Research Report DFE-RR040

Building on the learning from serious case reviews:

A two-year analysis of child protection database notifications 2007-2009

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Department for Education

This research report was written before the new UK Government took office on 11 May 2010. As a result the content may not reflect current Government policy and may make reference to the Department for Children, Schools and Families (DCSF) which has now been replaced by the Department for Education (DFE).

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

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Disclaimer
The views expressed are those of the authors and are not necessarily shared by the Department for Education.

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EXECUTIVE SUMMARY

Serious case reviews (SCRs) are local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected. They are carried out under the auspices of Local Safeguarding Children Boards (LSCBs) so that lessons can be learnt locally. Every two years an overview analysis of these reviews throughout England has been commissioned to draw out themes and trends so that lessons learnt from these cases can inform both policy and practice. This is the 5th such biennial analysis of serious case reviews, and relates to incidents which occurred during the period April 2007 - March 2009, and complements the two earlier biennial reports undertaken by the same authors.

This report is written in separate chapters and most chapters can, potentially, be used as 'stand alone' learning materials for different audiences and different interests.

Findings

- In the two year period there were 675 notifications of incidents to Ofsted, of which 268 progressed to serious case review.

- In 152 (57%) of these cases the child or young person died, and in 116 cases (43%) children and young people were seriously injured or harmed.

- The number of serious case reviews covered by this biennial report is higher than in either of the previous two years (there were 189 reviews in the 2005-07 report and 161 in the 2003-05 report). This amounts to a 43% increase in the number of deaths, and a 111% rise in the number of serious harm cases which were the subject of a serious case review between 2003-05 and 2007-09.

- The characteristics of the children, and their families, are very similar to those found in the earlier biennial reviews; there was, for example, a similar proportion of children with child protection plans, and a similar age range.

- Approximately half of all serious case reviews are in relation to babies under one year of age, underlining the importance of effective universal services provision for young children, for example health visitors and early-years services such as Sure Start Children's Centres.

- A quarter of the reviews concerned older young people who are likely to pose a risk to themselves and/or others, and whose needs are not always recognised, or met.

- Little difference was noted between those notifications for serious injury which became a serious case review and those which did not (based on the information available to the researchers).

- While more than three quarters of the children were killed or harmed at home, just over one in five incidents (21%) took place in a 'community context'.

- The incident that prompts a serious case review is not always preceded by practice failings.

Background

This analysis is briefer than previous biennial reviews since it has been undertaken during a period of transition when new ways of carrying out national analysis to prompt better learning are being considered (Sidebotham et al 2010). During these deliberations we have kept this biennial review modest and manageable, focusing primarily (but not exclusively) on the analysis of the child protection database notifications relating to all serious case reviews in the two year period. Since this is the third biennial review undertaken using the same methodology we now have six years worth of comparable data on *all* available serious case reviews. This amounts to a total of 618 cases, providing robust baseline material for any future analysis or comparisons.

The analysis of the brief information contained in the child protection database notifications provides little context to each case and tends to lose the reality of the children's experiences and the human tragedy that underlines each of these serious case reviews. For this reason we have, additionally, carried out a very modest piece of qualitative analysis about the children and young people who died or were seriously harmed not at home but at a community level. This has gone some way to bringing more detail about the children and young people back into the foreground.

The objectives for the analysis of serious case reviews from 2007-09 were as follows:

1. To collate and describe data from the child protection database reports on all notifications which progressed to a SCR during this two-year period, adapting the coding framework used in the 3rd and 4th biennial analyses (Brandon et al 2008 and 2009).

2. To compare those notifications (of serious injuries or harm) which do and do not become a serious case review.

3. To analyse the data to produce descriptive statistics and findings in relation to initial themes and trends emerging from the database reports.

4. To link the findings for 2007-09 to those presented in the 3rd and 4th biennial analyses.

5. To consider the cases from the perspective of family-level harm or community-level harm. This is primarily a qualitative analysis.

6. To provide an analysis and preliminary categorisation of cases of serious injury only (i.e. not child death cases). This complements the analysis previously undertaken on child death cases in the biennial report for 2005-07 (Brandon et al 2009).

Themes and trends

The major themes to emerge from the analysis of notifications between 2007 and 2009 are set out below:

An increase in the number of serious case reviews undertaken

There was a 43% increase in the number of deaths, and a 111% rise in the number of serious harm cases, which were the subject of a serious case review between 2003-05

and 2007-09. There could be a number of explanations for these increases, including a lower threshold for holding a review, and our improved access to the total set of reviews. The substantial growth in the number of reviews arguably diverts funds from operational services that can protect children. It has to be asked whether this is now beginning to outweigh the benefits to be gained from the learning. The policy implication, firstly of the substantial rise in the number of serious harm cases brought to serious case review and, secondly, of the uncertainty about which serious harm cases to bring to review, is to give consideration to taking serious harm cases out of the serious case review process. This would be in line with most other countries' enquiry processes into child death through abuse. This would not preclude the possibility of other kinds of review taking place for serious harm cases.

Overall themes and trends are very similar to the two earlier biennial reviews

There were, for example, similar proportions of children with child protection plans, and a similar age range. These findings can make repetitive reading for the practitioner audience but increase the reliability we can place on our findings; and reinforce a number of policy implications. The continuing trend for nearly half (45%) of the serious case reviews to be in relation to babies under one year of age, and two thirds of the cases to concern children aged under 5, underlines the importance of effective universal services provision for young children e.g. health visitors and early-years services such as Sure Start Children's Centres. A quarter of the reviews (24%) still concern older young people who may pose a risk to themselves and / or others and whose needs are not always recognised.

As in previous studies domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds, and it is the combination of these factors which is particularly 'toxic'. The incidence of these risk factors is, however, likely to be under-recorded in the notifications.

At the time of the incident, 42 (16%) of the children were the subject of a child protection plan and a further 33 (13%) had been the subject of a plan in the past. Nearly a quarter (23%) of these plans recorded multiple categories of abuse, while nationally only 8% of child protection plans in England record more than one category. This further highlights the particularly complex nature of these cases, where there are multiple concerns.

Little difference was noted in the available information between those notifications for serious injury which became a serious case review and those which did not

During the close examination of all notifications of cases, some of which became the subject of a serious case review, we noted that there was often some debate or confusion about when a serious case review should be initiated. When the in-depth analysis of serious injury cases was undertaken, it seemed that, given the information available at the time of notification of the incident, there was little to distinguish between those cases which progressed to a serious case review and those which did not. Despite the notification appearing to meet the criteria set out in *Working Together* 2006, LSCBs sometimes decided not to initiate a serious case review. An alternative review was occasionally proposed as a better method of learning lessons. These alternative reviewing methods included, among others, 'lessons learned reviews' and 'near miss review procedures'. These other processes for learning tend not to be published.

Community level violence and harm

While more than three quarters of the children who were the subjects of a SCR were killed or harmed in a family setting, just over one in five incidents (21%) took place in a 'community context'. A primarily qualitative analysis of these 55 cases produced learning in relation to themes connected with:

- **older young people** - risky adolescent behaviour including suicide and self harm, alcohol and drug misuse, street level violence and gang violence.
- **younger children** - harm from unsuitable carers, harm by parents or inadequate staff care in supervised settings like hospitals. Some harm in foster and respite care was linked to unsatisfactory or neglectful care of disabled children.
- **sexual abuse in the community**
- by people with known serious concerns who visited the family, but who were not household members. Victimised children had heightened or known risks of harm, for example as the subject of a child protection plan or with other vulnerabilities such as a disability.
- by a known sex offender who could be a person in authority. Often the extent and seriousness of the abuse was not apparent until the SCR was underway.

An analysis of those cases of serious injury and harm which became the subject of a serious case review

The United Kingdom is unusual in combining reviews of cases where children are seriously injured through maltreatment with cases where children die. There were 116 SCRs relating to non-fatal serious injury during 2007-2009. Using these reviews, a five-fold classification was developed, the purpose of which was to aid our understanding of the differences or similarities between these cases and those where the child dies. This complements the analysis previously undertaken on child death cases in the biennial report for 2005-07 (Brandon et al 2009).

1) ***physical assault*** accounted for 66 (57%) of the 116 incidents of serious injury, primarily inflicted on babies aged under one year within a family context.

2) ***sexual assault*** was the primary concern in 20 (17%) of the 116 reviews, 17 of which related to girls. This was the form of harm most likely to be perpetrated by someone from outside of the family.

3) ***neglect*** was the primary feature of 14 reviews (12%), and occurred across all age groups. In contrast to the other categories of serious injury, most of these children (10 of the 14) had a current or a past child protection plan.

4) ***risk taking or violent behaviour by a young person*** characterised 9 (8%) of the cases, nearly half of which took place in a 'community context'.

5) ***parental suicide attempt with the child, or the child witnessing a parent's murder*** featured in 7 (6%) of the reviews, and in three of these there were known child protection concerns.

Serious case reviews conducted for serious harm are more likely to feature neglect and sexual abuse than reviews undertaken for children who die. Approximately three in ten serious injury reviews arise primarily from neglect or sexual abuse, whereas these types

of maltreatment are rarely fatal. However, neglect is an underlying feature in the majority of serious case reviews where children die.

Summary of the three biennial analyses

Being able to carry out three consecutive biennial analyses of serious case reviews in England stretching back to 2003 (Brandon et al 2008, 2009) has provided helpful continuity. It has enabled the research team to develop, over a six year time frame, a close understanding of serious case reviews and of the different sources of information held in relation to these reviews and the child who is at the centre of the process. The final chapter of the report provides a summary of key learning from the three national analyses, and presents:

- learning about the serious case review process in the cases from 2005-07 and 2007-09;
- recurring findings from the three biennial reviews; and
- ways of thinking about safeguarding practice.

Throughout the three biennial studies we have emphasised the complexity of each child's circumstances and the consequent difficulties professionals face in making sound professional judgements. It is the individual *differences* in each child's case that pose the most challenges for understanding and hence for practice and decision making. The demands and the complexity of the task of protecting children and the importance of supporting professionals, especially social workers, to make sound professional judgments has been accepted by policy makers and, increasingly, the public. This is a promising context for the Social Work Reform Programme and Professor Munro's Review.

Serious case reviews present a lasting testimony and memorial to children who die in horrific circumstances. This must be remembered in the deliberations about learning from these reviews.

Chapter 1: Introduction

This report presents an analysis of 268 serious case reviews undertaken in England relating to incidents which occurred during the period 1st April 2007 – 31st March 2009. 152 (57%) of the children or young people died and the remaining 116 were seriously harmed.

The analysis was undertaken in a time of transition while the then National Safeguarding Delivery Unit was waiting for results from a number of projects focusing on developing better understanding and analysis of existing data and research findings (NSDU 2009:8). This included a project looking at what will help embed best practice in day to day activity, including more effective learning from serious case reviews (Sidebotham et al 2010), which ran in parallel with the current biennial analysis. During these deliberations we have kept the current biennial review modest and manageable, focusing primarily (but not exclusively) on the analysis of the child protection database notifications relating to all serious case reviews in the two year period. Since this is the third biennial review undertaken using the same methodology we now have six years worth of comparable data on *all* available serious case reviews. This amounts to a total of 618 cases, providing robust baseline material for any future analysis or comparisons.

The objectives for the analysis of serious case reviews from 2007-09 were as follows:

1. To collate and describe data from the child protection database reports on all notifications which progressed to a SCR during this two-year period, adapting the coding framework used in the 3rd and 4th biennial analyses (Brandon et al 2008 and 2009).

2. To compare those notifications (of serious injuries or harm) which do and do not become a serious case review.

3. To analyse the data to produce descriptive statistics and findings in relation to initial themes and trends emerging from the database reports.

4. To link the findings for 2007-09 to those presented in the 3rd and 4th biennial analyses.

5. To consider the cases from the perspective of family-level harm or community-level harm. This is primarily a qualitative analysis.

6. To provide an analysis and preliminary categorisation of cases of serious injury only (i.e. not child death cases). This complements the analysis previously undertaken on child death cases in the biennial report for 2005-07 (Brandon et al 2009).

Limitations

The decision to focus on the minimal information from the child protection database notification reports has enabled the whole two year sample of serious case reviews to be analysed speedily and efficiently. However what has been lost in this process is much of the context of the case and especially the reality of the children's experiences and the human tragedy that underlines each of these serious case reviews. Since we have found that children are readily overlooked not just at the time they were harmed or

killed but also through the different layers of the reviewing process, this is an important piece of learning about the approach to national analysis. To redress this we have, additionally, carried out a very modest piece of qualitative analysis about the children and young people who died or were seriously harmed not at home but at a community level. This has gone some way to bringing more detail about the children and young people back into the foreground.

Reading the Report

This report is best read as a whole biennial analysis of all serious case reviews in England stemming from incidents which took place between 2007- 2009. The report in its entirety is important to policy makers and provides a significant contribution to the safeguarding community and to the national and international evidence base about serious harm to children. However, different chapters may have particular relevance for different audiences as follows:

Chapter 2: This chapter discusses how many serious case reviews were undertaken and reveals the few differences between child protection notifications that go on to become a serious case review and those which do not, given the information available. It is likely to be of particular interest to LSCBs and their serious case review panels.

Chapter 3: The largely statistical analysis of the background characteristics of children, their families and key features of agency involvement, is an update of our earlier analyses. It is important for understanding the patterns in children's cases that come to review. It helps practitioners, LSCBs, policy makers and the safeguarding community to see how individual cases fit into the national pattern. Because the patterns over the six years of maintaining this careful dataset are so similar, practitioners may be more interested in the overall messages than the fine detail.

Chapter 4: Most children at the centre of the serious case review die or are seriously harmed at home, or in a family context. This chapter considers the under-explored but important minority of children and young people who are harmed, or harm others, in a community context. This new learning will be relevant to practitioners and the whole safeguarding community as well as policy makers and makes a new contribution to the evidence base. LSCBs may not have considered reviewing some of these types of cases.

Chapter 5: This chapter discusses the development of a classification of cases of children who were seriously harmed. It will help us to understand the contrasts and similarities with those cases of children who die. It is important not just from a research perspective but also for policy makers, and especially for LSCBs to understand the wider national picture of these cases, some of which could be viewed as 'near misses'.

Chapter 6: This chapter provides a brief digest of key points which have emerged from all three biennial analyses undertaken by the same research team and, alongside the executive summary, is of wide ranging general interest.

Chapter 2: The serious case review process

This chapter discusses how many serious case reviews are undertaken and considers the similarities and differences between information held on child protection notifications that go on to become a serious case review and those which do not.

2.1 How many serious case reviews are undertaken?

Our aim in conducting the biennial analyses has been to reflect themes and trends from *all* serious case reviews undertaken in each two year period. This has posed a challenge over the years as it has been difficult to determine with any confidence the number of reviews undertaken. Improvements to the notification database during the two year period under scrutiny (2007-2009) have provided a much clearer account of how many serious case reviews were undertaken. The new notification database, in use from 2007, has allowed us to track and count the maltreatment linked child deaths or critical incidents which then led to a serious case review.

- **A total of 268** serious case reviews were initiated which related to incidents of child death or serious injury occurring during 2007-2009.
- **In 2007- 08** there were 353 notifications recorded on the database of which 137 (39%) led to a serious case review, and 216 (61%) did not.
- **In 2008- 09** there were 322 notifications recorded on the database, of which 131 (41%) proceeded to review, and 191 (59%) did not.
- A further very small number of notified cases relating to the second year (08-09) may have progressed to a serious case review, but these were still unresolved at the time of analysis, and were excluded.

Overall there were notification records for 675 cases, which related to incidents which occurred in the two-year period1st April 2007 – 31st March 2009. Careful examination of every record was required to identify those which appeared to go to a serious case review. The Department was able to help with this process, initially by providing a spreadsheet of serious case review decisions and subsequently helping to resolve a number of queries which arose and by providing updated information on some outstanding cases.

Having gone through this rigorous process, we can therefore be far more confident than in previous years that this sample represents a full cohort of serious case reviews for the specified time period. The unresolved ('possible, but not confirmed') category from the previous two biennial analyses has been virtually eliminated this time round.

Table 2.1: Total number of serious case reviews in the analysis

	Number of cases proceeding to serious case review	Death of a child	Serious Injury
2007-2008	137	78	59
2008-2009	131	74	57
Two year total	268	152	116

The two-year total of 268 serious case reviews is markedly higher than the 189 reviews analysed for the previous biennial study relating to 2005-07, and the 161 reviews studied for the 2003-05 biennial analysis.

This could be due to a number of factors:

- The notification database is more comprehensive;
- Updated information was more promptly available to the researchers;
- There was a real increase in the number of serious case reviews undertaken;
- An increased propensity for LSCBs to consider undertaking a serious case review – although any effects on decision making stemming from the 'Baby Peter' case would only become a relevant factor at the very end of 2008-09. The full impact of the added pressure this is believed to have had on Safeguarding Boards is yet to be seen.

Access to Executive Summaries

Where data were missing from the notification reports, we attempted to obtain the information by searching online for relevant executive summaries. Over 50 executive summaries were located and used in this way. In this process, we noted:

Accessibility:

- Some safeguarding boards displayed links to their executive summaries quite prominently and the information was easily accessible.
- However, often the executive summaries were not readily apparent and appeared to be unavailable online.
- We also noted that instead of publishing online, some LSCBs chose to provide a telephone or email contact for requests for summaries. This system appeared to work well, and presumably gives the Safeguarding Board an indication of how frequently information is requested and by whom.

Variation in information provided:

- There was substantial variation in style and content of the published executive summaries. While some contained full information, others provided very little detail about the specific case, withholding even basic information on gender, age or other characteristics. While providing minimal information protects anonymity, on the other hand it can limit wider access to the learning from an individual case. LSCBs must however comply with legislation, for example the Data Protection Act 1998, so will always be required to consider carefully what information is made publicly available. There may be good reasons for excluding certain information, for example to protect the welfare of a child.

2.2 Which cases become serious case reviews and their scoping

In order to try to understand why some cases become serious case reviews, while others do not, we examined a sample of notifications, relating to the first year of the biennial period, 2007-08. Our curiosity was prompted initially as some cases not chosen for review appeared from the information available to have very similar characteristics to others which were selected. These included a number of cases where adults in authority were charged with offences (mostly sexual) against children. When a child dies and abuse or neglect is known or suspected a serious case review should always be conducted. However, when a child has been seriously harmed in abusive or neglectful circumstances the LSCB must decide whether or not the wide range of criteria for initiating a review have been met. Only serious harm cases were included in this analysis, since LSCBs have to make a judgement about whether to undertake a serious case review based on the criteria set out in *Working Together* (HM Government 2006).

- Of all 104 notifications for serious harm in 2007-08, 46 (44%) **did not** lead to a serious case review.

2.2.1 Explanations for not following the SCR route

A number of explanations were recorded as to why these 46 cases did not proceed to a serious case review, although many notifications held no information to indicate why this decision was made. Not meeting the criteria or threshold for a review as detailed in chapter 8 of *Working Together*, was the most common explanation.

> *"…this case did not reach the criteria for a full serious case review, case audit or single agency review. However the Panel made recommendations to three agencies who were involved, and these recommendations have been progressed and implemented.*"

Some, but by no means all, notifications spelled out why the criteria were not met, for example where there was insufficient or conflicting evidence that abuse or neglect had played a part in the injury. Others placed emphasis on only some aspects of the criteria, for example *"no concern about the way that agencies worked together"*, or an even looser interpretation, *"no previous significant agency involvement"*. One case indicated that there was not enough information available and that a review would therefore not be held.

A small number of cases were reported as meeting the criteria, but the decision was nevertheless made not to proceed. In fifteen cases where a serious case review was not initiated, including some where the criteria were said to have been met, an alternative method of reviewing was proposed as a better way of learning lessons. These were sometimes called "Lessons Learned Reviews", or followed the local "Near Miss Review Procedure". Many of these cases were scrutinised at the level of individual management reviews, or internal case audit, for example "an appreciative inquiry internal review" or a "workshop based approach". Two further instances where alternative reviews were initiated included a domestic homicide review and a serious further offence review, held by the probation service. Some, including 'Lessons Learned Reviews' (LLR), followed the full serious case review procedures but were not reported publicly and were not defined as a serious case review.

"The LLR follows the same structure, process and timetable as an SCR but outcomes will only be shared within LSCB agencies and not made public."

Concerns about media, publicity, and problems of timing in the enquiries, were present in a number of cases which were not brought to review, including in one complex investigation:

"It is possible that following further police enquiries and investigation, that our knowledge of paedophile activity and networks will be broadened and informed across all agencies; this may involve lessons to be learnt about the way in which organisations work together. However this review, evaluation and learning is likely to occur most effectively outside of the scope of a serious case review. This does not preclude any future consideration of a SCR in respect of any other child… "

Despite being recorded as meeting the criteria as set out in *Working Together*, some cases did not proceed to a serious case review. On occasion, an alternative type of review was proposed as a better method of learning lessons. These included an internal case audit, or a workshop based model or 'Lessons Learned Review' or 'Near Miss Review Procedures' to name but a few approaches.

2.2.2 Differences and similarities between SCR 'yes' and SCR 'no' cases

In order to discern common and distinct characteristics between the two groups, we examined features such as gender, age and the nature and context of the harm. Some tables are illustrated with additional information from the child protection database 'case outlines', to help offer a fuller insight into this process.

Table 2.2: Whether progressed to SCR by gender

	No SCR	Proceeded to SCR	Total
Female	23 (40%)	34 (60%)	57 (100%)
Male	22 (48%)	24 (52%)	46 (100%)
Total	45 (44%)	58 (56%)	103 (100%)

(Gender unknown in one case involving an unborn child)

Somewhat more incidents involving serious harm to girls were notified in the first place and proportionately more progressed to a review. Any interpretation of this gender difference is limited and there is not sufficient evidence from this cohort to suggest that incidents involving girls might be taken more seriously and thereby be more likely to prompt a review. We noted that of the six attempted suicide cases, all of which concerned girls, only one progressed from notification to a SCR. No cases of attempted suicide by boys were notified during this period.

Table 2.3: Whether progressed to SCR by age

	No SCR	Proceeded to SCR	Total
Under 1 year	18 (38%)	30 (62%)	48 (100%)
1-5 years	6 (40%)	9 (60%)	15 (100%)
6-10 years	4 (36%)	7 (64%)	11 (100%)
11-15 years	8 (47%)	9 (53%)	17 (100%)
16 and over	10 (77%)	3 (23%)	13 (100%)
Total	46 (44%)	58 (56%)	104 (100%)

The highest numbers of notifications overall are for infants aged under twelve months. After this age band, the volume of reports falls. Prior to the age of ten, just under two thirds of all notifications are raised to serious case review status. For cases of children over the age of ten, the proportion of notifications selected for review drops markedly.

Table 2.4: Whether progressed to SCR by child protection plan status

	No SCR	Proceeded to SCR	Total
No	38 (51%)	36 (49%)	74 (100%)
Yes	7 (41%)	10 (59%)	17 (100%)
Has been	1 (10%)	9 (90%)	10 (100%)
Total	46 (46%)	55 (54%)	101 (100%)

In these notifications from 2007-2008, nine out of ten cases where children had had a *previous* child protection plan progressed to a serious case review. However, 7 out of 17 (over forty per cent) of the cases where the child was *currently* the subject of a child protection plan (at the time of the incident) were *not* reviewed. When the child has a current child protection plan to keep him or her safe there are acute public concerns about what went wrong. A serious case review would, as part of its remit, consider these issues.

Clearly, based on the information available in these notifications from 2007-2008, there is no consistency about decisions to review children who were seriously harmed and have current or previous child protection plans. Since there was no requirement in the 2006 *Working Together* to consider holding a review for children with child protection plans who were seriously injured as a result of abuse or neglect, this is not surprising.

Working Together 2010 has addressed this anomaly and added children with current or previous child protection plans at the time of the incident to the list of factors which need to be taken into consideration when deciding whether or not to initiate a review for cases of serious harm (HM Government 2010a: 236).

Table 2.5: Whether progressed to SCR by incident category

	No SCR	Proceeded to SCR	Total
Physical assault	24 (40%)	36 (60%)	60 (100%)
Sexual assault	6 (40%)	9 (60%)	15 (100%)
Risk taking behaviour (young person)	8 (57%)	6 (43%)	14 (100%)
Neglect	6 (55%)	5 (45%)	11 (100%)
Parental suicide attempt with child or witnessed parent's murder	2 (50%)	2 (50%)	4 (100%)
Total	46 (44%)	58 (56%)	104 (100%)

Table 2.5 shows that physical assault cases and sexual assault cases are the most likely to prompt a serious case review and that neglect cases and those involving risk taking behaviour among older young people (for example substance misuse, offending and attempted suicide) are the least likely. Nevertheless, approximately four out of ten cases involving either physical assault or sexual assault did *not* progress to a serious case review. In some of these cases, based on the notification information, it was not apparent why this was so given the severity of the abuse, or the nature of the circumstances surrounding the case, and the apparent similarity to other cases for which a serious case review was initiated.

Examples of SCR not held (some details have been altered to preserve anonymity)

A serious case review was not held for a child who sustained a fracture while at a respite care facility. The child was unsupervised at the time, and staff did not appreciate the severity of the incident and did not seek appropriate medical care.

Another notification, which did not become a serious case review, concerned a young baby taken to A&E, and subsequently discharged without being seen by the on-call paediatrician. A few days later a professional working with the father alerted children's social care to his concerns, and a subsequent medical examination revealed a further number of serious injuries, including fractures.

A further example concerns images of sexual abuse of a young child, which were found posted on the internet. While the website group was international in its membership the abuser was traced to an address in England and he subsequently admitted his abuse of this child. This case did not result in a SCR on the basis that no concerns had been identified for the child prior to the assault and that no agency apart from universal health service providers had been in contact with the family.

Example of SCR held

It was suggested that young people who are 'perpetrators' do not fit easily into the criteria for a serious case review. In one of these cases arguments were put forward underlining the benefits of carrying out a serious case review to enable the findings to be incorporated in a more formal way into national learning about safeguarding. The LSCB expressed the view that more clarity was needed where a young person is a perpetrator and may also be subject to serious harm. It was suggested in one review that the

Ministry of Justice and the then Department for Children, Schools and Families needed to reconsider the Chapter 8 guidance to widen the scope of serious case reviews to include such cases.

Family or community context of the serious injury and decision to hold SCR

Injuries which occur primarily in the home, in the family context, are more likely to be prioritised for serious case review than serious harm which occurs in the wider community. This may simply reflect the fact that the children harmed at home are younger. (See Chapter 4 for a fuller discussion of the context within which incidents are taking place.) Some examples provoke thought about why some cases in the community context are not deemed to meet the criteria for a serious case review. For example a review was not held for a young woman with learning disabilities, who did not live at home, but was stabbed numerous times by associates, held captive and then abandoned on the street.

Table 2.6: Whether progressed to SCR by family or community context

	No SCR	Proceeded to SCR	Total
Family context	31 (40%)	46 (60%)	77 (100%)
Community context	14 (54%)	12 (46%)	26 (100%)
Total	45 (44%)	58 (56%)	103 (100%)

In the notifications from 2007-2008, there is an indication that serious case reviews are more likely to be initiated for cases of serious harm concerning:

- Girls
- Physical assault and sexual assault
- Incidents occurring within the 'family context'.

2.2.3 The scoping of the serious case review

Once the need for a serious case review has been decided, the review panel is required to consider the scope of the review and draw up clear terms of reference. It was evident when reading the free narrative sections of the database notification reports, that the scoping of many of the reviews was very complex. *Working Together* (HM Government 2006) suggests fourteen separate points to consider when drawing up terms of reference and these often appear to have been extended. For example some reviews also considered "*recommendations from previous SCRs that have or haven't been implemented and that are relevant to the case (if known)",* and "*any changes in safeguarding capacity/provision which might have occurred since the APA/JAR*." The scope and terms of reference listed often included as many as 25 separate actions.

A study of the way in which the reviews were scoped would be of interest in its own right. It appears from the examination of many of these notifications that the LSCBs scoping is drawn so widely that a nearly impossible task is set.

Chapter 2 Summary

- In the two year period 2007-09 there were 675 notifications of incidents to Ofsted, of which 268 progressed to a serious case review.

- The number of reviews covered by this biennial report is higher than in each of the previous two biennial reports (189 reviews were considered in the 2005-07 report, Brandon et al 2008, and 161 reviews in the 2003-05 report, Brandon et al 2009). While this probably reflects a substantial increase in the number of serious case reviews being undertaken, it may also reflect our improved access to the total set of reviews.

- When a child dies and abuse or neglect is known or suspected a serious case reviews should always be conducted. However, when a child has been seriously harmed in abusive or neglectful circumstances the LSCB must decide whether or not the criteria for holding a review have been met. In order to try to understand why some serious injury cases become serious case reviews, while others do not, we examined the available information on all 104 notifications for serious injury in 2007-08. Of the 104 notifications, 46 **did not** become a serious case review. There was often debate or confusion about which cases should have a serious case review. Aside from not meeting the criteria, explanations for not initiating a serious case review included having no concerns about the ways in which agencies worked together and therefore limited scope for learning lessons from the review. Other reasons given were concerns about the media or publicity and problems of timing.

- Despite serious injury notifications being reported as meeting the criteria as set out in *Working Together* 2006, LSCBs sometimes decided not to initiate a serious case review. Instead, an alternative type of review was occasionally proposed as a better method of learning lessons. These alternative reviewing methods included, among others, 'lessons learned reviews' and 'near miss review procedures'. The reports generated when using alternative processes for learning tend not to be published.

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

This chapter provides an update of the background characteristics of the children and their families and, for the most part, reveals a striking continuation of patterns and trends found in our previous two biennial analyses (especially in relation to the ages of the children, Brandon et al 2008 and 2009). The chapter also offers a brief examination of the incident or harm that prompted the review and a comparison of children's cases through time and by region.

Some information is also offered about agency involvement in relation to child protection and legal status where again patterns are very similar to our past studies. Child protection plan status is a mandatory question on the notification report form and we found, as before, that 16 per cent of the children were the subject of a child protection plan at the time of the incident. However the notification report form, the source of our information, does not include a question about whether the child or family was known to children's social care at the time of the incident which prompted the review. Given the constancy of other trends, it is frustrating that we cannot know or report this information for all of the 268 children, although our previous work using other sources from the serious case review itself (for example overview reports and chronologies) suggests that just under half of the children and families were not seeing a social worker at the time of the incident.

Although the known information is often limited at the point of notification, it would be helpful for the child protection database to have a question asking whether children are known to children's social care at the time of the incident or harm.

3.1 Characteristics of the children

Age

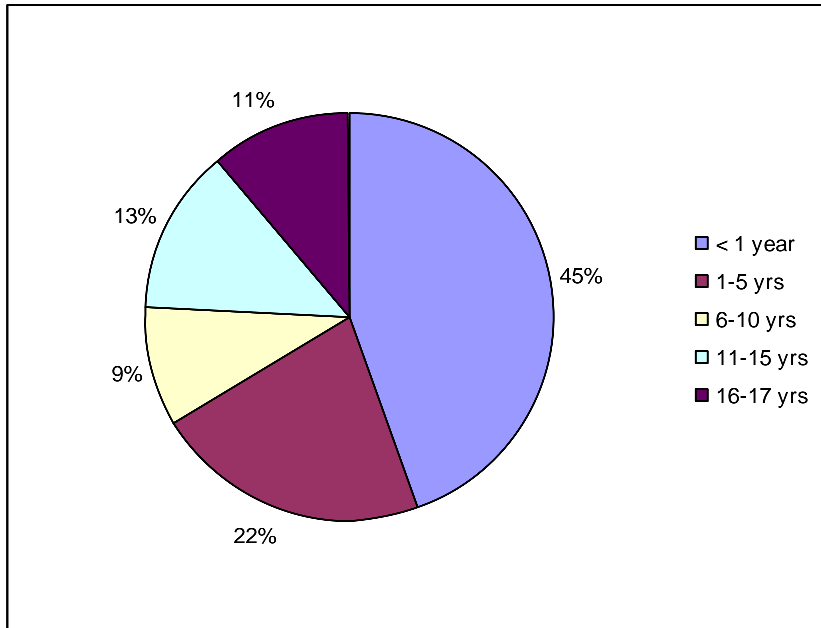
As in the two earlier biennial studies, just under half (119) of the 268 incidents which led to a review in 2007-09 related to a child who was under the age of one year. By way of comparison, only 6% of all children in the England population in 2007 were less than one year old (Table 3.1 and Figure 3.1). Information about the children's ages is displayed in both table and pie chart form for ease of understanding.

Table 3.1: Age at time of incident

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=268)	Population age distribution in England of under 18's * Mid-2007
<1yr	76 (47%)	86 (46%)	119 (45%)	640,700 (6%)
1-5yrs	33 (21%)	44 (23%)	59 (22%)	2,956,200 (27%)
6-10yrs	11 (7%)	18 (10%)	25 (9%)	2,923,100 (27%)
11-15yrs	26 (16%)	20 (11%)	35 (13%)	3,135,800 (29%)
16-17yrs	15 (9%)	21 (11%)	30 (11%)	1,339,000 (12%)

* Key Population and Vital Statistics 2007; Table A3 p.102. ONS (2009)

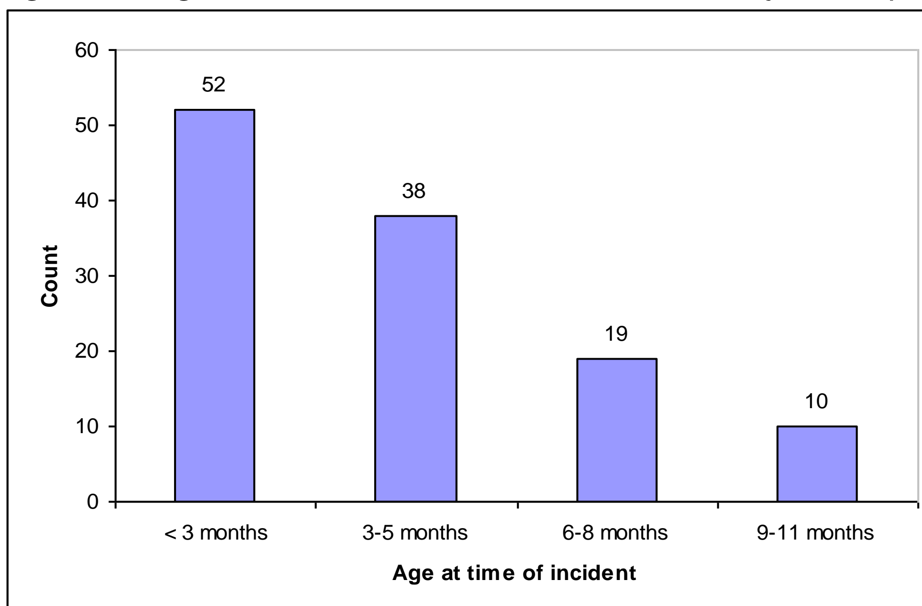
Figure 3.1: Age at time of incident



Of the 119 children aged under one year, 52 (44%) were under three months of age, 38 (32%) were aged three to five months, 19 (16%) were aged six to eight months, and the remaining 10 children (8%) were between nine months and one year old (Figure 3.2). This information is offered in a bar chart (Figure 3.2) to illustrate more clearly the predominance of very young babies in the cases from 2007-9, and indeed in all of the 618 cases analysed since 2003.

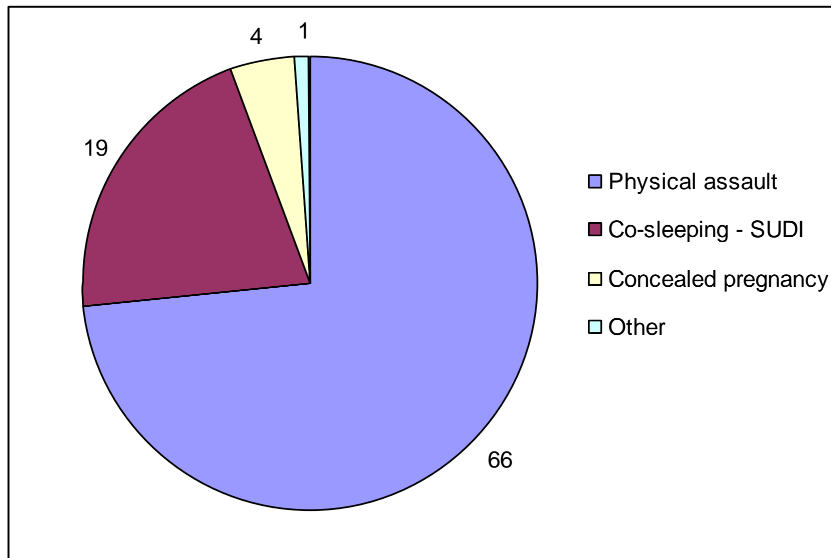
Within the very youngest group of 52 babies aged under three months, 11 (21%) were new-born or under one month at the time of the incident; 21 (40%) were one month old, and a further 20 (38%) were two months old. As in the previous biennial reviews, the vulnerability of the youngest babies highlights the importance of the safeguarding role for health staff, in particular midwives and health visitors.

Figure 3.2: Age at time of incident of babies under one year old (n=119)



There were three main ways in which the youngest babies aged under six months died or were harmed (Figure 3.3). These were primarily physical assault (66 cases), followed by sudden infant death/ co-sleeping (19 cases) and much smaller numbers of concealed pregnancies and unattended births (fewer than five cases). One baby was ultimately found to have died from natural causes rather than from a non-accidental injury.

Figure 3.3: Harm suffered by babies under six months old (n=90)



The database reports showed that many of the physical assault cases involved head injuries thought to be linked to shaking the baby. Sometimes there were other injuries too:

"*Colicky baby, head, and rib injuries – shaken by father who had been previously known to children's social care."*

In the cases of babies who died through overlying or co-sleeping, parental alcohol or drug use were almost always mentioned and often a context of neglect was also an issue:

"*It would appear that (the baby) died as a result of co sleeping with father;…(the baby) became subject to a child protection plan … under the category of neglect due to the outcome of a pre-birth assessment that identified issues with parental drug misuse, chaotic lifestyle, inability to parent the other children and the effect drugs had on them. There were periods of instability for parents and periods of homelessness.*"

The concealed pregnancies involved not only very young teenage mothers but also older mothers who had given birth to other children as in this example:

"*It appears that she had concealed her pregnancy, giving birth to the baby alone. The post mortem has shown that the baby was alive at birth and had been smothered.* (The mother) *has been arrested for the newborn's murder.*"

Gender

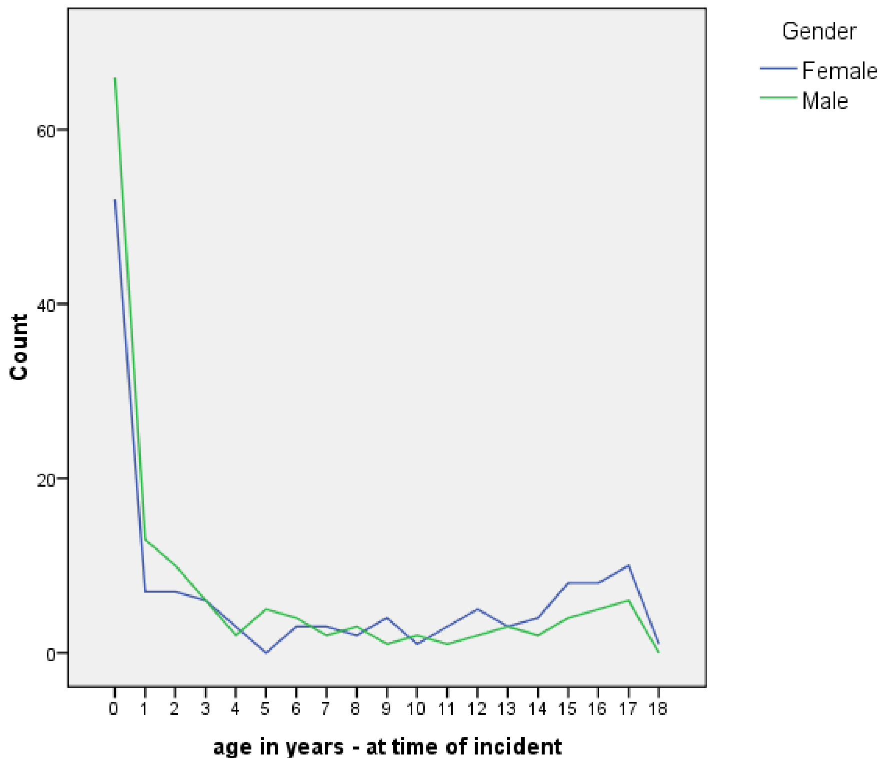
As in our previous studies, a slightly higher proportion of boys than girls were the subject of a serious case review, although this was less marked in 2007-09 (see Table 3.2). These most recent proportions are now the same as the population gender profile: in 2008, 51% of births were male (ONS 2010a).

Table 3.2: Gender

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=267)
Male	88 (55%)	106 (56%)	137 (51%)
Female	73 (45%)	83 (44%)	130 (49%)

Boys are still over-represented in the younger age groups (0-5 years), and newborn baby boys appear to be particularly vulnerable. In the age category of three months and under, 41 of the 67 (61%) babies were boys compared to 26 girls (39%). Conversely the older age groups (11 years and over) include more girls than boys (see Table 3.3 and Figure 3.4).

Figure 3.4: Age at time of incident by gender



The fact that there are more girls in the older age ranges might reflect the increased vulnerability and greater levels of risky behaviour among girls noted anecdotally by practitioners. A growing number of girls are involved in crime, with the number of offences committed by young women rising by 10% between 2004-05 and 2007-08,

while the number of offences committed by young men fell by 6% in the same period. By 2008 young women accounted for over 20% of all youth offending (Youth Justice Board 2010). Alternatively, LSCBs may be prioritising cases concerning older girls to learn lessons from these cases.

Table 3.3: Age at time of incident by gender

Age group	Gender 2005-07 (n=189)		Gender 2007-09 (n=267)	
	Female (n=83)	Male (n=106)	Female (n=130)	Male (n=137)
<1yr	34 (40%)	52 (60%)	52 (44%)	66 (56%)
1-5yrs	17 (39%)	27 (61%)	23 (39%)	36 (61%)
6-10yrs	11 (61%)	7 (39%)	13 (52%)	12 (48%)
11-15yrs	10 (50%)	10 (50%)	23 (66%)	12 (34%)
16 + yrs	11 (52%)	10 (48%)	19 (63%)	11 (37%)

Ethnicity

Data on ethnicity were more comprehensive in the 2007-09 notification reports than they had been in earlier years. These results are displayed in Table 3.4 and Figure 3.5. In only thirteen reports (5%) was ethnicity not stated. By contrast, ethnicity data were missing in 8% and 16% of the reports pertaining to incidents occurring during 2005-07 and 2003-05 respectively.

Table 3.4: Ethnicity

	Frequency 2003-05 (n=136)	Frequency 2005-07 (n=173)	Frequency 2007-09 (n=255)	Children aged 0-15 years England 2007 (ONS) *	Children Looked After 31st March 2009 **
White	101 (74%)	125 (72%)	195 (77%)	84%	76%
Mixed	8 (6%)	23 (13%)	23 (9%)	4%	8%
Black/Black British	17 (13%)	13 (8%)	24 (9%)	3%	7%
Asian/Asian British	8 (6%)	8 (5%)	11 (4%)	7%	5%
Other Ethnic Group	2 (1%)	4 (2%)	2 (1%)	1%	3%

* ONS (2010b) Population Estimates by Ethnic Group mid-2007. Table EE3
** DCSF (2009a) Children looked after in England: year ending 31 March 2009. Table LAA8

Additional data in Table 3.4 provide a context for considering the ethnicity of the children and young people who were the subjects of reviews. The fourth column of figures in the table gives the ethnic distribution of all children aged 15 and under in England (mid 2007 estimate), while the final column presents the ethnic distribution of the children who were looked after in 2009.

There is a tendency for children of mixed or black/black British ethnicity to be over-represented in serious case reviews, as they are in the population of looked after children. Children of Asian or Asian British ethnicity are likely to be under-represented in serious case reviews, as again they are in the population of looked after children. A slightly higher percentage of serious case reviews concern white children in 2007-09 than in the earlier biennial studies.

of this size (Bradshaw et al. 2006). The presence of neglect featured heavily in many of the cases involving large families.

These findings prompted us to consider cases involving large families in more depth by examining relevant executive summaries and producing a case vignette to illustrate pertinent issues. Further vignettes are presented at various points in this report to illustrate other themes. Note that all these vignettes are anonymous and composite, most being based on a number of cases which shared similar features. Each follows the same basic structure, providing a background to the case, followed by learning and key messages drawn both directly from the reviews and from our own analysis and research knowledge.

Case Vignette – Large Families

This family with six children were well known to agencies, some of which had been working with the family for nearly two decades. A SCR was undertaken in relation to the younger children following concerns about severe neglect and emotional abuse. Two older siblings were already in a long term placement. The family context included alcohol and substance misuse, domestic violence, poor home conditions, and parental mental ill health. Medical appointments were poorly attended, including developmental checkups and immunisations, and there was poor attendance by the older children at nursery and school. There had been little parental cooperation with professionals, such as health visitors, when they attempted to visit.

Learning:

There is a danger that historical concerns about older children are disregarded by professionals making assessments about the younger children. In this case these long standing concerns had been dismissed as “not relevant at the present time”. However no assessment of parental capacity for change was made. The focus on individual children within this large family tended to be lost. Staff need to ensure they see or speak to individual children alone. Moreover, when agencies work with a family with many children over an extended period of time, professionals may start to have low expectations about the standard of care, attention and security that the children are entitled to. In a large family of children with complex needs, the involvement of many agencies can lead to problems such as an overload of information, poor inter-agency communication, and the assumption that ‘someone else is dealing with it’.

The sample included six index children who were a twin, representing 2%. Nationally 1.5% of all deliveries are multiple births / twin births.

Birth Order

Birth order was not specifically given on the notification report but, in many cases, could be deduced from information provided on the date of birth of siblings (see Table 3.6). Where birth order could be determined, over half (52%) of cases were the youngest child, and a further 22% were only children. Since nearly half of all the cases were babies under 1 year of age, many were therefore the youngest child. The heightened vulnerability of the youngest child appears to be a recurring theme in the biennial reviews.

Table 3.6: Birth Order

	Frequency 2005-07 (n=169)	Frequency 2007-09 (n=225)
Oldest Child	22 (13%)	36 (16%)
Youngest child	75 (44%)	115 (52%)
Both Older and Younger Siblings	27 (16%)	22 (10%)
Only Child	42 (25%)	49 (22%)
Twin of single pregnancy	3 (2%)	3 (1%)

Child Disability

A total of 21 children (8%) were listed as being disabled (Table 3.7). Similar proportions were noted in our two previous studies. Learning from our previous biennial studies about the additional vulnerability of disabled children to maltreatment and the professional challenges this represents (especially in relation to neglect, Brandon et al 2008) is considered in the Practice guidance: *Safeguarding disabled children* (Murray and Osborne 2009).

Table 3.7: Disability (prior to incident)

	Frequency 2005-07 (n=187)	Frequency 2003-05 (n= 161)	Frequency 2007-09 (n=268)
No	173 (93%)	153 (95%)	247 (92%)
Yes	14 (8%)	8 (5%)	21 (8%)

Child Protection Plans

Information on whether the child was the subject of a child protection plan was more reliable than in the past. Child protection plan status is a mandatory question on the notification report form, and the member of staff inputting the information cannot progress further with the form until this information is recorded. Table 3.8 shows that at the time of the incident, 42 (16%) of the children were the subject of a child protection plan. A further 33 (13%) had been the subject of a plan in the past.

Table 3.8: Index child with a child protection plan

	Frequency 2005-07 (n=175)	Frequency 2007-09 (n=264)
No	127 (73%)	189 (72%)
Yes*	29 (17%)	42 (16%)
Has been	19 (11%)	33 (13%)

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

To place these figures in context, nationally 31 per 10,000 children under 18 years (0.31%) were the subject of a child protection plan at 31 March 2009 (DCSF 2009b). It is worth noting that this rate rose from 27 per 10,000 in March 2008, and from an average

of 24 per 10,000 in the previous five years from 2003-2007; the years covered by our biennial reviews. This rise might reflect a 'post Baby P' response to child protection.

The category of child abuse or neglect suffered by the child shows a similar pattern to previous years, with child protection plans being made most frequently in relation to neglect, followed by physical abuse (Table 3.9). A child protection plan can relate to abuse in more than one category, so the column totals sum to more than the number of children who were the subject of a child protection plan at that time. The more frequent use of the category 'emotional abuse' is reflected also in the national statistics on children who were the subject of a child protection plan (DCSF 2009b: Table 3C).

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

	Frequency 2005-07 (n=46*)	Frequency 2007-09 (n=75)
Neglect	30 (65%)	44 (59%)
Physical abuse	11 (24%)	25 (33%)
Emotional abuse	7 (15%)	21 (28%)
Sexual abuse	7 (15%)	9 (12%)

*Category of plan missing for two children. Children may be named in more than one category, and the columns therefore sum to more than 46 / 75.

Multiple recording of categories of abuse or neglect is not recommended in *Working Together* (HM Government 2006), but was still applied to 8% of child protection plans in England in 2009. It is striking that for our sample of children whose cases progressed to a serious case review where a plan was, or had been, in place, nearly a quarter (23%) were recorded with multiple categories of abuse or neglect. This is a further indication that these are the really complex cases where there are multiple concerns.

Legal Status

At the time of the incident, some of the children were the subject of legal orders, or were looked after under section 20 of the Children Act 1989 (Table 3.10). A total of 16 (7%) of the children or young people were the subject of either a care order or a supervision order. A further ten (4%) were accommodated under section 20. The category of section 20 accommodation included instances of mother and baby foster placement. Some of the notification reports indicated 'other legal status', but did not provide specific details. The 'other' category also includes adoption and some orders made under youth justice and mental health legislation, rather than the Children Act 1989.

Table 3.10: Legal status of the index child: pre-incident

	2007-09 (n=262)
No legal order	220 (84%)
Section 20 accommodation	10 (4%)
Care/Supervision order (including interim and EPO)	16 (7%)
Residence order	5 (2%)
Other	11 (4%)

In total, 57% of the ‘legal order’ cases related to the death of the child, with 43% relating to serious injury (in keeping with the total set of serious case reviews). Just over half of those children with orders (55%) were girls.

The average age of children who were the subject of statutory orders or accommodated was 10 years, compared with 4 years for the wider sample. The majority (62%) of these incidents took place in a ‘community context’ rather than a family setting (see Chapter 4). These findings are congruent with the type of incident occurring where an order is in place. These tended to relate to suicide, gang related violence, long-term neglect, substance misuse and sexual abuse. Relatively few cases related to physical injuries to a young baby.

Case Vignette - Mother and baby foster placements

A small number of cases concerned babies who were harmed or died whilst in foster care with their mothers (section 20 accommodation, Children Act 1989). There is a growing trend for mother and baby foster placements and whilst these are normally for teenaged mothers, this is not always the case. Some mothers were in their twenties. Managing the behaviour of these vulnerable mothers and the needs of their young babies was a challenge for the placement. Where two mothers and babies were in the same foster home, a tense and hostile relationship developed between the mothers, resulting in harm to one of the babies. The foster carer’s requests for one of the mothers to be placed elsewhere went unheeded. One of the mothers also regularly absented herself from the foster home.

Learning:
The high level of risk of harm to the babies was evident in these cases. There was an element of ‘start again syndrome’ in some of these situations since the placement was made even though the mother’s capacity to care for her baby safely was a very serious concern because of past and recent poor care of her other children.

When young women are accommodated with their babies it should be remembered that either or both may be a looked after child. Care plans, including arrangements for the children’s protection from harm, must be properly implemented. Midwives and GPs are a key part of the team and should work alongside the foster carers and social workers.

Some foster carers had inconsistent levels of support from children’s social care and at times were left to their own devices. These are high risk placements and foster carers need a high level of support and regular, reliable supervision and training. The suitability of placing more than one mother and baby in a single foster home requires very careful consideration.

Case Vignette - Supervision order cases

A pre-birth assessment was undertaken and a child protection plan was agreed because the child was living in a situation where a number of high risk factors were present, including domestic abuse and substance misuse. The baby was born drug dependent. Although this violent relationship ended (and no contact was maintained between the baby and father) the baby's mother began another relationship where the risk factors of domestic violence, drug misuse and criminality were also present.

A supervision order was made when the child was one year of age because the mother was no longer engaging well with services and was minimising agencies' concerns. She had not attended child protection plan core group meetings, nor a programme to address domestic abuse and had missed appointments with the health visitor. The health visitor expressed no major concerns since "these were routine checks only." The child was ultimately taken to hospital where he died. He had facial bruising, severe nappy rash and was found to have ingested methadone.

Learning:
Children living at home with a supervision order in place are by definition at heightened likelihood of suffering significant harm since the Section 31 threshold criteria for a supervision order to be made are the same as for a care order.

Routine health appointments for children (especially for those with known risk factors or harm) present good opportunities to pick up, note and consider (as part of a shared multi-agency service) mounting concerns. Persistent failure to attend routine health appointments are a cause for concern. NICE guidelines assert that persistent failure to attend missed health appointments should be a trigger for concerted efforts to make contact (National Collaborating Centre for Women's and Children's Health, 2009).

Where were the children living?

Information about where the child was living at the time of the incident is displayed in Table 3.11. This shows that, at the time of the incident, most of the children (81%) were living at home or with relatives. Chapter 4 examines the reviews of children harmed or killed in a community context which often included those accommodated or in other supervised settings.

Table 3.11: Where living at time of incident

	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=268)
Living at home	148 (78%)	217 (81%)
Living with relatives	10 (5%)	11 (4%)
With foster carers (short term, long term or short break)	7 (4%)	8 (3%)
Hospital, mother and baby unit and residential children's home	7 (4%)	14 (5%)
Semi-independence unit	5 (3%)	3 (1%)
Young Offender Institution		1 (<1%)
Other	10 (5%)	11 (4%)
Not yet known	2 (1%)	2 (1%)

Other case characteristics

The proportion of families where a risk factor such as domestic violence, substance misuse or neglect is known to be present in the child's caregiving environment is provided in Table 3.12. This information was often sketchy or missing because it represented what was known of the incident at the time of notification. Hence, as in our previous studies, these figures are highly likely to be under-estimates. Substance misuse, domestic violence and parental mental ill health pose significant risks factors for children. Previous reviews have emphasised that it is the combination of these factors which is particularly 'toxic'. Since this study has not included an in-depth analysis of overview reports and chronologies which provide richer detail, we cannot comment on the particular way in which these factors affected caregiving and the child's safety.

Table 3.12: Case Characteristics

	Frequency mentioned 2005-07 (n=189)*	Frequency mentioned 2007-09 (n=268)*
Parent characteristics:		
Domestic Violence	49 (26%)	91 (34%)
Mental health problems- parent	32 (17%)	73 (27%)
Drug misuse – parent	28 (15%)	60 (22%)
Alcohol misuse – parent	19 (10%)	58 (22%)
Child of teenage pregnancy	18 (10%)	19 (7%)
Parent has history of being in care	9 (5%)	19 (7%)
Child characteristics:		
More than one child abused	39 (21%)	50 (19%)
Serious Illness	15 (8%)	18 (7%)
Drug or alcohol misuse – child	10 (5%)	18 (7%)
Mental health problems – child	8 (4%)	17 (6%)
Factors related to case:		
Physical abuse	58 (31%)	147 (55%)
Long-standing neglect	33 (17%)	67 (25%)
Recent neglect	31 (16%)	48 (18%)
Sexual Abuse	29 (15%)	38 (14%)
Shaken Baby Syndrome	19 (10%)	22 (8%)
Emotional abuse	15 (8%)	30 (11%)

* The columns sum to more than 189 / 268 as more than one factor is generally cited in any one case.

With regard to the children and young people themselves, there is little information in the notification reports to help us understand the impact of serious illness, their drug or alcohol misuse, or their mental health problems. The analysis of community level harm in chapter 4 does, however, offer some insights into the young people's lives.

The apparent increase in the incidence of a number of known risk factors, particularly those relating to domestic violence and the parents' mental health and substance misuse, may reflect a change in the recording procedure rather than an actual increase in occurrence. The notification schedule in use for this latest set of cases requires the selection of at least one characteristic from a list of sixteen; it being mandatory to enter a response before being able to progress with the notification. Previously this field could be left blank, and this may account for fewer mentions of particular problems and characteristics in the earlier cohort. Nevertheless, it is likely that these risk factors were still being under-recorded.

3.2 The incident

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

It is striking that there has been a 43% increase in the number of deaths which have become the subject of a SCR, and a 111% rise in the number of serious injury cases which have become the subject of a SCR between 2003-05 and 2007-09 (see Table 3.13). There could be a number of explanations for these increases, including a lower threshold for holding a serious case review.

Of the 268 notifications which led to a serious case review - 152 (57%) were cases of child death and 116 (43%) were serious injuries. Compared to previous years, by 2007-09 a higher proportion of SCR cases relate to a serious injury (43% compared with 35% in 2005-07).

The increase in the number of serious injury cases becoming the subject of a serious case review over time may, in part, reflect the feeling expressed in some interviews in the 2005-2007 analysis (Brandon et al 2009), that it is easier to learn lessons from reviews where children survive than in cases where children die. However, the substantial growth in the number of serious case reviews can be viewed as diverting funds from operational services which are focusing on prevention and protecting children from suffering harm. It has to be asked whether initiating a SCR on this number of cases is now beginning to outweigh the benefits to be gained from the learning.

Table 3.13: Death / Serious injury

	Frequency 2003-05 (n=161)	Frequency 2005-07 (n=189)	Frequency 2007-09 (n=268)
Death	106 (66%)	123 (65%)	152 (57%)
Serious injury	55 (34%)	66 (35%)	116 (43%)

The serious injury group included a small number of atypical cases, for example where the child had witnessed the murder of a family member, or the child was the perpetrator of a serious incident. An analysis and classification of serious injury cases as a sub-group in their own right follows in Chapter 5. This complements the equivalent analysis undertaken for the fatal cases in the 2005-07 biennial report (Brandon et al 2009).

Table 3.14: Number of incidents which occurred in each quarter

Quarter	Fatal incidents	Incidents leading to serious injury	Total number of incidents which led to SCR
April 2007 – June 2007	22	19	41
July 2007 – September 2007	17	12	29
October 2007 – December 2007	19	11	30
January 2008 – March 2008	20	17	37
April 2008 – June 2008	21	20	41
July 2008 – September 2008	15	15	30
October 2008 – December 2008	24	9	33
January 2009 – March 2009	14	13	27

The notification database is ordered chronologically according to the date of notification. The researchers chose, instead, to consider cases by the date of the incident, in order to preserve comparability with their two previous reports covering the four years from 2003-07. In a few instances of non-fatal long-term abuse or neglect, or where a number of children were abused at different points in time, the date of notification was used as the incident date.

The number of incidents in each quarter is given in Table 3.14 above, while the numbers of incidents in the Ofsted and Government Office regions are presented in Tables 3.15 and 3.16. It is important to note that our data will differ from Ofsted figures for the equivalent time periods, which relate to the notification date, rather than the incident date.

Table 3.15: Number of incidents which occurred in each Ofsted region

Ofsted Region	Fatal incidents	Incidents leading to serious injury	Total number of incidents which led to SCR (n=268)
South	55 (51%)	52 (49%)	107
North	55 (59%)	39 (42%)	94
Midlands	42 (63%)	25 (37%)	67

The Southern region initiated the highest number (107) of serious case reviews, amounting to 40% of the total number, a figure which reflects the proportion (41%) of the English population residing in this region in 2008 (ONS 2010c). The Northern Ofsted region initiated 94 (35%) of reviews, and contains 28% of the population, whilst the Midlands Ofsted region initiated 67 (25%) of reviews, but has 30% of the population. A more nuanced understanding of these figures would need to take account of levels of regional deprivation, the age distribution and other factors.

The proportion of serious case reviews which relate to a fatal incident varies somewhat across the three Ofsted regions, ranging from 51% to 63%. At the micro-level of individual Government Office regions there are considerable variations (Table 3.16), with fatal incidents comprising from 42% to 79% of serious case reviews undertaken.

Table 3.16: Number of incidents which occurred in each Government Office region

Government Office Region	Fatal incidents	Incidents leading to serious injury	Total number of incidents which led to SCR (n=268)
North West	23 (54%)	20 (47%)	43
North East	8 (50%)	8 (50%)	16
Yorkshire and Humberside	25 (69%)	11 (31%)	36
East Midlands	8 (42%)	11 (58%)	19
West Midlands	22 (79%)	6 (21%)	28
Eastern	12 (60%)	8 (40%)	20
London	26 (54%)	22 (46%)	48
South East	17 (50%)	17 (50%)	34
South West	11 (46%)	13 (54%)	24

Media Interest

There was already media interest in nearly half of the cases at the time of notification.

Table 3.17 shows the extent of media interest in the serious case reviews. Nearly half (44%) had attracted media attention which was more often national than local - less than one in five cases attracted only local media interest. For the remainder of cases, media interest was ‘not known’ or ‘not anticipated’ at the time of data input. It is clear that these early reports represent an underestimate of eventual media attention.

Table 3.17: Media interest

	Frequency 2007-08 (n=268)
Local interest only	49 (18%)
National in addition to local interest	67 (25%)
No interest anticipated	76 (28%)
Not known	76 (28%)

The cause of the incident

The notification reports give the cause of the incident, of which the most frequent categories are either non-accidental death, or non-accidental injury. Where this information was lacking we were sometimes able to use other sources to update the primary cause of the incident (for example Executive Summaries). This revised list of incident causes is given in Table 3.18. There are however 46 cases (nearly 20%) where the incident cause is still unknown, or designated as ‘other’ at the time of notification.

Table 3.18: Incident cause

Incident cause (revised)	Number of incidents (n=268)
Non-accidental death	72 (27%)
Non-accidental injury	67 (25%)
Suicide	21 (8%)
Sexual abuse	19 (7%)
Neglect	16 (6%)
Natural causes	10 (4%)
Sudden infant death syndrome	7 (3%)
Drug / solvent misuse	5 (2%)
Self-harm	3 (1%)
Accidental injury	2 (1%)
Other	18 (7%)
Not yet known	28 (10%)

Categorisation of the primary cause of the incident in the child protection database helps to aid understanding of the type of harm the child suffered at the time of the incident. However, the simplification required to carry out this categorisation does not do justice to the complexity of many of the cases and the overlapping nature of the different types of harm that children and young people experienced. In addition, the single incident cause does not reflect the possibility that the incident may also have been prompted or influenced by abuse and neglect in the past, as is well illustrated in the following example of a young person who committed suicide.

> *"Post mortem confirmed suicide and no third party involvement. X, along with his brothers, were subjects of a case conference a decade earlier regarding concerns of sexual abuse by their father. It was decided not to add them to the child protection register as their father was no longer in contact with the family. …Six years earlier concerns were raised regarding x's behaviour … he had trashed the house and is understood to have said that he wished he was dead."*

Table 3.19 shows whether the maltreatment was fatal or non-fatal for children of different ages. The pattern remains broadly consistent with that found in the previous studies, with a higher proportion of deaths in the younger (0-5 years) and older (16+) age categories.

Table 3.19: Death / serious injury by age group

	Frequency 2003-05 (n=161)		Frequency 2005-07 (n=189)		Frequency 2007-09 (n=268)	
	Death	Serious Injury	Death	Serious Injury	Death	Serious Injury
<1yr	44 (58%)	32 (42%)	62 (72%)	24 (28%)	65 (55%)	54 (45%)
1-5yrs	26 (79%)	7 (21%)	24 (55%)	20 (46%)	37 (63%)	22 (37%)
6-10yrs	6 (55%)	<6	9 (50%)	9 (50%)	12 (48%)	13 (52%)
11-15yrs	16 (62%)	10 (39%)	12 (60%)	8 (40%)	16 (46%)	19 (54%)
16 + yrs	14 (93%)	<6	17 (81%)	<6	22 (73%)	8 (27%)

A similar breakdown by gender reveals that a higher number of the incidents involving boys resulted in deaths rather than serious injury (63% for boys; 50% for girls). This also reflects our previous findings (see Table 3.20).

Table 3.20: Death / Serious injury by gender

	Frequency 2005-07 (n=189)		Frequency 2007-09 (n=267)	
	Death	Serious Injury	Death	Serious Injury
Male	76 (72%)	30 (28%)	86 (63%)	51 (37%)
Female	47 (57%)	36 (43%)	65 (50%)	65 (50%)

Chapter 3: Summary

- The chapter provides a profile of the 268 children and their families and details of the incident which led to the review, based on information known at the time of notification of the case to Ofsted. In total, 152 (57%) of serious case reviews related to the death of a child and a further 116 (43%) concerned children who were seriously injured or harmed. This latter figure compares to about a third of children who were seriously injured, rather than killed, during the previous periods 2003-05 and 2005-07. This may indicate a lower threshold for holding a review during the period 2007-09.

- The tables in this chapter present information from the notification reports from 2007- 09 alongside the findings from the previous biennial national studies. Overall, these findings were consistent over time, in terms of the demographic characteristics of the child and his or her family. There continued to be a slightly higher proportion of boys than girls reviewed, but this was less marked in 2007-09 than previously. The ethnicity of the children who were the subject of reviews broadly reflected that of the national population.

- Just under half (119) of all serious case reviews concern a baby under one year of age – a proportion which has remained remarkably consistent over the six years, and which emphasises the vulnerability of this age group. Within these 119 cases, the majority - 90 children - were aged under six months old. Most of these reviews concerned physical assault (66 cases), with a further 19 relating to sudden infant death/co-sleeping (mostly involving parental alcohol or drug use) and a small number of concealed pregnancies and unattended births.

- Overall, two-thirds of the cases concern children aged under five years. This finding reinforces the importance of effective universal provision, in particular the safeguarding role of GPs, midwives, health visitors and other early years provision like SureStart Children's Centres, for this age group.

- One in five reviews related to families with four or more children. Our analysis of a sub-set of these cases indicated that neglect featured prominently and highlighted the danger that when agencies work with large families the focus on an individual chid can easily be lost.

- At the time of the incident, 42 (16%) of children were the subject of a child protection plan and a further 33 (13%) had been the subject of a plan in the past. Nearly a quarter (23%) of these plans recorded multiple categories of abuse, while nationally only 8% of child protection plans in England record more than one category. This further highlights the particularly complex nature of these cases, where there are multiple concerns.

- While the majority of children were not the subject of a legal order at the time of the incident, a total of 32 children were either the subject of a legal order or accommodated under section 20 of the Children Act 1989. Some further notifications recorded orders made under youth justice or mental health legislation. Most orders concerned older children who are especially hard to help and keep safe.

Chapter 4: An analysis of incidents occurring outside of the family context

It is well known that most abuse and neglect of children, including fatal abuse, occurs within families, at home (Finkelhor 2008). It was apparent in reading the summaries from the notification database reports however, that a minority of children, and particularly older young people, were being harmed or killed in circumstances that did not fit this pattern. The context within which these other incidents occurred seemed an important and under-explored area for scrutiny. This chapter considers the similarities and differences between children harmed in a family, or a community context. It also provides a thematic analysis of the 55 cases of community level harm.

Over three quarters of children were killed or harmed within the home or in a family context, but just over one in five incidents (21%) occurred *outside* of the family domain within a 'community context'. The existence of community level harm in serious case reviews suggests that learning is being sought about these wider issues in a number of serious case reviews in England.

4.1 The family or community context of the incidents

We determined and examined the family/community context in two broad categories:

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

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

Table 4.1: Family or community context by fatal/serious injury outcome

	Fatal incidents	Incidents leading to serious injury	Total number of incidents which led to SCR (n=268)
Family context	123 (81%)	90 (78%)	213 (79%)
Community context	29 (19%)	26 (22%)	55 (21%)

Table 4.1 shows that incidents which took place in the community were no more likely to result in a fatal outcome than those which occurred at home.

Points of interest:

- Serious case reviews about incidents occurring in a *family* context are slightly more likely to involve boys (54%) than girls (46%). (See Table 4.2)
- Conversely, serious case reviews about incidents occurring in a *community* context are more likely to involve girls (58%) than boys (42%).

The slightly higher proportion of girls harmed in the community may follow from the proportionately higher number of serious incidents notified for girls, and perhaps a tendency for LSCBs to hold a serious case review for serious incidents involving girls. It is also a reminder that girls are increasingly becoming involved in gangs, and in dangerous community level activities (Race on the Agenda 2010). Female involvement in violence is explored further later in the chapter.

Table 4.2: Family or community context of incident by gender

	Male	Female	Total number of incidents which led to SCR (n=267)
Family context	114 (54%)	98 (46%)	212 (100%)
Community context	23 (42%)	32 (58%)	55 (100%)

Taking into account the children's ages, it is not surprising that the younger the child, the more likely it is that the abuse or maltreatment will occur at home. Older young people, who become, increasingly, part of the wider community as they age, are more likely to be harmed or to self-harm within a community context. As young people mature, outside family factors and 'triggers' take on more importance in their lives and the perpetrators of harm are less likely to be family members. However, young people still carry with them the legacy of their early experiences of care and nurture which influences their ability to either cope with or to struggle to withstand outside influences (Brandon and Thoburn 2008).

Table 4.3: Family or community context by age at time of incident

	Family context (n=212)	Community context (n=56)	Frequency 2007-09 (n=268)
<1yr	112 (53%)	7 (13%)	119 (44%)
1-5yrs	54 (25%)	5 (9%)	59 (22%)
6-10yrs	17 (8%)	8 (15%)	25 (9%)
11-15yrs	17 (8%)	18 (33%)	35 (13%)
16-17yrs	13 (6%)	17 (31%)	30 (11%)

By considering the risks 'in the community' faced by both the older young people and the younger children, some implications for keeping these children and young people safe can be drawn.

4.2 Thematic analysis of community level harm

We have attempted to explore and understand these wider issues by treating the 'community level harm' cases as a sub-sample for qualitative analysis. Notification reports, executive summaries and, on occasions, overview reports for these 55 cases were carefully examined and used as a basis for identifying recurring issues. These 55 cases concern 20 younger children (aged ten and under) and 35 young people, aged 11 and over. The primary themes emerging from this analysis of community based harm are in three broad groups although there is some overlap between these categories:

Themes linked to older young people:

- Street-level/gang related violence and risky adolescent behaviour (including suicide and self harm) and young person as perpetrator of the serious incident;
- Supervised settings (for example school, hospital, residential care).

Themes linked to younger children:

- Childcare providers;
- Supervised settings, foster care.

Themes linked to Sexual Abuse (in either of the above age groups)

- Sexual Abuse by someone 'outside' the family including known sex offenders.

As before in this report, case vignettes are used to illustrate the above themes. All these vignettes are anonymous and composite, and are based on a number of cases which shared similar features.

4.2.1 Older young people

This section considers the largest number of children harmed or killed in a community context; namely 35 young people aged eleven and over (although most were older teenagers).

Gang and street related violence, and young people as perpetrators of violence

Over the two year period there were seven serious case reviews held where young people were involved in community level violence as victims or perpetrators of stabbings, shootings, or other assaults, sometimes as part of a gang or at the receiving end of gang violence. This is the first biennial review where there has been a small number of gang-related incidents. It is an indication of the wide reach of serious case reviews and shows that LSCBs are taking on a broad range of significant social problems. Recent practice guidance has been issued to help frontline practitioners safeguard young people at risk of harm from gang activity. The guidance points out that young people in gangs are often vulnerable individuals who can be both perpetrators and victims of harm (Department for Children, Schools and Families and the Home Office 2010).

Some young people at the centre of the serious case review might not have been directly involved with gangs themselves but had close family or friendship links. For example, one victim of a stabbing "was not known to be associated with gangs, but a brother is thought by the police to have involvement with a street gang." The impact of

street level violence fans out to affect many aspects of ordinary life. There was evidence in one case that patterns of behaviour from the street were played out in school, in a group assault of a child within school.

These cases of community level violence originate from several areas of the country, from metropolitan and other urban centres. Serious case reviews report that although gangs are not a new phenomenon in many urban areas, the involvement of younger teenagers is being recognised as a newer trend in large cities with gang cultures. Reviews also note that chaotic, anti-social and criminal activity rather than organised crime appears to be a newer development. One executive summary concluded that gangs are most dangerous to other young people associated with rival gangs. This executive summary called for the need to remain proportionate and not inflate the extent of gang related violence involving young people. However, it also acknowledged that the problem of gangs presents a significant challenge for both the young people involved and for the agencies working with them. The recommendations from this review were said to require a significant investment of resources and ongoing commitment, making it clear that the problem of gang violence cannot be resolved quickly, cheaply or easily.

The learning from a small number of serious case reviews involving gangs and street level violence identifies a range of overlapping factors that contribute to young people becoming involved in gang related activity that can result in death or serious harm. These include, not least, community and social factors like poverty and high rates of local unemployment. Lack of appropriate leisure and social facilities also play their part and it is significant that young people's access to facilities that do exist may be restricted because of risks posed by their gang affiliation. Other learning comes, in keeping with reviews held for other reasons, from the individual circumstances of the young people and their families and close networks.

Case Vignette – Gang violence
A fifteen year-old young man, who was himself a member of a gang, was stabbed in a gang-related attack, and died of his injuries. The attack took place in public, and the disturbance involved over two dozen young people. During his childhood and adolescence he had lived with a number of extended family members and had encountered problems at school since primary level. At the time of the attack the young man was homeless and excluded from mainstream education.

Learning:
Excluding young people from school has a wide ranging impact and limits their protection and their access to a range of other services. Mental health services, in particular, need to be delivered with more flexibility and in negotiation with young people, not just through parents and carers.
The serious case review was able to identify some examples of good practice during the time that he was at school, before his exclusion. School staff, and the school nurse (among others) had worked hard to develop and maintain a relationship of trust with him and were persistent in trying to meet his needs, including commissioning specialist services. The police were also commended for the written information provided about the known risks to the young man (see next section on Osman warnings).
As a response to this and other reviews about gang violence, the LSCB has developed a protocol for safeguarding young people at risk of harm from gang activity.

(See also *Safeguarding children and young people who may be affected by gang activity*, Department for Children, Schools and Families and the Home Office 2010.)

Osman warnings about threats to kill

Part of the protocol established in one LSCB in response to gang violence included the role of the police and other agencies working together when using Osman warnings to safeguard young people. Osman warnings are based on "the principle of taking preventative operational measures to protect an individual whose life is at risk from the criminal act of another individual" (from an Executive Summary). Usually these warnings are in relation to known threats to kill. Because *Working Together* (HM 2006) does not cover this issue, the police force, in consultation with other agencies in one LSCB, have devised their own template letter of concern when providing a warning to the named young person (aged under 18 years) under the Osman procedures. This and other elements of the protocol are now linked to the LSCB procedures. These include a referral and strategy meeting involving children's social care, and plans for subsequent action to minimise the risks to the young person and other relevant people. The police also provide information to the LSCB about adults made the subject of an Osman warning who share a household with children aged 18 and under.

Older young people: risky behaviour, suicide, self harm

The risky behaviour for many of the young people who were seriously harmed or died in a community context often involved excessive consumption of alcohol or dangerous drug use. In some cases deaths occurred after a night out with friends or taking drugs at a party. A number of suicides occurred after heavy drinking, sometimes following the break up of a relationship. It was often difficult to be clear whether the excessive consumption of drugs or alcohol was a deliberate suicide attempt.

Running away and absconding

Eight young people were in residential or foster care or another closely supervised setting at the time of the serious harm or suicide and a further small number were care leavers in supported lodgings. Some of the older young people who were not 'looked after' were living away from home with friends or distant relatives or were homeless at the time of the death or injury.

A pattern of risky and dangerous behaviour was very common among these older young people. Harm to the older looked after young people at the centre of the review or suicide often occurred while they were running away or absconding. 'Running away' in these reviews seemed to refer to a single episode of flight in response to a specific event while 'absconding' tended to encompass a regular pattern of behaviour where the young person was often or mostly absent from their placement. In both circumstances, the young people were at a distance from the support and oversight that might have kept them safe.

Two examples of young people who were 'running away' involved them taking their own life - in one case the suicide of a young person living at home, with mental health problems, who had run away after being discharged from a hospital out patients department, and in the second example the suicide of a child who had run away from a residential home after making an allegation of abuse against a carer.

More common than single instances of running away was 'absconding'. The term 'absconding' was found in many of the database notification reports and executive summaries of reviews concerning looked after children. 'Absconding' tended to be used as a short-hand term for a risk-taking lifestyle: "X frequently absconded from placements and had absconded when he was killed….X's lifestyle was such that he was often at risk of harm."

Young people are particularly vulnerable when they are away from their home base. The Children's Rights Director for England, Roger Morgan, reports on the views of children living away from home or receiving social care services. A recent consultation with young people revealed that children's 7th top 'message of the decade' was worrying about their safety when away from where they live – with 43% of children surveyed saying that they worry a little or a lot about this. Children reported that they feel safest in the building where they live and least safe when out in town. The top dangers children fear are drugs, alcohol, knives, kidnapping and bullying (Morgan 2010). Most children recognise the dangers they face when they are cut adrift from their protective base. Young people who are regularly absent from where they live are putting themselves in danger.

Child/young person as perpetrator of serious incident

A small number of young people at the centre of a serious case review were the perpetrators of the death or serious injury. They had been involved in gang crime, or the assault of young people or adults in the community, or sexual attacks on peers. They shared a similar profile to the young people who died or were seriously harmed in other circumstances, and this is discussed next.

Profile of victims and perpetrators of street level violence and risky behaviour and implications for the serious case review

There was usually a common profile of young people involved in dangerous behaviour (including suicide) and street level violence.

"*X was a looked after child, placed in a children's home. She had a history of absconding, involvement with gangs and criminal activity.*"

" X had an extensive history of offending and her schooling had been disrupted because of her behaviour, which was sometimes violent. … X's lifestyle was such that she was often at risk of harm – she appears to have been involved in gang activity and knife crime."

The same kind of profile was shared by the small number of perpetrators of the violence who were themselves the subject of a serious case review. It replicated the characteristics of the older 'hard to help' young people identified in the 2003-05 biennial analysis (Brandon et al 2008). Almost all of the young people had long histories of agency involvement, especially with the youth offending service, as looked after children and with mental health and substance misuse services. The long history of involvement added to the complexity of the serious case review, "*There could be up to 17 IMRs …which will demand a huge amount of commitment and co-ordination.*"

Most young people had experienced neglect and or abuse and had grown up living with the 'toxic trio' of family violence, parental substance misuse and parental mental ill health.

"X has been a very challenging girl to care for, having numerous separate periods in secure accommodation as a result of absconding, involvement in the sex industry and drug misuse…. X had a troubled relationship with her mother and long term health problems."

It is important to note however, that within the group of young people with these characteristics, there was the rare individual example of a young person who did appear to be turning their life around, making good use of help and making positive progress, until the incident which prompted the review. In the following example the young person fatally assaulted another young man.

"X, a care leaver, did well in his last two placements, had friends, was well liked by children and adults and worked well in school. He had moved into supported accommodation, was not experiencing any particular problems and was working hard to make a success of his life."

In a small but significant number of cases, as in the example above, street level violence (with or without gang culture) appear as a pervasive presence which can wreck young people's lives either as victims or perpetrators of the violence. Past problems cannot be left behind when family and friends continue to draw the young person into street level violence. This same example (given above) also shows that things can go very badly wrong even when young people are at the receiving end of good practice and good services. In addition it shows that the incident prompting a serious case review is not always preceded by practice failings.

Girls and serious violence

The issues discussed above applied to SCRs for both boys and girls, and reflects wider learning about female involvement in serious youth violence. The recent *Race on the Agenda* study into the impact of serious youth and gang violence on women and girls was prompted by the growing awareness of female involvement in knife and gun crime (ROTA 2010). The study notes, however, that much opinion has been based on a negligible evidence base and that the policy and practice response to gang crime takes account of women and girls as victims only, singling out males as the perpetrators of violence. They argue that responses that ignore both race and gender have the potential to increase the victimisation of gang-affected young women. Girls can be left further isolated without services in place to negotiate the risks they face.

The study asserts that women and girls linked to gangs rarely disclose victimisation because of fear of reprisals. Girls also believe that their criminal association forfeits their rights to state protection. In addition young women have little faith in any service's offers of confidentiality (ROTA 2010). The study argues that systems like youth justice and alternative education are designed to work with boys. Where girls have access to these interventions they are in environments dominated by boys. They conclude that this has a severe impact on young women's ability to address their offending behaviour and reduce their victimisation (especially sexual violence where rape is used as a weapon).

4.2.2 Younger children

The themes to emerge in relation to harm in a community context for the twenty younger children aged ten and under concerned:

- Formal or informal childcare or babysitting;
- Supervised settings (hospital, residential care, school);
- Foster care.

Formal or informal childcare or babysitting

For the younger children who were harmed or killed in a community setting a number of concerns centred around inappropriate and/or dangerous childcare arrangements, generally of younger children under five years of age. Risks of harm to children 'in the community' were posed within formal, regular child care arrangements (for example from a nanny and from un-registered child-minders and from a sexual offender whose wife was a registered childminder). Harm within the context of more informal, ad hoc childcare of young pre-school aged children came from leaving children in the care of unsuitable and often unstable young people or adults. Usually these informal carers or babysitters were known or loosely connected to the family, for example the teenaged son of a mother's boyfriend.

Case Vignette – Unsuitable/ dangerous child care arrangements

The child, who was aged two, was at home in the care of a young person, when she sustained serious head injuries. A number of agencies had been involved with the family, with concerns over domestic violence, substance misuse, and the level of parental care given to an older sibling. The babysitter had herself been a looked after child.

Learning:
The review showed a failure to respond to referrals from members of the public who were concerned about the child being left with a number of different carers. Other learning from the review concerned the importance of establishing who was involved with a family and who had caring responsibilities for the child. There was also an emphasis on the need to consider the impact of the parents' substance misuse on their parenting, and on the child.

Supervised settings (hospital, residential care, school)

Harm occurred to a small number of young children in a setting where professionals were providing overall supervision of a child's care. The settings included general or mental health hospitals, or other residential provision, including a mother and baby unit. One mother and child died together in supported accommodation. In some instances there was an assault on the baby or young child by a parent. In one example the baby had complex health needs.

Case Vignette – Harm in a supervised setting

The infant had been the subject of a child protection plan from the age of two months, and was judged to be at risk of suffering physical abuse in a context of domestic violence and substance misuse in the home. The baby was admitted to hospital, where staff became suspicious about the information given by the parents, and remained there for further tests over a number of days. Following a lengthy visit by the father, the child sustained a life threatening injury. The baby, who survived, was not returned to his parents' care, although the mother was granted restricted contact.

Learning:
Parents who pose a risk of harm to their child at home may also pose a risk of harm to the child outside of the home in other supervised settings; child protection plans should consider the safety for the child out of home as well as in it. Key information (especially known child protection risks) must be shared when children are first admitted to hospital.

Other examples included the failure of a hospital (or school) to alert the emergency duty social worker or the police when they had serious concerns about a child who was leaving their supervised setting to go home.

In the same way that serious case reviews show examples of involvement in gangs for increasingly younger children, they also reveal that dangerous behaviour can occur at younger ages in other contexts. One young pre-teenaged child was said to 'have little regard for her own safety' and was seriously sexually harmed on more than one occasion during regular episodes of running away from residential care. This young person's profile and risk-taking behaviour was very like that of the much older adolescents and not like that of most other children of her age.

Foster/ respite care issues – neglectful care of children with a disability

There were five cases involving younger children who died or were harmed while in foster and respite care. These SCRs concerned the neglect or inadequate care of children with a disability and/or complex health needs, and alleged physical assault or sexual abuse from carers.

The primary reason for some children being in foster or respite care was their disability and complex health needs. The expected life span of the child may therefore be, in some cases, very restricted. Notwithstanding this, for a serious case review to be held, the LSCB will have identified concerns over some aspect of the care given by the foster carers. Unsatisfactory or neglectful care of disabled children was an issue in some cases including one example where foster carers would not accept or follow medical advice and another where the child's complex needs may not have been sufficiently attended to. The issue raised in a previous biennial review (Brandon et al 2008) and in the practice guidance for safeguarding disabled children (Murray and Osborne 2009) was that aspects of neglect may be overlooked in the care of disabled children where lower standards of care may be condoned.

One executive summary identified that respite care breaks were often arranged between parents and carers informally without the involvement of children's disability services. Inadequate monitoring of the service was identified which had risked "losing the focus on what was best for x and what was possible and appropriate for the carer to provide".

A ‘team around the child’ model of key working was suggested as potentially providing a better service for disabled children receiving respite care.

This example highlights one of the dilemmas of recommendations stemming from serious case reviews which complicate informal partnership work. The holding of a serious case review presumes a low tolerance of risks of harm and recommendations tend to prompt extra monitoring and scrutiny for many or all children. Informal arrangements which work well for the vast majority of families needing a respite service for their child potentially come under threat because of the death (perhaps by natural causes) of a single child whose death is examined twice: once by a serious case review and once by a child death review team. The difficult balance to be achieved is to combine easy relationships and flexible arrangements with appropriate and proportionate oversight to help families and carers make sure that the needs and wishes of the child are not lost. This is a particular challenge when providing services for disabled children who are more likely than their non-disabled counterparts to be abused or neglected – including by outside the family offering care (Murray and Osborne 2009).

A recent literature review of short breaks for disabled children showed that there is poor evidence about the outcomes of respite care for disabled children themselves although it appears that for a minority of children these breaks are an unhappy experience (Robertson et al 2010). Families and children value flexible arrangements however, and this review suggests that the negative impacts of short breaks are likely to be minimised by tailoring the service to the needs of the family and child, The review says little however, about how to ‘quality assure’ the service to keep the child safe although it points out that innovations in services are ahead of research evidence in identifying good practice.

4.2.3 Sexual abuse

- Sexual assault by a known sex offender;
- Sexual abuse by a person about whom there are other serious concerns;
- Sexual abuse allegations against a person in authority, with a duty of care e.g. teacher, foster carer, youth worker.

In over a dozen cases the risks of harm posed to children by those outside of the family were related to sexual abuse. The abusers were usually either a ‘family friend’ or a ‘visitor to the house’ (six instances), or a non-immediate relative, like a step-grandparent. One example of a child sexually abused by her father was designated a ‘community context’ case because the sexual abuse extended outwards to many children in the community. The harm from sexual abuse rarely results directly in a child’s death, although in a number of child suicide cases there was evidence of past sexual abuse. Some other cases of child death through physical assault may also reveal evidence of possible sexual abuse.

The cases selected for serious case review will usually be the most serious cases of sexual abuse involving very serious harm to younger pre-teenaged children or to numerous children. All alleged sexual assaults in these cases were thought to be by men or boys (one young person sexually assaulted peers) and there were no identified female sexual abusers.

Known sex offender

In some cases the assault was perpetrated by a man who was a known sex offender.

"During the course of investigations concerns emerged that organisations involved with X may have failed to carry out proper Criminal Record Bureau (CRB) checks. If these had been carried out properly X's criminal past would have been revealed and he would not have been able to operate as he did."

Sometimes a person with a known conviction could also be in a position of authority and with a duty of care, in a paid or voluntary capacity. Access to children could be engineered via devious means, for example making a transition from working with adults to working with children. "*This case shows how easy it can be for a determined and manipulative sexual offender to evade the (CRB) process unless it is operated with rigour and attention to detail.*" Similar cases prompted the establishment of the Vetting and Barring Scheme in 2009. This scheme is being reviewed and the recent guidance is likely to be changed (HM Government 2010b).

Often the extent and seriousness of the abuse affecting numerous children was not apparent until the serious case review was underway. The complications and complexities of these cases can mean that there are a number of linked serious case reviews, or that the review may need to be undertaken twice. "*This case spreads over a number of years and is very complex, involving more than ten children. This SCR is linked to a SCR already commissioned and will overlap with the x review.*" This means that not only will the review be extremely costly but it will be very protracted and the learning may not filter through for many years. This will inevitably distance the learning from the events which caused concern in the first place unless the dissemination of learning occurs whilst the review is in progress.

Sexual assault by persons posing other serious concerns

A number of sexual assaults were not from known sex offenders but from other individuals about whom there were serious concerns, for example "*a known associate of the family about whom many long standing concerns had been held*". In these cases the children who were victimised were living in a family context where many risk factors were present, and they were the subject of a child protection plan or had other vulnerabilities such as a disability.

Case Vignette: Sexual abuse by family friend

The young, teen-aged girl was sexually abused by a family friend (who it was discovered had served a prison sentence for indecent assault). She was living with her mother and two siblings. Her mother had significant mental health and alcohol misuse problems. All three children in the family had been the subject of child protection plans for long-term neglect for the previous six years. Family members and a number of professionals had expressed serious concerns about the family and about the visiting family friend.

Learning:
The review stressed the importance of piecing together and acting with urgency on concerns from multiple sources (the family, school, health professionals). Instead a low priority was given to the case where the focus was on the mother not the child or children. Children with child protection plans over a long term basis need especially rigorous planning and review of their needs and their safety.

Sexual abuse by person in authority

A small number of the assaults on children were from someone in a position of authority with a duty of care, for example a teacher running an out of school club, a foster carer or a youth worker. In one example a community worker was thought to have abused over 150 young people.

Chapter 4: Summary

- While more than three quarters of the children were killed or harmed at home, just over one in five incidents (21%) took place in a 'community context'. A primarily qualitative analysis of these 55 cases produced learning in relation to themes connected with older young people, younger children, and sexual abuse (of both older and young children).

Themes linked to older young people

- *Street-level/gang related violence.* Although gangs are not a new phenomenon, SCRs report the involvement of younger teenagers, and chaotic, anti-social and criminal activity rather than organised crime as newer trends. The involvement of girls in serious violence is also a newer trend. Recent practice guidance points out that young people in gangs are often vulnerable individuals who can be both perpetrators and victims of harm (Department for Children, Schools and Families and the Home Office 2010).
- *Risky adolescent behaviour* (including suicide and self harm) often involved excessive consumption of alcohol or dangerous drug use. Harm or suicide for young people 'in care' often occurred while they were running away or absconding where they were at a distance from the support and oversight that might have kept them safe.

Themes linked to younger children

- *Formal and informal child care.* Harm from unsuitable informal carers occurred in families who were usually known to children's social care where there were a number of other risk factors present for the child.
- *Harm in supervised settings.* Parents who harm their child at home may also harm their child in other supervised settings; child protection plans should consider safety for the child out of home as well as in it. Where hospitals and schools have serious concerns about a child they should alert the emergency duty social worker or the police before the child goes home.
- *Foster/ respite care issues.* Unsatisfactory or neglectful care of disabled children included examples where carers would not accept or follow medical advice and where the child's complex needs were not sufficiently attended to. Lower standards of care may be condoned for disabled children.

Themes linked to sexual abuse

- There were no identified female sexual abusers.
- *Sexual abuse from people with known serious concerns.* This involved abuse from 'family friends', 'visitors' or non-immediate relatives. The children who were victimised had heightened risks of harm and tended to be the subject of a child protection plan or have other vulnerabilities such as a disability.
- *Cases of sexual assault by a known sex offender* or *a person in authority* revealed that access to children could be engineered via devious means, for example making a transition from working with adults to working with children. Often the extent and seriousness of the abuse affecting numerous children was not apparent until the SCR was underway. These reviews are often costly and protracted and the learning may not filter through for many years. This distances the learning from the events which caused concern in the first place, unless learning is disseminated while the review is still in progress.

Chapter 5: Developing a classification of serious injury cases

Most international studies of serious child abuse focus on child fatality. The United Kingdom is unusual in combining reviews of cases where children are seriously injured through maltreatment with cases where children die. For the English studies of serious case reviews to be compared internationally, it is therefore helpful to separate out the cases where children were seriously injured or harmed from those where children died. Considering the two groups separately also helps to aid our understanding of the differences or similarities between cases of fatality and these other 'near misses'. Our most recent study provided a classification, led by Dr Peter Sidebotham, of child fatality cases (Brandon et al 2009). This chapter considers, in parallel, cases of children who were seriously injured. The analysis therefore builds on the classification of 123 child deaths from the previous study of cases from 2005-07 (Brandon et al 2009). To this end we have, for the two years 2007-09, analysed all 116 serious injury cases which progressed to serious case review.

5.1 Overview of categories

The 116 cases of serious injury or harm analysed here, do not form one homogeneous group but can be disaggregated into a number of distinct categories. From careful scrutiny of the case outline for each child's notification we assigned every case to one of five sub-groups, which are as below:

A Physical assault;

B Sexual assault;

C Neglect;

D Risk taking or violent behaviour by the young person;

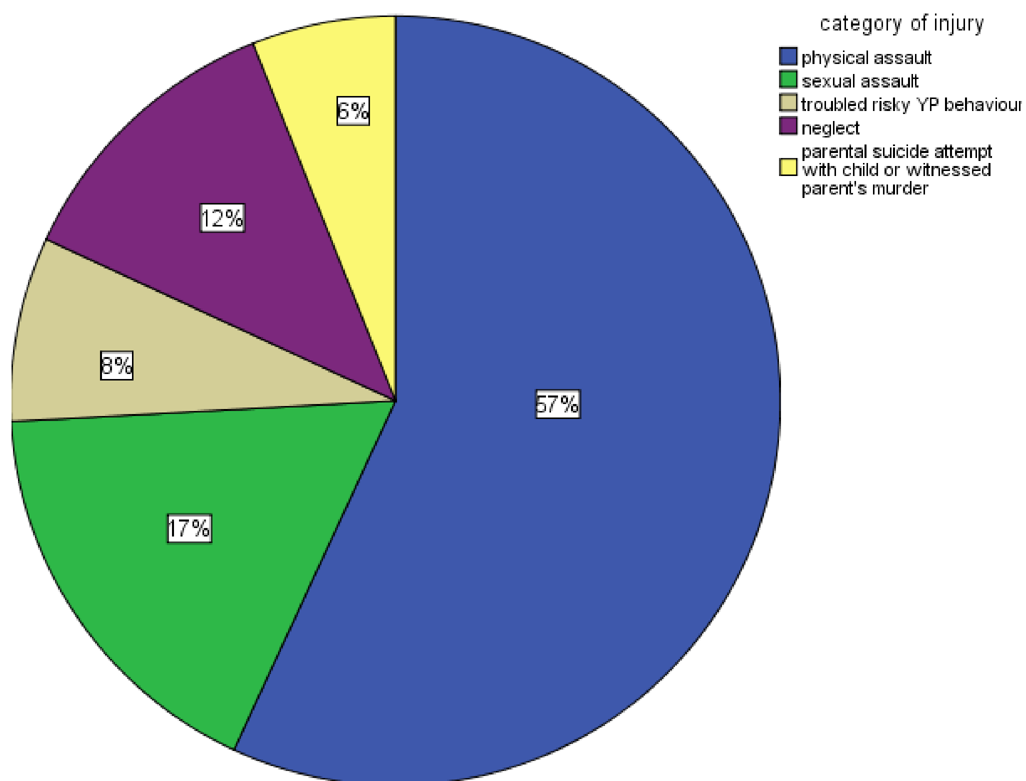
E Parental suicide attempt with the child, or the child witnessing a parent's murder.

It is important to reiterate, as our previous findings have shown, that there is often substantial overlap between these groups, but nevertheless these categories represent the prime cause of the maltreatment related injury. The number and proportions of children falling within these categories are presented in Table 5.1 and Figure 5.1 and are discussed in more detail later in this chapter.

Table 5.1: Serious injury categorisation

	Frequency 2007-09 (n=116)
Physical assault	66 (57%)
Sexual assault	20 (17%)
Neglect	14 (12%)
Risk-taking YP behaviour	9 (8%)
Parental suicide attempt with child or child witnessed parent's murder	7 (6%)

Figure 5.1: Serious injury categorisation

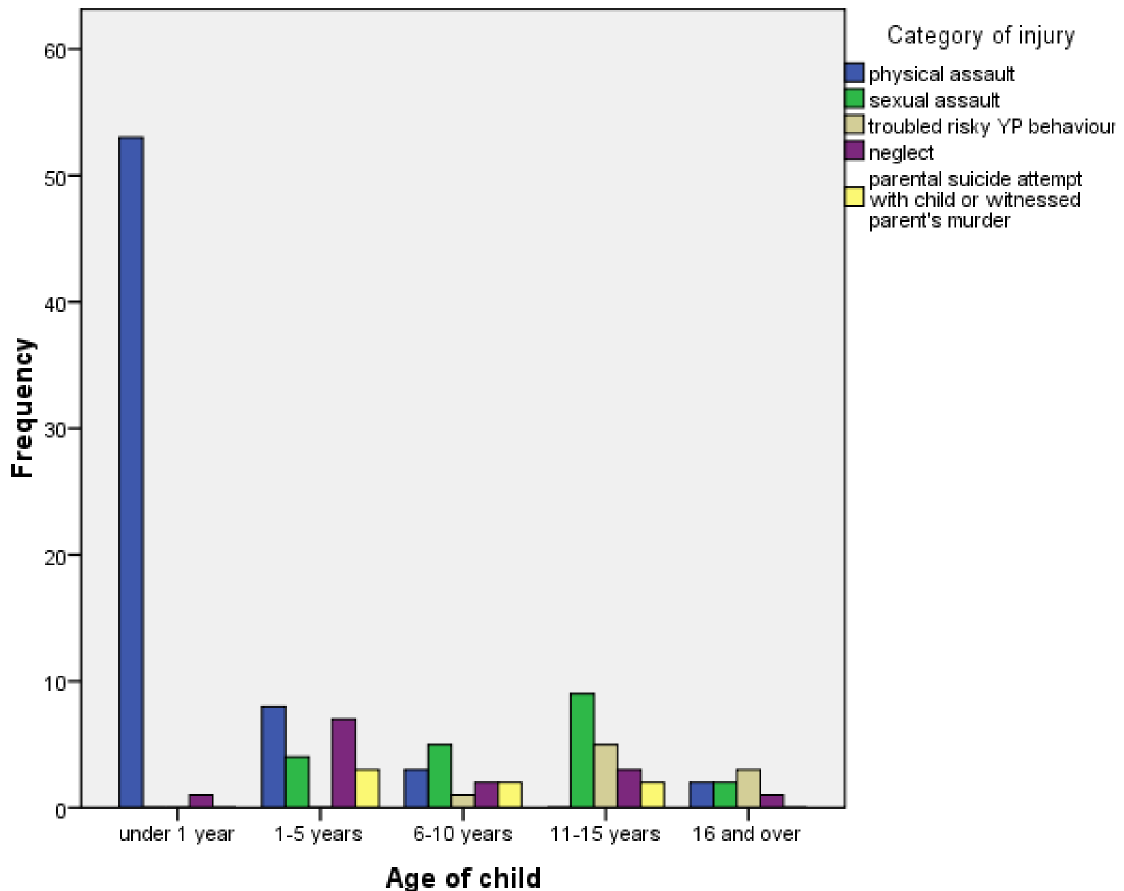


5.2 Categories of serious injury

This section presents a more detailed examination of our serious injury classification system. For each type of harm we also consider age, gender, child protection plan status and the family / community context. Figures 5.3 to 5.5, presented over the following pages, illustrate the type of injury in relation to the gender and child protection plan status of the child, and the family or community context of the harm.

The age profile of the different types of non-fatal maltreatment (Figure 5.2), can be compared with Sidebotham's classification of maltreatment related deaths in the 2005-07 biennial study (Brandon et al 2009). There are striking differences between the various categories of injury at different ages. As with the children who die, severe physical assault of infants is the most common type of harm. In contrast with the fatality cases, serious injury reviews are more likely to feature neglect and sexual abuse as the primary cause of the incident. Approximately three in ten of **serious-injury** SCRs arise from neglect or sexual abuse, whereas these types of maltreatment are rarely the *primary cause* of death.

***Figure 5.2*: Age and category of non-fatal injury (n=116)**



5.2.1 Severe but non-fatal physical assault

This was the largest category of serious injury and 32 girls and 34 boys were assaulted, as shown in Figure 5.3. These assaults accounted for 66 (57%) of the incidents looked at. The majority (53 or 80%) were inflicted on infants aged less than a year. Indeed only seven cases of non-fatal physical assault relating to a child aged three or over led to a serious case review (see Figure 5.2 above).

The majority of incidents involved non-accidental head injuries, including suspected shaking among babies under one year of age. Limb and rib fractures were also noted, along with bruising, and a small number of children also sustained internal injuries. A number of children suffered multiple injuries,

> *"X was admitted to hospital with an arm injury. X-rays revealed a suspicious fracture and further examination revealed skull, wrist and rib fractures apparently of varying ages. There is a very recent history of DV and substance misuse in the household."*

Nine of the 66 children (15%) had a child protection plan at the time of the incident, and a further five (8%) had been the subject of a plan previously (see Figure 5.4). It is worth noting that children who had suffered physical assault were the least likely of the sub-groups to be the subject of a plan, and the majority, 48 children (73%), had no plan in place. Information on the child protection plan status of the remaining four children was missing.

"X had a Child Protection plan as an unborn baby; together with her brother Y; owing to continuing concerns about the relationship between their parents; their parents' use of cannabis and alcohol and domestic violence ... X's mother returned home from an evening out, and was advised by X's father that the baby was unwell. X's mother called an ambulance and X was admitted to hospital… A paediatrician involved considered that there were early indications of shaken baby syndrome."

The child protection database does not always record whether a child was known to children's social care, so it was not possible to ascertain the full extent to which children and their families were receiving lower-level services from children's social care, either currently or in the past.

In nearly all (59) of the 66 (89%) cases categorised as physical assault, the incident(s) occurred in a family context with a family/household member believed to be responsible for the injury. In only seven cases was the physical assault perpetrated by a non-family member. Figure 5.5 illustrates the family or community context of the harm and Chapter 4 discusses harm in a community context in more detail.

5.2.2 Sexual assault

Twenty of the serious injury cases (17%) related, primarily, to sexual abuse. Seventeen of the victims were girls and three were boys. (See Figure 5.3).

Figure 5.3: Gender and category of non-fatal injury (n=116)

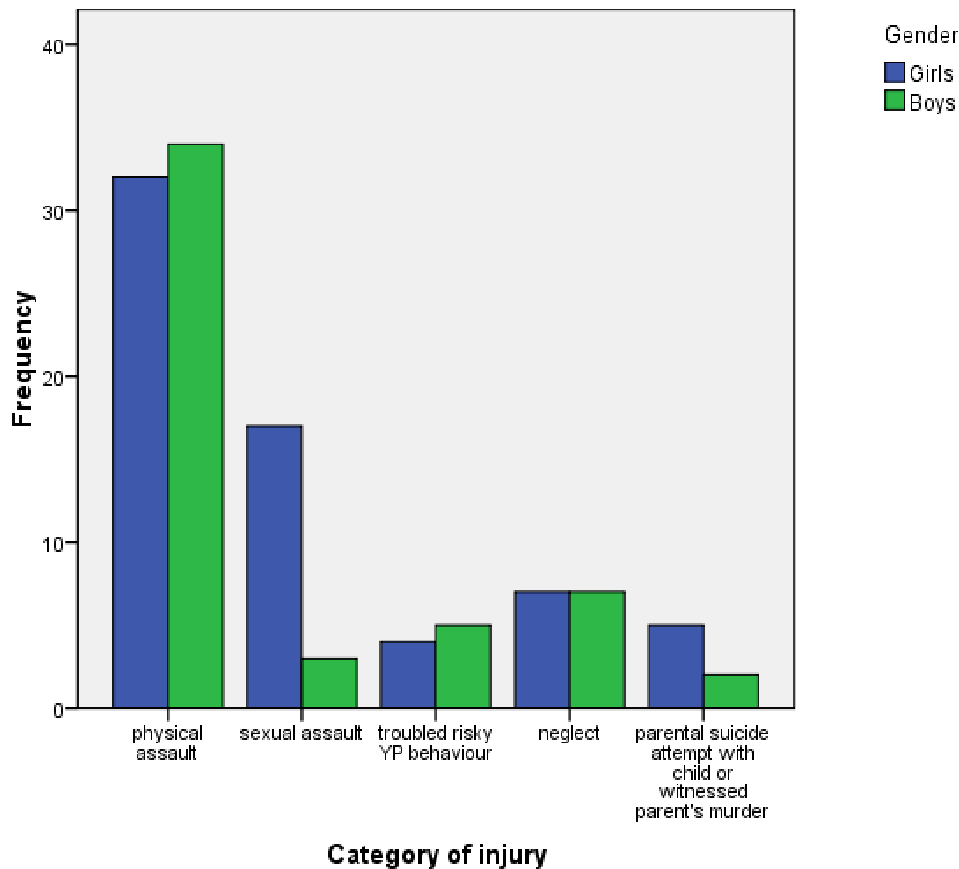


Figure 5.2 indicates that sexual abuse featured in every age band, but there were, not surprisingly, more cases involving older children or young people. However, four incidents of sexual assault involved very young children under the age of five years. Three of these four assaults were perpetrated within the family and, as in the example given below, could involve posting images of the abuse on the internet.

> *"Father linked to child pornography, investigated by FBI. Indecent images found on computer involving own children. Criminal proceedings against parents have been instigated."*

Three of the twenty children who were sexually assaulted had a child protection plan at the time of the incident which prompted the notification, whilst four children had been the subject of a plan in the past but not when the assault took place.

In under half of this group (eight cases) the sexual abuse occurred within the family but twelve children were harmed within the community with, for example, sexual abuse perpetrated by a person in a position of authority or a person known as a friend of the family. Sexual abuse is the category of maltreatment which is most likely to occur outside of the family setting and to result from behaviour by non-family members.

A small number of children were alleged to be sexually abused by their foster carer.

> *"Alleged sexual abuse of X by male foster carer alerted to EDT. The foster carer has been charged and is currently remanded to custody. A complex case investigation is underway. This is a complex case involving more than ten children and has involved more work than key agencies envisaged in their original planning."*

In this example, as in a number of others, there were concerns about wider risks of harm to other children, extending back over time, and /or involving other children and young people in the community.

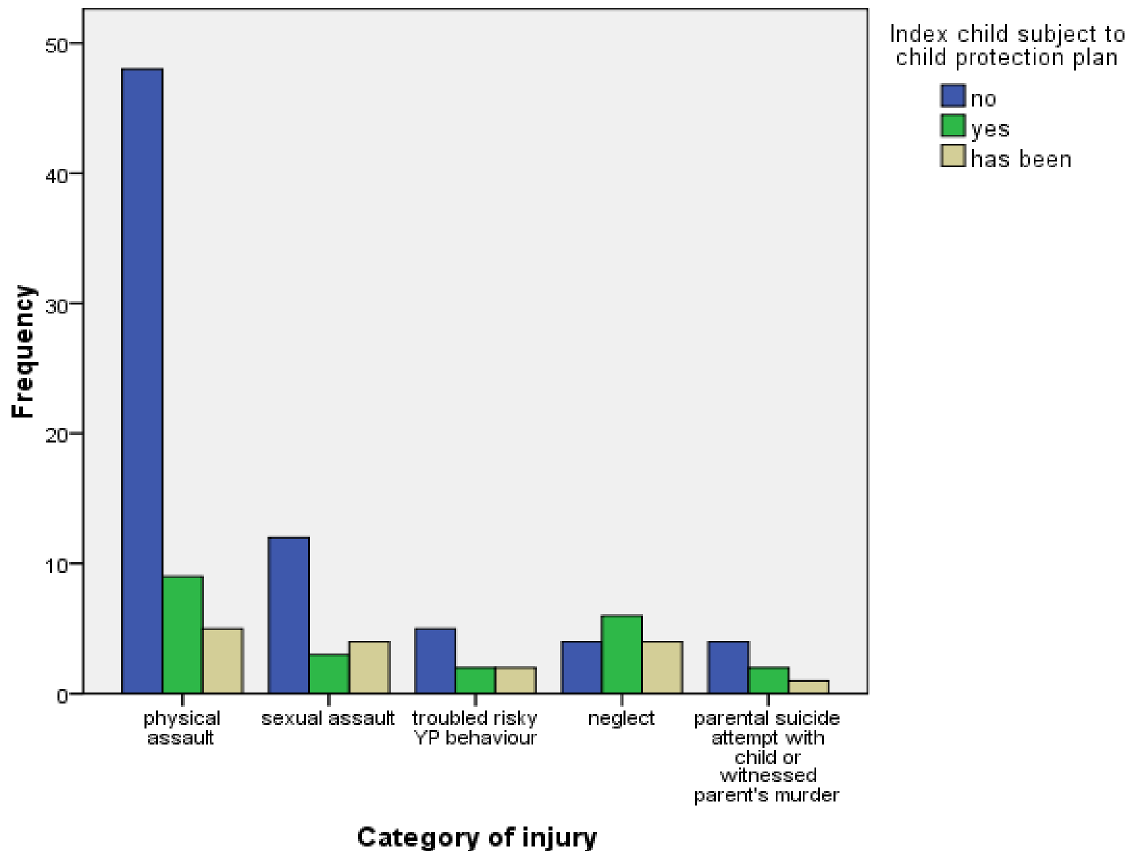
5.2.3 Neglect

In this category we included not only cases of extreme neglect, such as malnutrition, but also accidents which were likely to be related to parental neglect, for example ingestion of parents' drugs or burns sustained where parental supervision was absent. There were fourteen cases (12% of the incidents) where neglect was the over-riding characteristic of the child's caregiving, although we know neglect is very often a subsidiary factor present in physical injury cases and in the backgrounds of young people who harm themselves, or are violent or engage in risk-taking behaviour. Neglect featured across all the age bands, with at least one case in each of the age groups, and girls and boys were equally affected. (Figure 5.2 gives more detail about the children's ages in the different categories of injury.)

Figure 5.4 shows that six of the fourteen children had a child protection plan at the time of the incident, and a further four had had a plan in the past. Thus, ten of the children (71%) had known child protection concerns and previous or continuing high-level involvement with children's social care. This presents a particularly striking contrast with the category of physical assault, where only a minority of children (21%) had known child protection concerns and either a current or past plan for their safety. This underlines the need for neglect to be given a higher priority and to be considered with some urgency. We found in our previous study (Brandon et al 2009) that labelling a case as 'neglect' can blind professionals to other sources of harm and also lead them to

believe that neglect is somehow not as serious as other forms of maltreatment. We also found that the chaos apparent in the lives of many families where neglect is present was also reflected in professional responses to the child and family. The University of Stirling and Action for Children have been commissioned by the Department for Education to produce multi-agency training materials on neglect.

Figure 5.4: Child subject to protection plan and category of non-fatal injury (n=116)



Since children who are neglected are more likely to be known to children's social care and other agencies, and to be part of the child protection system there is, potentially, more scope to protect neglected children more robustly. It is difficult to know whether the barriers to achieving this come more from the mind set of neglect being less serious or from the confusion and emotional turbulence that is projected from these complex families. Barriers also come from practices in the court system where the threshold criteria for significant harm may be harder to meet in neglect cases.

The small number of severe malnutrition cases concerned not only pre-school aged children but also teenagers as the following examples illustrate:

> *"X (aged 3) had been neglected by his parents so there were serious issues of failure to thrive. Child was seriously under weight and had developmental delay. Alleged abusers are his parents."*

"Admitted to hospital (age 13), severely low haemoglobin levels, near fatal, also severe malnutrition, anaemia and poor growth, height and bone age equivalent to a 9 yr old."

All but one of the neglect cases occurred in a family context. There was one case, however, where the neglect happened in an institutional setting. In this instance a serious injury occurred while the child was unsupervised and the institution could not explain the circumstances which gave rise to the injury.

5.2.4 Risk-taking or violent behaviour by the young person

Risk-taking or violent behaviour was apparent mostly among the older young people (all but one were aged 11 years or over), was almost as common among girls as boys, and accounted for nine cases (8% of the serious incidents). Risk taking behaviour included drug or aerosol misuse and attempted suicide. The following example concerns a young pre-teen aged boy:

"X was found unconscious in his bedroom as a result of using aerosols…. he was on a life support machine but is making some improvement at the moment. X and his family were known to a number of agencies. Concerns have been expressed by agencies regarding possible neglect. It is thought that the mother may have mental health problems and that the father has poor health … neglect has featured throughout X's life."

In addition there were three reviews relating to acts of violence perpetrated by the young person, two whose victims were peers and one whose victim was an adult.

"X was convicted for sexual assaults and placed in [Secure Unit]. A previous allegation had been made against him, but was not substantiated. X experienced periods of foster care as a young child and both parents appear to have had a history of offending and alcohol misuse. X was accommodated two years ago under section 20, after alleging he had been thrown out of home by his mother."

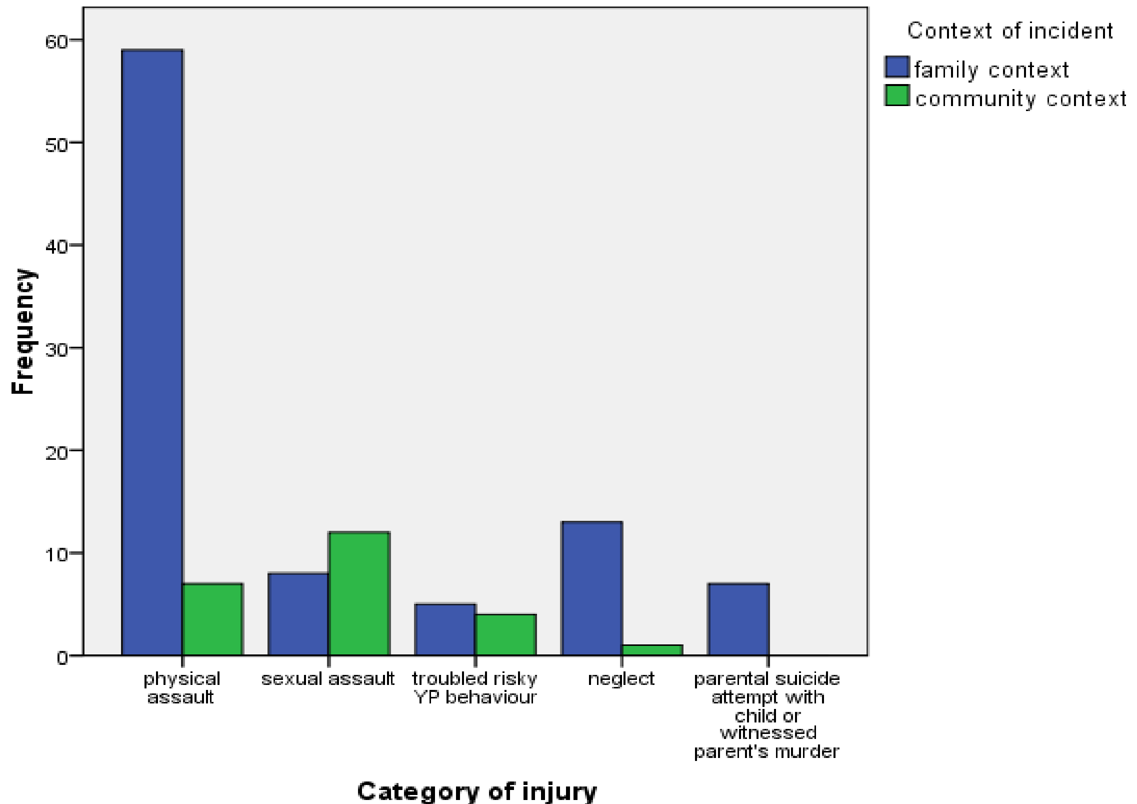
"X is charged with stabbing Y. X was known to the Leaving Care Services and was not believed to be at risk, or a risk to others. Currently it seems unlikely that his involvement in the incident was planned or predictable."

Two young people had a plan in place at the time the incident occurred, and two had been the subject of a child protection plan in the past.

Since this category of risk taking and violent behaviour involved older young people, it is perhaps not surprising that nearly half of the cases involved community level harm. Older young people are more likely than younger children to be out in the community and their behaviour is more difficult to contain and control. It is also harder to protect older young people from harm perpetrated by their peers or older adults or from within the family. This harm can also turn inwards in the cases of attempted suicide. One case of attempted suicide involved a young person living in a residential setting:

"X attempted to commit suicide by hanging - she was found, resuscitated and transferred to hospital - she suffered significant impairment of health although the long term prognosis is unknown."

Figure 5.5: Family or community context and category of non-fatal injury (n=116)



5.2.5 Parent's suicide attempt with child, or the child witnessing the murder of a parent

A small number of children seven (6%), were harmed through either a parental suicide attempt combined with an attempted killing of the child/ren, or through witnessing the murder of their parent. In these circumstances the children might have suffered both physical and emotional harm, with trauma likely to emerge from witnessing and experiencing such events. The cases related to five girls and two boys, aged between three and fifteen years and all took place within a family setting. Three of the seven children were already the subject of child protection concerns; two had a plan in place at the time of the event, while another had been the subject of an earlier child protection plan.

"Mr and Ms X were separated due to domestic abuse. The case was open to CSC because of the domestic violence concerns but had been recommended for closure the previous month. The children were staying with their father. The police were called but by the time they came Ms X was dead from multiple stab wounds."

Chapter 5 Summary

- The analysis of 116 cases of *serious injury and harm* led to a five-fold classification incorporating: 1) physical assault, 2) sexual assault, 3) neglect, 4) risk taking or violent behaviour by a young person, and 5) parental suicide attempt with the child, or the child witnessing a parent's murder.

- Severe but non-fatal physical assault was the largest category of serious injury, comprising 66 (57%) of the 116 incidents, and was primarily inflicted on babies aged under one year within a family context.

- Seventeen of the twenty incidents of sexual abuse involved girls. This was the form of harm most likely to occur outside the family setting.

- There were 14 cases, across all age groups, where neglect was the primary cause of the incident. In contrast to the other categories of serious injury, the majority of these children (10 of the 14) were the subject of a current or past child protection plan.

- Nine of the 116 cases of serious injury concerned risk-taking or violent behaviour by a young person. Nearly half of these happened in a 'community context'.

- SCRs conducted for serious injury to a child are more likely to feature neglect and sexual abuse than reviews undertaken for children who die. Approximately three in ten of serious-injury reviews arise from neglect or sexual abuse, in comparison with only a very small number of the fatal reviews.

- The United Kingdom is unusual in combining reviews of cases where children are seriously injured through maltreatment with cases where children die. Most international studies of serious child abuse focus solely on child fatality, which perhaps limits learning about neglect, sexual abuse, and other serious, non-fatal harm to children. The English (and UK wide) serious case review process offers a valuable opportunity for understanding the lessons which arise from non-fatal child abuse, although this does increase the volume of cases reviewed. The increase in the number of cases reviewed during 2007-09 may not be tenable.

Chapter 6: Reflections on the learning from the three biennial reviews

The prime purpose of a serious case review is to learn lessons to improve the ways in which individuals and agencies work to safeguard and promote the welfare of children. The newly revised *Working Together* (HM Government 2010) emphasised that this is about individual and collective working (not just about working together) and that the lessons need to be acted upon quickly. The understanding of the child and his or her daily life experiences should be at the centre of the review and the learning. Serious case reviews are not enquiries into how the child died or was seriously harmed, and are not part of disciplinary processes.

Being able to carry out three consecutive biennial analyses of serious case reviews in England stretching back to 2003 (Brandon et al 2008, 2009) has provided helpful continuity. It has enabled the researchers to develop, over a six year time frame, a close understanding of serious case reviews and of the different sources of information held in relation to these reviews and the child who is at the centre of the process. We have been able to amass findings, build on existing knowledge about serious child abuse and fatality and develop new ways of thinking about safeguarding practice. Appendix 1 presents some findings across the six years.

The child protection database, which records the initial notification to Ofsted, has improved during the six year period yielding fuller and more reliable data. Working from this, we have been able to build up a dataset of 618 serious case reviews relating to incidents which occurred between 1st April 2003 and 31st March 2009. This dataset offers an internationally important source of information which can be explored for current and future learning.

6.1 Learning about the SCR process

In the cases from 2007-2009

When children die and maltreatment is known or suspected to be a cause, a serious case review must be carried out. When serious injury or harm cases are notified, however, LSCBs have to decide based on the criteria in *Working Together* which cases should be reviewed. There is often little to distinguish between those serious injury or harm cases which do and those which do not become a serious case review.

The increase in the proportion of reviews relating to serious injury, and the new types of cases being reviewed, indicates that wider issues are being brought into the remit of serious case reviews, for example street level violence, and more cases of non fatal sexual abuse. While this extends the debate and the learning, it demonstrates the weight of responsibility resting with the serious case review process to try to tackle both new and longstanding problems linked with child maltreatment. The increasingly ambitious scope of many serious case reviews reflects this burden and begs the question of whether serious case reviews should continue to expand or be used more selectively. Some LSCBs are finding and using creative methods to review serious injury/harm cases, outside of the serious case review process, in ways that may improve the learning.

It is important to bear in mind that the substantial increase in serious case reviews (especially serious harm cases which have risen by 111% since 2003-05) does not necessarily reflect a parallel increase in practice failings. The current analysis has revealed that the incident that prompts a serious case review is not always prompted by

poor practice. Children can die even when practitioners have acted in an exemplary fashion.

Policy implication of the increase in serious harm cases

The policy implication, firstly of the substantial rise in the number of serious harm cases progressing to a serious case review and, secondly, of the uncertainty about which serious harm cases to review, **is to give consideration to taking serious harm cases out of the serious case review process.** This would be in line with most other countries' enquiry processes into child death through abuse.

Alternative, less time consuming, possibly non-paper based reviewing processes could instead be considered for serious harm cases that would otherwise have progressed to a serious case review. A number of reviewing models are already being used in this way. It is important to continue to capture learning from serious harm cases as these will include examples of neglect and sexual abuse which, as this study has shown, rarely feature in the fatality cases but which do prompt particular learning.

Summary of learning about the serious case review process in the cases from 2005-2007 (Brandon et al 2009)

The 2005-07 study examined the serious case review process through 24 interviews with those closely involved with either the child, and his or her family, or the SCR process (Brandon et al 2009, Chapter 4). In summary,

- **Scoping** of reviews needs to be managed carefully so that it is possible to make sense of the child and his or her circumstances and services offered within a current and a historical family context. Some areas kept the scoping timescale brief and manageable, but captured good information about the child and family through a succinct summary of early family history or a 'light touch' chronology.

- **Family involvement** was often common practice and learning from the child death overview processes was helpful in normalising this. Reasons for not involving family members mostly revolved around delay prompted by ongoing court proceedings and family sensitivities.

- **Practitioner involvement**: None of the practitioners interviewed felt adequately involved in the SCR process or its subsequent learning. This did not help the lasting distress practitioners experience when involved with families where children die through abuse.

- **Embedding the learning** in practice was taken seriously. Examples of positive practice in monitoring recommendations and making them achievable were given. Dissemination of learning included briefing seminars, training events, newsletters and bulletins or brief reports outlining key issues.

6.2 Recurring findings from the three biennial reviews:

Agency involvement and thresholds

Our findings indicate that approximately half of the children at the centre of the review are not known to children's social care, so safeguarding children really is 'everyone's responsibility'. It is particularly important that the responsibility for protecting babies and pre-school aged children is shared since two thirds of all serious case reviews concern children under the age of five (and half are for infants under twelve months). These proportions have remained constant over the six years. Many of the very young children do not come to the attention of children's social care, so the role of GPs, midwives and health visitors, and other early years provision like Sure Start Children's Centres, is crucial for this highly vulnerable group. All practitioners working with children and in services for adults need to be aware of the risk factors for children who are likely to suffer significant harm across all levels of need and intervention.

Professor Munro's review will consider the interface between universal services and social work teams asking: *"How can interaction between social work teams and universal services for children and families be improved? .... In particular, how can Sure Start children's centres and health visitors make sure that the families who need the specialist input of social workers are identified effectively?"* (Department for Education 2010). The call for evidence seeks submissions on how responsibility for the assessment and management of risk is shared between universal services or the various professionals involved with children's social care. The 40,000 or so child care social workers in England make up only a small proportion of 'front line staff' and cannot work with all of the estimated ten per cent of the child population who are maltreated (CWDC 2008, Gilbert et al 2009). Our findings reinforce the understanding that many children about whom abuse or neglect may be 'considered' rather than 'suspected' will not meet thresholds for services from children's social care. NICE guidelines on maltreatment acknowledge this group of children and accept that they need on-going management from health staff (NCCWCH 2009).

Many of the cases over the six years clustered just below the threshold for services from children's social care and also at the boundary between 'children in need' and 'child protection'. There was often a hesitancy about whether or not this was a 'child protection case' and a preoccupation with thresholds and which professional group was 'responsible' for the child (Brandon et al 2008:91). However, approximately half of the children were known to children's social care at the time the death or harm occurred. A sizeable minority of almost a third of the children were considered to be suffering, or likely to suffer, significant harm, with either a child protection plan being in place at the time of the incident or in the past.

The children's ages

There are recurring themes about the particular vulnerability of many of the babies at the centre of the reviews, especially prematurity, time spent in intensive neo-natal care, drug addicted babies, and 'difficult' babies. All these factors present particular stresses for caregivers, and potentially dangers for the baby, especially where the family is already struggling and experiencing other difficulties (Brandon et al 2009 Chapter 3). An awareness of public health messages can contribute to the safety of many of these youngest children. This includes the dangers of overlying from falling asleep with a baby (especially in a chair) after having consumed any alcohol or drugs (Brandon et al 2008:102).

Although children aged between six and ten years who die through abuse have been the focus of major inquiries into the child protection system (for example Victoria Climbié and Maria Colwell) they make up only about ten per cent of all serious case reviews. Children of this age are in the 'latency' period of development and may be 'easier' to care for. They are also almost all in school where there can be ordinary but successful oversight of their well being. However, children of this age still suffer maltreatment and are the most likely to be seen at hospital accident and emergency departments with unexplained injuries that could be attributed to abuse (Woodman et al 2009).

The deaths or serious injury of older young people regularly make up a quarter of all serious case reviews. The legacy of living with maltreatment is easily overlooked for these young people who may pose a risk to themselves (including a risk of suicide) and/or to others. The tendency for vulnerable 'hard to help' adolescents to be neglected by agencies, who give up on these challenging young people because their needs have become too overwhelming, was first identified in the 2003-2005 study (Brandon et al 2008 Chapter 5). This finding has also had resonance in the two later reviews (Brandon et al 2009 Chapter 3 and this study Chapter 4) and in other studies (Stein et al 2009).

Family Characteristics

Following the earlier work of Cleaver et al (1999) we have identified a potentially 'toxic trio' of parental substance misuse, violence and mental health problems which often co-exist. These factors are often compounded by poverty, frequent house moves and/or eviction. These cumulative problems and adversities are not uncommon and present significant risks factors for children; however, in individual cases, they do not act as 'predictors' for serious injury or death. Using an ecological transactional approach to analysis (as described in the next section) helps in understanding not only the underlying reasons for parental behaviour, but also the impact of these cumulative harms on children. It helps practitioners and supervisors to gauge children's safety and wellbeing in a systematic but nuanced way.

Large families were over-represented in each of the three studies. The extra stresses within large families can result in additional risks of harm to children who are lost as individuals, and professionals may focus attention on one particular sibling or on the parents' needs. In a large family of children with complex needs, the involvement of many agencies can lead to problems such as an overload of information, poor inter-agency communication, and an assumption that others are addressing the problems and needs of the family. Vulnerability was also highlighted for the youngest in the family in general, including for large families.

6.3 Ways of thinking about safeguarding practice

Some new themes and new ways of thinking about safeguarding practice have emerged from the analysis over the six year period. Other recurring messages are reminders about what is already known about good practice:

The ecological transactional approach to the analysis adopted at each stage has provided a theoretical framework for thinking about the dynamics of interactions between children, carers and agencies and the way that different risks of harm combine and interact to influence children's development and safety. This model, in some respects, extends the work of Reder and Duncan (Reder and Duncan 1993, 1999), although it relies more on learning from developmental psychopathology (for example Cicchetti and Valentino, 2006). It helps us to understand parenting capacity primarily in terms of the caregiver's psychological sensitivity and availability to their child. A major

predictor of poor parenting is a lack of understanding of the psychological complexity of children, especially babies (Sroufe et al 2005).

We explained in our 2003-05 study that maltreating parents' complex patterns of behaviour and responses are in part derived from their own past experiences of relationships (Brandon et al 2008, chapter 4). Parents' current resources and ability to keep their children safe are challenged by social and economic factors like poverty and community violence and other hardships which affect their capacity to be attuned and sensitive to their developing children (Brandon et al 2008:61, Howe 2005). A dynamic ecological explanatory view of parent-child interaction should allow practitioners to spot warning signs of abuse at an earlier stage, based on less information. It is what is done with information, rather than its simple accumulation, that leads to more analytic assessments and safer practice.

Building strong relationships with children and families and compassion is crucial to reducing maltreatment, but trust needs to be placed with care, and 'respectful uncertainty' towards families, and interest and curiosity in their narratives, needs to be part of the practice mindset. To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision (Brandon et al 2008, Chapters 4, 5 and 6; Brandon et al 2009, Chapters 3 and 6). The emotional and intellectual demands on social workers are substantial; this and their need for high quality supervision and support has been accepted by the Social Work Task Force. These are also key questions for Professor Munro's review which is considering *"How can social workers be supported to have the confidence to challenge difficult families".*

Patterns of cooperation including hostility, non-compliance and deception by families were a recurring theme in the 2003-05 and 2005-07 studies (Brandon et al 2008, Chapter 5 and Brandon et al 2009, Chapter 3). Persistent non attendance at appointments can be part of a pattern of non-cooperation and signal risks of harm. These can include admissions/attendances at hospital and accident and emergency departments, a history of injuries, or a history of illness. Non attendance should not be an 'excuse' to close a difficult case. Patterns of hostility and cooperation or lack of compliance can change rapidly in families and is an important component of assessment information. Hostility is not necessarily unchangeable and can be modified by practitioners' positive engagement and relationship skills. A recent review published by C4EO (2010) addresses effective practice with highly resistant families.

Respectful uncertainty sits alongside the importance of sustained and dogged **professional challenge** – the ability to question, with confidence and authority, professional colleagues both within one's own agency and in other sectors. 'Respectful uncertainty' needs to be part of a practice mindset alongside rigorous, systematic thinking and analysis, and apply to both clients and colleagues (Brandon et al 2009, Chapter 6).

The 'start again syndrome', first identified in the 2003-2005 study (Brandon et al 2008, chapter 5), has proved a helpful way of conceptualising practice and decision making especially in cases of neglect. In these circumstances knowledge of the past is put aside with a focus on the present and on short term thinking. There may, for example, be an unfounded assumption that a new baby, or a different partner, presents an opportunity for the family to embark on a more successful period of parenting, without adequate professional reflection about whether the capacity to care for the child has in reality changed.

This way of thinking and behaving tends to happen when workers are overwhelmed. 'Starting again' is a way of dealing not only with overwhelming amounts of information

but also the feelings of helplessness generated by families, especially in long term neglect cases. This strategy prevents workers from having a clear and systematic understanding of a case. Starting with a clean slate can be prompted by a worker leaving (or being away on sick leave) or a new practitioner starting afresh to form an 'unprejudiced' view of the case. It can also be prompted by the courts rejecting applications for care orders and instructing workers to give families another chance to demonstrate successful parenting.

Overwhelmed practitioners formed a theme in the 2005-07 study (Brandon et al 2009, Chapters 3 and 4) where the chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response. The families' disarray was often reflected in professionals' thinking and actions so that both families and workers were overwhelmed and failed to see or take account of the needs of the child. This also occurred in some serious case reviews where the child was also 'lost'. We pointed out that practitioners who are overwhelmed not only with the *volume* of work but also by the *nature* of the work will struggle to think, understand, make good decisions and do even the simple things well. It is arguably unhelpful to describe and think of the complex matters of relationship and professional judgement as simple (Ferguson 2005, Cooper et al 2003).

Efforts to think the best of families were found in the 2005-07 study (Brandon et al 2009) and echoed Dingwall's expression 'the rule of optimism' (Dingwall et al 1983). There was a reluctance among many practitioners to make negative professional judgements about a parent. Workers, including those in adult-led mental health services, domestic violence projects and substance misuse services were keen to acknowledge the successes of the often disadvantaged, socially excluded parents who were using their services, and reluctant to see them as parents and judge their behaviour as harmful to the child. In cases where adult-focused workers perceived their primary role as working within their own sector, failure to take account of children in the household could follow.

Flexible thinking is needed about families and about the source of harm to children. There were examples of flawed professional judgement and rigid or fixed thinking in a number of cases from 2005-07 (Brandon et al 2009, Chapter 3). Once a view had been formed (as Munro 1999 and Reder and Duncan 1999 have noted before) there is often a reluctance to revise a judgement about the family, or about individual family members. Thus a 'neglect' mindset could preclude the thought that the child might also be physically or sexually harmed. In other cases 'rough handling' injuries were seen as less serious acts of inconsiderate and careless parenting rather than as an indicator of much more grave underlying concern about physical injury. Rigid thinking may also exist about father figures as 'all good' or 'all bad', and men may be perceived, primarily, as posing a threat to workers. While the father, stepfather, or mother's partner might pose a risk to the child's safety, he may, on the other hand, act as a protective presence, or have important information and insights into the children's safety.

Children were missing or invisible to professionals in a number of ways. They include young people who were hardly consulted or spoken with, siblings who were similarly not engaged, young people who were not seen because they were regularly out of the home or were kept out of sight, non-attendance at school, young people who absconded, ran away or went missing and children who chose not to or were unable to speak because of disability, trauma or fear.

Conclusion

Throughout the three biennial studies we have emphasised the complexity of each child's circumstances and the consequent difficulties professionals face in making sound professional judgements. It is the individual *differences* in each child's case that pose the most challenges for understanding and hence for practice and decision making. Although each child's circumstances are unique, children and families at the centre of most serious case reviews look very much like those children and families who practitioners encounter in their day to day work. Our argument throughout our three studies has been for the need for practitioners and managers to be curious, to be sceptical, to think critically and systematically but to act compassionately. We wrote in the 2003-05 study that it is not helpful to be sceptical in the absence of compassion (Brandon et al 2008: 106). The demands and the complexity of the task of protecting children and the importance of supporting professionals, especially social workers, to make sound professional judgments has been accepted by policy makers and, increasingly, the public. This is a promising context for the Social Work Reform Programme and Professor Munro's Review.

Serious case reviews present a lasting testimony and memorial to children who die in horrific circumstances. This must be remembered in the deliberations about learning from these reviews.

Appendix 1

Combined statistics for the six year period 2003-2009

Being able to carry out three consecutive biennial analyses of serious case reviews in England (2003-05, 2005-07 and the current report for 2007-2009) has enabled the researchers to build up a dataset on 618 incidents which occurred between 1st April 2003 and 31st March 2009. Key information relating to the children's age, gender and ethnicity, in addition to whether the incidents proved to be fatal, is given in Table A.1.

Table A.1: Combined data 2003-2009

	Frequency 2003-09
Total number of serious case reviews:	618
Incident type (n=618)	
Fatal	381 (62%)
Serious injury	237 (38%)
Gender (n=617)*	
Male	331 (54%)
Females	286 (46%)
Age (n=618)	
Under 1 year	281 (45%)
1-5 years	136 (22%)
6-10 years	54 (9%)
11-15 years	81 (13%)
16 and over	66 (11%)
Ethnicity (n=564)**	
White	421 (75%)
Mixed	54 (10%)
Black/Black British	54 (10%)
Asian/Asian British	27 (5%)
Other	8 (1%)

* Gender unknown in one case involving an unborn child
** Information on the child's ethnicity was missing for 54 of the children and young people

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