Department of Health

Learning from Past Experience -

A Review of Serious Case Reviews

Posed by models

June 2002

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Foreword

It is always desperately sad and hard to understand when children die or are injured as a result of abuse or neglect.

But failing to understand why people abuse children will not make children safer. It will not reduce the chance of other children meeting a similar fate. We must learn why this abuse, these deaths, occur in order to do all we can to stop them from happening in the future.

There is a vital role here for local agencies, particularly Area Child Protection Committees, in conducting high quality Serious Case Reviews when a child dies or suffers serious injury as a result of abuse or neglect. There is also an important national role for Government in helping to co-ordinate and speed the common messages that emerge from these reviews.

This review, commissioned by the Government, is the first of an ongoing series of national overview studies of Serious Case Reviews. Its aim was simple - to draw out the key findings of a sample of such case reviews, and their implications for policy and practice.

Many of the key messages from these case reviews confirm what we already know. In common with findings from research, some family characteristics, such as parental mental health problems and domestic violence, were often identified. The children's circumstances, however, varied greatly. In some cases, the abuse occurred out of the blue, in others it occurred in a context of low level need and occasionally it arose in situations where it seemed to have been "waiting to happen".

A similar level of diversity is apparent in terms of the prior involvement of the child and family with welfare agencies. Some were virtually unknown to anyone, others were long-standing cases, often with parents being known since the time of their own childhood. In only six out of forty cases studied had there been enduring concerns about risks of harm to the child.

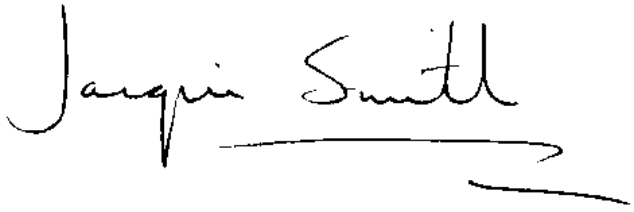
The researchers conclude that, unfortunately, the factors common to these cases have limited value in helping to predict with any accuracy which children will become the victims of abuse. The lessons to be learned from Serious Case

Reviews are, therefore, more about improving the processes for managing the risk of harm than for identifying vulnerable children. I hope that this review will help us to manage that risk.

We must continue to build on the findings from this review and other similar work to ensure that the lessons to be learned from these cases are integrated into our child care practice and management. The researchers emphasise the importance of `good epidemiological and clinical evidence on factors associated with children suffering significant harm; knowledge about how to implement effective services; and practice tools to improve decisions and practice consistency.' I am pleased to say that the Department of Health is taking positive action in each of these areas of child care services.

Research has been commissioned and disseminated on factors associated with significant harm; Social Care Institute for Excellence and the National Service Framework for Children together with the Children's Taskforce are all considering how best to implement effective services; and the Integrated Children's System will produce practice tools to improve decision-making and practice consistency.

In addition, we must continue to improve our understanding of the factors associated with harm to children. We must seek better to understand which interventions are most effective in both preventing children from suffering harm in the first place and in helping those children who have suffered harm to recover. We must learn these lessons. We are putting children's lives at risk of harm if we do not.



Jacqui Smith MP
Minister of State for Community
Department of Health

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We are deeply grateful to them all.

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Introduction

> *"Serious Case Reviews represent everything that is good about this country. Professionals devoted to public service, the comfortably off searching their souls to prevent child tragedies. It means that lonely and unloved children have not suffered in vain."*

This comment from an ACPC (Area Child Protection Committee) chair captures the strong emotions aroused by child abuse and sums up her way of easing her guilt and sorrow. 'I always remind myself', she continued, 'we are talking about dead babies'. Not all respondents were this complimentary; one respondent, originally from Southern Europe, said

> *while the English do not wish ill of their children, their society is not child friendly. While the depth of inquiry and compassion is impressive, the children would probably get just as much attention if they were going to be hung.*

Whatever the wider functions of Serious Case Reviews (previously known as Part 8 reviews), there is undoubtedly a genuine wish to examine and learn from child death or serious injury tragedies. This is made clear in the Government guidance, *Working Together to Safeguard Children* (1999), which lays out the purpose of reviews into child deaths and serious injuries, when they should be undertaken, their scope, timing and administrative arrangements and the need for subsequent action based on the lessons learned. To summarise, Para 8.1 dictates that:

> *when a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children at risk of harm who need safeguarding….. (and) whether there are any lessons to be learned from the tragedy about the ways in which they work together to safeguard children.*

Serious Case Reviews are almost certain to follow the death of a child if abuse or neglect is suspected as a significant factor. They are also likely to happen if the child suffers a potentially life threatening injury, serious sexual abuse or permanent impairment of health and development, when the combined working of local child welfare agencies is perceived as unsatisfactory. They need to be distinguished from reviews into child deaths as a whole and from inquests, the function of which is to identify the deceased and establish the cause of death, and from public inquiries which are intended to be more wide-ranging and may lead to changes in law and professional structures. These other activities have much wider implications, such as for criminal prosecutions and claims for damages.

The number of Serious Case Reviews

Currently there are no readily accessible data on the number of Serious Case Reviews that are undertaken. As John Hutton, then Minister for Health, reported in the House of Commons on 21 March 2001, 'information is not collected on the number of case reviews that have been carried out in accordance with Chapter 8 of *Working Together to Safeguard Children* 1999' (Hansard, 13 March 2001; col. 589w).

Local Authorities are required to inform the Department of Health, through the SSI Social Care Regions, of every case that is subject to a case review (Para 8.10). However, this information was not collated. The Department of Health has recently introduced an enhanced computerised database of deaths or serious injuries of children where there are child protection concerns. This database records details of the incident, the child and family, any criminal proceedings and whether or not a Serious Case Review has been conducted into the incident. The new database was launched in April 2002. Data is entered by Department of Health/SSI staff on the basis of notifications received from Local Authorities. There is no public access to the database, but it is hoped that its existence will enhance understanding of the volume and characteristics of such incidents. It will also help in the identification of cases where there have been serious reviews, for future reference.

Despite the previous lack of a national database, estimates have been made of the number of Serious Case Reviews at different times. James (1994) in introducing his overview reports of Part 8 reviews for the period 1991-1993 says:

each year in recent times the Department of Health has received about 120 notifications of child deaths or incidents of serious harm to children involving potential major public concern. These numbers include notifications of the death from any cause of any child being looked after by a local authority or of any child who dies in residential care. By no means all of these 120 or so notifications result in an Area Child Protection Committee case review. Currently the Department receives on average one Section 8/ACPC case review each week.

Information on the notification of child deaths was also provided by the Department of Health to Reder and Duncan for their study into child deaths between April 1990 and March 95 (Reder and Duncan, 1999). Their figures (p.23) are as follows.

TABLE 1: 'Part 8' notifications of child deaths to Department of Health 1990-95

Year	Non-Accidental	Natural Causes	Accident Suicide Solvent abuse	Other	Total
1990-1	55	35	10	22	122
1991-2	45	35	24	11	115
1992-3	59	32	14	11	116
1993-4	54	32	19	7	112
1994-5	54	29	28	9	120

Taking account of these different definitions and methods of recording, the Department of Health estimates that there are about 90 child deaths each year that are the subject of a full Serious Case Review.

The link between Serious Case Reviews and fatal child abuse is not straightforward. Serious Case Reviews include non-fatal abuse as well as natural cause or accidental death, especially where other concerns are raised. There is also variation in practice between ACPCs in their response to a reported child death. Under-reporting of fatal child abuse has also been noted (Wilczynski, 1994; Creighton, 2001) particularly where the cause of death is uncertain as in Sudden Infant Death Syndrome (Hobbs et al., 1995). Information on child homicide is equally uncertain (Browne and Lynch, 1995; Pritchard 1996); hence the continued use of the widely quoted statistic 'on average, between 1 to 2 children each week die as a result of abuse or neglect' (NSPCC, 2001).

An accurate statistical return on Serious Case Reviews could go some way towards improving our knowledge of the extent of fatal child abuse. It can also assist the Government in fulfilling its commitment to drawing key findings from case reviews to inform policy and practice.

Further, good management information is seen by government as fundamental to the evaluation of the success of the Government's *Objectives for Children's Social Services*, known as *Quality Protects* (DH, 1999). Objective 2.1 of *Quality Protects* is:

- to reduce the number of deaths of children, where abuse or neglect is a factor.

Much of the achievement of *Quality Protects* relates to activity at a local level and hence there are *Performance Assessment Framework* indicators that can be measured locally. But it is recognised that a reduction in child deaths requires assessment at a national level, a process that is only possible with accurate information on how many child deaths occur each year where abuse or neglect is a factor.

The purpose of Serious Case Reviews

The aims of Serious Case Reviews as laid out in paragraph 8.2 of *Working Together to Safeguard Children* 1999 are:

- to establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.

- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result;

- To improve inter-agency working to better safeguard children.

Hence, it can be seen that Serious Case Reviews focus primarily on the role of professional agencies and are less concerned with family or community responsibilities or wider reasons for the failure to keep a child safe and prevent the incident from happening (NSPCC, 2001). It can be argued that death and very serious injuries do not necessarily tell us enough about child abuse in general and the wider monitoring of successful as well as unsuccessful cases might give a better understanding of the issue.

Government Guidance

Serious Case Reviews have been subject to two sets of guidance. The 1991 publication *Working Together Under the Children Act* 1989 laid out requirements and suggestions in some detail but these were substantially revised in the later version *Working Together to Safeguard Children*, issued in draft in August 1999 and published in December of that year. There is a clear shift in focus between the two sets of guidance. The earlier publication opened by stressing the need for central government to be informed so that public statements could be issued and developments reviewed. It then offered seven principles that underpin the process. These were: urgency, impartiality, thoroughness, openness, confidentiality, co-operation and resolution. Following this, the aims of reviews and the agenda for conducting a Serious Case Review were specified. The ACPC was expected to co-ordinate all the activity, to produce an overview within three months of the incident and instigate a process for implementing the recommendations. Agencies were expected to respond to requests for information within one month.

The 1999 guidance is clearer and more prescriptive. There is less emphasis on checking whether child protection procedures were followed and more on learning lessons for improving collaboration and on remedial action within the local agencies. For example, the criterion of child protection cases where there is 'likely to be major public policy concern' is dropped and replaced with the more detailed list of incidents described on Page Five. Eight questions are posed to help managers decide whether a review is needed. These emphasise situations where there is evidence of unrecognised warnings, poor sharing of responsibility and information and inertia, rather than simply of a failing to follow procedures. It recommends that the ACPC sets up a multi-disciplinary Serious Cases Review Panel to decide on appropriate action. A framework is then proposed for the scope of the review and its terms of reference. A series of points replace the principles in the 1991 publication. These highlight the issues to be addressed, the contributors from inside and outside the local area, the extent that previous histories need to be compiled, the role of family members, the significance of other legal proceedings, the time-table and the dissemination of the final report.

On more specific detail, the new guidance specifies that decisions to review should be made within one month of the incident and the exercise completed within four. Moreover, each relevant service is expected to undertake an internal management review to be carried out by someone not involved with the case. Again, the emphasis (para 8.21) is

- to look openly and critically at individual and organisational practice to see whether the Serious Case Review indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

The subsequent action by the ACPC is similarly extended from 'producing a report' and 'identifying matters requiring further action' to ensuring there is agreement across agencies, fashioning a clear action plan with responsibilities, time scales and intended outcomes, a programme to adopt this plan, clarification about the circulation of the report, the dissemination of important findings, giving feed-back to staff, family members and the media and forwarding a copy to central government. A template is also provided showing how the facts, analysis, conclusions and recommendations should be organised. The guidance emphasises the special responsibility of the ACPC for handling the interface between the different parts of the process.

To summarise, there is much greater emphasis in the recent guidance on how conclusions should be drawn and how lessons learnt should be disseminated and incorporated into local policy and practice. Reviews are seen as a learning process rather than as a trial or ordeal and should feed a culture of organisational audit and review rather than one of investigation and blame.

Differences that might be expected as a result of the new guidance

Given the changes in the new 1999 guidance, what differences would these be expected to make to the reports on Serious Case Reviews? Ten seem likely. They are:

i. a change in emphasis from an inquisitorial perspective to a learning one. There would be less concern with whether guidance had been followed and more on lessons to be learned, particularly with regard to inter-agency working and the sharing of information

ii. in cases of serious injury, sexual abuse or maltreatment while looked after, clarity about why the review was being undertaken and what it would produce

iii. clearer scope of the review from the outset, with the questions to be answered and the sources of information better delineated

iv. 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

v. a more robust action plan in which the responsibilities of each agency, the time scales and plans for implementation are specified

vi. well prepared plans for the dissemination of reports and handling the media

vii. reviews undertaken and completed within the suggested time scale, that is initiated within a month of the incident coming to the notice of the ACPC chair and completed four months thereafter

viii. the public availability of an executive summary report

ix. the setting up by the ACPC of an inter-disciplinary Serious Cases Review Panel to consider whether a review should take place.

x. evidence that reviews will increase awareness of child protection issues among local policy makers and practitioners

Given these expectations, what are the aims of the research?

Chapter Two

Outline of the Study

As well as setting out expectations for Serious Case Reviews at a local level, the guidance also recognises the potential of reviews to inform national policy and practice. Para 8.33 sets out the responsibility of the Department of Health to identify common themes across reports and to commission an overview of reports every two years. This study was commissioned by the Department of Health to fulfil that commitment.

Aims of the study

The aim of the study was to scrutinise a sample of Case Reviews undertaken between 1998 and 2001 - that is before and after the new guidance - with the following objectives:

i. To identify what helps and what hinders the Serious Case Review process, as revised by *Working Together to Safeguard Children* 1999

ii. To ascertain if the revised Serious Case Review processes have led to any changes in policy or practice at a local level

iii. To identify from the reviews any lessons for policy and practice at a national level

Issues to be explored

To meet these aims, a series of questions were asked under headings that reflect the three research aims.

The case review process

Is there clarity and general understanding about when a Serious Case Review is required? How well does the establishment of a Serious Cases Review Panel work? How often and how successfully do independent parties and family members contribute to the review? Is the timetable in the Guidance kept to, and if not why? Does the review process take account of a Coroner's inquiry and any contemporaneous criminal proceedings related to the case? Who does

the internal management review and what are its effects? How is public, family and media interest handled, before, during and after the review?

Changes in policy and practice at a local level

What problems are encountered in producing overview reports? The issues relating to publication could be helpfully explored, for instance, when should publication take place? Or what constitutes publication? How can the Action Plans be characterised, for example in terms of specificity, immediacy, scope, level of decision-making, focus of change, implementation and time-tables? Are there any features that seem particularly useful in promoting change? How is the implementation of Action Plans monitored and how effectively? Has the local ACPC changed its local protocols or procedures as a result of the case review?

Lessons for policy and practice at a national level

Are there any patterns or common themes emerging from the reviews, in terms of children's circumstances and needs, case histories and inter-agency working? How far do these relate to local policy and practice issues or to the influence of national policy and supports? To what extent do ACPCs seek or receive feedback on review reports from the SSI? How are lessons of national interest disseminated?

Sample selection

Information on Serious Case Reviews is reported initially to regional SSI offices with the intention that this will be recorded on a national database. This information was used to provide a sampling frame for this study, particularly as it was supplemented by discussion with Social Care Region SSI to ensure that, as far as possible, it was complete. It has to be said that the accuracy of this database, in terms of it containing a complete record of all the Serious Case Reviews undertaken nationally, was dubious and the researchers had some difficulty in compiling the necessary information. However, as mentioned in Chapter One, changes to improve the central recording system are now being implemented and it is hoped that a more accurate record of all Serious Case Reviews will be available as a sampling frame by the time the next overview report is undertaken.

Out of all these cases notified to the researchers, twenty cases completed in 1998-9 and 20 completed in 2000-01 were selected randomly for study, using a sample stratification designed to ensure a balanced representation of geographical spread, type of local authority and the status of the review author.

Given the number of cases included in the study, the researchers have some confidence that the sample adequately represents the range of cases subject to Serious Case Reviews.

Research methods

The information needed to address the research questions was obtained from three sources: the case review reports, interviews with key informants in selected cases and interviews with SSI Social Care Region staff.

Case review reports: All the case review reports were read and a comprehensive framework was constructed to analyse their contents. Consistency between the researchers in applying the framework was tested. The framework included all those factors identified in other studies and reflected the questions posed earlier. The information from the reports was gathered under eleven headings:

- the child
- the death or serious injury
- background of primary carer
- background of secondary carer
- the relationship between carers
- social services department service history
- service history from all agencies
- organisational factors
- the review process
- details of overview report
- quality of practice

The structure of this framework is apparent from the detailed responses reported in the Appendix. This was used to provide information on the cases, the review process and the lessons learned. It was also used to assess the impact of the new guidance in relation to the expected changes i, iii, iv, v, vi and vii listed at the end of Chapter One.

Inevitably, there were some limitations in this material as a source of evidence on child deaths and on Serious Case Reviews. For example, in some cases only the overview report was available to the researchers and reports usually stopped at the point of the incident, drawing only on the information available to professionals at that time. Thus, some valuable information learned subsequently or provided in confidential reports from individual agencies was not available. Although Serious Case Reviews reports are important in providing information on agency involvement, they cannot be accepted as a comprehensive source of data on child deaths (Falkov, 1996).

Interviews: In order to assess the effectiveness of the process and to examine the impact of guidance in respect of expected changes ii, viii, ix and x listed at the end of Chapter One, the authors of the review and the chair of the local ACPC in half of the cases were asked to participate in interviews. The cases were chosen randomly and were evenly divided between 'old' and 'new' cases. Thirty three out of the 40 intended interviews were completed successfully: three people had moved on and did not respond to requests, in two cases the chair was also the author and two local authorities declined an author interview because the case was *sub judice*. The interviews were semi-structured and all but six were undertaken by telephone. To enhance the quality of the interviews, respondents were sent copies of the interview schedule in advance. The interviews covered a discussion of the selected case, wider issues concerning the process and outcomes of Serious Case Reviews and the impact of the new guidance.

In addition to these case-specific interviews, wider opinion on the operation and impact of the case review process and how this might have changed with the introduction of the new guidance was sought in interviews with three SSI-Social Care Region staff experienced in these matters.

The aims of the interviews were twofold. The first was to explore in greater detail the decisions to undertake the review, to consider the dynamics of the review process, to discuss the compilation of the report and to review the dissemination of the findings, to chart the implementation of recommendations and to examine the role of the SSI. The second aim was to canvass from experienced professionals opinions on the value of the Serious Case Reviews and the effects of the new guidance.

These interviews were included in the research design so that important issues could be discussed with a cross section of key professionals. This was felt to be important because serious child abuse is an area that is so politically and professionally sensitive that any research conclusions need to be supported by evidence gathered from as many sources as possible.

Chapter Three

Previous research on Serious Case/Part 8 Reviews

There is a wealth of literature on child protection and on perpetrators likely to murder or seriously injure children (Hagell, 1998; Dent, 1998; MacDonald, 2001). However, there is much less on Serious Case/Part 8 Reviews (Reder et al, 1993; James, 1994; Falkov, 1996; Munro, 1996; and Reder and Duncan, 1999) and the material that is available tends to seek common themes and messages rather than scrutinise the process and its value (Department of Health, 1991).

Hill (1990) was one of the first researchers to identify the benefits of child abuse reviews and highlighted many issues addressed in subsequent guidance. He warns against the process allowing society to distance itself from public responsibility for child care. He also expresses concern that too great a focus on incidents can divert attention from important wider social processes and the gender, power and social class issues intrinsic to them. He stresses what are now familiar criticisms raised in reports, namely failing to focus on the child as an individual in his or her own right, static assessments of family structures and relationships, pursuit of the 'rule of optimism' and in some cases a clear dereliction of legal duty. The effects of this, he argues, are to segregate abusers as 'abnormal' people, to preserve cherished values held by the majority of the population, to reinforce the social policing role of social workers, to miss possible solutions based on empowering people and communities, to divert attention from preventative practice and reinforce the belief in managerial solutions to complex problems. In short, the review process does little to 'create the social conditions and welfare systems which keep children safe'.

Munro (1996) writing in the mid-1990s after the publication of the 1991 *Working Together*, looked at 45 inquiry reports and emphasised the tardiness of social workers to alter their early judgements when evidence on risks to children accumulates. Although some tragedies result from poor practice compounded by these inflexible views, in many cases the incident is simply 'bad luck'. Domestic violence is a factor particularly neglected at this time. This is taken up by Brandon and Lewis (1996) who noted that although children assessed as experiencing 'significant harm' display a range of presenting symptoms, domestic violence is a frequent background factor. Nearly half (49 of 105) of the children they studied had witnessed such violence and 28 out of the 51 children looked at intensively had been harmed by it.

The most significant studies of child abuse inquiry reports have been commissioned by the Department of Health itself. These are the Department of Health (1991), Social Services Inspectorate (1994), James (1994), Falkov (1996), Reder et al. (1993); Reder and Duncan (1999) and Arthurs and Ruddick (2001). Another study by Owers and colleagues (1999) was commissioned by the National Assembly for Wales. The 1991 and 1993 overviews from central government identify many issues that recur in later studies. They show that the reports lack a clear format, include partial information, vary in length and focus mostly on services and compliance with procedures. Familiar administrative shortcomings are also highlighted. These include poor training, failure to share information, a plethora of unconnected recommendations and the isolation of the exercise from wider child care strategic planning.

James (1994) explores the children and families involved more extensively. He looks at 30 reviews conducted between October 1991 and December 1993. The sample is constructed to represent all regions of the country and children of every age. The reports are found to be of variable length and have considerable gaps, especially information on the men involved in the cases. The time taken to complete the work varies enormously and the recommendations which range in number from four to 99 are an unsatisfactory mixture of 'core' policy and practice concerns and everyday issues. He provides information on the children and families which will be used later in this report in discussions of the individuals scrutinised in Serious Case/Part 8 Reviews.

Falkov (1996) scrutinises 105 review reports undertaken in 1993 and 1994 looking especially at adult mental health. He finds that psychiatric disorder is detected in a third of the cases examined and that there is a distinct lack of integration between agencies providing services for the adults affected and their children. Training in mental health and child protection for the relevant professionals is seen as the best way of enhancing recognition, referral and intervention. He concludes, however, that this is unlikely to prevent individual deaths but 'to improve procedures and practices which impact on the much larger group of children who are abused but not killed and constitute the 'at risk' population from which many fatalities will arise'.

Owers and colleagues (1999) examined 10 reports undertaken in Wales between April 1996 and December 1998 using a 'layered reading' methodology. They find that the reports are extremely diverse in the nature of their compilation and in terms of the contribution of individual agencies. Prior to the incident, assessments of need and risk are poor, practitioners receive inadequate supervision and inter-agency communication is lacking. The quality of reports and the extent to which information is reviewed vary significantly. This is especially so for family histories where the absence of information on a

particular factor is often taken to mean that it is absent in reality. There is also too much emphasis on particular incidents and a failure to identify overall patterns. They stress the importance of national guidance but are dubious about the value of complicating the process further and making endless recommendations.

The report concludes that professional competence is the key to protecting children. The elements of this are: knowledge, values and professional identity; skills; professional/clinical supervision and training to enhance knowledge and skills. They conclude that Serious Case Reviews require clear objectives and to be part of an audit of services.

In this final point, they echo Reder and Duncan (1998) who, in their study of 86 child abuse deaths, exhort reviews to 'promote learning at different levels'. Indeed, revisions to procedures are thought likely to be more effective if they are based on these audits and not on single incidents.

Reder, Duncan and colleagues (1993; 1999) develop this theme of linking research and practice more effectively. One issue they seek to address is the assessment of accumulating risk. They argue that the most effective approach is to look at each facet of the situation and at each bit of practice in that context, including the effects of previous interventions – activity that is rarely evaluated. Echoing Owers and others, they value training as a way of helping people interpret information such as genograms and argue for a much more testing and argumentative agenda for analysing the information, a process termed by them as a 'dialectic mindset'.

Like Falkov, these authors emphasise that the Serious Case Reviews cases are only a sample of fatal child abuse cases and wider implications for child abuse policy have to be drawn cautiously. They see the value of Serious Case/Part 8 reporting as limited by the restricted aims of the exercise, the limited composition of panels, the type of information provided and the style of reporting. The focus on procedures is also a constraint. More outside experts, more material on children's personal development and past relationships, more effective participation by GPs and a standard format for presenting the material would help. Many of these points are echoed in the Bridge report *Childhood Lost* (2001) which also offers a possible format for presenting reports.

More recent surveys of Serious Case/Part 8 Reviews support these proposals. Arthurs and Ruddick (2001), for example, scrutinised 25 reports emanating between April 1998 and March 2000 from a National Health Service region covering 20 local and 14 health authorities. They also analysed thirteen other potential cases that did not lead to a full review. In addition to the problems already described, such as poor communication and inadequate recording, they

emphasise the importance of parental participation in the legal process, the need to maintain parental co-operation, the importance of ensuring that early child protection conferences set in motion a successful review process and the need in protection plans for a strategy plan to address failure. They pose forty two questions for ACPCs to consider in the routine audits of local practice that their report recommends.

Many common themes emerge in this research material. These can be summarised under broad headings as follows:

Inter-agency working

- Limited inter-agency co-operation and lack of service integration, especially between child and adult services
- Poor communication both between agencies and within agencies
- Health services and child protection: variable levels of knowledge, of both risks of harm and procedures, among different groups, especially GPs and those in adult mental health services
- Need for specialist forensic paediatric pathologists
- Greater clarity of the relations between criminal proceedings and child protection

Collecting and interpreting information

- Receiving, recording, interpreting and dealing with referrals appropriately
- Using information to assess risk factors, understanding triggers, and the need for accumulating evidence
- Understanding thresholds, especially the importance of neglect and emotional deprivation
- Importance of comprehensive family assessments, especially histories of male figures
- Need for medical evidence to be considered within the overall context

Decision-making

- Need for shared decision-making, especially in respect of not taking action or case closure
- Moving from data collection and sharing to strategic discussions and clear plans
- Planning a co-ordinated response across professionals and agencies

Relations with families

- Seeing the child as the client, focusing on his or her protection and not being distracted by other problems or by adult or sibling concerns
- Dealing with hostile families or those who withdraw
- Lack of awareness of the impact of domestic violence on children and their safety.

Chapter Four

Characteristics of children and families who are subjects of Serious Case Reviews

One of the functions of research is to test commonly held observations and child protection is an area ripe for such activity. With a group of individuals as diverse as abused children, almost anything said will be true for some, but few observations will apply to them all. As Serious Case Reviews are a relatively rare occurrence in a social services department, respondents to our interviews were often tempted to generalise from their single case or clutch of experiences. The validity of these perceptions, however, does not stand up to empirical testing. Here is a quotation from a senior manager, interspersed with results from this survey of 40 cases printed in italics.

> I have done four of these reviews and the same things keep coming up. It's young mothers *(9 of the 40 main carers were aged under 21 when the child was born)* who are depressed *(18 of the 40 had mental health problems)* and simply cannot cope *(for 16 children no concerns about their welfare had ever been expressed)* with their babies *(19 of the 40 children were aged less than 12 months)* in poor living circumstances *(in 23 cases there was no significant poverty or accommodation problems)*, especially when their situation is compounded by a violent partner *(22 of the 31 current partners were known to be violent)*.

Another ACPC chair, not from a social work background, opined

> it's usually social workers who are in the front line (*12 of the 40 children were not known to social services and only 12 were open SSD cases*) and despite their continual contact with families (*in 12 of the 40 cases there was a high level of service*) so often miss the warning signs (*a situation that applied to 23 of the 40 cases*) that should have alerted them to the possibility of a tragedy (*4 cases were high risk or high priority*).

Although these observations are useful for understanding the backgrounds of the children and the perceptions that staff hold, it is important to stress that they have limited predictive value when applied to a general population or even to a population of vulnerable children. Even though our knowledge may be increasing regarding the factors that contribute to child abuse and neglect, as MacDonald concludes from her review of the research, the likelihood of

abuse occurring will depend on the interplay of a range of factors and 'it is not possible to say how significant a particular feature, characteristic or circumstance might be' (MacDonald, 2001). Even if the forecasts of future abuse were accurate, attempts to predict which of those children would be murdered or suffer serious injury are virtually impossible (Corby, 1996; Hagell, 1998; Harris-Hendricks, 1998; Beaumont, 1999; Little and Mount, 1999). Browne and Stevenson's follow-up study of 14,238 children born in a selected geographical area in 1984 highlights the difficulties (in Browne and Saqi, 1988). They applied an abuse risk schedule informed by research to all of the children and found that 949 families displayed factors associated with a high risk of child abuse. On follow-up, 57 of the 14,238 children were abused in the following two years. Of these, 47 came from the families identified as showing high risk and 10 came from families displaying no or little risk. The fact that 47 (82%) of the 57 families that abused their children had been identified as being high risk is encouraging because it seems that they can be identified early. However, the problem is that the schedule also identified 902 high risk families that did not abuse their children in the follow-up period. Thus, for every correct prediction among the high risk group, there were just under 20 (19.2) incorrect ones or 'false positives'. These limitations should be borne in mind in discussions about the relevance to future events of the characteristics of the children and families.

Implications for practice

Box 1

This overview demonstrates a wide variety in the children who suffer fatal child abuse or serious injury and in the circumstances in which these occur. While some features appear frequently (such as poor standards of care, emotional neglect, domestic violence and mental health problems), the power of known indicators to predict such events is limited. This raises the possibility of inappropriate stereotyping of cases.

Practitioners should check whether they are focusing on a dominant theme or over- concentrating on some factors at the expense of recognising others, such as social isolation or frequent moves.

What, then, are the characteristics of the children and families in the sample? The complete results are laid out in the Appendix.

The children

The children were generally young (32 of the 40 under the age of six) and 19 were babies under the age of one, 12 of whom were aged less than four months. Six were over the age of 10. The details are as follows.

TABLE 2: Ages of children at time of incident

0-1 month	7
2-3 months	5
4-6 months	3
7-12 months	4
1-3 years	6
4-5 years	7
6-10 years	1
11-15 years	5
16 years or more	1
Not known	1
TOTAL	**40**

There were more boys (24) than girls (16) in the sample. Information on the ethnic background of children and carers was sometimes vague and also unsophisticated in that it failed to consider features of the child's culture, language, religion and race, as specified in the *Children Act* 1989. But, however unreliable the background information, it is known that six children were from minority ethnic groups (two African, two Asian and two mixed heritage) and in only four cases was a language other than English used in the family home. All 40 children were born in the United Kingdom.

Implications for practice

Box 2

Section 22 (5) (c) of the *Children Act* 1989 requires that when making decisions in respect of a child, a local authority *'shall give due consideration …to the child's religious persuasion, racial origin and cultural and linguistic background.*' A child's ethnicity is composed of these four elements – race, culture, religion and language. Before account can be taken of any particular needs associated with a child's ethnicity, first it must be ascertained and recorded. Within a case file that record of ethnicity needs to move beyond a simple uni-dimensional categorisation, such as that used for database purposes, and include a more sophisticated description of the several aspects of ethnicity. Further, this should be based, as far as possible, on self definition, asking the child or family how they describe their own ethnic identity.

Information on a child's ethnicity allows for a fuller description of the child, just as with age and sex. Similarly, as with age and sex, it may or may not give rise to particular needs but it alerts the practitioner to such a possibility. In undertaking an assessment, practitioners need to give careful consideration to any needs that arise in relation to any aspect of the child's ethnicity, ensuring these are clearly articulated. For example, the child and family's ability to speak and understand English; their familiarity with services in order to gain access to them; the impact of racism or uprooting from their country of origin and the significance of cultural or religious practices.

Twelve children lived with a lone mother, one with a lone father, 18 with both birth parents, eight with a step-parent and one with other relatives. Thirteen children were the only child in the family, seventeen having natural siblings, three having half siblings and one a step-sibling. Twenty children were the youngest child in the family and only four were the oldest.

Although the children had experienced a range of problems prior to the incident leading to the review, only one child was physically disabled, four had special educational needs and five had significant health problems. Two background factors noted as possible indicators of inadequate parenting are poor ante-natal care and irregular attendance at school or early years services. For eight children poor ante-natal care had been identified and in eleven cases, attendance at playgroup or school had been infrequent. In summary, they impress as a disadvantaged group of children but with no background characteristics that mark them out as victims.

Implications for practice

Box 3

In working with families, practitioners need to be sensitive to indicators of the child's social situation that suggest that the child is socially excluded and because of this is not getting appropriate mainstream services, such as developmental checks, early years services or schooling, whether this is caused by parents not recognising or meeting the child's needs or by putting their own needs first, by chaotic lifestyles or chronic neglect.

The incidents

Thirty one of the 40 children died as a result of the incident and eight were seriously injured. The one other child was seriously neglected to the extent that his behaviour spiralled out of control and he received a five year custodial sentence for a violent crime when aged 12. In situations where the immediate causes of death or injury were not apparently associated with abuse or neglect, there were always important contributory factors. Examples are, suffocation due to the overlying of a baby by a mother who was drunk, an accident occurring when children had been left alone or an illness possibly brought on by physical assault or neglect.

TABLE 3: The immediate causes of death and injury

	Death	**Injury**
Murder	12	0
G.B.H.	4	6
Sudden infant death	3	0
Illness	3	0
Accident	3	0
Neglect	2	1
Overlying	2	0
Fit	1	1
Induced illness	0	1
Overdose	1	0
TOTAL	**31**	**9**

The perpetrators of the incident varied and comprised the mother and/or father in only 22 of the 40 cases. The list is provided in the following table.

TABLE 4: Perpetrators of incidents

Mother	11
Father	8
Mother and father	3
Non-biological 'mother'	1
Non-biological 'father'	3
Sibling	0
Other relative	0
Family friend	0
Stranger	1
Other	2
Not known	5
Not applicable	6
TOTAL	**40**

Thirty of the incidents were isolated events but nine followed a history or pattern of abuse or neglect. In only one case was there evidence of extensive premeditation or preparation. Criminal proceedings followed in 24 cases but most reviews had been completed before the trial so the sentencing outcomes are not known. The purpose of the Serious Case Review is very different from that of criminal proceedings, nonetheless the reports do provide some insight into the parents' explanations for the incident. At the time of the report, in only 15 cases did the parent(s) admit responsibility; their explanations of what had happened were unclear in over half of the cases and in only 22 did a parent identify a specific perpetrator. In a quarter of situations, parents disagreed about what happened, as the following table shows.

TABLE 5: Parents' views of the incident

	YES	NO	NK	NA	TOTAL
Admitted responsibility	15	22	1	2	40
Perpetrator clearly identified	22	14	2	2	40
Uncertain about causes/events	22	17	1	0	40
Disagreement between carers	10	28	2	0	40

The Carers

Information was gathered on the child's primary carer and, where applicable, their secondary carer. Thirty eight of the forty primary carers of the children were female and all were the children's birth mothers. The two males were a birth father and a step-father. Their ages at the time of the incident ranged from 14 to 47 as follows.

TABLE 6: Age (in years) of primary carer at time of incident

Under 15	1
16-18	1
19-20	3
21-25	10
26-30	8
31-35	8
36-40	5
41 and over	1
Not known	3
TOTAL	**40**

As with the children, the ethnic background of the primary carers was not reliably recorded but it was noted that two primary carers were of African origin and two of Asian origin, although in seven cases it was noted that English was an additional language. The tendency was for nothing to be recorded when the mother was white. This poor recording of ethnicity of both parents and children was exacerbated by the limited reference to race or cultural implications in the overview reports, a feature noted by Reder and Duncan (1998) several years ago (p. 22).

In eighteen cases the primary carers had experienced mental health problems, mostly depression, and in eight they had been in care as children. Six carers are known to have been abused when young and in another case this was implied. Six had a criminal record but none were offenders under the *Sex Offenders Act* 1997 or Schedule 1 of the *Children and Young Persons Act* 1933. Ten were known to have displayed violent behaviour in the family home and 14 currently abused alcohol and/or drugs.

The secondary carers were more varied; 34 were male and one was female, one was not known and four children had no such person. Twenty five of these adults were the child's birth father and nine step-fathers or male co-habitees. Only one was the child's mother. Their ages were as varied as for the primary carers but were slightly higher, with no secondary carers under the age of 20, as the following table shows:

TABLE 7: Ages (in years) of secondary carers at time of incident

Under 15	0
16-18	0
19-20	0
21-25	9
26-30	6
31-35	9
36-40	6
41 and over	3
Not applicable	3
Not known	4
TOTAL	**40**

Twenty five of the secondary carers were living with the child at the time of the incident. As with the primary carers, they came from noticeably difficult backgrounds with nine having mental health problems, three a learning disability, four a history of being in care as a child, three from abusive backgrounds and 14 with a criminal record, although only one of them under legislation concerning sex offenders. Twenty two were known to have been violent at home and 15 currently abused alcohol and/or drugs, with another three having done so in the past.

Seven of the 38 parental partnerships had been in existence for less than a year at the time of the incident and 16 for less than three. On the other hand, 14 were long-standing unions of more than six years. Only nine relationships were described as 'long-term and stable' whereas 20, although long-standing, were perceived as 'unstable'. Relationships between adults appeared to be caring and supportive in only five cases, the norm being frequent argument. Twelve relationships were marked by chronic and serious violence and another 13 by intermittent outbursts.

Situational factors often compounded parents' difficulties. In 17 cases there was poverty and poor housing, in 15 conflict with neighbours, in 19 frequent moves and in seven changes in adult membership. Only nine were perceived as being members of a supportive extended family. However, in only two cases had there been a previous suspicious child death.

Implications for practice

Box 4

In almost half (19) of the cases, the provision of a service to a child, including monitoring their protection, was complicated by the geographical mobility and frequent moves by the family. This was further compounded when several agencies, often other than social services, are involved with the family. Here good inter-agency communication becomes even more important.

All agencies need to be alert to ways of informing others, including those in other local authorities, when children they are working with and for whom there are concerns no longer seek or receive services, whether through a change of accommodation, a stated intention to seek the service elsewhere or a sudden withdrawal from a service such as school or playgroup. Consent to share information should be sought unless to do so would place the child at risk of significant harm (see box 6).

The circumstances of the children in this study confirm the benefits to be gained from recent thinking about the use of multi-axial frameworks for the assessment of children in need (Department of Health et al., 2000; Sinclair and Little, 2002). It is known that child abuse is rarely related to a single cause, but rather to the interplay of several factors in particular circumstances (MacDonald, 2001). 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 (notably with this group domestic violence and mental health problems) and situational factors such as poverty. This study highlights the importance of those factors, often identified in the domain of the Assessment Framework relating to family and community relations and the environment in which the child is living. It is important to give as much attention to these factors as to those related more directly to the child and parent.

Chapter Five

Previous agency involvement with the child

The previous chapter reports on the background characteristics of the primary and secondary carers. However it must be noted that the quality and comprehensiveness of this information is often limited and reflects the degree of involvement that each family has had with welfare agencies. In this sample, prior to the incident that triggered the Serious Case Review, welfare agencies only held full case histories on seven of the 40 primary carers and on four of the 36 secondary carers. Some partial history was available on another 10 and seven respectively. For the majority of the primary carers (23) and secondary carers (28), however, only limited background information was available before the review.

Involvement with social services departments

Twelve of the 40 children were completely unknown to their local social services department at the time of the incident. Thirteen others, in contrast, had been known for more than three years, as the following table shows.

TABLE 8: Length of time child had been known to social services

Child not known to SSD	12
0-1 year	4
1-2	7
2-3	2
3-5	5
5-10	5
10+	3
No information	2
TOTAL	**40**

A similar range of social services involvement is found with the children's families, where the durations are as follows.

TABLE 9: Length of time the child's family had been known to social services

Family not known to SSD	7
Less than 6 months	3
6 months - 2 years	1
More than 2 years	23
Intermittently	1
Not recorded	2
Not applicable	3
TOTAL	**40**

Despite their professional knowledge of some children and families, social services' involvement was generally low. Although concerns had previously been expressed to the social service department about 24 of the children, and in 20 cases more than once, only 16 of these referrals led to a strategy discussion and only nine to a Section 47 enquiry. Thus, at the time of the incident, the names of only six of the 40 children were on the Child Protection Register, only 12 others were defined as a child in need and only five of these were open cases. Four children had been looked after at some point in their lives, three of them more than once and two for a period exceeding three months. There were only three child protection or 'child in need' plans in place at the time of the incident that led to the child's death or injury.

The Serious Case Reviews highlighted deficiencies in the involvement of all agencies. In 17 cases, social services were specifically criticised for not undertaking assessments following referral but concerns were not restricted to them. In seven cases the analysis of the information by one or more of the agencies was seen to be weak. In addition, the evidence on 11 children was not well accumulated by professionals within and across agencies and for 23 warnings were seen to have been ignored. More serious still, in six cases assessments had been completed but not acted on and one case was postponed because of delays in assessing parents.

Implications for practice

Box 5

The above findings raise many issues about the processes which link information about a child to the provision of a particular service – often thought of in terms of meeting thresholds.

Is there a common understanding, within and between agencies, of what instigates an assessment of need or risk of significant harm? Is there common understanding, within and between agencies, of the appropriate response to such an assessment?

While assessment of risk of harm will always be problematic, given the lack of any theory of causation of harm, nonetheless practice can be enhanced to bring greater consistency to decision-making among professionals, both within and across agencies. Testing for consistency will not be possible where case records contain assessments that are descriptive rather than analytical and planning that records decisions but not their rationale. Achieving consistency requires greater clarity in decision making – based on sound information, an articulated assessment of the child's developmental needs that this gives rise to an explanation for the actions taken, including the provision of particular services and how these will address the identified needs.

Involvement of all agencies

Although social services departments have lead responsibility in respect of child protection, many other professionals are likely to be involved with the family. Table 10 indicates which professionals held the child as an open case at the time of the incident. In a few cases the family was an open case in more than one agency, so these figures are not mutually exclusive.

TABLE 10: Cases held as open by various professionals

Social worker	12
Health visitor	18
Specialist health professional	5
Specialist education professional	4

Social worker 12 Health visitor 18 Specialist health professional 5 Specialist education professional 4 This highlights once again the important role played by health visitors in child protection. While previous research suggests that they appear to fulfil this role satisfactorily (Birchall and Hallett, 1995), it is important that new strategies to enable health visitors to undertake a broad public health role do not undermine their role in child protection (Lupton et al., 2001).

Lest this paints too one sided a picture laying too much blame on agencies and professionals, parents also raised difficulties for professionals by concealing their behaviour or failing to co-operate with plans. The relationship between professionals and children's families are described in Table 11 and echo those found in other studies (Reder et al., 1993). However, a difficult relationship between professionals and families is not universally the case, as nearly half of the families in this sample were seen as co-operative and responsible, but this masks others who were frankly deceitful and cunning. The details are as follows.

TABLE 11: The relationship between professionals and families

Failure to keep appointments	17
Disguised compliance	9
Dependency	4
Flight	2
Closure	11
Blocks access to child	8
Aggressive	5
Complaining	4
Seeks help	17
Co-operative	16
Appropriate	15

The above table classifies the relationships between professionals and families into three groups. The first four descriptors indicate withdrawal behaviour; the second four are associated with hostility to professionals and the third set of three factors suggests co-operation. Eleven of the 40 families displayed behaviour that fell completely into the third category, and so they can be defined as fully co-operative and keen to receive help. The other 29 less amenable families displayed a mixture of hostile and withdrawal responses. Only three showed behaviour that was solely in the withdrawal category and only four displayed behaviour that was completely hostile. Out of the 40 families studied, just over half - 28% who were continuously co-operative, 10% who were hostile throughout and 8% who were constantly withdrawn - stand out as showing consistency in their relations with professionals.

Services the children and families had received before the incident

It is already clear that the children and families were very diverse in terms of their previous involvement with welfare services. Some were virtually unknown to anyone, others were long-standing cases, often with parents themselves having been in local authority care or accommodation. However, only 12 cases were seen by the agencies involved to need a high level of service and only four cases in this sample were seen as high priority or at high risk of significantly harming the child.

The reviews attempt to document the range of services received by the family prior to the incident. As many of the children were infants, involvement had often been restricted to services universally available to young families, such as GPs and health visitors. A record was made of the services received by the child and by the family in the two years prior to the incident, where this was additional to the universal provision of services such as school. This also noted whether the involvement was limited or substantial. Full details are presented in the Appendix.

The main services that had been involved at any level with the 40 children studied within the past two years are laid out in the following table.

TABLE 12: Involvement of services with child in previous two years

Agency	Limited involvement	Substantial involvement
GPs	20	9
Health visitors	9	16
Social services	15	10
Hospitals	15	5
Midwives	15	0
Paediatricians	10	3
Education professionals	6	4

This list is not exhaustive and, overall, 34 types of professional had been involved. Rarer examples are home tutor (3), women's refuge (2), court welfare officer (1), special transport unit (1) and respite care staff (1).

The patterns of involvement with services for family members over the past two years are even more extensive, as the following table shows.

TABLE 13: Involvement of services with carers in previous two years

Agency	Limited involvement	Substantial involvement
GPs	23	13
Health visitors	8	20
Social services	20	13
Hospitals	18	7
Midwives	21	0
Paediatricians	3	3
Education professionals	5	5
Police	11	6
Accident and emergency	6	4
Housing	6	6
Probation	1	8
Domestic violence unit	4	5
Solicitor	2	2

The same professionals dominate – GPs (36), social services (33), health visitor (28), midwife (21), hospital (25) – but they are complemented by police (17), accident and emergency department (10), housing (12), probation (9), domestic violence unit (9), education welfare (7), educational psychologist (3) and solicitor (4). For the 40 families, a total of 38 different types of professional had been involved prior to the incident leading to the review. As with the children, the very substantial contributions came from health (20 health visitors, 13 GPs) and social services (13).

Although practice and procedural concerns will be discussed in more detail later, in respect of agency involvement it is worth noting that comments about services being well co-ordinated were made in only 10 of the 40 cases. The main deficiencies highlighted in the reviews were the training of staff in child protection - especially staff other than social services professionals, such as health professionals and notably GPs (13 cases) - and responsiveness to situations (20 cases) rather than lack of professional skill (2 cases) or poor supervision of staff (5 cases).

These findings about the relative levels of involvement of different professions have implications for the way in which standards in child protection are reviewed. While ACPCs reflect the multi-agency nature of child protection services and the responsibility of all agencies for safeguarding children, the fact that the social services department is seen as the lead agency does have implications for the way in which that responsibility is perceived and monitored. The lead role of social services departments means that the conduct of Serious Case Reviews is seen primarily as their responsibility. This may have consequences for the way in which the standards of intervention and adherence to child protection procedures by agencies other than social services are investigated and reported. One social services manager who was the author of a report noted that:

> *we struggled around the ACPC table about what would be said about the paediatrician and the GP…you build an effective working relationship with local agencies and you know there's no way health are going to accept this so you don't push it…..I think that when you're talking about supposed incompetence on the part of a doctor I think that case reviews will always fall shy of addressing those issues. If the practitioner is a social worker or a health visitor then… but where it is a doctor or maybe a police officer then case reviews will couch their language in much more mealy mouthed terms.*

This view is echoed in the findings from a major study by Lupton and colleagues of the part played by the NHS within child protection networks. They conclude that the response to pressures for increased accountability and the impact of the 'new public management' have been varied across different parts of the NHS. They write (p.63)

> *nurses, health visitors and social workers, as bureau-professionals, have succumbed more easily to increasingly incisive managerial scrutiny. In contrast, the medical profession…has presented more of a challenge and progress has been uneven.*

The lead role of social services on the ACPC is also reflected in the requirement for Serious Case Reviews to be reported to, and their progress monitored by, staff from the Department of Health Social Services Inspectorate within the Social Care Regions. Through these direct links to the ACPC, the SSI is in a position to challenge standards in social services departments as well as promote new learning locally and at a national level. There are no equivalent direct links from ACPCs to regional or national agencies with clinical governance or inspection functions in respect of health, education or police. Thus, questions arise about whether ACPCs deal adequately with any

identified shortfalls in procedures or practice in these services; and, whether there are effective mechanisms for ensuring that any lessons with implications beyond the immediate locality are taken forward to regional or national bodies with responsibility for health, education or policing.

A comparison between the findings of this and earlier studies

Two of the studies discussed in Chapter Three provide information that enable a comparison of their results with those from this study. The study by James discussed earlier provides information on 30 children subject to reviews between October 1991 and December 1993 and that by Owers and others on 10 children and families involved in Serious Case/Part 8 Reviews in Wales in 1996 to 1998. It is interesting to see how their figures compare with those obtained for this study.

TABLE 14: Comparing the children and families in James, Owers and current study

	James %	**Owers et al %**	**Current study %**
Family known to social services	87	100	70
Children known to be at risk of neglect or abuse	57	80	60
Convening a child protection conference	40	40	40
Children's names on protection register	33	20	18
Parent abused as child	37	30	18
Average age (years) of mother at birth of child	19.4	22.0	25.8
Only child in family	18	10	33
Mental health problems in parents	20	20	45
Schedule 1 offender in home	38	N/K	3
Previous child death in family	N/K	40	5
Adult with criminal conviction	N/K	90	35
TOTAL Number of Cases	**30**	**10**	**40**

It can be seen that in the current sample fewer families are known to social services and fewer children have their names on the child protection register, although the same proportion as in James study are known in some way to be at risk of significant harm. Parents are older at the time of the child's birth and there are more only children. Parents have more mental health problems but, perhaps most significant of all, there is only one situation where a Schedule 1 offender resides in the family home.

Other studies are more difficult to compare. Reder and Duncan's (1999) data, for example, include only child deaths and so comparisons have to be made with the 31 cases in the current sample where the child died. In 61% of their cases, death was due to violence and in 26% due to neglect. Figures in the current study are 52% and 6%. Just over half of their children (51%) were male compared with 61% in this research. The most significant difference is found in the ages of the children at the time of the incident. The proportion of children under one year of age is similar in both studies at 47% and 52% respectively but 86% of the Reder and Duncan children were aged under four compared with 65% in the current study. This latter figure mirrors that found by Arthurs and Ruddick (2001) in whose sample 67% of the children were under four years of age at the time of the incident.

Given the great variation in cases subject to Serious Case Reviews, it may be useful to classify cases into broad groups so that the characteristics and needs of children and the report recommendations are put in a clearer context. The 40 cases in the current study fell into 10 groups, the salient features of which were as follows.

Group		Number of cases
1	Accidental/natural causes death but possible neglect	10
2	Known significant protection risks or long-term neglect	6
3	Baby 'battered' by father/step father	5
4	Teenagers living in chaotic circumstances	4
5	Murder by mentally ill father/step father (one-off incident)	4
6	No known protection risks but suspicious death/injury	4
7	Murder by mentally ill mother (one-off incident)	3
8	Dramatic change in parenting following arrival of new male	2
9	Concealed pregnancy/abandonment	1
10	Fabricated or induced illness	1

This classification confirms much of the previous discussion, such as that in Box 1. But, within this variety of situations, clear groups can be identified. The characteristics and circumstances of the incidents in each group are very different and this needs to be reflected in the development of preventative and therapeutic services.

Chapter Six

The review process and findings on practice and organisation

How the reviews were conducted

There was considerable variety in the way that reviews were undertaken. In a quarter of the 40 cases studied, the review was conducted by an independent professional and in other cases responsibility was given to the NSPCC (1), police (1), probation (1) and other members of the ACPC or Serious Cases Sub-Committee. After social services, the most frequent membership of the Serious Cases Review Panel was police (28), health authority (22), health trust (24), education (20), probation (13), NSPCC (6) and other special advisers (16).

There was wide gathering of evidence from statutory services - from social services (39), health (36), police (31), education (20) and probation (10) – but additional information was sought from guardians *ad litem* (1), voluntary organisations (2) and adult (6) and child (1) family members.

Report Authors

As reported, independent authors were employed to prepare 10 of the review reports. The question of how the author was selected was discussed in interviews with the ACPC chairs, highlighting some of the advantages and disadvantages of seeking someone outside the agency. The value of using independent authors was emphasised in some circumstances, especially in small unitary authorities where all senior managers had probably been involved in earlier decisions about the child, and in situations where agencies might be defensive about revelations concerning their competence. But benefits are not always forthcoming, as one ACPC chair explained

> *it helps if you have an experienced person available but I have seen some very poor work coming back from independents. In one case I sent the report back to be re-written which caused all sorts of trouble because it appeared as interfering whereas I was actually seeking clarity and accuracy. It had nothing to do with imposing a view.*

In one contentious and complex case where a senior social services manager was also the chair of the review, she admitted,

> *I think we adopted the wrong process of being too democratic and consulting with people, we were anxious to hang onto our partnerships and I don't think we handled our 'agreeing to differ' as well as we might. There were differences and towards the end cracks started to open and people started getting very jumpy. So the report came out reading as if it said 'we all agree we have failed'.*

The role of an independent author is not always easy and one described an especially difficult experience.

> *When you are co-opted as an independent chair, you adhere to the terms of reference set by the ACPC. I have to say I would never do this in isolation again and the terms of reference must be mutually agreed with whoever the core ACPC person is. They wanted it done in two months and claimed to have scoped it and done a lot of work they hadn't. They also were unhelpful when I requested legal advice. In fact, social services ended up acting as their own lawyers, which created an immediate conflict of interest.*

The use of independent authors raises further question about costs and value for money on which the evidence gathered for this study seems very varied. One authority that used an external voluntary agency claimed they had to pay £70,000; an independent reviewer told us, 'of course I am expensive, I charge £1,500' and one local authority that carefully calculated the cost in terms of staff time and resource of a Serious Case Review on a relatively straightforward case of a smothered baby calculated a figure of £4,500.

Several interviewees commented on difficulties in appointing an outside consultant of high quality, within the necessary fast time-scale and while applying recognised principles of equal opportunity. The suggestion was made that perhaps SSI could establish a panel of possible independent authors who had already been through an appointments process and whose skills and experience were known and tested.

Organisational problems identified in the review

One of the functions of Serious Case Reviews is to identify practice shortcomings. It might have been expected that some of these would have arisen from staffing and organisational problems. However, this was not the case. In only one of the 40 cases was a high proportion of unallocated child

protection cases identified as a factor in the circumstances surrounding the incident. Moreover, in only two cases were high levels of staff absence and illness cited, in only three cases were problems arising from re-organisation significant, in only one was a new direction in policy relevant and in only two were concerns expressed over supervision and practice. Staff shortages were seen as slightly more important, being stressed as a factor for five of the 40 children studied.

The six most commonly identified practice shortcomings

Reading 40 Serious Case Reviews reports is a salutary experience. Behind the tragedy of each incident, certain themes or situations recur. The psychology of memory recall inclines readers to overestimate the incidence of some features or to be influenced by extreme or highly memorable cases but a detailed content analysis of the reports identified several important points.

The concerns expressed most often in the reports were:

- inadequate sharing of information 25
- poor assessment processes 23
- ineffective decision making 21
- a lack of inter-agency working 17
- poor recording of information 15
- lack of information on significant males 9

Other less frequent but important concerns were the influence of an approach to child protection informed by a limited or dominant perspective (8), poor referral procedures (5) and insensitivity to racial or cultural issues (4). Not all the comments were critical, however, and in eight cases the reports were highly complimentary about practice in these areas.

It is again the case that many of these issues recur in every study of Serious Case Reviews. James (1994) noted the poor quality of some information and lack of a framework to analyse it - Owers and colleagues (1999) added superficial assessment and a lack of agency co-ordination and so on. Additional features found in this study are the need for a clearer understanding of referral and decision making processes, a more sophisticated and sensitive approach to

racial and cultural factors and the underlying philosophies adopted by agencies with regard to the place of child protection in a comprehensive child and family service.

Behind each of these concerns also lies a number of important practice questions. For example, the linked issues of the ineffective sharing of information, poor inter-agency working and inconsistent recording reflect fears among some professionals about litigation arising from breaches of data protection law. What are the legal constraints? Similarly, different interpretations of assessments or accumulating evidence on low level need exacerbate ambiguities about what information should be appropriately shared within and between agencies. While there are no easy answers, this should not preclude the development of a protocol specifying what, when and how.

Several examples in the reports illustrate these difficulties. In several cases cumulative risks noted by different agencies were not explored let alone acted on, so a young teenage boy suffered severe cruelty even though his school attendance was poor, his name was previously on the child protection register, his mother had mental health problems, abused drugs and was generally uncooperative and a violent male with a known history of abusing children had moved into the house. In another case, a newly born baby known pre-birth to be at serious risk of harm was discharged unilaterally by the hospital on Christmas Eve with the result that by the time local social services offices reopened, she was dead.

Inadequate sharing of information was identified as an intra-agency as well as an inter-agency issue. For example, despite major changes in the way in which the police deal with child protection and domestic violence, these may not always be brought together. This was an issue in two cases. As one experienced social services manager explained,

> *officers from the same station could respond to a domestic violence incident in a family where there are children on the child protection register and the child protection team within the police force would not know....Police records are not always tied together.*

In two other cases, changes of school were not adequately recorded by the old and new schools or passed on to other agencies. The result in one was that the former school which had been heavily involved in the children's welfare dropped out, thinking that the new school would continue its work. The reality was that the children were imprisoned and tortured at home.

Implications for practice

Box 6

Information Sharing, Consent and Confidentiality

All agencies and professionals with responsibilities for protecting children and the investigation of crimes against children will hold information that is 'confidential', 'personal' and 'sensitive'. This will include:

- data that identifies personal characteristics, such as name and address or information about service providers, such as the child's GP;

- qualitative or descriptive information which includes the professional opinion of staff who know and work with the relevant child, such as information about a child's exposure to possible harm, a parent who may need help to care for a child adequately and safely and those who may pose a risk of harm to a child.

Timely information sharing is crucial in child protection. Research and experience have shown repeatedly that it is only when information from a number of sources has been shared and is then put together that it becomes clear that a child is at risk of, or is suffering, harm.

There is no insurmountable legal barrier to prevent the lawful and justifiable disclosure of 'confidential', 'personal' and 'sensitive' information between agencies and professionals for the protection of children or the detection or prevention of serious crime. However such sharing of information is best managed under arrangements or protocols which should be agreed between local agencies. The Data Protection Checklist (see Appendix Four of *Working Together to Safeguard Children*) helps to identify the issues that should be considered when drawing up such a protocol. Advice on devising a protocol can also be found on the Caldicott Guardians website at www.doh.gov.uk/confiden/.

All those working in child protection should have a basic understanding of the legal principles underpinning information sharing, including:

- The *Data Protection Act* 1998 which controls the sharing of personal and sensitive information about people;
- The importance of obtaining consent before sharing personal and sensitive information. But, as noted above, on occasion it will be justifiable and lawful to share such information without consent;
- The common law duty of confidence that is not absolute but is a balance between the public interest in maintaining confidentiality and the public interest in disclosing the information;
- The need to respect human rights. If a statutory body wishes to disclose information, it must ensure that that disclosure is lawful and in accordance with the *Human Rights Act* 1998.

Learning the lessons

In most instances a first step to ensuring lessons are learned is the development of an Action Plan as a final part of the review process. The interviews with the staff involved showed that action plans were usually carefully constructed and incorporated into local training as much as possible. 'For example, with regard to ingesting methadone, we've done whole training events around the executive summary and lessons learned' explained one senior manager. Nevertheless the process can still be somewhat superficial. As one experienced chair commented,

> *there's no point in saying 'well, with hindsight we've got this', because that will not help us understand what went wrong and what went right. There's a tendency to translate a rather big issue into something that can be measured and ticked because of all the frenzy about outcomes at the moment. In one case where there was serious intimidation, the Department of Health sent out messages saying 'you must be careful about parents who intimidate or lie' and 'what are you going to do about it?' Social workers need to be helped through this but the sort of thing you get is a proposal for a few days' awareness training, as if you could just de-intimidate social workers. It's ludicrous.*

Recommendations were variable in terms of the number and their specificity. Three reports (2 under old guidance, 1 under new guidance) contained no recommendations as such while 4 (all under old guidance) had more than 20.

Recommendations were seen as most likely to be effective when applied to the whole ACPC area rather than to a specific agency, such as a local hospital or social work team. The most difficult groups to reach in this respect were again GPs and school governors. It was claimed that progress on implementation was regularly reviewed by the ACPC. It was certainly felt that the action plans produced clear results in terms of policy and practice that reflected the lessons to be learned. Examples of the changes introduced included encouraging better practice by:

- more conclusive child protection conferences
- better links between agencies, especially mental health and social services
- clearer definitions of boundaries between culturally acceptable behaviour and abuse in a particular culture
- clearer roles and re-grading for clerks who record and respond to referral information
- better training of and co-operation of professionals perceived as difficult to reach, especially GPs and school governors

and finding better ways of conducting reviews by:

- better ways of gaining information on adults who are likely to cause harm to children and on mothers' partners
- exploring the effects of abuse on the child's siblings
- better identification of 'latent' problems such as alcohol or psychological problems
- greater focus on the needs of women in their role as mothers, rather than seeing them solely as individual adults
- attention to the needs of older children and to ways of listening to what they say

Most respondents were keen to emphasise the significance of Serious Case Reviews for everyday child care work. They stressed that the case selected for study was not particularly exceptional and they were often worried about the danger of perceiving all review cases as if they were all high profile tragedies marked by gross professional incompetence.

This is borne out by the analysis of this sample of reports. Only three of the 40 cases studied in this research resulted from gross incompetence by an individual or agency and were dealt with accordingly by further proceedings. However, in none of these cases did the fault lie clearly within a single agency. In one, social services were found to be remiss for not taking action to halt the escalation of the dangerous behaviour displayed by a seriously neglected boy but the issues were about whether a care order should have been taken or secure accommodation sought rather than harm to the child. In the other two cases, several agencies were heavily involved with dysfunctional families and the criticisms concerned social services's failure to take co-ordinated and decisive action rather than any non-involvement.

Generally, as one respondent said, there were 'few serious mistakes' and practice was said to be 'poor rather than neglectful'. In one case, the ACPC chair said,

> *I think there were one or two flaws in practice and one signal failure when the mother was told by the social worker to take her child to the doctor, but I couldn't put my hand on my heart and say that the overall level of practice revealed by the review was profoundly unsatisfactory…radical alterations are not always necessary, in this case a simple administrative change about informing others when a child moves school might have helped.*

> *These are typical reasons why in most cases the child's death or injury was seen as unpredictable and largely unpreventable, even when the vulnerability of some of the children was beyond doubt. Most of the reports made an assessment of the predictability and the preventability of the incident. These are as follows.*

TABLE 15: Predictability and preventability of the 40 cases

Incident perceived as:	Highly	Weakly	Not at all	No mention	Not applicable
Predictable	1	2	30	3	4
Preventable	3	7	24	3	3

There was, nevertheless, some association between poor practice and whether the incidents were seen as preventable. In the three cases where the incident was seen as highly preventable, there were more unfavourable comments about practice than in the other 37. The schedule in the Appendix recorded comments, whether favourable or unfavourable, in ten practice areas. The average number of unfavourable comments across the ten areas was 5.7 for the three cases seen as highly preventable compared with 3.5 for the 37 that were not. The four areas where practice was especially poor were the sharing of information, the assessment process, decision making and service response. Because the cases were well known to welfare agencies, inter-agency working escaped censure although it was a frequent criticism of work with 17 of the other 37 cases.

Chapter Seven

The value of Serious Case Reviews

The effects of guidance

We have explained that the Government issued new guidance on Serious Case Reviews in December 1999. This new guidance drew on the experiences of professionals conducting Serious Case Reviews and extensive consultations with all the parties involved. To see if the new guidance produced any discernible changes in the nature of reviews, 20 of those scrutinised for this research were undertaken under the old 1991 guidance and 20 under the new 1999 version. Thus, a comparison between early and late reports should highlight any changes. However it is unlikely that changes will be dramatic: first because guidance tends to reflect shifting opinion and second there was a lengthy period of consultation on a well formed draft. Hence several respondents said that they were already doing much of what was later included in the new guidance even before this was formally issued. Nevertheless, a before and after comparison is still a valid way of assessing any change.

The researchers approached the assessment in three ways, each of which reflected the ten changes encouraged in the new guidance, as set out in Chapter One. Changes number i, iii, iv, v, vi and vii were explored by scrutinising the reports, the results of which are laid out in the Appendix. Changes ii, viii, ix and x were explored in interviews with professionals.

The first test was a judgement by the researchers on whether the overview dealt satisfactorily with issues of multi-agency working. Thirty three of the reports were judged to be adequately multi-agency in their discussions, 26 dealt adequately with contrasting perspectives and none was seen as dominated by a single agency perspective. On the other hand, 16 were judged to have obvious gaps which limited the value of the review exercise. The most notable gaps were in family history, consideration of race and culture, information from some professionals and information learned after the event.

When the 20 pre- and the 20 post-new guidance Serious Case Reviews were compared, there was some indication of change in the desired direction. More of the later reports were adequately multi-agency (18 compared with 15), more deal with contrasting perspectives (15 as opposed to 11) and slightly fewer had obvious gaps (7 compared with 9). This is confirmed in the following table.

TABLE 16: Features of reports prepared under the new and the old guidance

Features of the SCR report	Old Guidance	New Guidance
Adequately multi-agency	15	18
Dealt with contrasting perspectives	11	15
Dominated by one agency's perspective	0	0
Had obvious gaps	9	7
TOTAL	**20**	**20**

A second measure examined the extent of wider consultation in the review process by recording those agencies, other than key players, who were consulted. A voluntary organisation was consulted in two of the 40 cases, family members in six and a child family member in one. All of these occurred under the new guidance. There was also a noticeable increase in consultations with probation; of the 10 cases where this occurred, 7 were post-1999 reports.

A third measure was an examination of the content of the reviews, looking especially whether they contained a genogram, family history, chronology, summary of who knew what and an analysis of events and procedures. Here the results are mixed. When reports pre- and post the December 1999 guidance are compared, there is a large increase in the frequency of discussions about the views of parents and better summaries of who knew what, the decisions made, the actions taken and compliance with procedures. There is less noticeable change in the areas of the inclusion of a genogram, summaries of family histories, chronologies of agency contacts and completed assessments. The results are given in the following table.

TABLE 17: Content of the overview reports

	Full and Clear		Partial		Limited/None	
	Old	New	Old	New	Old	New
Genogram/social network	7	5	11	11	2	4
Summary of family history	5	6	10	8	5	6
Chronology of agency contacts	18	15	2	3	0	2
Summary of who knew what	7	12	12	6	1	2
Views of parents	0	4	4	6	16	10
An Analysis of: -						
Events	11	13	9	5	0	2
Assessments completed	6	5	12	9	2	6
Decisions made	8	13	10	6	2	1
Actions taken	6	13	13	5	1	2
Compliance re policy/procedures	5	12	11	4	4	4
Whether child seen	1	2	3	2	16	16
Whether child gave views	0	1	2	1	17	19

Central to the new guidance is the construction of an action plan and the expectation that it will be integrated into the mainstream work within each agency and into their plans for taking services forward. Again, the evidence is inconclusive, with only a slight suggestion of change for the better, as the following table shows.

TABLE 18: Nature of action plans in the reports

	Full and Clear		Partial		Limited/None	
	Old	New	Old	New	Old	New
Action plan following the review	6	5	5	8	9	7

Finally, the researchers posed three questions that summarised the intended changes:

- Did the report have a clear structure?
- Did it emphasise the lessons to be learned?
- Was it conducted within expected time-scales?

There is a marked improvement in the structure of reports with all but two of the later reviews meeting this standard. Similar improvements are found for completion within expected time-scales. Changes with regard to lessons to be learned, however, are less apparent, but the majority of reports, whether written before or after, were generally satisfactory in this respect. The results are as follows.

TABLE 19: Structure, emphasis and completion of the reports

	Yes		No	
	Old	**New**	**Old**	**New**
A clear structure	12	18	8	2
An emphasis on lessons	16	17	4	3
Conducted within time-scales	8	13	12	7

Professionals' views on the process of undertaking Serious Case Reviews

All respondents without exception stressed the value of undertaking Serious Case Reviews and welcomed the 1999 guidance, saying that it was very helpful in its scoping recommendations and clear terms of reference. Details of how to tackle difficult problems, such as following a time-table that mirrors court proceedings, when and how to involve family members and getting consistent information from each agency, were seen as especially useful. They also liked the attention given to vulnerable groups, such as looked after children and young people with disabilities. Most welcome of all was the move from an inquisitive agenda to a spirit of learning and many felt that a satisfactory balance had been struck between prescription and respect for individual judgement in relation to each case.

All the local authorities participating in the study now appear to have a clear mechanism for deciding when to undertake Serious Case Reviews and Serious Cases Review Panels are central to setting up the process and checking on progress, although these may not be always clear cut. One ACPC chair explained, 'there are issues about who lets you know, matters of interpretation and signs not heeded. You may not appreciate the significance of these until after the review. The information you gather subsequently can be very important. So, we routinely get the reference book out and have a look at these kind of things even though we are quite experienced people.'

Despite the generally positive view of Serious Case Reviews, the interviews raised some issues that caused ACPCs concern.

Time scales

One common area of contention is the four month time scale which, although extended from the previous guidance, is still perceived as difficult to achieve. However, most welcomed the opportunity to request an extension when it was apparent that this would be necessary, either because of the volume of information available or the complexity of the case. However the need to establish a clear strategy, together with a realistic time-scale, at the outset was seen as essential for a successful review. Hence some thought it was good to be 'kept to task' as reviews can drag on and activity dwindles as staff move on and memories fade. Indeed, it was disquieting to discover how many staff involved in reviews only two years ago no longer worked in the authority or had the same job.

Gathering information

Difficulties often arise from getting material on time from agencies whose evidence has to be approved by various layers of management or where extraneous factors delayed the gathering of information. In one case, the police repeatedly refused to interview a mother saying that she was too distressed. This frustrated the review team as 'we thought we could understand her situation better if we had some information'. Co-operation from education authorities and schools was equally variable. The quality of information from GPs was also often poor, in one case it arrived after six months and comprised a list of rheumatism prescriptions and in two others there was a total unwillingness to co-operate with the review. One respondent commented in interview,

> *I think GPs are given too much liberty to opt in or out of the child protection system and I think that they need to be compelled to opt in. I think Working Together to Safeguard Children is completely weak on this issue.*

Despite recognition of their important role and the exhortation of Government policy documents, this view reflects the lack of engagement by GPs in the child protection process noted in other studies (Hallett and Birchall, 1992; Simpson et al., 1994; Lupton et al., 2001). The Department of Health's response to the Kennedy Report (Department of Health, 2002) proposes new arrangements to co-ordinate and integrate the contribution of health professionals working in child protection. It states (para 3.4) that

> *each strategic health authority, primary care group and primary care team should have a senior member of staff responsible for the planning and commissioning of local child health services and that each NHS trust that provides services for children should have a designated director with responsibility for protecting children's interests.*

The implications of this for the conduct of Serious Case Reviews and the ACPC more generally are as yet unknown, but potentially could be significant.

Confidentiality

Major issues of confidentiality confounded the review process in two cases. In one case, vital information from a clinic for sexually transmitted diseases was not passed on and in another evidence about a step-father's treatment for violent behaviour was withheld by a mental health authority in another part of the country.

Involvement of families, including children

A further area of difficulty which was mentioned frequently is the involvement of family members in the review. This is seen as potentially helpful in some cases, one example being information on the extended family of a mentally ill lone mother aged 47 who murdered her baby. But in other cases the issue created some anxiety. One ACPC chair said,

> *I haven't given a lot of thought to the question of consulting parents where possible. Obviously you can't if they are under prosecution. I am really desperately ambivalent about all this. I would say perhaps if the parent is concerned and had no part in it, but I think the whole issue in the reviews is whether you see people or only see paper.*

Publication of executive summaries

The publication of executive summaries and handling of the media were seen as difficult. Several respondents requested help from central government on this, continuing the tradition among social workers of reliance for advice on central government rather than professional associations. They argued that the guidance was too vague for such an important event. In the few high profile cases, press releases and launch conferences were convened which were usually successful - despite the difficulties that arise when, of necessity, these follow the conclusion of criminal proceedings, often with very explicit details of the incident.

In less dramatic situations several necessary conditions for success were noted. First, it was seen as important to brief all relevant staff of the likely media responses; second, if an outside agency or independent professional was involved, local authorities and health trusts/authorities must ensure that they do not simply expose themselves to unjustified criticism; third, the tendency for some agencies to give informal interviews to the media beforehand - the police and senior NSPCC managers who were not local ACPC members were cited - has to be avoided, as it undermines consensus and fuels a potentially hostile media audience.

The value of Serious Case Reviews

As noted earlier, all respondents stressed the value of Serious Case Reviews. Negative comments on the process mostly concerned the benefits of undertaking reviews rather than their intention. 'When do you reach a learning situation?' asked one respondent. There was a feeling that the process can be so exhausting that once the report is complete, people sit back and say 'that's it'. Others warn that it can become repetitive with the same conclusions being stressed each time. Some criticised particularly the absence of family members' views and, where possible, those of any children who might usefully be involved. More respondents were anxious about the tendency for reviews to dwell on whether agencies have done their job rather than on the quality of practice, 'There are too many lists of dates at the expense of what people actually did' bemoaned one – despite the obvious impact of the Action Plans in some instances. More sophisticated discussions of how the chronology links to the child's social and psychological development and to wider family dynamics were also recommended but some acknowledge that, although this might increase understanding, it could be perceived as going beyond the scope of a Serious Case Review.

The sophistication of the review process was often reduced by the limited experience among ACPC members of analysing diverse evidence and by the lack of a methodology for sifting important information from the rest. One police officer chair who confessed that he knew nothing about mental health commented, 'there were details of 80 consultations on the (mentally ill) mother but no-one ever seemed to have added it all up'. In another case, the report author said, 'the senior managers seemed oblivious to the intimidation that the social worker faced from this family'. This difficulty is not helped by the limited information technology that was available; much of the material comprised unedited extracts from paper files. In one case, an initially welcome ACPC member did not live up to expectation. As the ACPC chair explained, 'I was delighted when a GP joined the group but he's been a terrible disappointment. All he's interested in is where conferences are held and whether he's invited. There are so many other issues we would like him to raise. It creates such terrible tension.'

National policy and practice implications

All the participants in the study were clear about the value of Serious Case Reviews in informing local policy and practice. However, despite the commitment in *Working Together to Safeguard Children* to commission overview reports such as this at least every two years, they were less sure about the way in which lessons for national policy and practice were being drawn out or disseminated. Many felt that the full potential of Serious Case Reviews for informing practice more generally was not being met at present. This was acknowledged in the recent report by Arthurs and Ruddick (2001). They write,

> *at the time when this study began, in Spring 2000, there was no mechanism by which the experience and learning from Serious Case Reviews could be shared in a systematic way beyond the local ACPC.*

The roles of the Department of Health and the Social Services Inspectorate in the review process were generally unclear and most respondents felt, with the noticeable exception of two inspectors, that contacts had diminished over recent years. 'We used to talk but now there's a black hole', said one long-serving manager. Others who did get a response complained that it was often 'picky' or 'came too late' or 'missed the point'. 'The SSI are OK on technicalities but are vaguer on wider issues' said one chair. The SSI roles that would be valued by those interviewed were 'to be a source of advice on similar cases', 'to act as a critical friend', 'to alert authorities to wider issues about the case and child protection generally' and to feed back observations from its monitoring and inspection work.

The members of the Department of Health interviewed stressed that while it was under pressure to advise on the process, to encourage co-ordinators to meet and to conduct annual reviews to learn lessons, the role of central government is primarily to implement national policy on safeguarding children and to keep ministers informed.

> *It can certainly flag up issues, such as mental health problems, and monitor matters of national interest, such as the safety of adoptions, but it is hard to be highly prescriptive as cases vary so much. It is the regional SSI that should enter into discussions about individual reports and plans. However, this is very much a matter of personal relationships and perceptions of responsibility. Much depends on the quality of the people involved and some may not be child care specialists. Ultimately, it is down to good management of the strategic review process. There is a danger that everyone can point the finger at everyone else but they don't want to get on with their own issues; it's very easy to lose the plot. Sometimes they say this is to do with the complexity of the case but this is not necessarily so.*

One confusion for local authorities was the level of priority accorded Serious Case Reviews in inspections and quality assessments. One respondent complained that they spent a lot of time and money on producing what they thought was an excellent review but no external assessor has ever referred to it in reports, leaving them wondering whether it should have been such a priority.

Some of the professionals interviewed felt that there was a possible conflict within some wider child care policies, such as a perceived Government emphasis that local authorities should identify more children at risk but at the same time reduce the numbers whose names are on protection registers. The view was also expressed by some respondents that the division rather than the relationship between family support and child protection is being resurrected and that the needs-led focus encouraged by the *Children Act* 1989 is being lost.

Most respondents acknowledged that although some child protection situations were extremely dangerous, in the vast majority of cases the child's welfare was enhanced by good social work with families (Department of Health, 1995a). They supported the *Children Act* 1989 philosophy that this should be the dominant principle while acknowledging that, in a relatively small number of cases, child protection *per se* is required. 'Principles based on extreme cases are not good for the majority' opined one ACPC chair.

Three other less substantial points were raised by the interviewees. One was whether the executive summary should be written after the report has been accepted by the ACPC (in many cases it accompanied it); another was the use of names, addresses and confidential information in reports. These lie around on office shelves and could be read by anyone, probably contravening human rights legislation. Third, when agencies in different local or health authorities are involved, a written agreement is needed if co-operation is to be sustained throughout the review. Three respondents noted that initial interest waned, damaging the quality of the final product.

Generally, most respondents concurred that the value of Serious Case Reviews was greater if they were seen as a practice audit or as another way of looking at the effectiveness of inter-agency work. This approach is more common in health, although medical staff are not trained to share information in the same way as social workers. It raises staff confidence and avoids the production of recommendations that appear somewhat platitudinous and that lack any indication of how they might be done. An example is:

> *The ACPC should consider what process or procedure could be introduced to ensure that individuals who pose a significant risk to children but who do not have a criminal conviction are identified and the information shared with other agencies.*

Some went on to suggest that to do this effectively, it would help if some practice tools could be developed. For example, one might look at cases six months prior to an incident and ask 'would it have been possible to take emergency protection or obtain a care order at that point, and if so what would have happened?' Another common question to which the reviews returned time and time again was, how does a professional decide on whether a significant harm threshold has been passed, especially in cases where there is an accumulation of low level concerns?

Looking to the future, one issue of concern was how do ACPCs fit into the new planning framework and what precisely are their governance, powers and responsibilities. Some respondents worried that its role in a network of strategic health authorities and PCTs is not being addressed and there was a fear that ACPCs could be left in isolation.

Chapter Eight

Concluding Comments

The history of Serious Case Reviews is intimately tied to the development of child protection services generally. Initially seen as something of an inquisition into the circumstances surrounding a child's death or serious injury, they now focus more on lessons to be learned, particularly with regard to agency involvement and co-operation. They are thus best seen as an important part of the continuing audit and evaluation that form part of effective service development.

This report has presented findings from the study in three areas:

- the background characteristics of children who are subject to Serious Case Reviews
- indications of the main lessons to be learned from the cases
- findings about the operation of the Serious Case Review process and the impact of the new guidance.

These are summarised briefly in this concluding chapter and in Box Seven. They have also led the researchers to some broad overall conclusions about ways in which the value of Serious Case Reviews could be enhanced.

When the background characteristics of 40 randomly selected Serious Review cases were examined, some common features, such as parental mental health problems and domestic violence, were found but the variety of children's situations was wide. This is equally the case for the incidents. In some cases, they occurred out of the blue, in others they occur in a context of chronic low level need and occasionally they arose in situations where they seemed to have been 'waiting to happen'. A classification of incidents has been made in the hope that an understanding of the peculiar features of each category will promote better practice. But this is not an easy brief, as, unfortunately, the factors common to cases have limited predictive value for identifying which children will become victims of child abuse within the general population. The lessons to be learned from Serious Case Reviews are, therefore, more about processes for handling risk of harm than for identifying vulnerable children.

A similar level of diversity is apparent in terms of the prior involvement of the child and family with welfare agencies. Some were virtually unknown to anyone, others were long standing cases, often with parents being known since the time of their own childhood. Social services' involvement was generally low and usually less than that of health professionals, particularly health visitors and GPs.

While many of the findings about the incidents are scarcely new, it is important to note that the context in which they occur is changing. Whereas in the past, it was sufficient to talk about the involvement of 'education', organisational changes over the past decade make it necessary to distinguish the activities of the LEA from those of schools. Similarly, with the diversification of the National Health Service, information from different sectors, such as GPs and community and hospital services, varied in quality. Thus, blanket observations have diminishing relevance for understanding agency involvement. The agencies involved also display a tendency for continual reorganisation with the result that inter-agency relationships effective in the past may no longer be possible and the changed situations require regular review. Indeed, some past good practice may have to be re-learned in what are virtually new contexts.

It has been explained that the guidance on undertaking Serious Case/Part 8 reviews was substantially revised in 1999 and it was expected that this would improve the quality of reports. Ten areas of expected change identified by the researchers at the end of Chapter One were investigated by comparing 20 reports completed under the old guidance with 20 compiled under the new. The results are moderately encouraging. Using three different assessments, the researchers concluded that in five of the ten areas, recent reports were an improvement on earlier ones. The areas concerned were:

- a change in emphasis from an inquisitorial perspective to a learning one. There would be less concern with whether guidance had been followed and more on lessons to be learned, particularly with regard to inter-agency working and the sharing of information;

- in cases of serious injury, sexual abuse or maltreatment while looked after, clarity about why the review was being undertaken and what it would produce;

- clearer scope of the review from the outset, with the questions to be answered and the sources of information better delineated;

- the public availability of an executive summary report;

- the setting up by the ACPC of an inter-disciplinary Serious Cases Review Panel to consider whether a review should take place.

In another four of the ten areas, the results were mixed. There were improvements but some practice fell short of required standards. These areas were:

- a more robust action plan in which the responsibilities of each agency, the time scales and plans for implementation are specified;

- well prepared plans for the dissemination of reports and handling the media;

- reviews undertaken and completed within the suggested time scale, that is initiated within a month of the incident coming to the notice of the ACPC chair and completed four months thereafter;

- evidence that reviews will increase awareness of child protection issues among local policy makers and practitioners.

The evidence with regard to expected change iv in the original list, namely

- 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.

was less conclusive. While there was a greater inter-agency focus, wider consultation and more detail in some of the recommended areas, meaningful family genograms, chronologies of agency involvement and conclusions of previous assessments were brief or even totally absent in a number of cases.

Summary of the findings

Box 7

Although systematic information on the number of child deaths is unavailable, the Department of Health estimates that 90 child deaths or cases of serious injury a year are the subject of full Serious Case Reviews.

New guidance on Reviews was issued by the Department of Health in 1999. It altered the focus from compliance with procedures to lessons for collaboration and remedial action locally.

The study scrutinised 40 Reviews, 20 conducted before and 20 after the introduction of the new guidance. ACPC chairs and report authors were interviewed in 20 cases.

Compared with findings from earlier research, fewer children in this study had their names on the protection register (18%), more were only children (33%), carers were older (average age 25.8 years at birth of child) and more likely to have mental health problems (45%) and there were fewer Schedule One offenders (3%) living in the households.

Several common situations were found among the children and families. Among these were the young age of the children, histories of emotional neglect and poor care, parents' mental health problems and domestic violence. However, these were not universal and frequent observations, such as extensive previous social services involvement, were refuted.

The 40 cases fell into 10 groups, the largest (10 cases) of which concerned deaths due to accident or natural causes in a context of possible neglect. In only six cases had there been enduring concerns about risks of harm to the child.

Knowledge of common background factors has limited predictive value when applied to a general population of vulnerable children. Only one of the 40 cases scrutinised was seen as highly predictable and only three as highly preventable.

Health professionals were the most likely to have been previously involved with the children and families. Twelve of the 40 children were completely unknown to social services.

There was considerable variation in the way that Reviews were conducted. A quarter were undertaken by independent professionals.

Concerns expressed in the Reviews included inadequate sharing of information, poor assessments, ineffective decision making, lack of inter-agency working, poor recording and a lack of information on significant males.

Emanating changes included more conclusive child protection conferences, stronger links between agencies, clearer definitions of culturally acceptable behaviour, clearer roles for staff who respond to referrals and better training for professionals perceived as difficult to reach.

Professionals stressed the value of Serious Case Reviews and welcomed the 1999 guidance. They reported clear mechanisms for managing reviews and better integration of recommendations into service development. However, concerns remain about time-scales, collecting information, confidentiality, the involvement of families, the publication of reports and the role of the SSI.

Reviews undertaken under the new guidance reflect the desired changes but there were shortcomings in the structure of reports and the quality of information on family histories and work previously undertaken.

Improvements suggested by this study include better ways of gaining information on adults who endanger children, exploring the effects of abuse on children's siblings, the identification of alcohol and psychological problems, greater focus on the needs of women as mothers rather than as individuals and attention to the needs of older children.

Three developments in child care services – good epidemiological and clinical evidence on factors associated with children suffering significant harm; knowledge about how to implement effective services; and practice tools to improve decisions and practice consistency - are also identified as enabling service improvements.

These findings have wider implications for the review process. There is a danger that it could fossilise, causing wider ambitions to wither, especially as child welfare agencies face growing work demands and staffing pressures. It could also become ritualistic or reviewers might simply run out of new things to say. These developments would be unfortunate, as Serious Case Reviews cover many issues relevant to the development of services. Thus, there is value in considering changes at a more general level that would make Serious Case Reviews more effective. Three such developments are indicated by this study in addition to well-established conclusions about improving the assessment and decision-making skills of practitioners.

Better identification of children vulnerable to abuse

The first concerns the problems of identifying children vulnerable to abuse and predicting those at risk of violent death or serious injury. As was explained earlier, the large number of 'false positive' cases limits the value of such an exercise. This discourages policy makers from entertaining more preventative approaches because they could end up providing services to people who do not need them. But that is not to say that more could not be known. Vulnerable children clearly vary in the level of known risk of harm that they display and better follow-up information on them would increase knowledge about the chains of effects that lead to abuse. This is important because, given the fact that predisposing factors are unlikely to be eliminated, preventative strategies will have to block or divert these causal chains if they are to be effective (Little and Mount, 1999). The information needed to do this would be epidemiological, comprising evidence about the probability of children with certain characteristics within a general population coming to harm. This would need to be complemented by more rigorous knowledge about those who are actually maltreated so that the two sets of evidence can be linked. Some factors, such as domestic violence, appear important retrospectively but their significance when applied across the board to samples of children and families who are then studied over time will be less. But, by how much?

Information on children in need is increasingly available as a result of the implementation of the Government's *Framework for the Assessment of Children in Need and their Families* (Department of Health et al., 2000) and the findings from research studies (Little and Madge, 1998; Axford et al., 2001). However, this in itself does not ensure either the quality of the material or the rigour of its analysis. If professional confidence is to be increased, practitioners will need to be more certain about the factors highlighted. For example, are some more important than others, are they more dangerous in combination or particular sequences, are they inter-related or the product of some other factor not included in the analysis? They also need to know more about the interventions that best meet particular needs, otherwise the 'scatter gun' approaches characteristic of much social work with children and families will persist. Indeed, not knowing what to do for the best seems the greatest limit to effectiveness. This dearth of background knowledge restricts the value of Serious Case Reviews for understanding risks of significant harm and remedies in serious child abuse.

Better evidence on the vulnerability of children within general populations would also increase sensitivity to children's situations and would mean that practitioners did not need to rely so much on judgement and intuition. Further contributions to knowledge would also emerge from a clearer understanding of the thresholds set by agencies for the provision of services and

the 'avenues' that children take through welfare services. Ideally, if we are ever to know what is causing what, the significance of factors thought to have some influence on outcomes should be clarified in prospective follow-up studies of children and families. Without this knowledge, answers to key questions about the prevention of the deaths and injuries described in Serious Case Reviews will remain somewhat speculative.

Understanding the process of change in public services

Second, one of the aims of Serious Case Reviews is to produce an action plan specifying revisions to service and procedures. This again relies on knowledge about how to change child welfare services. Reliable evidence on effective methods is lacking as there are few systematic evaluative studies of innovation based on randomised controlled trials or quasi-experimental designs. Without proven methods of achieving service change, the effects of revisions to guidance and investment in the post-qualifying training proposed so frequently by Serious Case Review panels will remain unknown.

Again, some things are known (Bullock, 1995; Bullock et al., 1998). For example, it is clear that innovation is more difficult the more radical the proposals, especially with regard to its effects on people's roles. It is also the case that development work should be based on high quality research and will be more effective if it takes place in a context sensitive to the needs of children and sympathetic to evidence-based practice. Robust evaluation does not have to be extensive as elaboration is not necessarily an indication of good design, rigorous testing or originality. It does, however require a number of tests on a number of levels, each relying on different methods. A well designed development project that will generate new research findings can easily be incorporated into policy and practice. While this is not the function of Serious Case Reviews, such knowledge would increase the efficacy of the numerous recommendations that follow them.

The development of practice tools

Third, it is clear from the cases scrutinised that certain decisions are important in determining what happens to children at key points in their 'career'; family reconstitution and the closure of cases are two examples that have been identified. It seems likely from other child care research studies that there is practice inconsistency across local authorities and even amongst teams within them (Department of Health, 2001). This situation, again, undermines the professional aspirations of social work. The fashioning and research testing of practice tools designed to improve decision making are another development likely to have beneficial effects on vulnerable children. There are several reliable tools available, such as for assessing children's needs (Department of Health

and Cleaver, 2000), charting outcomes for looked after children (Department of Health, 1995b), designing needs-led services, setting thresholds or helping separated children return home (Dartington Social Research Unit, 1999, 2002a; 2002b). Other areas suggested by this research as ripe for such development are the decisions to close cases and, particularly important, reaching common definitions of 'being in need' or 'at risk of significant harm'. Many families scrutinised in this study display an accumulation of problems, none of which is severe enough to produce a significant service response. Without evidence on how key decisions are made, it is difficult to know whether this situation could be improved. However, what is certain is that without some developments of this kind, practice uncertainties will endure.

These three aspects of child care services – good epidemiological and clinical evidence on factors associated with children suffering significant harm; knowledge about how to implement effective services; and practice tools to improve decisions and practice consistency - are complementary. They would help distinguish between the needs of different children; clarify the levels and type of impairment to a child's development, encourage the measurement of outcomes in terms of child well-being and not system activity and facilitate a service where differentiation involves increasing the range of service responses to match the range of presenting needs. They thus underpin the principles of 'needs-led' and 'evidence-based' services that seem most appropriate in post-industrial societies where resources are scarce and litigation increasing.

If these features were in place, professionals could rest more comfortably with the conclusions of most of the reports studied, namely that the child's death or injury was unpredictable and unpreventable. The hopes of the ACPC chair which opened this report will only be fulfilled if her aspirations are matched by effective implementation.

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Appendix
Analysis of Content of Serious Case/Part 8 Review Reports

OUTCOMES OF THE INCIDENTS

	Old Guidance	New Guidance	Total
Death of child	16	15	31
Serious injury	3	5	8
Prison sentence for child	1	0	1

BACKGROUND CHARACTERISTICS OF THE CHILDREN

Gender

	Old Guidance	New Guidance	Total
Male	12	8	20
Female	12	8	20

Ages at time of incident

	Old Guidance	New Guidance	Total
0-1 month	3	4	7
2-3 months	4	1	5
4-6 months	1	2	3
7-12 months	1	3	4
1-3 years	0	6	6
4-5 years	6	1	7
6-10 years	1	0	1
11-15 years	2	3	5
16 years or more	1	0	1
Not known	1	0	1
TOTAL	**20**	**20**	**40**

Ethnic Origin

	Old Guidance	New Guidance	Total
White British	14	10	24
Black African	1	1	2
Asian	1	1	2
Mixed	0	2	2
Not Known	4	6	10

Was English an addition language, if yes, languages spoken in home?

	Old Guidance	New Guidance	Total
Yes	3	1	4
Punjabi	0	1	1
Cantonese	1	0	1
Not Known	2	0	2

Household members at time of incident (adults, relationship)

	Old Guidance	New Guidance	Total
Mother only	5	7	12
Father only	0	1	1
Mother and father	10	8	18
Mother, step F/cohab	4	4	8
Other	1	0	1

Household members at time of incident (children, relationship)

	Old Guidance	New Guidance	Total
None	5	10	15
Natural siblings	10	7	17
Half siblings	2	1	3
Step siblings	0	1	1
Not half/not step	2	1	3
Other	1	0	1

Household members at time of incident (significant others, relationship)

	Old Guidance	New Guidance	Total
None	18	20	38
Grand parents	1	0	1
Non relatives	1	0	1

Child's Place in family

	Old Guidance	New Guidance	Total
Only child	4	9	13
Oldest	2	2	4
Youngest	11	9	20
Middle	2	0	2
Not applicable	1	0	1

Age of mother at birth of child

	Old Guidance	New Guidance	Total
0-16	1	1	2
17-20	4	3	7
21-25	9	3	12
26-30	1	5	6
31-35	2	3	5
36 and over	1	3	4
Not known	2	2	4

Child born in UK

	Old Guidance	New Guidance	Total
Yes	20	20	40

Child's Health

	Old Guidance	New Guidance	Total
Physically disabled	0	1	1
Identified SEN	3	1	4
Health problems	1	4	5
Poor ante/post natal care	5	3	8

Child's playgroup or school attendance

	Old Guidance	New Guidance	Total
Good	2	1	3
Poor	8	3	11
Recent change	0	1	1
Not applicable	10	15	25

THE CHILD'S DEATH OR SERIOUS INJURY

Child's Age at Time of Incident

	Old Guidance	New Guidance	Total
0-1 month	3	4	7
2-3 months	4	1	5
4-6 months	1	2	3
7-12 months	1	3	4
1-3 years	0	6	6
4-5 years	6	1	7
6-10 years	1	0	1
11-15 years	2	3	5
16 and over	1	0	1
Not known	1	0	1

Place of death/injury/incident

	Old Guidance	New Guidance	Total
Home	17	17	34
Outside home	2	3	5
Hospital	1	0	1

Cause of death

	Old Guidance	New Guidance	Total
SID syndrome	3	0	3
Overlying	1	1	2
Murder	5	7	12
Neglect	3	0	3
GBH	4	6	10
Fit	2	0	2
Illness	1	2	3
Induced illness	0	1	1
Accident	0	3	3
Overdose	1	0	1

Relationship of perpetrator to child

	Old Guidance	New Guidance	Total
Not known	4	1	5
Mother	7	4	11
Father	3	5	8
Non-biological 'mother'	0	1	1
Non-biological 'father'	2	1	3
Sibling	0	0	0
Other relative	0	0	0
Family friend	0	0	0
Stranger	1	0	1
Mother and father	1	2	3
Other	1	1	2
Not applicable	1	5	6

Child's placement at time of Incident

	Old Guidance	New Guidance	Total
Home	19	19	38
Residential care	0	1	1
Hospital	1	0	1

Nature of victimisation

	Old Guidance	New Guidance	Total
Child sole victim	17	17	34
With siblings	2	3	5
With siblings and parent	0	0	0
Not known	1	0	1

Nature of the Incident

	Old Guidance	New Guidance	Total
Singular event	15	15	30
Premeditated/prepared	0	1	1
Following history of abuse	5	4	9

Outcome of criminal proceedings

	Old Guidance	New Guidance	Total
Prison	1	1	2
Probation	1	1	2
Not known	11	9	20
No proceedings	7	9	16

Parents admitted responsibility

	Old Guidance	New Guidance	Total
Yes	6	9	15
No	13	9	22
Don't know	0	1	1
Not applicable	1	1	2

Perpetrator clearly identified

	Old Guidance	New Guidance	Total
Yes	11	11	22
No	8	6	14
Don't know	1	1	2
Not applicable	0	2	2

Uncertainty about cause or nature of incident

	Old Guidance	New Guidance	Total
Yes	15	7	22
No	5	12	17
Don't know	0	1	1
Not applicable	0	0	0

Disagreement between carers about incident

	Old Guidance	New Guidance	Total
Yes	4	6	10
No	15	13	28
Don't know	1	1	2
Not applicable	0	0	0

PRIMARY CARER OF THE CHILD

Gender of primary carer

	Old Guidance	New Guidance	Total
Male	1	1	2
Female	19	19	38

Age of primary carer at time of incident

	Old Guidance	New Guidance	Total
0-15	1	0	1
16-18	1	0	1
19-20	1	2	3
21-25	7	3	10
26-30	3	5	8
31-35	4	4	8
36-40	2	3	5
41 and over	0	1	1
Not known	1	2	3

Ethnic origin of primary carer

	Old Guidance	New Guidance	Total
White British	15	12	27
White other	0	1	1
Black African	1	1	2
Asian	1	1	2
Not applicable	0	1	1
Not known	3	4	7

Relationship of primary carer to child

	Old Guidance	New Guidance	Total
Mother	19	19	38
Father	0	1	1
Step father	1	0	1

Language spoken in the home if English an additional language of the primary carer

	Old Guidance	New Guidance	Total
Punjabi	0	1	1
Cantonese	1	0	1
Not known	4	1	5

Employment of primary carer

	Old Guidance	New Guidance	Total
None	13	12	25
Professional	0	1	1
Semi-skilled	0	1	1
Unskilled	2	2	4
Not known	5	4	9

Background of primary carer

	Old Guidance	New Guidance	Total
Mental health problems	9	9	18
Learning disability	0	0	0
History of public care	4	4	8
History of childhood abuse	4	2	6
Implied childhood abuse	0	1	1
Criminal record	1	5	6
Registered: Sex Offenders Act 1997	0	0	0
Schedule 1 offender	0	0	0
Violent behaviour	6	4	10
Alcohol/drug abuse (current)	6	8	14
Alcohol/drug abuse (past)	0	1	1

SECOND CARER OF CHILD

Gender of second carer

	Old Guidance	New Guidance	Total
Male	16	18	34
Female	0	1	1
Not known	0	1	1
Not applicable	4	0	4

Age of second carer at time of incident

	Old Guidance	New Guidance	Total
0-20	0	0	0
21-25	4	5	9
26-30	4	2	6
31-35	5	4	9
36-40	1	5	6
41-45	1	0	1
46 and over	0	2	2
Not known	2	2	4
Not applicable	3	0	3

Ethnic origin of second carer

	Old Guidance	New Guidance	Total
White British	13	8	21
White other	0	0	0
Black African	0	3	3
Black Caribbean	0	0	0
Black other	0	1	1
Asian	1	1	2
Other	0	1	1
Not applicable	4	3	7
Not known	2	3	5

Relationship of second carer to child

	Old Guidance	New Guidance	Total
Mother	0	1	1
Father	11	14	25
Step father	5	4	9
Not known	0	1	1
Not applicable	4	0	4

Whether second carer living with child at time of incident

	Old Guidance	New Guidance	Total
Yes	14	11	25
No	2	8	10
Not known	0	1	1
Not applicable	4	0	4

Language spoken in the home if English an additional language of the second carer

	Old Guidance	New Guidance	Total
Punjabi	0	1	1
Cantonese	1	0	1
Not known	0	0	0

Employment of second carer

	Old Guidance	New Guidance	Total
None	3	3	6
Professional	0	1	1
Semi-skilled	0	0	0
Unskilled	2	1	3
Not known	11	15	26
Not applicable	4	0	4

Background of second carer

	Old Guidance	New Guidance	Total
Mental health problems	3	6	9
Learning disability	1	2	3
History of public care	2	2	4
History of childhood abuse	0	1	1
Implied childhood abuse	1	1	2
Criminal record	7	7	14
Registered: Sex Offenders Act 1997	0	0	0
Schedule 1 offender	0	1	1
Violent behaviour	11	11	22
Alcohol/drug abuse (current)	8	7	15
Alcohol/drug abuse (past)	1	2	3

RELATIONSHIP BETWEEN CARERS

Length of relationship

	Old Guidance	New Guidance	Total
0-1 year	3	4	7
2-3 years	4	5	9
4-6 years	2	3	5
7-10 years	6	4	10
11 and over	2	2	4
Not known	2	1	3
Not applicable	1	1	2

Stability of relationship

	Old Guidance	New Guidance	Total
Long-term stable	6	3	9
Long-term unstable	10	10	20
Recent	2	5	7
Not known	1	1	2
Not applicable	1	1	2

Quality of relationship

	Old Guidance	New Guidance	Total
Argumentative	15	10	25
Supportive	3	2	5
Caring	2	3	5
Other	0	5	5

Violence in the relationship

	Old Guidance	New Guidance	Total
Much violence	6	6	12
Some violence	9	4	13
No violence	3	5	8
Not known	1	4	5
Not applicable	1	1	2

Poverty, poor housing, neighbour conflict and mobility

	Old Guidance	New Guidance	Total
Poverty and poor housing	9	8	17
Conflict with neighbours	8	7	15
Frequent moves	10	9	19

Changes in family composition

	Old Guidance	New Guidance	Total
New birth	8	7	15
Frequent changes in adults	2	2	4
Recent changes in adults	1	6	7
No major changes	8	4	12

Previous death of child of one or both parents

	Old Guidance	New Guidance	Total
SID syndrome	1	0	1
Infection	1	0	1

Part of close extended family

	Old Guidance	New Guidance	Total
Yes	4	5	9
No	9	8	17
Not known	7	7	14

Case Histories

Whether case histories had ever been taken by SSD on mother/primary carer?

	Old Guidance	New Guidance	Total
Yes, in full	4	3	7
Yes, partial	4	6	10
No	12	11	23

Whether case histories had ever been taken by SSD on father/secondary carer?

	Old Guidance	New Guidance	Total
Yes, in full	3	1	4
Yes, partial	1	6	7
No	15	13	28
Not applicable	1	0	1

SSD SERVICE HISTORY

How long the child had been known to SSD

	Old Guidance	New Guidance	Total
Previously unknown	5	7	12
0-1 years	2	2	4
1-2 years	1	6	7
2-3 years	0	2	2
3-5 years	5	0	5
5-10 years	5	0	5
10 and over	0	3	3
Not recorded	2	0	2

How long the family had been known to SSD

	Old Guidance	New Guidance	Total
Previously unknown	3	4	7
Less than 6 months	0	3	3
6 months – 2 years	1	0	1
More than 2 years	13	10	23
Intermittently	0	1	1
Not recorded	2	0	2
Not applicable	1	2	3

Previous child protection concerns

	Old Guidance	New Guidance	Total
Concerns to SSD re child	14	10	24
Concerns re siblings	7	4	11
Concerns more than once	13	7	20
Strategy discussions held	9	7	16
S.47 enquiry	7	2	9
Formal C.P. conference	8	4	12
Child on C.P.R.	4	2	6
Child previously on C.P.R.	4	3	7
Sibs ever on C.P.R.	6	3	9

Child's involvement as a child in need (other than CP)

	Old Guidance	New Guidance	Total
Referred to as a CIN case	6	6	12
CIN assessment done	1	2	3
Open CIN case	3	2	5
Not applicable	1	2	3

Whether child ever looked after

	Old Guidance	New Guidance	Total
Yes	2	2	4
For less than 3 months	1	1	2
For more than 3 months	1	1	2
More than once	1	2	3

SSD PLANNING

Is there a care or protection plan?

	Old Guidance	New Guidance	Total
Yes, up to date	2	1	3
Yes, not recent	1	2	3
No	17	17	34

Have there been care proceedings for this child

	Old Guidance	New Guidance	Total
Yes	2	0	2
No	18	20	38

Care status of child at time of incident

	Old Guidance	New Guidance	Total
Care order	2	0	2
Home after care	2	3	5

CHILDREN'S COMPLETE SERVICE HISTORY

Assessment problems identified in reports

	Old Guidance	New Guidance	Total
SSD assessments not undertaken	10	7	17
Other assessments not undertaken	2	2	4
No/weak analysis	4	3	7
Evidence not accumulated	5	6	11
Warnings unrecognised/ unheeded	12	11	23
Assessment not acted on	4	2	6
Assessment paralysis	0	1	1

Agencies holding the case as open at time of incident

	Old Guidance	New Guidance	Total
SSD	7	5	12
Health visitor	7	11	18
Other health service	3	2	5
Special education	3	1	4
Other	0	1	1

Relationships between family and professionals

	Old Guidance	New Guidance	Total
Missed appointments	10	7	17
Disguised compliance	6	3	9
Dependency	1	3	4
Flight	2	0	2
Client closure	4	7	11
Blocks access to child	4	4	8
Aggressive	3	2	5
Complaining	1	3	4
Appropriate	8	7	15
Co-operative	6	10	16
Seeks help	8	9	17

Comments on aspects of professional work in reviews (figures in brackets indicate results under new and old guidance)

	Favourable	Unfavourable	None
Skill	2 (0.2)	2 (2.0)	36 (18.18)
Training	0	13 (7.6)	27 (13.14)
Seniority	0	1 (1.0)	39 (19.20)
Supervision	0	5 (4.1)	35 (16.19)
Competence	0	4 (3.1)	36 (17.19)
Responsiveness	5 (1.4)	20 (14.6)	15 (5.10)

Comments on services in reviews

	Old Guidance	New Guidance	Total
Co-ordinated	7	7	14
High input	5	7	12
High risk/priority	1	3	4

Involvement of services with child in previous two years

	Limited	Substantial	None
SSD	15	10	15
Family aide/support	1	1	38
Respite carer	0	1	39
Playgroup	0	0	40
Community child minder	0	0	40
NSPCC	0	0	40
Midwife	15	0	25
Health visitor	9	16	15
GP	20	9	11
Senior nurse	0	0	40
Clinical nurse specialist	2	1	37
Locality nurse specialist	0	0	40
Hospital	15	5	20
Outpatients	0	1	39
A and E department	7	2	31
Special care baby unit	1	2	37
Paediatrician	10	3	27
Dermatologist	2	0	38
Occupational therapist	1	0	39
Speech therapist	1	0	39
Drugs and alcohol team	0	0	40
Ambulance service	3	0	37
Portage worker	1	0	39
Learning disabilities team	3	0	37
School health nurse	2	1	37
Education	6	6	28
Home tutor	1	2	37
Education welfare	5	2	33
Education psychology	1	2	37
Women's refuge	0	2	38
Police	1	2	37

continued

Involvement of services with child in previous two years *continued*

	Limited	Substantial	None
Juvenile justice	1	1	38
Probation	1	0	39
Court welfare	0	1	39
Solicitor	0	0	40
Housing	1	0	39
Fire service	0	0	40
Transport service	0	1	39
DV unit	0	0	40

Involvement of services with carers in previous two years

	Limited	Substantial	None
SSD	20	13	7
Family aide/support	3	0	37
Respite carer	1	1	38
Playgroup	1	0	39
Community child minder	1	1	38
NSPCC	1	0	39
Midwife	21	0	19
Health visitor	8	20	12
GP	23	13	4
Senior nurse	0	0	40
Clinical nurse specialist	1	2	37
Locality nurse specialist	0	1	39
Hospital	18	7	15
Outpatients	1	2	37
A and E department	6	4	30
Special care baby unit	2	1	37
Paediatrician	3	3	34
Dermatologist	0	0	40
Occupational therapist	0	1	39
Speech therapist	1	1	38

continued

Involvement of services with carers in previous two years *continued*

	Limited	Substantial	None
Drugs and alcohol team	3	3	34
Ambulance service	3	0	37
Portage worker	0	1	39
Learning disabilities team	1	1	38
School health nurse	3	1	36
Education	2	5	33
Home tutor	0	0	40
Education welfare	4	3	33
Education psychology	1	2	37
Women's refuge	3	1	36
Police	11	6	23
Juvenile justice	0	2	38
Probation	1	8	31
Court welfare	1	0	39
Solicitor	2	2	36
Housing	6	6	28
Fire service	0	0	40
Transport service	1	0	39
DV unit	4	5	31
Other	1	1	38

ORGANISATIONAL FACTORS AT THE TIME OF DEATH

Did overview note:

	Old Guidance	New Guidance	Total
Numerous unallocated cases	1	0	1
High staff sickness/absence	2	0	2
Significant staff shortages	2	3	5
Recent reorganisation	3	0	3
New policies/leadership	1	0	1
Concern re supervision/ practice	0	2	2

Comments in reports on:

	Favourable	Unfavourable	None
Liaison adult/child services	3	10	27
Inter-agency working	10	16	14
Level of training on CP	8	10	22
Role/work of ACPC	2	4	34

REVIEW PROCESS

Composition of SCR panel

	Old Guidance	New Guidance	Total
Police	13	15	28
SSD	15	19	34
Health authority	8	14	22
Education	11	9	20
Health trust	10	14	24
NSPCC	4	2	6
Probation	5	8	13
Adviser	7	9	16

Was an extension requested?

	Old Guidance	New Guidance	Total
Yes	3	3	6
No	17	17	34

Author of report

Independent reviewer	10
ACPC member	2
SS manager	7
Police	1
NSPCC	1
Probation	1
Not known	18

Researchers' assessment of overview report

	Old Guidance	New Guidance	Total
Adequately multi-agency	15	18	33
Had obvious gaps	9	7	16
One agency view dominated	0	0	0
Dealt with contrasting views	11	15	26

Parties providing evidence to the review process

	Old Guidance	New Guidance	Total
SSD	19	20	39
Health	17	19	36
Education	12	8	20
Police	16	15	31
GALRO	1	0	1
Voluntary sector	0	2	2
Adult family members	0	6	6
Child family members	0	1	1
Probation	3	7	10

Whether separate management reviews undertaken

	Old Guidance	New Guidance	Total
SSD	15	18	33
Education	9	5	14
Health trust	12	11	23
Health authority	8	8	16
Police	12	12	24
Other	2	5	7

REPORT CONTENT

Length of overview report

	Old Guidance	New Guidance	Total
0-10 pages	5	3	8
11-20	5	9	14
21-30	2	3	5
31 and over	8	5	13

Did the overview contain?
(figures in brackets indicate results under new and old guidance)

	Full and Clear	Partial	Limited/None
Genogram/network	12 (7.5)	22 (11.11)	6 (2.4)
Summary of family history	11 (5.6.)	18 (10.8)	11 (5.6)
Chronology of agency work	33 (18.15)	5 (2.3)	2 (0.2)
Summary of who knew what	19 (7.12)	18 (12.6)	3 (1.2)
Views of parents	4 (0.4)	10 (4.6)	26 (16.10)
Analysis of events	24 (11.13)	14 (9.5)	2 (0.2)
Assessments completed	11 (6.5)	21 (12.9)	8 (2.6)
Decisions made	21 (8.13)	16 (10.6)	3 (2.1)
Actions taken	19 (6.13)	18 (13.5)	3 (1.2)
Compliance re procedure	17 (5.12)	15 (11.4)	8 (4.4)
Whether child seen	3 (1.2)	5 (3.2)	32 (16.16)
Whether child gave views	1 (0.1)	3 (2.1)	36 (18.18)

Action plan following review

	Old Guidance	New Guidance	Total
Full/clear	6	5	11
Partial	5	8	13
Limited/None	9	7	16

Number of recommendations

	Old Guidance	New Guidance	Total
None	2	1	3
1-3	1	1	2
4-5	1	2	3
6-10	3	10	13
11-20	9	6	15
21 and over	4	0	4

Evidence in report that the review had

	Old Guidance	New Guidance	Total
Clear structure	12	18	30
Emphasis on lessons	16	17	33
Conducted within time-scales	8	13	21

QUALITY OF PRACTICE

Comments in report on quality of practice in following areas

	Favourable	Unfavourable	No concerns	No comment
Referral process	1 (1.0)	5 (4.1)	6 (1.5)	28 (14.14)
Information recording	2 (1.1)	15 (10.5)	7 (1.6)	16 (8.8)
Information sharing	4 (1.3)	25 (14.11)	7 (3.4)	4 (2.2)
Assessment process	1 (1.0)	23 (11.12)	5 (3.2)	11 (5.6)
Information on fathers	0	9 (3.6)	6 (1.5)	25 (16.9)
Decision making	2 (0.2)	21 (10.11)	7 (3.4)	10 (7.3)
Focus of work	0	8 (5.3)	6 (2.4)	26 (13.13)
Inter-agency working	2 (0.2)	17 (11.6)	12 (5.7)	9 (4.5)
Cultural/racial issues	2 (1.1)	4 (0.4)	2 (1.1)	32 (18.14)
Service response	4 (2.2)	20 (11.9)	7 (3.4)	9 (4.5)

Conclusions about predictability and preventability of the incident

	Highly	Weakly	Not	No mention	Not applicable
Predictability	1 (1.0)	2 (2.0)	30 (13.17)	3 (1.2)	4 (3.1)
Preventability	3 (2.1)	7 (4.3)	24 (10.14)	3 (1.2)	3 (3.0

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