older children may be beyond the reach of existing services or that their vulnerability is not recognised or taken sufficiently seriously by the multi-agency groupings:

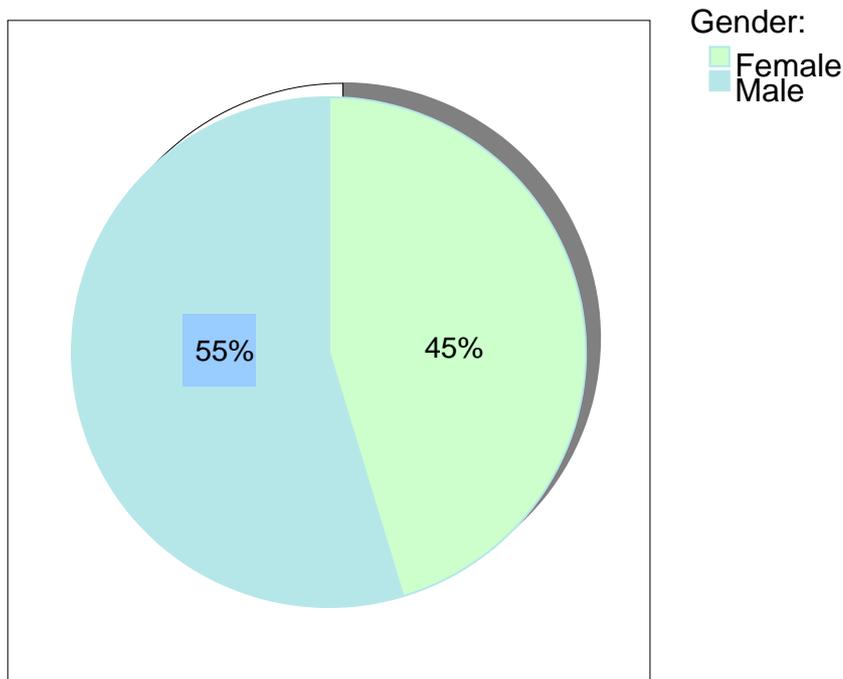
A young person who was the subject of bullying both at school and outside of school committed suicide. The parents had brought concerns about their son to the attention of several agencies but the risks were not taken seriously enough and there was no indication of working together, sharing information or implementing any plan of action.

Reviews also raised the issue of young people between the ages of 16 and 18 years who fall between child and adult services.

Gender

Figure 3 shows that there were slightly more boys than girls in the full sample (88 boys, 73 girls) but this difference was less pronounced than in Sinclair and Bullock's 2002 study. Our intensive sample comprised 20 boys (43%) and 27 girls (53%).

Figure 3: Gender of child



Ethnicity

Almost three quarters of the children were white/white British (74%), while 13% were black/black British, 5% Asian/Asian British, 6% of mixed ethnicity and 1% were 'other' ethnicities. Figure 4 shows the different ethnicities represented. There was much fuller information about ethnicity than has been recorded in other equivalent studies, although this was still far from a complete picture. The 'Notification of Serious Child Care Incident Form' which informed the database report, includes ethnicity and ethnic group as categories to be completed, and in 136 of the 161 cases this information was provided. It was not however possible to tell, with accuracy, how many children were born in the UK as this information was rarely provided and needed to be surmised from other details known. Nor, for the same reasons, was it clear for how many families English was not their first language. Thus although there was full information about ethnicity this was still lacking in any depth, and nothing was noted about each family's religion or culture.

Figure 4: Ethnicity of child

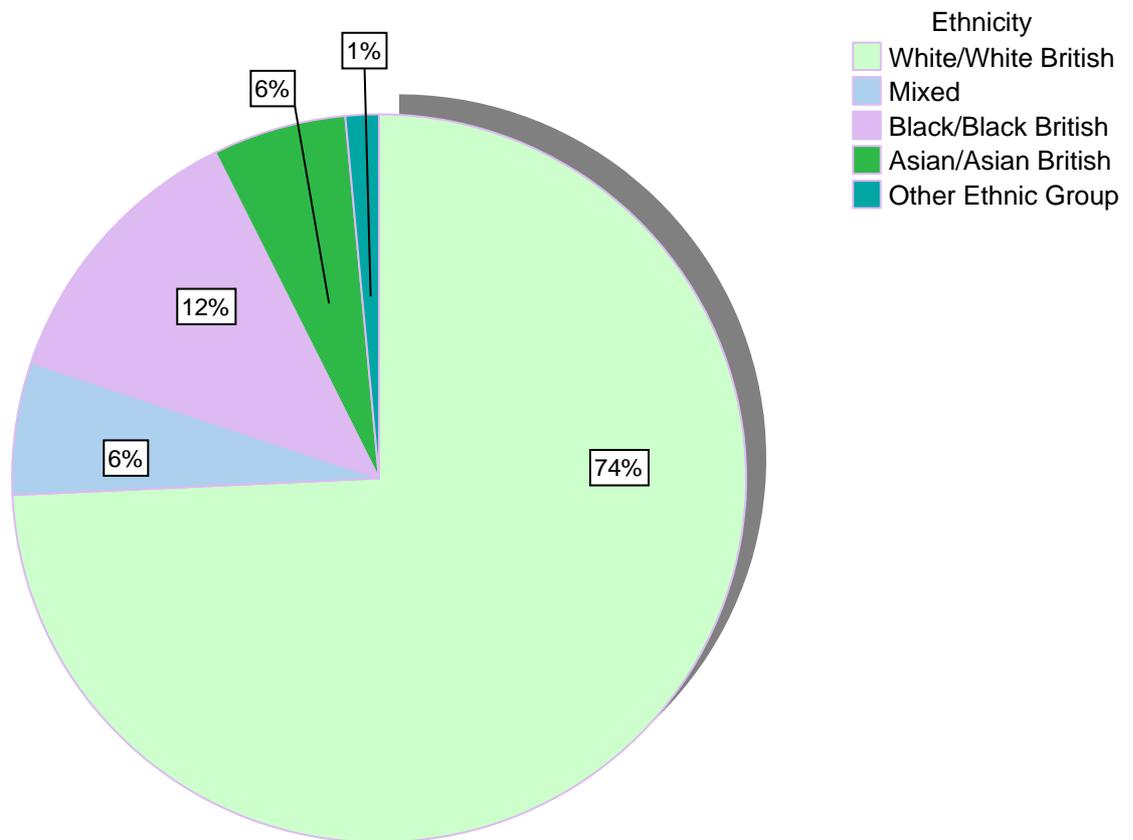


Table 1 details the ethnic breakdown of both the full sample and the intensive sample alongside comparable UK figures. Whilst the intensive sample has a higher proportion of both white and Asian or Asian British children, and a lower proportion of Black or Black British children, than the full sample, these differences are not statistically significant. For comparison, Table 1 additionally shows the ethnic distribution of all under-16s in the UK in 2001 (ONS 2001/2002) and the ethnic distribution of all ‘children in need’, given for a sample week in February 2003 (Department for Education and Skills 2004).

White children are somewhat under-represented in our full sample, compared to the proportion of all ‘children in need’ in the UK who are white; and this latter proportion is similarly a lower figure than the proportion of all under-16s who are white. Conversely, our full sample has a higher proportion of Black and Black British children than does the population of ‘children in need’, or the total population of under-16s.

Table 1: Ethnicity of child: comparative data

Ethnicity	Full sample n=136	Intensive sample n=39	All children in need (2003)	Under 16s in UK population (2001)
White/White British	101 (74%)	31 (80%)	80%	88%
Mixed	8 (6%)	3 (8%)	6%	3%
Black/Black British	17 (13%)	2 (5%)	7%	3%
Asian/Asian British	8 (6%)	3 (8%)	4%	6%
Other Ethnic Group	2 (1%)		3%	1%

It should be borne in mind that the ethnic breakdown of the cases in the full sample does not necessarily mirror the ethnic breakdown of all children who are seriously abused or neglected, but is a reflection of those cases for which it was deemed appropriate and/or necessary to hold a serious case review. For example, it was apparent that some areas were carrying out serious case reviews to learn more about complex issues associated with families newly arrived in the UK. One case, for example, was said not to have strictly met the serious case review criteria but the local Area Child Protection Committee decided that raising the case to review status would provide important learning in relation to children arriving through immigration with unofficial status. Similar concerns were raised in another review.

Where the child was living

The data displayed in Table 2 show that, at the time of the incident which prompted the review, almost half of the children were (73) living at home, apparently with both parents. This was a similar proportion to that found in the 2002 Sinclair and Bullock study. A total of 32 children appeared to be living with a lone mother and 21 with a mother and step parent. In this sample there was no indication that the father was the sole carer, although some children were staying with or visiting their father when they died or were injured. Eleven children lived with relatives other than parents and a smaller number lived in large extended households including both parents and other relatives. Some children were in foster or residential care - more information about children living under these and other regulatory arrangements is provided in Chapter 5.

The information about where the child was living at the time of the incident is not robust since the minimal data set examined does not collect information in all of the categories listed in the table below. The information presented here was amassed from various sections of the database notifications.

Table 2: Living circumstances at the time of incident

Living circumstances	Full sample (n=157)	Intensive sample (n=47)
With two natural parents	73 (47%)	20 (43%)
With one natural and one step-parent	21 (13%)	7 (15%)
With a lone parent - mother	32 (20%)	8 (17%)
With relatives	11 (7%)	4 (9%)
With foster carers	<6	1 (2%)
Children's residential facility	6 (4%)	3 (6%)
With parents and other relatives	<6	2 (4%)
Other	6 (4%)	2 (4%)

Information recorded on the number of siblings in the full sample was generally more robust because this was specifically requested in the notification form (see Table 3). However, it was not made clear whether the child was living with siblings, or whether siblings were full, half or step siblings. If we surmise family size from the available information, it seems that most children in the sample broadly reflected current patterns in UK society with three quarters coming from small or relatively small families. Forty one (27%) were only (or first) children, 50, (33%) had one sibling and 28 children (18%) came from families with three children. Table 3 reveals however, that a substantial minority of 33 children (22%) lived in large or very large families with four or more children. This is higher than the national average where only ten per cent of children live in a family of four or more children (Bradshaw et al 2006). The multiple stresses and adversities associated with parenting large families have been well documented (Bradshaw et al 2006) and poverty is the most prominent adversity faced. Since family stress is also known to be linked with multiple births and the additional caring responsibilities they bring, we checked the extent to which multiple births featured in this sample and discovered that a very small number (less than 6) of young children in the sample of 161 were a twin.

Table 3: Number of siblings

Number of siblings	Full sample (n=152)	Intensive sample (n=47)
0	41 (27%)	7 (15%)
1	50 (33%)	15 (32%)
2	28 (18%)	9 (19%)
3	13 (9%)	7 (15%)
4	7 (5%)	4 (9%)
5	7 (5%)	2 (4%)
>6	6 (4%)	3 (6%)

Other characteristics of the children

Aside from disability, detailed information on the notification form about the characteristics of the individual children was often unobtainable. Therefore the results displayed in Table 5 relate only to the intensive sub-sample of 47 cases. It also needs to be borne in mind that factors like disability or emotional and behavioural problems

might not yet have emerged for the many very young children and babies in this sample. Disability was recorded in 8 (5%) cases whereas in Sinclair and Bullock's 2002 study, only one child was known to have a physical disability. Chronic illness and complex health needs were listed for smaller numbers of children. The impact of these conditions was often grave and was arguably exacerbated by neglectful care. There are examples where parents failed to take their child to repeated medical appointments, with consequent delayed treatment.

One case concerned a three year old child with complex health needs and disabilities who was born premature, and had spent most of her life in hospital. The parents could not look after their child safely and she was readmitted to hospital after a short period at home. Once returned to hospital the child recovered from a potentially life threatening problem attributable to poor care. A further example involved a much older adolescent with disabilities who spent most of his life with relatives where he experienced long standing neglect.

These cases and the minimal information sources from which they are drawn, give little indication of family circumstances, nor the interaction between the child and caregiver which may help to understand why the care of these children was neglected or why their parents or carers acted in ways that caused them significant harm.

Table 4: Disability

	Full sample (n=161)	Intensive sample (n=47)
Disability	8 (5%)	4 (9%)

Table 5: Child's characteristics: intensive sample (n=47)

Child's characteristics*	1-3 years (n=28)	4 years + (n=19)
Complex health needs	2 (7%)	2 (11%)
Chronic illness	3 (11%)	2 (11%)
SCBU/Neonatal Unit	8 (29%)	1 (5%)
Previous hospital admissions	11 (39%)	6 (32%)
Emotional or behavioural problems	n/a	16 (84%)
Involved in juvenile crime	n/a	6 (32%)
Mental health difficulties	n/a	9 (47%)
Substance misuse issues	n/a	9 (47%)
Non/poor school attendance	n/a	13 (68%)
School exclusion	n/a	8 (42%)
Involved in sexual exploitation	n/a	5 (26%)
Receiving special educational support	n/a	4 (21%)
Other significant child characteristics	4 (14%)	1 (5%)

*Two or more factors may be present in any one case.

A number of the children in the intensive sample had difficult beginnings to their life, with 19% recorded as having spent time in a Special Care Baby Unit. Some of the difficulties in these circumstances are illustrated by the following case example:

The child was born prematurely and discharged home from the Special Care Baby Unit (SCBU). The baby's mother had difficulties with literacy and possibly English was her second language. The health visitor was concerned about lack of support arrangements - the child was discharged from SCBU with no GP or address.

A high proportion of the 19 older, school aged children (i.e. aged four or over) are recorded as having a number of difficulties which would have had an impact at home, at school and in the community. The majority of these children (84%) were reported as having emotional or behavioural problems and 68% had poor school attendance. A small number of children were recorded as receiving special educational support and eight (42%) were currently, or had been excluded from school. Six young people were recorded as being involved in juvenile crime and nine had mental health difficulties. Nine children were reported to have problems with substance misuse and nine were also involved in sexual exploitation. Many children were living with a combination of these difficulties as illustrated by the case example below:

The young person was known to agencies for a considerable period of time for seriously violent behaviour including several assaults (alleged) on different children younger than her. She spent just over a year on the child protection register under categories of neglect and emotional abuse. Her mother ...has a chronic alcohol problem. She was out of school for 2 years and has convictions for common assault and for criminal damage. She was missing at the time of the report.

The young woman was repeatedly absenting herself from residential care. A pattern was identified, showing that she ran away with friends....and met with young males. Concern surrounded sexual exploitation, abduction, false imprisonment, administration of alcohol and drugs.

3.3 THE INCIDENTS/CAUSE OF THE SERIOUS CASE REVIEW

In this sample of serious case reviews, two-thirds (106) of the children died and a third (55) were seriously injured as a result of the incident, or circumstances, which prompted the review (see Table 6). The two earlier biennial reviews both revealed a higher proportion of deaths than the current study where more children survived (Sinclair and Bullock 2002; Rose and Barnes 2008). This perhaps suggests that over time, safeguarding bodies may be selecting more cases of serious injury to review and may be less likely to restrict their learning to the cases where children have died. It also shows that the full serious case review sample should not be used solely as a child homicide measure.

Table 6: Incident type

	Full sample (n=161)	Intensive sample (n=47)
Death	106 (66%)	35 (75%)
Serious injury	55 (34%)	12 (26%)

A small number of serious case reviews were carried out separately on both the child who was injured or killed and the child who carried out the assault, addressing the learning in relation to both children.

A breakdown of incident type by age group is contained in Table 7. Once again, when interpreting these results it should be borne in mind that they represent cases selected for serious case review rather than occurrences of serious injury or death among children *per se*. Examination of this table shows that the proportion of reviews where the child died was highest among the 1-5 year (with 79% of reviews reporting a death) and 16+ age groups (with 93% relating to a death). In comparison, deaths accounted for 58% of reviews for babies under 1 year of age, 55% of reviews for 6-10 year olds, and 62% of reviews for 11-15 year old children.

Variations in the frequency of type of incident reported for different age groups appear to underlie these patterns. It is not possible to display detailed figures for these results when broken down by age group and incident type, as the numbers involved are often small (i.e. less than six). However, some of the more striking patterns are outlined below.

The comparatively low proportion of deaths for babies under one year of age is partially explained by the inclusion of a number of cases of head injuries in babies (usually referred to as ‘shaken baby syndrome’) resulting in serious injury. In total, 17 (68%) of the 25 incidents of head injuries to babies resulted in injury rather than death. Furthermore, a higher proportion of other non-fatal serious injuries (physical assault) were reported for babies than for older children. In total, 14 of the 26 (54%) incidents of physical assault for babies resulted in death, as compared to 11 of the 15 physical assaults (79%) reported for those aged 1-5 years. Reviews relating to house fires and accidents resulting in fatality also contributed to the higher proportion of deaths reported for the 1-5 year age group.

Fewer physical assaults tended to be reported for the older age groups, with 14 in total for all children aged six years and over. The kind of incident reported in reviews for children aged between 6-15 years also included non fatal sexual abuse and being missing from home, which contributed to the lower proportion of deaths in this age bracket. Nearly all of the reviews for those over 16 years of age were undertaken where a young person had died, most notably as a result of suicide.

Table 7: Incident type by age group

Age group	Full sample (n=161)		Intensive sample (n=47)	
	Death	Serious injury	Death	Serious injury
<1yr	44 (58%)	32 (42%)	16 (73%)	6 (27%)
1-5yrs	26 (79%)	7 (21%)	5 (83%)	1 (17%)
6-10yrs	6 (55%)	<6	4 (100%)	-
11-15yrs	16 (62%)	10 (39%)	6 (60%)	4 (40%)
16+yrs	14 (93%)	<6	4 (80%)	1 (20%)

Table 8: Type of injury/harm

Type of injury/harm	Full sample (n=161)	Intensive sample (n=47)
Head injury (Shaken Baby Syndrome)	25 (16%)	8 (17%)
Sudden Infant Death	<6	1 (2%)
Overlying	6 (4%)	3 (6%)
Physical assault	57 (35%)	14 (30%)
Neglect (including house fires, accidents and illness)	33 (21%)	10 (21%)
Poisoning/overdose	7 (4%)	1 (2%)
Suicide	14 (9%)	4 (9%)
Sexual abuse	6 (4%)	2 (4%)
Gone missing	6 (4%)	4 (9%)
Other	<6	-

Further details relating to the type of injury or harm are displayed in Table 8. Note that these figures refer to the *primary* cause of the incident, which often featured a combination of contributory factors. In many cases the cause of death or harm was uncertain:

Cause of death is still unknown. Post mortem identified historic and recent rib fractures. Inconclusive evidence that the child had been shaken. No concerns about care of other children and minimal previous involvement of children's social care.

In one case there was a suspicion of abuse because a half-sibling had been admitted to hospital some years previously with similar facial injuries. In another case where neglect was suspected the coroner later concluded that the baby had died as a result of an accident. In addition to the accidents were the six 'overlying' cases most of which involved parents falling asleep with the baby after drinking alcohol and waking to discover that the baby had suffocated. The information available to us showed that at least 65 cases featured aspects of neglect (which may not have been the primary cause of the incident).

The following is a typical example of the compound problems in neglect cases:

The child died following the inhalation of smoke from a small house fire. The child had been known to several agencies over time. Issues of drug misuse and neglect were indicated. Poor living conditions.

The fourteen cases of suicide mostly involved older adolescents. One young person's suicide note indicated he was being bullied at school and in the community. There was also a history of sexual abuse of this child by a relative many years ago.

In over half of the cases there was recorded evidence of some prior concerns or a history of abuse and neglect. For the remaining cases it appeared that the incident was a singular event which came without prior history or warning (again, as far as could be ascertained from limited information). It should be noted that the findings presented in Table 9 involved researcher judgement on the over-riding nature of the incident, based on the available information.

Table 9: Nature of incident

Nature of incident	Full sample (n=148)	Intensive sample (n=47)
Singular event	58 (39%)	10 (21%)
Following history of abuse	17 (12%)	6 (13%)
Following history of neglect	20 (14%)	9 (19%)
Previous concerns, including history of self harm	53 (36%)	22 (47%)

Most of the children appeared to be the sole victim of the incident or circumstances which led to the review (121 cases) but in 18 cases siblings were also harmed. In a small number of cases children and a parent were victims together, for example where a father killed the children and their mother, or killed the child and himself:

Police early indications are that father fatally stabbed his wife before leaving with the child. He committed suicide with the child.

These family killings prompt considerable media attention and it will be important to know whether there is an increase in their occurrence over time, as well as learning from dynamics within the individual cases.

Table 10 lists those alleged to be responsible for the incidents. In some cases, individuals admitted responsibility for the child's death or injury but in others it is less clear how the decision about responsibility was determined. In the instances where this information was available, only 59% of those alleged to be responsible were parents (a similar proportion to Sinclair and Bullock's 2002 study, where 55% of cases listed parents as perpetrators). In a small number of cases foster carers were alleged to be responsible. The following example also illustrates a review where a relative was alleged to be responsible for the child's death:

The child died from an accidental overdose. At the time of the incident, she was being looked after by a family member with a known history of drug misuse...There was concern that the relative may have allowed or encouraged her to take the substances and that the relative didn't seek appropriate medical assistance when the child was unwell.

The illustration above demonstrates that responsibility for the death or harm, including suicide, was often very difficult to establish. While 'self' is recorded in 13% of cases, this reflects the nature of the incident (suicide) rather than any attribution of blame. When a child commits suicide there are many strands of responsibility and parental rejection and rejection by helping agencies is a feature in some of these cases.

Table 10: Responsibility for incident or harm

Responsibility for incident or harm *	Full sample (n=130)	Intensive sample (n=42)
Mother	24 (19%)	5 (12%)
Father	24 (19%)	6 (14%)
Partner	9 (7%)	4 (10%)
Sibling	<6	1 (2%)
Self	17 (13%)	3 (7%)
Mother and father	25(19%)	8 (19%)
Mother and other adult	<6	-
Other	26 (20%)	15 (36%)

*based on information on *alleged* perpetrators contained in notification records.

Those cases listing 'mother and father' as perpetrator are a potential over-estimate as most reviews were conducted before any trial was concluded. Although both the child's mother and father may have been held responsible, it is not necessarily the case that both will be convicted, and indeed Table 11 shows that a prosecution was not pursued in all cases.

In 19 cases there was a decision not to bring a prosecution while in 68 cases the outcome was still uncertain with proceedings still 'ongoing'..Although there were convictions in 24 cases with ten resulting in custodial sentences, press coverage has revealed that a small number of these cases reported in the media have subsequently been brought to appeal and original decisions about culpability overturned.

Table 11: Outcome of criminal proceedings

Outcome	Full sample (n=130)	Intensive sample (n=44)
Prison	14 (11%)	7 (16%)
No proceedings	19 (15%)	11 (25%)
Ongoing	68 (52%)	19 (43%)
No conviction	16 (12%)	4 (9%)
Conviction - no details	10 (8%)	2 (5%)
Other	3 (2%)	1 (2%)

3.4 CHARACTERISTICS OF THE CARERS AND THEIR ENVIRONMENT

Little detail was available from the child protection notification records (CSCI 2005) to provide a profile of the carers, and the records did not include a judgement about who was the child’s primary carer. These records contain most information about parents and carers within a tick box section entitled ‘characteristics of case’ and occasionally more elaboration is offered in a free narrative section ‘case outline’. Details were also scanty for past history and environmental features, which drew on the same sections of the notification records.

Where information is recorded at the point the case was notified to CSCI, it is listed here, but it is important to note that absence of information does not indicate a lack of any particular feature, simply that it is not recorded. Even within the intensive sample it needs to be acknowledged that detail about parental characteristics is sometimes absent from the full reviews.

Parents’ age

Information about the parents’ age at the time of the incident is only requested in the later database reports (CSCI 2005) in relation to whether the parents were teenagers, (listed as ‘child of teenage pregnancy’) but some reports did appear to include parents’ dates of birth. Overall, this information is available for the ages of 61 mothers and 46 fathers. From this limited information it seemed that the bulk of mothers and fathers were older. However, 17 mothers were below the age of 21 and these included some very young mothers under 15 years of age. The age data available are broadly comparable to Sinclair and Bullock’s 2002 findings, showing a similar pattern of distribution across the age bands.

Table 12: Age (at time of incident)

Age (yrs)	Mother		Father	
	Full sample (n=61)	Intensive sample (n=40)	Full sample (n=46)	Intensive sample (n=31)
<18	9 (15%)	3 (8%)	<6	1 (3%)
19-20	8 (13%)	5 (13%)	<6	1 (3%)
21-25	14 (23%)	9 (23%)	11 (24%)	6 (19%)
26-30	9 (15%)	5 (13%)	9 (20%)	3 (10%)
31-35	7 (12%)	5 (13%)	7 (15%)	5 (16%)
36-40	7 (12%)	6 (15%)	<6	3 (10%)
41 +	7 (12%)	7 (18%)	12 (26%)	12 (39%)

Parenting characteristics

Information regarding the child's experience of caregiving for the intensive sample of 47 cases is presented in Table 13. There is evidence that domestic violence is present in two thirds of the cases (66%), substance misuse in 57%, and mental ill health in 55% of families (The extent to which these three parenting characteristics were found to coexist is reported in chapter 5). A total of 11% of parents/carers were reported as having a learning disability. Other studies of reviews have indicated that learning disability in parents often goes unrecognised (Brandon et al 2005). It is therefore possible that this feature will have been missed in a number of other cases.

Relatively little information on characteristics of parents/carers was available for the full sample of 161 cases and thus the likely frequency of occurrence of many of these key features was not revealed from analysis of data for the full sample. This is illustrated by the following examples which compare the information from the two samples:

- care history for parent/carer: documented for 5% of full sample, 30% for intensive sample;
- domestic violence: documented for 15% of full sample, 66% of intensive sample;
- mental health problems: documented for 11% of full sample, 55% of intensive sample.

The study also highlighted some cases which shared similar features regarding parenting characteristics yet with very different histories of intervention by agencies. The following two examples illustrate this:

Parents were known to police - domestic violence issues, alcohol, heroin and the parents moved a lot. Health records from another county indicate evidence of significant harm to both children...Children were previously on the child protection register in a previous county and this was only discovered when reports were sent to provide the SCR panel with background information.

Father admitted shaking the baby...Both parents have a history of mental illness. Little known about family, but they have had frequent house moves and changes of name.

Table 13: Child’s experience of caregiving: intensive sample

Characteristics of Parents/Carers	intensive sample (n=47)
Mental health problems/personality disorder	26 (55%)
Domestic violence	31 (66%)
Substance misuse	27 (57%)
Learning disability	5 (11%)
Care history	14 (30%)
Childhood abuse	20 (43%)
Criminal record	25 (53%)
Violence	33 (70%)
Sex offender	4 (9%)
Offender posing a risk to a child	3 (6%)
Previous child death	4 (9%)

An example of a parent with a known mental health problems is illustrated below.

The child (who died) and her mother were not known to children’s social care. The father was known to mental health services, had been diagnosed with a mental illness and prescribed medication...He had not been taking the drug for several months.

Analysis of our intensive sample reveals a higher frequency of parental mental ill health (55%) than has been reported elsewhere, for example Falkov’s findings from 1996 show 32% parents in serious case reviews had a psychiatric morbidity, although Reder and Duncan’s 1999 study reported 43%. It is important not to over-inflate the risk of parental mental ill health as a contributory cause of child death, but to understand whether or how this type of ill health in parents poses a risk to children’s healthy development and increases the risk of maltreatment and neglect. Falkov concluded that the combination of depression, substance misuse and personality disorder carried a poor prognosis with regard to severe child abuse, but that successful treatment could be a significant protective factor.

Where knowledge of past history is recorded, a history of being in care and incidents of violence and criminality feature most often. Incidents of violence and a criminal record were more often applicable to the child’s father or mother’s partner. One review (among many) demonstrates the gendered feature of much of the violence and criminality and illustrates the extent of a previous history of violence and offences against children in this case:

The child was not known to children’s social care. The mother’s partner was known to be a violent man including acts of domestic violence. He had been in prison for assaulting a young child but had not been made a Schedule One offender and was therefore not monitored. At the time of the child’s death he was wanted by the police for assault... He was not named as ‘wanted’ on the Police National Computer.

Environmental characteristics

Information relating to environmental characteristics mentioned in reports for the intensive sample revealed some positive as well as some potentially negative features (see Table 14). However, in only six families were there indications of positive support from extended family and only one family was noted to have positive community links. Seventeen families had a poor standard of living conditions in their home. The most recorded environmental feature, however which has also featured in some of the case examples already provided, was frequent house moves.

The most startling environmental feature was the number of families who were noted in reports to have moved frequently (more than a third of the intensive sample). The need to locate and protect children more robustly in these circumstances was exemplified in many of the cases.

The problems of tracing and tracking children at risk of harm who live in families who move frequently, were raised in the Laming Inquiry. Recommendations in the Laming Report gave rise to the government's establishment of the information system, 'ContactPoint'.

Table 14: Family environment: intensive sample

Family environment	Intensive sample (n=47)
Conflict with neighbours	7 (15%)
Frequent house moves	17 (36%)
Supportive extended family	6 (13%)
Positive community links	1 (2%)
On benefits	5 (11%)
Household employment	10 (21%)
Asylum seeking family	<6
Poor housing	7 (15%)
Poor standard of living conditions in home	14 (30%)

3.5 AGENCY INVOLVEMENT

The broad picture of services involved with the children and their families both within the last two years and at the time of the incident is patchy and sketchy. This is primarily because the information sources reflected more depth of information about high threshold cases rather than about families who were receiving universal services or services for early needs. However it is clear that professionals from the whole range of services, especially from health have been involved in the bulk of these cases. To capture a sense of which professionals were involved prior to the incident and at the time of the incident itself the sections concerning agency involvement are structured to take account of different levels of intervention.

Levels of intervention are broadly interpreted in line with *Every Child Matters* discussions of targeted services within a universal context (Cm 5860 2003 p21) and the Common Assessment Framework guidance continuum of needs and services (HM Government 2006b p7). These are as follows:

- Level 1: Universal services for all children and families;
- Level 2: Children with additional needs;
- Level 3: Children with complex needs (including the children's social care threshold of 'children in need');
- Level 4: Services for children at high risk/looked after (including child protection registration, children looked after, or compulsorily detained).

There were many examples of cases on the border to a higher level of service (eg between Levels 2 and 3 and Levels 3 and 4) or cases which did not reach the threshold for a higher level of service. We consider involvement with agencies prior to the incident and then consider involvement at the time of the incident.

PRIOR TO INCIDENT

Level 1: universal services for all children and families

There were a number of cases where the information indicated that the child only had contact with health professionals:

The baby was not known to social services prior to [the injury]. However, he attended Accident and Emergency at 20 days old with bruising – the parental explanation was that the mother had slipped whilst changing him.

In one case, health professionals had concerns but had not yet referred the baby (who died) to children's social care:

Child discharged from hospital to mother's partner's address. Number of 'no access' visits by midwifery followed. Child has lost weight and mother was observed to be roughly handling the baby...A child in need meeting was convened by Midwifery services to discuss concerns and agree an action plan.

Table 15 shows, from the limited information available, the range of professionals, other than children's social care personnel, who were involved with the family in the two years leading up to the incident.

Table 15: Services involved with family over last two years: intensive sample (n=47)

Services involved over last two years	
Health	
Midwife	18 (38%)
Health visitor	28 (60%)
GP	31 (66%)
Nurse	9 (19%)
Hospital	34 (72%)
Outpatients	7 (15%)
A & E department	28 (60%)
Special Care Baby Unit	10 (21%)
Paediatrician	18 (38%)
Speech Therapist	3 (6%)
Drugs and Alcohol Team	5 (11%)
Ambulance Service	8 (17%)
CAMHS	10 (21%)
Adult mental health team	14 (30%)
Education	
Education Welfare	7 (15%)
Education Psychology	6 (13%)
School Health Nurse	6 (13%)
Connexions	10 (21%)
Home Tutor	2 (4%)
Criminal Justice	
Police	37 (79%)
Juvenile Justice	7 (15%)
Probation	10 (21%)
Court Welfare	4 (9%)
Early Years (Sure Start, play group, childminder)	8 (17%)
Other	
Family aide/support	3 (6%)
Housing	14 (30%)
Respite Care	1 (2%)
Women's Refuge	2 (4%)
Guardian	5 (11%)

Level 2: Children with additional needs

In some cases the child had been referred to children's social care but did not meet the threshold for intervention. In addition, in a number of cases, the parent would not accept other offers of help:

There had been a previous referral by hospital ante natal staff to children's social care because of concerns about mother's ability to cope with the care of the baby because of problems with her own health and poor housing. The social work assessment of physical care of the baby had been 'good' and she

seemed to be bonding well with him. There were some concerns about her apparent isolation but she refused offers of further assistance.

Level 3: Children with complex needs (including ‘children in need’, the children’s social care threshold)

A total of 102 families (63%) from the full sample of 161 were previously known to children’s social care, including during the parents’ childhood. However this information is likely to be an underestimate since these details are not consistently recorded and the question was not directly asked in the notification records. Thirty nine families (83%) from the intensive sample of 47 were previously known to children’s social care over this long term time frame. Since this figure is drawn from fuller information it may be a more accurate representation across the whole sample.

Table 16: Families known to children’s social care (csc)

	Full sample (n=161)	Intensive sample (n=47)
Family previously known to CSC?	102 (63%)	39 (83%)
If known to CSC, for how long:		
< 1 year	22 (22%)	8 (21%)
1 year	8 (8%)	6 (15%)
2-4 years	11 (11%)	9 (23%)
5-9years	10 (10%)	7 (18%)
10 years +	10 (10%)	9 (23%)
Duration not known	41 (40%)	-

Information provided about those families who were known to children’s social care, made clear that many of the children and families were known over long periods of time. Table 16 shows that 27 families were known for three or more years and reveals that ten families were known for more than ten years.

Level 4: Services for children at high risk/looked after (including child protection registration, children looked after, or compulsorily detained)

Since at least 24 children were previously the subject of a care order or were previously looked after under s20 of the Children Act 1989, they were entitled to services from the local authority until well into their adulthood (under the Children [Leaving Care] Act 2000). These children were clearly not protected by this new legislation. The fact that almost as many siblings were also looked after suggests that there were entrenched problems within families.

Table 17: Past orders/involvement

Past orders/involvement	Full sample (n=161)	Intensive sample (n=47)
Child previously on Care Order? **	12 (7%)	8 (17%)
Child previously looked after s20? **	19 (12%)	9 (19%)
Sibling previously on Care order?*	10 (9%)	7 (18%)
Sibling previously looked after s20?*	16 (14%)	11 (28%)
Child previously on CPR?	35 (22%)	13 (28%)
Sibling previously on CPR?*	31 (28%)	18 (45%)
Parent known to CSC as a child?	30 (19%)	19 (40%)

*Percentages apply only as a proportion of those children known to have siblings

** 7 children had been both looked after and the subject of a care order at different times

AGENCY INVOLVED AT TIME OF INCIDENT

The findings from the sample of 161 children show that at the time of the incident which prompted the review, little more than half of the children (85) were recorded as receiving services from children’s social care. However, this may be an underestimate owing to the lack of comprehensive information about this agency’s involvement in the notification sources.

The circumstances of a significant minority of children had already aroused a high level of active concern for their safety and welfare. Thirteen children (8%) were already the subject of legal orders and 16 (10%) were being looked after under s20 of the Children Act 1989, and 20 children’s names (12%) were listed on the child protection register. All these children had crossed a high threshold of concern and surveillance in relation to their safety and welfare.

Table 18: Children known to children’s social care (csc) at time of incident

	Full sample (n=161)	Intensive sample (n=47)
Children known to CSC (at time of incident)	85 (53%)	30 (64%)

Table 19 shows that, at the time of the incident, three quarters of the children (120) were living at home and 11 were living with relatives. Sixteen of the children were living in regulated or supervised settings, some of whom were ‘on the run’ at the time of the incident. One of these young people recorded as a ‘frequent absconder’ had a myriad of difficulties including drug misuse, crime, and being a likely victim of sexual exploitation. His death was recorded as likely suicide and he had previously taken a drugs overdose. The fuller circumstances of similar cases in the intensive sample are analysed in Chapter 5.

Table 19: Child's placement at time of incident

Child's placement at time of incident	Full sample (n=159)	Intensive sample (n=47)
Home	120 (75%)	33 (70%)
Hospital	7 (4%)	2 (4%)
With relatives, but not looked after s20	11 (7%)	3 (6%)
In care/s20	16 (10%)	7 (15%)
Bed and breakfast accommodation	<6	1 (2%)
On the run from family home	<6	1 (2%)

Level 1: Universal services

At the time of the incident almost half of the children were known only to universal services like GPs, midwives, health visitors and non specialist education services. As for example in the following case:

The post-mortem discovered multiple bone fractures and a cerebral bleed. ...Neither parent was known to the police or social services.

Level 2: Children with additional needs

In other cases, the father's needs attracted specialist services, but this did not apply to either the child or her mother, who received universal services only:

Mother and baby were only known to usual health services where there were apparently no concerns. Father was known to mental health services with a diagnosis of a personality disorder.

As in the period leading up to the incident, there were a number of cases with complex family problems, for example where the child had been known to children's social care but the case was assessed to not reach the threshold for a continuing service. In one example the case was closed before the incident occurred and as in an earlier illustration, parents claimed they did not need other help:

The baby was born prematurely. Social worker contacted the mother ..., discovered the baby had been born, that she was coping and did not need assistance. Police were called to a domestic violence incident two months later. Both parents have a history of alcohol abuse and domestic violence. Father has numerous criminal convictions and has been sentenced to prison many times. The police had attended many domestic violence incidents where the mother suffered harm but she did not co-operate to prosecute her partner. Domestic violence police had referred concerns for the unborn baby to children's social care.

Lack of parental cooperation or unwillingness to accept help raises problems for interventions below the threshold of s47 enquiries, where consent is required. If a family fails to accept or take up a service this needs to be taken into account as part of the assessment and may raise the level of concern so that LSCB procedures need to be followed.

Level 3: Children in Need (children's social care threshold)

The risks of harm to some children who were being helped by children's social care had been down graded, often because the parent was believed to be cooperating:

The child died as a result of a car accident. The child's mother who was driving was thought to have been under the influence of alcohol when the accident happened. The child had been named on the child protection register because of his mother's alcohol misuse. There was a decision to de-register because mother was no longer drinking and was cooperating with appropriate services. A child protection conference was to be reconvened if there were renewed concerns about mother's care. The case remained open to children's social care as a support case, to be reviewed.

There were also cases where siblings were actively known to children's social care but other children in the family, including the child who was injured or died, were not considered to be as highly at risk of harm. This is illustrated in the following case example of a baby who sustained life threatening injuries:

Father suspected. There have been concerns about father's offending behaviour (arson), substance misuse and self harm. Older brother had been placed on the child protection register but not younger siblings. A family support meeting had been arranged but the incident took place two days before the meeting.

A similar situation was evident for a four year old who also sustained life threatening injuries:

The child and family were known to social services in proceedings in relation to a sibling. There may have been failings in child protection procedures in relation to THIS child when a s47 enquiry was undertaken for his sibling.

Level 4: High level services for children at high risk/looked after (including child protection registration, children looked after or compulsorily detained)

In terms of inclusion in child protection systems (from the point of s47 enquiries onwards), it is noteworthy that at the time of the incident, only 20 of the 161 children's names (12%) were listed on the child protection register signifying serious current child protection concerns.

At the time of the incident only twelve per cent of the children's names were listed on the child protection register. This represents a similar proportion to the 15% of cases found in Sinclair and Bullock's 2002 study and a lower proportion than found in other, previous studies of small numbers of cases (e.g. James 1994; and Owers et al 1999; and Brandon et al 2002). Theoretically, figures for children listed on the child protection register from the full sample of 161 should not be an under-estimate since this information was clearly requested on all versions of the database reports. However, the intensive sample of 47 cases, reveals a slightly higher proportion of seven children (15%) listed on the child protection register at the time of the incident.

Table 20 shows that a total of twelve children were registered in the category of neglect, six in the category of physical injury, and a very small number of children were listed in dual categories. In twelve cases siblings were named on the child protection register alongside the child at the centre of the review.

Table 20: Child protection registration

	Full sample (n=161)	*Intensive sample (n=47)
No. on child protection register	20 (12%)	7 (15%)
Reason for registration:		
Neglect	12	3
Physical abuse	6	3
Other	<6	1
Not known	<6	1

* numbers do not sum to 7 because of a dual registration.

In a number of cases, despite a high level of agency involvement, monitoring and procedures being followed, children were still injured or killed. For instance, one family where the child's name had been placed on the child protection register received frequent home visits by the social worker (the baby sustained a head injury):

An initial child protection conference was held before child's birth as both parents were known to probation due to offences and drug misuse...the social worker was a qualified and experienced senior practitioner who made numerous home visits after child's birth...following the child's birth there was no cause for concern registered in terms of her physical well being, though she had a low birth weight and is still a low weight...the child protection plan was being progressed by all agencies but there was increasing concern about parental cooperation.

There were other regulated settings where adults were under supervision or surveillance and where children should also have been protected. This included one case of a mother with mental health problems in a residential unit in order to assess her parenting skills:

Mother found (middle of night) by staff trying to harm baby. Baby stopped breathing, and was resuscitated by staff.

In another case, the child, his siblings and his mother were staying at a residential centre for a parenting assessment at the time of the incident:

The child was admitted unwell to hospital. He had been dehydrated for some time. Consultant Paediatrician wondered how he could have been allowed to become so seriously ill when overseen by staff at the centre.

Table 21 shows that 13 children were the subject of a legal order at the time of the incident, for ten a care order. A total of 16 children were looked after under s20 of the Children Act 1989. Previous case examples have illustrated that these, predominantly older, children have very complex needs and it appears that these may be extremely difficult to meet. It is not, however, always possible to determine quite how the system failed these children and the extent to which their cases magnify the challenges presented by high risk children who may not have received services until their problems were already entrenched.

Table 21: Children on legal orders/looked after

	Full sample (n=161)	Intensive sample (n=47)
No. on legal order	13 (8%)	7 (15%)
If yes, type of legal order:		
Care order / Supervision order	10 (77%)	6 (86%)
Other	3 (23%)	1 (14%)
No. of children looked after (s20)	16 (10%)	7 (15%)

Interpreting the information from this chapter

At the outset of the chapter we urged some caution in relation to the accuracy of some of the information presented here. We also indicated that there are many gaps in the information sources so that certain features of child and family profiles may have been under-reported. Also, information here about agency intervention and the context that practitioners were working in is sketchy. Some of the more robust information includes age, gender and ethnicity of the children, whether the case concerned a death or serious injury and whether the child was named on the child protection register.

Even with these notes of caution, the trends and patterns presented and the illustrations given about the children and their circumstances make powerful reading. The death or serious injury of children and young people arouses strong feelings and particularly so when abuse or neglect have played a part. Prevention of child deaths or injury in these circumstances is uppermost in the minds of practitioners and managers working with children and families. The attempts to learn from these cases, and the determination to prevent or avoid their reoccurrence can lead individuals to misinterpret and misapply information. It is important to stress that there are no clear causal relationships between, for example, domestic violence or parental mental ill health and child death or serious injury.

Many over-riding themes and questions which have emerged are returned to and considered further in Chapter 5.

Chapter 4

Assessment and analysis: an ecological-transactional perspective

4.1 INTRODUCTION

This chapter picks up a particular issue highlighted by previous reviews and explores it further. The lack of a thorough social history on which to base a more coherent and developmentally informed analysis (rather than description) has been identified as a particular weakness of many cases in which a child died or suffered serious injury or neglect. It remains a weakness of many of the serious case reviews examined in the current study.

The 1993 and 1999 studies of serious case reviews by Reder, Duncan and colleagues argued for better assessments of the relationship between accumulating risks. They also valued clearer links being established between research and practice, and more developmentally informed analyses.

Assessments should be based on a set of theoretical constructs that guide the type of information needed and the sense that can be made of it. The theoretical framework should be the central reference point for selecting the observations to be made, formulating appropriate questions and giving meaning to the responses. Otherwise, the assessment is directionless and generates a mass of discrete pieces of information that cannot be organised or understood...in our view, the most useful theoretical principles are those within an interactional framework that portray individuals as existing in relation to other people and functioning within a social and relational context. Their history helps to describe who they are and further evidence can be found in the pattern of their current relationships with significant others. In practice, this framework guides professionals to integrate historical and contemporary information about the family, its functioning, problems and relationships. (Reder and Duncan 1999 pp98 - 101)

It was apparent that not much of this advice had been followed in the conduct of many of the cases currently under review. Several years after the findings of Reder and Duncan, Sinclair and Bullock (2002 p7) also gave as one of their ten differences that might be expected as a result of the new guidance the need for 'clearer structures of both the reports from the welfare agencies and the ACPC overview and better information on key areas, such as the child's family history, family structure, previous referrals, decisions taken and work done.' Indeed, in their own review of serious case reviews, Sinclair and Bullock (2002 p10) analysed the reports under a number of headings including 'background of primary carer, background of secondary carer, and the relationship between carers.' They also cite the work of Hill (1990) who noted the 'static' nature of assessments, and the study by Owers et al (1999) which reported the absence of good quality family histories, too much emphasis on particular incidents, and a failure to identify overall patterns (cited in Sinclair and Bullock 2002 pp12-13). Sinclair and Bullock (2002 p 26) then go on to recommend that:

Assessments based on the three domain approach of the 'Framework for the Assessment of Children in Need and their Families' should allow greater account to be taken of the interaction between the characteristics of the child, the attributes of family members...and situational factors such as poverty.

Taken together, these observations and recommendations argue for:

- Good quality social and family histories including information about the parents' childhood, relationship and behavioural background.
- Analysing the interactive effect of vulnerabilities and risks (rather than static and descriptive accounts of incidents).
- A better understanding of the ecology of child abuse and neglect.

The 2003-2005 serious case reviews have been critically examined with these points in mind. However, before presenting the examination, a case will be made for theoretically linking family history, parental relationship experiences, the interactive effect of risks, and the need to identify patterns within an ecological-transactional-developmental model of child maltreatment (Cicchetti and Valentino 2006). In particular, a deeper understanding of how parents are likely to react and cope under stress based on an analysis of their developmental and relationship history will be teased out as a key dimension to consider in the conduct of case assessments and formulations (Howe 2005). An ecological transactional approach creates a common conceptual framework and language for professionals to share information and think about parenting capacity.

The biological function of caregiving is to provide protection and support for the developing child. Dependent, vulnerable young children need to experience their carers as available and responsive. To facilitate this sense of security, parents need to be sensitive and mindful of their children's needs, anxieties, joys and successes. The psychological sensitivity and emotional availability of parents is affected by their own relationship history as well as the supports and stresses experienced in their current environment.

To the extent that the caregiver develops supportive adult relationships and effectively manages stressors, he or she is likely to remain available to the child... Alternatively, a caregiver whose state of mind is characterized by a lack of resolution of trauma may be at increased risk for insecure adult attachments that are a source of stress rather than support... Overwhelmed by contextual stressors and the symptoms of his or her own psychopathology, the caregiver is likely to have much more difficulty maintaining available and responsive care to the child. Further, these stressors may lead to an abdication of the caregiving role or basic violations of caregiving boundaries...which may substantially increase the child's risk for atypical attachment and psychopathology. The transactions among caregiver states of mind, contextual supports and stressors, and caregiving quality are a promising but largely unexplored area for attachment research. (Kobak et al 2006 p 362)

For the last twenty five years, developmental scientists have been fashioning increasingly complex, subtle but probably more realistic models of human psychosocial development from infancy to adulthood. Development is now viewed as the dynamic product of nature *interacting* with nurture. It is also recognised that genes and environment interact across a number of systemic levels. Biology and culture, family and community, parents and peers are in continuous dialogue as genes express themselves in an ever-changing psychological, social and economic environment. Bronfenbrenner (1979) was one of the first people to recognise that human development had to be understood *ecologically*; that parents and their children are influenced by a wide range of factors, some operating at the level of genes, others at the level of the parent-child relationship, and yet others at the level of the economy where material wellbeing can affect people's ability to cope and deal with stress.

Others, following in the wake of these ideas, also realised that human development has to be understood as a *dynamic* process. The biopsychosocial outcome of each stage of development continuously interacts with the currently existing ecological environment to forge the next biopsychosocial outcome. As one element of a child's make-up interacts with a particular feature of the social and economic environment, so that element is *transformed* in the process. And in turn, the transformed element will go on to interact uniquely with yet other features of the child's environment. Thus, in this model there are complex and *reciprocal dynamic interactions* of the environment, caregiver and the child which together contribute to the outcomes of the child's development.

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

4.2 THE SOCIAL AND RELATIONSHIP HISTORIES OF PARENTS AND THE QUALITY OF CHILDREN'S EARLY ATTACHMENTS

Although an ecological-transactional perspective does not privilege any one factor, developmental outcomes achieved early on in the transactional process, by virtue of being early, will interact with and influence later stages.

*...the hypothesis is not that **only** early experience is important, or even that early experience is **more** important than later experience. Rather, the hypothesis is that early experience, because of its very place in the developmental course, has some special importance for the development of the person. (emphasis original, Sroufe et al 2005 p10)*

A child's attachment with his or her caregiver is one such early stage event. Children's attachment organisation is affected by the quality of the relationship they have with their primary caregivers. And the quality of care provided by parents or caregivers is itself the product of their own developmental history, their own interactional journey across a lifetime of ecological and relationship environments. Therefore, the psychological resources and behavioural responses that parents bring to the demands of caregiving can be understood as the product of their own relationship, developmental and environmental history. If we are to make sense of parents' capacities to care and protect, we need to consider both their childhood *and* adult experiences. Viewing children's development transactionally leads Sroufe et al (2005 p 7) to believe that:

...the explanation for why individual children and adults are the way they are lies in the entire cumulative history and the transactions between the child and significant others across each preceding developmental period, the surrounding stresses and supports, and the child's experiences of success and failure in a variety of contexts. (Sroufe et al 2005 p18)

From an ecological-transactional perspective, the primary attachment relationship remains a salient developmental issue across the lifespan, as it lays the foundation for representational models and subsequently shapes an individual's selection, engagement, and interpretation of all future experiences, including the ability to successfully resolve ensuing developmental tasks...including parenting. (Cicchetti and Valentino 2006 p 148)

Carers' experiences of being parented themselves and the history of their own relationships with family, peers, partners and professionals influence their representational models of self and others. These emotional histories, cognitive models and current life stressors will affect the way parents understand and interpret the needs and behaviour of their own children

. ...assessments of the parents' own developmental histories...have notable predictive power...Second...the stresses and other surrounding circumstances (e.g., violent neighbourhoods, substandard housing, and frequent moves) that impact on parents may also directly impact on the child. (Sroufe et al 2005 p 18)

Parents who have enjoyed more sensitive and psychologically available relationships during their own development tend to have more complex, differentiated and nuanced understandings of their own and other people's thoughts, feelings and behaviour. Again, this would extend to parents' ability to recognise, understand and respond to their own children's needs and behaviour in a sensitive, psychologically connected manner. If parents are insensitive and psychologically unavailable when their children experience distress and emotional dysregulation, there is a risk of setting in motion a train of developmental setbacks. These observations:

...are consistent with an organizational/transactional model whereby early parent-child relationships lead to poor organization of cognitive and affective processes, which in turn affects peer relationships and social dysfunction...

Many important issues of children's development are facilitated through relatedness with peers and exposure to an extended social network. Thus, the development of peer relationships represents an important stage-salient task for school-age children. (Cicchetti and Valentino 2006 pp156-7)

These models determine what is perceived and how it is interpreted; whether social and emotional information is processed in ways that are psychologically open and reflective or closed and defensive. These processing biases affect parental perceptions and interpretations including what is recognised and understood (and what is not recognised and understood) of children's needs and behaviour. Furthermore, as children's needs and behaviours raise parental stress levels, the more pronounced are these perceptual and processing biases. These representations or biases, formed in the context of relationship experiences, are the strategies that individuals use for coping with stress and regulating arousal. It is particularly important to understand the nature of these psychological processes in cases of child abuse and neglect.

Parenting under stress: hostile and helpless caregiving

The stress experienced by parents as they interact with their children at times of high need and vulnerability creates extreme emotional distress and dysregulation. In the case of parents who bring with them histories of unresolved issues of loss, abuse and trauma, such stresses trigger feelings of fear, helplessness and anger. In the case of physical abuse, emotional harm and rejection, stress catapults parents into hostile and aggressive states of mind. When stress precipitates feelings of helplessness or triggers a dissociative response, neglect of one kind or another is likely. In cases of neglect, stress appears to cause parents to go 'off-line' in the sense that they no longer register or process their child's needs for safety, care, regulation and engagement.

The most complex and potentially most dangerous caregiving environments are those in which parents switch unpredictably between hostility and helplessness, abuse and neglect (Howe 2005). This particular parenting pattern is often seen in carers who have suffered sexual abuse, violence and neglect both as children and as adults. Transactionally and ecologically, parents with these psychological vulnerabilities are at increased risk of breaking down into these disorganized hostile and helpless states of mind if their environment is characterised by high levels of stress and low levels of experience that help buffer against these stresses. Poverty, poor housing, low community support, social isolation, violent and emotionally unsupportive partners, and drug misuse are associated with increased stress. When these factors interact with the vulnerable caregiver's psychological characteristics, the parent's emotional availability, sensitivity and responsiveness to the needs of their children diminishes.

Information gathering and analysis

Children who sense that they have been psychologically 'abandoned' by their parents experience fear and distress that can lead to a variety of fight, flight, freeze or other survival behaviours. It is important to recognise that a child's behaviour and psychosocial functioning offer powerful clues about their probable parenting experience. Even if the practitioner knows nothing of the quality of a parent's caregiving, the child's behaviour and socio-emotional condition should encourage *curiosity* about what kind of parenting could have produced this condition. And in

turn, curiosity about what might account for such parent-child interactions should sponsor further enquiry about the parent's psychological sensitivity and emotional availability and what in their relationship history might explain how their child's needs and behaviour affect them. In other words, any one piece of information should lead to speculation, if not hypotheses about the possible character of the ecological context in which the key players function. The hypothesis should then be tested against the information held, or if the information is not known, then it directs the practitioner to further enquiry. In many cases, the enquiry will encourage the sharing of information between agencies. This gives a powerful rationale, framework and language for interagency communication and collaboration. The gathering, pursuit, sharing and collation of information is not conducted for its own sake, but is driven by a theoretically informed hypothesis about what might be driving the parent's psychology and behaviour, the child's mental health, or the worker's anxiety. When fed into the analysis, each piece of information will either confirm or disconfirm the hypothesis about what is happening at the level of parent-child interaction. The formulation will also help decide whether from the child's view, the caregiving is promoting or seriously impairing psychosocial development, safety and wellbeing.

Under this complex and dynamic mix of parent, child and environmental risks and vulnerabilities, the key caregiving functions of care, protection, regulation, recognition, understanding, structured stimulation, and play may disappear. Under these caregiving conditions, the child is at risk of abuse and neglect, and in extreme cases 'relational trauma.'

Insensitive, non-reflective parenting

Concepts such as 'reflective function' and 'mentalisation' refer to the individual's capacity to monitor, attend to, and reflect upon thought and internal emotional experience in the self and others in a dynamic and complex way:

The broader term, 'mentalizing', refers to the capacity to see, think about, and understand one's self and others in terms of inner states. Such capacities are acquired, as our work on empathy confirmed, through relationship experiences in which caregivers are emotionally attuned to young children.

Embracing these ideas leads to a new form of 'clinical listening', as the therapist focuses on gaps and inconsistencies in discourse. Such gaps reveal acquired styles of coping with attachment feelings in response to failures to be understood in an emotional, intersubjective way. Without such experiences of another engaging one's inner experience, the person is now unable to make his own or another's experience understandable. Fonagy ties insensitive parenting to such a history of failed shared experience, and thus explains the intergenerational process. This parent cannot engage and contemplate in a coherent manner the child's inner states, which undercuts the child's experience of the self 'as real. Known, and intentional (which) is central to security (Slade, 1999: p 581)'. (Sroufe et al 2005 p 280)

The above paragraph explains why it is important to know and understand the parent's own caregiving history, his or her current mentalising capacities, and the risks poor

mentalisation poses for the child (Howe 2005). It also has strong messages for assessment, analysis and intervention.

One of the major predictors of poor-quality parenting from Sroufe et al's (2005) Minnesota study was a lack of parental understanding of the 'psychological complexity' of the infant, and that the infant both seeks and enjoys autonomy and yet is vulnerable and dependent on the parent for his or her wellbeing.

We learned that the way parents treat their children is a complex product of their histories, and the resultant understandings that they have about childrearing, as well as their supports and stresses. (Sroufe et al 2005 p 287)

Maltreating parents, observe Cicchetti and Valentino (2006 p180) 'exhibit a complex pattern of cognitive, affective, interpersonal, and behavioral processes that are in part derived from their own childhood relational experiences. Parental resources are further challenged by the influence of macrosystem factors as well as by poverty, community violence, and other aspects of the exosystem.' Poverty and hardship correlate with neglect independent of parenting characteristics.

Similar ideas are met in 'vulnerability-stress' models of caregiving and child development. Here, when vulnerabilities in the parent's or child's genetic or psychosocial make-up interact with environmental stresses, the risk of a poor outcome increases. Moreover, stressors are not experienced randomly. Certain characteristics will predispose particular individuals to experience negative life events or stressors more frequently. For example, a mother who suffered rejection and sexual abuse as a child may find her baby's vulnerability and dependency particularly evocative and stressful. The mother's distressed state increases the risk of the baby feeling anxious. The behaviour of anxious babies is likely to be more difficult and demanding. This compounds the original stress experienced by the mother. A mother who does not carry this particular vulnerability would not get into this cycle of stress.

Ecological-transactional models help us to understand parenting capacities in terms of the caregiver's psychological sensitivity and availability to his or her young child. Parents' who recognise and understand their children at the psychological (mental state) level as well the behavioural level are experienced by children as emotionally available, caring and protective. At times of distress and emotional arousal, their children feel understood, regulated, managed and contained. These children learn to cope well with stress.

In contrast, parents who fail to recognise or understand their children as complex emotional and psychological beings are less sensitive and available at times of need. The feeling of 'abandonment' that this engenders in young children only adds to their arousal and distress putting the parent under further stress. Parents who have suffered abuse and neglect, loss and trauma, rejection and hurt are at increased risk of behaving in a highly dysregulated, disorganised way under stress. Such vulnerabilities are only overcome or buffered by exposure to sensitive and protective relationships, perhaps with alternative carers or understanding partners. However, it is often the lot of those who have suffered relationship trauma that they are not well equipped, either emotionally or socially, to engage with those who are most likely to benefit them psychologically.

A transactional model of development does not view an insecure attachment leading to maladaptation in a linear fashion, 'rather prior history influences the subsequent selection, engagement and interpretation of experience'. Thus, early insecurity in attachment can be conceptualized as an 'initiator of pathways probabilistically associated with later pathology' (Sroufe et al 2005 p 1)' (Cicchetti and Valentino 2006 p148). This brief, simplistic example of an abused child illustrates how the developmental outcome of one previous stage affects the way a child interacts with subsequent environmental experiences. These transactional risks can continue into adulthood and parenthood. Most maltreating parents are classified as insecurely attached. There is also evidence of assortative mating, that is people tend to find partners with similar psychological, social and economic characteristics to themselves. Among maltreating couples, it is most likely both partners will be insecure.

4.3 DESCRIPTION VERSUS DYNAMIC ANALYSIS

The *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000) is firmly based on an ecological model. It also understands the importance of recognising the presence of multiple risk and protective factors and their possible interactions. This approach is neatly captured in the form of a triangle with sides representing a child's developmental needs, parenting capacity, and family and environmental factors. These three 'systems' or 'domains', each with their critical dimensions, are seen as inter-related.

The interaction or the influence of these dimensions on each other requires careful exploration during assessments, with the ultimate aim being to understand how they affect the child or children in the family. The analysis of the child's situation will inform planning and action to secure the best outcome for the child. (Department of Health et al 2000 pp 17-18)

Attention is drawn to this quote as a transactional-ecological model was clearly in the minds of those who helped developed the Assessment Framework, even if that particular form of words was not used. The quote is also highlighted because it is the belief of the review that this key feature of the Assessment Framework is not always fully appreciated or practised by practitioners.

Much of the practice described in the serious case reviews is static. Too often, the Assessment Framework appears to be used in a flat, non-dynamic way. This leads to the accumulation of facts but little appreciation of how to formulate the facts in the manner of a clear explanation (rather than a dense description). Theoretically informed explanations are able to accommodate and make sense of what might otherwise appear to be a simple accumulation of facts. They guide observations. They sponsor curiosity and new lines of enquiry. They offer a framework and a language that enable different professional groups to communicate and recognise the value of sharing information helping to deepen the case formulation. But perhaps more critical, a dynamic ecological explanatory view of parent-child interaction should allow practitioners to spot warning signs at an earlier stage based on less information. It is

what is done with the information rather than its simple accumulation that leads to more analytic assessments and safer practice.

One of the key bits of information that helps frame a transactional understanding of parent-child interaction, children's psychosocial development, and children's care and protection is the carer's state of mind. This is the product of a long history of developmental transactions, the broad trajectory of which is launched by the caregiver's own experiences of being cared for, protected, and understood or not by his or her own parents. Caregiver states of mind can therefore be understood in terms of the parent's relationship history and current patterns of interaction with children, partners, peers, professionals.

Detailed descriptions of the parent's developmental, attachment and relationship history appear to be under-represented in the serious case reviews. This is in spite of strong guidance given by several of the Assessment Framework's contributors and commentators to collect and analyse social histories (Adcock 2001). For example, Rose (2001 p 43) writes 'If parents are experiencing difficulties in their parenting tasks, then knowing the parents' own family history, assessing their understanding of the impact of what is happening to them on their children, and their capacity to adapt and change becomes crucial.' In similar vein, Jack (2001 p 56-57) suggests that a family history should include a 'history of childhood experiences of parents... [It] is ...important to consider the way in which childhood experiences influence the sort of parent that a child is likely to become.' Thinking about the *meaning* that individuals give to their own and other people's needs and behaviour is critical if parents, their caregiving and relationship style is to be understood. In their review of serious cases Reder and Duncan (1999 p 22) also found few descriptions of parents' relationship histories:

...an important omission from the majority of files was information about the personal and family histories of the parents, since this restricted our ability to make sense of their relationship with other adults and with their children.

Understanding the carer's parenting capacities in terms of mental states, attachment organisation, cognitive representations, and information processing biases, particularly under conditions of environmental and relationship stressors and supports should help assessors understand parent-child interactions at the level of process. The level of process offers a more dynamic, explanatory picture of what is going on beyond a static, events-based description (Adcock 2001). In many cases, it was all too common for agencies and assessors to 'describe' their way around the three sides of the Assessment Framework without properly generating an analysis or formulation of what was happening at the psychosocial level between the key actors, including the professionals themselves. An emphasis on simply recording what happened rather than why it happened was never the intention of those who acted as consultants or who were members of the Assessment Framework's original advisory group.

Quality and quantity of information collected and analysed

Table 22 analyses the content of 42 of the intensive sample of the serious case reviews. (Although 47 cases were available, 5 involved families that were either not extensively known by health and children social care services prior to the child's death, injury or neglect, or in which the death could not reasonably have been anticipated). The focus of the analysis is on what information was collected by and available to all the agencies involved, whether or not they had shared all of that information. In other words, Table 22 provides a rough picture of the inferred quantity of ecologically based information theoretically available on which to make an assessment and formulation. It also describes the extent to which a full, coherent, and integrated assessment and formulation was achieved by the agencies involved, individually or collectively.

Table 22: Inferred levels of information collected and available in each case and its analysis, assessment and formulation (n = 42)

		HIGH	MEDIUM	LOW
<i>Quantity of information collected by or available to all agencies, whether shared or not</i>	Child's developmental needs	14 (33%)	25 (60%)	3 (7%)
	Family and environmental factors	19 (45%)	19 (45%)	4 (10%)
	Mother's/female carer's developmental/relationship history	9 (21%)	10 (24%)	23 (55%)
	Father's/male partner's developmental/relationship history	3 (7%)	10 (24%)	29 (69%)
	Parenting capacity: mother/female carer	18 (43%)	17 (40%)	7 (17%)
	Parenting capacity: father/male partner (n = 38)	6 (16%)	14 (37%)	18 (47%)
	Level of information sharing between agencies	4 (10%)	27 (64%)	11 (26%)
	Information synthesis/integration/holistic ecological description	2 (5%)	8 (19%)	32 (76%)
	Case analysis/ assessment/ formulation	2 (5%)	6 (14%)	34 (81%)

In the majority of cases, agencies collectively appeared to have accumulated medium to high levels of information about the child's developmental needs (93% of cases) and family and environmental factors (90% of cases). Descriptive evidence of the mother's (or female carer's) current parenting capacity was available at respectable levels (high or medium) in 83% of cases. A lower figure of 52% was achieved for information about father's (or male partner's) parenting capacity.

However, in 55% of cases in which there was a mother/female carer and 69% of cases in which there was a father/male present, there was little, if any information about the carer's own developmental and relationship history. The absence of information about the parent's developmental and relationship history is likely to limit the value, usefulness and insightfulness of any assessment. Although descriptions of current parenting behaviours (capacities) are necessary, on their own they lack the dynamic quality achieved when a psychological and historical perspective is taken. This deficiency was identified by a number of serious case reviews:

As the Single Agency Report states 'The assessment into the risks to [the baby] was static; a snap shot in time. Its superficiality led to a decision not to proceed with a full section 47 child protection investigation, when proper consideration of the history of either parent on its own should have generated sufficient concern to continue with child protection processes'.

...there was a lack of attention to the impact of the mother's difficult and complex experiences as a child and young woman on her ability to safely and effectively parent her children.

From the birth of [the baby] to the closure of the case [4 months later] there was no assessment of the couples [sic] relationship past or present undertaken, despite ongoing difficulties in the social worker gaining face to face contact with [mother] and the children, conflicting information being given by [mother] and [father] in respect of their relationship, and concerns about [father's] drug use and his ad hoc contact/residence with his children.

There is overwhelming evidence that the detailed information of [the mother's] past was available. There is evidence that the detail of this information was known as it was included in reports submitted to the case conference. There is nothing to indicate that this information was made effective use of by the staff in the work with the mother and the decision making regarding the care arrangements for the children...The fact that attention was not given to specifically working with her history and the implications on her needs and her abilities to parent is regarded as a major failing. There was no consistent role models upon which she could develop her parenting style. She did not experience a consistent and stable relationship during her childhood. There were significant issues of loss...There was no apparent link to the historical diagnosis and [the mother's] extended history of disruption and loss and her ongoing experiences as a parent...The work undertaken by Mental Health Services appears to have focussed on the symptoms of [the mother's] current difficulties. It appears that her background has resulted in professionals viewing [the mother] as a victim who needed support. As a consequence agencies have given her opportunities to parent that were not fully assessed in

the context of her background. As a consequence an accurate judgement on the level and nature of the risk of her parenting skills was not fully undertaken. In the plans for the children there was no indication that the issues emerging from [the mother's] past, and which clearly impacted upon her ability to parent, were addressed. Her issues of loss, the impact of her sexual abuse experiences on her ability to form relationships, the complex relationship with her mother should have featured in the assessment and decision making processes and have been the subject of specific detailed work with her. The fact that this did not occur is of major concern. [We recommend] that all agencies take action to ensure that full historical details of key family members is known and appropriately acted upon.

The perennial problem of agencies failing to share information was detected in the analysis. Full sharing was observed in only 10% of cases, although a further 64% did manage to achieve moderate levels of information exchange.

Assessments are based on the systematic collection of information and evidence, including making systematic observations. An assessment needs to be made in the context of the relationship and developmental processes that have shaped children, parents and their families. The majority of assessments and case analyses in the intensive sample were judged to be weak. Some were weak in the sense that an assessment was not explicitly undertaken. Approximately a third of cases were inadequate because insufficient evidence and information had been collected. Others were weak because, even when there was information available, they failed to examine the evidence and formulate an understanding or explanation of what was taking place. Many assessments amounted to little more than the accumulation and presentation of disparate facts and information. The interactive and diagnostic effects of vulnerability and risk, resilience and protective factors were rarely explored. Several serious case reviews mentioned this point:

Reviewing the case to this point, it is rather striking that no formal assessment of parenting has yet been undertaken, despite the persistent concerns about the quality of care being offered by [the mother]. Such an assessment would have been useful at almost any point during the last two years. Without formal assessment, there is inevitably some danger that decisions about the likelihood of significant harm and about the appropriateness of case closure may be made on the base of impressionistic and anecdotal evidence rather than detailed analysis.

The accumulating evidence...clearly pointed to the need for a comprehensive multi-agency assessment of the needs of both [mother] and [7 year old daughter] and there were a number of significant events that should have acted as the initiator of such an assessment that were sadly missed.

In order to conduct a full analytical assessment, it is first necessary to create a sound holistic ecological description of the case addressing all three domains of the Assessment Framework. This was observed to be weak in 76% of the intensive sample cases:

There is little evidence of the influence of the triangle of assessment as outlined in the Framework of Children in Need and their Families...[We recommend] that agencies undertake a review to ensure the effective use of case histories/chronologies in the management of care and child protection plans.

One of the most common themes of this Case Review is the amount of data collected by individual agencies. This Review has had the opportunity to holistically analyse all of the agencies information. From the analysis it becomes quite striking just how many indicators of risk each agency held...Failure to protect [the baby] arose from professionals failing to sit down and consider all the information they held about this family in a multi-agency meeting.

The *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000) provides 'a systematic way of analysing, understanding, and recording what is happening to children and young people within their families and the wider context of the communities in which they live' (p viii). Ideally therefore, the ecological description should form the basis of a detailed assessment, analysis and formulation of the problems, vulnerabilities and risks of harm. Their origins, possible causes and interactive effects should also be considered.

4.4 CASE FORMULATION

A *case formulation* should summarise, integrate and synthesise the knowledge brought together by the assessment process. The formulation, drawing on developmental and psychosocial theory, should provide a coherent framework for (i) describing a problem, (ii) examining its genesis, development and maintenance, and (iii) planning an intervention. It is out of this formulation that hypotheses emerge about the causes and character of the problem/concern. In turn, provisional hypotheses guide future observation and data collection. In the light of new evidence and practice outcomes, hypotheses are under constant review, evaluation and revision.

It is within the context of the analysis and formulation that new facts might be located or pursued. Each new piece of evidence should help confirm or modify the working hypothesis of the nature of the caregiving environment and the developmental risks and protections afforded by that environment for the child. Or as Reder and Duncan put it, 'it is the *meaning* of individual attributes in the context of interpersonal functioning that gives the valid clues to the risk' (p 74). Admittedly, such an analysis demands high quality practice and good interagency working but it was judged weak in 81% of cases. Although not all serious case reviews explored this issue (indeed some reviews themselves seemed weak in terms of case analysis), a number of the reports were also concerned about the quality of assessments:

No single [social] worker appears to have had the full picture and there appears to have been no systematic evaluation of the information gained through the assessment process before the case was closed.

The whole process was just an exchange of information. There was a lack of analysis of risk factors by [the Team].

Without appropriate assessment, effective intervention in child welfare cases is very difficult to achieve.

Some agencies have their own risk assessment formats that were used in this case. However, risk factors were not brought together and their significance went unrecognised. The combined risk factors of prematurity and young maternal age, in a household where there had been repeated domestic violence and alcohol misuse and which was seriously overcrowded, did not lead to a thorough assessment and co-ordinated plan of help for the children. The case raises questions about professionals' knowledge and understanding of risk factors, particularly the risk of emotional as well as physical harm arising from domestic violence.

While accepting any Initial Assessment is completed at the beginning of involvement with a family, necessitating a level of accepting information on 'face value' and with an element of basic trust, it is also fundamental when working with families, even in the initial stages, for some hypothesis to be established by social workers, in order that these and the information given can be confirmed/discounted. Thereby assisting the decision making in respect of whether or not more rigorous or not more rigorous assessment is necessary...It is my view that even limited hypothesis testing...during the Initial Assessment stage would have resulted in a clearer understanding of the family dynamics on which to base case planning.

Social work assessments should consider patterns of past behaviour, in addition to any new information about family circumstances, to more accurately reflect risk. The production of comprehensive family assessments, especially history of male figures, is imperative...Child protection for social workers should stress the importance of considering historical information as potential indicators of abuse, and, as lead professionals in child protection, address social worker's confidence to challenge the views of other professionals.

Interestingly, the serious case reviews that identified the lack of a good assessment and formulation as a concern offered a thesaurus that strongly hinted at what was needed but missing in many cases. The reviews talk of the need for *comprehensive* assessments that should be more *holistic* and *coherent* in order to paint a *full picture*. There is a demand that practitioners should look for *patterns* in the evidence and these patterns should be the subject of a systematic *analysis*.

4.5 RECOMMENDATIONS

The following recommendations emerge from the analysis of the overview reports:

- Information and evidence should be collected, and systematic observation assessed within the context of an ecological framework based on clearly understood developmental and psychosocial theories including the relationship and developmental histories and processes that have shaped parents, families and children.
- The ecological developmental framework should also provide a conceptual structure and language for presenting a case formulation that should include (i) a clear case summary and synthesis of the knowledge brought together by the assessment, (ii) a description of the problem/concern, (iii) a hypothesis about the nature, origins and cause of the need/problem/concern, and (iv) a plan of the proposed decisions and/or interventions. It needs to be emphasised that the Assessment Framework provides an ecological developmental structure which, if used well, should ensure that both practitioners and managers work together in a clear, co-ordinated and collaborative way.

Chapter 5

Key themes, understanding the cases from an interacting risk perspective: children and families

[The child's mother] had a series of violent partners... suffered with mental health problems, anxiety and depression and was misusing alcohol. The family changed address frequently ... and all three children witnessed serious domestic abuse... [The child's mother] failed to attend a number of medical appointments with the children.

This family scenario was typical of many of the case reviews, but it needs to be acknowledged that this profile is also typical of many families on the case load of a social worker. Understanding which features constitute serious and life threatening risk to children is not a straightforward matter and we do not claim to be able to produce easy answers in this respect. However this chapter tries to address how we can make sense of this kind of knowledge not only about children, their parents and the broader caregiving environment, but also about the agencies' responses to families and to colleagues from other disciplines.

This chapter discusses key themes using examples from the reviews and provides accompanying anonymised, composite case studies. The themes are drawn from the examination of overview reports, chronologies and other documentary material from the sub-sample of 47 serious case reviews (the intensive sample). The information was scrutinised to chart decision making processes, identify thresholds for agency action and intervention in each case, and highlight where gaps occurred.

5.1 THEMES EMERGING FROM THE 47 CASES

Table 23 charts the themes which emerged from the 47 case reviews in relation to domains which are similar to but not wholly compatible with the assessment triangle, and an overarching aspect of practice/professional issues that Horwath has called the 'practitioner domain' (Horwath 2006). Most themes interact and straddle all columns. For this reason, and in keeping with the ecological transactional approach discussed in the previous chapter, the majority of themes will be discussed and analysed in combination, rather than as discrete issues linked to the separate domains. The discussion relating primarily to the practitioner domain ends the analysis of factors listed in the table.

Table 23 Themes emerging
N=47

Child factors and experiences	Family and environmental factors	Practice/professionals, agency factors
Very young babies	Domestic violence	Agency context, capacity and 'organisational climate'
Illness in babies	Substance misuse	Preoccupation with thresholds e.g. CP threshold not met
Older child, hard to help	Mental ill health	Professional anxiety and reluctance to act
Sexual exploitation	Fathers, hostility, criminal convictions	Professional challenge
Going missing	Patterns of hostility and compliance	Supervision
Bullying	History of neglect	Ethnicity challenges
Suicide	Previous child death	Understanding and dealing with neglect, 'start again syndrome'
Disability, chronic illness	Poverty	Communication
	Poor living conditions	Keeping track of families
	Frequent house moves	Child not seen/ heard
	Accidents	

In-depth analysis of the intensive sample revealed that cases tended to cluster naturally into the following broad groups:

- Neglect
- Physical assault
- Older Children (aged over 13 years) and agency neglect.

It should, of course, be emphasised that these categories are not mutually exclusive. For example, physical abuse may have featured alongside neglect in a case involving an older child. Nevertheless, characteristics were identified which distinguished these groups from each other, and it is these characteristics which will be explored in more depth in this section.

A total of 15 cases were categorised as 'neglect', 17 as 'physical assault' and 15 as relating to 'older children'. It is important to note that these figures are not analogous to those cited in Table 8, Chapter 3 which refer to the primary cause of the *incident*

itself. The categorisation presented in this chapter draws on the entire history of the child and family, and was undertaken specifically for the purpose of thematic discussion of the cases contained within our intensive sample.

5.2 NEGLECT CASES

Fifteen cases categorized for analysis as ‘neglect cases’ here are those from the intensive sample of 47 which had features of neglect in the circumstances leading to the review and in past history. They included cases involving ‘overlying’, illness, accidents, house fires, as well as other more commonplace indicators of neglect or emotional harm. Three additional cases, where neglect was a significant feature involved older teenagers. These cases are considered in a separate section in this chapter which discusses older children.

Age

Six of the fifteen ‘neglect’ cases included very young children under the age of one, and the remainder covered a spread of children’s ages up to the age of eleven.

Factors linked to the child’s mother

In relation to the profile and history of the child’s mother, common factors in reviews involving neglect included many combinations of the following:

- A history of emotional and/or physical neglect, with their own mother (the child’s grandmother) being unable to offer reasonable mothering.
- Caregiving by mothers (or other carers) who were mentally and /or physically ill and either failed to seek, or accept or receive effective treatment - some histories revealed that the mother’s mother often took refuge in illness.
- The mother’s father (the child’s grandfather) is rarely mentioned.
- Periods of time in state care or in the care of relatives (for example with a maternal grandmother or aunt who tended to have significant problems of their own).
- Frequent house moves or moves at key times, for example after a death, causing a lack of continuity.
- Concerns about sexual abuse and/or sexual exploitation (for example from stepfathers etc). Sometimes explicit information was available about past sexual abuse.
- Leaving home early, in their teens, and evidence of early sexual relationships.
- Multiple pregnancies (4 -11) with many losses due to termination, miscarriage, adoption, a child or children being cared for by a relative etc. The child’s mother often appeared traumatized during pregnancy, often an early pregnancy was concealed.
- Mental ill health; depression, mood volatility, anxiety, anorexia, self-harm.
- Alcohol and drug misuse often seemed to follow later but this is sometimes a predominant feature from early on and throughout.
- Strong ambivalence to helping agencies.
- Often ‘survival’ despite appalling early history and without external support.

Factors linked to the child's father

The children's fathers either had similar early history to their mothers or, more commonly, no history was available. In addition there was evidence of criminality among fathers in neglectful families. In some cases children lived with multiple or successive adult male figures, and with half siblings. Violence and/or physical abuse of the child's mother was also common. Relationships with helping agencies were characterized by ambivalence or hostility, sometimes for example because a father (or male figure) did not consider himself to be in a parental role. Frequent uncontrolled /concealed or denied alcohol or drug misuse was associated with the events leading to the serious case review in several cases.

Environment

Information about environmental factors was sparse in almost all the reviews but more of this information tended to be available about families where neglect was a feature than the other families. This was partly a reflection of the longer term involvement from children's social care for these families. The combination of known factors indicated that the majority of families were living in poverty. Most appeared to live in poor conditions, or in some cases parts of the house or flat (often the bedrooms) were in a very poor state. There was evidence that in some families adult members of the household were in employment, but there was deep poverty despite this. While there is a known association between poverty and neglect, it is important to reiterate that not all poor families neglect their children (Stevenson 1989). It was not possible to be clear about the extent of social isolation of these families but given the profile of the parents demonstrated above, support available from family members was likely to be from individuals who shared their physical and emotional impoverishments (Tanner and Turney 2005).

The reviews also revealed isolation and lack of support for asylum seeking families who failed to meet their children's physical and emotional needs.

The combination of poverty, isolation/dislocation and racism can seriously impact on family functioning with particular implications for dispersed minority ethnic and asylum seeking/refugee families (Tanner and Turney 2005 p120).

Factors linked to the children

Younger children

In neglectful families, where the review concerned very young children, the child in question was often the last to be born in a long series of pregnancies, some of which resulted in loss through miscarriage or stillbirth. This might imply that maternal expectations of this child living may be low and it may be too frightening to invest hope in this child where a previous child had died or been removed. Most of the young children who were neglected had difficulties at birth, for example low birth weight and admission to the Special Care Baby Unit. In spite of this mothers would often discharge themselves and their babies early. Attendance at ante and post natal appointments was poor. Babies tended to receive inappropriate physical care or

discipline and/or be physically abused. Many babies were left with inappropriate carers or with individuals who were in an unfit state to care for a young child.

Older children

The profile of the small number of older children (not considered in this section) who had lived with neglect for long periods was an alarming one featuring self harm and suicide attempts which in some cases were successful. These young people are discussed more fully later in the chapter.

Engagement with agencies

In these families parents tended to avoid agencies, but agencies also appear to avoid or rebuff parents. Evidence of this rebuttal was seen through offering a succession of workers, closing the case, losing files or key information, by re-assessing, referring on, or through initiating and then dropping court proceedings. Whatever mechanisms are used, the end result is a systemic failure to engage with the parents' fundamental problems in parenting and the child's experience of direct or indirect harm:

When a Health Visitor failed to gain access to a family she referred the case to a voluntary organization and Sure Start who also failed to gain access and closed the case.

Staff also, understandably, demonstrated a fear of violent and hostile men. In these circumstances of fear and avoidance, parents had control and agencies reacted to or believed what they were being told by parents, often without knowing either parent well enough to be able to gauge whether what they were being told was likely to be true. In these circumstances of practitioner fear, workers can become paralysed. The theme of family /worker cooperation and engagement is discussed in more detail later in the chapter. Another possible consequence of worker paralysis was the failure to pick up conflicting evidence about the child. There was a tendency for practitioners working with families where neglect was a feature to see a positive report as effectively cancelling out a concern. For example in a review where a child 'appeared healthy' and was reported as having 'no behavioural problems' at school, frequent non attendance and lateness were missed, and so too were alarming observations that the child was '*often seen to be deeply unhappy*' at school.

Understanding parenting and the 'start-again' syndrome

The significance for parenting of early severe maternal deprivation from which the parent has not recovered was rarely acknowledged, nor was the impact of severe early trauma, parental death, abuse, or mental illness. In particular, multiple pregnancies and losses were not "counted" in terms of their cumulative effect. The build up of such severe hindrances to parenting often came to light only during the serious case review.

Even if these features were recorded and analysed they were not always actively taken into account, for example if care proceedings were dropped or an order was not granted, a "clean sheet" was sometimes presumed and the impact of the history went unused in future work and planning. Typical reviews of this kind featured a very young child whose mother had experienced up to 11 pregnancies, both parents had

multiple problems, and there were serious problems with older children. Families lived in very poor conditions.

The stresses that come with increased family size tended to be ignored or downgraded and escalating difficulties were missed '*as the family increased in size, so too did the parents' abilities to cope become increasingly strained*'. This could be because of a false belief that parents with a large number of children will be experienced and hence will be able to cope with a new baby. It is possible to recognize mounting stresses however, through being alert to a changed pattern of parental behaviour, and by contrasting past and present patterns. In this way it is possible to notice, for example, an escalation of substance misuse and /or domestic violence, and a worsening record of attending health appointments. In isolation these elements do not necessarily signify substantially increased stress or risk of harm to the child, but pieced together, a powerful message emerges of parents failing to cope.

Many of the families where neglect featured were well known to children's social care over many years, often over generations. The histories of these families, as we have shown, were complex, confusing, and often overwhelming for practitioners. Neglect is notoriously difficult to work with in a clear, systematic fashion and we know that the chaos and confusion apparent among the families can be mirrored by the practitioners working with the family (Mattison 1975). One common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present in what we have called the '**start again syndrome**'. In this respect a new pregnancy or a new baby would be seen to present a fresh start. In one case the child's mother had already experienced the removal of three children because of neglect, but her history was not fully used in considering her and her partner's capacity to care for this child. Instead agencies were more focused on supporting the mother and the family to 'start again'.

There was evidence that behavioural approaches focusing on the present and family strengths (for example parenting programmes) were being used as part of the 'start again syndrome'. The principle of concentrating on strengths, and breaking down desired parental change into small achievable targets is appealing and appears to offer stigmatized families a chance to prove their ability as parents. However, although apparently successful for families with low level needs, this approach can have serious drawbacks when used with families with deeper more entrenched problems, not least the dangers of setting aside family history in the focus on the present and not taking into account a lack of progress. There is a growing evidence base indicating that short term, behavioural approaches are not likely to succeed with families with long standing, complex problems (Utting et al 2007, Howe and Hinings 1998).

Referral on to short term programmes can be a coping mechanism for practitioners and managers who feel overwhelmed by families. These programmes are unlikely however, to produce the long term changes needed in families to protect children from the harmful impact of serious neglect:

[The father's] lack of interest in attending [parenting classes] was clear evidence of his continued unwillingness to address the issues causing professionals concern but this evidence appeared to be ignored.

The strategy of starting with a clean slate could be prompted by a worker leaving and a new practitioner starting afresh to form an 'unprejudiced' view of the case, thus losing the opportunity to learn from the family's history. Similarly, a worker being absent through long term sick leave could prompt the 'start again syndrome'. In one case, worker absence resulted in the removal of the child's name from the child protection register and care proceedings being halted in an attempt to manage workload problems.

The 'start again syndrome' prevents practitioners and managers having a clear and systematic understanding of a case informed by the knowledge gleaned from past history. This should not be confused, however, with the benefits to be gained from a fresh perspective on a case which can allow professionals to think differently and reconsider and revise earlier judgements. Reder and Duncan note Munro's point that reviewing judgements is hard, not only intellectually, but emotionally (Reder and Duncan 2004a p97). Revising professional opinion in these difficult, long term neglect cases might mean acknowledging that enough is enough and that the child or children should not remain at home.

The following composite case study illustrates features of many of the cases where children experienced neglect.

Case study: Ellie (age 3)

- Neglect
- Poverty and social isolation
- Not meeting the threshold for intervention from children's social care
- Parental alcohol misuse and depression

Theme of case and background

Ellie, aged three, and youngest of four children in the family, was seriously burned in an accident at home. There had been a number of reports to children's social care of all the children being seen with bruises, being left at home unsupervised and found wandering in the street. There was a pattern of the family being visited by children's social care, an initial assessment being carried out, advice given and the case being closed. Concerns about the parents' abilities to meet the children's needs were judged not to meet the threshold for safeguarding intervention.

(i) Child's needs/characteristics/behaviour

Ellie's nursery, and her siblings' schools, had expressed some concerns about the children's appearance, that they were often unkempt, and wearing inadequate or dirty clothing. Ellie and her siblings' school attendance records were poor.

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

Ellie's mother had spent several years in care as a child because of concerns about her own mother's caregiving. She returned to live with her mother in her teens and had a difficult relationship with her. As a teenager she was known to child and adolescent mental health services for behavioural problems at home. The relationship with Ellie's father began at the age of 16 and he is the father of all four children. Ellie's mother's parenting of the children was judged to be just about 'good enough' by professionals although there were persistent concerns about adequate supervision. She suffered with depression and panic attacks.

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

There was evidence of some domestic violence from Ellie's father, with one incident being attended to by the police. Ellie's father was noted to have problems with alcohol misuse. In common with many other fathers and father figures, there was little recorded information about him or his past.

(iv) Family environment

Overcrowding and unhygienic conditions were reported in the home. Ellie's parents had little support from their wider family and were socially isolated. Neither parent was in work and the family had financial difficulties.

(v) Professional involvement

The family were well known to a number of universal agencies, and the children were frequently referred to children's social care. Parents frequently failed to attend appointments, for example ante-natal appointments. Although parents complied with children's social care initial assessments, they were reluctant to accept any support offered. Some professionals felt that children's social care needed to be more involved with the family, but there was little challenge of their decision making.

(vi) Analysis of interacting risk factors

This household may be a typical example of what has been called 'depressed neglect' where "the run down feeling that pervades passively neglectful families can affect the spirits of those who work with them" (Howe 2005 p135). The missing medical appointments, poor school attendance and resigned compliance with children's social care assessments are indicative of the pervasive apathy common in families where there is this type of neglect.

Ellie's mother's own history and her current depression will mean that it is difficult for her to keep her children 'in mind'. Her caregiving will tend to be unresponsive so that her children's signals of need, distress and ultimately danger are seldom noticed. Only basic care is provided which has prompted practitioners to report that her care is 'just about good enough'. Whenever children or home life make heavy emotional demands on Ellie's mother she is likely to cope by disengaging, becoming more hopeless and depressed, or panicky and frightened.

The part that Ellie's father plays in providing caregiving is less well described. The extent of domestic violence is unclear but it is well known that alcohol misuse may be a trigger for violence. Alternatively, alcohol misuse by Ellie's father may be a means of shutting down and shutting off from the hopelessness at home. It is important to know more about Ellie's father to understand whether his behaviour contributes to the pervading helplessness and listlessness in the family, or whether his presence also provokes fear in the children and his partner, and is thus a risk of physical as well as emotional harm. Either way, in the presence of a drunk parent the child is likely to feel emotionally abandoned and frightened (Howe 2005 p184).

What could have been done differently?

A thorough core assessment led by children's social care, rather than numerous brief, initial assessments, should have been carried out on Ellie and each of her siblings to appraise the developmental progress and the ongoing concerns about the individual children. The assessments would have produced a better understanding of family functioning and dynamics if it they had incorporated knowledge of the parents' own childhood experiences and the children's and the parents' own perspectives.

Professionals needed to consider the debilitating impact that neglectful families like this have on how they think, feel and behave. This understanding might have clarified why professionals did not challenge decisions, or have the energy to keep challenging decisions.

Since many factors present in this family will be typical of a large number of families on the caseload of a health visitor or other 'early years' professionals it is important to have *clear mechanisms to report and discuss concerns and to build up a clear picture of risks and protective factors*. With families like this clear plans are needed to support children and parents over a long term period. It is also important to be able to gauge when the care is not adequate to meet children's developmental needs or ensure their safety, and to consider that children might need to be removed.

5.3 PHYSICAL ASSAULT AND HEAD INJURIES IN BABIES

This section offers an analysis of 17 reviews in the intensive sample of 47 cases where physical assault was the cause of the death or injury and was also a dominating feature of the case. Almost half of these cases involved head injuries to young babies. (Nine reviews featured physical assault, and eight head injuries to babies, which were usually referred to as 'shaking injuries').

Although the profiles of these 17 cases shared similarities with cases where neglect featured, there were also important differences. Overall these differences were the presence of "volatility", coupled with a history of previous injury, illness or admission to Accident and Emergency for the baby or child. Other differences included less contact with children's social care, or involvement for briefer periods of time and greater involvement with services for early needs or universal services.

Age

All head injury or 'shaking injury' reviews involved children under one year of age, and most of the other 'physical assault' reviews in the intensive sample related to children who were younger than 10 years of age.

Factors linked to the child's mother

In relation to the profile and history of the child's mother, very common factors in reviews involving physical assault and head injuries included many combinations of the following:

- A history of witnessing domestic violence in childhood, sometimes, but not always, linked to parental separation.
- Current or recent domestic violence, including domestic violence during pregnancy, sometimes requiring hospital admission.
- The effects of domestic violence on the child were minimised by the mother.
- Significant maternal illness during pregnancy, including illness requiring hospital admission, sometimes including discharging self against medical advice.
- For some a history of mental health difficulties. Past but rarely current involvement with children's social care, CAMHS, or other mental health services.
- A minority had a known history of sexual abuse.
- Some had learning difficulties or SEN statements when at school, and some were aggressive/violent at school and/or at home.
- Some young mothers were described as "immature", in comparison with other young mothers, with many having "poor temper control".
- Concerted efforts to conceal identity and whereabouts, for example moving frequently and changing name several times.
- Partner or father is an adult who poses a risk to a child (formerly known as schedule 1 offender).

Factors linked to the child's father

There was domestic violence in most of the households where children were living (see environmental features) and this was most often linked directly to the child's father (or their mother's partner) who often had a history of living in a violent household as a child. Where information was recorded about fathers or father figures, behavioural problems in childhood were common. Current links with probation and mental health agencies were more frequent than links with children's social care. For some fathers there was a past history of contact with children's social care.

Factors linked to the child

Some of the children were born prematurely (e.g. at 25, 32, 34 weeks) and spent their early days or weeks in Special Care Baby Units. These tiny babies with additional medical and emotional needs presented challenges to parents or others caring for them. Babies who were normal at birth might have made good early progress, but developed other problems that rendered them more difficult to care for in their early weeks, for example numerous infections, colic, or 'persistent crying'. A baby who was frequently ill and often crying could also initiate a dangerous response in carers outside of the family. One baby with no known additional needs (but who had been unwell) from a family who had used universal services only, died in the care of someone outside of the family.

A number of young babies already had a history of admission to hospital for illness or accidents which in retrospect were linked to abuse (e.g. a mistaken diagnosis of meningitis, rolling off a chair etc). Some babies had a higher number of contacts than average with primary health care services, for example visits to the GP.

Factors linked to the environment

In general, family background and environmental features were comparable with the profiles of other families in the intensive sample of 47 reviews. However, a higher number of these 'physical assault' cases were recorded as having a history of domestic violence within the household. This appeared to be especially marked where head/shaking injuries to babies were reported - domestic violence had been recorded for 7 of these 8 cases.

The key environmental factor common in many families was an atmosphere of volatility, and the word "volatile" cropped up numerous times in these particular reviews. Volatility was apparent within the household where the child was living or among extended family, and often erupted into violence. In a small number of cases the violence also extended to the use of guns. Some children were living in households of large extended families characterised by volatility and a general sense of chaos and confusion. The police were the agency most involved with these families often containing domestic or community conflict or violence.

Although there was evidence that some families had financial problems they were not showing the same signs of deep and long standing poverty apparent in the families where neglect was present. Some families were known to be owner occupiers, but this does not preclude the possibility of debt or financial problems. Multiple moves were again commonplace among some of these families and some moves signalled adversity and poverty for example a mother moving to Bed and Breakfast accommodation whilst pregnant.

Engagement with agencies

Families had more contact with low level and universal services than children's social care or other regulated services. At the time of the incident, half of these families had only low level help from agencies. No history of abuse or previous concerns were recorded for 4 of the 8 cases concerning babies with head injuries, although only 2 of the 9 cases of other physical assault were not known previously.

Some families had high levels of contact with various health professionals, especially mental health practitioners. Many, but by no means all, families were 'difficult to engage' with pre-arranged appointments missed or cancelled. When reluctant engagement was coupled with frequent moves, records would be sketchy or inaccurate and practitioners would not be aware of the sequences of events and behaviour which revealed serious risks to the child, for example *'the pattern of attendance at A&E departments, the numerous contact with out of hours services and the history of domestic violence.'*

Although there were more cases in this group than the neglect group where family violence was a factor, this did not appear to spill over into professional involvement

and engagement as often as cases in the neglect group. In one case where a father was described as ‘always violent’ there was no evidence that relationships with professionals were characterised by fear. The review suggested that triggers for the violence were not linked to engagement with professionals - *‘his use of drugs and his jealousy and possessiveness were triggers for his violence’*.

Some of the case reviews also point to a lack of awareness on the part of health staff and some branches of the police force to the link between domestic violence and the risk of harm to the child. There were several instances where this went unrecognized. In one case a mother arrived at A&E with injuries sustained as a result of domestic violence - a list of the specific injuries was recorded but *‘no mention was made that there was a child with [mother] at the time who had also sustained an injury’*.

Case study: Carly (age 9 weeks)

- Head injury in babies
- Universal services only
- Domestic violence
- History and current presence of parental volatility
- Demanding baby

Theme of case and background

Carly suffered a head injury (thought to be a shaking injury) when she was 9 weeks old. At the time of the injury the family had not been receiving any services beyond universal health care. Carly lived with her mother (aged 19), and her father (aged 20) in rented accommodation. During her pregnancy, Carly’s mother presented four times to Accident and Emergency, twice reporting assaults to her abdomen.

(i) Child’s needs/characteristics/behaviour

Carly was born at term with a normal delivery. In her early weeks she fed well, gained weight and responded well although she was also reported to have colic and to cry persistently at times. There were two recorded attendances at Accident and Emergency by the time she was 4 weeks old, one for a viral infection and the other with a rash.

(ii) Mother’s history/profile/parenting capacity

Carly’s mother was known to children’s social care and child and adolescent mental health services when younger. She had Special Educational Needs and left school early and was reported to be ‘self contained and withdrawn’ at school and aggressive at home. Police were regularly called to the family home during Carly’s mother’s adolescence to respond to reports of violence among family members. She moved frequently between family members during her childhood and adolescence.

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

Carly's father had a history of mental health problems and behavioural problems throughout childhood. He had taken a number of overdoses and was reported to have poor anger management and poor self control. There was domestic violence in his household when he was younger and his mother had long term depression.

The health visitor noticed that both parents' emotional reaction to Carly was immature and exaggerated in comparison to other young parents.

(iv) Family environment

The family suffered harassment by neighbours. There were financial difficulties in the household and police had been called to an incident of violence between parents. The parents did not feel supported by extended family.

(v) Professional involvement/ engagement

Both parents had high levels of contact with a range of health professionals, including the health visitor, the GP, NHS Direct out of hours service and attendances at Accident and Emergency in the early weeks of Carly's life. Although parents sought help actively, pre-arranged appointments, for example with the health visitor, were often missed or cancelled. No health professionals were aware of the high level of contact with different branches of the service, nor of the pattern of contact (for example the repeat attendances at A & E.)

Medical professionals were not aware of the domestic violence and did not explore this possibility with Carly's mother or consider the potential risk to the unborn baby, nor did they consider the impact of the both parents' mental health difficulties on their parenting abilities.

(vi) Analysis of interacting risk factors

There were many interacting risk factors in this case namely: high levels of domestic violence in pregnancy including blows to the mother's abdomen, mental health problems, frequent moves, lack of family support, financial worries and poor anger control for both parents. The combination of these issues signal that stress levels in these young parents were high and the capacity to deal with the demands of a new baby would be likely to be compromised. 'Persistent crying' and colic provided markers that this baby was at a high risk of injury from these parents whose emotional reaction to their baby had been noted as 'immature' and in whom a distressed baby would prompt high levels of anxiety, distress and agitation (Howe 2005 p71).

In volatile parents with this sort of profile the safest ways for children to behave are to be emotionally self contained and independent thereby making low demands on their caregivers. In this sense babies are always at risk of provoking a stress response since they cannot fend for themselves and need to seek care and make demands on their carers in order to survive. 'Easy' undemanding babies may cause less distress and agitation in carers but premature, unwell, frequently upset and fractious babies will cause high arousal in parents which may then trigger violence.

What could have been done differently?

Information sharing. There was a need for information to be shared within and across health services in the ante and post natal period so that the risks of harm to the baby could have been properly considered. Given the parents' frequent moves this information needed to be widely accessible.

A holistic assessment. A holistic assessment during the ante-natal period could have incorporated an understanding of the parents' history and the expertise of key professionals who knew the parents to consider the impact of parental history, mental illness and domestic violence on their parenting capacity.

Taking account of the parents' responses. When the baby was born the early responses of the parents were a significant clue to their coping capacity. Had the parents' pattern of seeking help been logged, their mounting panic at times of stress would have been evident.

5.4 DOMESTIC VIOLENCE, SUBSTANCE MISUSE AND MENTAL HEALTH DIFFICULTIES AMONG PARENTS AND CARERS

The examination of the intensive sample of 47 reviews showed that families shared many similar characteristics, particularly in the preponderance of domestic violence, mental health difficulties and substance misuse among parents and carers. The reviews revealed that it was much more common for these features to exist in combination than singly. This is clearly demonstrated for the intensive sample of 47 cases in the Venn diagram (Figure 5) which displays violence, (broadly defined) mental ill health (including learning disability) and substance misuse and includes cases where:

- a) there was a history of parental substance misuse
- b) either or both parents had mental health problems or a learning disability
- c) there was evidence of parental violence, including domestic violence

(More details about Venn diagrams and other examples are listed in Appendix 2.)



Figure 5: Intersection of parental characteristics: violence, mental health issues and substance misuse (n=47)

All three factors present	16 cases	(34%)
Any two of the three factors present	16 cases	(34%)
A single factor present	9 cases	(19%)
No factors apparent	6 cases	(13%)

In over a third of reviews (16) there was evidence that all three factors were present, and these are represented in the central segment of the diagram. There were seven cases where violence and mental health problems co-existed, but no apparent substance misuse; a further six where violence and substance misuse were noted, but no recorded mental health problems and a further three cases combined substance misuse and mental health problems, but no reported violence. Far fewer cases reported one of these three factors singly. There were four, three and two cases respectively where violence, mental health problems or substance misuse were

reported, but in the absence of the other factors. It is, however, important to note that in six of the 47 cases (13%) none of these factors were reported as being present.

This study of serious case reviews shows a higher level of co-morbidity than Cleaver et al's recent study of 357 referrals to children's social care where in only a fifth of cases domestic violence and substance misuse co-existed (Cleaver et al 2007). Since their study sought out cases where there were known concerns of domestic violence or substance misuse, our findings of both a greater volume, and more overlap of these potentially damaging parental characteristics are brought into sharper focus. Our findings reinforce Cleaver et al's view that when domestic violence and parental drug or alcohol misuse coexist, the effect on children's lives is more serious, but our study also raises important questions about the added impact of parental mental ill health, which need further examination. This is a key finding which should inform both assessment and intervention.

5.5 OLDER CHILDREN AND 'AGENCY NEGLECT'

The theme of older adolescent children who were very difficult to help emerged powerfully from the detailed examination of the 47 cases. Fifteen of the 47 cases involved older children over the age of thirteen (most were over the age of fifteen). Twelve of these older young people had a long history of high level involvement from children's social care and other specialist agencies, including periods of state care often as the subject of a care order, while three young people had limited or no contact with specialist services.

Profile of 'hard to help' young people who had intensive involvement with agencies

Children who had experienced extensive contact with agencies shared most of the following features:

- A history of rejection and loss (often including the death of a parent) and usually severe maltreatment (physical, sexual, and neglect often in combination) over long periods of time: *'G had been repeatedly abused over time by several family members, but no-one in her family was willing or able to look after her.'*
- A history of long term intensive involvement from multiple agencies e.g. from children's social care, Child and Adolescent Mental Health Services and often Youth Offending Teams.
- Parents or carers with their own history of abuse and rejection, most of whom misused substances and had mental health difficulties: *'assessment of mother's parenting unable to continue because of her mental health difficulties; all children placed outside of the family'*
- It was difficult to contain these young people in school. Challenging and threatening behaviour to staff and fellow students resulted in temporary or permanent exclusions from school: *'x excluded from school for bullying and theft.'*
- By adolescence, if not earlier, these young people were typically harming themselves and misusing substances (drugs, alcohol, aerosols).

- A pattern of self neglect could accompany the self-harm and this might include an inability to manage chronic illness or other serious health problems, and a habit of presenting at Accident and Emergency for emergency treatment or to seek nurture.
- Numerous placement breakdowns: *'Setting fires in foster home, placement breaks down'*
- Running away and going missing.
- Going missing increased the risk of sexual exploitation and risky sexual activity and sexual exploitation was a significant concern in a number of reviews.
- At times these young people were placed in specialist therapeutic settings or secure units, but they were often discharged home because of persistent running away, so that at the time of the incident which prompted the serious case review they may have been receiving low level services only.

This list amounts to a catalogue of risk factors which reinforce Rutter's findings that it is the cumulative interaction between these difficulties that produces the most harmful effects (Rutter 1979). Adolescence as a stage of development can mark the start of serious problems for some young people; mental health problems are more likely to emerge and there is an increased risk of drug use, offending and running away (Biehal 2005). Difficulties in adolescence may be associated with family relationships.

'Running away and youth homelessness are also indicators of family problems for young people, as they are often associated with abuse, neglect and unresolved conflicts between teenagers and their parents' (Biehal 2005 p23). For the young people who were at the centre of serious case reviews the mediating factors that could perhaps redress some of the impact of family difficulties, for example a pro-social peer group, a supportive school environment, or good problem solving skills, appeared to be missing. The reviews showed that state care did not always support these young people fully and that they experienced 'agency neglect'.

Two young people were discharged home from residential care because of persistent running away. Both were living at home at the time of their death even though in both cases relationships with parents were known to be very damaging. For these older young people whose vulnerability was often clear, age was in some cases used as a reason for services not being imposed. One overview report writer pointed out that there was no judgement of the young person's capacity to refuse services (Gillick/Fraser competence), and that an unfair onus was put on the young person to 'choose' services.

In most of these cases there had been pockets of excellent practice in past years but by the time of the incident, for many of the young people, little or no help was being offered because agencies appeared to have run out of helping strategies. In one case foster carers struggled hard over many months to look after a young woman of sixteen but gave up because they could not cope with her self destructive, self harming behaviour, and she was moved to a homeless person's hostel.

Agency involvement

Agency responses to these 'hard to help' young people often included the following:

- A reluctance to assess these young people as mentally ill and /or with suicidal intent (CAMHS).
- Failures to respond in a sustained way to the young people's extreme distress which manifested itself in their very risky behaviour (e.g. suicide attempts, self harm, sexual exploitation).
- Arguing about which agency is responsible for which service and whether thresholds were met. This delayed the provision of services that the young people needed.
- The causes of running away (usually underlying effects of loss, rejection and abuse) were not properly addressed. Instead the young person would be contained until the next opportunity to run away presented itself.
- Discharge home because of persistent running away.
- Older age was used as a reason for services not being imposed.
- Lack of coordination of services for these young people 'in transition'.

There is a need for more creative, more responsive services for these young people. Current evidence suggests that specialist adolescent support teams in the community, with good links with a range of agencies, appear to offer the best opportunities for engaging these hard to reach young people (Biehal 2005, 2006). Stein et al's ongoing study about adolescents and neglect may also shed more light on how to work more sensitively with this group.

Ian's case study exemplifies the effects of serious long term neglect, rejection and abuse for older children, and demonstrates how young people who have lived with significant harm for many years carry the effects of abuse with them and may be extremely hard to help (Brandon et al 2005b).

Case study: Ian (age 16)

- Long term neglect
- Rejection and serious abuse
- 'Hard to help' young person
- Suicide

Theme of case and background

Ian was one of four half siblings and was 'on and off' the child protection register from the age of four because of neglect, physical and suspected sexual abuse. He was 'in and out of care' from the age of thirteen. Whilst in care he regularly ran away, met older men and was suspected of being involved in sexual exploitation. At the age of fifteen he was discharged home from residential care because of persistent running away. He was living at home and getting very little support at the time of his death through suicide.

(i) Child's needs/characteristics/behaviour

Ian's behaviour at school and at home was described as 'unruly', and from the age of thirteen, 'threatening and violent' including the use of weapons, which prompted numerous exclusions from school. Ian started to run away from home at the age of ten and by the beginning of adolescence he started to harm himself seriously, misuse substances (drugs and alcohol) and to talk of suicide. He had convictions for assault following fights with friends, although he was unable to keep friends for long. He moved into foster care at age 13, ran away repeatedly and experienced numerous placement breakdowns with intermittent return home (which was never successful). Recent placements had included therapeutic residential care and a period in a secure unit.

(ii) Mother's history/profile/parenting

Ian's mother experienced depression and low self esteem and was subject to domestic violence over many years from different partners including Ian's father. There had been serious concerns since Ian's birth about his mother's parenting ability. Her own history was one of severe abuse and neglect.

(iii) Father's history/profile/parenting

When Ian was five years old his father died from a drug overdose. Ian had a number of step father figures, the most recent of whom was a heavy drinker, with convictions for physical assault.

(iv) Family environment

Domestic violence was a recurrent feature of Ian's home life.

(v) Professional involvement

Ian's name was listed on the child protection register intermittently from the age of 5-9 (neglect and physical injury). At 13 Ian was first accommodated and later made

the subject of a care order. From the age of eleven he was known to Child and Adolescent Mental Health Services and from age 14 to the youth offending service. Ian was assessed as 'not mentally ill with no real suicidal intent' numerous times.

(vi) Analysis of interacting risk factors

As he matured and entered adolescence the effects of many years of neglect and abuse at home became apparent in Ian's behaviour. His responses typified those of young people with similar experiences where feelings switch between hostility and aggression, and fear and helplessness. The need to feel in aggressive control is a characteristic response to the kind of caregiving that Ian experienced over many years. In addition, his early adverse experiences are likely to have increased his sensitivity to stress leaving him vulnerable to stress related psychiatric disorders, self harm and suicidal ideation (Howe 2005 p163). Discharging Ian home to his mother's care catapulted him into danger as he was reminded that he was unwanted and bad and he would not have been able to cope with the feelings this evoked. His mother was also helpless to contain his powerful and self destructive urges.

What could have been done differently?

Help the carers. Ian will have transferred his unsuccessful coping strategies from home to his placements. As such he will have sabotaged attempts to contain him and offer safe and trusting relationships. Good quality support and training for his carers may have helped them to understand the complexities of his behaviour and how helpless and angry he made them feel. If they could have been given strategies for dealing with and anticipating his behaviour they may have been helped to stick with him for longer and perhaps reduce Ian's need to run away. Such help could be available within, for example, Multi-Dimensional Treatment Foster Care (Chamberlain and Smith 2003). This treatment model produces good outcomes (Utting et al 2007) and is currently being piloted in England and evaluated by York University.

Provide high level support to young people who return home. Although it may be the worst place for them, many young people in transition, like Ian, feel compelled to go back home and will push for it relentlessly. Once back home he and his mother needed a high level intensive support not a low level service.

Suicide

Suicide was the known or probable cause of death for fourteen of the 161 young people in the full sample and some of these cases were found in the intensive sample of 47 cases analysed in this chapter. Some other 'accidental' deaths, in the intensive sample, including 'overdoses' may also have included suicidal intent:

[The child's death] which may or may not be suicide, gives rise to concerns about the degree to which neglect, by her parents and /or services may have been a factor which gave rise to concerns about the way in which local professionals and services work together to safeguard children.

Suicide in young children is rare and thirteen children aged between 10 and 14 lost their lives in this way in England between 2002- 2004. A larger number of 237 older young people, aged between 15 and 19, killed themselves over the same period (NSPCC 2006). These official statistics may not be reliable however and could be an under estimate. Coroners may be reluctant to conclude suicide as a cause of death in the absence of a suicide note and determining the difference between a tragic accident and suicide is difficult if certain precipitating behaviours at the time of the child's death are not known (NSPCC 2006). The more robust information being gathered by the new child death review teams, proposed in Chapter 7 of *Working Together to Safeguard Children 2006*, may produce a better understanding of child suicide, and will help to provide a clearer backdrop for understanding these deaths within serious case reviews.

The suicide of children and young people is also a specific criterion which requires consideration for a serious case review in Chapter 8 of *Working Together to Safeguard Children* (HM Government 2006a) and it is notable that Area Child Protection Committees, during the period 2003-05, felt this issue was their concern and were using a child's suicide as a reason to call a serious case review.

The small number of cases concerning suicide divide into those young people who were well known to a large number of welfare and protective agencies, over many years, with the same profile as the hard to help young people discussed above, with histories of severe maltreatment and rejection. For a couple of other young people, only lower level problems (being bullied and /or bullying) were known to fewer agencies, for example schools, and in one case there was limited involvement with children's social care. The additional information gleaned through the course of the serious case review about these young people thought to have low level needs did however reveal other, deeper problems like experiences of loss and bereavement and difficulties at home:

Professionals didn't share information with each other and didn't take account of the interaction of the young person's needs - including losing his mother at age 4,being bullied, and ...his difficult relationship with his stepmother.

The author of one overview report concerning the suicide of a young person who had been the victim of bullying had undertaken a brief literature review on the circumstances which predicted an increased risk of suicide for young people (e.g. Samaritans 2001). The serious case review was thus able to disseminate the

knowledge that adolescents who are bullied, or bullies themselves, are at increased risk of suicidal ideation (Royal College of Psychiatrists 1999 factsheet 290) and that previous suicidal behaviour among family members or friends may offer a precedent to adolescents and thus becomes a further risk factor.

Not all of the young people who experienced bullying appeared to be ‘victims’. One young person was described as “challenging and robust” and was thought to be as likely to bully as be bullied. Being a bully was not thought to be a vulnerability. Being ‘feisty’ and popular at school appeared to lead children’s social care to believe that a young person was resilient and thus ‘immune’ to problems at home so that when behaviour at school worsened this wasn’t picked up as a marker of other difficulties at home. The school also believed that the young person would be able to seek help and advice when needed.

A model of suicide prevention is presented in Appendix 7.

5.6 AGENCY CONTEXT AND ‘ORGANISATIONAL CLIMATE’

Managing workload under pressure and ‘capacity’

The state of ‘health’ and capacity of agencies providing services for the children at the centre of these reviews was rarely apparent from executive summaries or other minimal information sources. The fuller detail provided in overview reports available for the 47 cases, tended to describe this context more often and thus shed more light on the pressure agencies were under, especially, in this cohort of reviews, children’s social care.

In situations where social workers were carrying, for example, 70 cases, priorities were decided which often led to serious lapses in safeguarding. This included cases being closed without core assessments completed (despite at times this being in child protection conference recommendations) and cases which reached the threshold for children’s social care help but which remained unallocated, or were kept out of the child protection system:

In deciding that this case was not to be followed up under child protection arrangements, it became one of, at the time, eighty ‘child welfare’ referrals awaiting attention.

This ‘*serious backlog of work*’ also produced delays in appointing other professionals for example children’s guardians:

No social worker was allocated to the case for five months despite all four children being on the child protection register under categories of emotional abuse, physical abuse and neglect, and three children under the category of sexual abuse. As a consequence, there was no core assessment, no written child protection plan and no written agreement with parents.

In one case the absence of a nurse practitioner, due to sick leave, was thought to have exacerbated the deterioration of the young person's mental health difficulties, in another worker absence meant that the agency was unable to keep to their plan of visiting a family with high levels of domestic violence and alcohol misuse on a weekly basis. A worker's absence can coincide with a crucial period in the life of a child and the importance of managing cover and providing vital support for children and their families was stressed in a number of reviews. High levels of staff sickness and absence need to be managed actively.

It was not only front line staff who were absent, however, but also managers. Difficulties in filling team manager posts, part-time managers, acting managers, peri-managers and periods of time for teams with no manager at all, contributed to a lack of support and oversight for hard pressed practitioners. In these circumstances supervision falls by the wayside:

Supervision has a key role in monitoring and overview of case progression when unpredictable day to day events can distract involved professionals.

Resource constraints and performance indicators are perceived as providing incentives for low or dropping numbers of children looked after, and promote a reluctance to accommodate or provide placements to safeguard children. In this context children are (reluctantly) left at home or discharged home:

the current climate in [local authority] would have put pressure on staff to keep as low as possible the numbers of children looked after.

Thresholds, levels of involvement and intervention

Understanding thresholds was a key component of the study and the analysis of the 47 reviews provided the opportunity to understand the way that thresholds between agencies and services were interpreted. All 47 cases were plotted on a chart to represent the level of service offered at the time of the incident. Another dimension which emerged as a significant issue in the reviews was the way in which families cooperated or resisted services. This too was charted. Thus the plotting represented two concepts; firstly levels of intervention during one snapshot of time (the time of the incident) and secondly the degree of family cooperation with agencies at the same time. A simplified version of the threshold mapping exercise is explained below while a more detailed threshold maps are displayed in Appendix 4 and 6.

Figure 6: Threshold map of level of intervention and degree of family or child co-operation with agencies at time of incident n=47

	Lack of co-operation	Co-operation
Levels 3 and 4 (Children in need, and regulatory/ restoratory services)	23	3
Levels 1 and 2 (Universal services and early needs)	9	12

Figure 6 charts the position of the 47 serious case reviews studied in depth in relation to two factors; firstly the level of service or intervention (Levels 1-4) that the child was receiving at the time of the incident or circumstances which prompted the serious case review, and secondly, the degree of cooperation from the family or the child with agencies providing the services.

Levels of intervention

The vertical axis of Figure 6, shows levels of intervention, with levels 1 and 2 combined and represented along the bottom half of the axis, and levels 3 and 4 combined and represented in the top half. It is apparent that there was a spread of agency involvement in the 47 reviews across all levels. Although twenty six children were receiving high level services above the threshold for intervention from children’s social care (top two quadrants at levels 3-4), for twenty one children only additional needs or ordinary universal needs had been recognized (bottom two quadrants at levels 1-2). This reinforces the findings presented in Chapter 3, where the analysis of all 161 cases showed that only a small proportion of children were listed on the child protection register (12%) at the time of the incident which prompted the serious case review.

This offers an important reminder of Lord Laming’s comment in the Climbié Inquiry report that “child protection does not come labelled as such” and has significant implications for the need for all practitioners to be aware of the risks of significant harm across all levels of need and intervention. At the lower levels of intervention (levels 1 and 2) it reinforces the need for practitioners from all agencies to have a holistic understanding of children and families and to consider the way in which

separate factors can interact to cause increased risks of harm to the child. This means that practitioners working at levels 1 and 2 who are identifying additional needs for children (for example those who are working with the Common Assessment Framework and Lead Professional structures) need support in understanding when it is safe to work with early, low level safeguarding concerns and when to engage with children's social care and, if appropriate, to adopt LSCB safeguarding procedures. Although *What To Do If You're Worried a Child is Being Abused* (HM Government 2006c) sets out the key roles and responsibilities of practitioners and how they should respond to their concerns about a child's welfare, it does not deal with the subtleties of working with, for example, early stage low level neglect, or parental stress.

It is also important to point out that the threshold map took account of the time of the incident or circumstances which prompted the serious case review and that thresholds for services changed over different periods of time. A number of cases had been 'closed' to specialist services days or weeks before the incident.

Co-operation

Degrees of co-operation between families and agencies in the 47 cases did not fit neatly along the continuum which makes up the horizontal axis of Figure 6, and there were many different strands within the notion of 'cooperation'. However it was possible to divide the evidence about engagement with services by parents, carers, or older children, into a continuum representing degrees of co-operation. The concept of 'lack of co-operation' included hostility, avoidance of contact, many missed appointments, disguised or partial compliance, ambivalent or selective co-operation. 'Co-operation' included neutral co-operation, a willingness to co-operate or engage and persistent help seeking. Figure 6 shows that more than in more two thirds of the 47 cases studied in depth there was 'a lack of co-operation' and this often included overt hostility, and sometimes threats, towards staff.

An example of a case in the top left quadrant of 'lack of co-operation' and high level services includes a family where children were listed on the child protection register because of risks posed to the children by domestic violence:

Patterns of resistance and lack of co-operation need to be considered in terms of what they may mean in any particular case and how that affects the safety and welfare of the children.

Many factors influence the way that families engage with services. The way that professionals respond to parents can often promote more or less cooperation or hostility. A recent government policy review discussed families' motivation to engage with services and found that families who suffer from problems that hamper their ability to parent effectively may be reluctant to engage with services and not trust the support offered (HM Treasury/DfES 2007 p85). This was found to be because they:

- Do not feel staff understand their needs, do not think that the support on offer meets their needs, or have had negative experiences with services and the way they have been treated by staff;

- Are in denial about their problems or afraid of sanctions if they ‘own up’ to having difficulties managing their life, e.g. they fear that their children will be taken away from them;
- Get no support for non-acute problems for a long time even if they ask for it, and then an overwhelming amount of support when problems become so bad that they meet service thresholds; or
- Do not get joined up support.

(HM Treasury/Department for Education and Skills 2007p 85).

The evidence drawn from this policy review about why families may be reluctant to engage is quoted in detail as much of it matches the information gleaned about families from the case reviews in this study. In particular there was evidence of families ‘in denial’ or not owning up to problems, and of disguised or partial compliance where families were ‘good at keeping things from professionals’. The following examples demonstrate these points:

There is no evidence of any relationship with a professional in which she becomes substantially engaged and which she uses to tackle her problems. [The child’s mother’s] repeated failure to keep appointments and comply with other requirements could have been confronted more pro-actively.

Advice and guidance from child protection agencies about the welfare and protection of the children was ignored or minimised by the family and the concerns of child protection agencies remained unabated.

Patterns of co-operation and the effects on workers

In situations where there was parental hostility, there was evidence that workers often became frozen and this hampered their ability to reflect, make judgments and act clearly, and to follow through with referrals, assessments or plans:

Workers can become paralysed by their own fears and anxieties, which can lead to the assessment process remaining incomplete.

The emotional demands of work with children and families are well documented and a number of authors (for example Cooper 2005; Horwath 2006; Woodhouse and Pengelly1991) have identified anxiety among practitioners which spills over into practice with the families and work alongside other professionals. The national evaluation of CAF and LP discovered that these anxieties are not restricted to practitioners working with high level risk but also occur in practitioners working with children with additional needs (Brandon et al 2006b p411).

Disguised or partial parental compliance also wrong-footed professionals. Apparent parental co-operation often prevented or delayed understanding of the severity of harm to the child, as demonstrated in the following review:

Overall, professionals appeared to tolerate the lack of progress on the protection plan over the years.....there were periods where [the mother] agreed the protection plan, complied with some aspects for short periods, and ignored others, usually with excuses that focused on immediate and urgent problems e.g.

illness, domestic violence, housing arrears, deaths of siblings and family members. In this situation of 'apparent compliance' it is extremely difficult for professionals directly involved in the family to sustain an objective view of a lack of progress in safeguarding children's welfare. The role of managers and particularly the conference chair is critical in ensuring that these cases do not drift.

The links between co-operation and not seeing or 'hearing' the child

A better understanding of the lack of focus on the child, and children not being seen alone may be achieved if this recurrent failing is viewed as part of the pattern of 'co-operation'. Not 'attending' to children needs to be understood as a component of professional engagement with parents or children. For example, in one case parents made it very difficult for workers to see the children alone:

A recurrent issue is the virtually complete failure to seek, far less establish, the wishes and feelings of each child of the household...[the mother] effectively prevented any direct individual contact with the children, even when this was belatedly attempted by the social worker. The protection plans did not include any contingency arrangements to address this failure in assessment.

In other instances apparent compliance disguised the way in which a parent engineered the focus away from allegations of harm:

The health visitors did not consider the implications of the dissonance between [the mother's] description of [the child] and their own professional observations of his behaviour. The possibility that [the mother] might have been deflecting attention away from the allegations to focus on [the child] as a problem was simply not considered.

Where the needs of the parents overshadowed those of the children, the focus of professional engagement was parents and children were missed. This also applies to babies who are not yet able to speak for themselves and can be ignored:

[The baby] was too young to express an opinion about his care but it was known that he had been described as 'constantly crying'. Opportunities to examine him, to check for any other indications about his well-being, were not taken. The opinion of his mother, who was known to have been unable to care for her first child, was accepted. At a time in his life when it was known that he had not been taken to four planned appointments with health, and that his mother had failed to be in when she knew the health visitor was due to call, a further attempt to see him was abandoned despite the sound of a crying baby being heard at his address.

Thresholds wrangles

Many of the cases plotted on Figure 6 clustered just below the threshold for services at level 3 (the 'eligibility criteria' for children's social care, s17 Children Act 1989, or 'child in need'). Cases also grouped at the boundary of level 3 and 4, usually representing a hesitancy about whether or not this was a 'child protection' case. The

detail available from the reviews often reflected a preoccupation with these boundaries and which professional group was 'responsible' for the child:

There appears to be confusion and disagreement between agencies over what services can be offered and are appropriate to be offered.

The problems of struggling to achieve the threshold for child protection are particularly acute in working with neglect:

Referrals of neglect in some ways require a different approach than other child protection concerns. It is important that agencies adequately support staff, particularly by being clear and explicit about thresholds for urgent intervention. This was the third referral of this family to Social Services in seven months, which did not result in appropriate follow-up. That suggests that services may have been operating at thresholds for intervention which were set too high.

It is now a function of Local Children's Safeguarding Boards to agree thresholds and this is discussed further in Appendix 5.

Supervision

The effects of limited capacity on supervision of staff was commented on in many reviews: *'the standard of social work and health visiting raise questions of supervisory standards and/or capacity of supervision opportunities.'* Effective and accessible supervision is essential if staff are to be helped to put in practice the critical thinking required to understand cases holistically, complete analytical assessments, and operate an ecological transactional perspective. Supervision is also essential to help practitioners to cope with the emotional demands of work with children and their families which has an impact at all levels of intervention (Brandon et al 2006b; Horwath 2006).

Scrutiny of the 47 reviews revealed a number of concerns about poor supervision to front-line workers, especially social workers. Staff in education, health and the voluntary sector were also found to need access to support, supervision and in particular to child protection advice. In some of these sectors supervision may be less of a priority than in children's social care and therefore less likely to take place.

Deficits in social work supervision mean that there is no objective overview of a case and no scrutiny of the quality of social work practice, for example in assessment:

At the heart of the critique of this case lies concern that the core assessment work undertaken on members of the family was incomplete and the work of the professionals concerned not sufficiently challenging.

An objective overview is particularly important in cases of chronic neglect which are prone to drift. One review recommends a supervision framework in neglect cases to monitor progress in implementing the protection plan and checking the extent to which the children's needs were being met.

Similarly, supervision for social workers should provide a clear record of decision making and accountability, although in some reviews it was not clear whether decisions made were those of the manager or the social worker. Other confusions and disagreements were sometimes evident in the divisions of role and responsibility between social worker and manager. Clarity of role and leadership were also important when a number of different agencies were working together:

...clear leadership with consistent messages would have been beneficial to provide clarity and support for workers.

Geographical mobility and keeping track of families

A recurring theme was the difficulty faced by professionals working with families who moved frequently and the potential for agencies to 'lose track' of children in these highly mobile families. This issue was a key finding in the Victoria Climbié Inquiry and has been acted on by the government through the establishment of the new information sharing system 'ContactPoint,' which will include basic identifying information for all children in England (name, address, gender, date of birth and a unique identifying number for all children aged up to 18 years).

This study showed that frequent moves may contribute to a significant lack of clarity among professionals. This was exemplified by one family who had at least 9 moves during a 10 year period, including stays with relatives, permanent and temporary housing, bed and breakfast accommodation and stays at women's refuges. Continuity of service provision was lost for these children because of the extremely high mobility of the family, a situation which was compounded by lack of GP registration and irregular school attendances. Key information regarding neglect, sexual and physical abuse was not transferred from one agency to another. As a result, professionals lacked a full knowledge of the family history and at one stage the children 'disappeared' from all professional monitoring following a move. As was so often the case, the 'whole picture' was only to become evident at the time of the serious case review:

Information was 'patch-worked' across a network of agencies and areas, with no single agency holding the whole picture of a family or even agency history.

A number of other examples, contained within the intensive sample, serve to reinforce this point. These reviews highlight the need for professionals to endeavour to maintain a continuous record and minimise disruptions to service provision following the geographical move of a family.

The issue of poor agency information transmission between geographical areas was not only relevant to families who moved frequently - as the following case demonstrates, just one move can present similar difficulties:

...the lack of availability of historical background information from [Area A] at the outset of [Area B]'s SSD's involvement with this family had a significant impact. Initially, the serious nature of the case was not recognised and agencies were not working together effectively.

Ethnicity, religion and professional reluctance to act.

Lack of accurate cultural knowledge, cultural relativism and misplaced sensitivity were evident in professional attitudes to some cases concerning black and minority ethnic families. Examples include believing that anaemia in a child was attributable to weaning practice when it was more likely to have been linked to neglect, and failure in separate reviews by a teacher, school nurse and police officer to follow child protection procedures because the community considered that intervention from children's social care would bring shame and stigma to the family. One young woman had spoken about her fears about a forced marriage but professionals were reluctant to act because of anxieties about bringing shame on the family through their actions.

The sense that '*it was a difficult situation because of cultural issues*' dampened down the kind of professional curiosity essential if interacting risk factors were to be considered and promoted, instead, a reluctance to act. In one case a child was fearful to go home but was obliged to do so because, again, agencies were reluctant to intervene in family life.

A typical factor which caused increased stress, and needs to be taken into account by all professionals working with children and families, was lack of support from extended family because of family opposition to an inter-faith marriage.

Professional Challenge and Communication

The reports contained some examples of good practice, where professionals had correctly challenged the judgement of other individuals or agencies, and other illustrations of difficulties in calling into question the opinions of colleagues. Hesitancy in challenging others seemed to stem from a lack confidence, a lack of knowledge, or a lack of experience. So for example in one case although many workers disagreed with a decision, none were prepared to act on their professional judgement in the interests of the child:

...although not all agencies agreed with this, no one took decisive unilateral action to try to prevent it.

Sustained professional challenge was difficult and a difference of opinion or judgment was rarely pursued to a satisfactory conclusion:

The efforts made by [the senior police officer] to get the grave concerns of some professionals translated into decisive action at the previous conference and to achieve an appreciation of what would ensue if the planned work was not achieved, appeared to have been dissipated.

One review describes how only one professional (a child protection nurse), working with a family, had recognised the mounting risk of harm posed to the children and wrote a series of letters and faxes expressing her concerns. Despite this, no consequent action was taken. The review points out that the form of communication used (letter writing and fax sending without verbal follow-up) probably led to the information becoming diluted. This observation has implications for practice, with

the suggestion that direct verbal communication may provide a more immediate and effective way to share concerns. Since there is considerable emphasis currently on electronic information sharing it is very important to remember the power of personal contact.

In some instances, professionals had refrained from voicing concerns when these had been dismissed by others considered to be better qualified or to have more authority. One single agency report (probation) describes how staff were reluctant to challenge children's social care for this very reason:

...the [probation] staff appear to have lacked confidence in being more proactive in the face of a consistent dismissal of their concerns by the social worker to whom the case had been allocated...

In a further striking example, where a child had been brought into A&E, a nurse was alert to signs of non-accidental injury and persistently challenged the opinion of the consultant paediatrician. The nurse's assessment was informed by her extensive experience of working with child abuse cases during her previous job at an inner-city hospital:

[The nurse] mentioned the extensive marks she believed to be bruising on [the child's] body. The response from the Paediatric Consultant was that the bruising appeared consistent with that of a normal three year old. [The nurse] did not pursue it further at that stage as she was a nurse and the doctor was a consultant.

The report describes how eventually, given her colleague's reaction, the nurse doubted her own judgement and began to wonder whether she was over-reacting. In common with other examples of professional challenge highlighted in the reports, her relevant expertise appears to have been under-valued:

The fact that the nurse raised the issue, and continued to raise it, is highly commendable. The fact that the rationale for her assessment i.e. her recent and considerable experience of child abuse and protection was not used as part of a whole team response is lamentable.

In contrast, an A &E sister challenged the opinions of two Senior House Officers and insisted a referral be made to children's social care. It is worth noting that, in this case, the A&E sister had more experience than her colleagues and had the confidence to act on her own professional judgement.

Previous studies of serious case reviews have emphasized the importance of sustained and dogged professional challenge (Brandon et al 2002). Evidence from the reports analysed for this study add further weight to these findings:

It is not enough for agencies to attend to share information, they may need to act. It is for each agency to challenge [the other agency] where it is in disagreement and to bring to the attention of their own line management and ultimately the line management within [the other agency] should they feel that inadequate account has been taken of their view.

There were particular messages for children's social care:

The Social Services must....ensure that there is a lack of defensiveness in the response of its staff to the challenge and disagreement of partner agencies.

The following composite case study exemplifies some additional stumbling blocks to successful professional challenge in work with child with a disability who experienced neglect at home.

Case Study: Andrew (age 12)

- Professional challenge
- Child disability
- Neglect
- Working with powerful families

Theme of case and background

A serious case review was undertaken after Andrew was accommodated at the age of 12 in a severely neglected state. He was disabled, though professionals differed in their opinion of his diagnosis. Several agencies assessed that Andrew needed to be cared for outside of the home but there was a year's delay in this happening. The insistence of a senior health professional finally led to the admittance of Andrew into foster care.

(i) Child's needs/characteristics/behaviour

Andrew was born premature and he was referred to the local Child Development Centre because his early development was slow. Andrew's parents failed to attend these appointments and he was not offered any early help. His behaviour caused difficulties for his parents at home, and problems arose at school during his early years in education. Andrew was always fully dependent on his parents or others for all his self-care needs and his appearance was described by professionals as grubby and unkempt. His parents explained that this was because he wouldn't cooperate with them (or anyone else). His parents chose to educate him at home from the age of eight and Andrew became socially isolated, as he rarely left home and had limited outside contact. Andrew did not have a clear diagnosis for his condition, which was the subject of much dispute among parents and professionals.

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

Little is known about Andrew's mother's childhood. She had post natal depression after Andrew was born and in the early years spoke of some difficulties in caring for her son.

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

Little is known about Andrew's father's past.

(iv) Family environment

Andrew's parents were both articulate, well qualified professionals who owned their own home. Andrew's mother gave up work to look after her son and his father ran his own business from home. The house was clean and tidy, with the exception of Andrew's bedroom which was described as very untidy and unhygienic.

(v) Professional involvement.

A large number of professionals were in contact with the family during the course of Andrew's life and at various points concerns were raised about his care. On one occasion a child protection conference was held but Andrew's parents and some professionals opposed these concerns and the decision was made to work within the 'child in need' procedures. Parents were reluctant to accept most services for their son however and a core assessment was not undertaken. Over the years professionals continued to disagree among themselves and found it difficult to challenge both the parents and each other. Significant professional focus was placed on treating Andrew as a disabled child, focusing on his behaviour, with little assessment of the daily care he received.

(vi) Analysis of interacting risk factors.

Andrew's parents' articulate manner and social competence enabled them to exert power and control over their son and outside professionals without challenge. Andrew as the least powerful person in the family is denied a voice doubly (first as a child and secondly as a child with a disability). Without being aware of these dynamics, professionals cannot cut through the control.

What could have been done differently?

Not treating a child differently because of their disability. Andrew was allowed to live in conditions which for any other child would have been considered degrading and unsuitable. His disability was held responsible for his state of welfare and the care he was receiving. He needed to be treated as a child first, with his special needs coming second.

Challenging parental power. Working in partnership is important but the child's needs must not be lost or overshadowed by the parents' power and authority. Parents' social status should not influence professionals' behaviour.

The need for a lead professional. A lead professional should ensure that services are co-ordinated, coherent and achieving intended outcomes for the child. A lead professional in this case should have avoided the considerable delay and lack of unity in providing services for Andrew, particularly regarding his educational needs. Conflict with parents might have been avoided in these circumstances, although if Andrew's needs were still not being met it would be necessary to insist that child protection procedures be followed. This would have been a very challenging role for a lead professional who would need good support.

The need for professionals to have the confidence to challenge each other's opinions. Individual professionals were concerned about neglect but none followed through their concerns in a sustained manner. The presence of a large number of professionals made it more difficult to speak out against the opinions of others. Each professional has the individual responsibility to challenge others when necessary and to keep the child central in the progress of the case.

Chapter 6

Implications for Safer Practice

6.1 INTRODUCTION

The reviews studied took place in the immediate aftermath of the Victoria Climbié Inquiry when widespread policy changes were being put in place with the aim of preventing further avoidable deaths to children. The professional failings in the serious case reviews would have been felt acutely by staff working with children and families at this time. Workers would have felt that if the lessons had been learnt, then lives should have been saved. In spite of the efforts to move away from the blame culture, serious case reviews do sap morale and leave professionals feeling defeated. There is a pervading sense that knowledge and resources will never be enough to cope with the increasing demands from families and from employing agencies. The findings from this study illustrated the struggle that practitioners and managers faced in trying to deal with overwhelming workloads and cope under pressure.

To work effectively with complex cases, like many of those in this study, professionals must be self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions (Cooper et al 2003, Glisson and Hemmelgarn 1998). If management structures and staff support systems collapse, the result is often paralysis in the workers, or ill health, or absenteeism or other signs of stress (Brandon et al, 2002). Without the basic infrastructure needed to undertake this demanding work, mistakes will be made at all levels of intervention. We are arguing that identifying and understanding interacting risk and protective factors is a core task in work with children and families. Safe, thoughtful, practice is not possible without proper support for front line staff.

The analysis of the reviews here has shown that the numbers of factors that interact and increase or decrease the risk of harm to children are extremely complex. Even if the 'whole picture' of family circumstances had been known, it would not have been possible to accurately factor in and compute a clear outcome for most of the children at the centre of the reviews. As Lord Laming commented "It is unrealistic to expect that it will ever be possible to eliminate the deliberate harm or death of a child – indeed, no system can achieve this" (para 17.89 Cm 5730 2003). Similarly, it is not possible to anticipate with any certainty the effects of interventions, even though Jones and colleagues (among others) have shown that interventions can be planned and evaluated more systematically (Jones et al 2006). The complexity of many of the reviews studied means that most cases of serious harm may be essentially unpredictable. Thus living with uncertainty and risk is at the core of work with children and families - a further reason that good support is needed.

Even if serious abuse to the children could not have been accurately predicted, the reviews revealed that there were numerous childhood adversities in the majority of the cases under scrutiny and that professionals had not always grasped this. The most common place adversities echoed many of the key indicators of recurrence for maltreatment in Hindley, Ramchandani and Jones' systematic review (Hindley et al 2006). Neglect, parental conflict, parental mental health problems, parental substance

misuse, 'family stress', a lack of social support; families with younger children and parental history of abuse were found in different combinations in many cases. The Hindley et al study's key risk factor of previous *known* maltreatment was *not* present however in most of the serious case reviews studied here. It is therefore essential that professionals are alert to the way in which difficulties *interact* if they are to understand the child's experience of day to day care and have a better sense of how significant harm might arise.

In order to have a better chance of understanding how difficulties interact, practitioners must be encouraged to be curious, and to think critically and systematically. Although predicting serious abuse to children is not straightforward, it is crucial for professionals to feel that they and their employing agency have done their best for the child. Being aware of interacting risk and protective factors and analysing how they are playing out in child and family dynamics is a vital step in this process. Thinking critically and systematically will also help to avoid over-reaction which is extremely dangerous. It is important to remember that the majority of children living with high levels of adversity will *not* be subject to serious abuse. There is not a straightforward causal link between these adversities and serious abuse to children.

Rather than interpreting the findings from this analysis through a failure lens, it is better to consider the kinds of responses and working conditions that are more likely to produce safe practice. It also needs to be reiterated that safeguarding children is everybody's business, not just the domain of professionals working with children and young people.

Key messages:

- If management structures and staff support systems collapse, the result is often paralysis in the workers, or ill health, or absenteeism or other signs of stress;
- Good support is needed so that practitioners can work effectively with complex cases. Practitioners must be self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions;
- Most serious child abuse is essentially unpredictable - even if the 'whole picture' had been known, it would not have been possible to anticipate serious abuse for most of the children at the centre of the reviews;
- There were numerous childhood adversities (including indicators of recurrence of maltreatment) in the majority of the cases but these were not known to all of the professionals involved prior to the serious case review being undertaken.
- It is crucial for professionals to feel that they and their employing agency have done their best for the child. Professionals must be alert to the way in which difficulties and protective factors interact if they are to understand the child's experience and how significant harm might arise.

6.2 WHICH INTERVENTIONS MAY BE MORE SUCCESSFUL?

Ages of the children and patterns of injury

Two-thirds (106) of the children in this sample died and a third (55) were seriously injured as a result of the incident, or circumstances, which prompted the review. This proportionately lower number of deaths than in previous studies suggests that safeguarding bodies may be selecting more cases of serious injury to review and are not restricting their learning to the circumstances where children have died. It also shows, from a research perspective, that the full serious case review sample should not be used as a child homicide measure nor should it be compared solely to other cases of fatality. Since this is the first study of a near full sample of serious case reviews, it is premature to be considering patterns of injury in any depth. Further studies of similarly full samples will be able to build on our analysis and offer more insights into patterns and other possibilities for detection and prevention of abuse.

Infants and pre-school aged children

The group of 161 children were highly vulnerable in terms of their age and developmental stage, particularly since almost half were less than twelve months old. There was some evidence that different patterns of injury and incident applied to children and young people of different ages. There was a comparatively low proportion of deaths for the youngest children aged under twelve months, particularly among those babies who suffered head injuries. Although two thirds of these babies survived the injury, some suffered permanent damage. This highlights the urgent need for early detection of parenting difficulties, particularly since many of these very young babies already had a history of previous injury, illness or admission to Accident and Emergency which could have been seen as warning signals. Further study is needed to evaluate whether attendance at A&E or hospital admission (or other health care attendance) might be markers of children who are vulnerable to assault and whose families are in need of supportive early intervention.

For older infants aged 1-5 years there was a higher proportion of deaths than for the younger babies. House fires and accidents prompted the reviews as well as physical assault. Providing either earlier intervention or intensive intervention *may* have prevented some deaths or serious injury among these youngest children and their families. The review of intensive programmes for parents and toddlers by Olds (2006) draws attention to the effectiveness of focused interventions for these very young children. These kind of intensive interventions have been found to be effective for families with more severe problems (Utting et al 2007).

A small number of the families had been helped by Sure Start programmes. These, or similar types of accessible early intervention, may be helpful in containing some parental stress in families with less severe problems, thereby raising parents' capacity to be 'mindful' of the needs of their young children. The national evaluation of Sure Start found that where it was successful, this provision did lead to higher levels of maternal acceptance so that mothers were less likely to slap, scold or use physical restraint with their child. However a number of 'hard to reach groups' tended not to use Sure Start facilities, and these included single lone parents, those involved in

domestic violence, substance misuse, asylum seekers and refugees (Anning et al 2007).

For services to be effective hard to reach families need flexible responses which take account of their individual circumstances. One-size-fits all approaches are rarely effective.

The diversity of family structures and the multi-faceted nature of the problems facing excluded families make tailored, flexible and holistic services vital to improving outcomes. Many services offer little flexibility to respond to complex lifestyles and rapidly changing circumstances. Families with multiple problems are often the least able (or willing) to navigate the complex web of support to which they are entitled. Consequently, interventions can be least effective with some of the most vulnerable families. (Cabinet Office 2007 p42)

Older children

Fewer physical assaults were reported for the older age groups, with 14 in total for all children aged six years and over. The kind of incident reported for children aged between 6-15 years also included sexual abuse, sexual exploitation and being missing from home, which contributed to a lower proportion of deaths. Nearly all of the reviews for those over 16 years of age were undertaken because a young person had died, most notably as a result of suicide.

It was clear that most of the teenaged children had grown up in climates of significant adversity. The deaths of older adolescents show the consequences of the failure to address trauma. A trauma perspective (Batmanghelidjh 2006, Bentovim 1996) would acknowledge the cumulative stresses to which these older young people had been exposed through their lives. When trauma is not addressed there are risks for school failure, anxiety, depression, substance misuse, and engaging in violence. Such problems will become apparent to children's social care, child and adolescent mental health services, substance misuse treatment services and criminal justice groupings. All these agencies have the opportunity to identify and address the roots of these problems.

Key messages:

- Early detection of parenting difficulties is crucial so that timely help can be offered;
- Patterns of help seeking can be warning signs of parenting difficulties and abuse. These can include (for babies and young children in particular): admissions to Accident and Emergency, a history of injuries, or a history of illness;
- Accessible early intervention programmes like Sure Start may be helpful in containing parental stress in families with less severe problems, while intensive and focused intervention can be effective for families with more severe problems;

- ‘Hard to reach’ families need flexible, individually tailored services;
- For older children, including ‘hard to reach’ young people, the effects of early maltreatment and trauma need to be acknowledged and addressed by all agencies working with young people and their networks.

6.3 INTER-AGENCY LINKS

There were variations in the types of agencies who knew about the children and young people. While the majority of families had been known to children’s social care in the past (83%) only just over half of the children (53%) were receiving services from children’s social care at the time of the incident. The rest of the children were known only to universal agencies like health and education, or to other specialist services. The families of very young children who were physically assaulted (including babies with head injuries) tended to have had the least, or the briefest, contact with children’s social care. The possibilities for detection of difficulties and preventive work with this group of children and their families needs further study.

Some of the children’s parents were known to specialist adult services like substance misuse services, or adult mental health services, but links were not made with children’s social care. This offers a crucial reminder for managers and practitioners in adult services that they must be aware of the risks of harm to children and work together with colleagues from children’s services (Falkov 1998, Cabinet Office 2007). Two thirds of the children in the intensive sample of 47 cases were living with extreme family conflict including violence. The police were the agency which responded most often in the many cases where there was ‘volatility’ and domestic violence.

The Children Act 2004 provides a mandate for agencies to work together to improve the wellbeing of children, and through Local Safeguarding Children Boards, to safeguard and promote the welfare of children. Section 11 (2) places a duty on those statutory agencies who are most likely to be in contact with or working with children, including the police, to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children. Police officers responding to calls where there is violence, probation officers seeing offenders and mental health specialists working with parents or carers need to be alert to the effects of adult behaviour on children in the household.

In many of the reviews there was an overlap of parental problems of domestic violence, substance misuse and mental health difficulties. As in previous studies of serious case reviews, and other children’s services cases (e.g. Cleaver et al 2007), there was little evidence of shared expertise between specialist services like substance misuse services and domestic violence units with children’s social care. Safer practice requires professionals from different agencies to look beyond their individual specialism and to think more broadly to acknowledge the impact of parental behaviour on children in the household (Brandon et al 2005; Cleaver et al 1999).

The Cabinet Office’s latest review of families at risk reinforces this view (Cabinet Office 2007) and asserts the need for joint working to grasp the root causes of

problems and develop appropriate responses accordingly. Children's services cannot achieve this without better join up with adult services:

Even the most effective integrated responses from children's services will only ever ameliorate the impacts of parent-based risk factors on a child. To reduce the actual risk factor at source, joint working with adults' services is required to tackle the parents' problems. (Cabinet Office 2007 p29)

This implies that mental health, substance misuse, criminal justice services and indeed all other services aimed at adults not children must make children as well as adults a priority in their services. This echoes the findings of Cleaver et al 2007 who also underline the importance of passing on information about adults to agencies working with children.

The recent use of the Common Assessment Framework and of lead professional roles, has raised awareness of the possibility, and the desirability, of staff from any agency identifying a child's needs for additional services so that early help can be provided (HM Government 2006b). If staff from all agencies grasp the dynamics of interacting risk and protective factors they are more likely to understand the impact of different forms of parental behaviour on children and the risks of harm they might face. This approach may also help practitioners to decide whether it is more appropriate to carry out a common assessment or to simply report an incident, for example, of family violence (Cleaver et al 2007 p10).

Key messages:

- The families of very young children who were physically assaulted tended to have the least, or the briefest, contact with children's social care which puts a greater onus on universal agencies to recognise signs of harm to children;
- Understanding and using an interacting risk perspective will help practitioners to recognize the possible effects and risks of harm to children from a wide range of adult behaviour. This is important for staff carrying out common assessments or acting as lead professionals;
- Staff in specialist adult services like substance misuse services, the police and adult mental health services must also prioritise children and work together with colleagues from children's social care;
- Substance misuse, mental ill health and domestic violence may co-exist. Practitioners should understand that this may increase the risk of harm to children but does not *predict* serious injury or death;

6.4 IMPLICATIONS FOR SERVICES

Universal services and early needs Levels 1 and 2

At the lower levels of intervention, findings reinforce the need for *all* practitioners to have a holistic understanding of children and families and to be aware of the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child.

Guidance and training for the Common Assessment Framework and lead professional roles stress the voluntary nature of these services and emphasise that where there are child protection concerns, child protection procedures must be followed (HM Government 2006b). However, effective early intervention will uncover *early* risks of harm, many of which will not need to be referred to children's social care. All staff working with children with additional needs should understand that they are working *within* the safeguarding continuum and not in a separate sphere of activity. This may require a shift in the mindset of practitioners and managers working with early needs and of government departments issuing guidance for these staff.

There is not a clear blue line between working with additional needs and the safeguarding continuum. This should be reflected in training and guidance so that staff can be helped to understand when it is safe to work with early, low level concerns where parents are giving their consent, and when to follow Local Safeguarding Children Board procedures without delay. The Secretary of State's address at the DCS/ DASS Annual Conference in October 2007, appeared to acknowledge that early intervention work does involve working with risk at an early stage:

And when children are at risk, intervene early to help children and their families get back on track and prevent problems turning into crises (Ed Balls 2007)

Some widely applicable public health and public information messages have emerged from the findings which are borne out in other much larger studies. These messages are pertinent universally but have a particular resonance where maltreatment occurs. There is substantial danger to babies from parental volatility and loss of control, which in this study, seemed to be linked to physical assault and head injury in babies. This message needs to be publicised widely and information needs to be spread, via ante-natal classes, and through large scale public advice campaigns on television and hoardings. Simple advice needs to be given so that, for example, parents and carers know that if a baby is crying and they fear they will lose control and harm the baby - it is best to walk away. Similarly, contact details of advice lines need to be publicised widely.

A number of infant deaths occurred through 'overlying', where parents or carers smothered their babies while sleeping. Sharing a bed with your baby is not of itself risky behaviour, and is commonplace in many countries and cultures. However the research base demonstrates that there are substantial risks to infants in the following

circumstances: if the parent has taken drugs (prescription or illegal) or alcohol, if the parent or carer falls asleep with the baby on a sofa or chair rather than in a bed, and if the parent is a smoker (Blair et al 2006).

Other danger comes from water scalds. Dressler (2001) and Titus et al (2003) have demonstrated that in relation to burns, the highest level of morbidity and mortality to infants results from scalds. However, the damage from these burns can be reduced dramatically if water flowing from taps is held at a lower temperature (e.g. 55 degrees Celsius). In terms of public health, there are simple messages from the wider research community and from this study that have particular relevance for families where other stresses are in play.

Key messages:

- *All* practitioners need a holistic understanding of children and families and need training about the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child;
- Early intervention and working with early needs is part of the safeguarding continuum and not a separate sphere of activity;
- There is substantial danger to babies and children from parental volatility and loss of control. Parents need strategies for managing babies and young children in particular, if they feel they are losing control;
- To reduce the risks of ‘over-lying,’ public messages should make it clear that it is safer to share a bed with a baby than to fall asleep on a sofa or chair, but bed sharing with babies should never happen if a parent or their partner is a smoker or has been drinking alcohol or taking drugs;
- To reduce the risk of scalds and burns water temperature at home should be kept down, especially with young children in the household.

High level services

Levels 3 and 4:

In just over half of the reviews there was a high level of involvement and monitoring from children’s social care or from staff in other supervised settings (for example hospital care or adult residential establishments). Where families were known to children’s social care at the time of the incident or circumstances which prompted the review, they tended to have been known over long periods of time and sometimes over generations. However, only 12% of children’s names were listed on the child protection register suggesting that for most of the children, the risk of significant harm was not considered to be high by professionals, or that the risks were not recognised.

Thirteen children (8%) were already the subject of legal orders and a further sixteen (10%) were being ‘looked after’ indicating a high threshold of concern and surveillance for their welfare and safety. These included the older adolescent children, many of whom were very difficult to help. All of the hard to reach young people had

experienced long term, high intensity services. However for some of the neediest young people, services were being withdrawn or scaled down at the time of their death through suicide. Performance indicators, requiring a reduction in the numbers of children looked after, may be making it difficult for workers to provide services for hard to help young people who tend to spurn help.

These very vulnerable hard to help young people need more creative, more responsive, individually tailored services that extend into their adulthood. Services should be sustained and planned on a long term basis so that they can address root cases and not just respond (or fail to respond) to young people's distress. There needs to be a clear transition from children's services to effective and responsive adult services. Since these young people are often extremely challenging to help, excellent support is needed for those providing their care.

Specialist adolescent support teams in the community, with good links with a range of agencies (Biehal 2005, 2006) or Multi-Dimensional Treatment Foster Care, (Chamberlain and Smith 2003) have been found to offer good opportunities for engaging these hard to reach young people and to achieve good outcomes (Utting et al 2006). If carers can be given strategies for dealing with, understanding, and anticipating young people's difficult behaviour, they may be helped to contain them for longer and perhaps reduce the need for young people to run away and reject those caring for them. If vulnerable young people return home, both the young people and their parents or carers need a high level support service not a minimal service.

The problems of struggling to achieve the threshold for intervention to protect children from harm were widespread and increased the harm to young people leaving them isolated and without help. Arguing about which agency is responsible for which service and whether thresholds are met must be replaced by a shared commitment to young people and clear, well coordinated multi-agency involvement. Local Safeguarding Children Boards have a key role to play in rectifying the long standing problems with thresholds. Their success in relation to establishing clarity and a common understanding of thresholds will be an important measure of their effectiveness. This issue is considered in more detail in Appendix 5.

Key messages:

- Vulnerable, hard to help young people need creative, responsive, long term services. Agencies need a shared commitment to providing these services and there should be a clear transition from children's services to adult services;
- Specialist support should be available for carers (including family) to help them cope with difficult and rejecting behaviour of 'hard to reach' young people.
- Arguing over thresholds and finding ways to avoid providing services, leaves vulnerable people cast adrift. Local Children Safeguarding Boards have a remit to consider thresholds.

6.5 WORKING WITH NEGLECT

Many of the families where neglect featured were well known to children's social care, mostly over very many years. Hindley, Ramchandani and Jones' study has revealed that the risks of recurring abuse are higher with neglect than other types of maltreatment (Hindley et al 2007). Yet these were the cases where practitioners appeared to be most at sea in their work and decision making was at its most tentative. The histories of families where children experienced neglect were complex, confusing, and often overwhelming for practitioners. Practitioners from all agencies struggled to engage properly with children and parents in these circumstances and address the harm children were experiencing.

Neglect is notoriously difficult to work with in a clear, systematic fashion (Gardner forthcoming, Stevenson 2007, Horwath 2007). If those who supervise practitioners support them in undertaking systematic and rigorous work, the tendency to put aside knowledge of the past and focus on the present could be dispelled. The '**start again syndrome**' that we have identified prevents practitioners and managers from having a clear understanding of a case informed by the knowledge gleaned from past history which can be matched to present understanding.

Professionals need to consider the debilitating impact that neglectful families have on the way workers think, feel and behave. It is important to have clear mechanisms to report and discuss concerns and to build up a systematic picture of risks and protective factors. Where neglect is endemic, long term plans are needed to support children and parents over an extended period. Practitioners and managers must also be able to gauge when care from parents and networks is not adequate to meet children's developmental needs or ensure their safety, and to consider that children might need to be removed from home.

The government emphasis on prevention and early intervention can make this problematic for practitioners and their managers. The document *Reaching Out: Think Family* includes statements like 'it's never too late to act preventatively' (Cabinet Office 2007 p32). While this is valid advice in respect of most families in difficulty, it is not always so in cases of entrenched long term neglect where the hard decision that 'enough is enough' may need to be made. This document's specific example of childbirth providing an opportunity for families to be more receptive to services could, arguably, be encouraging a 'start again' mentality. This approach can be a stumbling block, preventing practitioners thinking and acting systematically in cases of long standing neglect.

Key messages:

- The risks of recurring maltreatment are higher with neglect than other types of abuse. Practitioners need support to prevent them becoming overwhelmed and to help them to think and act systematically in cases of neglect and to avoid the 'start again' syndrome.
- The policy emphasis on early intervention and prevention can make it harder for practitioners and managers to make difficult decisions about removing children from home in cases of severe neglect.

6.6 SUPERVISION AND WAYS OF WORKING TO PROMOTE BETTER CO-OPERATION

Effective and accessible supervision is essential if staff are to be helped to put in practice the critical thinking required to understand cases holistically, complete analytical assessments, and operate an ecological transactional perspective. While supervision is needed to give practitioners a sense of direction and keep them on track, it is not adequate for it to be restricted to checking and accountability. As a process it needs to help practitioners to think, to explain and to understand. Supervision is also essential to help practitioners to cope with the emotional demands of work with children and their families - and this has an impact at all levels of intervention, not just in social work. Within agencies where supervision is not readily available, at a minimum, a structured process of consultation should exist for child protection concerns. Without supervision or accessible professional consultation, practitioners working with children and families with early needs may struggle to cope. Supervisors, like practitioners, need access to regular training.

Patterns of co-operation between families and professionals were complex and affected the way that workers behaved with families and thought about the child and the case. Practitioners need to be mindful not only of how and whether or not the young person or family are cooperating, but *why* they might be behaving in this way, at this time, with this particular professional? Psychosocial and developmental theories can help to explain why, for example, young people including parents who have never learnt to trust, will test workers who, in turn, need to prove their reliability and responsiveness. Why families might be avoiding or cancelling appointments also needs to be thought through in the context of other aspects of their lives. Practitioners should be aware of their gut feelings and reflect on what they might mean. If a family makes you feel frightened, what is it like to be a child living in this household? In the many cases where there was parental hostility, workers often became frozen, which hampered their ability to think and act clearly. Robust supervision is needed to help the worker to recognize the impact of hostility and also to guard their own safety.

Many factors influence the way that families engage with services. The way that professionals respond to parents can promote more or less co-operation or hostility. The service user literature is replete with examples of families who feel they are not treated with respect, kindness or compassion and often fail to get any service beyond assessment. Besieged workers may feel they have nothing left to give. Being self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions is a much better platform from which to notice potentially damaging patterns of cooperation like disguised compliance.

Lack of parental cooperation or unwillingness to accept help raises problems for interventions below the threshold of formal safeguarding procedures, where the state has no mandate to intervene compulsorily and families must agree to agency involvement. If a family fails to attend appointments that are necessary to safeguard the child's welfare or safety, or refuses to take up a service that the child requires, this should be taken into account as part of the assessment. As a consequence, the level of concern may raise the case to a higher threshold. This too is a management as well as a practitioner issue. The Victoria Climbié Report reinforced the need for senior managers to be committed to safeguarding children and this commitment needs to

extend to an organizational climate and organizational practices that value and support children, families and workers.

Key message:

- Supervision helps practitioners to think, to explain and to understand. It also helps them to cope with the complex emotional demands of work with children and their families.

6.7 End note

Our argument throughout this study has been for the need for practitioners and managers to be curious, to be sceptical; to think critically and systematically but to act compassionately. It is not helpful to be sceptical in the absence of compassion. It is our hope that the findings presented here will go some way towards promoting this way of thinking and will safeguard and promote the welfare of children more effectively.

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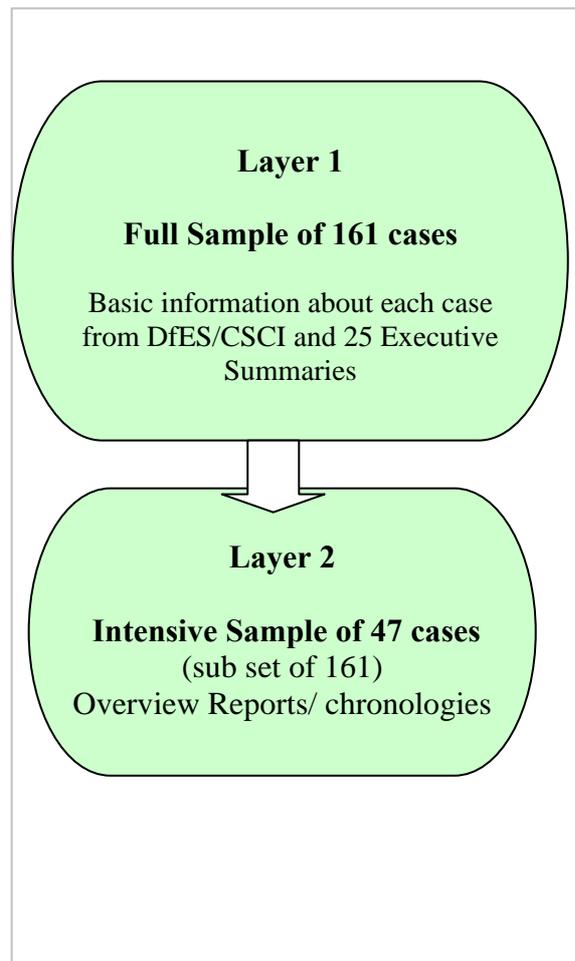
APPENDIX 1: METHODOLOGY

1. Introduction

A mixed methods approach was used to carry out the inter-linking parts of the research. A primarily quantitative technique was employed in the collection and analysis of data from the total of 161 Case Reviews, while a qualitative technique was undertaken for the documentary analysis of the sub sample of 47 cases in Phases 2 and 3. Figure 7 simplifies the whole process, including the complex route by which the sample was captured.

In order to manage the relatively large number of cases, the ‘layered reading’ method developed in the team’s earlier studies of Welsh Serious Case Reviews (Brandon et al 1999, 2002) was adopted. This involved building information about both the Full Sample of 161 and the Intensive Sample of 47 from layers of initially minimal, and later more detailed information as it became available. For the total sample of 161 cases, information was systematically collected from layers which are simplified here into Layers 1 and 2. Layer 1 was made up of initial DfES and CSCI held information on all of the 161 cases recorded on the CSCI database following notification of Critical Child Care Incidents (CSCI 2005), during the period 1 April 2003 to 31 March 2005. It also included executive summaries from some of the serious case reviews. Information was collected from these sources and analysed using a Researcher Completed Coding Framework. The Intensive Sample of 47 cases formed Layer 2 and comprised the fuller more detailed material about each case contained in the Overview Reports from each of the 47 Serious Case Reviews (and chronologies where they were supplied).

Figure 7: Access to the Full Sample of 161 cases and the Intensive Sample of 47 cases



2. Researcher Completed Coding Framework

A Coding Framework was drawn up to enable analysis of background data from the full sample (from Layer 1, see Figure 7). The choice about which variables and categories to select were drawn from a number of sources:

- those used by Sinclair and Bullock (2002) in their report analysing data from English Serious Case Reviews. This was to optimise comparability with the current study;
- from Brandon et al's (1999, 2002) studies of Welsh Serious Case Reviews to enable comparability with other British reviews;
- from items in the CEMACH protocol (2006) to provide a potential point of comparison with analyses for this new data collection instrument which was being trialled for all child deaths in England;
- from elements within the ALSPAC longitudinal study of children in Avon (Sidebotham et al 2001, 2002, 2003), which includes an examination of risk factors for children on the child protection register;
- from learning derived from the initial reading of 25 Executive Summaries.

3. Access to and selection of the full sample of 161 cases.

The process of access to the sample which is simplified in Figure 7, is explained in more detail below.

1. Access was initiated via information provided from CSCI (and passed to DfES) about 139 of the serious case reviews reported within the two year time period 1/4/03-31/3/05. CSCI held basic data which included the child's name, date of birth, the originating local authority, child's ethnicity, incident type, date notified and the SSI region.
2. A web search was used to locate publicly available Executive Summaries from each of the relevant local authorities (via LSCB/ACPC websites). This identified only 17 summaries which matched the list of 139 cases. A further 8 Executive Summaries were sent by DfES resulting in a total of 25 Executive Summaries with some information which could potentially be coded.
3. Further information about 301 potential cases was derived from the information reported to CSCI when a local authority completes the form 'Notification of Serious Child Care Incident' (CSCI 2005 Appendix B). *"The notification process also supports the child protection process. The CSCI is responsible for populating the database, which can be accessed by DfES for reporting and analysis purposes. It is therefore important that local authorities and providers understand and deliver their notification duties, but also that BRMs and other CSCI staff ensure that all necessary action is taken on receipt of such notifications"* (CSCI 2005 p2).

Information requested in these notifications includes: the local authority and notifier details, linked cases, the type of notification, child's name, date of birth, and gender, parents names (nb. parents' dates of birth are *not* requested in the

CSCI 2005 edition but appear in some earlier completed notifications), siblings names and ages, ethnicity, child on child protection register and category, siblings on child protection register and category, legal status, child disabled, type of incident, date of incident/death, residence/placement at time of incident, incident cause, media interest, name of institution (if accommodated) institution sector, outline of case, characteristics of case, whether the case is linked to a complex abuse investigation, name(s) of alleged abuser(s) and information about criminal proceedings and conviction (CSCI 2005 Appendix B).

4. The notifications were categorised into four different groups according to their labelling;
 - ‘serious case review confirmed’ (164 cases);
 - ‘death of a child looked after’;
 - ‘serious harm’ and
 - ‘serious case review possible but not confirmed’ (5 cases).

The reviews labelled ‘serious case review confirmed’ (164 cases) and ‘serious case review possible which were later confirmed by the Executive Summary web search, (5 cases) made up the potential research sample. Eight ‘SCR confirmed’ cases were removed, either because multiple reviews concerned siblings in the same family or because of anomalies which cast doubt on the accuracy of their labelling as a serious case review (for example a small number of cases concerned adults who posed a risk to children which would have been more correctly dealt with under MAPPA arrangements). This produced a total sample of 161 cases.

5. All available material relating to the 161 cases was read and Coding Frameworks were completed. Researchers also compiled a written summary for each case. Data were entered into SPSS Version 14 for analysis.

There were some initial concerns about the quality, quantity and comparability of some of the information received in these early phases of the study. This raised some doubts, initially, about the quality and quantity of information available for the Full Sample of 161 cases which had potential implications for the reliability and consistency of the data to be analysed. The information compiled has, however, proved to be useful and cross checking has ironed out many inaccuracies. Areas where more accurate and consistent information was recorded and held included information on gender, type of injury/death, ethnicity, where the child was living at the ‘time of incident’ and some other features. Other potentially reliable information included whether the child’s name was listed on the child protection register, and whether the child is /was the subject of an order.

The information available for the Full Sample of 161 cases therefore provided a useful opportunity to analyse some data from a large number of serious case reviews in England. This is the first time a national analysis has been undertaken of a near full cohort of serious case reviews.

5. Access to and selection of the Intensive Sample of 47 cases

1. By September 06, detailed information in the form of Overview Reports was available for only 27 of the 40 Reviews needed to make up the Intensive Sample. To keep within timescales it was imperative to gain access to the remainder of the Intensive Sample quickly.
2. The Commission for Social Care Inspection indicated that 30 additional reviews containing an Overview Report could be made available quickly. A selection from these 30 cases was made considering a spread of age, ethnicity, family factors (i.e. mental health, drug misuse) and a mix of cases which had and had not been known to Social Services Departments at the time of the incident. As a high number of neglect cases had been noted in the full sample, cases involving neglect were also reflected in the intensive sample.
3. A total of 47 Overview Reports and some full serious case reviews were subsequently provided by CSCI. It was originally proposed that detailed analysis be conducted on a sub-sample of 40 of these reviews. However, in order to make best use of the additional material available to us, the sample size was extended to encompass all 47 cases received.

A qualitative approach was undertaken for analysis of the documentary material available for the intensive sample. The process of analysis was informed by holding regular team meetings (comprising researchers from different professional backgrounds) to discuss emerging ideas and themes. The initial findings and themes were further explored with local advisory group and project Steering Group.

The first stage of data analysis involved the construction of analytical chronologies. The history of each case was reviewed by a member of the research team and written up as a brief chronology. Family events were listed alongside services that were known to be offered to the family over time. Thus it was possible to see the evolving pattern of support or protection and legal status over time, matched to family incidents and relationships, life events or patterns of harm to the child. The information contained within chronologies was colour coded according to levels of intervention and need at different points in time. Completed chronologies were utilised in two ways:

- ‘Threshold mapping exercise’. Each case contained within the intensive sample was plotted on a large chart (the ‘threshold map’). The plotting represented two concepts: firstly levels of intervention at the time of incident and the degree of family cooperation with agencies at that time. Further details about this process, along with the findings from the exercise are discussed in Chapter 5 and Appendices 3 and 4.
- The completed chronologies were carefully examined and used as a basis for identifying recurrent issues within the data. A list of the themes which emerged in this way is presented in Table 23, Chapter 5. As analysis progressed, it became evident that the cases tended to cluster naturally under

the three broad categories of ‘neglect’, ‘physical assault’ and ‘older children’. These themes form the headings for discussion of issues in Chapter 5.

Having identified salient themes, data sources were re-examined, with a focus on identifying potential case studies and additional illustrative material. When this process was completed, case studies were compiled. All case studies that appear in this report are anonymous and composite, each being based on a number of cases which shared similar features.

6. Presentation of statistics in Chapter 3

In Chapter 3, statistics are presented, in tables, for the full sample of 161 cases, and the commentary usually relates to this sample. However, statistics from the intensive sub-sample of 47 cases are listed alongside the 161 cases. Since the information sources for the full sample were often minimal and there were many missing values, the intensive sample could be said to be a better reflection of what is known about the cases and child and family profiles. Where information was either extremely limited or unavailable for the full sample, figures are only reported for the intensive sample.

When statistical tests (χ^2) were applied to the two samples, they showed that they were broadly comparable. Table 24 illustrates in detail that on key demographic characteristics the sub-sample reflects the full cohort. Although there are more girls in the intensive sub-sample than boys (in contrast to the full sample) this is not a statistically significant difference.

Numbers of less than 6 are not displayed for the full sample of 161 where this may potentially allow identification of individuals (this does not apply to the sub-sample of 47 cases). Where results have been suppressed for this purpose, this is clearly indicated in the tables as ‘<6’.

Wherever percentages are recorded they always relate to the population for whom information is available which may vary, and is shown in each table as n =. The percentages displayed in the tables below may not always total 100 because of rounding.

Geographical sources of reviews

Grouping the full sample of 161 serious case reviews by Commission for Social Care Inspection regions shows that cases originated from a broad spread of English areas covering most geographical regions (see Table 24 above). Gaining access to overview reports to build the intensive sample was easier for some areas than others, possibly due to different regional policies about making this information available. For example, although cases from London made up 19% of the full sample of 161 reviews, only 9% of the intensive sample of 47 were obtainable from this geographical area.

Table 24: Sample characteristics: full sample vs. intensive sample*

	full sample	intensive sample	P Value
Age			
<12 months	76 (47%)	22 (47%)	0.75 (N/S)
1-5 years	33 (20%)	6 (13%)	
6-10 years	11 (7%)	4 (9%)	
11-15 years	26 (16%)	10 (21%)	
16+ years	15 (9%)	5 (11%)	
Gender			
Male	88 (55%)	20 (43%)	0.14 (N/S)
Female	73 (45%)	27 (57%)	
Ethnicity			
	n=136	n=39	0.64 (N/S)
White/White British	101 (74%)	31 (80%)	
Mixed	8 (6%)	3 (8%)	
Black/Black British	17 (13%)	2 (5%)	
Asian/Asian British	8 (6%)	3 (8%)	
Other Ethnic Group	2 (1%)		
Incident Type			
Death	106 (66%)	35 (75%)	0.27 (N/S)
Serious Injury	55 (34%)	12 (26%)	
Type of Injury/Death			
Shaken Baby syndrome	25 (16%)	8 (17%)	0.90 (N/S)
Sudden Infant Death	<6	1 (2%)	
Overlying	6 (4%)	3 (6%)	
Physical Assault	57 (35%)	14 (30%)	
Neglect (including house fires, accidents and illness)	33 (21%)	10 (21%)	
Poisoning/overdose	7 (4%)	1 (2%)	
Suicide	14 (9%)	4 (9%)	
Sexual abuse	6 (4%)	2 (4%)	
Gone missing	6 (4%)	4 (9%)	
Other	<6	-	
Region			
			0.51 (N/S)
West Midlands	21 (13%)	6 (13%)	
South East	15 (9%)	4 (9%)	
South West	17 (11%)	6 (13%)	
East of England	15 (9%)	2 (4%)	
Yorkshire and the Humber	17 (11%)	6 (13%)	
North East	16 (10%)	8 (17%)	
London Region	31 (19%)	4 (9%)	
North West	13 (8%)	3 (6%)	
East Midlands	16 (10%)	8 (17%)	

* full sample n=161, intensive sample n=47 unless otherwise stated

APPENDIX 2: OVERLAPPING CHARACTERISTICS, VENN DIAGRAMS

In this section use has been made of Venn diagrams to illustrate the overlapping nature of factors which may have been present in the cases. A Venn diagram provides a stylised picture which simplifies the complex nature of the individual cases, and allows an exploration of the extent to which not only are there overlapping factors, but the frequency or prevalence with which these factors occur together.

The following analysis has been confined to the 47 intensive sample cases, for whom there is good information, although even in these cases one cannot assume that the absence of a factor being mentioned guarantees that that factor was not in fact present.

The Venn diagrams in this section have three symmetrical, intersecting circles, with each circle representing a separate factor or dimension which might be present. At the centre of the diagram is a central segment where all three factors are present; in addition there are three further segments where each combination of two of the three factors intersect. Finally the remaining area of each circle represents cases where only that factor is apparent. It is important to note that no causality, nor any direction of causality, between factors being present and the existence of neglect or abuse is inferred.

In Figure 8, three aspects of parental behaviour or circumstance are considered. Cases were analysed as to whether

- d) there was a history of parental substance misuse
- e) either or both parents had mental health problems or a learning disability
- f) there was evidence of parental violence, including domestic violence

As was shown earlier in Table 14 (Chapter 3) violence was a factor in 33 of the 47 cases (70%), mental health problems or a learning disability were noted in 29 cases (62%) and substance misuse in 27 cases (57%). However in this section it is the co-existence of these factors which is of interest.

In 16 cases (34% of the 47 in the intensive sample) all three factors were noted as being present, and are represented in the central segment of Figure 8 below.

Figure 8

**Intersection of Parental Characteristics:
Violence, mental health issues and substance misuse**

All three factors present	16 cases	(34%)
Any two of the three factors present	16 cases	(34%)
A single factor present	9 cases	(19%)
No factors apparent	6 cases	(13%)

(n=47)



There were seven cases where violence and mental health problems were both present (but with no substance misuse reported), and a further six where substance misuse and violence were noted (but no reported mental health issues). A further three cases had substance misuse and mental health problems present, but no record of violence.

Far fewer cases reported only one of these three factors present on its own. There were four, three and two cases respectively where violence, mental health problems or substance misuse were reported, but in the absence of the other factors. Finally one should note that in six of the 47 cases (13%) none of these factors were reported as being present.

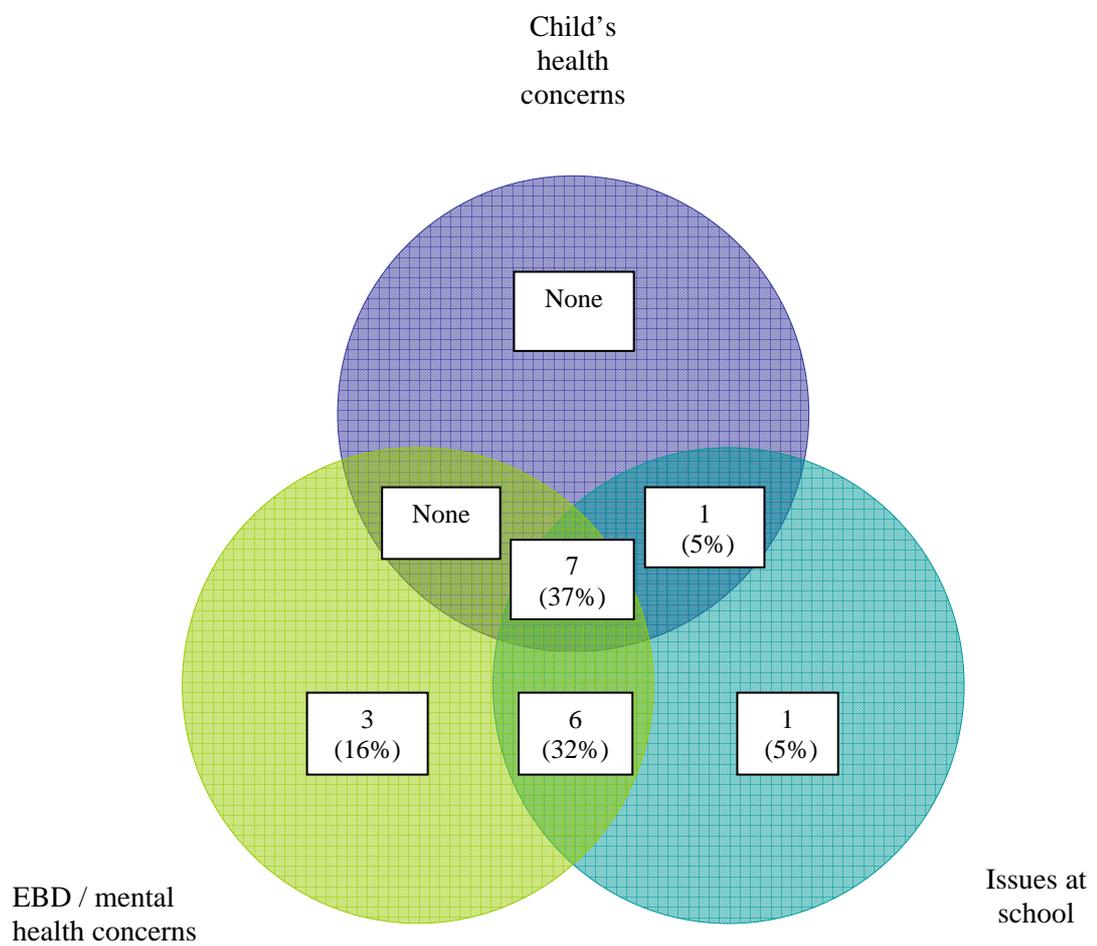
In the second diagram, Figure 9, characteristics/circumstances of the child are considered, but only for the subset where the child was aged 4 or above, and the inclusion of school problems was applicable.

Figure 9

**Intersection of Characteristics of Child (aged 4 and above):
Child's health concerns, school problems and EBD/mental health issues**

All three factors present	7 cases	(37%)
Any two of the three factors present	7 cases	(37%)
A single factor present	4 cases	(21%)
No factors apparent	1 case	(5%)

(n=19 children aged 4 and above)



Again the central segment of seven cases, where all three circles intersect, depicts those children where all three factors of health problems, emotional/behavioural problems and school issues were present. For nearly as many children, six or 32%, there were both issues at school (non or poor attendance, exclusion or the receipt of special educational support) and emotional/behavioural or mental health concerns (but no record of concerns for the child's physical health).

Health concerns, which included a reporting of disability, complex health needs, chronic illness, low birth weight, prematurity, special care baby unit, or previous hospital admissions, were less likely to arise in combination with concerns about the other two facets of the child's life.

There were just four cases where only one of these three factors was present on its own. In three cases emotional/behavioural problems were noted, in the absence of the other two factors, and a single case where only school issues were noted.

Whilst these first two diagrams have been concerned with either various aspects of the parental circumstances, or of the child's history, the third diagram seeks to bring together aspects of the three domains of the 'assessment triangle'. The extent to which there is an overlap between one key variable in the child's history (health), one key issue in the parental background (violence) and a 'poor' environment is explored. The home environment was considered poor if either poor living conditions, poor housing, or frequent moves were noted in the background information to the case.

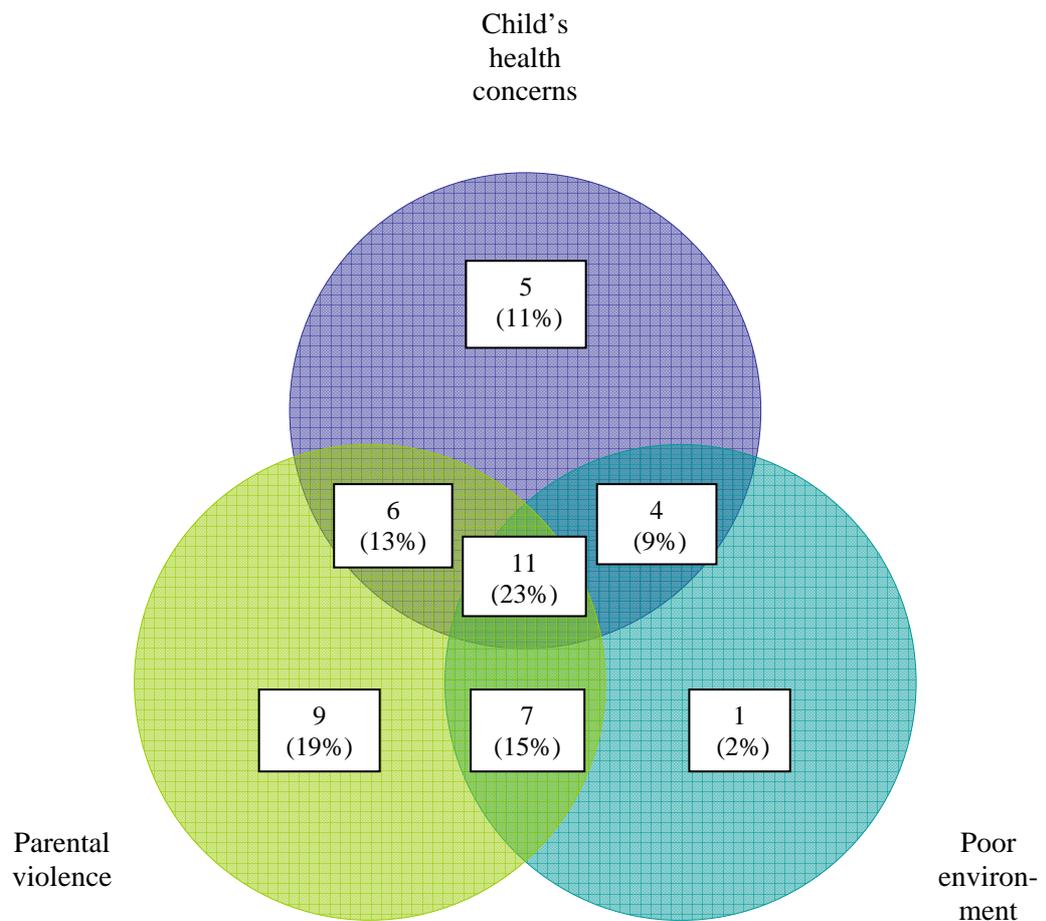
As can be seen in Figure 10, just under a quarter of the cases fall in the central segment, indicating that all three of the characteristics or circumstances were relevant to the case. Parental violence and a poor living environment were factors in a further seven cases (but with no reported child health concerns), and the combination of parental violence and a health problem for the child (but no record of a poor environment) was present in a further six cases. The third combination of health concerns for the child and a poor living environment (but with no recorded parental violence) was present in a further four cases.

In 15 cases only one of these three factors had been noted. Most frequently, in nine instances, this was parental violence on its own, whilst in five cases only concerns over the child's health had been noted. A poor living environment, on its own, was only a feature of one case. In addition there were four cases where none of these factors were mentioned as being present.

Figure 10

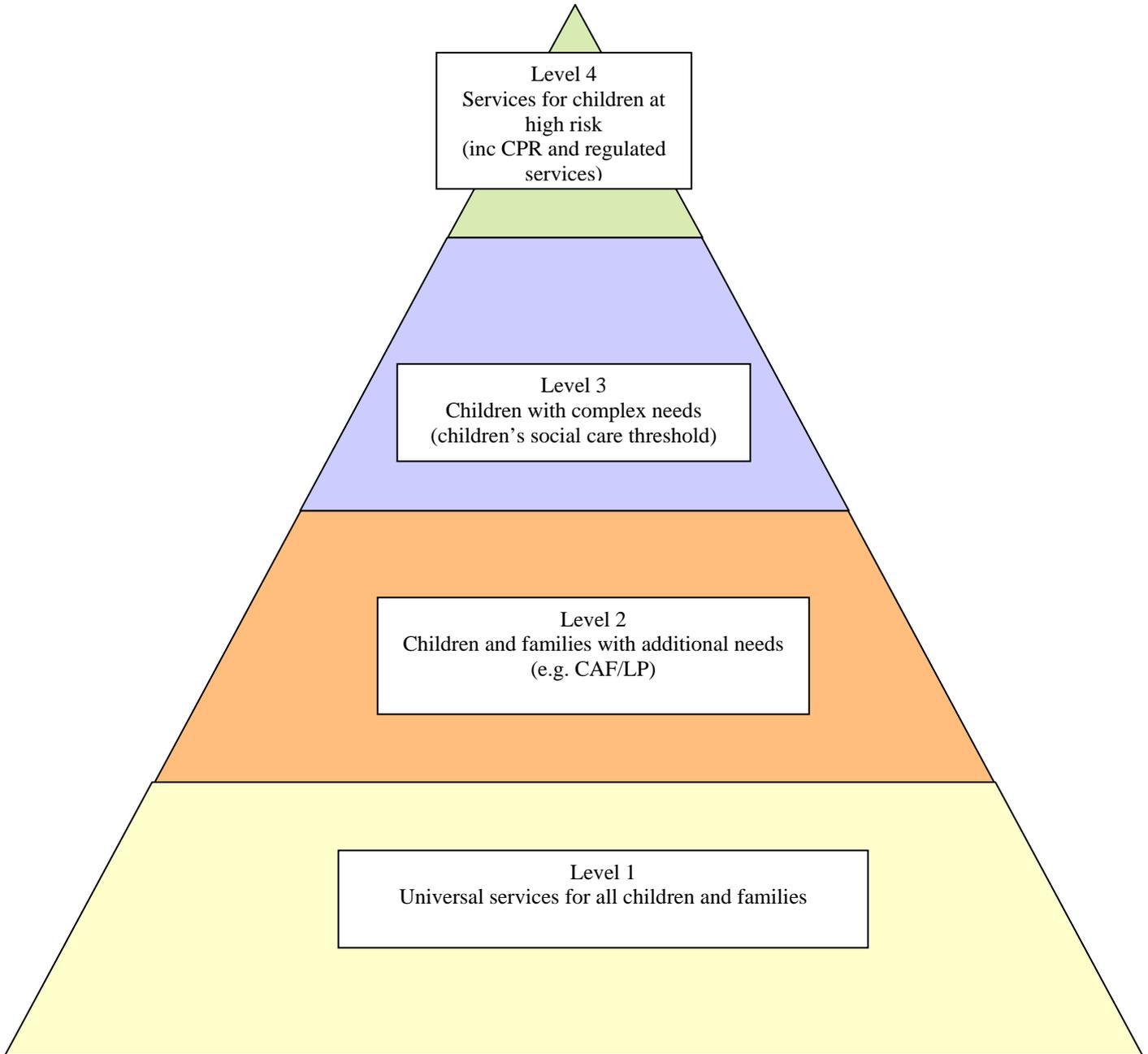
**Intersection of Characteristics representing:
Child's health concerns, parental violence and poor environment factors**

All three factors present	11 cases (23%)
Any two of the three factors present	17 cases (36%)
A single factor present	15 cases (32%)
No factors apparent	4 cases (9%)
(n=47)	

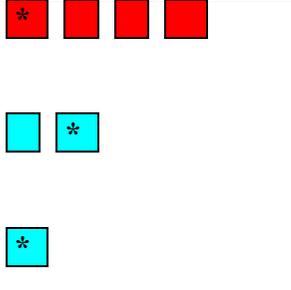
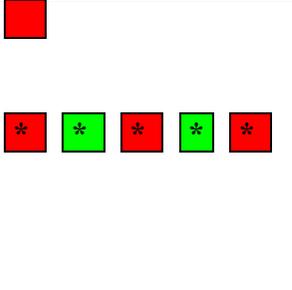
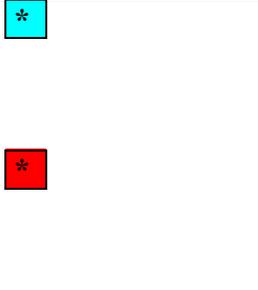
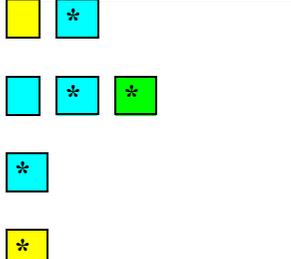
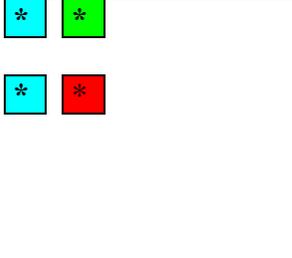
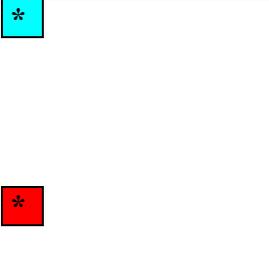
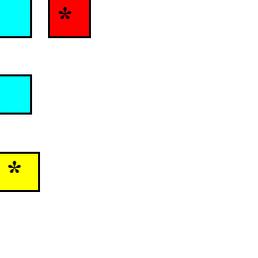
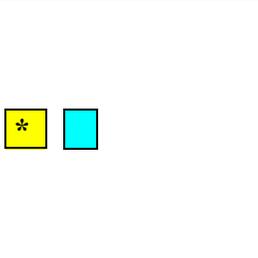


APPENDIX 3: THRESHOLDS OF NEEDS AND INTERVENTION

(adapted from *Every Child Matters* (Cm 5860 2003 p21 and *The Common Assessment Framework for Children and Young People: Practitioners Guide* (HM Government 2006b p7))



APPENDIX 4: THRESHOLD MAPPING EXERCISE (at time of incident)

<p>Level 4 Services for children at high risk (including child protection registration and regulated/restoratory services)</p>					
<p>Level 3 Children with complex needs (including the Social Services threshold of Children in Need)</p>					
<p>Level 2 Children with additional needs</p>					
<p>Level 1 Universal Services for all children and families</p>					
	<p>1 Not co-operative eg. Avoiding involvement/hostile</p>	<p>2 Low co-operation</p>	<p>3 Neutral/Some co-operation</p>	<p>4 Co-operative</p>	<p>5 Highly co-operative/persistently seeking help</p>

Degree of parental/child cooperation →

KEY:  <1 year  1-3 years  4-15 years  >16 years

Note: Deaths highlighted by an asterisk

APPENDIX 5: CASE STUDIES

Anonymised and composite case studies are presented as training and learning tools for Local Safeguarding Children Boards. The case studies have a number of potential uses, for example in LSCB training particularly in relation to understanding interacting risk and protective factors. The sub headings used in the case studies and elaborated below provide a framework for understanding families which is compatible with and complements the Integrated Children's System and the Common Assessment Framework. They provide a way of organising information and evidence within the context of an ecological framework based on clearly understood developmental and psychosocial theories including relationships and developmental histories and processes that have shaped parents, families and children.

CASE STUDY TEMPLATE

- **Key features of the case**

- **Child and Family background**
 - child's needs/characteristics/behaviour

 - mother's/carer's history/profile/parenting capacity

 - father's/carer's history/profile/parenting capacity

 - wider family and environment

- **Professional involvement**

- **Analysis of interacting risk and protective factors to include:**
 - (i) a clear case summary and synthesis of the knowledge brought together by the assessment,
 - (ii) a description of the problem/concern,
 - (iii) a description of protective factors and supports
 - (iv) a hypothesis about the nature, origins and cause of the need/problem/concern, and
 - (v) a plan of the proposed decisions and/or interventions.

Case Study: Ellie (age 3)

- Neglect
- Poverty and social isolation
- Not meeting the threshold for intervention from children's social care
- Parental alcohol misuse and depression

Theme of case and background

Ellie, aged three, and youngest of four children in the family, was seriously burned in an accident at home. There had been a number of reports to children's social care of all the children being seen with bruises, being left at home unsupervised and found wandering in the street. There was a pattern of the family being visited by children's social care, an initial assessment being carried out, advice given and the case being closed. Concerns about the parents' abilities to meet the children's needs were judged not to meet the threshold for safeguarding intervention.

(i) child's needs/characteristics/behaviour

Ellie's nursery, and her siblings' schools, had expressed some concerns about the children's appearances, that they were often unkempt, and wearing inadequate or dirty clothing. Ellie and her siblings' school attendance records were poor.

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

Ellie's mother had spent several years in care as a child because of concerns about her own mother's caregiving. She returned to live with her mother in her teens and had a difficult relationship with her. As a teenager she was known to child and adolescent mental health services for behavioural problems at home. The relationship with Ellie's father began at the age of 16 and he is the father of all four children. Ellie's mother's parenting of the children was judged to be just about 'good enough' by professionals although there were persistent concerns about adequate supervision. She suffered with depression and panic attacks.

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

There was evidence of some domestic violence from Ellie's father, with one incident being attended to by the police. Ellie's father was noted to have problems with alcohol misuse. In common with many other fathers and father figures, there was little recorded information about him or his past.

(iv) family environment

Overcrowding and unhygienic conditions were reported in the home. Ellie's parents had little support from their wider family and were socially isolated. Neither parent was in work and the family had financial difficulties.

(v) Professional Involvement

The family were well known to a number of universal agencies, and the children were frequently referred to children's social care. Parents frequently failed to attend appointments, for example ante-natal appointments. Although parents complied with children's social care initial assessments, they were reluctant to accept any support offered. Some professionals felt that children's social care needed to be more involved with the family, but there was little challenge of their decision making.

(vi) Analysis of Interacting Risk Factors

This household may be a typical example of what has been called 'depressed neglect' where "the run down feeling that pervades passively neglectful families can affect the spirits of those who work with them" (Howe 2005 p135). The missing medical appointments, poor school attendance and resigned compliance with children's social care assessments are indicative of the pervasive apathy common in families where there is this type of neglect.

Ellie's mother's own history and her current depression will mean that it is difficult for her to keep her children 'in mind'. Her caregiving will tend to be unresponsive so that her children's signals of need, distress and ultimately danger are seldom noticed. Only basic care is provided which has prompted practitioners to report that her care is 'just about good enough'. Whenever children or home life make heavy emotional demands on Ellie's mother she is likely to cope by disengaging, becoming more hopeless and depressed, or panicky and frightened.

The part that Ellie's father plays in providing caregiving is less well described. The extent of domestic violence is unclear but it is well known that alcohol misuse may be a trigger for violence. Alternatively, alcohol misuse by Ellie's father may be a means of shutting down and shutting off from the hopelessness at home. It is important to know more about Ellie's father to understand whether his behaviour contributes to the pervading helplessness and listlessness in the family, or whether his presence also provokes fear in the children and his partner, and is thus a risk of physical as well as emotional harm. Either way, in the presence of a drunk parent the child is likely to feel emotionally abandoned and frightened (Howe 2005 p184).

What could have been done differently?

A thorough assessment by children's social care, rather than numerous brief, initial assessments, should have been carried out on Ellie and each of her siblings to appraise the developmental progress and the ongoing concerns about the individual children. The assessments would have produced a better understanding of family functioning and dynamics if they had incorporated knowledge of the parents' own childhood experiences and the children's and the parents' own perspectives.

Professionals needed to consider the debilitating impact that neglectful families like this have on how they think, feel and behave. This understanding might have clarified why professionals did not challenge decisions, or have the energy to keep challenging decisions.

Since many factors present in this family will be typical of a large number of families on the caseload of a health visitor or other 'early years' professionals it is important to have *clear mechanisms to report and discuss concerns and to build up a clear picture of risks and protective factors.* With families like this clear, plans are needed to support children and parents over a long term period. It is also important to be able to gauge when the care is not adequate to meet children's developmental needs or ensure their safety, and to consider that children might need to be removed.

Case Study: Carly (age 9 weeks)

- Head injury in babies
- Universal services only
- Domestic violence
- History and current presence of parental volatility
- Demanding baby

Theme of case and background.

Carly suffered a head injury (thought to be a shaking injury) when she was 9 weeks old. At the time of the injury the family had not been receiving any services beyond universal health services. Carly lived with her mother (aged 19), and her father (aged 20) in rented accommodation. During her pregnancy, Carly's mother presented four times to Accident and Emergency, twice reporting assaults to her abdomen.

(i) child's needs/characteristics/behaviour

Carly was born at term with a normal delivery. In her early weeks she fed well, gained weight and responded well although she was also reported to have colic and to cry persistently at times. There were two recorded attendances at Accident and Emergency by the time she was 4 weeks old, one for a viral infection and the other with a rash.

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

Carly's mother was known to children's social care and child and adolescent mental health services when younger. She had Special Educational Needs and left school early and was reported to be 'self contained and withdrawn' at school and aggressive at home. Police were regularly called to the family home during Carly's mother's adolescence to respond to reports of violence among family members. She moved frequently between family members during her childhood and adolescence.

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

Carly's father had a history of mental health problems, and behavioural problems throughout childhood. He had taken a number of overdoses and was reported to have poor anger management and poor self control. There was domestic violence in his household when he was younger and his mother had long term depression.

The health visitor noticed that both parents' emotional reaction to Carly was immature and exaggerated in comparison to other young parents.

(iv) family environment

The family suffered harassment by neighbours. There were financial difficulties in the household and police had been called to an incident of violence between parents. The parents did not feel supported by extended family.

(v) Professional involvement/ engagement.

Both parents had high levels of contact with a range of health professionals, including the health visitor, the GP, NHS Direct out of hours service and attendances at Accident and Emergency in the early weeks of Carly's life. Although parents sought help actively, pre-arranged appointments, for example with the health visitor, were often missed or cancelled. No health professionals were aware of the high level of contact

with different branches of the service, nor of the pattern of contact (for example the repeat attendances at A & E).

Medical professionals were not aware of the domestic violence and did not explore this possibility with Carly's mother or consider the potential risk to the unborn baby, nor did they consider the impact of the parents' mental health difficulties on their parenting abilities.

(vi) Analysis of interacting risk factors.

There were many interacting risk factors in this case namely: high levels of domestic violence in pregnancy including blows to the mother's abdomen, mental health problems, frequent moves, lack of family support, financial worries and poor anger control for both parents. The combination of these issues signal that stress levels in these young parents were high and the capacity to deal with the demands of a new baby would be likely to be compromised. 'Persistent crying' and colic provided markers that this baby was at a high risk of injury from these parents whose emotional reaction to their baby had been noted as 'immature' and in whom a distressed baby would prompt high levels of anxiety, distress and agitation (Howe 2005 p71).

In volatile parents with this sort of profile the safest ways for children to behave are to be emotionally self contained and independent thereby making low demands on their caregivers. In this sense babies are always at risk of provoking a stress response since they cannot fend for themselves and need to seek care and make demands on their carers in order to survive. 'Easy' undemanding babies may cause less distress and agitation in carers but premature, unwell, frequently upset and fractious babies will cause high arousal in parents which may then trigger violence.

What could have been done differently?

Information sharing. There was a need for information to be shared within and across health services in the ante and post natal period so that the risks to the baby could have been properly considered. Given the parents' frequent moves this information needed to be widely accessible.

A holistic assessment. A holistic assessment during the ante-natal period could have incorporated an understanding of the parents' history and the expertise of key professionals who knew the parents to consider the impact of parental history, mental illness and domestic violence on their parenting capacity.

Taking account of the parents' responses. When the baby was born the early responses of the parents were a significant clue to their coping capacity. Had the parents' pattern of seeking help been logged, their mounting panic at times of stress would have been evident.

Case Study: Ian (age 16)

- Long term neglect
- Rejection, and serious abuse
- 'hard to help' young person
- suicide

Theme of case and background

Ian was one of four half siblings and was 'on and off' the child protection register from the age of four because of neglect, physical and suspected sexual abuse. He was 'in and out of care' from the age of thirteen. Whilst in care he regularly ran away, met older men and was suspected of being involved in sexual exploitation. At the age of fifteen he was discharged home from residential care because of persistent running away. He was living at home and getting very little support at the time of his death through suicide.

(vi) child's needs/characteristics/behaviour

Ian's behaviour at school and at home was described as 'unruly', and from the age of thirteen, 'threatening and violent' including the use of weapons, which prompted numerous exclusions from school. Ian started to run away from home at the age of ten and by the beginning of adolescence he started to harm himself seriously, misuse substances (drugs and alcohol) and to talk of suicide. He had convictions for assault following fights with friends, although he was unable to keep friends for long. He moved into foster care at age 13, ran away repeatedly and experienced numerous placement breakdowns with intermittent return home (which was never successful). Recent placements had included therapeutic residential care and a period in a secure unit.

(vi) mother's history/profile/parenting

Ian's mother experienced depression and low self esteem and was subject to domestic violence over many years from different partners including Ian's father. There had been serious concerns since Ian's birth about his mother's parenting ability. Her own history was one of severe abuse and neglect.

(vi) father's history/profile/parenting

When Ian was five years old his father died from a drug overdose. Ian had a number of step father figures, the most recent of whom was a heavy drinker, with convictions for physical assault.

(iv) family environment

Domestic violence was a recurrent feature of Ian's home life.

(v) Professional involvement.

Ian's name was listed on the child protection register intermittently from the age of 5-9 (neglect and physical injury). At 13 Ian was first accommodated and later made the subject of a care order. From the age of eleven he was known to Child and Adolescent Mental Health Services and from age 14 to the youth offending service. Ian was assessed as 'not mentally ill with no real suicidal intent' numerous times.

(vi) Analysis of interacting risk factors

As he matured and entered adolescence the effects of many years of neglect and abuse at home became apparent in Ian's behaviour. His responses typified those of young people with similar experiences where feelings switch between hostility and aggression, and fear and helplessness. The need to feel in aggressive control is a characteristic response to the kind of care-giving that Ian experienced over many years. In addition, his early adverse experiences are likely to have increased his sensitivity to stress leaving him vulnerable to stress related psychiatric disorders, self harm and suicidal ideation (Howe 2005 p163). Discharging Ian home to his mother's care catapulted him into danger as he was reminded that he was unwanted and bad and he would not have been able to cope with the feelings this evoked. His mother was also helpless to contain his powerful and self destructive urges.

What could have been done differently?

Help the carers. Ian will have transferred his unsuccessful coping strategies from home to his placements. As such he will have sabotaged attempts to contain him and offer safe and trusting relationships. Good quality support and training for his carers may have helped them to understand the complexities of his behaviour and how helpless and angry he made them feel. If they could have been given strategies for dealing with and anticipating his behaviour they may have been helped to stick with him for longer and perhaps reduce Ian's need to run away. Such help could be available within, for example, Multi-Dimensional Treatment Foster Care (Chamberlain and Smith 2003). This treatment model is currently being piloted in England and evaluated by York University).

Provide high level support to young people who return home. Although it may be the worst place for them, many young people in transition, like Ian, feel compelled to go back home and will push for it relentlessly. Once back home he and his mother needed a high level intensive support not a low level service.

Case Study: Andrew (age 12)

- Professional challenge
- Child disability
- Neglect
- Working with powerful families

Theme of case and background

A serious case review was undertaken after Andrew was accommodated at the age of 12 in a severely neglected state. He was disabled, though professionals differed in their opinion of his diagnosis. Several agencies assessed that Andrew needed to be cared for outside of the home but there was a year's delay in this happening. The insistence of a senior health professional finally led to the admittance of Andrew into foster care.

(i) Child's needs/characteristics/behaviour

Andrew was born premature and he was referred to the local Child Development Centre because his early development was slow. Andrew's parents failed to attend these appointments and he was not offered any early help. His behaviour caused difficulties for his parents at home, and problems arose at school during his early years in education. Andrew was always fully dependent on his parents or others for all his self-care needs and his appearance was described by professionals as grubby and unkempt. His parents explained that this was because he wouldn't cooperate with them (or anyone else). His parents chose to educate him at home, from the age of eight and Andrew became socially isolated as he rarely left home and had limited outside contact. Andrew did not have a clear diagnosis for his condition, which was the subject of much dispute among professionals.

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

Little is known about Andrew's mother's childhood. She had post natal depression after Andrew was born and in the early years spoke of some difficulties in caring for her son.

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

Little is known about Andrew's father's past.

(iv) Family environment

Andrew's parents were both articulate, well qualified professionals who owned their own home. Andrew's mother gave up work to look after her son and his father ran his own business from home. The house was clean and tidy, with the exception of Andrew's bedroom which was described as very untidy and unhygienic.

(v) Professional involvement.

A large number of professionals were in contact with the family during the course of Andrew's life and at various points concerns were raised about his care. However, his parents always opposed these concerns and refused to allow child protection procedures to be followed. Professionals found it difficult to challenge parents' and other professionals' decisions and insist that child protection procedures be initiated. Significant professional focus was placed on treating Andrew's behaviour, with little focus or assessment on the daily care he received.

(vi) Analysis of interacting risk factors.

Andrew's parents' articulate manner and social competence enabled them to exert power and control over their son and outside professionals without challenge. Andrew as the least powerful person in the family is denied a voice doubly (first as a child and secondly as a child with a disability). Without being aware of these dynamics, professionals cannot cut through the control.

What could have been done differently?

Not treating a child differently because of their disability. Andrew was allowed to live in conditions which for any other child would have been considered degrading and unsuitable. His disability was held responsible for his state of welfare and the care he was receiving. He needed to be treated as a child first, with his special needs coming second.

Challenging parental power. Working in partnership is important but the child's needs must not be lost or overshadowed by the parents' power and authority. Parents' social status should not influence professionals' behaviour.

The need for a lead professional. A lead professional could have avoided the considerable delay and lack of unity in providing services for Andrew, particularly regarding his educational needs. Without parental consent for a child protection route the lead professional would have needed to make a clear child protection referral. They could also have noted the absence of a core assessment and similarly set this in motion.

The need for professionals to have the confidence to challenge each other's opinions. The presence of a large number of professionals made it more difficult to speak out against the others than if fewer had been involved. Each professional has the individual responsibility to challenge others with appropriate assessment material and to keep the child central in the progress of the case.

The need for training about recognising neglect. There was clear evidence of neglect in this case yet agencies failed to follow these pointers consistently or effectively. The *model* of neglect used was based on defining the concern in relation to parental action or omission rather than viewing neglect as a set of needs for care and protection regardless of the efforts of those caring for the child concerned.

APPENDIX 6: CONSTRUCTING AND USING CHRONOLOGIES IN PRACTICE

The key purpose of conducting serious case reviews, and in particular the two yearly analyses of these cases, is to learn from the reviews and to disseminate the learning nationally. The application of some of the tools which emerged from the research process is discussed here in the hope that the tools may also prove helpful to individual Local Safeguarding Children Boards (LSCBs) and to practitioner teams or to individual practitioners. The tools were derived from research techniques used to make sense of and analyse the cases individually and as larger groupings of reviews. These tools may have applications for practice in two senses: firstly in relation to conducting serious case reviews, and secondly in relation to everyday multi-agency work with children and their families. The aim of these practice tools is to encourage practitioners and managers to think more critically in these two contexts.

DESCRIBING ANALYTICAL CHRONOLOGIES AND THRESHOLD MAPPING

The themes presented and analysed in Chapters 5 and 6 were compiled after brief analytical chronologies were written for the child who was the subject of each of the 47 reviews in the intensive sample. The brief chronologies (normally no longer than four pages) were studied and each case was ‘mapped’ to identify thresholds of services offered both over many years, and at the time of the incident. Both the method of chronology writing and the threshold mapping which followed it lend themselves to a variety of uses as practice tools.

The history of each case was reviewed by a member of the research team and written up as a brief analytical chronology. Chronologies were written in three columns namely: family events, timescale, and professional involvement (see page 165). Family and life events (which aided the understanding of the child’s likely care) were listed alongside services that were known to be offered to the family. Thus it was possible to see the evolving pattern of support or protection and legal status over time, matched to family incidents and relationships, life events or patterns of harm to the child. Reder and Duncan’s ‘double chronology’ was adapted as a guide (1999 p13) to interrogate each review. The template used for the chronology is shown on page 154.

The template includes a social history and key features of each case, taking account of the domains and dimensions in the ‘assessment triangle’ from the *Framework for the Assessment of Children in Need and their Families* (DH et al 2000). The process of synthesising the extensive information and selecting key features and events for the abbreviated chronology was informed by the ecological transactional perspective explained in Chapter 4. The abbreviated chronology helped to achieve a more rounded, holistic, understanding of each case. The learning from this exercise could be transferred to practice in the attempt to go beyond description to achieve an analysis of complex cases.

CHRONOLOGY TEMPLATE

Brief summary of family history:

Child's history, profile, characteristics and behaviour:

Mother's (or carer's) history, profile, parenting capacity:

Father's (or carer's) history, profile, parenting capacity:

Family environment:

Characteristics of professional involvement:

Family events and environmental issues (including family strengths)	Timescale	Professional activity /involvement/ engagement with family
	Early family history (Inc. parents childhood and birth of siblings)	
	Pregnancy of subject child	
	Birth of child	
	Child's first year	
	Age 2-5 yrs	
	Age 5-9 yrs	
	Age 10-15 yrs	
	Age 16+ yrs	

Analysis of interacting risk factors: Colour coding the chronology

When the brief chronologies were completed they were colour coded to identify different levels or tiers of agency action or intervention over time. The tiers of intervention considered were in line with the levels of need and intervention adapted from the 'pyramid' of levels of need from *Every Child Matters* (Cm 5860, 2003 p21) and the 'windscreen' of levels of need from the guidance accompanying the Common Assessment Framework (Department for Education and Skills 2006, p7) This is represented in Appendix 3: Thresholds of Needs and Intervention. Chronologies were colour coded in 'Word' in the following way:

- **red** was used to indicate periods when services had been offered for children deemed to be at high risk (including Child Protection Registration and regulated services, including care orders etc) (**Level 4**)
- **pink** was used to mark times when services had been offered for children assessed to have complex needs (i.e. to meet the 'child in need' threshold for children's social care) (**Level 3**)
- **yellow** was used to show when services were offered for children's additional needs (**Level 2**)
- **green** was used to mark times where only universal services were offered (**Level 1**).

Once the 'colour coding' was completed the service history of the family became apparent at a glance so that it was possible to tell whether there were long periods with high levels of services for the family for known risks to a child, or alternatively, whether there were times when no known concerns were apparent. If information was available for the parents' childhood it was possible to gauge historic agency activity in the same way. Colour coding chronologies in this way is not time consuming and may help to reveal patterns of service delivery in relation to particular family events or difficulties in cases which have been known to agencies over long periods of time.

Lessons learnt from constructing chronologies *Serious Case Reviews*

- Software packages are available which help to assemble a multi-agency chronology by entering events and sequencing and updating them, for example 'Chronolater' (Berrick 2007).

This package may be useful for LCSBs constructing chronologies for the purposes of serious case reviews. Although software packages may make chronology writing an administrator's task it could be argued that the knowledge of skilled professionals is needed to make the choices about which information will be most pertinent for a theoretically driven analysis.

Brief Chronology writing in everyday practice with individual cases

- In day to day practice, more nuanced information than dates and facts is needed to really understand a child within the context of their family.

Abbreviated chronologies are useful in everyday practice as part of the analytical task. In order to construct this brief document, it is best to have more detailed information, including a full chronology, from which to draw. The very full information requested in the chronology in the Integrated Children's System should help to provide this. Once detailed information is available, key features and events of both the child and family's life and also of multi or single agency intervention can be selected.

The research team were working with chronologies compiled from summary reports, rather than with extensive case files. It needs to be noted that some practitioners undertaking this exercise may have a greater volume of information to deal with. Even with the more limited information available for the current study, the difficulties faced in deciding what information to include and exclude were apparent. It became clear that certain features provide particularly helpful clues for developing a chronology informed by developmental and psychosocial theories. To this end, some pointers towards constructing a developmentally sensitive chronology, which can provide a basis for understanding interacting risk factors are presented below. The headings from the Chronology template should be used and the additional points considered:

- Information about children's early years is important.

The brief information about children should include not only the timing of the birth of each child but also a summary of the attitude and behaviour of parents during the ante-natal period, including any indication of domestic violence or other 'risky' parental behaviour. In addition any information about whether the baby was born premature or needed any special early care is pertinent as is the way the parents and baby responded in the early stages. Strengths should of course be noted including the availability of positive family support.

- Critical and life incidents should be included for example significant illnesses or patterns of minor illness, and accidents including any patterns of attendance at A&E.
- House moves should be noted as should significant changes in family circumstances and care-giving such as a parent leaving or new partners appearing.

These items are requested in the Integrated Children's System chronology (DH 2003, www.ecm.gov.uk/ics) particularly on page 18 titled 'significant events and changes'. 'Significant health events' are requested on page 7.

- Features of professional activity over time should include key events, for example a referral or services provided by children's social care, child's name placed on child protection register, placement history

These items are listed on the ICS chronology page 3, 4 and 16. Additional areas to include are child's performance and school changes including school exclusion (see ICS chronology pages 8- 13); patterns of police responses to domestic violence incidents; but also short summaries of professional help offered and assessments made at that time and the quality.

With cases where there has been long term involvement it may be helpful for a practitioner to separate their analysis into periods of time. Some of the serious case review reports did this, summarising the situation for the child and family along with the impact of professional intervention at different time points.

The threshold map

The research tool, the 'threshold map', discussed in Chapter 6, combines levels of need and intervention with degrees of cooperation or engagement with the family. It would appear to lend itself to a number of uses that could help to clarify understanding and interpretation of thresholds and illustrate the nature of engagement with families.

Once analytical chronologies had been constructed for all 47 cases, and colour coded, each review was plotted on one large chart. The plotting represented two concepts; firstly levels of intervention during one snapshot of time (the time of the incident) and secondly the degree of family cooperation with agencies at the same time. The findings from this exercise are discussed in Chapter 6 and a more detailed threshold map is presented in Appendix 2, while a simplified version is listed over the page.

- **Levels of intervention:** The vertical axis of figure x, shows levels of intervention, with levels 1 - 4 represented along the left hand, vertical axis.
- **'Less' and 'More' cooperation:** The horizontal axis represents degrees of cooperation between families and agencies.

THRESHOLD MAPPING EXERCISE - AT TIME OF INCIDENT

Level 4 Services for children at high risk of harm (including child protection registration and regulated/restoratory services)					
Level 3 Children with complex needs (including the Children's social care threshold of Children in Need)					
Level 2 Children with additional needs					
Level 1 Universal services for all children and families					

1 Not co-operative e.g. Avoiding involvement/hostile
 2 Low co-operation
 3 Neutral/Some co-operation
 4 Co-operative
 5 Highly co-operative/persistently seeking help

Degree of parental/child cooperation→

Uses for ‘Thresholds’ in LSCBs

Chapter 3 of *Working Together to Safeguard Children* (HM 2006) clarifies the role, objectives and functions of the Local Safeguarding Children Boards. Their role extends across the whole safeguarding continuum to include:

- identification and prevention of maltreatment or impairment of health and development,
- proactive work with vulnerable groups and
- responsive work to protect children already suffering or at risk of suffering harm.

There is particular mention of the Boards’ remit to consider thresholds. The flow chart of objectives and functions on page 75 of *Working Together to Safeguard Children* (HM 2006) includes developing policies and procedures for safeguarding and promoting the welfare of children and “actions where there are concerns, including thresholds” (p75). The emphasis is on clarity of thresholds and common understandings to ensure appropriate referral (p78). However, as we have demonstrated here and in previous chapters, a number of serious case reviews uncovered not only confusion and misunderstanding of thresholds, but also a preoccupation with the thresholds for services rather than a primary concern with the child or children at the centre of the discussion. It will be a key test of the effectiveness of Local Safeguarding Children Boards to rectify the long standing problems with thresholds.

Threshold map

The threshold map exercise could be used in the following ways:

- **for LSCBs as part of the audit of serious case reviews** to consider the role of thresholds and/or levels of engagement and cooperation in the reviews under consideration over a particular time period.
- **as part of a LSCB training exercise**, bringing together practitioners from different sectors to find out how thresholds are being interpreted between or within agencies (e.g. between children’s social care and adult social care or different health sectors). Practitioners could plot and discuss their ‘borderline’ cases or ‘neglect’ cases. Discussions could be facilitated to consider how shared responsibility between agencies for supporting and protecting children in these circumstances can be improved. The LSCB could decide to follow up some ‘borderline’ or ‘neglect’ cases over a period of time to consider the pattern of services the children receive and to track evidence of risk and protective factors.
- **in practitioner teams’ individual supervision**, where the worker and supervisor could plot individual cases or a whole workload of children’s cases. The discussion with the supervisor could focus on the level of cooperation with families and how workers can be supported to understand the dynamics behind the engagement with individual family members.
- **in group supervision**, plotting the caseload of the team (could be single or multi-agency) to understand more about thresholds or family engagement or types of cases, featuring for example older children, or neglect etc. Discussion

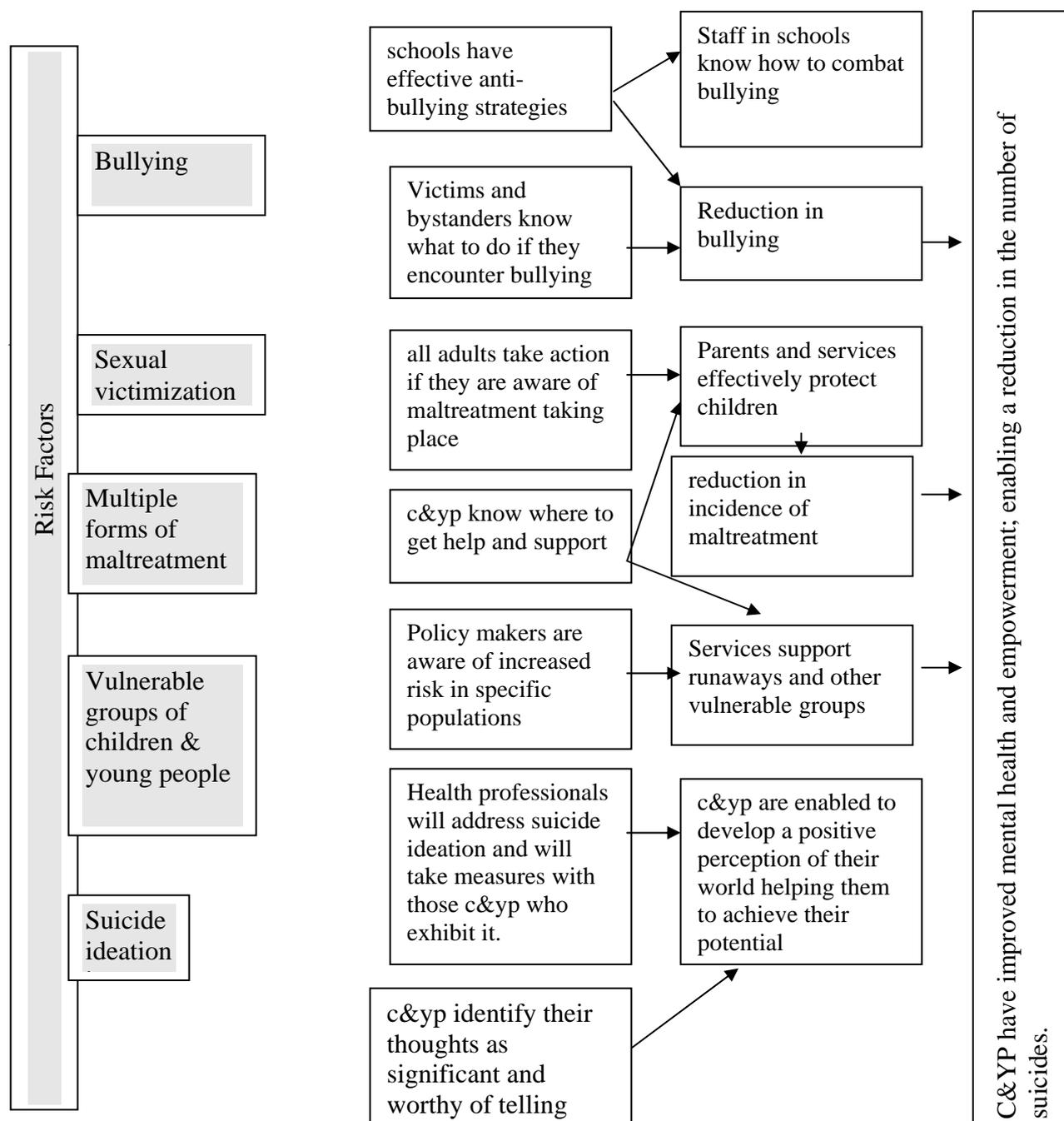
could consider how practice and decision making could be improved in the cases in question.

- **to understand thresholds over time in complex cases.** This could be used as a supervision tool or for individual practitioners to make sense of a difficult case. It would work best in conjunction with the use of an analytical chronology

APPENDIX 7: A MODEL OF SUICIDE PREVENTION

The cases of suicide and the extent of self harm and suicidal ideation in many of the reviews concerning young people have been a significant feature of this study. Suicide needs to be considered as a risk for young people in transition, particularly those with a history of maltreatment. However suicide is also a risk for young people who have not had extensive involvement with children’s social care or other specialist services. A small number of these reviews echoed findings from other studies which hypothesised that some suicides might be linked to experiences of being bullied, or being a bully in school. The following model of suicide prevention in children and young people is being tested by the NSPCC and includes this wide range of experiences. It could be used by schools and Local Safeguarding Children Boards. It is reproduced here with the kind permission of Dr Fiona Colquhoun and the NSPCC (Colquhoun 2007).

Figure 11: A model of suicide prevention in children and young people



Ref: DCSF-RR023

ISBN: 978 1 84775 096 9

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www.dcsf.gov.uk/research

Published by the Department for
Children, Schools and Families