

**Assessing the Feasibility of Using an Actuarial Risk
Assessment Tool to Identify Risks in Child Protection Cases**

One volume

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In partial fulfilment of a Doctorate in Philosophy
Bournemouth University

30 November 2011

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Assessing the Feasibility of Using an Actuarial Risk Assessment Tool to Identify Risks in Child Protection Cases

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Acknowledgements

This work was funded by a full time PhD studentship awarded by Bournemouth University.

I am very grateful for the wisdom and expertise of my supervisors, Professor Colin Pritchard and Professor Jonathan Parker and for the access to Serious Case Review reports granted by the Welsh Assembly Government Department for Health, Social Services and Children.

I should like to thank Mary Taylor for her help in proof reading and correcting the text and Bill and Rovena Harris, Claire McDonald and Ronald Howard for their valuable practical and moral support.

My husband, Graham Wood, has been my mainstay throughout everything.

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Definitions of terms used in this study

Actuarial risk assessment tool: a formal risk assessment tool based on a large scale statistical analysis of those risk factors which are more closely correlated with the subsequent occurrence of the adverse outcomes which the tool is designed to predict.

Child abuse: a form of maltreatment of a child (i.e. a person who has not yet reached their 18th birthday). It may take the form of physical bodily maltreatment or psychological or emotional actions which cause distress and hurt, or exposure to, or involvement in, sexual activities to which the child cannot give valid consent without duress and where they may not fully understand the implications of their involvement. It may also take the form of actions which induce physical illness, or create the appearance of fabricated illness in a child. Emotional abuse also includes peer bullying and the exploitation or corruption of children.

Child maltreatment: any form of abuse or neglect of a child which either results in significant harm, or is likely to do so.

Child neglect: is a form of maltreatment which takes the form of persistent failure to meet a child's basic physical and/or psychological needs, resulting in significant harm. It includes maternal lack of care for a foetus during pregnancy, such as substance misuse, and also failure to seek necessary medical attention or treatment.

Child protection: this function is seen as a part of the overall social and legal responsibility to safeguard and promote the welfare of children. Child protection services apply to those children who are suffering, or are likely to suffer significant harm.

Consensus based assessment tool: a formal assessment tool based on factors (with or without weighting) which have been agreed by a group of experts in the area to be assessed as the most important in determining risks likely to result from their effects.

Decision making: the process of making a decision

Decision: the final and definite result of examining a question; a conclusion, judgement.

Liberalism: a political term for a philosophy supporting or advocating individual rights, civil liberties, and political and social reform tending towards individual freedom or democracy with little state intervention or support and favouring free trade.

Libertarianism: Wholehearted political and economic liberalism, opposed to any social, fiscal or legal constraints on individual human freedom.

Risk assessment: the evaluation or analysis of potential hazards in an enterprise; an instance of this.

Risk: (Exposure to) the possibility of loss, injury, or other adverse or unwelcome circumstance; a chance or situation involving such a possibility.

Shaken baby syndrome: a medical term used to describe an often fatal form of brain injury in infants, with intracranial and retinal haemorrhage, caused by or attributed to violent shaking or impact to the head.

Significant harm: This term was introduced into English law by the 1989 Children Act to justify compulsory intervention to protect children. A court may make an order to receive a child into local authority care or to enable the local authority or a probation officer to supervise their upbringing of the child is suffering significant harm or is likely to do so AND that harm is attributable to a lack of adequate parental care or control. Significant harm also has to be understood in the light of the normal development of children, whether this be their physical growth, mental and intellectual development, emotional or social development towards adulthood. If a child is born with, or develops a mental or physical impairment, they may not achieve the same outcomes as a child of the same age without such impairments, but in this type of case, significant harm may include additional; preventable physical, mental or developmental impairments or disabilities which do not arise from the underlying damage or disease process.

Abstract

The problem: Risk and uncertainty are integral to child protection decisions because of the need to protect children from intrafamilial maltreatment, which is more common than abuse by strangers and occurs in the private sphere of the home. The problem of assessing intrafamilial risks to children following abuse and neglect referrals has received little attention in the UK compared with North America. Improved assessment of such risks would inform child protection plans, enabling risk reduction and improved safeguarding of children. There are currently no UK recommended valid and reliable risk assessment tools available for child protection teams, who rely on unaided professional judgement where information may be incomplete, expertise is variable and the process open to bias. Currently, UK child protection risk assessments are based on professional opinions about the range and weighting of factors associated with families where children have been abused or neglected.

Study purpose: Selecting and weighting the most significant predictive factors of risk to children by using actuarial statistical methods is more likely to lead to yield accurate risk ratings. Whilst not perfect predictors, such actuarial tools categorise cases into low or high risk groups better than unaided professional judgements or consensus based assessments. Actuarial risk assessments have not previously been tested for UK child protection work, so this study selected and applied the best available North American tool.

Method: The Michigan Family Risk Assessment for Abuse or Neglect (FRAAN) was selected on the basis of its published evidence base and applied to a cohort of UK Serious Case Review reports from Thirteen Counties (SCRs) to identify and rate pre-existing risks before the abusive event.

Further analysis of risk factors singly and in combination was extended to compare the Thirteen Counties data with two large recently published SCR studies and one study of UK child homicide perpetrators.

Findings: The FRAAN assessment scores correctly identified most cases as High or Intensive Risk. FRAAN performed adequately in identifying these very high risk cases (Sensitivity = 88%) but specificity could not be assessed using these exclusively high risk cases.

Most frequent neglect risk factors were inadequate physical care of children, unsupported primary carers and their inability to prioritise the child's needs over their own. Most frequent abuse risk factors were families not cooperating with a need for parenting improvement, prior abuse incidents, a youngest child aged <6 years and domestic violence.

Comparing those cases where children died versus those where they survived, risk factor frequencies for Deceased and Survivor groups were strongly positively correlated, showing no statistical differences between the direction of scores for the two groups. Parental substance misuse was more common in the Deceased group, whilst households where a child had a disability or delinquency problems were both more common in the Survivor group. FRAAN risk scores could not effectively distinguish between fatal and non fatal outcomes.

Comparisons between this Thirteen Counties study dataset and a UK study of child homicides and two major recent reviews of SCRs demonstrated no statistical differences between the ages and sexes of the children, the causes of death and parental characteristics, except for in the cases of men with convictions for violence, which were possibly under recorded in SCRs. Key risk factors in all the studies were parental mental illness, chaotic neglectful families and substance misuse. These factors appear to distinguish high risk families where there are further risks of fatal child abuse.

Conclusions: The use of formal risk assessment tools is likely to help child protection teams identify cases where extra support, or substitute care, is required to protect children at high risk of further intrafamilial maltreatment. The use of such

tools in low and medium risk cases was not tested in this study due to lack of access to a mix of cases.

Policy, practice and further research directions are recommended to extend the testing of the FRAAN risk assessment tool.

Chapter 1

Introduction

This chapter outlines the area of concern for this study, the current gap in provision of risk assessment tools for professional practice in child protection and the problems of the current approach to cases where children suffer serious harm from neglect or abuse.

The motivation for this work arises from awareness of the value of standardised tools for risk assessment in other areas of professional practice and concern about the blaming of professional practitioners when current child protection efforts fail to prevent the subsequent injury or death of a child.

1.1 The purpose of this study

The issue of risk in child protection decisions about children who have already been referred or reported to child protection services has had limited attention in English and Welsh child protection guidance. This is surprising in an area where risks are a key concern for professionals and policy makers alike because it is not feasible to simply remove all children who may be at risk of further maltreatment from their homes. Although such drastic responses have been discussed (Brandon 2001), the costs of providing substitute care for any child who was considered to be at any risk of further maltreatment would be prohibitive and the potential public response can be gauged from the media furore over the use of 'Place of Safety' Orders in Cleveland in the 1980s (Donaldson and O'Brien 1995). In practice, most child protection cases do not result in children being removed from their birth families and they remain at home. Given the privacy of the family home and the broad freedom of parents to bring their children up as they choose, there has to be trust between parents and child protection professionals who are trying to help them and their children. Child protection plans are made collaboratively and the professional

expectation is that parents will not re-abuse or neglect their children if they receive the help and support of the child protection services. This expectation extends to policy makers, who expect that child protection services will prevent children suffering and that perceived failures to protect will result in Serious Case Reviews (Laming 2009).

In spite of this importance of preventing future harm to children subject to child protection plans, no formal methods have been introduced to help professionals take the complex and sensitive decisions involved. Child protection teams currently rely on professional judgement rather than formal risk assessments when assessing risk of a child suffering future neglect or abuse when they remain with their families following initial recognition that neglect or abuse has occurred. Professional judgement is flexible and informed, but in urgent, complex and emotive situations where information is incomplete, it is difficult. Expert professionals make sounder decisions than novices (Hutton and Klein 1999), but individual human decisions remain exposed to human error and bias (Munro 1996, Munro 1999, Rzepnicki and Johnson 2005). Professional use of decision support methods and standardised tools for assessment, including risk assessment, are well established in complex professional practice in psychology and medicine without undermining professional expertise or responsibility.

Standardised assessments should not be used without knowing their applicability, their strengths and weaknesses. The task of this study is to assess the feasibility of using a formal risk assessment tool to identify those children who are most at risk of abuse or neglect following initial referral. Since abused and neglected children may suffer injury or impairments which may affect their long term developmental outcomes, it is important to be able to identify those at greatest risk as early as possible and prevent further significant harm.

The thesis begins with an overview of the social policy context, and a review of the published evidence for a range of risk assessment tools. Early risk assessment tools

have previously been based on professional consensus about the range and weighting of factors associated with families where children have been abused or neglected (Powell 2003). The difficulty in choosing and weighting the most significant predictive factors of risk to children has been addressed more recently using actuarial statistical methods to identify the most significant factors. While these actuarial risk assessment tools cannot be perfect predictors in any of the areas of decision making where they are used, such methods of risk assessment generally demonstrate better identification of high risk situations than either unaided professional judgements, or consensus based assessments (Meehl, 1954, Grove and Meehl, 1996).

1.2 Aims

This study considers whether a North American developed actuarial risk assessment questionnaire tool can be used to identify risk to children in British child protection cases, using data derived from Serious Case Review files. It also looks at whether the most serious outcomes (those resulting in the death of a child from neglect or abuse) can be predicted from their risk scores before the incident which led to the Serious Case Review.

To establish the potential usefulness of a child protection risk assessment developed in another society, this study will test the feasibility of using a particular empirically based risk assessment tool developed for child protection teams in North America to identify the risks to children in UK cases. The risk assessment tool chosen is the Michigan Family Risk Assessment for Abuse and Neglect (FRAAN) (Baird et al. 1995). FRAAN was designed to identify those cases which were more likely to lead to re-abuse within a period of six weeks from initial reporting of a child protection case. A second part of the research considers whether this risk assessment model can identify those cases where children died as a result of intrafamilial abuse or neglect, since this is the worst outcome from any child protection process.

1.3 The background to this study

This study stems from the sense of frustration expressed in successive inquiries and reviews of child deaths resulting from neglect and abuse within families (Blom-Cooper 1987, Blom-Cooper 1985, Brandon et al. 2009, Brandon et al. 2008, Department of Health 1991, Field-Fisher 1974, Laming 2009, Laming 2003, Reder and Duncan 1999, Rose and Barnes 2008) The objective of such reviews was to learn lessons from such tragic cases and identify missed opportunities to protect children from serious harm and in many cases, death. Although deaths from maltreatment have fallen over the years since the death of Maria Colwell in 1973 (Pritchard and Sharples 2008, Pritchard and Williams 2010), such reviews suggest that human and organisational failings can still lead to risks being overlooked (Laming 2009, Laming 2003).

The cases reviewed by published inquiries have also led to media criticism of child protection services, particularly social workers who have been responsible for helping families and children, but increasingly, including managers and heads of services (Haringey Local Safeguarding Children Board 2010, Patrick 2001, Parton 2004). It is clear from reviews of cases that parents can and do maltreat children and that both lawyers and researchers who have reviewed such cases believe that if information had been shared and brought together in a timely manner and child protection professionals had learned the lessons of previous reviews indicating risks to children, at least some of the deaths might have been prevented. Censure of professionals and their managers seems unlikely to help, but practical risk assessment tools may offer child protection teams better support.

The cases involving child deaths and other forms of serious harm represent the most dramatic outcomes for children and families, but such cases lie at one end of the child protection spectrum, if not in a particular category of their own. They are not representative of the bulk of child protection work, since most child protection cases result in children not being seriously harmed and surviving any neglect or abuse they experience. Child deaths attributable to maltreatment appear to be decreasing

in numbers in the United Kingdom and have been for some years ((Pritchard and Butler 2003, Pritchard and Sharples 2008, Pritchard and Williams 2009, Pritchard and Williams 2010). .

In spite of the rarity of child deaths, there is an expectation that child deaths can be prevented and that such serious consequences of child abuse ought to be prevented through effective social work interventions (Parton 2004). The responses of policy makers since the inquiry into the death of Maria Colwell (Field-Fisher 1974) have been to increase the volume of child protection guidance and prescribe processes and documentation for professionals to complete complete (Cleaver et al. 1999, Department for Children Schools and Families 2009a, Department for Children Schools and Families 2005, Department for Education and Skills 2003, Department of Health 1991, Department of Health 1995a, Department of Health 1988, Department of Health et al. 2000a, Department of Health et al. 2000b, Department of Health et al. 1999, HM Government 2006, HM Government 2010, Home Office et al. 1991, Laming 2009) This plethora of guidance, frameworks, documentation and information systems presents problems of its own when it fails to fit with professional ways of working and results in increasing bureaucratisation of child protection work, audits of compliance with guidance and a range of challenges to professional discretion and naturalistic decision making (Broadhurst et al. 2009, Calder 2003, Pithouse et al. 2009, White et al. 2008, White et al. 2009) . It is also argued that such structures tend to push practice towards gathering specific information rather than building a relationship with clients and can divert professionals from their focus on helping families towards simply estimating risks (Pithouse et al. 2009, Stanley 2006). This study will consider this theoretical debate about the value of risk assessment in child protection within the social policy context in which it has been conducted to date.

Chapter 2

The Social Policy Context of Child Protection in England

2.11 Introduction

This chapter will outline the successive child protection related social policy developments in England between the 1940s and the present day. Alongside the instigation of change and the development of policy are two main series of factors which influence policies. These are the development of theoretical and empirical understanding about that group of behaviours which we have come to class as ‘child abuse’ and child neglect’. There have also been changes in the understanding of the nature of the child, their development and the causes of parenting problems. Secondly, the influence of major child protection cases, inquiries and expressions of public concern can be very powerful for elected politicians at any level of government, because it makes the current system appear to be failing children and their families.

2.12 The Family and the State

Since the Industrial revolution, the family has been the target of advice and charitable interventions to relieve poverty and destitution. The condition of poor families in cities came to the attention of Engels and Mayhew in the nineteenth century (Engels 2005, Mayhew and Douglas Fairhurst 2010) . The exposure of the conditions of families living in such absolute poverty led initially to philanthropic responses, but in the twentieth century these early responses were increasingly supplemented and replaced by government policies to support families and children (Beveridge 1942, Blair 1999, Department of Health 1995, Madge 1983, Parton 2006).

The public policies to promote family welfare and public health also led to a concern for how families used such help and whether it was effective (Madge 1983). Partly,

this arose from a concern about the fiscal costs involved in helping families, but also because there was limited evidence that such support helped to prevent future children following their parents into poverty in an intergenerational ‘cycle of deprivation’ (Jordan 1974).

Each culture has its implicit norms relating to child rearing and family life (Archard 1993). Protection of children from neglect or other maltreatment within their families implies that the state has an interest in what happens within family life, which is normally considered to be a private sphere where day to day decisions are taken by adults on behalf of children and where the adults act in the interests of their children. The state interest in children as future citizens and the scope of intervention has changed over time, but within the UK the welfare model for state policy in this area will be considered since the Second World War.

Even the most radical government cannot start with a clean slate in terms of public policy. Previous events and legislative decisions have shaped our society and its institutions. In addition, there are pressures of events. In a liberal democracy with a wide range of press and broadcast media as well as the internet, public opinion constitutes a major pressure on politicians and institutions. These factors form the basis for policy on children and families and for dealing with maltreatment of children.

The policies a society develops in relation to the safeguarding of children are influenced by the predominant social construction of abuse and neglect (James and James 2001). James and James (2001) argue that the way in which childhood is framed and constructed by any society is reflected through its values in the laws that it passes to protect and regulate children and young people and that in this social sense, family law is an integrative mechanism which brings together the different perspectives into policy affecting children’s lives (James and James 2001). This common language is the means society uses to express its dominant moral values and its constructs of right and wrong. In the context of this study, it is essential to

consider how legislation and social policy affecting children and families has developed.

From a philosophical point of view, Hacking (1988) argues that societies construct moral perspectives based on their social beliefs about the rights and wrongs of specific types of behaviour and phenomena. In his 1988 paper, he argues that our understanding of the concept of child abuse is recent, dating back for about 50 years (Hacking 1988). He points out the surprising heterogeneity of the activities covered by the term 'child abuse'. For example, the activities involved in infanticide or neglect by a mother of an infant are very different from the sexual abuse of any child or the viewing of child pornography produced by that abuse, but both are included under the idea of child abuse or maltreatment and this confuses our initial reactions of moral certainty about the inherent wrongness and heinous nature of child abuse.

The current UK divisions of registration of cases of child maltreatment into types such as physical abuse, neglect, emotional abuse and sexual abuse are different from those which were included in Kempe's original ideas about the battered child (Hacking 1971), but even these current categories do not adequately cover actions such as abandonment, exposure to domestic violence or pornography, peer bullying, fabricated illness and infanticide (Kempe 1971a). Hacking (1988) describes the idea of abuse and neglect as 'malleable and expansionist', tending to include a wider range of behaviour over time, but they have originated from a class of concepts which were believed to have been linked, although time has eroded our certainty about their conceptual and ontological similarity and the links. In addition, there are ideas from psychiatry about the nature of the kinds of behaviour that are described as personality disorders or paedophilia and the definitional problems of risk or dangerousness or significant harm, as well as ideas about what kind of action constitutes an offence against a child and the culpability of the agent responsible. Child maltreatment currently comprises direct physical, psychological, emotional and sexual abuse as well as neglect (Department for Children Schools and Families 2010). It is also currently extended to cover exposure to pornography or adult domestic violence as well as fabricated illness and obesity or malnutrition from poor

feeding. These are strikingly diverse behaviours, but their common basis lies in their direct and indirect effects on the safety, health and development of children.

The direction of this chapter follows development of policies together with events over time. The chronology of child protection related policy is influenced by political and social policies, together with the prevailing ideas and understandings about the development of children and the responsibilities and rights of families within society. Alongside this underlying policy and theory base runs the powerful influence of a number of high profile inquiries into the deaths of children following abuse or neglect. Such inquiries have also sought to identify the reasons why children already known to have been abused remained exposed to risks at home or in care settings (Department of Health 1991). There was a series of inquiries which began in the early 1970s with the report on the death of Maria Colwell in 1973, published in 1974 (Field-Fisher 1974) and these were widely covered in the popular media. This marked a difference from deaths of children under similar circumstances in the 1950s and 1960s and there were further highly publicised cases over the next decade. Policy is sensitive to public opinion and to media coverage because it is in itself a powerful political process (Walton 1993). The individual reports and the trends in published studies identified by Behl et al (2003) have helped to develop our present understanding of the phenomenon of child maltreatment. They help form prevailing social and moral perspectives as well as influencing current systems and legislation.

2.4 The scope of child neglect and abuse

In current English law, evidence of neglect and abuse lies in the likelihood, or occurrence, of 'significant harm' to the child, as outlined in guidance on Section 47 of the Children Act 1989 (Home Office et al. 1991). Under s31(10) of the Children Act 1989, 'significant harm' means ill-treatment or the impairment of health or development of the child compared with that of a similar child, including, for example, impairment suffered from seeing or hearing the ill-treatment of another (Home Office et al. 1991). The significant harm (actual or potential) must be

considered to be due to the actions or inactions of the child's family or carer. 'Development' means physical, intellectual, emotional, social or behavioural development, 'health' means physical or mental health; and 'ill-treatment' includes sexual abuse and forms of ill-treatment which are psychological or emotional (HM Government 2006).

The concept of significant harm distinguishes those children who are in need of protection, as opposed to be in some more general state of need. One important point about the potential significant harm, which a child is likely to suffer if there is no child protection intervention, is that this implies that the child is *at risk*. Despite this implicit risk, no current tool for child protection risk assessment is included in the recommended standardised assessment tools (Department for Children Schools and Families 2010, pp. 350-352). This is unfortunate, because the risk of significant harm remains a contentious idea (Ayre 1998). It means that more insidious forms of maltreatment such as chronic neglect, emotional or psychological abuse, which do not produce clear signs of acute injury, can be considered to be less obviously harmful than a physical assault. Ayre (1998) finds that this tends to shift professional focus from the experiences of the child onto the attitude of the parents in assessing risk of harm. He also points out the problem of gradual professional acceptance of a degree of chronic harm to the child when parents are resistant to making real change (Ayre 1998).

Newer forms of abuse include harm resulting from more indirect activities such as child pornography (which is certainly not indirect for the children abused in its creation), domestic violence, exposing children to adult sexuality or violence which they cannot comprehend and the creation of fabricated illnesses all seem to risk the same problem where there are no signs of immediate physical harm to the child. Although our concept of child abuse has expanded to include other forms of harm, the lack of clarity on risk to children may make it more difficult to identify boundaries to potentially harmful parental behaviour.

The main chronological pivot points for social policy in relation to child abuse since 1948 are marked by the Children Act 1948, the Seebohm Report in 1968, the inquiry reports on the case of Maria Colwell in 1974 and the subsequent inquiries into the deaths of individual children during the 1970s and 80s, the Cleveland Report of 1988 and the Laming Report on the case of Victoria Climbié in 2008. These points in time mark major changes in ideas and policies affecting child protection, but they occurred within a context where the epistemology of child protection practice and overarching political philosophies operated to produce those changes. The argument of this chapter is that these pivot points led to major shifts in guidance on child protection, mostly through the medium of central government guidance to professionals and agencies, but also through media criticism of perceived child protection failures.

A further argument in this chapter is that if child protection were a professional activity with a secure and established evidence base and a shared understanding of the roles of practitioners, the need for central government guidance would be very limited. In the absence of a substantial evidence base for practice, the disparate groups making up child protection teams are directed by their government guidance, which is itself exposed to pressures from political reactions to high profile cases and media coverage. The effect of research based evidence can be relatively muted in this clamour. The pivot points identified in this chronology mark moments where media responses and political and economic pressures appear to be very powerful in instigating and influencing the changes in subsequent policy directions.

The growth of child abuse as a social problem is outlined by Parton (1979) as moving through a ‘natural history’ with the following four stages:

- Discovery – the issue is seen as a problem by individuals with an interest in a type of behaviour;
- Diffusion – the initial individuals demonstrate that there is a problem and convince others of its importance;
- Consolidation – the problem becomes a recognised task for a welfare agency;

- Reification – the issue is taken as a natural concern by professions and the general public.

(Parton 1979)

Parton characterises the model of handling child maltreatment before the World War II as being quite different from the one operating in the late 1970s (Parton 1979). Cruelty to children was an individual moral problem, not a social problem for the wider society and its agencies. Serious criminal offences were punishable on an individual basis by appropriate legal sanctions, whereas a social problem demands a wider social response.

2.5 The history of child protection

The problems of neglect and abuse of children are fundamentally human ones and a small number of adults have always maltreated children. Prior to the state assuming an overall welfare role within England and Wales following the 1939-45 war, welfare responsibilities for such children and their families lay with the Poor Law and its local guardians. Their main duty lay with abandoned children, local families who were deemed unfit parents and providing for those children who could not live at home with their parents, including orphans. The family was, and remains, legally responsible for the care and upbringing of children and this is fundamental to considering the role of the wider liberal society in relation to children. Any challenge to the right of the family to remain the custodians of children born within it requires legal decisions. These may be taken by designated organisations with the powers to do so, but there is nothing arbitrary about child protection activities and decisions always require appropriate justifications. One of the first of these lay in stopping cruelty to children.

Cruelty to children was a matter of some public debate during the latter half of the nineteenth century with the growth of a public press and popular literature as well as formal studies. The novels of Charles Dickens pictured the brutality of cruelty to children and the descriptions of the lives of street children in Henry Mayhew's

‘London Labour and the London Poor’ as well as the writings of Friedrich Engels described the suffering of children in very poor families and their exploitation by others. This awareness found its expression in action. Local Societies for the Prevention of Cruelty to Children were founded in the 1880s. The National Society for the Prevention of Cruelty to Children (NSPCC) was founded in 1895. The first Act of Parliament to formally make ‘bodily injury’ of children a criminal offence was passed in 1889, but otherwise, parents and teachers were entitled to punish children physically if they chose (a point still covered in the current United Nations Convention on the Rights of the Child, provided such punishment is not violent). Corporal punishment by caning was so well known that it featured in comics and children’s books as a common hazard of childhood. The responsibility for child protection remained with voluntary organisations like the NSPCC until it was transferred to the statutory Children’s Departments after 1948.

The growth in voluntary agencies included philanthropic societies such as Dr. Barnardo’s, who provided homes for destitute children and the Ragged School in east London. The impetus was similar to religious missionary work and often conducted with similar fervour (Hacking 1991). The objective was child rescue, whether or not the adults involved could be prosecuted. Decisions on actions were made by the rescuing agency without reference to a court or any legal order to remove the child. The problem of child maltreatment was a matter for charities: although abandoned and vagrant children could be received into the workhouse, the costs should be met by the parish where they were born, if possible.

The roots of poverty and cruelty were seen to lie in personal idleness and vice, rather than being part of wider social disadvantage or parental psychopathology. The concept of ‘child abuse’ as a distinct set of behaviours was not one which would have been familiar in 1945, but cruelty, excessive punishment, neglect of children through abandonment or failure to provide them with the basic care necessary to live were all part of the professional and public understanding of child welfare and so was sexual assault involving children (Smart 2000). The idea of ‘child abuse’ as a socially constructed entity did not exist, but the suffering of children in consequence of perceived adult cruelty and fecklessness was very well understood (Hacking

1991). Sexual abuse of children by unrelated adults, including child prostitution, was set slightly apart from these parental wrongdoings, except for incest, since this was seen as a family matter (Smart 2000).

Public concern about the welfare of children existed well before national legislation to create what we would recognise as social services and universal health services after World War II. Some of the earlier models on which national services were developed arose from enlightened local authorities in the northern cities of England, responding to the poor quality and condition of working class urban housing and to the high infant mortality in overcrowded and unsanitary homes. For example, the registration of births began in Huddersfield in 1906, but did not become compulsory across England until the Notification of Births Act (Extension) 1915 (While 1987). Lack of birth registration and compulsory schooling renders children invisible to a modern state.

Additional themes running through this overview of policy from 1948 are summarised as follows:

- The scope and expansion of the concept of ‘child abuse’ as particular type of behaviour by adults;
- Understanding of child development and the effects of neglect and abuse;
- The tension between family autonomy and the privacy of the home versus the public and political concern about children who died as a result of abuse within the family and those in child care institutions;
- The understanding about the effects of poverty on families and children within the prevailing political climate.

2.6 The Children Act 1948 and Children’s Departments

The postwar Labour government won a landslide election victory campaigning to provide public services to improve the health and welfare of the population after the war. The Labour manifesto promising a chance to 'win the peace' by creating a new and more equal society based on income related taxation to fund public services for everyone. The election was fought on an unabashed socialist agenda for public services and the redistribution of wealth, but also for full employment.

Following the introduction of a range of public services as part of a national welfare system, the responsibility for children's welfare, education and services moved from locally determined provision to universal services across England and Wales, a processes assisted by the powers remaining from the Emergency Powers Act of 1939 and 1940 and the Defence Regulations to enable controls on the workforce and matters such as food rationing. The continued need for rationing and austerity after the war had finished meant that these central control measures remained in place for some time after the war (Addison 2010).

The expectations of post war Keynesian economic policies were that full employment and the rebuilding of prosperity after the war would fund universal state services, including the National Health Service to improve the health of the nation (particularly mothers and young children). It also promised old age pensions and benefits for families where the breadwinner was out of work, plus direct welfare services for the elderly and disabled. The legislation implementing the new children and families policy was brought forward in the Children Act 1948 and introduced a new tripartite structure for personal social services:

- Health departments - public health, health visiting and some social care;
- Welfare departments - providing residential care and support for elderly or disabled people;
- Children's departments - child care, including receiving children into care if suffering from neglect or abuse.

The Poor Law systems previously providing services to families were abolished. Family Allowances were introduced for families with children, payable directly to mothers. Local authorities were given responsibilities for children who lived with their families, but the regulation of residential child care settings lay with the Home Office, together with responsibility for young offenders in Approved Schools.

The 1948 Children Act came into force after the Monkton Inquiry investigated the death of a child boarded out with a foster carer, Dennis O'Neill (Monkton 1945). The link between legislative change and political pressures to act after public scandals will be noted throughout this overview of child protection policy, but in this case the review of child care law was already in progress due to other political pressures, notably from influential women in political circles (Cretney 1997, Holman 2005, Women's Group on Public Welfare 1943). It is easy to see such juxtapositions cynically as a stimulus for overdue reforms by a reluctant administration and such pressures have affected public opinion of services for children and families. Such scandals probably helped ensure a degree of political consensus for major change, but there were also reports and public concern about the poor condition of some children from urban families who had been placed away from home during the bombing attacks on major cities (Hughes 1998).

Evacuation of children from the cities had brought the problem of the 'deprived child' to wider public attention, but it had also led to unsuitable and abusive placements in some cases (Mays et al. 1983). At the end of the bombing, some children had no homes to return to and this increased political pressure to consider the needs of children who could not live with their birth families (Cretney 1997). Pre-war child care systems were revealed to be chaotic and poorly managed. The Children Act 1945 led to the creation of specialist Children's Departments whose main duties were to protect and rescue children who could not be cared for by their families (Thoburn 1998). Despite the history of the Dennis O'Neill case, foster care was the first choice for placements, creating a new family to replace the birth family, some children were adopted outright, but residential children's homes remained for others. The costs of foster care and adoption were lower than long term residential

care, but it was also seen to offer children a chance of growing up in a supportive new family rather than institutional care.

Child protection actions under the 1948 Act required multidisciplinary assessment of children at risk from the outset, but no compulsory action could be taken to safeguard a child unless their abusive parents were prosecuted. In addition, parents of children who were removed could request that their child be returned to them (Cretney 1997, Hughes 1998). Removal of a child deemed to be maltreated or neglected did not require a court order, but relied on an executive decision within the local authority with the powers to do so. Decisions to remove a child depended on the parent being considered unfit to look after them, either because of their mental ill health or because of their lifestyle.

The role of the state in relation to family life was influenced by evidence relating to child psychosocial development, as well as being vested in law. Psychologically, families were already seen as the best places for a child to grow up. The growth of understanding about the long term developmental and psychological importance of attachment between mother and child emphasised the importance of maternal care in the early years of childhood for the future mental health of children (Bowlby 1946). The phenomenon of 'attachment' between mother and child describes that emotional bonding between the parent and child which occurs when a baby becomes aware of the care of a familiar adult, responds to comfort and care and turns to the caring adult for comfort and support in the infant's basic needs for food and care. The intimacy between a parent and child is important developmentally because it contributes to the wellbeing and development of the child as a secure and valued person. The person to whom the infant is attached is their main source of comfort and feelings of safety, but also their secure base to which they can turn when afraid. Babies who lose sight of their familiar carer will become distressed and prefer to stay close. It is easy to see this as an evolutionary development to prevent young children from wandering and out of danger. The security of attachment depends on the availability of the caring adult and their responses to the infant. Some adult psychopathologies have been attributed to disorders in attachment during early

childhood (Cicchetti and Toth 1995, Hecht and Hansen 2001, Hooper 2007, Svedin et al. 2005, Yates 2004, Yates and Wekerle 2009) .

Bowlby based his ideas about the importance of the close family relationships on his background in Freudian studies, but also through his work at the London Child Guidance Clinic (van der Horst and van der Veer 2010). Bowlby observed children and young people presenting at the clinic with behaviour problems and delinquency which he attributed to their disrupted childhoods and early experiences of loss and separation from their parents. Such disrupted childhoods were real experiences for the children concerned and this understanding marked a separation for Bowlby from Freudian thinkers like Melanie Klein, who tended to attribute the trauma of the children to internal mental processes, rather than their real experiences. London had many children during and after World War II who had experienced separations from their parents due to evacuation, death and population displacement and Bowlby went on to develop the group of psychological ideas about the importance of early nurturing relationships which are now collectively known as attachment theory.

The importance of maternal care and the family environment for child rearing had a number of effects on child care policy. The Curtis Report advocated fostering in a substitute family for those children who could not live with their birth families. There were concerns about the institutional care of children in large residential homes because of their lack of a close parental figure and one to one care, but fostering and boarding out was already established as a placement option for both local authority and voluntary societies (Packman 1981). It also had advantages in being a cheaper option to providing suitable small scale residential units and Packman (1981) quotes concerns about payment for foster carers in case this might affect the altruistic motives of foster parents. Residential care also had serious problems due to the physical conditions and poor facilities of some homes as well as the lack of a warm, intimate, domestic environment. Poorly trained staff cared for children with a range of needs which went well beyond the capacity of most foster families and some children could not be placed in foster homes because of their mental or physical problems. The Curtis report had advocated closure of the largest

and most impersonal establishments, but the influence of Bowlby suggested that children should not be moved frequently within the care system and where they had lost touch with their birth families, children tended to remain in care long term (Merrick 1996).

The newly formed Children's Departments within local authorities inherited a substantial workload in the early post war years because they brought together work which had been done by a number of departments and agencies before the war. Stresses within families also led to more children coming into the care system and Packman (1981) described the numbers rising steeply between 1946-1953 (Packman 1981). Whilst the Children's Departments struggled to find adequate and suitable placements for children coming to care, their role in prevention of neglect and cruelty within birth families was limited by their capacity. Concerns about prevention resulted in the Children and Young Person's (Amendment Act) 1952 which required Children's Departments to follow up on information about possible cases of child neglect or cruelty with a view to supporting families who could be helped to change and thus to prevent their child being taken into care. This was the first move to try to address cruelty or neglect by supporting those families who could be helped to change while preventing their child coming into care. It served to combine the preservation of family ties advocated by Bowlby with savings on the costs of substitute care for hard-pressed departments (Mays et al. 1983).

Even with support, some families proved unable to meet the needs of their child and this led to a lasting dilemma of choosing between psychologically damaging a child by removing him or her from their birth family and allowing them to continue to suffer where parents could not cope with the pressures of life in substandard accommodation (Women's Group on Public Welfare 1943). The socioeconomic problems following a war which had destroyed thousands of homes meant that many families coped in poor accommodation, often with inadequate space (Addison 2010). The 1951 Census revealed that 52% of all homes had a fixed bath, a lavatory, a stove for cooking and piped running water, so almost half of UK households lacked at least one of these facilities.

As well as these philosophical understandings and possible consequences of maltreatment, there are current social and economic circumstances which are important facets of the phenomenon of abuse. Poverty and life in poor families still presents a form of stress which is particularly difficult to manage when trying to provide and care for young children. One study of family poverty published in 1997 identified the cost of providing for a growing child could amount to £50,000 (at contemporary cost levels) by the time the child reached the age of seventeen (Middleton et al. 1997). The gap between such expectations and the incomes of families on benefits or in low paid work is substantial, suggesting that many such families would have no chance of providing the kind of care and material benefits available to those on higher incomes. Although the idea of parental unfitness still carried strong moral overtones, the stresses of families coping with poor accommodation and low incomes had been reported following city evacuation during the war years (Women's Group on Public Welfare 1943). It may be that such forthright reminders of the realities of poverty are still needed to inform policy making.

Family circumstances had been changed by the war years in other ways, together with the loss of husbands and fathers during any war. Many mothers had had to take paid work outside the home, using local nurseries for child care. The 'marriage bars' which had applied in many occupations to prevent married women from holding some posts, were suspended to allow them to take up jobs where men had left for the duration of the war. They were never reinstated to the same extent because society had changed and many married women continued to form part of the workforce through jobs and full careers, although the wartime provision of local child care nurseries was no longer available.

The separation of families had its own effects when families were reunited. Children born during the war were initially unfamiliar with their long absent fathers. For both parents, there might have been extramarital relationships and people were changed by long separations. The pre-war stereotype of domestic life where men worked and brought in a wage adequate to support their families while women

remained as housewives (as envisaged by Beveridge) was changed by six years of war when many women with children took up war work. In the post war era, many of the caring jobs which were created within the new welfare state were taken by women (Dale and Foster 1986). Many women found their work was economically essential to support families and provide for increased expectations of prosperity. Others enjoyed their independent earnings or their work too much to simply return to domestic work. In the post war years, increasing availability of contraception enabled pregnancies to be planned and couples could choose to have smaller families.

The full employment proposed by post war economic policies essentially meant male employment and married women with children needed to secure good child care before they could take up full time work. Women's employment continued to be important, but wartime support for working mothers (practical and social) was no longer available. The importance of the mother-child bond was interpreted as mothers being responsible for their own children and their own child care. The role of mothers in the workplace was also affected by post war industrial growth, keeping women with children within the workforce, but limited child care meant that mothers were not always able to take full time or well paid work (Hunt 2009).

The role of the family in child rearing has changed since World War II with more complex family structures and increased numbers of lone parents, usually mothers, who may or may not work outside the home. These social changes affect the ways in which social policy supports the family unit and the concept of the family itself.

2.7 Support for families and ideas about the family

The Family Allowances Act of 1945 made the family and needs of children a key part of the welfare state changes following the war and it implemented ideas outlined in the Beveridge Report of 1942 (Beveridge 1942). Beveridge deals largely with social allowances from a national insurance scheme, but its underlying principles recognise some state responsibility for families alongside that of their

own parents which seems more inspirational than the minimal provisions of the Poor Law

'... the small families of to-day make it necessary that every living child should receive the best care that can be given to it. The foundations of a healthy life must be laid in childhood.'

(Beveridge 1942, p154, para. 413)

Beveridge envisaged a family income derived from the earnings of an economically active man supporting a wife who did not work outside the home, but who cared for their children. Merrick (1996) uses the term 'familialism' to describe this type of policy focus on the family as a unit. This focus on the family as a social unit tends to overlook the different individual interests of the members of that family (Merrick 1996).

The growth of the women's movement in the 1970s is also important in highlighting the interests of women as people and differentiating these from the interests of the male head of household. Similarly, children's interests may differ from those of their parents (Parton and Otway 1995). The idea that individuals within a family might have different or even conflicting interests was brought into sharp focus by the publication of cases of a 'battered baby syndrome' described by paediatricians in America (Kempe et al. 1962a). Feminists have argued that a family focused policy perspective would emphasise full time maternal care of children and overlook the needs of women with children who need or choose to work. There is also a tension between a focus on family support as the best means of ensuring children's needs are met and the recognition that, even with support, some families do not meet the needs of their children or prioritise their needs over those of adults. This is a particular problem in relation to child protection when parents have chaotic lifestyles or there is discord and violence between adults. The family is not always a place of safety (Davies and Krane 2006, Forrester and Harwin 2008, Herrenkohl and Herrenkohl 2007, Shlonsky and Friend 2007).

2.6 Children as holders of human rights

One fact underpinning the value of the individual child was the loss of many young people in World War II, together with exposure to the injustices which could result from totalitarian government and disgust at the horrors perpetrated during the war (duly recorded by newsreels and the modern popular media in ways that would have been impossible in earlier conflicts) made universal human rights a higher priority than in earlier ages. The foundation of the United Nations (UN) led to the unprecedented Universal Declaration of Human Rights in 1948 (General Assembly of the United Nations 1948). Such international aspirations are easier for governments to sign than to implement and enforce, but the moral purpose has persisted in subsequent work on control of atomic weapons, working against genocide and torture and promoting the rule of law and the rights of women and children. The value accorded people as human beings is more inclusive than valuing them as citizens of a particular state and it applies beyond the boundaries of state institutions. The UN Declaration and the Convention on the Rights of the Child (signed by Margaret Thatcher in 1989) still serve as a moral standard by which governments can be judged and any injustices and violations of the human rights of children are highlighted by modern media and have become matters of concern beyond their own families and societies.

Any state guarantee of the rights of children cannot be addressed without welfare systems in place to identify and respond to the needs of children whose rights are violated by threats to their lives or health or whose fundamental needs cannot be met by their parents. Prior to the 1940s, children who were orphaned, abandoned, mistreated or delinquent were subject to the 1933 Children and Young Persons Act and provided for through charitable bodies, local authorities working under the remaining Poor Law provision. Children in trouble with the law were the responsibility of the Home Office, but this was a welfare based approach which took

the perspective that children who committed an offences were still children, with similar needs to their non-offending peers (Cretney 1997, Merrick 1996). After the war this continued, but during the 1950s, awareness of the role of family breakdown in the problem of delinquency was increasingly important to child care services.

2.8 The child within the family

The Children Act 1948 sought to improve the care of children who could not be raised in their own family homes. It did not address the wider needs of children in their communities, but could provide help to families, if such provision helped to prevent a child having to come into care (Stevenson 1998). Underpinned by contemporary theories such as those of Bowlby on infant monotropic attachment to single adult, usually the mother. Families might be the source of many children's problems, but they were also important to their development (Parton 1991). The report on the case of Maria Colwell (Field-Fisher 1974), a child fostered in the care her aunt, but removed to that of her birth mother after years of consistent foster care marked a change in the assumptions about the strength of the natural bond with birth mothers (Bowlby 1946, Bowlby 1990). In the immediate post war years, mothers and blood ties were considered very important for a child's development, but later studies demonstrated that separation from either parent affected the development of children and that there were disordered types of attachment in children with disrupted parental relationships (Ainsworth 1971, Rutter 1981).

While foster care was seen as the best placement option for children who could not return home, the role of children's homes and other residential models of care tended to dwindle, but they remained in place for particular vulnerable groups of children and became a focus for scandal and public inquiries following the 'Lost in Care' inquiry (Utting et al. 1997, Waterhouse et al. 2000).

In terms of Parton's outline of the natural history of the problem of child abuse and neglect, the phenomena that make up the current concept of child abuse were well known, i.e. the problem had been discovered by those who worked in this field (Parton 1979). Diffusion of the problem was relatively slow and the public

awareness of the issues was very much less developed. The issues had been consolidated in the sense that Children's Departments existed for the purpose of rescuing children from cruel or neglectful parents or carers, but public awareness was limited and work took place away from the attention of the media.

2.9 The Ingleby report and the Seebohm Report: Failing Families

During the 1950s, juvenile delinquency became a focus for concern due to high profile riots and violent street fights among young men, which were blamed on inadequate parental care and neglect (Addison 2010). The response to the delinquency problem informed the remit of the Ingleby Committee between 1956 and 1960, which recommended raising the age of criminal responsibility to twelve years and advocated a preventative role for children's departments in local authorities through support (financial and otherwise) for families to prevent their children becoming criminals. This was a move towards working with families in a welfare sense, rather than simply focussing on rescue for abused children. This found expression in policy through the Children and Young People Act 1963, based in findings of the Ingleby Report. The emphasis was placed on social work with the family, using a 'consistent, trusting, professional relationship' to nurture inadequate or immature parents so that they can care better for their children (Parton 1991, p.22-3). Social workers were already empowered to investigate neglect, but the state and parents were to be seen as working in partnership. Social workers had discretion to deliver services appropriately, including provision of preventative and financial support for families to prevent children coming into care.

This family welfare approach greatly increased the range of families and children for which Children's Departments were responsible (Jordan 1974) and the answer to this was to combine social services for adults with the previously specialist departments dealing only with children. The proposal to integrate social work departments across the generations and produce a system capable to addressing the needs of the family as a whole was recommended in the Seebohm Report of 1968. The Seebohm Committee was set up in 1965 following the publication of a White

Paper on the prevention of delinquency through provision of services for the wider family and its recommendations informed the Local Authority Social Services Act 1970 (Packman 1981).

Ingleby emphasised preventative family support when neglect first was identified. This marked a move away from the previous focus on rescue of children from unfit families and towards a more preventative model. However, the effects of increased support for families to prevent delinquency and family breakdown resulted in intrafamilial problems becoming much more visible. The persistence of family problems encountered during preventative work raised some moral concerns which had distinctly eugenic overtones of disapproval because they were seen as transmitting deprivation from generation to generation through their poor child rearing (Coffield 1983). Some families were already perceived to be at high risk of breakdown and violent discord and they struggled to cope with the demands of work, home and child care. They were described as ‘problem families’ (Women's Group on Public Welfare 1943). By the early 1970s, the difficulties of such families were still recorded despite almost twenty five years of welfare state measures and increased family support, but the reasons were not understood. This ‘transmitted deprivation’ was the focus of a series of government funded studies into aspects of family life (Brown and Madge 1982). The objective was to identify ways in which families could be supported to prevent successive generations of family breakdown and forestall young people getting into trouble with the law (Packman 1981).

The intergenerational aspect of the problem family was prioritised by Keith Joseph in 1972, while speaking as Secretary of State for Social Services. He described the perceived issue as a ‘The Cycle of Deprivation’ where children grew up in families where dysfunctional behaviours and attitudes were seen to have persisted through successive generations (Tonge et al. 1983). The intergenerational effects on children of such families was described as a social handicap which affected the development and later progress of children, limiting their future prospects for successful and stable lives (Madge 1983). This concept of intergenerational transmission of deprivation and failure plays down the effects of structural economic factors

affecting such families which form such an important set of confounding variables in the analyses of the problem (Jordan 1974, Townsend 1979). This kind of perspective is also found in North American ideas on child maltreatment, where the effects of ethnicity and poverty across the generations tend to be lost in a discussion of the effects of poor parenting and a moralistic attitude to adult behaviour (Brandon 2001, Hacking 1991).

The notion of a 'cycle of deprivation' tends to create the impression that the families' behaviour was perpetuated like a form of communicable disease or inherited syndrome (Parton et al. 1997). The 'problem family' descriptions included a surprisingly diverse range of problems including low intelligence, poor maternal housekeeping standards, involvement in crime and a tendency to have very large families. Interest in this group of problems led to increased research into families through the research funding offered by the Department of Health and Social Security in the 1970s did balance the eugenic tendencies and demonstrated that there were helpful interventions which could help young parents overcome their own bad experiences. The issue was considered prospectively by Rutter et al (1983) in a controlled study of a cohort of young women who had been brought up in residential care homes as they became parents themselves. The study started in 1964 and continued until 1978 and identified a five times greater tendency towards poor parenting in the mothers who had been in care themselves compared with the control group, but demonstrated that mothers with good support from their partners coped much better and that much disadvantage arose from later educational and material factors as well as their own childhood experiences. School and early adult life experiences also played a substantial role in overcoming difficult childhoods and the intergenerational effect implied by a cycle of deprivation (Rutter et al. 1983). Such evidence demonstrated that change could occur and the cycle of deprivation could be broken. This was a period of optimism when the problems of families could be addressed through skilled and well informed social work and the application of financial help to help children stay in their homes (Parton and Otway 1995). The problems of neglect arising from debt and lack of basic necessities were certainly amenable to change, but subsequent events identified that there was more to child

maltreatment than material want and ignorance and this in turn undermined the response of social work as the sole professionals making the decisions about child welfare. The concept of abuse became more complex and was seen as requiring a more multidisciplinary approach than traditional child and family welfare (Hacking 1991, Parton and Otway 1995).

2.10 Medical input and the diagnosis of child abuse

The key point at which the medical profession became involved in identifying child abuse also marks the point at which the term 'child abuse' itself first entered popular discourse as a description for non-accidental injuries caused by assaults by parents and family carers. Like many changes in medical practice, it arose through an improvement in medical technology which began during the 1940s and led to improved radiological examinations of children's limb bones and skulls. This produced new information about injuries and their causes and led to the development of new theoretical ideas about non-accidental injuries to infants and very young children (Griffiths and Moynihan 1963, Kempe et al. 1962).

It was not news to child welfare professionals that parents sometimes assaulted and injured their young children, but Kempe's work considered particular patterns of injuries to children younger than three years old. The new radiological techniques allowed old healing fractures to be visualised alongside new injuries, suggesting repeated trauma which did not tally with parental explanations. Kempe described such cases as generally psychiatric in origin, but also '*among people with good education and stable financial and social background. However... in these cases, too, there is a defect in character structure which allows aggressive impulses to be expressed too freely. There is also some suggestion that the attacking parent was subjected to similar abuse in childhood.*' (Kempe et al. 1962).

This insight into non-accidental injuries marked a point at which the whole phenomenon of child abuse became a distinct socially constructed category with a

range of phenomena included under the umbrella of the term (Hacking 1991). It was also considered that abused children might grow up to become abusive parents in their turn – a kind of variation on the cycle of deprivation with its origin in psychopathology rather than social inadequacy.

Non-accidental injuries were not the sole presentation of child abuse because the problem of longstanding neglect was never identified as a medical condition and the weight of evidence from the Social Science Research Council and DHSS research programmes placed responsibility for addressing both problems in the context of family welfare and social services rather than medicine. Although Parton and Otway describe the 1960s as a period where child abuse was constituted as essentially a ‘medicosocial’ problem, they describe it as becoming more of a socio-legal problem in the 1970s and 1980s, because of the authority of legal expertise (Parton and Otway 1995). Paediatric specialists in child sexual abuse and non-accidental injury remained sources of expert advice for child protection teams, especially in relation to sexual abuse, non-accidental injury and fabricated/induced illness, but the medical concepts never dominated the essentially social model of child maltreatment in the UK.

2.11 The child abuse Inquiries of the 1970s and 1980s

The 1970s marked a time of increased numbers of children coming into the care system for a number of reasons, including neglect and abuse, but also because policy towards the youngest groups of offenders changed in response to the Children and Young Person’s Act 1963 (Corby et al. 2001). Children who committed crimes were noted to come from families where neglect of one form or another was as frequent as those already deemed to be in need of substitute care. Although the population of children in the care system had increased during the post war period, there was a real growth in substitute care for children ‘in need of care and protection’ as well as the transfer of young offenders from detention to care categories (Packman 1981).

The 1970s and 1980s also saw a series of formal inquiries into the deaths of children who had been neglected and abused. These were generally held under Section 98(2) of the Children Act 1975. There were at least twenty six such inquiries in the ten years following that into the case of Maria Colwell in 1974 (Field-Fisher 1974), but not all of them have been conducted in a full legal format where witnesses were called and cross examined and not all were held in public (Hallett 1989). The high media profile of some of the inquiries had a major impact on child protection work and sometimes led to sanctions against practitioners (Parton and Otway 1995). Some of the reports were highly critical of the social workers and some other professionals who had been involved in the cases, but they also criticised policy and guidance (Blom-Cooper 1985, Blom-Cooper 1987). They could be very costly if all parties were legally represented and public hearings were required, but most were local inquiries with independent chairs and few reached the levels of statutory legal formality of the Cleveland report on 1987. Not all could compel witnesses or the production of documentary evidence (Hallett 1989).

The Colwell inquiry report resisted blaming professionals involved in the case, but instead placed responsibility on the wider system (Munro 2004). This no-blame approach did not persist and further public inquiries have named both practitioners and managers, leading to a wide range of professional sanctions and fierce media criticism. While Munro acknowledges that some incidences of professional practice described in SCRs had fallen well below acceptable standards, there were also organisational faults which had been ignored for long periods prior to the case in question (Munro 2004). It is easier to blame individuals than to fix a system and perhaps it is easier politically for the public to be encouraged to castigate individual 'rogue' practitioners than to question an ineffective child protection service.

The development of policy on child protection in the 1970s operated in the shadow of the case of Maria Colwell and subsequent legal inquiries into the deaths of children at the hands of family carers (see Chronology at Appendix A). The identified weaknesses in communications and joint agency working triggered a

growth in directions from the centre (Packman describes ten guidance documents issued by the then Department of Health and Social Security (DHSS) between April 1974 and December 1976) and further local procedures and policies within local authorities (Packman 1981). Local authorities were required to set up 'at risk' registers to identify children at risk and help highlight their needs across agencies and areas, although the type of case which might be registered varied. They included children at risk of different kinds of abuse, including sexual and emotional abuse.

Packman (1981) states that the Colwell report identified failures by social workers and that they had placed undue confidence in the strength of the blood tie between Maria and her biological mother. Maria was removed from her foster mother's care after six years away from her birth family and she returned to a reconstituted family with a new stepfather. She had had limited contact with her mother because there was family disharmony between her mother and the aunt who fostered Maria.

The effects of the successive inquiry reports was gave the impression that all was not well with some families and that children were suffering needlessly through the inaction or poor decision making of the child protection teams. The actual social work ethos was summarised by Parton (1979) as needing to adjust the family functioning through compassionate and therapeutic engagement and endeavouring to improve children's safety through rehabilitating their parents. This compassionate response was contrasted with the punitive approach of the law seeking to punish crimes against children and the medical approach that construed child abuse as a psychiatric syndrome manifesting as deviant behaviour

The relationship between the troubled family and the agencies seeking to help them and their children had been seen as collaborative, which tends to overlook the power disparities in such cases. Parton and Otway (1995) see the inquiries into child deaths producing a new focus for child protection professionals and policy makers. Instead of being critical of individual incompetence by particular staff (sometimes inexperienced, poorly supervised and poorly trained) they took a forensic

perspective on the deaths which was critical of both policy and practice. They emphasised that social services had a legal mandate to protect children at risk of such miserable deaths and that workers needed to be aware of the signs and risk factors which were evident when viewing cases retrospectively. Social workers in particular were seen as 'naïve and sentimental' about parents and failing to consider the child's individual interests and safety (Parton and Otway 1995).

2.12 The Cleveland Inquiry and the Children Act 1989

In early 1987, some 197 Cleveland children were taken into care during a six-week period on suspicion of sexual abuse. These suspicions arose from physical examinations by two paediatricians who used a novel technique of testing for anal dilatation alongside more conventional examinations to establish whether or not children had been sexually assaulted (Butler-Sloss 1988). On identification of such signs of sexual contact, the paediatricians felt unable to allow children to return to families where they believed that they had been assaulted and so large numbers of these otherwise healthy children were admitted on Place of Safety Orders to the children's ward of the local hospital. The Place of Safety Orders did not require consent from parents or a court and were granted by a magistrate. The orders allowed the children to be cared for away from their families and without contact with them for as long as 28 days, during which time children were interviewed to enable them to disclose any abuse which they had experienced.

The abrupt removal of their children and the suspicions of sexual abuse had severe consequences for many of the families involved. There was also conflict between the doctors and social services on the one hand and the police and police surgeons on the other (Butler-Sloss 1988). The local member of Parliament was critical of the social services department and the local hospital was overwhelmed by the problems of providing care for so many children in such a short period of time. The cases of suspected sexual abuse of children in Cleveland led to as much, if not more, coverage in the national and local press as the larger public inquiries into the deaths of children had done (Donaldson and O'Brien 1995). Under such circumstances, there are pressures on both local and national government to address their policies

and practice to assure themselves that legislation and guidance is in place to address issues arising from the inquiries. The difference in the case of the Cleveland cases was that although most laypersons reading about a case of cruelty and physical abuse or of extreme neglect could judge such behaviour in relation to that in their own families, the issue of sexual abuse was very new to journalists and to their readers and lay outside their own immediate experience. Like most sexual offences, it also led to feelings of shock and revulsion which challenged established beliefs and assumptions. Many people could not believe that such things happened in families and there was a real gap between the understanding of incest and sexual abuse among professionals and that of the general public. The overall effect of the inquiries into fatal abuse and the Cleveland and later Orkney cases of sexual abuse was to bring such cases into public prominence and lead to concerns about the safety of children and the nature of child protection work itself.

Following the repeated inquiries into the deaths of children and the Cleveland findings, the Children Act 1989 takes a firm line on the rights of children not to be left in abusive or neglectful homes. The Children Act 1989 was implemented in 1991, alongside a substantial body of new detailed guidance to agencies involved with children and families. The Act stated that 'the child's welfare is the court's paramount consideration' and introduced a requirement to ascertain the child's wishes and best interests in child protection actions. It replaced parental rights with parental responsibility for children (Home Office et al. 1991). For the first time, the idea of 'significant harm' to children was introduced as the grounds for a Care Order to be granted by a court, transferring parental responsibility for the child from the parents to the local authority. The child's likelihood of suffering significant harm, as defined by the Children Act 1989 is the rationale for intervention to protect that child.

The Children Act 1989 also led to a range of guidance to child protection teams, including a complex assessment guide designed to incorporate the full range of factors which might indicate that the case was one where a child was at risk of serious harm. Parton and Otway (1995) consider that this focus on preventing harm

to children and the statement that the interests of the child were paramount indicates that risk of harm has become the threshold for intervention specified in the detailed national child protection guidance. This implies a need to consider the future, as well as the present likelihood of significant harm to the child. The process of doing this is that of risk assessment, but the only previous tool provided to enable child protection teams assess this risk was the so called 'Orange Book' assessment 'Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment' (Department of Health 1988). This is large and cumbersome document containing 167 questions, many of which might be considered quite intrusive. There is no further algorithm which would enable an assessor to decide whether or not a child was at risk of significant harm, depending on the answers to this comprehensive set of questions and as a risk assessment tool, it falls short of some the earlier UK based work which attempts to predict neglect and abuse through identifying some of the factors present in cases where children were abused (Browne and Saki 1988, Department of Health 1991, Rutter et al. 1983). Whilst this apparent to those who have never worked in social work, the professional debate around assessment within social work affected the essence of practice (Lloyd and Taylor 1995). The technical component of assessment is not enough structure for a people-focused assessment without placing also individuals and families at the centre of the process, respecting their rights and their particular social and cultural situations. Assessment also needs to consider of the power and responsibility of child protection agencies in people's lives (Lloyd and Taylor 1995). They argue that too rigid a framework for assessment can be reductionist and overlook important strengths or risks which stem from the complex realities of human lives in their own context (Lloyd and Taylor 1995). Poor assessments could lead to inappropriate responses, but as in medical practice, professional child protection practice may be more ready to adopt evidence based tools which assist specific areas of assessment, rather than comprehensive frameworks which cannot incorporate values and principles. The critique of Lloyd and Taylor (1995) was applied to the 1988 guidance 'Protecting Children' (Department of Health 1988), but might also be applied to the later 'Framework for the Assessment of Children in Need and their Families' (Department of Health et al. 2000a).

The Framework guidance issued after the 1989 Children Act was also strongly prescriptive, with detailed models of documentation and instructions (Department of Health et al. 2000b). However, Parton and Otway (1995) point out that if the risk of significant harm resulting from neglect or abuse is to be the criteria for investigations and intervention to protect children, other sources of harm, such as extreme poverty, would not in themselves constitute a reason to become involved unless these circumstances themselves placed the child at risk.

The Children Act 1989 also led to a change in placement practice, by not removing children from home as a matter of urgency unless they were deemed to be '*in acute physical danger*' and requiring that authorities should '*weigh up the likely immediate and long term effects of removing the child against the possibility of harm if they leave the child at home...balance this with the need to secure evidence of criminal offences*' and consider arresting suspected abusers rather than removing the child from home (Home Office et al. 1991, page 10). The idea that children might be protected from abuse and neglect whilst remaining at home was not new and had long been considered to be a good way of dealing with neglectful families and preventing care from deteriorating (Packman 1981). It also enabled a new way of addressing child sexual abuse concerns arising following the Cleveland inquiry where children had been removed from their families on Place of Safety Orders rather than the removal of their suspected abusers pending investigation and longer term planning. The removal of abusers and intensive support for neglectful families might be secured whilst enabling children to remain at home, but there is no suggestion in the guidance at the time that this was less likely to be an effective safeguard for children at risk of serious harm from violent assault. The likelihood of a child suffering significant harm requires a *de facto* assessment of risk and there is no guidance in 'Working Together under the Children Act 1989' to help assess the risk of physical abuse (Home Office et al. 1991). The need for children to be taken into care was to be in emergency circumstances only, so the previous Place of Safety Order was replaced by an Emergency Protection Order. Parental responsibility was

not removed wholly from parents under the Care Order, but could be shared between parents and local authority and contact continued between family members.

The other effect of the post-Children Act 1989 guidance was to change the system under which child deaths were reviewed from the mixed approach on public and private inquiries, with their legal emphasis and sometimes adversarial processes. The new requirement was for individual reviews (referred to as 'Part 8 reviews' from that part of the child protection guidance) into cases where child deaths gave risk to suspicions that abuse was involved. They were centrally notified to the English and Welsh government offices, but the process was to be quick and confidential, designed to inform local agencies about problems and enable them to learn lessons from cases where children had died. The nature of this process was to reduce the public visibility of such deaths and although cases continued to be exposed in the media through court proceedings, inquiries and reports became much more local and most were unpublished.

The Children Act 1989 addressed the public concerns by requiring authorities and professionals involved in child protection to collaborate with other agencies and to comply with a range of new central government guidance. The days of local professionally led decision making within a Children's Department were long gone and the courts and central government and related guidance documents were much more directive in the day to day conduct of child protection work. The volume of material issued by central government departments in relation to the abuse of children increased substantially and the purpose became more directive and less advisory in response to the child death inquiries and the Cleveland report (Ayre 2001). Both types of inquiry tended to criticise social services responses and in the case of Cleveland, paediatricians too. Ayre (2001) notes the increased volume of recommendations and child protection guidance, reflecting a growing mistrust of professionals during the 1980s and 1990s. This has continued to grow after the Climbié inquiry in 2003 and the current 'Working Together' guidance document is 390 pages long compared with the 199 pages of the 1999 edition (Department for

Children Schools and Families 2010, Department of Health et al. 1999, Laming 2003).

Media and public concern is particularly aroused by coverage of prosecutions and cases where children have died (Ayre 2001). It is tempting to speculate on how these have affected policy, perhaps impacting on politicians more immediately than published research. During the eight years period between 1974 and 1982 there were twenty seven major case inquiries and reports and substantial changes in child care law were proposed in the Short Report of 1984, followed by a review of legislation in 1985 and funding for a research programme through the Department of Health and Social Security (DHSS) and the Economic and Social Research Council (ESRC). This flurry of policy activity and funded research indicates the impact on politicians of criticism stemming from the series of inquiry reports. Children had certainly died as a result of neglect and abuse during the 1950s and 1960s, but prior to Maria Colwell's death in 1973, the media coverage would have focused on prosecutions of perpetrators rather than criticism of professionals and agencies (Ayre 2001, Field-Fisher 1974).

The Cleveland Report on child sexual abuse (Butler-Sloss 1988) spotlighted the issue of child sexual abuse as an issue of public concern, but also the problems of producing unambiguous evidence of abuse. As with the discovery of the 'Battered Baby' in the 1960s, medical diagnosis has proved very important in identifying sexual abuse and fabricated illnesses (Southall et al. 1997, Hobbs and Wynne 1989, Kempe 1971b). The Cleveland cases also demonstrated the difficulties of using Place of Safety Orders to separate children from their families when the range of safe places available was very limited. The media coverage during the period of the Cleveland Inquiry reached a new zenith of hostility towards paediatricians (Donaldson and O'Brien 1995). Part of this may have stemmed from the power of senior medical staff to label particular findings as child abuse. This also seems to be an issue in the controversies involving other paediatricians such as David Southall and Roy Meadows (Williams 2010). In these two latter cases, the media coverage is more measured than the online coverage published by a range of pressure groups

such as Justice for Families (<http://justiceforfamilies.freeforums.org/paediatrician-defends-southall-t275.html>) .

Residential care was not excluded from these increasing public concerns. The series of investigations into children's homes culminating in the first Utting Report (Utting et al. 1997) and the Waterhouse Report (Waterhouse et al. 2000) led to the development of new procedures for the care of children living away from home, which were subsequently extended and adapted as the Common Assessment Framework for children in need and their families (DFES 2007).

More recently, the deaths of Victoria Climbié (Laming 2003a) and Baby Paul in Haringey (Haringey Local Safeguarding Children Board 2010) and the recommendations have led to major series of changes under the policy umbrella of 'Every Child Matters', including such diverse areas such as the education of social workers, new interagency structures and procedures and new inspection regimes for Children's Services (Department for Children Schools and Families 2009b). Current policy areas range from early years of life and child care through health and education services throughout childhood and youth services alongside safeguarding and child protection. Among the current work programme is a review of ways in which children can be safeguarded whilst remaining with their families during the course of a child protection plan (Munro 2011). This is where the issue of formal risk assessment may contribute to the child protection process by identifying which situations present the highest potential risk in the process of working with families.

During the 1990s, the role of direct central government guidance was balanced by professional developments and a series of research studies into aspects of child protection, undertaken as part of a Department of Health programme (Department of Health 1995a). The recommendations emphasised the need to balance child protection with family support and prevent future occurrences when large numbers of children were removed suddenly from their homes, as had happened in the Cleveland cases (Butler-Sloss 1988). The précis document bringing this programme together, 'Messages from Research', mentions further work taking place in North

America, but does not draw upon it or even cite it because the systems were seen as being too different for any insights to be transferable to British child protection practice (Department of Health 1995). This decision was rather a sweeping dismissal of a large and diverse body of research which was not brought to the attention of practitioners at the time.

The Children Act 1989 and the related guidance attempted to change the orientation of child protection teams towards family support rather than child protection measures, but given the limited resources and the high risk nature of the work, this was not always successful and the professional assessment of risk to children remained a priority for many practitioners (Spratt 2000, Spratt 2001).

One major new trend during the 1990s and early years of the 21st century was the rise in formal right based approaches to children and young people. This moves the debate on child protection from the child as an object of concern to the child as a holder of rights.

2.13 The United Nations Convention on the Rights of the Child and children's rights

The UN Convention was signed by the then UK Prime Minister, Margaret Thatcher in 1989. This led to the Children Act 1989 requirement for paramountcy of the child's best interests, which needs to be seen in relation to the general rights of individuals under the UN Convention and the later Human Rights Act 1998. The Human Rights Act 1998, in particular includes Article 8, which gives the right to respect for private and family life, which can conflict with the rights of the individual child for protection from intrafamilial maltreatment. The legal duty of care by public authorities and the state in relation to child abuse and neglect is also covered by the Human Rights Act 1998 and the European Convention on Human Rights, Articles 2 and 3. These require state bodies to act to protect any child who is at risk of death or suffering inhuman or degrading treatment. The Convention underpins the safeguarding of young children as part of state compliance.

The UN Convention on the Rights of the Child is generally broader in scope than the Human Rights Act 1998 or European Convention on Human Rights and focuses on the particular needs of children and their families. Article 6 states that a child has the right to life and Article 9 that they should not be separated from their parents unless it is for their own good (for example, to protect them from abuse or neglect by a parent). Article 9 links to Article 8 of the Human Rights Act 1998 in that private family life is to be respected, unless action '*is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*'. Article 19 requires ratifying governments to protect children from violence, abuse and neglect by a parent or carer. Articles 25 and 26 respectively require that children in the care of local authorities have their circumstances reviewed regularly and that families with children should receive extra funding if they are in need. Article 34 requires governments to protect children specifically from sexual abuse and Article 36 to protect children from activities which could harm their development, which might include some circumstances of neglect or abuse.

In general, parents are the adults who act on behalf of their children to obtain their legal rights, but in the cases where the local authority or a court holds parental responsibility, they have that duty, especially for children living in residential care. Although the focus of this study is to look at maltreatment within a family context, the nature of the local authority as a parent requires consideration of the care system and the policies relating to neglect and abuse within care settings.

2.13 Residential care and Institutional Abuse

Residential care had already been viewed as a less desirable option for placement of children in care at the time of the Curtis Report (Packman 1981, Butler and Drakeford 2005). Packman described the children's homes of the time as 'mouldering bastions' with decrepit buildings, inadequate and unsuitable equipment

and almost Dickensian lack of homeliness. Staff in children's homes seldom held the same professional qualifications as those undertaking community based social work. Whilst the older Poor Law homes were replaced under the new postwar administrations, the Williams Committee in 1963 still recommended that residential care staff should be qualified above the level of domestic workers, but their skills were still based on household skills with limited theoretical input at 'elementary level' and the workforce was largely female (Packman 1981).

Efforts had been made to make homes more human in scale and to develop more family scale groups (Packman 1981). Corby et al (2001) point out that it was not until funding became more difficult due to wider economic problems in the late 1970s that local authorities began to increase the numbers of children placed in less expensive accommodation such as foster care or adoption (Corby et al 2001, page 32). Residential care was still the option for placement of children and young people with severe problems and challenging behaviour who could not be accommodated in foster care and still required residential units. Corby et al (2001) also argue that poor standards of residential care and inadequate staff training served to deter the use of such care, except as a last resort. They blame this neglect of residential care for the periodic scandals about the quality of care in residential settings since the 1970s. This seems a plausible link, but the enclosed and isolated settings of some larger or more troubled residential care units would also appear to be a factor, given the limited scope for management overview of some child care practices (Waterhouse et al. 2000, Utting et al. 1997, Staffordshire County Council 1991). Colton (2002) considered the findings of these inquiries into abuse and neglect in residential homes and identified the following risk factors:

- Poorly trained carers with no links to codes of professional ethics, limited management supervision and poor record keeping;
- Children in residential care were generally hard to place, often hard to like very much, sometimes with behavioural or mental health problems, with attenuated links to birth families, schools and home communities. Some had been young offenders and there was peer bullying and assaults;

- Care settings were often isolated, with resident staff at risk of institutionalisation;
- Low status of residential care and staff recruitment problems;
- Lack of independent complaints or advocacy services for children;
- Weak management oversight and organisational accountability;
- Post-Seebohm reorganisation means that generic social services departments had relatively few child care specialists working with children in residential care and able to monitor homes closely;
- The vulnerability of the isolated settings and the children in homes attracted staff with paedophile intentions and gave them scope to abuse children with relative impunity (Butler and Drakeford 2005, Colton 2002, Corby et al. 2001).

The poor quality of training and vetting of staff also meant that some of the most difficult children were being cared for by small, isolated groups of ill equipped staff who seemed equally defeated by the children and by a small number of unsuitable and abusive individuals who sought out such vulnerable settings (Waterhouse et al. 2000). The inquiries into residential homes and the risk factors which applied led to criticism at every level, including central government departments and local authorities (Corby et al. 2001).

There are major underlying differences in policy on child maltreatment, even within English speaking western societies. Mainland Europe lacks the adversarial approach which tends to produce findings which attribute blame, while the UK and US systems remain firmly adversarial, even in child care reports (Ayre 2001). Much of the blame sits with abusive parents and carers, but in public terms, they often appear as unsatisfactory villains due to their obvious poverty, mental health problems and social exclusion. The US context depends on reports of neglect and abuse rather than the UK framework of universal family support services. ‘Messages from Research’ also notes important systems differences between the two countries because US family support services are usually quite separate from those for child protection, leading to a higher level of children in substitute state care and a greater

death rate (Department of Health 1995, p. 94-95). There is no relative cost effectiveness data on either type of system, but the costs of long term state care are likely to be higher, relative to a system where at least some children can remain with their families.

The emphasis in the USA is seen as '*child rescue and strong prevention*' through substitute placement of neglected or abused children, whilst the UK favours '*child protection and family support*' (Department of Health 1995, p. 96, italics in original text). The US system which separated family welfare services from child protection did not persist in the UK following the Seebohm report in 1968, which recommended that child care specialists work within a generic social work department, able to deal with the needs of the family as a whole unit. Whilst family support as a mechanism for supporting children in need has been a priority in the UK since 1948, the public expectation that children will remain safe within struggling family units has been reiterated by successive legal inquiries into the deaths of children at the hands of family member since the case of Maria Colwell in 1974. The deaths of children are unusual events in a developed western society and although more children die in accidents involving road use than in abusive incidents, child homicide remains a major political issue.

2.14 Children's needs and family welfare

The incoming New Labour administration in 1997 announced child and family welfare measures across a number of departments of state, including the ending of child poverty within twenty years (Blair 1999). There have also been major policy developments affecting child protection, renamed child safeguarding to reflect the wider scope of the policies it covers. The growth of devolved governments and the scope of policy covered by these administrations have resulted in some diversity of approaches. The focus for this study will be UK and English policy and the theme reflects the overall welfare approach to families and children, rather than targeted therapeutic or social interventions for families deemed to be at risk of neglecting or abusing their children.

Poverty is a major barrier to families seeking to enable their children to achieve their genetic potential for health, growth and development. The idea of ending child poverty in the UK is a radical policy objective, as outlined in the Beveridge Report and the original post war welfare reforms. The implications in terms of child neglect and ideas about the cycle of deprivation which influenced policy in the 1980s suggest that poverty and deprivation may require more than fiscal interventions to make a major difference.

The relative poverty factors which affect children in very low income families are slightly different from those affecting adults in the same families, but they relate to a relative lack of ability to take part in the play and activities enjoyed by children not in severe poverty (Magadi and Middleton 2007). This is quite different from the absolute poverty of earlier centuries experienced when children did not have enough to eat or access to medical care when ill. Severe relative poverty means the inability to afford holidays or school trips, a separate bedroom for children of different sexes aged over 10, go swimming or own a bicycle or sports equipment prevents children in severe poverty taking part in age appropriate activities with their peers (Magadi and Middleton 2007). A recent study conducted by Save the Children found that the children most at risk of severe child poverty in the UK lived in the following types of household:

- living in London and Wales, but with the addition of Northern Ireland
- with workless parents
- if parents have low educational attainment
- living in rented accommodation
- if parents have no savings/assets
- in large families of four or more children
- from ethnic minority groups, especially of Asian origin
- in families with disabled adult(s).

(Magadi and Middleton, 2007 p.21)

One policy to address the needs of children living in poverty was the Sure Start programme, which began in 1998 as a series of diverse local projects involving local services and local people, targeted at areas of high social deprivation. The purpose was to support families and children in their earliest years so that the children would be socially and developmentally prepared for school entry, but it was difficult to demonstrate that the interventions made a rapid difference or were even accessible for the most needy children and families (The National Evaluation of Sure Start (NESS) Team 2010). By 2000, the scheme was expanded and following this, resources started to be concentrated in Children's Centres, which were transferred to local authority management in 2004.

The welfare based approach which characterised family policy in the New Labour government of 1997-2010 was replaced by a much more punitive attitude to young offenders and generally unruly children, who had previously been regarded as children in need in the terms of the 1989 Children Act. The policy for young offenders moves from the Department of Health and local authorities to a national Youth Justice Board which was responsible to the Home Office, marking a change in policy which had prevailed since the implementation of the Children and Young Persons Act 1963. A number of new measures accompanied this change including Anti Social Behaviour Orders (ASBOs) for older children and Child Safety Orders for children aged under ten years to enforce supervision of parenting. In addition, Child Curfews were introduced to allow local bans on children under sixteen in particular areas and Parenting Orders were introduced to require parents to supervise their children.

Parton (2010) describes the changes focus on the child as one which considers the child as a state asset, not to be damaged by poor parenting, neglect or abuse. Whilst this stems from the consideration of the child's welfare as paramount and the child as a holder of rights as an individual, it also echoes the libertarian perspective of (Brandon 2001). Brandon's view is that the parent must either raise the child adequately themselves, with welfare support, or earn enough to be able to provide substitute child care. If the parent is unable to function adequately in either of these

two roles, the child is likely to be disadvantaged (Brandon 2001). This is where risk assessment is so important in directing scarce support and resources to children who need it most.

The child focused approach implied by paramountcy of their welfare also appears to have roots in the new understandings about child development, derived from neurological studies of the developing child's brain rather than waiting for any changes to manifest themselves in behaviour or missed milestones. Studies of the outcomes of child neglect and abuse in relation to brain and cognitive development are grouped under three main themes:

- neurological development as evidence by direct studies of the brain;
- neurological development and responses to stress hormones, both in terms of the brain itself and in terms of behaviour and mental health;
- indirect study of behaviour and mental health alone without reference to neurology.

The processes of child development occur from conception onwards. The influences on the outcome of the development range from the intrinsic genetic inheritance and the biological growth and differentiation processes they encode through a range of widening environmental and cultural effects including interaction with family members and the effects of parental care. The kind of parental care an adult will provide relates to their feelings toward the child, including maternal bonding and attachment, the parents' understanding of the nature of the child and their expectations and the models of childhood which inform cultural norms about what children can do and understand. Given this range of influences, the child can be considered a bio-psycho-social entity; developing according towards his/her genetic potential, provided that the parent is able to meet their various needs and support the child.

Studying the outcomes of child neglect and abuse is complicated by the fact that the range of behaviours currently considered neglectful or abusive are diverse in nature

and appear to have varying impact depending on their duration and the age of the child at the time. Similarly, the outcomes attributed to neglect and abuse also range from inadequacy and school failure, depression, substance abuse and dissociative symptoms, through to violent and aggressive behaviour towards other adults and children (Bolger and Patterson 2001, Cicchetti and Howes 1991, Cicchetti et al. 2006, Coggins et al. 2007, Crouch and Milner 1993, De Bellis 2001, De Bellis 2005, Downey and Walker 1992, Eigsti and Cicchetti 2004, Hildyard and Wolfe 2002, Joukamaa et al. 2008, Lupien et al. 2006, Maughan and Cicchetti 2002, Maughan et al. 1996, Paz et al. 2005, Pears and Fisher 2005, Perry 2002, Reynolds et al. 2004, Scarborough and McCrae 2008, Veltman and Browne 2001, Warr-Leeper 2001, Widom et al. 2007, Zielinski and Bradshaw 2006).

Legislative and policy responses tend to group together the kind of behaviours towards young children that are described as neglectful and abusive as if they formed a single social phenomenon, but this is not supported by detailed studies of the experiences of children or the outcomes which are linked to them (Cahill et al. 1999, Chartier et al. 2007, Makhija and Sher 2007, Manly et al. 2001, Spencer et al. 2006, Strathearn et al. 2001, Vig and Kaminer 2002, Zhou et al. 2006, Zielinski and Bradshaw 2006). This is important if areas of therapeutic provision are difficult to access or underprovided, such as specialist child and adolescent mental health care (McDougall et al. 2008, Stiffman et al. 2010).

Potential influences on the outcome of child development range from the intrinsic genetic inheritance and the biological growth and differentiation processes they encode through a range of epigenetic, environmental and cultural effects, including interaction with family members and the effects of parental care. The kind of parental care an adult provides relates to their feelings toward the child, including maternal bonding and attachment, the parents' understanding of the nature of the child and their expectations and the models of childhood which inform cultural norms about what children can do and understand. Given this range of influences, the child should be considered as a bio-psycho-social entity, developing according

towards his/her genetic potential, provided that the parent is able to meet their various needs and support the child.

Neurological impairment is easier to relate to direct head injury than to emotional abuse or neglect (Karandikar et al. 2004). Given the complexity of the phenomena comprising our ideas of neglect and abuse and their aetiology, the problems of severity and chronicity and the changing vulnerability of the developing child, establishing any common mechanisms to account for their outcomes is unlikely to be simple (Rutter 2002). There is no simple syndrome of effects resulting from neglect and abuse which affects either the brain itself or other aspects of development, but there are developmental sequelae commonly identified in children and adolescents who have suffered maltreatment early in life (Glaser 2000).

The likelihood of links between the observed psychopathologies of children who have suffered various forms of sustained neglect or abuse and the physical and cognitive vulnerability of the developing brain has been the focus of thoughtful reviews although there is limited in vivo evidence of such processes, or indeed, of normal child neurological development (Gogtay et al. 2004, Paus et al. 1999, White et al. 2002). The evidence may be limited, but the theoretical links have been extensively explored (De Bellis 2005, Haskett and Willoughby 2006, Hildyard 2002) and so have the correlations between childhood experiences and cognitive ability (English et al. 2005).

The direct study of children's neurological development is difficult because even modern imaging techniques such as magnetic resonance imaging (MRI scans) are difficult for young children to tolerate. Samples are often too small to identify age related changes, plus findings need cautious interpretation because of differences related to genetics, gender and other organic neurological conditions as well as a range of environmental factors, including poor nutrition, prematurity and dysmaturity (De Bellis 2005, Thompson et al. 2007, Toga et al. 2006). Studies of stress and responses have tended to require extrapolation from animal studies and from work with adults who can give consent to examination, but there is one series

of sequential MRI scan studies of brain development in subjects aged from 4 years to 21 years which demonstrates the areas of development and the relative growth and change patterns in cortical development at different ages which suggest that even primate animal studies may not accurately reflect the reality of human neurodevelopment (Giedd et al. 1999).

Other research tends to consider the functional effects of maltreatment on child neurological and psychological development and the correlation between early experiences and later behaviour, such as aggression (Lee and Hoaken 2007). The link between adult psychopathology and violent behaviour and a self reported history of various forms of neglect and/or abuse in childhood is not easy to attribute to specific effects on neurological development, but Lee and Hoaken (2007) link problems with emotional regulation and reactive aggression in adult life with the difficulty of developing regulation in the absence of any positive interactions for children who suffer severe long term neglect. The outcomes included in their overview of the literature include cognitive impairment in relation to potentially threatening situations, which tends to result in abused children showing more aggressive responses than others without such a history. Lee and Hoaken (2007) also suggest that there is evidence that higher cognitive functions may be different among abused children, affecting the young person's ability to attribute thoughts and feelings to others and processing of social information. (Lee and Hoaken 2007).

The physiological and psychological responses to stresses such as pain, fear and chronic anxiety have been studied in adult humans and in animal experiments and the results compared with the outcomes of post traumatic stress disorder (PTSD) in adults (Flinn 2006, Glaser 2000, Perry and Azad 1999, Perry and Pollard 1998). The harm suffered by children who are neglected or abused is reflected in the numbers of children who suffer problems later in their lives, either in terms of their mental health, their relationships with others, or conflict with the law.

Some families appear unable or unwilling to provide an adequate and safe environment for children and present a number of barriers to effective intervention

by agencies which might otherwise seek to protect children. This type of problem is illustrated by the report of the Inquiry into the death of Victoria Climbié (Laming 2003). Victoria was brought to the UK following a sojourn in France with her great aunt. She was not identified as living under an assumed name, nor as a child suffering significant harm at the hands of her great aunt, Marie-Therese Kouao and her male friend, Carl Manning. Victoria was isolated by the fact that she spoke too little English to express her needs and never attended school in the UK, although she had contact with adults outside her family as her great aunt sought help with housing and child care. The isolation of migration, separation from family, cultural and language differences was increased by her great aunt's reliance on religious sources of advice which also failed to pick up Victoria's abuse or Kouao's behaviour towards her. She died of serious neglect and abuse without ever coming to the attention of child protection professionals and the inquiry was conducted by a former inspector of social services who was profoundly critical of those professionals who had failed to pick up and address Victoria's needs (Laming 2003). This critique of much of the professional practice was justified by some of the events described, but the actual abuse and neglect was conducted by individuals who successfully concealed the child's own name and her true relationship to them and who failed to help her access school and normal children's universal services. The Climbié report also failed to highlight the role of mental illness in the adults responsible for Victoria's care (Laming 2003). The problems of dealing with adults who lie or withhold information are compounded when they come from a different culture and their motives, mental health and personal histories are not understood in their new country of residence. If the adults in such cases are also overtly hostile and reject or avoid services, there is limited scope for learning about the situation of the child.

The policy response was to instigate major reviews of child protection across England and to begin the development of a major sequence of new guidance (Department for Children Schools and Families 2009a, Department for Children Schools and Families 2005, Department for Education and Skills 2003, HM Government 2006, Laming 2009). The radical review of child protection services in

England was given added impetus by a further child death, that of the toddler, Peter Connolly, in 2008. Unlike Victoria Climbié, Peter was a white British born child living with his biological mother. The isolation of the migrant child was not present, but the lies and withholding of information were common to both cases and so were the criticisms of the professionals who were judged to have failed to protect the child. The women in these cases, Marie-Therese Kouao and Tracy Chapman, both chose to cohabit with violent men and the risks and harm to the children were not identified.

These two cases both represent families where adults presented dangers to children, but their choices to avoid or deceive service providers effectively prevented children being seen and involved. Whilst the Climbié case involved individuals from another culture, mental health issues were very prominent too. In the case of Peter Connolly, his mother actively concealed injuries and facts about the child's abuse. Such families are very different from the Beveridge idea of the family as functional unit of two adults raising their biological children. They raise concerns and doubts about assumptions that family life is benign and the best place for a child to grow up. Adult self interest is not always set aside when some adults become parents and this goes beyond mental illness and impulsive acts of violence. Such ill treatment is pervasive. The chronic neglect and abuse inflicted on Victoria and Peter went beyond the point at which an adult loses control and lashes out at a child. It is this chronic and sadistic nature of such behaviour which is difficult to understand and challenges a normally compassionate approach towards parents who fail to cope with child rearing. In the social policy context where children are perceived as future citizens with human rights and claims upon a society which promotes egalitarian values, it is hardly surprising that a Green Paper outlining main stream of policy work is entitled 'Every Child Matters' rather than 'Every Family Matters'. The focus on the child also includes the concerns about substitute child care identified in the Waterhouse and Utting reports (Utting et al. 1997, Waterhouse et al. 2000).

‘Every Child Matters’ picks up from the Climbié case, but it does not promise to safeguard all children from maltreatment. The aims are broader and there is a strong economic undercurrent, seeking to prevent the costs of some of the child and family related problems which were highlighted under the New Labour government (Parton 2006). These include the school failure rates among Black boys from minority ethnic backgrounds, youth offending, antisocial behaviour, the poor educational outcomes of children brought up in local authority care, persistent health inequalities affecting children from poor families and high levels of teenage pregnancies.

The current context in Spring 2011 is one of change as a new coalition government halts the policy work started by their predecessors and starts to develop its own directions. The major influences will continue to be influenced by the human rights of children and the wider social implications of neglect and abuse of children. Inquiries into child abuse with institutions and families have always challenged policy makers and governments to address failings and prevent future scandals.

The economics of welfare are more challenging in times of economic recession and increased unemployment. This means that services and support for families are likely to require what politicians describe as ‘targeting’ of resources for those families who require support, whilst preventative measures are intended to reduce demand. The child remains a vulnerable person, even within families, and this makes it more likely that formal risk assessments will form part of this targeting or rationing process. (Parton 2006) suggests that the evidence that early intervention is essential to prevent lasting harm to children involves a combination of surveillance and prevention which does not taken the essential beneficence of the family for granted. It remains to be seen how families will respond to such monitoring.

Summary

The protection of children from harm within their own families and other care settings was not always a concern for the British state. Prior to the 1948 Children Act, voluntary bodies acted against cruelty to children and religious groups and Poor Law guardians provided substitute care. The consequences of neglect and severe

deprivation were highlighted when mass evacuation of children from inner cities emphasised the contrast between their lives and those of middle class families (Women's Group on Public Welfare 1943). However, in general, families were acknowledged as the best places for children to grow up and the role of mothers in building normal attachment and bonding with their young babies was seen as essential for children's happiness and development (Bowlby 1946, Bowlby 1990). The need for a consistent and loving carer is still recognised through the later work to develop attachment theory (Ainsworth 1971, Rutter 1981).

The Children Act 1948 created specialist Children's Departments in every local authority with a remit to care for children who could not live with their families, either because their families were not available to do so or because their parents were declared unfit and prosecuted. The role of supporting families was limited, but families whose children became delinquent became part of the Children's Department workload following the Ingleby report in 1960.

Physical abuse acquired a higher professional and public profile during the 1970s following published medical studies on the 'Battered Child Syndrome' (Kempe 1971b) and the death of Maria Colwell at the hands of her violent stepfather in 1973 (Field-Fisher 1974). The concept of 'child abuse' has expanded and now includes much more than physical abuse (HM Government 2010, Hacking 1991).

Successive reports into the deaths of abused and neglected children demonstrated that families were not always safe places for children and the 'rights' of parents to bring their children up as they chose needed to be balanced with the rights of children for safety and care (Blom-Cooper 1985, Blom-Cooper 1987, Reder and Duncan 1999, Reder et al. 1993). This has led to a continuing tension between rescuing children from cruel homes and prevention of the long term consequences of extreme deprivation and neglect on one hand (Laming 2009, Laming 2003, Magadi and Middleton 2007, Marmot 2010) and the pressures to reduce child protection costs and prevent extreme interventions by social workers or doctors (Butler-Sloss 1988, Department of Health 1995). The current rationale for intervention rests on

whether a child has, or is likely to suffer ‘significant harm’ (Home Office et al. 1991). The role of risk assessment is crucial to determining a child’s likelihood of future harm.

In response to public and political concern about child abuse and neglect, central government has become much more prescriptive about how such cases should be investigated and handled (Department for Children Schools and Families 2010, Department of Health et al. 1999, HM Government 2006, HM Government 2010, Home Office et al. 1991, The Welsh Assembly Government 2006). Part of this trend has been to expand the role of locally commissioned Child Death Reviews into child deaths and Serious Case Reviews into serious cases or abuse or neglect. The focus has been increasingly critical of social workers and paediatricians working in child protection (Laming 2009, Laming 2003a, Blom-Cooper 1985, Blom-Cooper 1987, Haringey Local Safeguarding Children Board 2010, Butler-Sloss 1988, Jones 2009).

This increased concern has led to voluminous guidance, including guidance on training, practice and management of social workers (Department for Children Schools and Families 2009, Department for Children Schools and Families 2005, Department of Health 1995, Department of Health 1988, Department of Health et al. 2000a, HM Government 2010) and a new ongoing review into child protection (Munro 2011). The rules based approach of prescriptive guidance naturally expands in volume as the scope of child abuse as a socially constructed category expands (Hacking 1991). This has not always been welcomed by the child protection professionals themselves (Pithouse et al. 2009, White et al. 2008). Despite this plethora of guidance, formal risk assessment tools have not been advocated in English child protection policy and guidance. This reflects the lack of UK research studies into risk assessment tools in this context, although the use of risk assessment for recidivism and violence has been recognised in criminology and forensic mental health settings respectively (Douglas et al. 1999, Douglas et al. 2009, Douglas and Skeem 2005, Doyle and Dolan 2006, Dutton and Kropp 2000, Hart et al. 2007, Hilton et al. 2006).

Prevention implies that future needs can be reduced, but early intervention requires early identification of problems in child welfare and it remains to be seen how this will be delivered.

Chapter 3

Literature Review: Theoretical Background to Risk Assessment in Child Protection

3.1 Theoretical perspectives on risk assessment

The epistemology of risk assessment in this context is an area of dispute among experts in child protection in the English speaking literature on child and family welfare. The dispute concerns the nature of child abuse: whether it is an objective reality, or a socially constructed category of behaviour. The way in which the concept is considered affects the methods used to study it. In particular, because this work looks at formal risk assessment models, it affects whether formal statistical estimates of risk can or should be undertaken in the decision making process about whether a child is safe to remain at home if abuse or neglect has already taken place. The debate illustrates the conflict between positivist scientific research perspectives and the concern to reflect the uncertainty about the diversity of the phenomenon and the families where it takes place, the meaning of such acts and the socially constructed nature of the mixed category of activities comprising child abuse. The phenomenon of child abuse has expanded over the last fifty years. The experiences it includes are diverse (Hacking 1991). This expansion is reflected in the history of the literature published in English (Behl et al. 2003).

Parton et al (1997) and Behl et al (2003) seek to demonstrate that the discovery and social construction of the concept of child abuse and neglect has proceeded through stages which progress from the physical signs of deliberately inflicted injuries to subtle forms of adult behaviour which is construed as harmful to children (Parton et al. 1997, Behl et al. 2003). Whilst each stage of new understanding and inclusion of new forms of neglectful or abusive behaviour and the factors underpinning them have involved reconsideration of the concept of child abuse, Parton et al (1997) state: 'For the victims, perpetrators and families involved an experience which they choose to call abuse clearly does exist.' Parton et al, 1997, p. 71. The long term

effects of neglect and abuse affect the growth, development, mental health and life chances of maltreated children and these are substantial consequences, although both neglect and abuse of children are rare.

Much of the published material remains focused on exploratory, phenomenological approaches seeking to understand the psychological and sociological factors which contribute to the neglect and abuse of children. Some studies also look at how the behaviour and deeper subjective understandings of social workers involved with such cases affect their understanding of cases and the decisions they take (Ferguson 2004, Firkins and Candlin 2006, France et al. 2010, Horwath 2007, Houston and Griffiths 2000, Houston 2001, Webb 2001). Such approaches encourage reflection and learning, but in terms of finding the most effective means of preventing harm to children within the private space of the family, they pay too much attention to professional subjectivities and too little to the problems of parents who maltreat their own children. They generate useful theoretical insights and hypotheses, but not practical tools to support professionals who work daily with the most difficult decisions in child protection. In such an exposed and difficult task, it is at least as important to be able to identify the family circumstances which may place children at risk of maltreatment so that preventative and therapeutic interventions can be applied and children appropriately protected.

3.2 A positivist approach to risk assessment

If children are to be prevented from suffering abuse and neglect to their danger and detriment, prevention through family welfare services and early identification of children in need of protection will be essential. In a state where the welfare of children is a priority for producing a healthier and more productive population, a society as a whole accepts a need to prevent such ill effects whenever possible. The costs to states of failing to prevent child maltreatment where possible tend to result in greater costs for mental health and criminal justice interventions which may be required to address the consequences (Brandon 2001).

Early intervention minimises the ill effects of adversity in infancy and childhood. This need to predict and prevent significant harm is implicit in the successive guidance documents on protecting children issued after the Children Act 1989 (Department of Health 1988, Department of Health et al. 1999, HM Government 2006, HM Government 2010, Home Office et al. 1991).

Very few families ever abuse or neglect their children. In UK society, child rearing is an essentially individual activity conducted largely in the private sphere of the family. It is unlikely that decisions on risk assessment for child neglect or abuse would be made with perfect information, but even if it were, the existence of risk factors does not determine that a parent will maltreat a child. These two circumstances mean that means that precise prediction of the outcomes of any specific case is unrealistic, but probabilistic estimations of broad levels of risk may be possible. This would enable more intensive resources and support to be allocated to families and children whilst they are in difficulties, in order to reduce the risks of neglect and abuse.

3.3 Risk assessment: the research approaches in Britain and North America

Risk assessment in general is an attempt to predict possible events and in the case of probabilistic risk assessment, to quantify the likelihood of some specific type of event based on knowledge that is available, even though it is incomplete and calculations cannot include all the possible factors which might affect outcomes. In complex human situations, such as that of adults and children in a family, some circumstances will be known and others not known. For example, complex physical systems such as weather systems and climate studies contain many unknown factors too and probabilistic predictions must be made with a degree of uncertainty. This is true for assessments of risks for children within families too. The fact that we choose to use statistical methods in studies where data cannot be complete defies

uncertainty in the hope of making some sense of complex systems. From such beginnings, by refining assessments of risks and the known factors we use to calculate them it is possible to gradually improve their accuracy. The same hope underpins research to develop risk assessment tools for child protection work. The following chapter on the nature of these assessment tools will describe some of these processes.

This commitment to empirically derived standardised risk assessment tools has been particularly notable in North American research published between 1990 and 1999. A brief tracking exercise to compare the numbers of publications on this subject showed sixty research publications, of which nineteen were of UK or Australasian origin (attached as Appendix D). Whilst some of these non-US studies attempted to use Serious Case Reviews, localised prospective studies or studies of child homicides as their sources for potential risk factors, none used large case-based datasets as their sources and a few were positively sceptical about the usefulness of such approaches (Agathonos-Georgopoulou and Browne 1997, Browne 1995a, Browne 1995b, Dingwall 1999, Dingwall et al. 1995, Drury-Hudson 1999, Falkov 1995, Goddard et al. 1999, Gordon and Gibbons 1998, Gough 1998, Hetherington 1999, Lindsey and Trocme 1994, Lloyd and Taylor 1995, Munro 1996, Munro 1999, Parton 1998, Reder and Duncan 1999b, Reder et al. 1993a, Wilczynski 1997, Wilczynski 1995). It is tempting to conclude that the scope of research and choice of methodologies in child protection research may be limited by the lack of large, adequately detailed databases populated from real cases and their outcomes.

The social policy responses to such requirements have taken many forms, depending on the nature of the society and the degree of oversight of family life that is considered proper by citizens, the extent of central government funding for agencies and professionals may to undertake surveillance, assessment and interventions on behalf of the wider society, together with that society's perceived duty towards children and the alternative forms of care available. While most of this study will focus on the systems for child protection within the UK, specifically within English

law and welfare systems, there will be references to different modes of addressing similar problems in North America.

Government funding for welfare services within US policy debates is controversial because of the relatively libertarian approaches to social policy compared with much of Western Europe, including Britain. This makes redistributive taxation measures less acceptable to many north American voters and 'big government' is seen as undermining individual constitutional freedoms (Nozick 2003). One interesting factor in North America was the introduction of mandatory reporting of suspected cases of child neglect and abuse introduced between 1963 and 1967 (Mathews and Kenny 2008). This policy increased initial reporting rates substantially and child protection agencies were interested in using risk assessment tools to prioritise cases, allocate resources and manage workloads.

Much of the empirical research on risk assessment models in child protection work derives from north American studies, because during the 1990s large databases of case data and outcomes information were available to researchers working on child protection issues from the National Data Archive on Child Abuse and Neglect (NDACAN), whose mission is 'to facilitate the secondary analysis of research data relevant to the study of child abuse and neglect. By making data available to increasing numbers of researchers, NDACAN seeks to provide an accessible and scientifically productive means for researchers to explore important issues in the child maltreatment field.' (See the National Data Archives website at <http://www.ndacan.cornell.edu/NDACAN/AboutNDACAN.html>). Even such large dataset have their defects, including a high attrition rate among the very families who are most needy and who move frequently. Such databases are unusual in the UK and despite the current UK Data Archive (administered by the Economic and Social Data Service (ESDS), at the University of Essex); no comparable data sets exist for the study of British child protection cases. More complete information is available on child homicide cases, where the legal processes tend to result in retention of all data (Pritchard and Bagley 2001).

The UK Data Archive is a research resource drawing on data from three large cohort studies: 1958 National Child Development Study (NCDS), the British Cohort Study (BCS70), and the Millennium Cohort Study (MCS). Whilst each is a rich resource for developmental and health data on a group of children, socioeconomic circumstances and parental problems are not recorded in the level of detail envisaged by the Framework for Assessment of Children in Need and their Families (Department of Health et al. 2000a). As they stand, these cohort studies are too narrowly focused on child health to yield the kind of data mining results for researchers which has been achieved by the north American National Child Abuse and Neglect Data System (NCANDS) (see the National Data Archive on Child Abuse and Neglect at Cornell University (http://www.ndacan.cornell.edu/ndacan/Datasets/Abstracts/DatasetAbstract_NCANDS_General.html)).

As with all statistical tools, the larger the data set used to develop the tool, the more likely it is to be accurate. Insurance companies draw on very large population data relating to deaths in order to minimise the costs of meeting claims for health insurance in high risk groups, such as smokers. Smokers may be denied insurance, or charged a higher premium for cover. The higher the risk that an insurance company will have to pay out on a claim, the higher they are likely to make the premium cost of the insurance policy to the customer. In practice settings, it is unlikely that any one local child care organisation will have the necessary large, complete and accurate data sets to undertake the prospective statistical work required to make their risk assessment tools as accurate as a population data set over a long period of time. In the UK, there are no large computerised databases of children's information and it is unlikely that these will be available in the near future because of concerns about data security and the social implications (Penna 2005) of using data collected for one purpose (care provision) to promote another purpose (research). This means that it would take a substantial prospective study to develop a new set of properly validated and reliable factors for risk.

There are such data sets available for child protection in the USA, where welfare and health care services tend to be insurance based and richer in data. In addition, there are substantial data sets from multi-centre longitudinal studies of growing children such as the American Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) consortium of researchers commenced in 1991 and contributes to the National Data Archive on Child Abuse and Neglect (NDACAN). Such data has been made available to a wide range of researchers studying child abuse outcomes since 1989 and this is reflected in the brief review undertaken below. The growing data set has formed the basis for more than eight hundred published studies linking a range of bio-psycho-social circumstances with adverse outcomes like neglect and abuse.

This disparity in access to cohort data for quantitative studies of child neglect and abuse has tended to limit UK based child protection studies to qualitative approaches using secondary data from Serious Case Reviews (formerly Part 8 Reviews) rather than accessing large scale anonymous databases from a wide range real cases (Brandon et al. 2009, Brandon et al. 2008, Brandon et al. 2002, Reder and Duncan 1999b, Reder et al. 1993). Unfortunately, the successive ‘Working Together’ government guidance publications have tended to emphasis looking for agency communication failures and problems in carrying out prescribed assessments (Littlechild 2008). This is reflected in the successive reports from reviewers and in recent published reviews such as the Ofsted review, there is frustratingly little hard information about the families and children most involved in the incidents (Ofsted 2010). The purpose of such reviews is to learn lessons from cases where children have died or suffered serious harm, but although airline risk management emphasises the need to review process failures, in the context of child protection this needs to extend to service users as active participants in the creation of risks to children. Understanding families and their circumstances can only emerge from studies of those families and those circumstances, not from studies of agency responses and failures.

Recent proposals from the Social Care Institute for Excellence (SCIE) have suggested a systems approach similar to that used to investigate complex engineering and aviation systems failures (Fish 2009). This applies techniques which have been honed in industrial settings for identifying and remedying failures in child protection services in a less exposed and forensic manner than the child abuse inquiries of the 1980s and 90s. This is a promising development, but tends to be focused on managerial and service focused issues and these are not the main causes of child neglect and abuse. Social workers and other child protection team members are not fundamentally responsible for the abuse, so learning more about their behaviour may not help to identify family-related risks or develop strategies for primary prevention of neglect and abuse. Any such developments depend on understanding how and where direct risks of abuse arise.

The implementation of prospective child protection risk assessment as a policy within the UK is controversial and an inadequate risk assessment may be more misleading than unassisted professional decision making. In the second part of this literature review, specific risk assessment tools and their reliability will be considered in more detail.

3.4 Measurement of risks as public policy

In order to measure risks and allow them to influence public policy, it is argued that three conditions should be satisfied. This is based on the requirements for the introduction of public health measures such as vaccination or screening programmes for inherited diseases, which are themselves conducted to reduce the risks of disease. Firstly, there has to be an adequate good quality scientific evidence that the behaviour or situation which poses the risk is linked to the undesirable outcome to be avoided. If vaccinating babies against measles, mumps and rubella cannot be demonstrated by properly conducted scientific studies to be a major cause of

childhood autism or intestinal problems, the less likely it is that immunisation is a risk for such outcomes compared with the risk of the disease that it is intended to prevent (Wakefield et al. 1998, Hornig et al. 2008). No amount of anecdote or assertion can take the place of scientific evidence resulting from well conducted research.

Secondly, there must be minimal harm to potential victims of abuse and their families resulting from Type I and Type II errors, i.e. false negative assessments and false positive assessments. If there are large numbers of false negative assessments with any standardised tool, then either some children are placed at risk of harm because that risk is missed by the assessment, or families and children are unnecessarily stigmatised and disrupted by being falsely placed under suspicion of child abuse and neglect. Testing for the sensitivity and specificity of the assessment tool using suitable samples with known outcomes, retrospectively assessed using archived records and prospectively tested using 'live' cases should allow this to be calculated. A poorly developed risk assessment test can be expected to operate no better than chance and certainly no better than expert professional opinion, so appropriate statistical tools are required.

The next requirement relates to the measurement of risks which occur very infrequently in populations. Child neglect and abuse are rare phenomena (Sidebotham 2003). Most parents, irrespective of their poverty and difficult personal circumstances will not neglect or abuse their child. The factors which place families at risk cannot be entirely socioeconomic in origin or there would be clear links between similar social circumstances and rates of maltreatment. As Belsky and Vondra (1989) identified, there are intrinsic personal and behavioural risks as well as extrinsic social stressors operating in the rare cases of child abuse (Belsky and Vondra 1989). To identify those families where children are at greater than usual risk and to address their needs requires more than a 'broad brush' child and family welfare approach to whole populations or neighbourhoods (Frederick and Goddard 2007, Klevens and Whitaker 2007, Merritt 2009, Rivaux et al. 2008, Sellstrom and Bremberg 2006, Wadsworth et al. 2008). Prevention through

improved overall child welfare is good. Such policies reduce the stress for even the most high risk families, but they are not in themselves enough explanation of abuse and for many families, intrinsic intrafamilial risks remain important.

The difficulties of population based risk assessments were identified by some early work in England drawing on the characteristics of known abusive families, derived from earlier retrospective studies (Browne and Saki 1988, Browne 1995a, Browne 1995b). The risk assessment tool was used in the perinatal period to identify families at higher risk of abuse and neglect and the cases were reviewed when the children were due to start school to identify the predictive power of the risk assessment. Both sensitivity and specificity were inadequate because of the low prevalence of abuse within the overall population (Browne 1995b). Statistical risk assessments in the USA do not use whole population screening for child maltreatment risk at all, but instead focus on assessing the risk of further abuse within a short period of less than two months from the point at which a child has already been reported as suffering one episode of maltreatment and services are being considered, including removal of the child from home (Baird et al. 1995). This reduces the size of the target population to be assessed and the effects of the rarity of child abuse as a source of statistical error.

3.5 Risk assessment in other complex systems

Risk in general is defined as the probability of an unwanted event which may or may not occur. This is a probabilistic definition which lends itself to being expressed as a statistical statement about how likely the event is to happen, based on the knowledge that we have about the circumstances likely to produce it and the occurrence of these predisposing circumstances. This assumes that we actually know what increases or decreases the risk of the unwanted event *and* that we know the circumstances which pertain at the time when we want to state the level of risk applying in a given situation.

There is a long history of the development of risk assessment and risk management systems in engineering, particularly in the airline industry where the consequences of quite minor flaws in safety or small human errors may lead to catastrophic consequences (Stewart and Melchers 1997). Such systems have also been adopted in food manufacture, to ensure food safety (Foegeding 1997). This trend has led to analysis of the requirements for ensuring safety, the probability that this can be achieved and the consequences if there is failure (Stewart and Melchers 1997). In engineering, but not yet in child protection, there is an explicit need for financial costs such as litigation and reputational losses to be included in the potential consequences of all significant decisions (Guthrie 1998). It is possible that child protection cases could lead to litigation if young adults can establish that the actions (or failures to act) of public authorities had resulted in their coming to harm, but to date all such claims brought in the UK have been settled out of court to avoid formal court judgements creating legal precedents for others to follow. In practice, the public criticism of individual social workers, their managers and heads of services already has considerable impact on public authorities (Laming 2009).

Risk analyses are complex in engineering, which is a relatively 'hard' physical system with known components, predictable in its operations (including management of human operations) and limited in the extent to which the system has to allow for unknown factors. In simple decision making systems, risk can be assessed intuitively, but as soon as the consequences of a decision become substantial or the complexity of the process makes it difficult to ensure a safe system, decision makers need more rational processes to account for their choices (Gordon and Gibbons 1998). One of the approaches used is the inclusion of other expert opinions on methods of ensuring safety, for example by Delphi studies of significant risk factors and developing checklists and risk scores based on those factors which the consensus of expertise considers most important. This approach has been widely used in child protection work and underlies most of those risk assessment tools classified here as 'consensus based risk assessment tools' (Browne and Saki 1988, Milner 1994, Powell 2003).

For engineering systems, it is technically possible and socially acceptable to control processes very tightly to ensure a predictable degree of safety but even in such systems, human error can be hard to manage because the context in which human activities operate and uncertainty which surrounds the risk criteria involved. In practice, complex and variable human systems like a family are hard for a child protection practitioner to even know in detail, let alone predict with any accuracy. To avoid, control or transfer risks identified in hard systems like engineering requires costly safety measures and strict enforcement of process through checklists and processes, programmed component checks and renewals and close monitoring to identify when any deviation from expected pathways occurs (Stewart and Melchers 1997). In contrast, families and their children exist in a private space where there are limits on the acceptability of state sanctioned interventions, let alone controls. Examples of the consequences of overstepping such social limits in relation to families are demonstrated in the Cleveland Inquiry (Butler-Sloss 1988). In practice, professionals also tend to mistrust decision support systems which they do not fully understand, or which appear counterintuitive, or draw on evidence which contradicts their own experiences even when the evidence for formal assessment tools is compelling (Grove and Meehl 1996, Grove et al. 2000, Meehl 1954).

In work with human beings, formal risk assessment has a longer history than child protection in forensic mental health and domestic violence for the prediction of future violence by a specific potential perpetrator rather than the risk to any potential victim (Hoyle 2008). This is a potentially important difference because the focus is in the opposite direction when considering the risks to children from unspecified others, rather than the risks posed by a specific individual to an unspecified potential victim. Risk assessments which focus on 'risk to' rather than 'risk from' are widely used in critical care in hospitals where physiological data is used as scores for key physiological parameters to identify patients at a high risk of sudden deterioration (Duckitt et al. 2007). The common factor with the most accurate predictive tools in each of these diverse systems is the use of well designed prospective statistical studies to identify and weight key factors and (for continuous variables and overall scores) the cut-off points which should apply. This type of assessment of risk is

characterised as actuarial risk assessment, because it uses the same kind of statistical approach as an insurance company uses to identify risk of early death for life insurance and for detailed exclusion clauses in insurance agreements.

3.6 Risk of child neglect and abuse within populations

In the context of child protection, risk assessment attempts to predict the likelihood of further neglect or abuse in future and to reduce this risk through child protection interventions and family support as well as removal of the child from dangerous circumstances (Hindley 2006). Sidebotham notes that in one study, a strong risk factor for child maltreatment was to have a father who had grown up in care himself, but out of 169 families with such a paternal history, 162 never actually maltreated any of their children - approximately 4% true positive cases (Sidebotham 2003). Risks of child neglect and abuse within the population are very low and we do not know how much maltreatment may be concealed. This makes it virtually impossible to estimate the prevalence of such behaviour in whole populations, as though they were cases of a disease (Browne and Saki 1988, Browne 1995a, Browne 1995b). In practice, therefore, most studies of risk assessment relate to the recurrence of further episodes of abuse following an initial report and risk assessment tools are not used to screen whole populations for a primary risk of child maltreatment. All the actuarial risk assessment tools considered in this study screen for risks of future abuse in families where there have been previous episodes of maltreatment.

3.7 Bio-psycho-social effects of child neglect and abuse on child development

The model of childhood used in this study considers child development as a bio-psycho-social model (Cullis and Hansen 2008) based within the ecological system of the child at the centre of a family, within the wider social context of the neighbourhood and community (Belsky 1993, Bronfenbrenner 1974). A child's

family relationships and their environment are important to the achievement of normal adult functioning (Belsky 1993, Bronfenbrenner 1974). If families cannot provide adequate bio-psycho-social support to meet the developmental needs of young children, this can affect their potential development and lead to preventable impairments (Anda et al. 2006, Herrenkohl et al. 1995, Herrenkohl and Herrenkohl 2007). In adult life, such children may be at increased risk of educational failure, poverty, unemployment, mental health problems and even criminality or substance abuse (Rutter et al. 2006).

Human development is influenced by genetics, but long term cohort studies of children demonstrate that their outcomes in adult life are dependent upon external factors from conception onwards, especially those influences which occur early in life (Wadsworth and Kuh 1997). Maternal health and nutrition during pregnancy, parental education and socioeconomic conditions affect many aspects of physical and mental health in later childhood and well into adult life, including some disabilities, education success and social circumstances (Drummond and Colver 2002, Hediger et al. 2002, Kramer et al. 2000, Wadsworth and Kuh 1997). Given the evidence that substantial adversity and parental disadvantage can affect their children's outcomes so diversely and for so long makes the wider policy on child welfare very important (Conroy et al. 2010). Improving the outcomes for the next generation depends on improving the health and welfare of their parents, especially mothers, but some of these disadvantages persist even where welfare and maternity services are good (Thompson et al. 2006). There are tensions for child protection teams between the desire to support families to care for their own children and the paramountcy of the child's individual best interests together with any expressed views of children themselves. This complex range of factors makes it very difficult to weight them singly and in combination when undertaking unaided decision making but given an adequate dataset, this is the sort of process that is suitable for statistical analysis to identify the most significant factors increasing the risk of future neglect or abuse.

For the purposes of this study, child abuse or neglect covers the kind of parenting behaviours which fail to meet the needs of the child for the biological, psychological and social support which will enable their normal health and development expected for their age. It also includes acts which would be considered morally wrong or legally proscribed behaviour in relation to any another individual (e.g. offences against the person such as rape, assault or homicide) irrespective of their resulting effects on the child's health and development. Children are vulnerable to significant harm resulting from neglect or abuse in ways that adults are not, because of their immaturity and because they require reasonably favourable circumstances throughout their childhood years of development in order to achieve their full potential as adults.

The difficulties of children who have suffered chronic high levels of stress in childhood resulting from various types of neglect and abuse have also been correlated with higher rates of adult mental health diagnoses of posttraumatic stress disorder, depression and disorders of mood (Bremner 2006). In more recent work, links are identified between a history of childhood neglect or abuse or chronic exposure to violence and later health, cognitive and behavioural problems in children and young people (Chartier et al. 2007, White and Widom 2008). These links appear to be modified by factors such as resilience, protective circumstances affecting individual children and by the environment around the child (Jaffee et al. 2007, Rutter 2006, Rutter et al. 2009, Zielinski and Bradshaw 2006). The difficulty of distinguishing specific causes and effects is clear from the link between poor health and cognitive outcomes in children who have grown up in poverty and deprivation, especially given the links between early childhood adversity and poverty (Sellstrom and Bremberg 2006). The links are not easy accounted for in such complex life circumstances; whilst studies of the developing brain can show changes in response to chronic childhood stress, it is more difficult to demonstrate the mechanisms behind the correlations (Jaffee et al. 2007, Rutter 2006, Rutter et al. 2009, Zielinski and Bradshaw 2006). The relationship between neglect, abuse and developmental outcomes is not simple and deterministic, because some children appear to flourish despite some adverse circumstances and experiences and others

find solace and support which enables them to cope better with adversity. Many studies identifying the nature and circumstances of abusive families contribute to our understanding of the complex nature of child neglect and abuse, its aetiology and its sequelae (Beckett et al. 2006, Famularo et al. 1996, Modestin et al. 2005). There is a correlation between the experience of a neglectful and abusive childhood and psychopathology in adult life, including abuse of the children of previously abused adults (Glaser 2000, Rutter 2003, Springer et al. 2007). The mechanism is unclear because such adverse experiences in childhood do not consistently determine adult outcomes and many children are protected from, or appear resilient to, circumstances which would harm others (Collishaw et al. 2007, Hardt and Rutter 2004, Horwitz et al. 2001, Rutter 1997, Rutter 1996, Rutter 2002) .

Resilience is difficult to define, but is characterised by a capacity within some children subjected to adverse circumstances in childhood, including neglect or abuse, to cope with the difficulties they face and to develop normally despite their personal histories. It is a comparative term which suggests that an individual has coped better than might be expected, given their circumstances (Hill et al. 2007) and it relates to the expected trajectory of growth and development which they might be expected to achieve over time (Rutter 1985). Indeed, Hill et al (2007) see resilience as a counterbalance to elements of risk, together with the presence or absence of protective factors which protect a child or moderate the effects of risk (Hill et al. 2007). Given this interaction of factors and circumstances, predicting risk in specific cases is unlikely to be simple. The possibility of resilience among abused children could not justify their being exposed to risks which might be reduced through effective child protection interventions.

Despite the difficulties of protecting children, the evidence that some types of support and positive experiences can counterbalance the adversities of neglect or abuse mean that many children can be helped to recover from early adversities and catch up with their peers. Some children have been identified for whom there are buffering factors which prevent the worst effects of childhood adversity or enable

children to remain resilient to them (Rutter 1993, Rutter 2007, Rutter and Colvert 2007). Hill et al (2007) identify the concept of resilience as having 3 levels:

- *individual or internal*, e.g. intelligence, gender
- *family*, e.g. quality of relationships, cohesion
- *community or society*, e.g. level of social support

(Hill et al 2007, p.9)

Just as the factors underlying resilience could operate at any of these levels to support the child through adversity, risk can also arise from a range of sources. Risks could arise on any of 3 broad levels: the individual child, the family and the community of neighbourhood, analogous to the model of childhood which sites the individual child in the context of the ecology of the family and the society in which it lives (Belsky 1993). This makes the task of risk assessment much more complex because child maltreatment is the result of a range of factors from each of these 'layers' of context (Individual, families, community and culture), each of which may interact and change over time. The review into the death of Victoria Climbié conducted by Laming (2003) identified the need to ensure that agencies communicated information which they previously held within their own records systems, so that there was a single core assessment of any child in need. The Framework for Assessment would have supported this, if the child herself had ever attended school or received normal primary health care, but it would not have enabled any access to the information known to informal contacts such as Victoria's childminder, church members or acquaintances. Many of the witnesses who brought information to the Inquiry would never have met or exchanged information on such cases and this is true for many other review cases where full disclosure was only available after the children had died.

3.8 Risk assessment and decision making in English child protection teams

Child protection is a complex area of practice and cases may involve a number of children within a family, sometimes over periods of many months and more than one episode of care. The current mandate for child protection in England and Wales is based on the legislation in section 47 of the Children Act 1989 and prior to 2000, guidance for child protection investigations was provided through 'Protecting children: A guide for social workers undertaking a comprehensive assessment', otherwise known as the Orange Book, which applied in England and Wales (Department of Health 1988). This focused wholly on the assessment of factors which related to possible neglect or abuse. It was replaced by the Framework for the Assessment of Children in Need and their Families and related computerised information systems, launched in 2000 (Department of Health et al. 2000a). The Framework for Assessment still forms the outline for most assessments although its relationship to professional ontologies and values and the realities of busy practice have been questioned (Daniel et al. 2005, Gilligan and Manby 2008, Pithouse et al. 2009, White et al. 2008) .

In practice, the process of assessment of cases also involves data collection over a period of time and from more than one agency or worker. Records for children and families may become bulky and hard to search over time because there may be limited structure and scope for summaries and updates of key information. Rules of evidence in presenting cases which require court decisions also affect the information which needs to be collected to inform the judicial decisions. Child protection decisions may have to be taken urgently, with incomplete information, but they can have massive implications for children and their families (Drury-Hudson 1999). Access to information is also fundamentally controlled by the family because the family home is a private place and there are limits to public services' knowledge of this sphere and their ability to judge its functioning. The Children Act 1989 s.31 introduced the idea of 'significant harm' as a way of identifying the child who was suffering, or at risk of suffering harm from neglect or abuse (Brandon et al. 1996).

The Framework documentation (Department of Health et al. 2000a) was designed to improve the outcomes of children by enabling better information sharing between agencies and professionals. Communicating and sharing information between agencies has been highlighted in many of high profile case reviews which follow a death or serious harm resulting from neglect or abuse (Reder et al. 1993b). Following the inquiry into the death of Victoria Climbié, the UK government also proposed that a national linking information system would enable the key professionals involved with a child to be listed on a nationally available database relating to named children in England (ContactPoint), although this was suspended in 2010 and data will be destroyed. The Framework is described as an empirically based approach to the management of child protection cases where children in need of protection were seen as a subset of those with wider family-related needs where the child is at risk of suffering ‘significant harm’, or has done so. It sits within a family welfare context, where abuse and neglect is a rare finding, although rationing of limited services tends to mean that only cases in the greatest need may receive continuing support.

The role of assessment is presented as a dynamic process within the Framework for Assessment from the outset. The needs of the child are linked with parenting capacity (Department of Health et al. 2000a). The knowledge base required for decision making to assess needs for family support and specific needs for child protection is stated to be part of the existing knowledge of the professional/s undertaking the assessment, so no new competencies are specified, although parental responses to the developmental needs of the child (depending on his/her age and whether the child has any existing impairments) may affect their ability to reach normal developmental milestones (Department of Health et al. 2000, p. 55-56).

3.9 Problems with risk assessment in current English child protection practice

Cooper (2003) analyses how the Framework for Assessment copes with the issues of risk in child safeguarding. Risk is seen as an interaction between components of

value and probability, but Cooper finds it almost impossible to determine risk to specific children within the Framework (Cooper 2003) and (Calder 2003) finds no clear interface between family support and child protection (Calder, 2003, p.9).

There is a danger that checklists tend to restrict risk assessment to the factors which form the listed components of any given tool (Cooper 2003, White et al. 2008). Cooper (2003) criticises existing published risk assessment models on the grounds that none of them provide a 'sufficiently detailed and systematic child-focused structure facilitating the identification of 'risk relations' to guide the assessment.' (Cooper, 2003, p. 103). They fail to analyse risks and benefits or strengths of the factors symmetrically and are unable to bring the risks of specific factors together in a valid way to identify asymmetries which may pose a risk to the child concerned. In terms of the Framework for Assessment, factors would have to be assessed in terms of their symmetry on the 3 separate dimensions being assessed – the child's developmental needs, the family's capacity and the environmental circumstances. This would give rise to a very complex risk calculation which is not included in the Department of Health publication on assessment (Department of Health et al. 2000a). Cooper (2003) uses three dimensions of assessment based on the Framework for Assessment domains to map the risk to children in relation to the possible deficits in these parameters, relative to acceptable family and environmental factors and to normal child development.

The issues Cooper identifies which underpinned the development of the Framework for Assessment lie in social work practice and the nature of the circumstances under which child and family assessment has to be carried out (Cooper 2003b). These include time pressures, limited knowledge or ability to manage multiple sources of data and an intuitive approach to decisions. He cites Beach (1997) in relation to research on naturalistic decision making by professionals such as fire fighters and ambulance personnel in situ (Beach 1997). Beach in turn draws upon earlier work by Klein on his Recognition-Primed Decision Model which requires the practitioner to recognise the situation as familiar and as one for which they have been trained to

set particular goals and expectations and to give an appropriate response (Klein, 1993).

This type of pattern recognition based decision making is not a formal analytical process, but it does have advantages in familiar situations when there are time pressures and decisions have to be reached quickly. If the situation is not familiar, the model requires the practitioner to gather further information in the hope of recognising the type of situation presenting itself and being able to envisage appropriate goals and adapt existing solutions to the specific circumstances. This is common in medical diagnosis, where the focus moves from dealing with signs and symptoms to identifying specific pathologies as test results and investigations narrow the range of alternative diagnoses and physicians seek to confirm a final opinion. Recognition increases as the practitioner becomes more experienced in their area of practice, but beyond this description of the behavioural patterns, the psychological mechanisms of recognition and decision making remain unclear (Beach, 1997, p. 146.).

The problem of making decisions in child protection work also relates to the way in which social workers in child care work gather and manage their information. 'Messages from Research' requires practitioners to engage with every level of the ecological model of the child in their family and community context (Department of Health 1995). For Cooper (2003), the pressure to move away from use of child protection processes to manage cases of children and families in need, together with the lack of structure offered by the 'Orange Book' (Department of Health 1988) to practitioners meant that decision making tended to be of poor quality and not well directed (Cooper 2003).

Successive reviews such as that of Utting (1997) demonstrated a need to provide a framework for practice which fitted with the naturalistic decision making patterns of practitioners under pressure by providing basic set of cues, but avoiding complex risk assessment tools. This enables the focus to remain upon the child and their experiences of their circumstances, but also to allow the assessment to develop over

time as things change within the family and the child develops (Cooper, 2003, p. 109-110). For many practitioners working with human beings, the idea of mechanistic processes of risk factors leading to predictable outcomes is difficult to accept. They work towards risk mitigation and reduction through positive, respectful and optimistic support for families who struggle to cope in adverse socioeconomic circumstances, but at the same time, the consequences of failure to protect a child are severe for social workers and their employers (Laming 2003a). Decision making within the realities of everyday practice may not be well informed by the developing evidence base on what works for children and families (Webb 2001). As Stephen Webb's critique of the epistemology of evidence based practice states:

‘Heuristics induce people to attend to certain forms of information and ignore others in developing judgements.... Biases in judgements occur as a consequence of using an heuristic to predict an outcome.’

(Webb 2001, p64-65.)

Webb's outline of social work decision making in real life describes the biases as resulting from motivational or cognitive factors. Motivational bias results from the human tendency to form and hold on to beliefs in spite of contradictory evidence when the implications of changing beliefs are distasteful. Cognitive bias arises when information is presented in a form which the individual cannot easily follow. For many people, statistical information requires more effort to understand and follow than verbal reasoning (Webb 2001). Other factors include the interpersonal aspects of the decision, for example if the client is aggressive or hostile, the best intentions can be biased by an urge to maintain peaceful relationships. In addition, information may not be available to the practitioner, or it may be in a form which they cannot fit within their theoretical understanding of their work, or they may simply have no time or practical support to develop or implement decisions based on best evidence. Decisions may be based on personal or professional values, pragmatic inclinations, organisational circumstances and ‘unreflective expectations of how things will change’ as a result of choices made (Webb 2001, p 67.)

To inform professional decisions, child protection services collect information on the child, his/her family and the context in which they live in order to assess the needs of the various family members (DFES 2007). Such information needs to be comprehensive enough to inform a wide range of decisions from immediate need through to long term family support, but also in a form which enables professionals to make decisions on the specific risks to children at any stage and allocate resources accordingly. The process of making child protection decisions requires a balance between supporting parents with limited parenting skills and resources to bring their children up successfully and removing a child who is at risk of significant harm (Drury-Hudson 1999). This means weighing up competing human rights of distressed parents and children at risk, whilst ensuring that the interests of the child are paramount (HM Government 2010, Munro and Ward 2008), responding to the needs of parents whose lives may be very unhappy and chaotic without losing sight of the child's needs (Ayre 1998, Munro 1996), considering the effects of power relationships within families and between families and agencies (Leeson 2007, Rivaux et al. 2008, Webb and Moynihan 2010) and dealing with a body of information which may be voluminous, scattered throughout a chronological record and still incomplete (Munro 2005). This complex task must be accomplished in line with current guidance (HM Government 2010, DFES 2007), draw on relevant research based evidence (Gambrill 2011) and use current assessment systems which do not always fit well with practice processes (White et al. 2008). It must be undertaken by personnel who may have limited experience, at any time of the day or night (Cameron and Statham 2006, Clifford and Williams 2002, Regehr et al. 2010). Professionals also know that their judgements may be exposed to severe criticism if they make a mistake (Blom-Cooper 1987, Blom-Cooper 1985, Donaldson and O'Brien 1995, Haringey Local Safeguarding Children Board 2010, Laming 2003). Under any circumstances, child protection decision making would be considered a complex and difficult task and a major limitation of current decision support tools lies in their ability to help focus and analyse the particular risks to children in this difficult practice environment (Cooper 2003).

The policy emphasis in the Framework for the Assessment of Children in Need and their Families places child protection investigations and actions (under Children Act 1989, Section 47) in the wider context of working with children and families with a range of needs for help and support (under Children Act 1989, Section 17) arose from the influential publication of a selection of research work in 1995, 'Messages from Research' (Department of Health 1995b). This group of (mostly) UK based research teams considered child abuse research following the Cleveland inquiry report and the effects of child protection investigations on parents is a important theme of the collected studies (Butler-Sloss 1988). They identified a model of abuse which placed it on a continuum of carer behaviour, with carers themselves often coping with poverty, violence and mental illness which might lead them to maltreat a child (Cleaver and Freeman 1995).

The Framework was also launched to place children in need of protection alongside children with many other needs. It drew on previous documentation developed for 'looked after children' in the care system developed in response to the Review of the Safeguards for Children Living Away from Home (Utting et al. 1997) and reflecting the ecological model of child development in context developed earlier by Belsky and Vondra (Belsky and Vondra 1989). The Framework requires data to be grouped under a new set of related domains, with the child and their developmental progress at the centre of the assessment process (Belsky and Vondra 1989). It is not intended as a tool specifically for child safeguarding work, but as a framework for assessing every child considered to be in need, with those in need of protection as a subset. This sets child neglect and abuse on a continuum of child and family welfare needs, rather than maintaining them as a separate category of 'at risk' children. It marked a change from the earlier Department of Health guidance '*Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment*' (Department of Health, 1988), which tended to consider family and socioeconomic circumstances primarily in the light of their effects on the child and their risk they might present. The Framework for Assessment is stated to be derived from evidence, but the exact empirical sources in primary research are not explicit in the published guidance documents. There is more evidence of careful consideration of

social work practice, its values and its theoretical bases informing this model for assessment (Seden et al. 2001). This may reflect a preference for rationally derived theory over empirically derived evidence, but any evidence based practice needs to draw upon high quality research and this is not always available, accessible or acceptable to practitioners (Crisp et al. 2007, Horwath 2007, Munro 1996, Munro 1999). The Framework was intended from the outset to be the single main structure for all assessments around children in need, not just those in need of protection. It incorporated a number of other assessment tools for specific purposes, such as the Parenting Daily Hassles Scale and Core Assessments for children depending on their age group, alcohol and home conditions assessments (Department of Health et al. 2000b).

Whilst the Framework for Assessment does not offer an additional component to enable risks to be identified for specific children within a family, there is a history of the development and use of such tools in both the UK and North America. The following section will focus on these risk assessment tools and the research that produced them and identify the ways in which the large north American datasets have contributed to the identification of the most important risk factors.

In summary, risk assessment is essential for effective child protection practice and to comply with the requirements of the Children Act 1989 to protect children considered likely to suffer significant harm. The evidence of outcome studies of maltreated children demonstrates that the earlier intervention can take place, the better the outcome for the child's development. Although judgemental approaches based on risk assessment are unpalatable in the context of positive family support and maintaining children in their own homes, the use of effective probabilistic methods of risk assessment is likely to produce a more accurate result and introduce less scope for bias than unaided professional judgement. There are persuasive ethical reasons for using standardised risk assessment models in UK child protection, but there are no current models recommended by the Department for Children, Schools and Families to practitioners.

Chapter 4

Formal tools for risk assessment in child protection

This section deals with the development and evidence base for formal standardised risk assessment tools for child protection. These methods will be compared with others in the fields of criminology, forensic mental health and other health care applications.

4.1 Checklists in decision making

As described in the previous chapter, professional decision making is a highly skilled activity requiring multiple factors and the ability to weigh risks and benefits of different options. In human services, it also involves factors such as compassion for the client and concerns for others than the immediate client. The individual complexity of human beliefs and behaviour will also affect the process. There are possible sources of bias arising from inadequate knowledge, the personal beliefs of the decision maker, the influence of other people involved and the organisation and context in which the decision must be made.

In order to support effective decision making in complex situations, many professions used checklists to bring together factors considered to be important in decisions. These usually refer to risks of adverse events: for example, British nurses commonly use an assessment tool when assessing a patient at risk of developing pressure sores in order to ensure that they consider all the physical and physiological factors which are believed to contribute to the risk of tissue damage (Edwards 1995). Health professionals also use 'early warning scores' from checklists developed to alert them to the risk of a patient's acute medical condition deteriorating and leading to collapse (Duckitt et al. 2007). Neither of these examples are particularly sophisticated and validation and reliability testing is limited, but they serve as

mnemonics to support clinical decisions. The factors included in the assessments are clinically derived and not tested for the predictive power, but dependent on the quality of the clinical knowledge that informs them. This can mean that some included factors are not relevant to the risk that is to be predicted, whilst others which are relevant are excluded (Silver and Miller 2002).

One of the earliest applications of such checklist risk assessments was developed for use in criminology in an attempt to predict whether offenders would re-offend in future if paroled, for example Burgess (1925), cited by (Harris and Rice 2007). Such simple early tools allocated one point for each factor present and summed them for a total risk score. From criminology, the techniques spread into areas where violence risk prediction was important, such as mental health settings (Doyle and Dolan 2006, Dutton and Kropp 2000, Farrington and Loeber 2000, Steadman et al. 1998, Steadman et al. 2000). As the development of simple assessment checklists became more common, the use of statistics to weight different factors and produce different scores for different components led to the development of actuarial scoring systems based on the different predictive powers of each factor.

Checklists in professional decision making are usually developed from a consensus among a professional group about the factors which are important. They tend to rely on common terminology, which avoids definitional differences affecting inter-rater reliability, unless the instrument is used by those outside the professional consensus.

The more sophisticated violence assessment tools used in psychiatry have weighted components, based on the strength of evidence behind their inclusion (Douglas et al. 2009) or on their statistical power to predict the unwanted outcome (Harris and Rice 2007). These developments go beyond the checklist approach, basing risk assessments on evidence and statistics rather than simple professional consensus.

In child protection work, Browne (1995) is critical of the use of checklists such as the tools used to bring together risk factors for neglect or abuse but Cooper defends them as ‘the indispensable guides to alertness and informing our judgement on risk

issues.’ (Cooper, 2003, p. 111). The nature of the checklist and the basis for factors and weightings may partly account for these differences in perspective, but there are real difficulties for practitioners in adopting tools which appear reductionist and superficial in the face of complex human emotions, circumstances and behaviour (Little et al. 2004).

Practitioners working with human beings in all their complexity may regard checklists as superficial and unsafe for use in circumstances where human needs and child safety are priorities (Grove and Meehl 1996, Meehl 1954). It is important that practitioners have a reasonable understanding of how such checklists are based, because they are drawn from post hoc frequencies of adverse outcomes and not designed specifically as reliable predictive tools for the particular new case circumstances in which they are applied. Just because some factors are commonly found in families where children have been abused or neglected does not mean that such factors are causative in themselves. Such socioeconomic factors such as poverty, unemployment and stress are found in many families where abuse never occurs and they cannot be regarded as deterministic. In addition, some researchers such as Saki and Browne (1988) attempt to use risk checklists as postnatal screening tools for whole populations, rather than specific groups of families who are already in difficulties. Since the checklist factors are derived from known maltreating families, rather than whole populations, there is no evidence to support their application to whole populations. Other factors (or interactions between factors) not identified in screening tools may affect the outcome for the child, including the resilience of the child or the ‘buffering’ effect of secure family relationships when the family comes under stress (Browne 1995b, Rutter 2007). Poverty makes it more difficult for any parent to meet all of their child’s needs (Connell et al. 2007), but although such socioeconomic factors are frequently identified in child abuse cases, most low income families do not neglect or abuse their children in the absence of other factors (Klevens and Whitaker 2007, Wadsworth et al. 2008).

The dynamic nature of family circumstances also means that assessment has to be a dynamic process which prompts new reconsideration of risk in response to these

changes. Parents may be cooperative or uncooperative, motivated to change or preferring to avoid the need to do so. The power relationships within families and child protection agencies may challenge assumptions about relationships and motives (Houston 2010). Unquestioning acceptance and support for parents in the expectation that this will improve their parenting may place children at greater risk if their motives are not clear (Haringey Local Safeguarding Children Board 2010).

Cooper (2003) states that social work offers little in the way of strategies for improving parental motivation to change and that there is even less empirical evidence for specific interventions reliably producing successful outcomes (Cooper, 2003, p. 112). Nevertheless, he advocates that cooperation and motivation as essential elements in human behaviour become the third factor in risk assessment alongside the severity and likely probability of harm in order to guide the practitioner in their interventions (Cooper, 2003, p. 113).

The importance of record keeping rests on the fact that it is the practitioner's only way of objectifying their judgements and the evidence on which they have drawn in making them, a distinct improvement on the intuitive and unstructured approaches which preceded the Framework for Assessment introduction (Cooper, 2003, p. 114). Unless the judgements and their rationale are made clear in case discussions or in the context of supervision, it is not possible to explain and account for them.

Browne (1995) identifies five factors which he considers important to the assessment of the parent-child relationship:

- Caretaker's knowledge and attitudes to parenting the child;
- Parental perceptions of the child's behaviour;
- Parental emotions and responses to stress;
- Observations of parent-child interaction and behaviour;
- The quality of child-parent attachment.

(Browne, 1995)

These relate to the parent-child dyad (in practice, usually to the mother) and appear to derive from work relating to Attachment Theory and the ideas of Bowlby (1990). Like Cooper (2003), Browne emphasises the need to use empirically derived tools to assess some of these factors rather than expecting screening tools to do all the work of prediction. They are part of the process of assessing risk, but need to be supplemented by additional data and the use of specific diagnostic tools, where these are available (Browne 1995b). He also concurs on the importance of the potential for change within the child's circumstances and parenting (Browne, 1995, p. 132.). As with most professional decisions and interventions, child protection practitioners lack empirical evidence for much of their practice and interventions and beyond the specific task of risk assessment, there can be very little hard evidence to draw upon.

Precey (2003) considers the issues of risk in relation to current assessment processes and feels that although it is solidly focused on the needs of the child concerned, the Framework for Assessment contributes little to the specific task of risk assessment in child protection cases, because although it structures the multi-agency organisation of knowledge, it does not frame risk factors as a specific element. Risk assessment in relation to future abuse or neglect is more specific than the broad domain of 'ensuring safety', especially in those cases where the parent themselves is either harming a child or placing them at risk of harm from others, for example, by inducing fabricated illness and allowing the child to be subjected to unnecessary and invasive tests and medical treatment. In addition, the 35 day time frame for a core assessment may be either too long to allow action to protect the child, or too short to allow for complex investigations (Precey, 2003, p 307-8). In addition, the requirement to share information with parents from the outset can be highly dangerous where there is a risk that a child may then be harmed more seriously by a parent. There is a reasonable assumption that most parents seek to safeguard their children, or that those who fail to do so fail because they are inadequate and lack support, rather than deliberately harming the child (Precey 2003). There is also limited scope to record details of the mother's own history, which is often significant in cases of fabricated illness.

Precey (2003) also criticises the lack of a requirement for a genogram or a detailed chronology of events such as medical interventions and family changes in the prescribed recording forms to identify what has happened to the specific child and other children in the family. This may include frequent home moves and frequent changes of medical care, important in many cases where parents seek to avoid or frustrate unwelcome investigations. Precey (2003) also notes the failure to draw upon evidence relating to specific abusive behaviours such as fabricated illness. Completing the documentation for the Framework depends on information gathering, but like the Framework for Assessment model as a whole, they do not aid the analysis of risk. There is also an additional possible constraint on social work practice where the forms structure the information gathering to a point where the 'real life' presentation of the situation cannot be properly recorded (White et al. 2008, Penna 2005, Precey 2003). The demands of professional judgement can lead to a rich collection of data, but this is difficult to focus on risks to a specific child.

4.2 Use of statistically based risk assessment tools

Actuarial risk assessments differ from consensus or rationally derived tools in that they are essentially based on statistical methods (Hilton and Harris 2005). Actuarial risk assessment tools are used in a number of settings where accurate risk of violence is important, notably in assessing risks of violence in mental health care settings and in predicting repeated spousal violence (Antle et al. 2007, Bair-Merritt et al. 2008, Casanueva et al. 2009, Davies and Krane 2006, Devaney 2008, Dutton and Kropp 2000, Hilton and Harris 2005, Humphreys 2007, Irwin and Waugh 2007) and in the management of violent offenders in forensic mental health contexts (Cooper et al. 2007). The purpose behind their use is to increase the likelihood of professionals coming to an accurate assessment of risk using statistical probability to identify and weigh the factors most likely to lead to an undesirable outcome (Grove and Meehl 1996, Grove et al. 2000, Meehl 1954). It is possible to reach such assessments without such tools if the individual is experienced and knowledgeable

about the important factors and able to compute the risk. Actuarial tools do still lead to false negative or false positive judgments, but they have been demonstrated to do so less often than unaided human processes (Grove and Meehl 1996, Meehl 1954).

Hilton and Harris (2005) point out that being able to predict outcomes is not the same as being able to explain them. For example, a history of domestic violence is strongly predictive of future episodes of domestic violence, but does not serve to explain either the past or possible future violent episodes. The characteristics of families who abuse their children may be remarkably consistent, but although they are common descriptors, their very common occurrence means that they apply both to families who will, and to those who will not abuse a child in future, so they cannot serve to predict the risk of which parents will subsequently abuse their children. Assessment tools like the Framework for Assessment (Department of Health et al. 2000a) can describe the nature of the situation at a given point in time, but cannot predict the likelihood of future abuse or neglect. It is even possible that factors not included in such assessments might be the most powerful predictors of future risks to children in the family concerned. Hilton and Harris (2005) use the example of psychopathy in domestic violence, which is a very uncommon characteristic among men who abuse their spouses, but a powerful predictor of repeated violence.

Actuarial tools in professional decision making have a long history in clinical psychology and also in risk prediction in forensic settings where they have been used to assess the likelihood of future violent behaviour in previously violent offenders). Grove and Meehl (1996) provide a useful outline of the arguments for the use of actuarial tools for general clinical and other human decision making situations and a criticism of the arguments raised against the use of them in clinical practice.

The fundamental difference between consensus tools, such as the informal checklists of family vulnerability used by health visitors, and the actuarially based methods lies in the theoretical understanding of the phenomena being considered. Grove and

Meehl characterise them respectively as ideographic methods (emphasising the individual particular case and tending to avoid generalisation) and nomothetic methods (which seek to use statistical studies to identify generalisable laws about the behaviour of types of individuals) (Grove and Meehl 1996). The checklists are developed from the particular observations and impressions from a group of practitioners, whilst the actuarial assessment tools require larger data sets and more rigorous selection of significant factors which correlate with adverse outcomes.

There is a link to the kind of research methods - ideographic and nomothetic. These categories are linked to two supposedly different areas of study – that of variable societies and individual human behaviours on one hand and of predictable natural physical phenomena on the other. Accordingly, descriptive, phenomenological and other qualitative methods have been used to study these using ideographic methods and in micro, rather than on broader terms. Grove and Meehl acknowledge that sometimes the purely ideographic approach is essential, for example, historical research into particular individual past events (Grove and Meehl, 1996, p.310). They assert that there is a false epistemological dichotomy between quantitative ‘hard’ scientific approaches and the purely qualitative and ideographical alternatives. This distinction is based on the ideas of the German philosophy, Wilhelm Windelbrand, who divided scientific study into 2 types of discipline *Geisteswissenschaften* (relating to psychology and the social sciences) and *Naturwissenschaften* (relating to material and biological sciences) (Grove and Meehl, 1996, p.310).

Grove and Meehl point out that ‘softer’ decision making approaches using individual clinical judgements and localised consensus may not always use all the most relevant factors, so that such assessments may be no more accurate predictors than chance, statistically (Grove and Meehl, 1991). There is a body of meta analytic work in the field of psychology relating to human behaviour which demonstrates this difficulty in clinical practice, including the likelihood of recidivism in offenders or violent behaviour in people with mental health problems (Grove and Meehl 1996, p. 296, (Aegisdottir et al. 2006a). This dilemma may be better addressed using

probabilistic methods using appropriate actuarial statistical techniques, rather than purely mathematical or qualitative methods (Grove and Meehl, 1996).

Assessing the dangerousness of male offenders incarcerated for offences of violence, including sexual violence, has formed the professional basis for the development and validation of a range of tools for assessing risk posed by individuals to themselves or others if allowed to leave secure forensic psychiatric settings (Cooper et al, 2007). This type of work looks at the risk posed by adult males, but the actuarial approaches developed in this field have been adapted for use in assessing risk to children who remain with families who may have neglected or abused them.

The point of risk assessment in child protection is to try and establish whether a particular child is at risk of neglect or abuse. Teams and courts need to know the relative risk to the child of remaining with a birth family or being received into the care system, since both can present problems for children and represent major institutional costs and life changing interventions for an individual and their family. Much of the work on risk assessment has been derived from earlier research into the prediction of risk in forensic mental health services and the response to domestic violence. Reviewing this work illuminates some of the ethical, legal and methodological difficulties in predicting risks to children.

Forensic psychiatric criteria for civil (as opposed to criminal) detention changed in the 1970s in the USA from a requirement to establish a 'need for treatment' to that of dangerousness, but this was reversed when it became apparent that mental health professionals could not predict dangerousness reliably. This has parallels with the current debate on personality disorder in UK forensic mental health services. The condition does not appear to have a pathological basis as such and is defined by attitudes and behaviour. It is not amenable to treatment in medical terms, but predicted behaviour and danger to the general public requires consideration before an individual can be considered safe to live in the outside community.

Cooper et al (2007) review the current state of risk assessment and the prediction of dangerousness in male offenders with a history of violence. They state:

‘The risk assessment literature is replete with discrepant terminology describing the criterion variable to be used in risk assessments... and, to date, there is no consensus concerning the definition of logical criterion variables such as dangerousness or violent behaviour’

(Cooper et al, 2007, p. 4).

There is no hard definition of dangerousness and it cannot even be assessed as if it were a trait or medical condition, such as introversion or depression or dementia, through the application of assessment tools for mental health. It has a legal meaning, but even this is difficult to establish because even if an individual has a history of violence, it does not imply that they are at risk of future violent behaviour because the reasons for their actions will differ between individuals. The concept of dangerousness does not imply its likelihood or the most likely consequences. This may vary in different contexts and the only rational methods of assessment of risk are probabilistic.

Cooper et al (2007) review the changes in offender risk assessment techniques since the 1960s and groups them into 3 types:

- Traditional clinical assessments;
- Actuarial assessments;
- Combined adjusted actuarial approaches with structured clinical judgements – the conditional and tree-based actuarial models;

On follow up, the first generation clinical assessments showed very poor predictive power with only one in three cases assessed predicted correctly. There were a high number of false predictions which led to individuals being detained for long periods

past the point at which they could have been allowed to return safely to the community. The reasons suggested for this are:

- Forensic psychiatric patients form a very heterogeneous population in terms of mental disorder and this may have underpinned the variability of outcome;
- Although there were high rates of past violence among the offenders when first detained, samples for research were drawn from those who had low rates of violence and were being considered for return to the community;
- Base rates for violence were estimated from arrest rates, which excluded those who had not been arrested following subsequent violent episodes;
- Only mentally disordered offenders from long term custodial settings were studied, so that their responses could not be predicted for the very different circumstances they would encounter in the wider community ;
- The methodology used was that of subjective clinical opinion, rather than a more structured approach. The mechanism of decision making is intuitive and based on professional experience.

Some of these do not apply to child safeguarding risks, but the very poor predictive power of the 'expert' assessments of professionals in mental health suggests that those seeking to establish risks to children may be exposed to similar difficulties. This does not prevent media coverage that implies that fully accurate risk assessment is possible (Donaldson and O' Brien 1995).

The 'second generation' of risk studies in the typology proposed by Cooper et al (2007) uses actuarial approaches to overcome the problems of subjectivity inherent in the unaided professional judgements which preceded it. These are a relatively recent application of established statistical techniques more commonly found in the insurance industry where they are used for setting premiums based on the perceived risk of the insured suffering the event for which they purchase insurance. They are based on statistical relationships identified through empirical research between

specific risk factors and the probability of an undesirable outcome. The empirical work requires careful follow up of a number of relevantly similar cases and statistical analysis of the strength of the relationship between the risk factors and the predicted outcomes, which are then used to develop an algorithm to predict the outcomes of future similar cases. This approach is already used widely in forensic psychiatry, to identify people who may pose a greater risk of violent behaviour

The advantages of actuarial methods are that they are more accurate in predicting risk than unaided clinical judgement. They are also more explicit and do not rely on subjective opinion, which makes them less open to bias. However, Cooper et al (2007) suggest that there is more to the prediction of violence in future than can be summed up in an algorithm alone (Cooper et al, 2007, p. 14). They regard the presence of specific clinical findings to be influential too – for example, homicidal ideation or substance misuse. There is also a problem with the static nature of some of the initial actuarial risk factors in predicting the outcomes of lives lived in dynamic and changing circumstances (including interventions intended to reduce the risk of violence, such as anger management courses, parenting support), each of which might affect the risk over time. Some of these factors will be protective, some increasing the likelihood of violence, but all may serve to modify the risk over time. This leads Cooper et al to review the evidence for the third generation of risk assessments – the adjusted actuarial approach.

This third approach allows the combination of different mental health comorbidities in the prediction of violence in a classification tree to determine the overall risk (Cooper et al. 2007). Much of the work is based on large scale actuarial studies undertaken by the MacArthur Violence Risk Assessment project in the USA. Unlike the purely actuarial models based on regression analysis, this one enables clinicians to combine empirically derived actuarial factors together with specific clinical findings (e.g. psychopathy, schizophrenia, responses to treatment, lifestyle changes) in a decision tree which predicts the risk of violence for the individual patient's circumstances. Such clinical guidelines and decision support tools endeavour to bring together the best of both worlds, but the validity of such mixed

methods is more difficult to establish. This is the model of assessment chosen for this study and reflected in the assessment tool to be used (Shlonsky and Gambrill 2001, Shlonsky and Wagner 2005). It combines a group of actuarially derived risk factors which occur commonly in families known to have abused children alongside very rare circumstances where the risks cannot be assessed statistically because their rarity makes them very unlikely.

Since this study relates to risks of child neglect and abuse, the next stage was to identify and evaluate formal risk assessment tools developed for child protection risk assessment, assess the validation and reliability testing undertaken and clarify the evidence on which they had been developed.

4.3 The search strategy

The search strategy was developed following wide reading in the area of child protection and the outcomes of long term abuse and neglect of children. The literature is very broad and ‘mapping’ of specific areas of interest is not well developed because of the breadth and diversity of issues involved. Many published papers relate to small case studies or ways in which staff could be trained or organised in services. Others considered the effects of specific interventions such as parenting classes or counselling as preventative or therapeutic approaches. In addition, the issue of risk of future neglect or abuse and risk assessment related to more than one form of maltreatment and more than one type of outcome. The possible harmful effects of maltreatment on the infant and developing child are diverse and the cause/effect relationship between maltreatment and specific outcomes is a probabilistic relationship rather than a simple dichotomous one. These two factors made it difficult to predict where publications relating to formal risk assessment in child protection might be found. The systematic search process chosen used a broad range of databases to identify relevant publications in as many different journals as possible rather than just the key professional publications. This

approach also allowed setting of criteria for inclusion and exclusion by topic, methodology type and quality of study. This enabled a large body of literature to be filtered for relevant work using key words as much as possible, but it did mean a very large volume of reading to ‘funnel’ the search down to the most relevant papers. The quality of many abstracts was also limited; so many papers had to be read in full before their relevance could be assessed.

The search strategy focused on identifying published studies which look at the development, validity and reliability of formal risk assessment tools for use in child protection cases to weigh risks to children, allocate resources and focus caseworker effort.

4.4 Scope of the formal risk assessment literature

The review of literature relating to child protection and risk is an ongoing process, because these tools are being re-refined and tested over time as large volumes of data become available to researchers to improve their sensitivity and specificity and reduce the numbers of false positive and false negative cases identified.

The search identified many widely disparate studies, many with methodological problems such as small samples, inconsistent definitions of terms and methods of collection, plus the wide range of different designs of risk assessment tools with varying content and structure. This heterogeneity precluded meta-analysis and meant that a narrative format was required. This search was extended into a detailed search specifically for material on validation of actuarial risk assessment tools in child protection work.

4.5 Sources of the literature

Published sources and studies relating to formal risk assessment were largely North American, most of them from work undertaken in the United States. Whilst this

may reflect a bias in indexing particular publications for inclusion, it also reflects practice in North America compared with Europe and Australasia. Child welfare in the USA differs from that in the UK in that reporting of suspected cases of child maltreatment is mandatory, so that large numbers of cases are required to be screened for possible services. In the 1990s, this led to a growth in the use of formal risk based screening tools based on earlier retrospective work into the characteristics of neglectful and abusive families and the effects of maltreatment on children (Behl et al. 2003).

Risk assessment is also a well established approach in any health and welfare system based on individual insurance because of the need to ensure eligibility and allocation according to rules (Browne 1995a). The search was conducted to yield a broad range of studies and funnel the literature to include only those papers which considered formal risk assessment tools (i.e. those with some empirical basis) to measure the risk to children of any form of abuse or neglect (see Table 4 -1, below).

4.6 Contexts of risk assessment in child protection

The US process of risk assessment is used where there is a history of neglect or abuse and seeks to predict the likelihood of re-abuse within two months of the original abusive incident. In the UK, risk has generally been considered in a primary predictive sense (Browne and Saki 1988, Browne 1995b). This public health model has already been discussed earlier, but since child maltreatment is very rare within whole populations, such events are very rare. On validation using a cohort of 14,252 births, the sensitivity and specificity of Browne's consensus based predictive tool failed to reach acceptable levels, so he identified large numbers of false negative and false positive assessments of risk and rejected his tool on the basis of its low sensitive and specificity. Any public health risk assessment screening needs to consider the rarity of actual maltreatment in wider populations (Macdonald and Macdonald 2010, Sidebotham 2003).

Many of the earlier US developed risk assessment tools are consensus based and the risk factors and weightings have not been empirically tested. Such tools provide little more than practice wisdom systematised in a neat format (Cash 2001).

4.7 Types of risk assessment in child protection

The risk assessment tools this study will use to classify cases by their risk level are derived from empirical studies using actuarial statistical methods, mostly developed in the USA and Canada dating from the early 1990s. This kind of tool is not currently used in UK child protection teams and no large scale database exists to duplicate this work. This is surprising, given the high profile of child protection cases and the political implications of poor outcomes. Other areas of UK practice such as forensic psychiatry and criminology already use risk assessments and whilst these are not perfect tools, they do enable practitioners to use evidence based factors to assess their cases and support their judgements.

Current UK requirements for case assessments include detailed assessments based on the Framework for Assessment (required for effective care planning and case management in all settings), in conjunction with risk assessments framed on the professional judgment of individual social workers or on local consensus based tools, rather than empirically based or statistically tested models (Department of Health et al. 2000a).

Practice wisdom can be impressive, but it takes a long time to acquire and is vulnerable to bias from a wide range of sources, including professional beliefs, organisational pressures and poor data access (Gambrill and Shlonsky 2000). It is not an accurate basis for risk assessment. There is too much scope for bias and subjectivity, definitional differences and the influence of client aggression.

One factor which emerges as common to both professional judgement and actuarial risk assessments is the subjectivity which enters the process as judgements are made about the application of risk factors. This is reduced by effective training and clear instructions, but a recent study shows that this remains a problem affecting risk ratings (Regehr et al. 2010). In general, actuarial models demonstrate a higher construct validity and better reliability (Baird 2002, Baird et al. 1999a, Baird and Wagner 2000, Baird et al. 1995, Baird et al. 1999b, Meehl 1954, Shlonsky and Gambrill 2001). They use relatively few objective criteria determined statistically for their assessments, so they are easier to complete than comprehensive assessment models such as the cumbersome British ‘*Guide for social workers undertaking a comprehensive assessment*’ (Department of Health 1988). The actuarial component cannot identify very low risk factors, such as parental psychopathy, but these are very important in considering risk. For this reason, some form of override factors of a professionally chosen component of the risk assessment which includes factors like this is helpful.

4.8 Types of methods used

The different designs of the studies identified in the searches were grouped into broad categories.

Table 4-1 Typology of studies

Type of study	Numbers	References
Reviews of other studies on risk assessment	2	(Connell-Carrick 2003, Stith et al. 2009)
Cohort studies using various data sources and studies based on child protection records samples	9	(Fraser et al. 2000, Cadzow et al. 1999, Perillo et al. 2008, Wu et al. 2004, Street et al. 2004, Fuller and Wells 2003, Fuller et al. 2001, McCurdy 1995, Lee et al. 2008)
Studies drawing data from child protection	9	(Antle et al. 2007, Fuller and Wells 2003, Fuller et al. 2001, Proeve et al. 2006,

Type of study	Numbers	References
case records only		Rushton and Dance 2005, Whitehead et al. 2004, Coohy 2003, Lyle and Graham 2000, Kahn and Schwalbe 2010)
Literature reviews	9	(Goddard et al. 1999, Shlonsky and Wagner 2005, Cash 2001, Gambrill and Shlonsky 2000, MacMillan 2000, Levenson and Morin 2006, Gambrill and Shlonsky 2001a, Wald and Woolverton 1990)
Evaluative studies of risk assessment tools	10	(Baird et al. 1995, Regehr et al. 2010a, Baird et al. 1999b, Baumann et al. 2005, Rittner 2002, Camasso and Jagannathan 2000, Doueck et al. 1993, Barber et al. 2008, D'Andrade et al. 2008, Johnson 2004, Regehr et al. 2010b)
Development of risk assessment tools	1	(Sprang et al. 2005)
Data mining studies	2	(Schwartz et al. 2004, English 1998)
Economic study	1	(Bonomi et al. 2008)

4.8 Reviews of other studies on risk assessment

The earlier of these two studies only considered risks of further child physical abuse and neglect. Neglect is a more pervasive problem than a single physical or sexual abusive act and which affects more than half the children in the US who die as a result of maltreatment (Connell-Carrick 2003). Part of this is due to their relative youth since very small children (aged 0-5 years) are unable to help themselves if not cared for by adults. The study found evidence that neglect and physical abuse co-occurred in 27.8% of the fatal cases. The review included 21 previous studies of neglect and found the following predictive factors emerged:

- Child age – younger children and babies were more likely to die, but they are at greater risk of neglect overall

- Gender – the findings were inconclusive.
- Ethnicity – findings were mixed and the relative risk strength of this factor was inconclusive
- Poverty and the number of individuals living in the home – findings showed both were predictive of greater risk of neglect
- Single parenthood, short parental relationships and parental conflict in 2 parent families placed children at greater risk of neglect
- Parental factors which were most significantly correlated with an increased risk of child neglect were a mother's own troubled childhood, poor education, parental unemployment, younger mothers (17 or younger), maternal depression, poor social support, substance misuse (although this was more significantly correlated with a risk of physical abuse) and poor parenting skills.

The later and larger of the two reviews covered 155 studies and 39 risk factors relating to child physical abuse and neglect. They used meta analysis to identify the strongest predictors of re-abuse (Stith et al. 2009). The findings showed that demographic variables did not seem to be important risk factors for child physical abuse.

Those that did emerge as significant were:

- Physical abuse risk - Parental adjustment variables, notably social support and interpersonal support, parental anger, family conflict and family cohesion were important risk factors for physical abuse;
- Child neglect – the strongest risk factors were parent-child relationship, parent perceiving the child as a problem, parental stress levels, parent anger and hyper reactivity and parental self esteem.

4.9 Cohort studies, mixed data sources

These studies looked for factors which might increase the risk to children from specific demographic, parental, socioeconomic and lifestyle factors. All used some data drawn from interviews or direct assessments of families and children and were not wholly records based. The overall quality of evidence was weakened by methodological problems.

Fraser et al (2000), one of only two Australian studies in this trawl, only used risk assessment to select from a cohort of births in a city hospital to identify those families at higher risk of child neglect or abuse than others (Fraser et al. 2000). The main focus is on a randomised controlled trial (RCT) of home visiting as an intervention, which allowed a prospective approach. They identified statistically significant reductions in Child Abuse Potential Inventory (CAPI) risk scores for the intervention program group during the first seven months postpartum, but high attrition rates affected results (Fraser et al. 2000). However, the study uses the CAPI scores rather uncritically without considering what flaws exist in this instrument. Further problems stem from assessment tools like CAPI, a consensus based risk assessment tool criticised in other studies because of its poor predictive capacity (MacMillan 2000). A similar problem arose from similar uncritical use of early risk assessment tools in a second Australian study with a similar design (Cadzow et al. 1999).

One primary predictive study looked at child protection cases using a single year birth cohort in Florida (Wu et al. 2004). This study sought to identify factors which predisposed children to later child protection referrals using a whole birth cohort, rather than families with existing difficulties. Of 1,602 children (0.85%) of the 1996 birth cohort had verified instances of maltreatment by the time the infant reached one year old. Of fifteen perinatal and sociodemographic variables studied, five were found to be significantly related to infant maltreatment. Infants who had four of these five risk factors had a maltreatment rate seven times higher than the population average. However, the researchers noted that these apparent predictors of

maltreatment may be no more than associated socioeconomic problems rather than predictors of abuse. The researchers were unable to follow families who moved into or out of the state.

Other cohort studies were smaller. The single UK study in this set looked only at the risk of maternal drug use. No paternal drug misuse data was obtained (Street et al. 2004). In this case, infants of non-drug users were matched for social class and gestational age, a fairly small localised study which could not follow up those families who moved from the area. Sixty eight infants of drug users and one hundred and twenty seven infants of non-drug users were checked for enquiry or registration on local Child Protection Registers at age eighteen months. Higher risk for children with drug user mothers was found, but abstainers showed no more risk than the control cases. Risk outcome data was skewed by removal from home of children of two crack cocaine users and a larger group who were de-registered after a short period. The use of a single factor in assessing a complex risk which other studies have identified as being multifactorial may be inadequate in itself. There are problems arising from the preconception that only maternal drug use is problematic in child abuse when male perpetrators and violence are major factors (Forrester and Harwin 2008, Yampolskaya et al. 2009).

Two studies by Fuller et al (2001 and 2003) looked at risk to infants of alcohol abusing mothers, but this records based study had problems with missing data which made it difficult to follow cases retrospectively. In the first study, follow up was limited to five days (Fuller et al. 2001). The specific risk assessment tool, the Illinois Child Endangerment Risk Protocol (CERAP) was not always completed and retained on record files.

Relatively few of the studies identified undertook prospective risk assessments at the outset and re-assessed families over time. There were inconsistencies in definitions. Much of the evaluation of risk was based on records kept by child protection services and the quality of data was dependent on the completeness of specific detail held in those records (Antle et al. 2007, Brandon et al. 2009, Devaney 2008,

Humphreys 2007, Irwin and Waugh 2007, Ofsted 2010, Shlonsky and Friend 2007). This has direct relevance to the feasibility study phase proposed in this work. The same quality of record keeping also affected studies which could not take into account local policies on child protection registers and the duration of registration (Street et al. 2004).

Maternal data alone tended to be the source of parental related risk factors, especially where families were headed by a lone mother, but the virtual invisibility of fathers and cohabiters tends to make some risk factors invisible to both researchers in the current group of studies reviewed (Street et al. 2004, Lee et al. 2008) and to child welfare workers in cases which have been subject to review (Brandon et al. 2008, Brandon et al. 2005, Laming 2003, Pritchard 2004).

4.10 Evaluative studies of risk assessments

This largest group of studies used a range of different approaches, depending on what tools were available for risk assessment at the time they were conducted. All such studies tended to suffer from small sample sizes and problems with longer term follow up of outcomes. Access to cases for such studies is very difficult in the UK, due to the protective application of data protection requirements affecting all public bodies and the early stage of information technologies in child protection services. Early publications did not indicate access to later developments in actuarially derived risk assessment tools and methods of risk assessment ranged from professional opinion to consensus based tools with a limited empirical basis (Camasso and Jagannathan 2000, Doueck et al. 1993). Much of the actuarial work was conducted during the 1990s and informed the later studies (Baird et al. 1999, Baumann et al. 2005)

Some studies sought to develop fresh risk assessment tools and did not always demonstrate attention to existing evidence (Whitehead et al. 2004, Rittner 2002, Sprang et al. 2005). These dated from a perceptive and influential critique of risk

assessment problems in 1990 (Wald and Woolverton 1990) to concerns about using a single risk assessment tool for a diverse group of circumstances ranging from neglect to sexual abuse (Levenson and Morin 2006). The quality of these was thoughtful, although the data used in the original studies considered was variable.

The general trend showed that actuarial tools such as the Michigan Family Risk Assessment of Abuse and Neglect (FRAAN) were considered most helpful, although in need of further work (Cash 2001, D'Andrade et al. 2008, Gambrill and Shlonsky 2001, Gambrill and Shlonsky 2000, Kahn and Schwalbe 2010, Ryan et al. 2005, Shlonsky and Wagner 2005). The newer California variant of this original risk assessment (California Family Risk Assessment CFRA) has also been evaluated, but the evaluation is not yet published in a peer reviewed journal and is only to be found in a report from the research body concerned (Johnson 2004). For this reason, the Michigan FRAAN original was preferred as a model for the empirical part of this study. There is a subsequent refinement of the Michigan FRAAN by the US Children's Research Center, but the evaluation of the validity of the risk factors in this new California Family Risk Assessment (CFRA) had not been published in any peer reviewed journal at the time of data collection for this study (Johnson 2004, Johnson Forthcoming). The FRAAN risk assessment has well developed guidance for practitioners using the assessments and these serve to clarify terms and standardise interpretations (State of Michigan Department of Human Services 2008).

The Michigan FRAAN assessment tool uses two separate sets of risk factors identified as statistically significant correlates of subsequent further neglect and abuse episodes respectively. There is some overlap of such factors, but only where both are important for neglect and abuse. Apart from this difference, the various types of abuse (physical, emotional, sexual) are not subject to separate risk assessments.

Training and real understanding of the power and limitations of such tools is vital to their successful uptake and use because there is evidence from two studies that risk

assessments can be affected by different interpretations, definitions and professional perspectives (Munro 2004b, Regehr et al. 2010a). The two studies by Regehr and colleagues (Regehr et al. 2010a, Regehr et al. 2010b) went beyond expressing concerns and produced evidence of wide variations in the use of standardised assessment tools. Risk assessment should be based on the best empirical evidence, but such evidence is not static and sensitivity and specificity needs improvement. The effects of using tools developed for one culture to assess cases in another cannot be predicted, even assuming the same language is used. Both the FRAAN and CFRA use override factors which are based on professionally attributed risk factors and have no further empirical basis.

4.11 Excluded studies

These fell into two categories: special samples, not representative of child protection issues as a whole, and studies which did not consider risks to children.

Special samples were a study looking at the risk of offending by Catholic priests rather than the risk to children specifically (Perillo et al. 2008) and another which considered only risks of sexual offences (Proeve et al 2006). Neither matched the search criteria.

Non risk assessment studies comprised a single US based data mining study (Schwartz et al. 2004) which was excluded, and a second which quantified economic consequences of specific types of abuse (physical and sexual abuse) on the health costs of adult women, but not specific risks to children (Bonomi et al. 2008).

4.12 Summary

Neither consensus based tools nor heuristic professional judgements are reliable enough to enable workers to predict risk accurately. It would be unethical to use an unsound methodology to make decisions where a child's safety and the risk to

families of disruptive child protection investigations and proceedings are concerned. Actuarially developed tools show greater predictive power, although more development is required to improve sensitivity and specificity (Shlonsky and Wagner 2005). False positives risk an unacceptable stigma for families and unnecessary interventions which might, at worst, lead to a child being removed from a birth family. False negatives may lead to services failing to identify risk and not safeguarding a child from harm while false positives risk needless investigations and interventions. The use of risk assessment tools developed for a North American socioeconomic and welfare context may also limit their usefulness in the different circumstances of English children's services.

The Framework for Assessment introduced in 2000 is designed to support a professional assessment of need, but its limited empirical basis means that it is unsuitable for developing into a formal risk assessment tool (Cooper 2003a). Given the evidence from US studies, developing another potentially misleading and inaccurate consensus based risk assessment tool would be unhelpful to practitioners. More importantly, if the actuarial models are more sensitive and specific assessments of future risks to children, it would be unethical not to use them.

Developing a wholly UK based actuarial tool from scratch would be beyond the scope of a single researcher undertaking a PhD study. In addition, developing such a tool would require a very large and full database of cases from which an adequate cohort could be followed up using statistical methods to identify the most strongly predictive factors for high, medium and low risk cases. Currently, no such database exists in the UK.

The most robust US developed actuarial tool for child protection risk assessment is the Michigan Family Risk Assessment of Abuse and Neglect (FRAAN) which has now replaced older consensus based tools in most states (Shlonsky and Gambrill 2001, Shlonsky and Wagner 2005). It had been developed from large samples of cases with known outcomes, at least within six weeks after the initial child

protection referral. The risk factors for neglect and for abuse had been developed using statistical tests of the significance of the factors in predicting whether or not the children would be abused or neglected again after their original reports to child protection services. The tool had undergone validation and reliability testing and it was found to be a better measurement of risk category than the previous consensus based tools.

The FRAAN risk assessment forms make no specific reference to the context of American welfare systems and the current version of FRAAN initial risk assessment is applicable as it stands without modification. It cannot be modified without revalidation, but it has detailed instructions for completion and is suitable in language and format for UK trial of its feasibility using UK derived Serious Case Review reports as a data source. This empirical part of the study is reported below.

There are two main areas for consideration in the empirical section of this study. In order to support the feasibility of the FRAAN in a British child protection system, it must be possible to populate the risk assessment tool with appropriate data which matches the definitions used in the original Michigan system. If this is possible, the next stage is to establish that risk assessment scores for the index children in Serious Case review reports can be calculated. If such risk assessments can be completed, the nature of Serious Case Reviews cases are all high risk, because all led to the death or serious harm to a child. This should be reflected in the FRAAN scores obtained. Finally, the death of a child is the most serious consequence of child neglect and abuse and the study will consider whether the risks scores for fatal cases reflect the seriousness of the outcome. These requirements are framed in the following two hypotheses.

4.13 The hypotheses

1. That the FRAAN risk assessment tool would identify all the cases as high risk or intensive/ very high risk cases, because all were known to have been

high risk in practice on account of the seriousness or the abuse or neglect they reported;

2. That the FRAAN risk assessments would identify statistically significant differences between the cases where children died as a result of neglect or abuse and those with the children survived.

Chapter 5

Methods and Materials

The hypothesis testing required access to as large a number of closed case files on child protection cases as could be obtained. The files needed to be closed, firstly so that no results from risk assessments might influence any later child protection decisions and secondly, so that the case outcomes were known and recorded. The Michigan FRAAN risk assessment assesses risk of re-abuse, so risks which affected families and children prior to an abusive incident needed to be identified.

5.1 Access to data for research

This study endeavours to measure risks after an initial referral and link this risk assessment to *subsequent* outcomes for the child. Ideally, a mixed sample of low risk and high risk cases with known outcomes would have been preferable to discover whether the outcomes correlated with the risk levels, but access to archived cases in social services or children's departments was not obtained. This difficulty may have arisen because applications for research access were made at a time when the Baby Peter cases in Haringey was receiving considerable media attention and reviews of cases across England and Wales were in progress following a critical report by Lord Laming on arrangements for child protection in local authorities in England (Laming 2009). This was a difficult time for local authorities and although five authorities were approached for access, none were able to offer permission for this research.

It is worth commenting briefly on this problem of access, which has proved difficult for other British researchers in child protection (Sidebotham and Golding 2001). In the absence of large anonymous datasets derived from practice records, there are few sources of data on child protection case characteristics and their outcomes and none on a large scale. Concerns about confidentiality and data protection make it very

difficult for individual local authorities to grant access for research purposes and gaining informed consent for access from individuals and families in case records is also likely to present difficulties because of past or current experiences with child protection, as well as family vulnerability and geographical mobility.

Difficulties are compounded by the complicated nature of teams, with information held in agency records in social services, health services for adults and children, including sensitive material in mental health and drug and alcohol services, general medical practice, perhaps several hospitals including emergency departments, housing, police, domestic violence services and voluntary agencies. Some material will be held on computer systems, but most will be paper based, with few summaries of information gathered over time.

If child protection assessments and interventions are to be based on the best empirical evidence, research is essential. The best material for such research is contained in case records, but these are extremely difficult to access and paper based material may make it quite difficult to extract data. Systems such as the Integrated Children's System (ICS) have been used in England for very limited data sharing on current cases (Munro 2005). This minimal approach is far from a full computerised record of all agency assessments, planned interventions and outcomes for children and their families. There is no UK system for archiving anonymous records for research and the only current source of such multiagency archives lies in the Serious Case Review reports, which may not be collated in future if government policy and guidance changes (Munro 2011).

Access to data from Serious Case review reports to test the FRAAN risk assessment tool was obtained by writing with full application details and proposal documents, including clearance from the Bournemouth University Research Ethics Committee, to the Welsh Assembly Government Division of Children, Education, Lifelong Learning and Skills (DCELLS) (see Appendix C). Serious Case Reviews undertaken within Wales are submitted to this Division and previous researchers have also accessed data from these anonymous reviews.

5.2 Data security

The files were securely stored and were accessed on the premises of the government department. All the data collection took place in the offices of the department and no files were removed at any time.

All the files were numbered, but the names of families and children were not given in the documentation. This means that total anonymity was ensured and the researcher could not identify any of the children, their families or their child protection team except by a file number.

Data collection used separate storage on portable hard disks, which could be securely locked away when not in use. All files were password protected and encrypted using Truecrypt encryption software.

5.3 The Serious Case Review reports

The study considered a complete set of child protection Serious Case Reviews undertaken in thirteen counties in Wales over a period of twelve years from 1997-2009. The whole available cohort of cases comprised ninety seven case files.

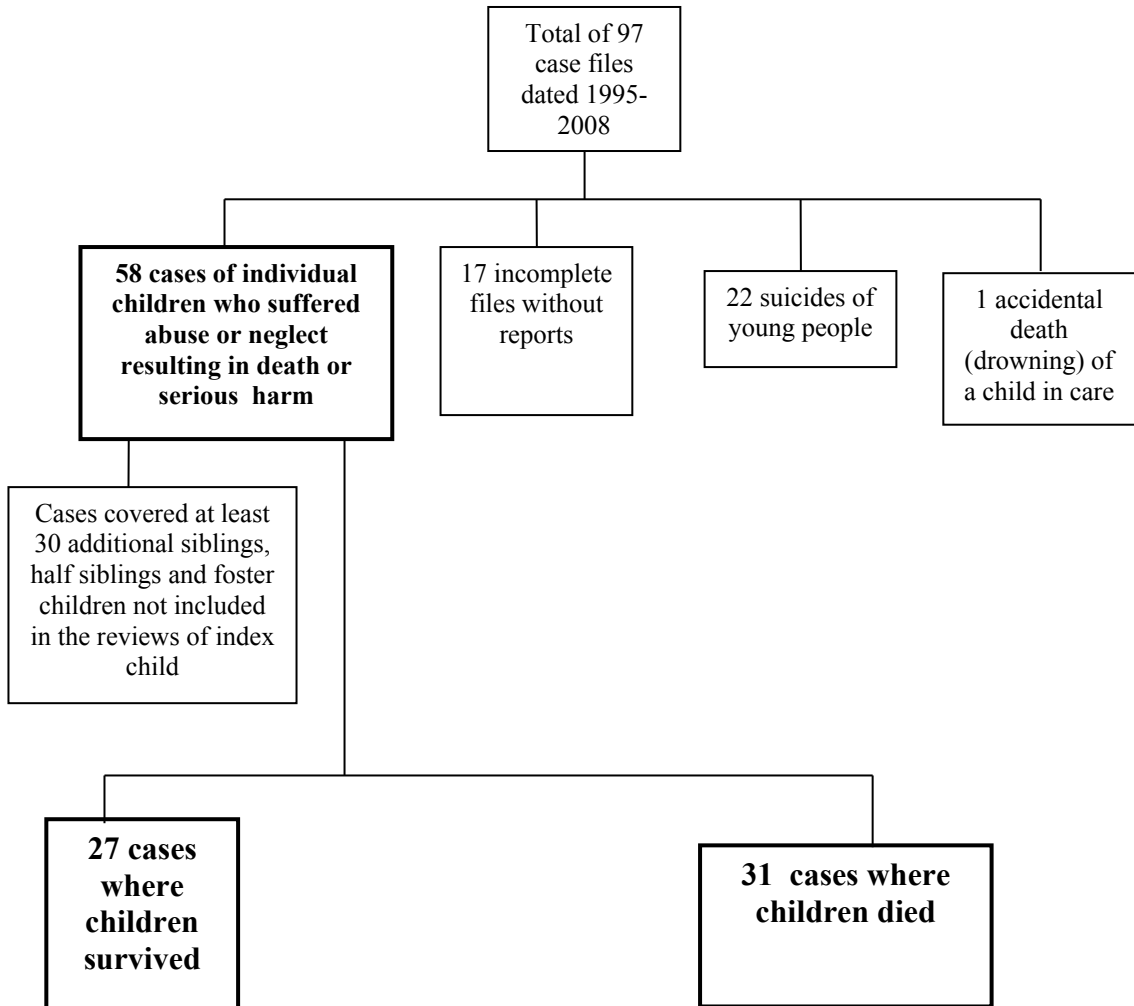
No sampling was used to select a group of study cases from the whole continuous cohort of cases available. This means that all the cases were considered and none were lost to the study as long as there was a review report available. The study considered risks of abuse of children living with their families, but the policy in England and Wales for Serious Case Reviews also extends to reviewing the suicides of young people aged under eighteen and twenty two of the report files covered these tragic cases. They were unsuitable for testing a risk assessment for neglect or abuse by adults and their deaths were due to self inflicted harm, so they could not be included in the study.

One case referred to an abuser who had worked in a position of trust with children but the FRAAN risk assessment is designed to highlight risks relating to specific children within families, so this report was also excluded. Another single case dealt with an accidental death of a child in foster care and there was no mention of neglect or abuse of this child, so this case also was excluded.

A further seventeen files lacked reports altogether. Copies had been requested, but the reviews had either not been undertaken or not submitted. This lack of information on some cases has been reported in other studies of Serious Case Reviews (Brandon et al. 2009, Brandon et al. 2008a, Rose and Barnes 2008b).

Fifty eight case files met the completion and relevance criteria for inclusion in the study. The cases dated from 1997 to 2008. Three earlier reports from before 1997 had been retained and no reason was recorded for these three to be held on file. Delays in completing Serious Case Reviews are quite common and this was also remarked by Brandon et al (2009). Two of these three outliers related to extremely complex long term neglect and sexual abuse within large and chaotic families which might have needed more time to review. The third dealt with the homicide of an infant whose mother was very young and had herself a complex history of abuse and neglect. These three earlier cases were included in the main data collection because they were complete reports, materially similar to the main body of cases studied and their earlier start date did not affect the essential process and nature of the reviews.

Figure 5-1 Types of cases included in the Serious Case Review process



5.4 Data collection

The FRAAN risk assessment tool and the instructions issued by the Michigan Child Protection Services were used to collect recorded data from the Serious Case review reports, searching the file reports and additional correspondence and papers for relevant information about risks which had been known to any of the child protection services or other agencies working with the family.

The risk data was entered into a large Excel spreadsheet of the factors included in the FRAAN, plus three additional risk factors for fatal child abuse, added from the Wessex child homicide studies (Pritchard 2004). The spreadsheet listed the FRAAN neglect and abuse risk factors across the horizontal boxes and each case was entered on a new row, numbered simply in the order in which the case was searched. Data was entered directly into the spreadsheet of risk factors for each case at a time. This involved several readings of each file to check that all factors were extracted from the reports.

Each case record was searched in detail for recorded evidence of each risk factor. Interpretation of data from the files was cautious, to avoid attributing risk factors which were not clearly identified in the file material. Wherever possible, a factor was cross checked between the main report, the management reviews and the chronologies which accompanied them to verify that the factor applied in the case. There was no attempt to apply any risk factor if the record statements were ambiguous on the issues to which it related, or if a factor was not mentioned in the review report. Only unambiguous statements from reviews were recorded in the risk assessments, but since no assumptions could be made about sharing of information prior to the review, it was considered adequate if any of the agencies involved with the family had held the information.

The files were encrypted and password protected using Truecrypt software. Storage media used for data collection were kept separately from all other work files relating to this study and under lock and key when not in use.

Inter-rater reliability was tested using a randomly selected group of twenty cases already scored by the researcher which were then re-scored by an independent reviewer also using the FRAAN assessment criteria. The scores were compared to assess the degree of agreement between the two sets and this is given in the Findings chapter below.

5.5 Data analysis

The FRAAN risk scoring for each of the cases was applied using the specified method and interpretations (State of Michigan Department of Human Services 2008). This gave the overall risk score for each of the cases based on the knowledge held by the various agencies involved prior to the event which had led to the review report. If any of the Wessex factors were present, a single binary score of 1 was allocated; otherwise, zero indicated that the factor was either not present or not recorded for that case.

To identify the frequency of each individual factor within the FRAAN risk assessment, the FRAAN scores were converted to a simple binary 1 or 0, indicating that the factor was present or not present in the report. The frequency of each of the factors was then calculated and used to analyse the importance of each specific factor in the fifty eight study cases, using Spearman's Rho and Chi square tests to compare the results across the whole group of cases and between those where children survived and where they died as a result of their maltreatment.

The scores were then broken down into subcategory factor components to consider the individual possible answers for each of the questions which formed the risk assessment. This was used to reflect where answers indicated a degree to which a problem applied in a specific case, for example, question N8 is stated as in Figure 5.2 below.

Figure 5-2 FRAAN scores for Question N8

N8	Primary caretaker involved in harmful relationships	0
	a. No	
	b. Harmful relationship(s) or one of more domestic violence incident	1
	c. Multiple (2 or more) domestic violence incidents	2

This allows the assessor to allocate scores of zero or one, or even two, depending on the circumstances. This enables individual elements of the risk factor to be separated out from the overall risk scores to see if one part of the risk factor was more frequently recorded than the other parts.

One other question within the FRAAN risk assessment refers to a group of unrelated factors which might each constitute a component of the FRAAN risk score. This is question A9, as in Figure 5.3 below.

Figure 5-3 FRAAN scores for Question N9

A	A child in the household has one or more of	
9	the following characteristics	
	No child has any of the characteristics below	0
	Yes (check all that apply and indicate the highest score)	
	• Developmental disability	1
	• History of delinquency	1
	• Mental health issue	2
	• Behavioural issues	2

This breakdown of the risk factors into their subcategories did not change their overall application, but was intended to identify the strength of each sub factor separately as well as their combined score on the risk rating for the case. This gave an expanded data set of individual subcategories for each of the cases, as illustrated in the partial data table in Figure 5.4 below.

Figure 5-4 The Expanded Data Set including Sub Categories, (where applicable)

Case	N1	N2	N3	N4a	N4b	N4c	N5
1	1	1	0	0	0	1	0
2	0	1	0	0	1	1	0
8	1	1	0	0	1	1	1
18	0	0	0	0	0	0	0
22	0	0	0	0	0	1	0
26	1	1	0	0	1	1	1
27	1	1	0	0	1	1	1

Cases which resulted in a child death were labelled Deceased cases and those where the outcome was serious harm but not fatal were designated Survived cases. These two groups of cases were then compared to test the second hypothesis above.

The results of the risk assessment tool feasibility study are given in Chapter 6 below.



Chapter 6

Findings from the Serious Case Reviews: the Thirteen Counties Study (T.C.S.)

The first section of this chapter will outline the demography of the study sample of Serious Case Reviews drawn from an area of Thirteen Counties (the T.C.S. study) and the scores for the FRAAN risk factors and their subcategories. This section will also compare the cases of children who died with the cases of those who survived. The second section outlines the data from three external comparator studies which deal with cases similar to the T.C.S. material, two dealing with child protection Serious Case reviews (Brandon et al 2009 and Ofsted 2010) and a third with child homicides (Pritchard 2004). The third section will compare the T.C.S. data with that from the external studies to see whether the results provide any external validation for the findings in this Thirteen Counties Study (T.C.S.).

6.1 The Thirteen Counties Serious Case Reviews (SCRs)

As stated in the Methodology, no sampling was used, so all the available reports which were complete, or substantially complete, were accessed and read. These were a subset of the whole possible population of SCR cases, however, because some cases were not directly related to neglect or abuse, but concerned teenagers who had killed themselves. Other reports did relate to abuse, but were incomplete or still awaited. Some reports were less well completed than others. For this reason the term 'sample' is used for the subset of the population of children who came under Serious Case review processes.

6.2 Missing information

The reports varied considerably in quality and quantity. Where information was missing, no attempt was made to infer risk factors which were not clearly reported. This may mean that some of the cases scored lower risk scores than they would have

done if the report had been more complete. All scores were applied according to the directions developed in Michigan State (State of Michigan Department of Human Services 2008). The risk assessment tool is found in Appendix B and the Michigan State directions at <http://www.mfia.state.mi.us/olmweb/ex/PSM/713-11.pdf>. The FRAAN risk factors were coded only if a factor was definitely reported in the review documentation as present in the case. If a circumstance was not mentioned at all, or was unclear from the case documents, the risk factor was considered to be absent.

Some reports were complete and detailed, including management review reports from individual agencies such as health services and police. Others were surprisingly brief and gave only a summary of the facts relating to the cases. This kind of summary report was noted in those cases where very young children died in the care of parents who appeared to have had little contact with social services prior to the death or serious injury to the child. Other families had only lived in the area for a short time prior to the child's death and it was unclear whether there had been any concerns or services in place in their original home area. Police involvement was mentioned in cases where the family had been seen in relation to drug dealing, drug abuse, antisocial behaviour or domestic violence, but it was not possible to tell whether this had been shared before or after the abusive incident involving the child.

Some of the reports even lacked detailed information on the children and their families and despite diligent searching, some data was missing. The sex of the child was omitted from some files and where more than one child was involved in incidents or longstanding neglect, ages were not always specified and many reports omitted information on fathers and male partners of the child's mother. Information about the men involved with the families may not have been known to universal services like health or education providers or to child protection agencies during their care of the family, but it was also missing from some Serious Case Reviews. Missing information frequently included presence or absence of men's previous criminal convictions, violent relationships with their previous partners and their parenting history where they had had previous children. Siblings within the index

child's family were not covered by the reports, although all would have been affected by the incident.

Psychiatric histories of adult carers were generally vague in child protection reports and only one case contained a full contributory report from adult mental health services. As with the FRAAN risk factors, where there was missing information, or it was incomplete, related risk factors were not attributed to the case. Only information which was clearly reported in the case file was used in the study, so if information was not clearly stated, no related risk was recorded. This means that there may have been additional risk factors in poorly completed cases, but they could not be reported if they were not recorded. This is a common problem with Serious Case Review reports and has been noted by others (Brandon et al. 2008a, Rose and Barnes 2008b). In practice, men in the families were responsible for many of the violent physical assaults on children and important information on their previous histories of violent behaviour did not emerge until after the event.

6.3 Ensuring Anonymity

Case files were already anonymous when received, so neither children nor parents could be identified, except for a few homicide cases where criminal proceedings had resulted in some family details entering the public domain through inquests and court reports before the case review was submitted. In addition, all the raw data was held and managed in securely encrypted files as described in the Methods chapter.

6.4 Reliability of the FRAAN Risk Assessment Scores

Scores were attributed using the original Michigan State instructions issued to guide child protection services in using the assessment tool. Inter-rater reliability of the researcher's scoring was assessed using a random sample of twenty of the study case files which were reassessed by an independent rater (one of the research supervisors with a professional social work background), blind to the scores assigned by the

researcher. The correlation between the two groups of rated scores showed adequate statically significant agreement between the two raters ($Rho = 0.7825, p = <0.001$).

6.5 Demography of the T.C.S. Study Cases

The fifty eight study cases each focused on one or two index children, but within these fifty eight study cases, there were references to at least thirty siblings whose experiences were not covered by these reviews, although it is likely that all were affected by the events involving their siblings and any child protection care plans. One case mentioned an uncertain number of children fostered and adopted within a foster carer's home where abuse occurred. These children's experiences were not covered by the reports on the index child and nothing further can be said about them because there was no information in the case review file. All scores relate only to the family of the index child in each case.

Ethnic origin details for the families and the status of any child protection care plans were not formally collected as they formed no part of the FRAAN assessments, but ethnicity was not consistently reported. It was not clear whether or not there were active child protection plans in place for the families in this study because the Serious Case Review documentation did not always refer to their prior involvement with social services.

6.6 Age and Sex of the T.C.S. Index Children

The index children in the Serious Case Reviews included thirty two girls and twenty three boys. Three cases gave no sex for the index child because a number of children in the family were equally involved and no particular index child was specified in the reports.

Table 6-1 T.C.S. Sex of Index Children

Sex of index child	Cases (n = 58)
Male	23 (40%)
Female	32 (55%)
Unspecified in report	3 (5%)

The age groups of the index children are given in Table 2 and it can be seen that very young children predominated in the study cases. Forty six out of the fifty eight index children were aged under school age (76% of the index children), and thirty of the fifty eight index children (52% of the total) were babies under one year of age.

Table 6- 2 Ages of T.C.S. Children at the Time of Review Incident

Age group of Index Child	Cases n = 58
Aged <1 year	31 (55%)
Aged 1-5 years	12 (21%)
Aged 6-10 years	8 (14%)
Aged 11-14 years	3 (5%)
Aged 15+ years	4 (7%)
Total number of index children with known ages	56
The ages of two children were not specified.	

The problems of prematurity and poor antenatal care were also recorded for some cases. Eleven cases involved children who were born prematurely (19%). Cases where children were born prematurely were 7, 26, 31, 39, 41, 48, 52, 57, 59, 60 and 67. Such children present substantial challenges even for experienced and well motivated parents, but some parents appeared to have been particularly ill equipped to cope. For example, in case 26, a vulnerable premature infant who required oxygen to breathe was discharged home to the care of very young, first time parents aged under 20 years who had shown little interest in caring for their baby whilst he was in hospital.

The FRAAN risk assessments were used to profile the nature of the risks recorded across the study sample. The scores are outlined in the sections below.

6.7 *The Family Risk Assessment for Abuse and Neglect (FRAAN) Scores*

The scores are given in four subsections. The first gives the risk scores for all the cases, divided into two tables showing the outcomes depending on whether the index child covered by the review survived or died. The second section gives the scores for Neglect, followed by those for Abuse. The third and fourth sections give the question score **frequencies** (the risk factors as present or not present) followed by the individual answer components (the sub factors).

Tables 6.3 and 6.4 follow.

Table 6.3 Risk factor scores for Survived cases obtained using the FRAAN Risk Assessment to identify risks known to agencies before precipitating incident

Survived	N1	N2	N3	N4	N5	N6	N7	N8	N9	N10	N11	A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11
3	1	0	1	2	0	1	0	2	0	0	0	1	0	1	0	0	0	0	1	3	0	0
7	1	1	0	1	1	1	0	0	0	0	1	1	1	1	1	0	0	0	1	0	0	0
9	0	1	0	2	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	3	0	0
10	0	1	0	1	0	1	0	2	0	0	1	0	1	1	0	0	0	0	1	0	0	1
12	0	1	0	2	0	1	0	2	0	0	1	0	1	1	0	0	0	0	1	1	0	1
13	1	1	0	2	1	2	1	2	0	0	1	1	1	1	0	0	0	2	1	0	1	1
15	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0
16	0	1	1	1	0	1	0	0	0	0	0	1	1	1	1	0	0	0	0	4	0	0
21	1	1	0	2	1	2	1	2	1	2	1	0	0	1	0	0	1	2	1	0	0	1
23	0	1	0	2	1	1	1	2	1	0	1	0	0	1	0	0	0	1	1	1	0	0
25	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1	-1	0
32	1	1	1	2	1	2	1	2	1	2	1	1	1	1	1	0	0	2	1	3	0	1
33	1	1	0	2	1	2	1	2	1	1	1	1	1	1	1	1	0	1	1	1	0	1
36	0	0	1	1	0	1	0	0	0	0	1	1	1	0	1	0	0	0	0	2	1	0
44	1	1	0	0	0	2	0	0	0	0	0	1	1	0	0	0	0	0	0	6	0	0
46	1	1	0	2	1	2	0	2	1	2	1	1	1	0	0	0	0	2	1	2	0	0
52	1	1	0	2	1	2	1	2	0	4	1	0	1	1	0	1	0	2	1	1	0	1
53	1	1	0	1	1	2	1	2	0	2	1	1	1	1	0	1	0	1	1	0	0	0
55	1	1	1	2	0	2	0	0	0	1	0	1	0	1	1	0	0	0	0	1	0	0
56	1	0	0	1	0	2	0	2	0	0	0	0	0	1	0	1	0	0	1	0	1	1
57	0	0	0	2	0	1	1	2	1	0	1	1	1	1	0	1	0	1	1	1	0	1
58	1	1	1	2	1	2	0	2	0	2	1	1	1	1	1	0	0	2	1	1	0	1
65	0	0	0	1	0	1	1	2	0	0	0	0	0	1	0	1	0	0	1	0	0	1
66	0	0	0	0	1	1	1	1	0	1	0	0	0	1	0	0	0	0	0	0	0	1
67	0	0	0	1	1	1	1	0	0	0	0	0	-1	1	0	1	1	0	1	0	0	0
69	1	0	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1
71	1	0	0	2	0	2	0	1	0	0	1	0	-1	1	0	0	0	1	0	0	0	0

Table 6.4 Risk factor scores for Deceased cases obtained using the FRAAN Risk Assessment to identify risks known to agencies before precipitating incident

Deceased	N1	N2	N3	N4	N5	N6	N7	N8	N9	N10	N11	A1	A2	A3	A4	A5	A6	A7	A8	A9	A10	A11	
1	1	1	0	1	0	2	1	0	0	0	1	1	0	1	0	1	1	0	1	0	0	1	
2	0	1	0	2	0	1	1	1	1	0	1	1	0	1	0	1	1	0	1	0	0	0	
8	1	1	0	2	1	2	1	2	1	1	1	1	1	1	1	0	0	2	1	2	0	1	
18	0	0	0	0	0	1	0	1	0	0	0	0	-1	1	0	0	1	0	0	0	0	0	
22	0	0	0	1	0	0	1	2	1	1	0	0	0	1	0	1	0	0	1	0	0	0	
26	1	1	0	2	1	1	0	1	0	0	1	0	0	1	0	0	0	1	0	0	0	0	
27	1	1	0	2	1	2	1	2	1	2	1	0	1	1	0	1	0	1	1	0	0	0	
30	1	1	0	2	1	2	1	2	0	1	1	1	1	1	0	1	0	0	1	0	0	0	
31	0	0	0	2	0	1	1	2	0	0	0	1	1	1	0	0	1	2	1	0	0	0	
34	0	0	0	2	1	1	0	2	0	0	1	0	1	1	0	1	1	1	1	0	0	1	
35	0	0	0	2	1	2	0	2	0	0	1	0	0	1	0	1	0	0	1	0	0	0	
38	1	1	0	1	1	2	1	1	1	0	1	1	1	1	0	1	0	0	1	1	0	1	
39	1	1	0	2	1	2	1	2	1	1	1	1	1	1	0	1	1	0	1	0	0	0	
40	1	1	0	1	0	1	0	0	0	0	0	1	-1	0	1	0	0	0	0	2	-1	0	
41	1	1	1	1	1	2	1	2	1	1	1	1	1	1	1	1	1	2	1	1	0	1	
42	1	1	1	2	1	2	1	2	1	2	1	1	1	1	1	0	0	2	1	2	0	1	
45	1	1	0	2	1	2	1	2	1	4	1	1	1	1	0	1	0	0	1	2	0	1	
48	0	0	0	1	0	0	1	0	1	0	1	0	0	1	0	0	0	0	0	1	0	0	
50	0	1	0	1	1	1	0	2	1	0	1	1	1	1	0	0	0	0	1	2	0	0	
51	0	0	0	0	1	0	1	1	0	0	1	1	-1	0	0	0	0	0	1	0	0	0	
54	1	1	1	2	1	2	1	2	1	0	1	1	1	1	1	1	0	2	1	0	0	0	
59	0	0	0	2	0	2	1	1	0	1	1	0	0	1	0	1	0	0	1	0	0	0	
60	0	1	0	2	1	2	1	2	1	0	1	0	0	1	0	0	0	0	1	0	0	0	
61	0	0	0	2	1	1	1	2	1	0	1	1	1	1	0	1	1	2	2	0	1	1	
62	1	0	0	2	1	1	0	1	1	0	1	1	0	1	0	0	0	0	1	0	0	0	
63	1	1	0	2	1	2	0	2	1	1	1	1	-1	1	0	1	0	1	1	0	0	0	
64	1	1	0	2	1	2	1	2	0	1	1	1	0	1	0	0	0	1	1	0	0	0	
68	0	1	0	2	1	2	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	
70	1	1	0	1	1	2	0	0	1	0	1	0	0	1	0	0	0	0	0	0	0	0	
72	0	0	0	2	1	2	1	2	0	0	1	1	1	1	0	0	0	0	1	0	0	1	
73	1	1	1	2	1	1	1	2	0	0	1	1	1	1	0	1	0	1	2	1	2	0	1

6.8 The T.C.S. Neglect Factors across the whole T.C.S. sample (n = 58)

Neglect factors ranged from high frequency factors like N6 (Primary caretaker's physical care and/or supervision for child) identified in 93% of the study cases (54 out of 58 cases); factor N4 (Primary caretaker's social support) in 88% of the cases (51 out of 58 cases) and N8 (primary carer involved in harmful relationship/domestic violence) in 76% of the cases (44 out of the 58 cases). The low scoring risk factors were N3 (Four or more children in the household) found in just ten (17%) of the cases and factor N9 (Carer's current substance abuse) in 40% of cases. Factor N10 (Family accommodation problems) was found in twenty (34%) of the cases, where it related to the physical safety of the home environment, rather than security of tenure.

The average Neglect risk factor frequency across the fifty eight cases for the 11 FRAAN neglect factors was 34.9, yielding a standard deviation (SD) of 12.8 (see Table 6.5 below). Factors N6 and N4 scored more than one standard deviation above the mean (+48) and these two risk factors were overarching features in the neglect of the T.C.S. children. Some of the factors were relatively rarely recorded in the study cases. Factor N3 (Number of children in the household is 4 or more) was identified in just ten of the fifty eight cases (17%) , meaning that this factor frequency was less than one standard deviation below the mean (22). This factor was an infrequent risk factor for child neglect identified in the T.C.S. high risk case reports and most of the families were small, with just one or two young children.

**Table 6-5 T.C.S. Neglect Risk Factors Rank Ordered by Frequency
(All Cases N = 58)**

	Neglect risk factor	Frequency	% cases
N6	Primary caretaker provides inadequate physical care and/or inadequate supervision for child(ren)	+54	93
N4	Primary caretaker's social support is limited or negative	+51	88
N8	Primary caretaker involved in harmful relationships/domestic violence	44	76
N11	Primary caretaker unable/unwilling to put child's needs ahead of own	43	74
N2	Number of prior assigned neglect allegations and/or findings	36	62
N5	Primary caretaker is unable/unwilling to control impulses	35	60
N7	Primary caretaker currently has a mental health problem	33	57
N1	Current allegation and/or finding includes neglect	32	55
N9	Primary caretaker currently has substance abuse problem	23	40
N10	Family is homeless or children are unsafe due to housing conditions	20	34
N3	Number of children in the household = 4 or more	-10	17

Average 35, standard deviation = 13.1 Scores in Bold indicate + or - 1 s.d.

6.9 FRAAN Neglect Risk Factors Subcategories

The sub-categories in this section are components of the risk assessments for each of the study families in that they represent each of the alternative answers possible to the assessment questions in the FRAAN risk assessment documentation (Appendix B, attached). These case details are listed as sub-categories whenever more than one assessment tool answer was available. The use of these subcategories allows more detailed components of the risk factors to be identified where more than one answer was possible to the assessment questions. These circumstances are not necessarily linked, except that they all relate to problems within the family.

This analysis of the subcategories provides a refinement of the Neglect scores in that the specific issues expressed by the answer subcategories for each assessment question are identified. For example, the high frequency of factor N4c shows that families did not simply lack support from family and friends, but their closest relationships were reported as actually harmful. It is helpful to separate these answers to identify the strength of each separately as well as their combined score on the risk rating for the family.

6.10 Neglect Risk Factor Subcategory Findings

Table 6.6 below includes these separate risk assessment question components of the FRAAN neglect risk factors applying to cases in this study.

High frequency risk factor sub-categories were:

- N6b (Inadequate physical care for child) and
- N4c (Relatives & others have a negative impact)

These were each found in 83% of the study cases (48 out of the total 58 cases).

- Factor N11 (Caretaker unable to put child's needs ahead of own) was found in 76% of cases
- Factor N8b (Primary caretaker involved in harmful relationship(s) or one or more domestic violence incident).

This finding suggests that poor physical care and the carer's harmful relationships were important elements of risk for child neglect in this overall high risk study sample.

Relatively infrequently occurring sub-categories included N10b (Family is homeless or about to be evicted), which was recorded for just four cases out of the fifty eight (7%), indicating that few of the case families were completely homeless or were at risk of eviction with young children.

This small number of cases showing insecure tenure and pending eviction in this UK group of cases suggests that family evictions may be less common in this UK sample than in US data because of the provision of help with social housing and housing benefits.

Factor N10c was recorded for fifteen of the cases (26%) where accommodation was chaotic and unsafe because of the family's own domestic circumstances, rather than the nature of their housing tenure.

Other very low scoring sub-categories (N8a, N6a, N4a and N10a) represent answers where the active risk factor was absent from the case, so if they had been recorded, their presence would demonstrate a positive absence of risk. This sample showed none of these positive circumstances were in place for any of the fifty eight case families.

The average score for the 19 neglect sub-categories was 25.5, yielding a standard deviation (SD) of 17.9. Sub-categories N6b and N4c scored more than one standard deviation above the mean and these two risk sub-categories were overarching features in the neglect of the case children.

**Table 6-6 Neglect Sub-Category Scores Rank Ordered By Frequency
(All Cases n = 58)**

	Neglect risk sub-category score	Frequency	%
N6b	Caretaker provides inadequate physical care for child(ren)	48	83
N4c	Relatives & others have a negative impact	48	83
N11	Primary caretaker unable to put child's needs ahead of own	44	76
N8b	Primary caretaker involved in any harmful relationship(s) or one or more domestic violence incident	44	76
N4b	No supportive relationships or limited social support	39	67
N5	Primary caretaker is unable/unwilling to control impulses	36	62
N2	Number of prior assigned neglect allegations and/or findings	34	59
N8c	Multiple (2 or more) domestic violence incidents	36	62
N7	Primary caretaker currently has a mental health problem	36	62
N6c	Caretaker provides inadequate supervision for child(ren)	34	59
N1	Current allegation and/or finding includes neglect	33	57
N9	Primary caretaker currently has substance abuse problem	24	41
N10c	Housing is physically unsafe	15	26
N3	Number of children in the household = 4 or more	10	17
N10b	Family is homeless or about to be evicted	4	7
N8a	Primary caretaker not involved in any harmful relationships	0	0
N6a	Caretaker provides adequate physical care and/or supervision for child(ren)	0	0
N4a	Social support is appropriate & available	0	0
N10a	No housing problems	0	0

Average = 25.5, standard deviation = 17.9. Factors 1 standard deviation + or – in bold

6.11 Abuse Risk Factors

The factors in this section are binary coded as either present, or not present, in the case report (see Table 6.7 below). Any weighting applied by the FRAAN scores to the factor is not included.

High frequency risk factors:

- A10 (Need for improved parenting, but parents will not participate) was present in 98% (57 out of 58 cases),
- A2 (Previous abuse allegations) was present in 90% and
- A3 (Youngest child under 6) present in 86%.

These are important Abuse risk factors for this group of cases.

The average score for the 11 abuse risk factors was 28.3, yielding a standard deviation (SD) of 17.2.

Risk factors A10 (Need for improved parenting, but parents will not participate), A2 (Previous abuse allegations) and A3 (Youngest child under 6) scored more than one standard deviation above the mean and these three risk factors were overarching features in the abuse of the case children.

This finding reflects the parenting problems identified by the FRAAN Neglect risk factors and the overall youth of the children in these cases, where 76% of the index children were younger than two years.

The finding that 90% of the study cases recorded a history of previous abuse allegations or findings is high, but given that many of the index children were very young babies or toddlers, it was surprising that so many families already had a history of previous concerns about abuse.

Infrequently identified factor:

- A6 (Secondary caretaker has low self esteem) which refers to the mental health of the mother's partner.

However, any male partners involved with these families were not described in detail in the Serious Case Review reports and their personal health history was not always mentioned. The infrequency of this finding in the case reports may reflect this lack of detailed information available to the child protection agencies, rather than an absence of risks relating to carer self esteem.

Table 6-7 follows.

**Table 6-7 Abuse Risk Factors Rank Ordered By Frequency
(All Cases n = 58)**

	Abuse risk factor	Frequency	% cases n = 58
A10	Caretakers need to improve parenting skills but will not participate	+57	98
A2	Number of prior assigned abuse complaints and/or findings	+52	90
A3	Age of youngest child is < 6 years	+50	86
A8	Either caretaker has current or a history of domestic violence	45	78
A1	Current complain and/or finding includes mental injury	33	57
A9	A child in the household has one or more of the following characteristics Developmental disability, History of delinquency, Mental health issues, Behavioural issues	22	38
A5	Either caretaker was abused and/or neglected as a child	22	38
A11	Primary caretaker views incident less seriously than department	21	36
A7	Either caretaker is domineering and/or employees excessive and/or inappropriate discipline	19	33
A4	Number of children in the household is 3 or more	-12	21
A6	Secondary caretaker has low self esteem	-8	14

Average = 31, standard deviation = ± 17 Bold indicates + or - 1.s.d

6.13 Abuse risk factor subcategories

Table 6-8 below looks at the individual components of the FRAAN abuse risk factor questions applying to cases. This is done by coding case details as factor sub-categories where more than one answer was possible. This allows more detailed elements of abuse risk to be identified.

The most frequently identified abuse risk factors were:

- A3 (Age of youngest child is <6 years), which was found in 86% of the cases (fifty out of fifty eight cases) and reflects the demography of the study cases overall.
- Factor A8 (Domestic violence) was found in 78 % of the study cases (forty five out of fifty eight cases).

Other frequent sub-categories included negative risk factors for abuse A7a (Neither caretaker is domineering or uses excessive discipline) and A6b (Lack of carer self esteem problems) represent answers where the negative aspects of the risk factor did not apply to the case and their presence would demonstrate a positive absence of abuse risk in many cases.

The finding of frequent negative risks would lower the risk score in these cases, but risk factors could only be attributed to the cases if there was a definite statement within the Serious Case Review papers and this evidence of high numbers of negative risk factors in a special high risk sample may indicate that the relevant information was missing from the report, especially where full reporting had not been completed or where male partners were effectively unknown to services working with the mother and child.

The relatively few cases recording children with a history of delinquency may suggest that the children had had little or no contact with police services. This also reflects the profile of a group of children where 76% were aged less than two years old and simply too young to be in trouble with the law.

The average score for the 19 abuse sub-categories was 23, yielding a standard deviation (SD) of 15.

The most frequent risk factors were:

- A3 (age of the youngest child under 7 years) and
- A8 (domestic violence)

Both scored more than one standard deviation above the mean and these two risk factors were overarching features in abuse of the case children.

The least frequently recorded risk factors were more than one standard deviation below the mean:

- A4 (number of children in the household was three or more) and
- A6 Secondary caretaker has low self esteem.

There were relatively few large families in the case files (12 out of 58, 21%) and although some parents had children by previous relationships living elsewhere, 79% of the index children were living in small families.

Table 6-8 follows.

Table 6-8 Abuse Risk Sub-Category Scores Rank Ordered By Frequency (All Cases n = 58)

	Abuse risk sub-category score	Frequency	% cases
A3	Age of youngest child is <7 years	-50	86
A8	Either caretaker has current or history of domestic violence	-45	78
A7a	Neither caretaker is domineering and/or employees excessive and/or inappropriate discipline	43	74
A6b	Secondary caretaker has no self esteem problems	41	71
A1	Current allegation and/or finding includes psychological harm	34	59
A9a	No child has any of the characteristics below - Developmental disability, History of delinquency, Mental health issues, Behavioural issues	30	52
A2c	Three or more prior abuse complaints or findings	30	52
A5	Either caretaker was abused and/or neglected as a child	22	38
A2b	One or two prior abuse complaints or findings	22	38
A9b	A child in the household has a developmental disability	19	33
A4	Number of children in the household is >3	13	22
A7c	A caretaker uses inappropriate discipline	13	22
A7b	A caretaker is domineering	11	19
A6a	No secondary caretaker in family	8	14
A6c	Secondary caretaker has self esteem problems	-7	12
A2a	No previous abuse complaints or findings	-5	9
A9c	A child in the household has a history of delinquency	-3	5

Average = 22, standard deviation = 15, bold indicates +1 or - 1 S.D

6.14 Case Outcomes: Comparing Deceased and Survived Cases

This section considers the outcomes for children in the study cases. Thirty one index children died as a result of neglect and abuse (53%), twelve of them following severe physical assault (39% of the Deceased cases). Twenty seven children survived their maltreatment, but of these twenty seven, six were ‘near miss deaths’ (22% of the Survived cases) where the child suffered serious brain damage likely to shorten their lives and seriously impair their development.

The current policy on child protection is designed to prevent harm to children where at all possible. Since the most serious harm that can befall a child is death or serious injury resulting from abuse or neglect, preventing child deaths relating to neglect or abuse is a high professional and political priority for child protection services. Accordingly, it was decided to see whether the FRAAN risk assessments were consistently higher in cases where children died and whether they were different from those cases where children survived.

Within this special group of fifty eight Serious Case Reviews, thirty one index children died. In two cases, all the children in the family were killed. A further fatal case included four neonaticides in a single family. In another, a mother and her toddler were both killed by the mother’s former partner. More girls than boys died and girls formed just over half of the Deceased group of index children (55%) in this sample.

6.15 Correlation between Deceased versus Non-Deceased Neglect Scores

The next task was to test for the direction of the scores between the two outcome groups and the original Neglect and Abuse scores of the Deceased and Survived cases were correlated to determine the extent to which they were alike.

The original two sets of FRAAN risk factors (neglect and abuse) showed a significant positive correlation between the two ranked frequency groups despite the different case outcomes. Spearman's rank coefficient (Rho) for the Neglect risk factors $Rho = +0.6851$ ($p = <0.001$) and the Abuse factors $Rho = +0.8727$ ($p = <0.001$), showing no statistical differences between the directions of the scores in the two outcome groups – Deceased and Survivors. A significant positive correlation also applies between the two groups of sub-categories for neglect and abuse risk. These similarities are shown in Tables 7, 8, 9 and 10 below.

The most frequently identified neglect factors related to the social support of the primary caretaker (N4) and the lack of physical care or supervision of the children (N4).

Table 6-9 follows.

Table 6-9 FRAAN Neglect Risk Factors Frequencies: Correlation Between The Two Outcome Groups

FRAAN Neglect Factors		Factor frequency Deceased	Order of frequency	Factor frequency Survivors	Order of frequency
		n=31		n=27	
N1	Current allegation and/or finding includes neglect	17	8	14	5
N2	One or more prior assigned neglect allegations and/or findings	20	6.5	13	6
N3	Number of children in the household = 4 or more	5	11	4	11
N4	Primary caretaker's social support is limited or has a negative impact	29	1	23	2
N5	Primary caretaker is unable/unwilling to control impulses	22	5	12	7
N6	Primary caretaker provides inadequate physical care and/or inadequate supervision for child(ren)	28	2	25	1
N7	Primary caretaker currently has a mental health problem	20	6.5	11	8
N8	Primary caretaker is involved in harmful relationships with incidents of domestic violence	23	4	19	3
N9	Primary caretaker currently has substance abuse problem	16	9	7	10
N10	Family is homeless or children are unsafe due to housing conditions	13	10	8	9
N11	Primary caretaker unable or unwilling to put child's needs ahead of own	26	3	17	4

Rho = +0.6851, p = <0.001

6.16 Correlation between Deceased and Survivor Cases for Neglect Subcategory Factors

There is a significant positive correlation between the two groups of subcategory scores (Rho= +0.6851, $p = <0.001$). The overall trends of the neglect risk factor frequencies were similar for both outcome groups.

As in previous tables above, the least frequently recorded factors for both Deceased and Survivor cases were those for negative risks (the absence of risk factors) and for the risk of family eviction and homelessness (N10b).

The lack of physical care for children in the study cases (N4b) was more common than the lack of supervision (N4c) and the social support from relatives and friends was negative in its effects (N4c).

Table 6-10 follows.

Table 6-10 Neglect Sub-Categories: Correlation between Deceased And Survivor Cases

	DECEASED	Frequency		SURVIVED	Frequency
N1	Current allegation and/or finding includes neglect	18	N1	Current allegation and/or finding includes neglect	15
N2	Number of prior assigned neglect allegations and/or findings	21	N2	Number of prior assigned neglect allegations and/or findings	15
N3	Number of children in the household	5	N3	Number of children in the household	5
N4a	Social support is appropriate & available	0	N4a	Social support is appropriate & available	0
N4b	No supportive relationships or limited social support	24	N4b	No supportive relationships or limited social support	15
N4c	Relatives & others have a negative impact	28	N4c	Relatives & others have a negative impact	20
N5	Primary caretaker is unable/unwilling to control impulses	23	N5	Primary caretaker is unable/unwilling to control impulses	13
N6a	Caretaker provides adequate physical care and/or supervision for child(ren)	0	N6a	Caretaker provides adequate physical care and/or supervision for child(ren)	0
N6b	Caretaker provides inadequate physical care for child(ren)	29	N6b	Caretaker provides inadequate physical care for child(ren)	19
N6c	Caretaker provides inadequate supervision for child(ren)	19	N6c	Caretaker provides inadequate supervision for child(ren)	15
N7	Primary caretaker currently has a mental health problem	22	N7	Primary caretaker currently has a mental health problem	12
N8a	Primary caretaker not involved in any harmful relationships	0	N8a	Primary caretaker not involved in any harmful relationships	0
N8b	Primary caretaker involved in any harmful relationship(s) or one or more domestic violence incident	25	N8b	Primary caretaker involved in any harmful relationship(s) or one or more domestic violence incident	18
N8c	Multiple (2 or more) domestic violence incidents	20	N8c	Multiple (2 or more) domestic violence incidents	16
N9	Primary caretaker currently has substance abuse problem	17	N9	Primary caretaker currently has substance abuse problem	7
N10a	No housing problems	0	N10a	No housing problems	0
N10b	Family is homeless or about to be evicted	4	N10b	Family is homeless or about to be evicted	0
N10c	Housing is physically unsafe	7	N10c	Housing is physically unsafe	8
N11	Primary caretaker able to put child's needs ahead of own	27	N11	Primary caretaker able to put child's needs ahead of own	17

Rho = +0.6851 (p = <0.001).

6.17 FRAAN Abuse Risk Factors Frequencies: Correlation between Deceased and Survivor Cases

Table 6.11 below considers the relationship between the direction of the FRAAN risk factor scores for abuse risk for the Deceased and Survived groups.

There is a significant positive correlation between the two groups of sub-category scores $Rho = +0.8727$ ($p = <0.001$). The overall trends in the abuse risk scores were similar for both outcome groups.

Table 6-11 follows.

Table 6-11 FRAAN Abuse Risk Factors Frequencies: Correlation between Deceased and Survivor Cases

	FRAAN Abuse Factors	Deceased		FRAAN Abuse Factors	Survivors
A1	Current allegation and/or finding includes psychological harm	19	A1	Current allegation and/or finding includes psychological harm	13
A2	One or more prior abuse allegations and/or findings	14	A2	One or more prior abuse allegations and/or findings	24
A3	Age of youngest child is six years or younger	27	A3	Age of youngest child is six years or younger	23
A4	There are 3 or more children in the household	7	A4	There are 3 or more children in the household	5
A5	Either caretaker was abused and/or neglected as a child	13	A5	Either caretaker was abused and/or neglected as a child	8
A6	Secondary caretaker has low self esteem	6	A6	Secondary caretaker has low self esteem	1
A7	Either caretaker is domineering and/or employees excessive and/or inappropriate discipline	9	A7	Either caretaker is domineering and/or employees excessive and/or inappropriate discipline	8
A8	Either caretaker has current or a history of domestic violence	24	A8	Either caretaker has current or a history of domestic violence	20
A9	A child in the household has one or more of the following characteristics: Developmental disability, History of delinquency, Mental health issues or Behavioural issues	11	A9	A child in the household has one or more of the following characteristics: Developmental disability, History of delinquency, Mental health issues or Behavioural issues	11
A10	One or both caretakers needs to improve parenting skills but will not participate	29	A10	One or both caretakers needs to improve parenting skills but will not participate	24
A11	Primary caretaker views incident less seriously than department	9	A11	Primary caretaker views incident less seriously than department	12

Rho = +0.8727 (p = <0.001).

6.18 FRAAN Abuse Risk Factor Sub-Categories: Correlation between Deceased and Survivor Cases

As with the FRAAN risk scores for Neglect risk, there is a significant positive correlation between the two groups of sub-category scores $Rho = +0.8866$ ($P = <0.001$).

Table 6-12 follows.

Table 6-12 Abuse Sub-Categories: Correlation Between Deceased and Survivor Cases

DECEASED		Frequency	SURVIVORS		Frequency
A1	Current allegation and/or finding includes psychological harm	21	A1	Current allegation and/or finding includes psychological harm	13
A2a	No previous abuse complaints or findings	2	A2a	No previous abuse complaints or findings	3
A2b	One or two prior abuse complaints or findings	13	A2b	One or two prior abuse complaints or findings	9
A2c	Three or more prior abuse complaints or findings	17	A2c	Three or more prior abuse complaints or findings	13
A3	Age of youngest child is <7 years	28	A3	Age of youngest child is <7 years	22
A4	Number of children in the household is >3	7	A4	Number of children in the household is >3	6
A5	Either caretaker was abused and/or neglected as a child	15	A5	Either caretaker was abused and/or neglected as a child	7
A6a	No secondary caretaker in family	4	A6a	No secondary caretaker in family	4
A6b	Secondary caretaker has no self esteem problems	22	A6b	Secondary caretaker has no self esteem problems	21
A6c	Secondary caretaker has self esteem problems	6	A6c	Secondary caretaker has self esteem problems	1
A7a	Neither caretaker is domineering and/or employees excessive and/or inappropriate discipline	23	A7a	Neither caretaker is domineering and/or employees excessive and/or inappropriate discipline	18
A7b	A caretaker is domineering	8	A7b	A caretaker is domineering	3
A7c	A caretaker uses inappropriate discipline	6	A7c	A caretaker uses inappropriate discipline	7
A8	Either caretaker has current or a history of domestic violence	26	A8	Either caretaker has current or a history of domestic violence	19
A9a	No child has any of the characteristics below Developmental disability, History of delinquency, Mental health issues, Behavioural issues	20	A9a	No child has any of the characteristics below Developmental disability, History of delinquency, Mental health issues, Behavioural issues	10
A9b	A child in the household has a developmental disability	6	A9b	A child in the household has a developmental disability	13
A9c	A child in the household has a history of delinquency	0	A9c	A child in the household has a history of delinquency	3
A9d	A child in the household has a mental health issue	1	A9d	A child in the household has a mental health issue	2
A9e	A child in the household has behavioural issues	5	A9e	A child in the household has behavioural issues	7
A10a	All caretakers motivated or improvement not needed	1	A10a	All caretakers motivated or improvement not needed	0
A10b	Yes, parenting skills needed but caretakers are willing to participate	0	A10b	Yes, parenting skills needed but caretakers are willing to participate	0
A10c	No, one or both caretakers needs to improve parenting skills but will not participate	31	A10c	No, one or both caretakers needs to improve parenting skills but will not participate	26
A11	Primary caretaker views incident less seriously than department	11	A11	Primary caretaker views incident less seriously than department	13

Rho = +0.8866 (p = <0.001).

These strong positive relationships between the risk scores for the Deceased and Survivor groups were unexpected, given that the working hypothesis had been that there would be differences between the two groups which could be identified by their risk scores on FRAAN assessment.

The evidence from this group of cases demonstrates that the overall FRAAN risk assessment scores as such cannot distinguish between the risk factor scores for cases where children died as a result of their abuse and cases where they survived. The ability to distinguish between the two outcome groups was one of the properties of the FRAAN which formed the second hypothesis to be tested in this empirical study, but the findings failed to support it.

It was decided to continue examining the data for differences in regard to each specific neglect and abuse factor using Chi square tests for consistency between the individual risk factor and subcategory scores for the two groups to see if any of these factors might have indicated the potential for a fatal case outcome. As before, the neglect risk scores and the assessment question subcategories were tested, followed by the Abuse risk factors and question subcategories.

Chi Square tests of independence between the two groups were performed. These results are given in Tables 6.13 and 6.14. This test compares the two sets of risk assessment scores are by comparing observed frequencies of the risk sub-categories for neglect with the theoretically expected frequencies if there were no differences between neglect risk factors for the Survivor and Deceased groups (see Table 6-13 below). No significant differences existed except for neglect risk factor N9 (Carer has a substance abuse problem) and N5 (Caretaker is unable/unwilling to control impulses). Substance abuse was more commonly recorded in the reports for the Deceased cases (16 cases) than the Survivors (7 cases), as was the lack of impulse control (22 cases in the Deceased group and 12 in the Survivor group).

The result for the neglect risk factor N1 shows that the proportion of Deceased children where families were reported as having this risk factor was 0.55, whereas the proportion for Survivor children was 0.52. These are not very

different proportions and the difference between them is not significant if $p = <0.05$. For factor N1, $\chi^2(df=1, n=19) = 0.037, p = 0.88$, using a two tailed test of significance. As a further check for any elements of the FRAAN risk neglect factors which might differentiate significantly between the Deceased and Survived cases, a similar comparison was used to compare the question subcategories as well as the risk factors themselves. Although two of the factors were significant at the level $p <0.05$, none of Chi Square tests for independence between the risks factor for the Deceased and the Survivor cases were significant at the level $p = <0.01$.

Table 6-13 follows.

Table 6-13 Chi Square Goodness of Fit Test for Neglect Risk Factors

	FRAAN Neglect Factors	Factor frequency Deceased	Factor frequency Survivors	Chi square	P value
N1	Current allegation and/or finding includes neglect	17	14	0.052	0.8201
N2	One or more prior assigned neglect allegations and/or findings	20	13	1.576	0.2093
N3	Number of children in the household = 4 or more	5	4	0.019	0.8903
N4	Primary caretaker's social support is limited or has a negative impact	29	23	1.088	0.2969
N5	Primary caretaker is unable/unwilling to control impulses	22	12	4.185	0.05
N6	Primary caretaker provides inadequate physical care and/or inadequate supervision for child(ren)	28	25	0.094	0.7587
N7	Primary caretaker currently has a mental health problem	20	11	3.279	0.0702
N8	Primary caretaker is involved in harmful relationships with incidents of domestic violence	23	19	0.106	0.7452
N9	Primary caretaker currently has substance abuse problem	16	7	3.979	0.05
N10	Family is homeless or children are unsafe due to housing conditions	13	8	0.946	0.3307
N11	Primary caretaker unable or unwilling to put child's needs ahead of own	26	17	3.290	0.0697

No significant differences existed except for neglect risk factor A2 (One or more prior abuse allegations and/or findings), which was significant at the level $p = <0.005$, with quite different proportions between the two groups. Prior allegations of abuse were much more common among the Survivor group than the Deceased group, which was unexpected.

Table 6-14 Chi Square Goodness of Fit Test for Abuse Risk Factors

	FRAAN Abuse Factors	Factor frequency Deceased	Factor frequency Survivors	Chi square	p value
A1	Current allegation and/or finding includes psychological harm	19	13	1.008	N sig
A2	One or more prior abuse allegations and/or findings	14	24	12.214	p<0.005
A3	Age of youngest child is six years or younger	27	23	0.044	N sig
A4	There are 3 or more children in the household	7	5	0.145	N sig
A5	Either caretaker was abused and/or neglected as a child	13	8	0.946	N sig
A6	Secondary caretaker has low self esteem	6	1	3.331	p<0.07t
A7	Either caretaker is domineering and/or employees excessive and/or inappropriate discipline	9	8	0.002	N sig
A8	Either caretaker has current or a history of domestic violence	24	20	0.088	N sig
A9	A child in the household has one or more of the following characteristics: Developmental disability, History of delinquency, Mental health issues or Behavioural issues	11	11	0.169	N sig
A10	One or both caretakers needs to improve parenting skills but will not participate	29	24	0.398	N sig
A11	Primary caretaker views incident less seriously than department	9	12	1.484	N sig

The following two tables (Tables 6-13 and 6-14) cover the Chi square calculations for the subcategories for Neglect and Abuse. Five Neglect factor subcategories showed significant differences at $p<0.05$ but none at $p < 0.01$.

Table 6-15 Chi Square Goodness Of Fit Test For Neglect Risk Assessment Question Sub-Category Findings

	Neglect risk sub-category findings	Deceased	Survivors	Chi square	P <0.05
N1	Current allegation and/or finding includes neglect	18	15	0.037	N Sig
N2	Number of prior assigned neglect allegations and/or findings	21	15	0.910	N Sig
N3	Number of children in the household	5	5	0.058	N Sig
N4a	Social support is appropriate & available	0	0	Both groups have zero scores	N Sig
N4b	No supportive relationships or limited social support	24	15	3.132	N Sig
N4c	Relatives & others have a negative impact	28	20	2.670	N Sig
N5	Primary caretaker is unable/unwilling to control impulses	23	13	4.158	p<0.05
N6a	Caretaker provides adequate physical care and/or supervision for child(ren)	0	0	Both groups have zero scores	
N6b	Caretaker provides inadequate physical care for child(ren)	29	19	5.433	t p<0.05
N6c	Caretaker provides inadequate supervision for child(ren)	19	15	0.196	N Sig
N7	Primary caretaker currently has a mental health problem	22	12	4.185	p<0.05
N8a	Primary caretaker not involved in any harmful relationships	0	0	Both groups have zero scores	
N8b	Primary caretaker involved in any harmful relationship(s) or one or more domestic violence incident	25	18	1.471	N Sig
N8c	Multiple (2 or more) domestic violence incidents	20	16	0.169	N Sig
N9	Primary caretaker currently has substance abuse problem	17	7	4.973	p<0.05
N10a	No housing problems	0	0	Both groups have zero scores	
N10b	Family is homeless or about to be evicted	4	0	3.742	p<0.05 t
N10c	Housing is physically unsafe	7	8	0.374	N Sig
N11	Primary caretaker unable to put child's needs ahead of own	27	17	4.590	p<0.05

Only the following factor subcategories differ significantly between the Deceased and the Survivor groups.

- N5 - Primary caretaker is unable/unwilling to control impulses
- N6b - Caretaker provides inadequate physical care for child(ren)
- N7 - Primary caretaker currently has a mental health problem
- N9 - Primary caretaker currently has substance abuse problem and
- N11 - Primary caretaker unable to put child's needs ahead of own

With the exception of these subcategories, the Neglect subcategories do not enable differentiation between the risk scores for the two possible outcomes. All these risk factors were more frequently found in cases where children died.

6.19 Abuse Risk Assessment Question Sub-Category Findings

No significant differences existed except for abuse risk factors A9b (A child in the household has a developmental disability) and A9c (A child in the household has a history of delinquency).

The differences between the frequencies of each sub-category are as follows:

	Deceased	Survived
A9b (A child in the household has a developmental disability)	6	13
A9c (A child in the household has a history of delinquency).	0	3

The direction of the difference shown in Table 6.14 below shows that the Survivor group of families contains more children with these problems than the Deceased cases. This effect cannot be followed up easily from the review reports alone, but it is possible that children with such extra needs may also

attract extra supportive input and help for their families which may have a protective effect.

Table 6-16 follows.

Table 6-16 Chi Square Goodness of Fit Test for Abuse Risk Assessment Question Sub-Category Findings

	Abuse risk sub-category findings	Deceased	Survivors	Chi square	P value
A1	Current allegation and/or finding includes psychological harm	21	13	1.4438	NSig.
A2a	No previous abuse complaints or findings	2	3	0.5093	NSig.
A2b	One or two prior abuse complaints or findings	13	9	0.2201	NSig.
A2c	Three or more prior abuse complaints or findings	17	13	0.0561	NSig.
A3	Age of youngest child is <7 years	28	22	0.1004	NSig.
A4	Number of children in the household is >3	7	6	0.0119	NSig.
A5	Either caretaker was abused and/or neglected as a child	15	7	0.4255	NSig.
A6a	No secondary caretaker in family	4	4	0.1004	NSig.
A6b	Secondary caretaker has no self esteem problems	22	21	1.0808	NSig.
A6c	Secondary caretaker has self esteem problems	6	1	3.0025	P <0.05t
A7a	Neither caretaker is domineering and/or employees excessive and/or inappropriate discipline	23	18	0.0484	NSig.
A7b	A caretaker is domineering	8	3	1.6914	NSig.
A7c	A caretaker uses inappropriate discipline	6	7	0.5510	NSig.
A8	Either caretaker has current or a history of domestic violence	26	19	0.5510	NSig.
A9a	No child has any of the characteristics below : Developmental disability, History of delinquency, Mental health issues or Behavioural issues	20	10	3.3196	Trend towards significant
A9b	A child in the household has a developmental disability	6	13	6.3659	Significant P<0.02
A9c	A child in the household has a history of delinquency	0	3	3.8937	Significant P<0.05
A9d	A child in the household has a mental health issue	1	2	0.6101	NSig.
A9e	A child in the household has behavioural issues	5	7	1.1159	NSig.
A10a	All caretakers motivated or improvement not needed	1	0	0.8268	NSig.
A10b	Parenting skills need to improve and caretakers are willing to participate	0	0	Zero scores	NSig.
A10c	One or both caretakers needs to improve parenting skills but will not participate	31	26	0.8268	NSig.
A11	Primary caretaker views incident less seriously than department	11	13	1.4438	NSig.

6.20 Other differences between the Deceased and Survivor Groups

The cases were examined in order to identify other differences and potential risk factors not included in the FRAAN Neglect and Abuse risk assessments. This involved returning to the cases to look at additional aspects which went beyond the risk factors in the FRAAN assessments.

6.21 Causes of child deaths

The largest proportion of the child deaths resulted from severe physical assaults (12 cases, 39% of the deaths), but the second most frequent category is where the causes were not clearly reported or remained undetermined (7 cases, 23% of the deaths). This is a major gap in the information which might have been expected to be included in Serious Case Review reports, perhaps through including the narrative inquest verdicts on cases.

However, there were six cases among the Survivor group which could be regarded as ‘near miss deaths’, where young children suffered severe life threatening injuries from physical assaults, but survived with major disabilities which were due to head trauma consistent with the baby having been shaken or struck. These children may not have survived without access to specialist medical care and the reports indicated that their disabilities may have been life limiting. Brain injuries were the most frequently recorded type of violent physical assault and formed the most likely cause of death from maltreatment in the study group.

The typology of causes of death was developed by Sidebotham (2011).

Table 6-17 follows.

Table 6-17 Child Deaths and Causes

Cause of death	Frequency in the T.C.S. sample (n = 31)	Cases
Infanticide/Covert homicide	2 (6%)	22 and 26
Severe physical assault (fatal)	12 (39%)	1, 6, 18, 27, 31, 34, 35, 37, 38, 42, 59, 60
Extreme neglect (fatal)	1 (3%)	30
Deliberate/Overt homicide	6 (19%)	2 (two children), 40, 48, 51, 61
Death related to, but not directly caused by maltreatment	1 (3%)	41
Sudden Unexpected Death in Infancy (SUDI)	2 (6%)	39 (two children)
Death, cause not specified in SCR report	7 (23%)	8, 45, 50, 54, 62, 63, 64
Total child deaths	31	

6.22 Relationships of the Abusers and Index Children

It was surprising to note that there were ten cases within the study sample of fifty eight cases (17%) where no specific intrafamilial abuser was identified within the report, but there was no suggestion that any of these cases involved an extrafamilial abuser. They included relatively recent reports where criminal proceedings were still pending and others where carers denied any knowledge of the causes of a child's injuries and no attribution of responsibility could be made.

The fifty eight study cases were overwhelmingly attributed to intrafamilial abusers (83% of the identified abusers, n = 48). This proportion of intrafamilial abusers matches the findings of a ten year child homicide study in England (Pritchard and Bagley 2001, Pritchard 2004). The most frequent abusers were the sixteen cases where a male and female carer were together jointly considered to have abused the index child (33%).

Excluding those ten cases where no abuser was specified in the Review report, there were forty eight cases with reported abusers. The relationship between these abusers and the index children is given in Table 6-18 below.

Table 6-18 Relationship of Known Abusers to Index Child in T.C.S. Cases

Abuser type in all cases with a reported abuser (n = 48 cases)	Number and percentage of reported abusers
Mother alone	10 (21%)
Father or male partner alone	19 (40%)
Both carers jointly involved	16 (33%)
An older child	1 (2%)
Non-familial adult	2 (4%)
Total identified abusers	48

Where both partners were reported to be jointly involved in the abuse of a child, these sixteen cases were divided up into male and female perpetrators (sixteen of each, since all the mother's partners were male) showing that of those cases with known perpetrators, males were responsible for thirty five of the forty eight cases (73%) and females for twenty six cases (54%). Setting aside the cases involving another child and two extrafamilial abusers, thirty five out of the total of forty eight is a surprising preponderance of male abusers.

The difference between the abusers in the fatal and non fatal cases was examined to see if there were gender differences related to the outcomes of the maltreatment.

There were no extrafamilial abusers involved in the fatal cases in this study and all the fatal abusers were adults. There were forty abusers involved in these thirty one deaths, including the couples who were reported as jointly responsible and the three cases with unspecified abusers. In the thirty one cases where children died, reports stated that fifteen mothers were solely or jointly responsible. These fifteen mothers formed 38% of the forty abusers,

whilst the male abusers formed 55% of the abusers. This is a substantial preponderance of male abusers.

Among the twenty seven Survived cases, two cases involved extrafamilial male sexual abusers and one an older sibling, also a sexual abuser. All of these were males. The intrafamilial adult abusers in the non-fatal cases were more equally distributed between female abusers acting either alone or jointly with a male partner/biological father (eleven cases, 32% of the abusers) and adult intrafamilial male abusers acting alone or jointly with the child's mother (thirteen cases, 38% of the abusers). Males of all types constituted sixteen of the thirty four non-fatal abusers (47%).

Table 6-19 Relationship of Abusers to Index Child in T.C.S. Cases

Abuser	Abusers in the 31 Deceased cases n = 40 abusers	% Abusers in Deceased cases	Abusers in the 27 Survived cases n= 34 abusers	% Abusers in Survived cases
Mothers	15	38%	11	32%
Fathers / mother's male partners	22	55%	13	38%
An older child	0	0%	1 male	3%
Non-familial adult	0	0%	2 males	6%
Not specified	3	7%	7	21%
Total abusers	40		34	

Spearman's Rho = 0.928, P = <0.01, demonstrating a strong positive correlation between the abuser types for both the Deceased and Survivor children

In summary, the attributed responsibility for the abuse between male and female carers was more evenly distributed in the cases where children survived. Many more male abusers were reported as responsible for the cases of fatal abuse.

The lack of an identified abuser in ten cases (17% of the T.C.S. cases) was surprising, but where the circumstances were not clearly reported, responsibility could not be attributed.

6.24 Additional Family Related Factors Identified in T.C.S. Reports

The factors in this section reflect some of the family circumstances identified in the T.C.S. Serious Case Reviews. They are broader in scope than the FRAAN risk factor definitions and have no similar actuarial basis, being drawn from previous child protection literature relating to serious cases (Brandon et al. 2009). These definitions also include previous, as well as current, circumstances mentioned in the review reports. Since some of the more complex families had multiple issues in their lives, the sum of factors exceeds the number of cases (see Table 6.19 below).

Issues of parental mental health problems and domestic violence were recorded at frequencies more than one standard deviation above the mean, appearing to be more important factors in this group of cases. Two family factors were less than one standard deviation below the mean were sexual abuse and mothers aged 18 years at the time of their pregnancy.

Table 6-20 follows.

Table 6-20 T.C.S. Family related factors

Family related factors	Overall frequency of factor (all cases n = 58)	Percentages of cases with this factor
Parental mental health problems (current or past)	+44	76%
Domestic violence known or suspected	+46	79%
Male partners with reported conviction/s for violence	21	36%
Mental health problems <i>plus</i> conviction/s for violence <i>both</i> present	12	21%
Substance abuse by either or both carers	25	43%
Families with evidence of neglect or previous child on Child Protection Register	25	43%
Sexual abuse of index child or a sibling	-6	10%
Mother aged under 18 years at time of pregnancy	-4	7%

Average of overall frequencies = 23, standard deviation = 16
 Scores in Bold indicate + or – 1 s.d.

These factors were compared to identify differences between the Deceased and Survived groups of index children.

The overall frequencies showed two factors (parental mental health problems and domestic violence) recorded more frequently than one standard deviation above average and the Deceased cases frequencies considered alone featured the same factors (see Table 6.21 below).

The Deceased cases also showed that parental mental health and domestic violence were both recorded at frequencies more than one standard deviation above the mean.

For the Survived cases, only the domestic violence frequencies were more than one standard deviation above average for that outcome group.

Sexual abuse and very young mothers were both reported at less than one standard deviation below average. This special group of cases reflect particularly serious outcomes for the children concerned, so these low

numbers of sexual abuse cases may indicate that there were few sexual abuse cases in the thirteen counties, or that few cases of sexual abuse were considered to have caused such serious harm. The low numbers of very young mothers at the time of their first pregnancy relates to the quality of some reports which contained limited detail on mother's histories. Where it was not possible to be sure of ages, mothers were assumed to have been aged over eighteen.

Chi square values comparing the frequencies of these factors were performed for two outcome groups. Only two factors were significantly different between the Deceased and the Survived groups. These were Parental mental health problems ($\chi^2 = 4.590$ significant at $p < 0.05$) which were more commonly found in the Deceased group and Families with evidence of neglect/previous child on child protection register ($\chi^2 = 5.376$, significant at $p < 0.05$) which was more commonly recorded among the Survivor cases.

Table 6-21 follows.

Table 6-21 T.C.S. Additional Family Related Factors In Deceased And Survived Cases

Family related factors	Frequency in Deceased Cases (n = 31)	Frequency in Survived Cases (n = 27)	Overall frequencies (all cases)
Parental mental health problems (current or past)	+27	17	+44
Domestic violence known or suspected	+24	+22	+46
Male partners with conviction/s for violence	8	13	21
Mental health problems <i>plus</i> conviction/s for violence <i>both</i> present	8	4	12
Substance abuse by either or both carers	16	9	25
Families with evidence of neglect or previous child on Child Protection Register	9	16	25
Sexual abuse of index child or a sibling	-1	5	-6
Mother aged under 18 years	4	0	4

Average of overall frequencies = 23. Standard deviation = 16

Average of Deceased frequencies = 12. Standard deviation = 9

Average of Survived frequencies = 11. Standard deviation = 8

Scores in **Bold** indicate + or – 1 s.d.

6.25 Overlapping problems in the T.C.S. cases

Some factors overlapped where families faced more than one problem in their lives and the most frequently recorded combinations are given in Table 21 below. For example, thirty one of the fifty eight T.C.S. case families (53%) had recorded evidence of parental mental illness, together with domestic violence.

Parental mental illness and substance misuse were both recorded as present in twenty of the fifty eight cases (35%).

Parental mental health was also linked to reports of a chaotic family life with evidence that children were neglected in nineteen cases, forming 33% of the whole sample of fifty eight.

The combination of parental mental illness with domestic violence and substance misuse suggest combinations of circumstances where parents may sometimes find it difficult to attend to the needs of young children. In this sample, 76% of the children were aged under two years and over half (55%) were aged under one year. Such small children would be highly dependent on the attention of their parents and unable to care for, or protect, themselves.

Table 6-22 Frequently Identified Overlapping Family Factors in the T.C.S. Sample (n = 58)

All cases n = 58	Parental mental health problems (current or past)	Domestic violence known or suspected	Male partners with conviction/s for violence	Substance abuse by either or both carers	Chaotic families with evidence of neglect/CPR
Parental mental health problems (current or past)	x	31 (53%)	12 (21%)	20 (35%)	19 (33%)
Domestic violence known or suspected	31 (53%)	x	9 (15%)	19 (33%)	16 (28%)
Male partners with conviction/s for violence	12 (21%)	9 (15%)	x	4 (7%)	13 (22%)
Substance abuse by either or both carers	12 (21%)	19 (33%)	4 (7%)	x	9 (15%)
Chaotic families with evidence of neglect/CPR	19 (33%)	16 (28%)	13 (22%)	10 (17%)	x

The degree of domestic violence in each case could only be determined from text references in the case reports rather than a criminal conviction, but even this relatively ‘soft’ data could be linked to high risks for children. It was decided to look in more detail at the family circumstances in the two groups of cases, combining the additional details identified in the review reports alongside the FRAAN risk factors N8 and A8 to group them together in domestic violence categories which are more inclusive and broader than the FRAAN risk factors alone.

The case records were searched for details on family and abuser characteristics and circumstances. Some of these attributions were made on the basis of firm evidence such as police reports of convictions for offences. The records of parental mental health in SCRs rarely included formal reports from psychiatric services, but additional details on postnatal depression and other previous mental health problems emerged from the text of the reports on parental histories as well as the risk factor N7 – primary carer currently has a mental health problem. These are given in Table 6.23 below.

Mental health problems were recorded for one or both of the carers in twenty seven of the thirty one fatal cases (87%). In twenty three of these cases the mental health problems affected the child's mother (75% of the fatal cases).

The relationship between outcomes and the parental characteristics is statistically significant for the following factors:

- Parental mental health problems (current or past) were found in 27 out of 31 Deceased cases (87%) compared with 17 out of 27 Survived cases (63%) $\chi^2 = 4.590$, $p < 0.03$
- Substance abuse by either or both carers, found in 16 out of 31 Deceased cases (52%) compared with 6 out of 27 Survived cases (22%) $\chi^2 = 5.295$, $p < 0.01$
- Chaotic families with evidence of neglect or Child Protection Registration registration was found in only 9 out of 31 Deceased cases (29%) compared with 16 out of 27 Survived cases (59%) $\chi^2 = 0.376$, $p < 0.01$.

This indicates that parental mental illness, substance abuse and families where households were chaotic and indicated that children were neglected were all frequently reported. These factors were all significant correlates in cases where children died as a result of neglect or abuse.

The following factors showed a trend towards significance:

- Male partners with conviction/s for violence $\chi^2 = 3.119$, $p < 0.10$. This factor was more frequently found among the non-fatal cases, which differs from the findings of the child homicide studies so this factor trends towards a negative association with a fatal outcome in this study sample. The paucity of information about the histories of male partners in the review reports means that this finding needs cautious interpretation because of the frequent recording of domestic violence in the absence of formal convictions.
- Mother aged <18 years at first pregnancy, $\chi^2 = 3.742$, $p < 0.05$, again trending towards a positive association with a fatal outcome in this sample. The small numbers involved (four cases, all fatal) mean that this finding is difficult to interpret, but suggests that these very young parents may need greater support services.

Table 6-23 follows.

Table 6-23 Characteristics of the Perpetrators in Fatal and Non-Fatal Cases

Factors noted in review	Frequency in fatal cases N = 31	% of fatal cases with factor	Frequency in non fatal cases N = 27	% of non-fatal cases with factor
Parental mental health problems (current or past)	27	87	17	63
Domestic violence known or suspected	24	77	22	81
Male partners with conviction/s for violence	8	26	13	48
Mental health problems plus conviction/s for violence both present	8	26	4	15
Substance abuse by either or both carers	16	52	6	22
Chaotic families with evidence of neglect or CPR registration	9	29	16	59
Mother aged <18 years at first pregnancy	4	13	0	0
Sexual abuse	0	0	6	22

Note: Some factors occur together, so their total frequencies will exceed the total number of cases in each outcome group

6.25 Co-occurring Parental Characteristics in T.C.S. Fatal Cases

The use of drugs or alcohol by people with mental health problems was identified when this additional analysis of case records noted that 52% of the fatal cases occurred in families where carers were recorded both as having had mental health problems and to be involved in substance misuse.

Overlaps between the cases where these factors were recorded showed other possible relationships between particular pairs of factors in the cases where children had died. Twenty four cases (77% of the total thirty one fatal cases) reported both parental mental health problems and domestic violence.

Sixteen of the thirty one fatal cases (52%) included both parental mental health problems and substance abuse. Fifteen of the thirty one fatal case

reports (48%) stated that both domestic violence and substance abuse were features of the parents' lives. All three problems co-occurred in thirteen of the thirty one fatal cases (42%).

There were relatively few cases where male carers had criminal convictions for violence known to the child protection reporters, only eight (26%) of the fatal cases. However, four out of these eight cases also showed multiple problems with parental mental health problems, domestic violence and substance abuse. Domestic violence findings were not based on recorded convictions, but was reported as part of the home circumstances in the SCR reports for 24 (52%) of the cases where children died.

6.26 Co-Occurring Parental Factors in T.C.S. Non-Fatal Cases

Of the non-fatal cases, sexual abuse was the only factor which did not feature among the fatal cases. None of the mothers in the cases where children survived was younger than eighteen years old at the time of her first pregnancy. Animal cruelty was only identified in one case, but the same family also had a record of domestic violence and substance abuse.

Among the more frequent factors identified in the non-fatal cases, domestic violence was the most frequently recorded. The reports identified it in twenty two of the twenty seven reports (81%). Of this group of families living with domestic violence, eight (30%) were also described as chaotic families with evidence of child neglect or previous Child Protection Register registration. Seven case reviews (26%) identified parental mental health problems co-occurring in families where domestic violence occurred.

Some features of cases were seldom found in the T.C.S. study and then only reported in the non-fatal cases. Sexual abuse was reported for six of the non-fatal cases T.C.S. (22%) and in just one of the fatal cases. In one non-fatal case, there had been previous cruelty to a dog living at the home. The same case also included issues relating to parental mental health, domestic violence and substance abuse.

Comparing the two sets of results for these non-FRAAN factors in Tables 23 and 24 below, significant differences between combinations of factors in the two outcome groups were as follows:

- Parental mental health problems combined with domestic violence ($\chi^2 = 17.608$, $p = 0.0001$) was extremely significant and much more frequently recorded for the Deceased cases, recorded in 24 out of the 31 cases (77%) compared with just 7 of the 27 Survived cases (26%) ;
- Parental mental health problems combined with substance abuse by either or both carers ($\chi^2 = 8.649$, $p = 0.003$) was very significant and much more frequently recorded for the Deceased cases, found in 16 of the 31 Deceased cases (52%) compared with 4 out of 27 Survived cases (15%);
- Domestic violence with substance abuse by either or both carers ($\chi^2 = 7.384$, $p = < 0.007$) was significant and much more frequently recorded for the Deceased cases with 15 out of the 31 cases (48%) compared with 4 out the 27 Survived cases (15%);

None of the other combinations of factors in the matrix demonstrated statistically significant differences in the two outcome groups.

These combinations of factors which included some of the FRAAN factors with other broader data categories which emerged from the text of the SCRs highlight very significant differences between the Deceased and Survived groups.

Tables 6-24 and 6-25 follow.

Table 6-24 Co-Occurring Family Factors in Fatal Cases

Overlapping case factors in Fatal Cases % of total cases	Parental mental health problems (current or past)	Domestic violence known or suspected	Male partners with conviction/s for violence	Substance abuse by either or both carers	Chaotic families with evidence of neglect/CPR	Mother aged under 18 years	Animal cruelty	Sexual abuse of child or children
Parental mental health problems (current or past)	n/a	24 77%	8 26%	16 52%	9 29%	0	0	1 3%
Domestic violence known or suspected	24 77%	n/a	6 19%	15 48%	8 26%	0	0	0
Male partners with conviction/s for violence	8 26%	6 19%	n/a	4 13%	8 26%	0	0	0
Substance abuse by either or both carers	16 52%	15 48%	4 13%	n/a	5 16%	0	0	0
Chaotic families with evidence of neglect/CPR	5 16%	8 26%	8 26%	6 19%	n/a	0	0	0
Mother aged under 18 years when first pregnant	0	0	0	0	0	n/a	0	0
Animal cruelty	0	0	0	0	0	0	n/a	0
Sexual abuse of child/children	1 3%	0	0	0	0	0	0	n/a

Table 6-25 Co-Occurring Family Factors in Non-Fatal Cases

Overlapping case factors in Non-Fatal Cases % of total cases	Parental mental health problems (current or past)	Domestic violence known or suspected	Male partners with conviction/s for violence	Substance abuse by either or both carers	Chaotic families with evidence of neglect/CPR	Mother aged under 18 years	Animal cruelty	Sexual abuse of child or children
Parental mental health problems (current or past)	n/a	7 26%	4 15%	4 15%	10 37%	0	1	2 7%
Domestic violence known or suspected	6 22%	n/a	3 11%	4 15%	8 30%	0	1	1
Male partners with conviction/s for violence	4 15%	3 11%	n/a	0	5 18%	0	0	1
Substance abuse by either or both carers	4 15%	4 15%	0	n/a	4 15%	0	1	1
Chaotic families with evidence of neglect/CPR	10 37%	8 30%	5 18%	4 15%	n/a	0	0	0
Mother aged under 18 years when first pregnant	0	0	0	0	0	n/a	0	0
Animal cruelty	1	1	0	1	0	0	n/a	0
Sexual abuse of child/children	2 7%	1	1	1	0	0	0	n/a

6.27 Sensitivity of the FRAAN Risk Assessments

Working from the reported information available to child protection teams before the maltreatment incidents, FRAAN correctly identified twenty seven out of the thirty one Deceased cases as High or Very High/Intensive Risk (87%). In the Survivor group of cases, twenty four out of the twenty seven cases were correctly identified as being either Very High/Intensive Risk or High Risk (89%). These are shown below as Figures 6-1 and 6-2.

Figure 6-1: Total Risk Scores for Survivor Children

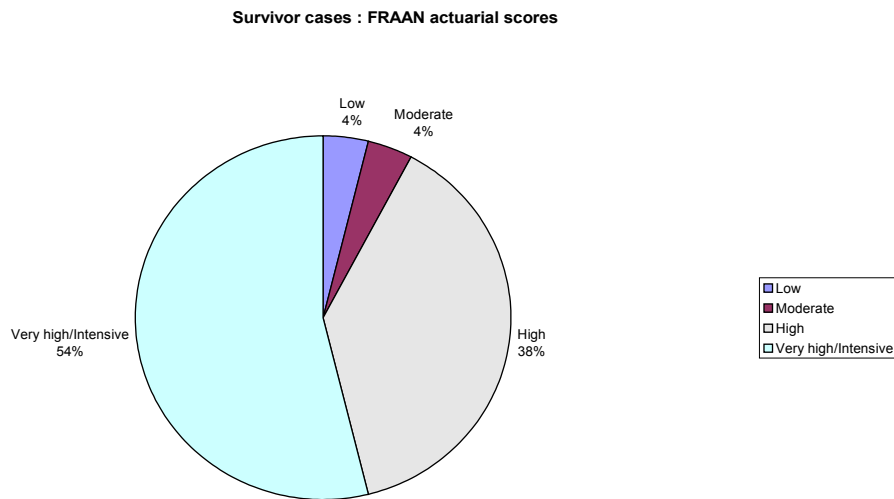
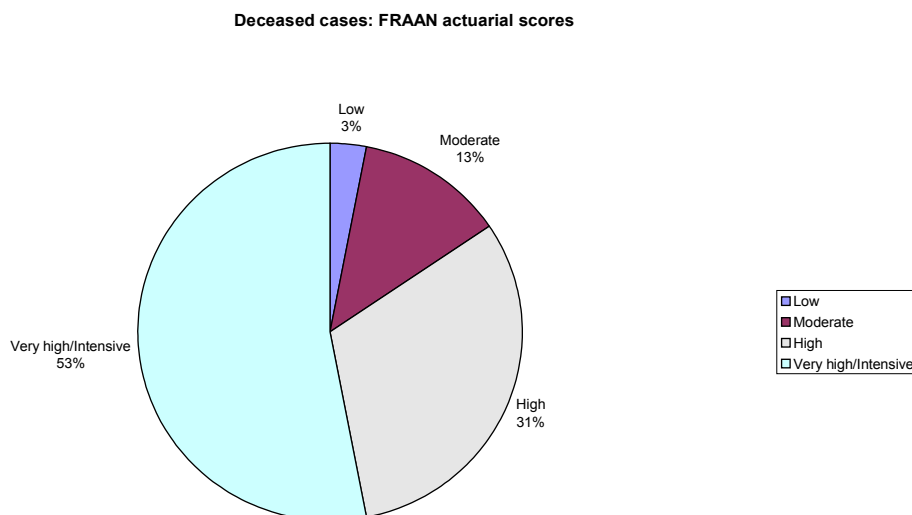


Figure 6- 2: Total Risk Scores for Deceased Children



These sets of scores show that the bulk of the Serious Case Review cases were classified as Very High/Intense Risk or High Risk on the basis of the recorded data in the Review reports. The sensitivity of the FRAAN risk assessment to the high risks of the study cases was 88% (ratio = 0.879). Six cases with very serious outcomes formed a group of false negative assessments. Specificity could not be measured since all the cases in the T.C.S. sample were high risk, because they had resulted in such serious outcomes. A retrospective study of a mixed sample of high and low risk cases with known outcomes would be required to measure specificity of the FRAAN scoring.

6.28 The Low Scoring Cases (False Negatives)

Some cases in each group were identified as Moderate or Low Risk, which would represent false negatives in the context of the serious maltreatment outcomes for the children concerned. Since all of the outcomes were serious in this particular special sample of child protection cases, false positive risk scores could not be attributed. The sensitivity ratio of the FRAAN assessment to high or intensive levels of risk in the whole sample of cases was reasonably high at 0.879, but specificity of the risk assessment could not be determined without false negative cases. Further research on a more mixed sample of cases (including both high and low risk cases) would be required to test this in the UK context.

It should be noted that 16% of fatal cases were not identified as high risk, which, whilst lower than most risk assessment protocols used in other settings such as mental health and criminology, still means that there will be false negatives. Possible reasons for this will be discussed later.

FRAAN scores for the case sample identified six cases where the score was Low or Moderate only and five of these were fatal cases of abuse and neglect. These cases require further consideration to identify any reasons for the low risk scores. The details of the cases involved are in Appendix E.

Neither the FRAAN factors nor the individual weighted sub-categories suggest that the FRAAN risk assessment alone is able to identify any significant differences in risk scores between Deceased cases with a fatal outcome to maltreatment and the Survivor cases.

The gaps in information held by child protection agencies on fathers and male partners who were involved with the family made it difficult to know whether any additional circumstances relating to fathers and male partners might have affected the outcome of the maltreatment which led to the review. This information gap was particularly striking in cases whose previous criminal convictions were unknown to children's services until after a child had been assaulted or killed.

Neither the FRAAN risk factors nor the factor sub-categories suggest that the FRAAN risk assessment alone is able to find a substantial difference in the risk scores between the Deceased and Survived groups of cases.

Although these have not been used, there are some override factors which have been added to the actuarial component of the FRAAN assessment. The evidence base for these factors is not empirical, unlike the main body of the risk assessment scoring and they are simply professional areas of concern. These were not included in the study of the actuarially based factors.

The FRAAN was developed to predict the likelihood of re-abuse of a child following an earlier episode within the child's family, so would be intuitively expected that it might

detect a difference between cases where there was high risk of re-abuse and those likely to result in a fatality. The findings of the above T.C.S. study risk assessments show that it did not do so. This requires further work to identify factors which may predict the different outcomes.

6.29 Key risk factors

The risks posed to young children by adult carers who have particular problems relating to mental illness, violent behaviour and substance misuse are not the usual focus for child protection reviews, but analysis of the T.C.S. cases indicates that these were frequent factors for the cases where children died. This finding is similar to some of the findings in other studies focused on adult perpetrators in child homicides. This type of study is included in the next section of this chapter.

The rarity of serious child abuse and resulting fatalities means that wider actuarially derived risk assessments are unlikely to be sensitive enough to identify specific risk of homicide. The FRAAN risk assessment is based on sound statistical methods and emerged as the best risk assessment tool for predicting future neglect and abuse available at present. However, The FRAAN actuarial factors alone did not differentiate between the high risk factors for neglect and abuse in these serious maltreatment cases and those cases where the death of a child was more likely. Further evidence was sought from the data on cases in other recent SCR studies and research on child homicide perpetrators.

Chapter 7

External Validation Comparator Studies versus T.C.S. findings

As noted in the Methodology, the hierarchy of research design places the highest value on evidence derived from randomised controlled trials, where findings can be internally validated by comparison with a matched control or comparator group of subjects (Machin and Campbell 2005). This kind of design is not possible in child protection for both ethical and practical reasons since children at risk of similar outcomes to those in this study cannot be used as research controls. In addition, the levels of abuse reported in these cases are too rare in relation to the UK child population for adequate sample sizes. If a random controlled sample is not possible, one possible source for external validation data is a comparison group of similar and contemporaneous cases, to see whether the T.C.S. cases are similar to those in other larger studies in order to support the value of the findings.

Whilst there are no UK based studies using the FRAAN risk assessment tool to look at Serious Case Reviews, there are two recent and major national reviews of Serious Case Review child protection cases. The sources for external child protection Serious Case review data were a recent review of 189 Serious Case Reviews in England and Wales (Brandon et al. 2009) (The Brandon Team Study) and an Ofsted report on 147 English Serious Case Reviews (Ofsted 2010) (The Ofsted Study).

Since the second main hypothesis in this T.C.S. study (that FRAAN scores would be different between the Deceased and Survived groups of cases) was not supported by the risk scores of the two groups, it was decided that UK studies of child homicide cases may offer comparable cases and potential risk factors. A UK study of similar size using a ten year cohort of child homicide cases was chosen (Pritchard 2004) (The Wessex Study). The next section will summarise the key data to be used from the two child protection studies and from the Wessex study of adults who kill children.

The working null hypothesis will be that there will be significant differences between the T.C.S results and those of the Brandon and Ofsted studies. The null hypothesis would require that there be significant statistical similarities between the T.C.S. data and the two external study samples.

The first two parts of this external comparison will outline the most important findings of the Brandon team and Ofsted studies. The main findings of Wessex study of child homicide assailants will also be outlined below.

In Section 3 of this chapter, the data available from each of the three comparator studies will be matched to the findings from the T.C.S. outlined above. Comparisons are made with these three UK based studies and findings are tabulated to discover how the T.C.S cases differ and to what extent the external studies yield similar results. Close correlations between the child and family related risk factors in the unrelated studies would tend to support the null hypothesis stated above i.e. that the cases covered by the T.C.S. reviews are similar to those in other serious case reviews and that the FRAAN risk assessment findings may also be expected to be similar.

The Wessex study relating to people who killed children will be compared with the additional family and abuser factors which differentiated between the Deceased and Survived groups in the T.C.S. cases.

7.8 Section 1: The Brandon Team Study (Brandon et al 2009)

A contemporaneous review of English and Welsh SCRs undertaken by a team based at the University of East Anglia is used to compare the T.C.S. finding with a similar data set and, where possible, to identify clusters of child and family related factors which might indicate a pattern of different risks and adversities (Brandon et al. 2009). This review of 189 Serious Case Reviews undertaken by (Brandon et al. 2009) drew upon reports from both England and Wales. In particular, they include a detailed risk assessment focus on a subset of forty cases from English local authorities for which they had greater detail information, selected from a wider study sample of sixty three cases to represent the range of demographic characteristics found in the wider study cases (Brandon et al. 2009).

Brandon's 189 cases were represented by summary notifications provided for the central Department of Children, Families and Schools (D.C.S.F.) database. These were not full reports and included limited information rather than full copies of the reviews

with their supporting documentation from the wider range of child protection agencies. While they yielded statistics on the cases, the detail was limited to a brief free text summary. Brandon's team then selected a stratified sample of forty cases for intensive study, involving half boys and half girls. These were chosen from a slightly larger set of sixty three redacted reports supplied from D.C.S.F., some with chronologies and management reports. This Intensive sample was not entirely selected from the wider Notifications list of 189 cases but selected as representative of the overall demographics. Brandon et al (2009) report that missing data was a problem for their study, even for the selected Intensive sample of forty cases. The 189 Notified cases were already represented by less than full reports.

Data collection was structured using a template developed for previous reviews. They also carried out seventeen interviews with child protection managers or professionals directly involved with the cases, covering 43% of the cases in the intensive sample. These interviews were structured using a formal interview schedule (Brandon et al. 2009).

7.9 Demographics of the Brandon Study Cases

The 189 notified cases included 123 deaths (66%) and 66 serious injuries (35%). Brandon states that the quality of the information was sketchy even for an initial notification in 44% of her cases and 5% of the reviews revealed only the administrative processes followed, not child and family information (Brandon et al 2009, p 17).

Table 7.1 shows the distribution of the age groups in both the larger Notified group of 189 cases and the smaller Intensive group of 40 cases. Chi square tests indicate that there are no significant differences between the distribution of age groups within the Intensive group and that of the wider Notified set of cases.

Table 7-1 follows.

Table 7-1 Age Group at Time Of Incident of the Notified Children (n = 189) and the Intensive Sample (n = 40)

Age group of Index Child	Cases with known ages n= 189	% in each age group	Cases with known ages n= 40	% in each age group
Under 1 year	86	46	17	43
1 to 5 years	44	23	9	23
6 years to 10 years	18	10	4	10
11 to 16 years	20	11	7	18
16 years and over	21	11	3	8
Total included cases	189	100	40	100

The large notified set of 189 cases comprised 106 boys (56%) and 83 girls (44%). Spearman’s Rho shows that the age distribution for boys was strongly positively correlated with that for girls (Rho= 0.87). The smaller intensive group of forty cases was selected to include equal numbers of boys and girls.

The case outcomes for the Notified group of 189 cases include twenty apparent suicides among older and teenaged children. Despite this, Table 7.2 below shows that the majority of the deaths (69%) occurred among the children aged less than five years, with 46% being babies aged less than one year. These will not include suicides.

Table 7-2 Gender and Age of the Brandon Notified Cases (n = 189)

Age Group of Index Child	Cases with known ages n= 189	% in each age group	Female n = 83	% female = 44%	Male n = 106	% male = 56%
Under 1 year	86	46	34	41	52	49
1 to 5 years	44	23	17	20	27	25
6 years to 10 years	18	10	11	13	7	7
11 to 16 years	20	11	10	12	10	9
16 years and over	21	11	11	13	10	9
Total included cases	189	100	83	100	106	100

The causes of death show that the most frequent cause of death was a severe physical assault, but 21% of the cases had no definite cause attributed. Table 7-3 shows the distribution of causes recorded for the Notified group of 189 cases, which included 103 deaths.

Table 7-3 Case Outcomes within the Intensive Group (Brandon et al, 2009)

	Case outcomes Brandon et al (2009) Intensive subset n= 40	Percentage of total cases (n= 40)
Deceased (includes unknown number of suicides)	27	68%
Survived	13	32%
Total	40	100%

Table 7-4 Causes of Death in Brandon et al (2009) Study Fatal Notified Cases

Cause of death (excluding 20 suicides)	Brandon et al 2009 (n = 103)
Infanticide/Covert homicide	7 (7%)
Severe physical assault (fatal)	27 (26%)
Extreme neglect (fatal)	5 (5%)
Deliberate/Overt homicide	9 (9%)
Death related to, but not directly caused by maltreatment	17 (16%)
Sudden Unexpected Death in Infancy (SUDI)	20 (19%)
^D death, category not clear	21 (20%)
Total child deaths	103

(Brandon et al, 2009, p. 31)

The intensive stratified sample of cases was the main focus for the comparisons with the T.C.S. cases because the sample sizes were closer and they provided more information, although the T.C.S. set is not stratified to represent any larger population but represents all the available reports except the suicide and adult perpetrator cases. Brandon et al (2009) provides a limited set of data was available for comparison with the T.C.S. cases because it was not collected using any formal risk assessment, but the Brandon team used a template developed in previous reviews.

^D

The following Table 7.5 uses the data from the Intensive Sample of 40 cases, chosen to represent the wider Notified set of 189 cases. The data is divided into child related factors and family related factors.

Taking the child and family related factors as identified risk factors emerging from the forty review reports, the average frequency for the child factors is 10, standard deviation = 5. The only child related factors which occur more frequently than one standard deviation above the mean are known vulnerability at birth and known Accident and Emergency (A&E) attendances. These are important child related risk factors in the cases reviewed by the Brandon team.

The family related factors have an average frequency of 14, standard deviation = 6. The key family factors emerging with frequencies above one standard above the mean are domestic violence and parental mental health problems

Table 7-5 follows.

Table 7-5 Child and Family Characteristics of the Brandon Team's Intensive Group of Cases

Child related factors	Brandon et al (2009) Intensive Sample	
	n = 40	% cases
Death	27	68
Serious injury	13	33
Male	20	50
Female	20	50
Aged <1 year	17	43
Aged 1-5 years	9	23
Aged 6-10 years	4	10
Aged 11-15 years	7	18
Aged 16 years and over	3	8
Prematurity	8	20
Known vulnerability at birth	15	38
Known disability	7	18
Known A&E attendances	18	45
Known hospital admissions	12	30
Known audiology or ophthalmic needs	8	20
Known speech and language therapy needs	3	8
Family related factors		
1 child household	12	30
2 child household	9	23
3 child household	11	28
4 or more children household	8	20
Frequent house moves	18	45
Domestic violence, current or past	21	53
Parental substance abuse, current or past	13	33
Parental mental health problems, current or past	25	63
Learning disability	6	15
Criminal convictions (all types)	18	45

Child factors average = 10, standard deviation = 5,
 Family related factors average = 14, standard deviation = 6
 Scores in Bold indicate + or - 1 s.d.

The bulk of the report by the Brandon team uses qualitative information only and deals with the management of child protection services and it gives no further data that can be compared with the T.C.S. cases.

7.10 Section 2: The Ofsted Review of Serious Case Reviews (2009-2010)

This second review of 147 English Serious Case Reviews was focused on the performance of the agencies undertaken the reviews and the data on the children and their families was sparse. The descriptors used for the causes of death were quite different from those used by Brandon et al in their studies of 2008 and 2009, which made it impossible to extract comparable data (Brandon et al. 2009, Brandon et al. 2008a). Indeed, it was surprising to see that the Ofsted mortality data failed to differentiate between markedly different causes of death e.g. young adult suicides appear to be included with homicides. Most studies of deaths use recognised typologies of deaths in relation to the victims' ages and genders, ideally using standardised internationally recognised typologies usually applied to mortality statistics published by the Office for National Statistics or World Health Organisations. Despite the cases being subject to detailed review, the largest group of deaths were given as Undetermined or Unknown Causes (n= 28, 31%).

The report states that the most common incidents involved physical abuse and long term neglect, but no figures are supplied in relation to these causes and deaths appeared to be attributed to parental backgrounds and adult problems, rather than the child's maltreatment.

Risk factors relating to the circumstances of the children and their families were not identified in the Ofsted report, but the few comparable data items which were available are given in Tables 7-6, 7-7, 7-8 and 7-9 below.

Table 7-6 Age Distribution of Children in the Ofsted (2010) Cases

Age Group of Index Child	Cases with known ages n= 194	% in each age group
Under 1 year	69	36
1 to 5 years	47	24
6 years to 10 years	26	13
11 to 16 years	31	16
16 years and over	21	11
Total included cases	194	100

The gender distribution among the Ofsted cases was not available in the report, although there were 91 girls (47%) and 103 boys (53%) (Ofsted 2010). Out of the 194 children covered by the 147 reviews, 90 children died. The following Table 7.7 gives the number of deaths excluding these 11 suicides and leaving just those 79 children who died in circumstances related to neglect or abuse.

Table 7-7 Case Outcomes within the Ofsted Cases

	Case outcomes Ofsted (2010) excluding suicides (n= 79)	Percentage of total cases (n=183)
Deceased	79	43%
Survived	104	57%
Total	183	100%

Table 7-8 gives the age profile of the children who died. There were ninety child deaths included in the Ofsted study.

Table 7-8 Ofsted (2010) Age profile of children who died n = 90

Age at death	Numbers of children who died n = 90	Percentage of total fatal cases
Aged <1 year	36	40
Aged 1-5 years	21	23
Aged 6-10 years	8	9
Aged 11-15 years	10	11
Aged 16 years and over	15	17

Attribution of cause of death among the children who died as a result of abuse and neglect by others was difficult because the Ofsted report presents this information in a very different format from the Brandon study and inclusion criteria for the categories chosen by Ofsted were unclear (Ofsted, 2010, p. 12-13). The interpretation requires care to be able compare the findings.

Five of the children died as a result of accidents following previous concerns about neglect, so these five have been allocated to the Extreme neglect category. They might possibly have been placed in the group where death was related to, but not directly caused by maltreatment, but neglect seemed the major issue. Homicides by parents or others included a wide range of harmful activities including deaths described as ‘*arising from malnourishment, neglect, physical abuse, shaken baby syndrome or arson*’ whilst deaths from fire or drowning are counted separately (Ofsted, 2010, p. 13).

It would appear that only 15 of the 90 deaths of children aged 0-16 (17%) could be definitely ascribed to intrafamilial maltreatment by their carers (Ofsted 2010, p. 13, para. 28). This figure cannot be aligned with the categories given for causes of deaths in Table 7.9 (Ofsted 2010, p. 12, para. 25).

Substance misuse is given as an accidental death and not suicide, so these five deaths are added to the category for ‘Covert Homicide’ rather than that of ‘Extreme Neglect’. One death classified by Ofsted (2010) as due to an accident or adverse event was included as ‘Category Not Clear’.

Table 7-9 Causes of Death in the Ofsted (2010) Fatal Cases

Cause of death, excluding suicides	Ofsted (2010) cases n = 79
Infanticide/Covert homicide	7
Severe physical assault (fatal)	Not specified
Extreme neglect (fatal)	5
Deliberate/Overt homicide by carer or other	21
Death related to, but not directly caused by maltreatment	9
Sudden Unexpected Death in Infancy (SUDI) }	37 combined category
Death, category not clear }	
Total child deaths (minus suicides)	79

Similar difficulties were encountered in populating the table comparing child and family characteristics for the whole group of case children in the Ofsted sample. The demography section of Table 32 (below) includes the suicide cases and so does the data provided by Brandon et al (2009). The denominator for the demographic percentages of children is 194, and for the Child and Family related factors, the case total of 147 cases is used because the cases are not represented by a single index child.

There are a number of gaps in the data, but key family related factors identified by the Ofsted report relating to domestic violence, substance misuse and mental health problems are highlighted.

The most salient factors reported in the Ofsted study were:

- domestic violence (61 cases, 42%),
- substance abuse (63 cases, 43%) and
- parental mental health problems (44 cases, 30%)

These factors appeared to overlap in some cases.

Table 7-10 follows.

**Table 7-10 Child and Family Characteristics of the Ofsted Group of Cases
n = 194 children within 147 cases reviewed**

Child demography (n = 194 children)	Ofsted (2010)	% cases
Death (including suicides)	90	46%
Serious injury	104	54%
Male	103	53%
Female	91	47%
Aged <1 year	69	36%
Aged 1-5 years	47	24%
Aged 6-10 years	26	13%
Aged 11-15 years	31	16%
Aged 16 years and over	21	11%
<u>Child related factors (n = 147 cases)</u>		
Prematurity	Not available	-
Known vulnerability at birth	Not available	-
Known disability	23	16%
Known A&E attendances	Not available	-
Known hospital admissions	Not available	-
Known audiology or ophthalmic needs	Not available	-
Known speech and language therapy needs	Not available	-
<u>Family related factors (n = 147 cases)</u>		
1 child household	Not available	-
2 child household	Not available	-
3 child household	Not available	-
4 or more children household	Not available	-
Frequent house moves	Not available	-
Domestic violence, current or past	61	42%
Parental substance abuse, current or past	63	43%
Parental mental health problems, current or past	44	30%
Learning disability	Not available	-
Criminal convictions (all types)	Not available	-

7.11 Section 3: The Wessex Study of Child Homicide Cases (Pritchard 2004)

The third external study which will be compared with the T.C.S. findings is an English study of adults who have killed children (Pritchard and Bagley 2001, Pritchard 2004, Stroud and Pritchard 2001). The cases are drawn from a cohort of child homicides in two English counties over a ten year period. Unlike the three studies of Serious Case Reviews, the Wessex focused only upon known child homicides (aged 0-14) and the assailants, which it might be said was at the extreme of any cohort. Self-evidently a SCR indicates that the child concerned has suffered extremely serious outcomes, but not necessarily fatal, whereas the Wessex study only dealt with fatalities. Nonetheless, the Wessex study forms a useful and important comparison with T.C.S. cases because it provides much more information on assailants in child homicides than the two external child protection reports.

The extreme rarity of child homicide is illustrated by the figures in this substantial British cohort, which was based upon an analysis of police and social service records and a regional suicide register providing one of the most reliable data bases in the field.

Pritchard and Bagley (2001) considered the cases of thirty three children killed by twenty seven assailants, including fourteen mothers and thirteen men, not all of whom were biological fathers. There was a mix of assailants, including those from outside the family, so the study includes both intrafamilial and extrafamilial assailants, but there were no extrafamilial cases among the T.C.S. Deceased group. . These extrafamilial assailants form a very distinct and special group within the Wessex study, but are not included in the comparison with the T.C.S and Brandon study cases because there are no matching extrafamilial fatal cases in the child protection samples.

Table 7.11 below outlines the original data from Pritchard (2004) for the twenty eight of the thirty three children who were killed within their own families, excluding five children murdered by strangers. This intrafamilial data set represents 85% of the Wessex study and emphasises how unusual it is for a child to be murdered by a stranger, even within a ten year study of child homicides.

Table 7-11 Age and Sex of the children in the Wessex homicide study (Pritchard, 2004)

Intra familial victims	Boys	Girls	Total
Age 0-7 years	15	11	26
Age 8-16 years	1	1	2
Total	16	12	28

The types of assailants identified fell into three distinct categories, mentally ill parents, mothers whose child was on the Child Protection Register following earlier reports of neglect or abuse and men who were not the biological father of the child i.e. they were step fathers/cohabiters. These categories given in Table 7.12 below. The original study also gave the ages of these perpetrators, but the child protection studies did not provide this kind of detail for abusers.

Table 7-12 Types of Assailants in Wessex Child Homicide study

Category	Males n = 13	Females n = 14	Total n= 27
Within family n = 22			
Mother s (1 stepmother)	0	14	14
Father	4	0	4
Step parent cohabitee [joint]	4	0	4
Category of assailant			
Mentally ill [Aged M24-69, F18-34]	4	8	12
Neglect and abuse [Aged F18-24]	0	6 (all joint)	6
Violent offender [Aged M18-37]	4 (all joint)	0	4
Extra-family (n = 5) Category			
Child sexual abuser only	0		0
Multi-criminal child sexual abuser	5		5

Note: The category of ‘Neglect and Abuse’ includes parents who had had a child registered in the Child Protection Register and considered to be at risk. (Pritchard 2004, p. 117).

The Wessex study highlighted the epidemiological risk levels of the assailants to show that whilst mentally ill mothers were the most frequent assailants in terms of rates of homicide, it was the men i.e. stepfathers/ cohabiters with previous convictions for violence who had the highest rate of child homicide. The Wessex study especially highlighted the mental health and violence elements amongst abusing carers.

7.10 Comparisons between the studies

The comparison between the two studies of Serious Case Reviews (Brandon et al, 2009 and Ofsted, 2010) is appropriate because the data closely matches the type of report from which the T.C.S. data is drawn. The main findings from the two external studies were compared with the T.C.S. cases using Chi square correlations and Spearman's Rho as previously.

7.11 The Brandon team study of 189 Notified Cases and 40 Intensive Cases

The major family factors for the Brandon team study cases in their intensive sample of forty cases were parental mental health problems (n = 25, 63% of cases) and domestic violence (n = 21, 53% of cases). Both were recorded at frequencies more than one standard deviation above the average.

Among the child related factors, hospital admissions were significantly more frequently recorded for the T.C.S. cases. Hospital admissions were recorded for twelve of the forty cases in the Brandon et al (2009) Intensive sample (30%) and fifty cases (86%) of the fifty eight T.C.S cases ($\chi^2 = 32.181$, $p = 0.0001$). The number of recorded A&E attendances was more frequent in the Brandon team sample (n = 18, 45% of cases) than in the T.C.S. study (n = 19, 33% of cases).

There was a significant difference between the frequency of domestic violence in the Brandon team and T.C.S. studies, with more frequent recording in the T.C.S. cases ($\chi^2 = 7.868$, $p = 0.005$). There was no statistically significant difference between the numbers of families in each study where there was parental substance misuse.

The child related factors showed that a greater percentage of the index children died as a result of their maltreatment in the Brandon team sample (n = 27 deaths, 68% of cases) than in the T.C.S. cases (n = 31, 53% of cases), but the difference was not statistically significant. There was a similar age profile among the cases in the two studies, with no significant differences between the frequencies for any of the age groups. Children under the age of one year constituted the largest percentage of the abuse children in both groups (Brandon team study n = 18, 45% of cases and T.C.S. cases n = 31, 53% of cases).

A comparison of the frequencies of the individual factors identified in the Brandon Intensive sample and the T.C.S. cases showed some further statistically significant differences between the frequencies of some individual case factors as outlined in Table 35 below. These included families who had moved house frequently, with eighteen cases of the Brandon team sample (45%) and only seven of the T.C.S. cases (12%) ($\chi^2 = 13.510$, $p = 0.0002$) and households with three children with eleven cases in the Brandon team sample (28%) and just seven in the T.C.S. cases (12%) ($\chi^2 = 3.760$, $p = 0.05$).

Parental learning disabilities and children with sensory and language impairments were both more frequently recorded in the Brandon team cases, but the numbers of cases with each problem were small, with frequencies less than one standard deviation below the mean for both studies.

Spearman's Rho showed a strong positive correlation between the scores for the two studies

Table 7-13 follows.

Table 7-13 Comparing Frequencies of Individual Factors between the Brandon Team Study and the T.C.S. Study

Child related factors	Brandon et al (2009) Intensive Sample n = 40	TCS cases n = 58	χ^2	p value
Death	27 (68%)	31 (53%)	1.935	N Sig
Serious injury	13 (33%)	27 (47%)	1.935	N Sig
Male	20 (50%)	23 (40%)	0.626	N Sig
Female	20 (50%)	32 (55%)	0.254	N Sig
Aged <1 year	17 (43%)	31 (53%)	1.136	N Sig
Aged 1-5 years	9 (23%)	12 (21%)	.0046	N Sig
Aged 6-10 years	4 (10%)	8 (14%)	0.317	N Sig
Aged 11-15 years	7 (18%)	6 (10%)	1.053	N Sig
Aged 16 years and over	3 (8%)	1 (2%)	2.017	N Sig
Prematurity	8 (20%)	11 (19%)	0.016	N Sig
Known vulnerability at birth	15 (38)	25 (43%)	0.308	N Sig
Known disability	7 (18%)	5 (9%)	1.757	N Sig
Known A&E attendances	18 (45%)	19 (33%)	1.510	N Sig
Known hospital admissions	12 (30%)	50 (86%)	32.181	0.0001
Known audiology or ophthalmic needs	8 (20%)	2 (3%)	7.078	0.008
Known speech and language therapy needs	3 (8%)	3 (5%)	0.223	N Sig
Family related factors				
1 child household	12 (30%)	22 (33%)	0.657	N Sig
2 child household	9 (23%)	18 (31%)	0.864	N Sig
3 child household	11 (28%)	7 (12%)	3.760	0.05
4 or more children household	8 (20%)	11 (19%)	0.016	N Sig
Frequent house moves	18 (45%)	7 (12%)	13.510	0.0002
Domestic violence, current or past	21 (43%)	46 (79%)	7.868	0.005
Parental substance abuse, current or past	13 (33%)	25 (33%)	1.121	N Sig
Parental mental health problems, current or past	25 (63%)	44 (76%)	2.029	N Sig
Learning disability	6 (15%)	2 (3%)	4.214	0.04
Criminal convictions (all types)	18 (45%)	27 (47%)	0.023	N Sig

Brandon et al 2009

Child factors average = 10, standard deviation = 5

Family factors average = 14, standard deviation = 6

T.C.S.

Child factors average = 18, standard deviation = 14

Family factors average = 21, standard deviation = 15

Scores in Bold indicate + or - 1 s.d.

Spearman's Rho comparisons between the frequencies of the child and family related factors in the two studies showed strong positive correlations between both sets of factors (Child related factors Rho = 0.8400, $p < 0.001$, and Family related factors Rho = 0.8205, $p < 0.005$).

The Intensive sample of cases had limited quantified information in the report, so detailed comparisons with the T.C.S. were not possible. Comparisons of T.C.S. findings with the larger Notified set of cases is limited by the detail available to the Brandon team (Brandon et al. 2009). Table 7.14 compares the numbers of fatal and non fatal cases for the two Brandon team samples with the TCS cases. Chi square tests showed no significant difference between the proportions of Deceased and Survived children in each comparison (T.C.S. and Intensive sample $\chi^2 = 1.935$, $p = 0.1642$, T.C.S. and Notified sample $\chi^2 = 2.558$, $p = 0.1098$). There was a slight trend towards significance in the distribution of the sexes between the two studies, but it was not significant ($\chi^2 = 3.480$, $p < 0.10$).

Table 7-14 Case Outcomes of Intensive Group and Brandon Intensive and Notified Samples

	<i>Case outcomes Brandon team Intensive sample</i>	<i>Percentage of Intensive cases (n= 40)</i>	<i>Case outcomes Brandon team Notified sample</i>	<i>Percentage of Notified cases (n= 189)</i>	<i>Case outcomes T.C.S. sample</i>	<i>Percentage of T.C.S. cases (n= 58)</i>
Deceased	27	68%	123	65%	31	53%
Survived	13	33%	66	35%	27	47%
Total	40	100%	189	100	58	100

The forty cases reviewed by Brandon et al (2009) in their Intensive study of a selected representative stratified group of SCRs were similar to those in the T.C.S. study, which were included only on the basis of their availability, except for the twenty two teenage suicide cases, which were excluded. The difference between the two case groups was that Brandon's team included an unspecified number of adolescents who had committed suicide. The Brandon sample included more significantly more children in the age

group 11-15, but this Brandon age group sample may have included suicides and the overall numbers of children in this age group for both studies are small.

The extraction of the additional family and parental factors in the T.C.S cases allowed particular differences in families in the Deceased group to be identified in Tables 35 and 36 above, in addition to the risk factors picked up by the FRAAN scores. These were parental mental health problems, domestic violence and substance misuse. Similar factors are identified by (Brandon et al. 2009). Mental health problems and domestic violence were frequently recorded factors in both studies, over one standard deviation above the mean frequencies, but the factor for domestic violence was found more frequently among the T.C.S. cases. These are important factors for both sets of Serious Case Review cases. The findings of parental mental health problems and parental substance misuse by Brandon et al (2009) correlate closely with the T.C.S. cases with no significant differences. The only significant difference between these two sets of study findings was that domestic violence was recorded in the T.C.S. reports more frequently (79% of cases) than the Brandon Intensive sample (53% of cases) (Brandon et al. 2009).

Other influential factors were parental substance misuse and criminal convictions, although the Brandon team study does not identify the numbers of families where either carer had convictions for a specifically violent offence (Brandon et al. 2009). Families where one or both carers had existing criminal convictions for any offence formed almost half of each set of cases (45% of the Brandon team cases and 47% of the T.C.S. cases). There were no significant differences between these studies in relation to the frequency of criminal convictions. Substance misuse was recorded slightly less frequently (33% of the Brandon team's cases and 43% of the T.C.S. cases), again with no statistically significant difference between the two study samples.

Since the methods used in their study are predominantly qualitative, the Brandon team study reports limited quantitative data on their study cases, so it was not possible to match any other factors from the text of the report (Brandon et al. 2009).

The most important factors emerging from both studies were parental mental health problems and domestic violence.

7.12 The Ofsted Report on Serious Case Reviews (Ofsted 2010)

The Ofsted report contained less information on the children and their family circumstances than the Brandon Intensive sample, so points of comparison were limited. Statistically significant differences between the T.C.S cases and the Ofsted reports were considered in relation to the child factors and the family findings. Children aged under 1 year formed a significantly greater percentage of the T.C.S, cases (53% of T.C.S, n = 31, versus 36% of Ofsted cases, n = 69, $\chi^2 = 5.965$, p = 0.02). In addition, children aged over 16 years formed a significantly greater percentage of the Ofsted cases (11% of Ofsted, n = 21, versus 2% of T.C.S. cases, n = 1, $\chi^2 = 4.461$, p = 0.03). This latter finding may be related to the inclusion of adolescent suicide cases among the Ofsted sample.

The family related factors showed that domestic violence was recorded in more of the T.C.S. cases than the Ofsted ones (79% of T.C.S, n = 46, versus 42% of Ofsted cases, n = 61) ($\chi^2 = 4.875$, p = 0.0001). Parental mental health problems, current or past, were recorded in more of the T.C.S. cases than the Ofsted ones (76% of T.C.S cases, n = 44, versus 30% of Ofsted cases, n = 44) ($\chi^2 = 55.568$, p = 0.0001).

Although the Ofsted data sets were limited, the directions of the scores were compared for the Ofsted and T.C.S. factor frequencies and Spearman's Rho was +0.83 for the Child related factors (which were available for the demographic factors and index children with a disability), showing a strong positive correlation between the two groups of factors. The Family related factors identified by Brandon et al (2009) were mostly not identified by the Ofsted study, so all the available matched factors were included together in a single correlation and Spearman's Rho was +0.66, indicating a moderate positive correlation across the whole set of data for both studies.

The Ofsted study (Ofsted 2010) provided much less comparable data on children or their family circumstances than that of the Brandon team (Brandon et al 2009). The

material which could be matched was limited to basic demographic information on the 194 cases included, but the individual and family risk factors identified by the Brandon team were not published for the Ofsted cases and the only data which could be confidently identified related to children with disabilities, families with domestic violence, parental substance abuse and parental mental health problems.

The Ofsted study showed that the most frequently recorded issues affecting maltreating families were domestic violence, mental ill-health, and drug and alcohol misuse. None of these factors featured at frequencies more than one standard deviation above average, but they were still the most frequently identified factors relating to the families in their study (Ofsted 2010).

The T.C.S. study showed that domestic violence was more frequently recorded than in the Ofsted cases. T.C.S cases showed that 79% (n = 46) featured domestic violence against 42% of the Ofsted cases (n = 61), ($\chi^2 = 23.834$, p = 0.0001). There was no significant difference between the numbers of cases in the Ofsted and T.C.S. studies where there was parental substance misuse.

Parental mental health problems were also more frequently recorded among the T.C.S families. T.C.S. cases showed that 76% (n = 44) recorded parental mental health problems against 30% of the Ofsted cases (n = 44), ($\chi^2 = 35.812$, p = 0.0001). The limited comparable factors as a whole showed a moderate positive correlation (Rho = 0.66) and the child factors (largely the demographic data) showed a strong positive correlation between the Ofsted and T.C.S. cases (Rho = 0.83).

In summary, the most frequently recorded factors in the Ofsted Serious Case Reviews were:

- Domestic violence, current or past 61 cases (42%)
- Parental substance abuse, current or past 63 cases (43%)
- Parental mental health problems, current or past 44 cases, (30%)

The Ofsted and T.C.S. cases showed no statistically significant difference in the frequencies of recording of these important factors, except for a higher number of

domestic violence incidents recorded among the T.C.S. cases. The predominance of these family related factors in the Ofsted and T.C.S. cases is also found in the findings of the Brandon et al study (2009).

The factors and their respective frequencies in the Ofsted and T.C.S. cases are given in Table 7-15 below.

Table 7-15 Comparison between Factor Frequencies for the Ofsted (2010) and T.C.S. Cases

Child related factors	Ofsted (2010)	% Ofsted cases	T.C.S. cases n= 58	% T.C.S. cases	χ^2	P value	
Death (including suicides)	90	46%	31	53%	0.891	0.36	
Serious injury	104	54%	27	47%	0.891	0.36	
Male	103	53%	23	40%	2.179	0.14	
Female	91	47%	32	55%	2.179	0.14	
Aged <1 year	69	36%	31	53%	5.965	0.02	
Aged 1-5 years	47	24%	12	21%	0.001	0.98	
Aged 6-10 years	26	13%	8	14%	0.097	0.76	
Aged 11-15 years	31	16%	6	10%	4.468	0.04	
Aged 16 years and over	21	11%	1	2%	4.641	0.03	
Prematurity	Not available	-	11	19%	-	-	
Known vulnerability at birth	Not available	-	25	43%	-	-	
Known disability	23	16%	5	9%	0.473	0.49	
Known A&E attendances	Not available	-	19	33%	-	-	
Known hospital admissions	Not available	-	50	86%	-	-	
Known audiology or ophthalmic needs	Not available	-	2	3%	-	-	
Known speech and language therapy needs	Not available	-	3	5%	-	-	
Family related factors (n = 147 cases)						-	-
1 child household	Not available	-	22	38%	-	-	
2 child household	Not available	-	18	31%	-	-	
3 child household	Not available	-	7	12%	-	-	
4 or more children household	Not available	-	11	19%	-	-	
Frequent house moves	Not available	-	7	12%	-	-	
Domestic violence, current or past	61	42%	46	79%	23.834	0.0001	
Parental substance abuse, current or past	63	43%	25	43%	0.001	0.9744	
Parental mental health problems, current or past	44	30%	44	76%	35.812	0.0001	
Learning disability	Not available	-	2	3%	-	-	
Criminal convictions (all types)	Not available	-	27	47%	-	-	

Child factors Rho = 0.83, showing a strong positive correlation. Family factors Rho could not be calculated because of the lack of comparable data, but total factors Rho = 0.66, indicating a moderate positive correlation overall.

As with the Brandon et al (2009) study, the most important factors in the Ofsted (2010) study cases were domestic violence, parental mental health problems and substance misuse. Both the external child protection studies drawing on Serious Case Review reports identify these same significant factors in their findings as the T.C.S. cases.

In summary, the findings of the three Serious Case review studies are very similar in terms of the parental and family factors which were more frequently recorded in these special groups of cases where children were killed or suffered serious harm. This close correlation across different study teams, using different methods of analysis and different sources for their cases is strikingly consistent. Each set of findings supports and validates that of the others.

7.13 The Wessex Study of Child Homicide Cases (Pritchard 2004)

The difference between the two previously compared child protection reports and the Wessex homicide study cases lies in the focus on assailants and their circumstances. This study provided data which could be compared with the thirty one fatal cases among those included in the T.C.S. study. Caution in interpretation is important because the Wessex study used descriptors which applied to the assailants' killing of the child, following police investigations and legal procedures for homicide. These were much firmer definitions which attributed blame for the death of a child in a way which the Serious Case Reviews did not mention.

None of the T.C.S. fatal cases involved an extrafamilial assailant. The Wessex study does include five extrafamilial assailants, but these are rare and special cases and could not be included in the comparisons between the Wessex and T.C.S. cases. There were some differences in the extent of the detail on adults. The Wessex child homicide study considered assailants in detail, drawing on both police and psychiatric reports. There are difficulties in deriving this quality of data from a child protection source, because parental and carer information was limited in the case review reports used in the T.C.S. study.

All the apparently joint assailants in the T.C.S. study were mothers jointly with biological fathers, whereas the jointly attributed cases in the Wessex study involved mothers with unrelated male carers. To overcome this problem in attributing responsibility for joint assailants, the T.C.S. co-abusers were reallocated to their separate mothers and biological father categories and the Wessex assailants were counted as male partners or the child's mother. This cautious attribution allowed the thirty one T.C.S. fatal cases to be divided into three categories of relationship to the index child in Table 7-15 below. Differences between the proportions of each type of assailant showed no significance, although the numbers of biological fathers and mothers trended towards significance.

Table 7-16 Comparing the Relationships with the Index Child in Wessex Intrafamilial Homicide Assailants and the T.C.S. Fatal Abusers

Relationship to index child	Wessex assailants n = 22	TCS Abusers n = 38	χ^2	p value
Mothers	14 (64%)	15 (40%)	3.258	0.07 t
Biological fathers	4 (18%)	16 (42%)	3.589	0.06 t
Mother's male partners	4 (18%)	7 (18%)	0.001	N Sig
Total adults involved	22	38		

Table 7-16 below shows the distribution of the factors identified by the Wessex study applied to the twenty two Wessex intrafamilial assailants and the thirty eight T.C.S. abusers. There was no significant difference between the numbers of male partners with convictions for violence in this Thirteen Counties study and the findings of the Wessex study (Pritchard 2004, Stroud and Pritchard 2001), but the detail provided in the Serious Case Reviews was comparatively sparse on male partners, whether or not they were biological fathers and the T.C.S. figures may have allowed an underestimate.

Testing for differences between the proportions of different assailants between the two studies showed that only the increased involvement of biological fathers as assailants (individually and jointly) in the T.C.S. cases was a significantly larger assailant group compared with the Wessex study at the level $p = <0.05$. There were just 4 biological fathers among the Wessex cohort of 22 cases (18%) and 16 in the 31 T.C.S. cases (42%), $\chi^2 = 5.519$, $p = 0.012$. There were no significant differences between the two study samples for the numbers of mothers and male partners involved in child deaths.

The characteristics of the assailant were compared between the Wessex and T.C.S. cases, omitting the two new categories of domestic violence and substance misuse assigned to some of the T.C.S. families. There was only one category where there was a significant difference between the two studies in relation to men who previously

neglected or abused children or had previously had a child on the Child Protection Register. There were no offenders in this category among the Wessex cases, but seven men involved in the deaths of children in the T.C.S. cases were recorded in this category ($\chi^2 = 5.574$, $p = 0.02$). . They had all neglected or abused other children within the current family or in previous relationships. All the other assailant categories showed no significantly differences between the Wessex and T.C.S. studies.

No comparisons could be made in relation to domestic violence in the absence of criminal convictions for violent offences, or for substance misuse because these factors were not included in the Wessex study (Pritchard 2004).

Table 7-17 follows

Table 7-17 Characteristics of Intrafamilial Assailants in Wessex Child Homicide and T.C.S. studies

Category of assailant	Wessex males n = 13	T.C.S males	χ^2	p value	Wessex females	T.C.S females	χ^2	p value	Wessex total	T.C.S total	χ^2	p value
Mentally ill	4	6	0.012	0.91	8	6 (2 jointly)	1.789	0.18	12	13	0.698	0.40
Neglect and abuse	0	7	5.574	0.02	6	3	2.716	0.10	6	10	0.143	0.71
Violent offender	4	5 (1 jointly)	0.036	0.85	0	0			4	5	0.036	0.85

The ages of the T.C.S. Deceased children were divided into the two broad groups used in the Wessex studies. There were no statistically significant differences between the age and sex distributions for the two studies.

Table 7-18 Age distributions of Wessex study and T.C.S. Deceased Children

Intra familial victims	Wessex boys	T.C.S. Boys	χ^2	p	Wessex girls	T.C.S. Girls	χ^2	p	Wessex - all children	T.C.S - all children
Age 0-7 years	15	12	1.187	0.28	11	16	1.187	0.28	26	28
Age 8-16 years	1	1	0.000	1.00	1	2	0.139	0.71	2	3
Total	16	13			12	18			28	31

The T.C.S. and Wessex studies show similar distributions of assailants and victims. The nature of the family problems relating to the assailants differed slightly and there were differences in relation to the numbers of biological fathers involved in the T.C.S. cases. There are uncertainties in attribution of information derived from child protection Serious Case Reviews which do not affect the more ‘cut and dried’ information for adults who are known to have killed children. This makes the calculation of rates of killings per 100,000 population rather an uncertain process because attribution of responsibility is less certain than if perpetrators were convicted of a crime.

7.14 Overall findings

The first hypothesis was that the actuarial risk factors in the FRAAN risk assessment tool would accurately predict that all the Serious Case Review cases in the T.C.S cohort were high risk and might have been identified as such before the incidents occurred to precipitate the Serious Case Review. The sensitivity ratio of the FRAAN assessment to high or intensive levels of risk in the whole sample of cases was reasonably high at 0.879 (88%), but specificity of the risk assessment could not

be determined without false negative cases and these were all cases where there were serious outcomes. To test specificity would require a sample of cases where some cases indicated high risk, but led to good outcomes for the child and family. Such cases could only be found in a larger sample with mixed outcomes over time, not a group of Serious Case Reviews.

The low scoring case reports in general contained inadequate evidence on key facts about the families known to child protection services before the episode which precipitated the case, although one case (48) demonstrated a sudden increase in risks due to parental separation, again unknown by child protection services. One case (51) showed major risks which were known only to adult mental health services and not disclosed to children's services. Some of the reports were extremely brief overall with inadequate detail on family circumstances to fully assess risks (cases 15 and 69). Given the quality of the data, the first hypothesis can be supported with reservations from the sensitivity of the FRAAN, but the nature of the T.C.S. case mix did not allow specificity measurement.

FRAAN risk assessments of the T.C.S. cases showed that 54 out of 58 cases (93%) recorded poor physical care of the predominantly very young children in the cases, plus a lack of social support for mothers in 51 out of 58 cases (88%). Parenting skills were poor in 57 of the 58 cases (98%) and previous abuse allegations had been recorded for 52 out of 58 cases (90%).

The second hypothesis was that the FRAAN risk scores would show a significant difference between the cases where children died and those where they survived. Whilst some individual factors suggested that they might form part of a group of predictive risks, this hypothesis was not supported. Indeed, there was a remarkable concurrence between the high scoring risk factors in both groups and the direction of the scoring. This suggests that the whole sample demonstrated similar risks and that the FRAAN assessment could not predict the possibility of a fatal outcome in a high

risk child protection case. The null hypothesis is supported in this case. Individual case characteristics were considered in addition to the FRAAN assessments and parental mental health problems were recorded in 27 of the 31 fatal cases (87%) against 63% of the cases where children survived.

Overlapping factors were also noted, especially parental mental health problems together with domestic violence – 24 out of the 31 fatal cases (77%) versus just 7 of the 27 non fatal cases (26%). Other combinations of family factors which were significantly greater in the fatal cases were parental mental health problems together with substance misuse (found in 16 out of 31 fatal cases, 52%).

The third hypothesis was that the factors identified within the Wessex child homicide study undertaken by Pritchard (2004) and also Stroud and Pritchard (2001) would help to predict the likelihood of a fatal outcome in cases which show high risks for further child abuse and neglect. Within the high risk sample in this study, the relationship of the abuser to the index child was not a good predictor of risk of a fatal outcome, but the factors which were significant were as follows:

- Parental mental health problems (current or past)
- Substance abuse by either or both carers
- Chaotic families with evidence of neglect or CPR registration

The detail on male partners and fathers in the case files and review reports was not adequate to determine that men with an existing conviction for violence would predict an increased likelihood of a fatal outcome. With this exception and with the added factor of substance misuse by one or both parents, the intrafamilial risk factors identified by the Wessex study of child homicides appear to be predictive of the likely outcomes of high risk child protection cases. The strong positive correlations between parental mental illness in the Wessex and T.C.S studies tends to support the predictive importance of mental illness. There were some differences

in the findings on families where children had been neglected or abused in the past and biological fathers were the assailants. Neglect and abuse of children may be attributed to a male, or a female carer, or both, but there were no male assailants in this category in the Wessex data (Pritchard 2004) and males were identified as assailants in seven of the T.C.S cases. The comparison with the Wessex cases did not wholly support the third hypothesis, but these between the two T.C.S outcome groups, these factors show consistency across the rare cases where children die at the hands of their carers and the null hypothesis cannot be supported either.

The findings of this study show that the characteristics of the deaths and the child relationship to the abusers appear very similar to those found by Brandon et al (2009), with no major differences between the data sets. This suggests that the T.C.S. sample comprised a similar mix of cases to those of the larger Brandon et al (2009) study with its more expert team.

The Ofsted study cases were different in terms of age distribution, with relatively few babies aged less than one year compared with both the Brandon team's Intensive sample and the T.C.S. cases. The family characteristics described as important by the Ofsted report were mental ill health, domestic violence and drug and alcohol misuse and these factors were also identified by T.C.S as the most significant differences between the Deceased and Survived groups and thus potentially important risk factors for a fatal outcome. Although there were no significant differences in the numbers of children that died and survived between the Ofsted and T.C.S studies, the frequencies of domestic violence and parental mental ill health were strikingly different. It is possible that the discrepant factors arose from a different distribution of these factors between fatal and non-fatal cases of neglect and abuse within the Ofsted sample, but there is inadequate information in the report to support or reject this possibility and a similar finding was not identified in the mixed Brandon team Intensive sample (Brandon et al. 2009). Even if study differences in cohort size, inclusion of suicide cases and the variable quality of many Serious Case Review reports, are considered, this result from the Ofsted comparison

does not support the use of parental mental ill health or domestic violence as possible predictors of fatal outcomes within cases already deemed at high risk.

The FRAAN risk assessment was able to identify the T.C.S. cases as high risk and the similarities between this sample and the larger England and Wales study make it likely that a similar pattern of high risks would be found in a larger sample of Serious Case Reviews.

The close correlations between the findings of the Wessex study and the T.C.S. Deceased cases suggest that the Wessex factors of parental mental illness, men with previous violent convictions and a family history of neglect and abuse of children may help predict those rare high risk cases which may result in a child's death from abuse or neglect (Pritchard 2004).

7.15 Summary of key findings

1. The FRAAN risk assessment tool correctly identified 88% of the Serious Case Review families as High Risk or Intensive Risk for further neglect or abuse, but the number of false negative ratings in such a special group of cases remains an issue for concern;
2. Whilst there is evidence that the FRAAN assessment is sensitive to risk in child protection cases, specificity could not be tested;
3. Details on secondary caregivers (in this group of cases, male partners of the child's mother or biological fathers) were sparse, but most of the abusers were males (55% of the Deceased cases, 38% of the Survived cases);
4. FRAAN was unable to identify significant differences between those cases where children survived their abuse and those where children died;

5. Where FRAAN scores did not identify differences between the two outcome groups, combinations of broader family factors operating together showed significant differences between Deceased and Survivor groups. Cases where children died had more frequent reports of domestic violence in conjunction with parental mental illness (79% of families); especially where substance misuse was also present. Families where children survived showed different patterns of combined factors with parental mental illness coinciding with chaotic, neglectful parenting in 37% of cases and neglect with domestic violence in 30% of cases;
6. Using data from the two external studies drawing on different groups of Serious Case Reviews, the factors noted in the FRAAN were not always recorded, but the Ofsted (2010) and Brandon et al (2009) key findings showed strong positive correlations with the T.C.S. findings;
7. The Wessex study of child homicide cases also showed that the characteristics of intrafamilial assailants correlated closely with the parental characteristics in the T.C.S. Deceased cases. These were: violent men in the home, parental mental illness and chaotic, neglectful parenting in the most serious child abuse cases, with the additional factor of substance misuse,
8. The two previous child protection external studies and the Wessex child homicide study are supported by the findings of the T.C.S. study cases and this suggests that very similar factors emerge from the most serious child abuse cases.

Chapter 8

Discussion

This chapter outlines the evidence offered by this study for the use of the FRAAN risk assessment model in UK child protection work. It will argue that formal risk assessment is an important element currently missing from the standardised tools on offer to support child protection teams (Department for Children Schools and Families 2010). In addition, child protection teams need to be aware of those rare high risk cases where there is a possibility that a child is at risk of death. The additional factors originally identified in the Wessex study of child homicides have also emerged in the T.C.S. data and the way in which the risks from such extreme cases can be handled will be explored.

The argument is that factors linked to an increased risk of child deaths from neglect and abuse can supplement actuarially developed risk assessment tools and serve to alert child protection professionals to potentially fatal cases in the context of high risks for further neglect or abuse identified by the FRAAN risk tool.

The implications for the findings of this study for the child protection knowledge base, for practice and for policy will be described, with additional points on the handling of suicide investigations.

8.1 Limitations to this study

There were clear limitations to this study, as with any study undertaken on written reports produced under different sets of directions and standards. Most of these related to the use of post hoc written summaries on serious incidents which extracted a subset of the broader information available to many agencies and may have tended to focus on the proximate incident rather than the long term problems affecting families. Access to actual case files was not available, so the reports could not be

supplemented by additional searching. Interpretation of statements in the reports was cautious in relation to definitions and any potentially subjective statements were checked elsewhere in the reports. The absence of a risk factor in a specific case might not mean that it did not exist, simply that it was not mentioned in the review report. The perspectives of the writers of the review reports could not be ascertained. Their theoretical, political and philosophical views are not explicit and the reports are the product of a collective Local Child Safeguarding Board rather than a named author.

Even those reports which were ostensibly complete tended to omit some details, particularly on the histories and parenting skills of fathers and other men who were living with the family. This has been noted in other studies of Serious Case Reviews (Brandon et al. 2009, Brandon et al. 2008, Rose and Barnes 2008, Sidebotham et al. 2011).

The focus of this study was on risks pertaining to children in the family at the time of the case incident and this family focus highlighted that fact that some information which might have increased the risk rating in some cases was not recorded in the files. Specific missing elements related to the history of father and other male partners of mothers, whether resident with the family or not. The reports on the primary caretaker, generally the biological mother, varied in quality, but fathers and male carers tended to be almost invisible to agencies until children died in their care. Their experience of parenting young children could not always be assessed, nor their involvement with substance abuse or crime, especially violent crime. This is not a unique finding in relation to children's reports and the issues are also outlined both in Dubowitz's (2006) review of fathers and their influence on child maltreatment and in a substantial Dutch study showing increased risks of abuse by male stepparents (Dubowitz 2006, van Ijzendoorn et al. 2009).

This lack of detail in some of the Review reports is likely to have affected risk assessment scores in some parts of the FRAAN assessments. For example, risks could not be confidently attributed in relation to the mental health and self esteem of

the mother's partner. This factor (Factor A6 - Secondary caretaker has low self esteem) was recorded for only 8 of the 58 case files. The mother-child dyad appeared to be more thoroughly described than fathers or male partners, even when the men concerned with living with the family and involved in the child's day to day care. This is important because men were involved in most of the deaths of children. There were 31 child deaths, attributed to a total of 37 abusers. Of these, 22 (60% of the fatal abusers) were fathers or male partners in contact with the child. Their role was clearly very important and deserved more attention, both in practice and in Case Reviews.

The cause of death in fatal cases was also omitted from reports on 7 cases, 23% of the deaths. It was impossible to say whether these deaths had resulted from neglect or from a violent assault. Violent assault was the most common cause of death (12 cases, 39% of fatalities) and this was also reported in other studies (Sidebotham et al. 2011). This means that existing violence in the home or involving either parent or carer was important, but poor information on fathers' and male carers' histories meant that violence towards previous partners and children from whom they were separated was not always mentioned. Their care of their previous children in earlier relationships was also rarely mentioned, whilst the parenting involvement of the one mother who had deserted her previous children was described in detail (Case 27).

Where there were several children involved, reviewers tended to handle them as a group, with limited detail on the neglect or abuse to individual children, although their experiences and outcomes cannot be assumed to be similar. The maltreatment of more than 30 siblings of index children also went unreported in the Reviews. This missing information may have given additional information on parental risk factors for abuse of the index child.

8.2 US and UK approaches to risk assessment in child protection

The approach in this study involves coding risks for abuse and neglect reported in British Serious Case Review reports using the most reliable North American risk assessment tool, the Family Risk Assessment for Abuse and Neglect (FRAAN) developed for the state of Michigan (Baird et al. 1995). The group of studies relating to this risk assessment tool were the most useful because adequate work had been undertaken to test its validity and reliability for use in child protection cases and it was published in peer reviewed journals. Among all the risk assessment models it was the most developed and best documented.

The body of published material on risk assessment in child protection is large and diverse, but only the North American studies and the work of Browne in the UK came close to the size and quality of the US empirical work (Browne 1995a). Searching the literature for relevant material depends on technical search skills, but the largest part of the literature dealt with social and psychopathological risks considered to have arisen from the experience of an abusive childhood, rather than the risks of being abused, there are implications here for the indexing of a large body of publications as the volume continues to grow.

The closest UK work to identify statistically significant risk factors for repeated child maltreatment is the Browne studies and these were hampered by the statistical problem of trying to predict child outcomes over a period of four years based on a single perinatal assessment. The dynamic nature of family life made this implausible from the outset (Browne 1995b). The risk factors were similar to some of the components of the FRAAN, but unweighted. The study failed to achieve acceptable sensitivity and specificity to make it safe to use (Browne 1995b). This appears to have links with the different histories and development of child protection services in the US and UK. In the UK, the focus of such studies has been on a public health approach, identifying risks across a whole population through universal services. In the US, service access is determined by insurance status or eligibility for free government funded services and there is no single universal

pattern of maternal and child health provision. Services are dependent on limited funding and must limit access to support, monitoring and care for children to those who are at the greatest risk of further abuse. The pressure to cope with increased referrals when the process became mandatory instigated the research programmes of the 1980s and 1990s to develop effective risk assessment tools. The Michigan FRAAN risk assessment serves to limit access to services to the most needy families and children in danger, but the ability to actually assess such risks means that such decisions on whether or not to provide services must depend on less consistent and transparent factors and processes in British child protection work..

The chronology of child protection policy and guidance in England shows none of the same pressures to move to formal risk assessment tools and there is no mandatory reporting policy. At the same time, UK services were urged to refocus child protection services into a subset of wider universally available welfare services for children in need of all kinds (Butler-Sloss 1988, Department of Health 1995, Department of Health et al. 2000a, Department of Health et al. 1999).

The recent publication of the Munro report into child protection in England identifies problems with the current systems of documentation and computer stored records on clients because they do not enable social workers to ‘tell the story’ of the case, nor do they facilitate good decision making (Munro 2010a). Whilst risk and uncertainty will always be present in child protection decision making, Munro points out that poor communication of information held by a wide range of agencies and the current problems with highlighting cases where children are considered to be at risk of further maltreatment also hamper informed and timely decisions (Munro 2011b). As well as scrapping the complex current documentation systems for assessment, Munro recommends that performance review should look at the outcomes of child protection cases rather than the timing of processes. This requirement depends on the interventions chosen to meet the needs of children and families should be effective in producing good outcomes. If assessments do not consider the assessed risks to children, service allocation may continue to be based on current local thresholds and vary according to the availability of help, rather than

the needs of the child and his/her family. Evidence based risk assessment is independent of local circumstances and thresholds and forms a less contingent basis for allocation of scarce resources and service planning than currently available in the UK.

Munro recommends a 'systems approach' for investigating cases where outcomes involve significant harm for the child/ren involved (Munro 2010, Munro 2011, Fish et al. 2008). Whilst this allows retrospective analysis of successive decisions, they will always be seen in hindsight, where risks may be seen more clearly than they appeared to child protection teams at the time of assessment. The systems approach to such case reviews would be easier if the risks at each stage of a case were made explicit through the use of formal risk assessment tools.

Munro also recommends that professional judgement should determine the interventions required in child protection cases, rather than strict application of centrally developed guidelines and time frames (Munro 2011). This change also calls for professionals to have access to better information and effective tools to support their decisions. The use of evidence based risk assessment tools in medicine, engineering and other areas of professional decision support suggests that such tools assist, rather than direct, deskill or pervert professional decision making and that they are valued resources to support any complex professional decisions. Whilst such tools are no currently in use among UK social workers and there is a history of ineffective consensus based risk assessment tools by health visitors (Browne and Saki 1988, Browne 1995), This does not preclude testing and evaluating better risk assessments, even if they are not developed in Britain.

8.3 Feasibility of using the FRAAN Risk Assessment in British Child Protection Cases

The feasibility of using a formal risk assessment method depends on its ability to correctly classify high and low risk cases with minimum numbers of false positive and false negative results.

The hypotheses for this work were that:

Hypothesis 1: That the FRAAN risk factors would be present in the reports of the Serious Case Review cases in enough detail to assess risks present prior to the incident that led to the review. It was expected that these would be uniformly assessed as high risk or intensive (i.e. very high) risk cases, because all were known to have been high risk in practice on account of the seriousness or the abuse or neglect that occurred;

Hypothesis 2: That the FRAAN risk assessments would identify statistically significant differences between the Serious Case Reviews where children had died as a result of neglect or abuse and those with the children survived.

8.4 Hypothesis 1: Identification of High Risk Cases

The first hypothesis was supported by the T.C.S. data in that FRAAN identified 27 out of 31 Deceased cases as High or Intensive Risk (87% sensitivity) and 24 out of the 27 Survived cases (89% sensitivity). Overall, the sensitivity was 88%, with 7 cases which formed false negatives (12%). This is rather better than most of the risk assessments used in other settings to estimate the risks posed by offenders who may re-offend or psychiatric patients who may behave violently to others (Dolan and Doyle 2000). This is not to disparage these applications, because even imperfect risk assessments alert professionals to risks and allow them to address sources of risk through suitable interventions. The 12% false negative risk assessments are troubling, especially in those five out of the six false negative cases where children

died as a result of their abuse (see Appendix E for case details). False positive risk assessments may lead to unnecessary and unwelcome interventions which may themselves cause harm to families and children, as well as stigmatising the parents as potential abusers, but false negative assessments in these cases would have left children unprotected from significant harm. The problem appeared to relate to those cases where there was limited information on families and the risks posed to children prior to the incident or where those risks were simply not recognised or referred for child protection help. False positive risk assessments also undermine confidence in child protection services and individual professionals and have led to major public controversy, for example in the Cleveland report (Butler-Sloss 1988).

It is important to note that the absence of any mention of pre-existing risks does not mean that those risks did not exist. They appeared to have been unrecognised or not communicated to child protection services until after the index incident occurred. In some cases, the family was socially isolated or had moved house recently and information about the cases was not communicated. Parents who seemed to have deliberately concealed information about child deaths may have had very powerful and worrying motives for doing so. Where information is withheld, it cannot contribute to any assessment of risks to children.

Specificity for the FRAAN could not be established with this study because the T.C.S. cases were all effectively high risk, on account of the outcomes for children. Further work would be required to ensure that there are no excessive rates of false positive risk assessments on low and medium risk cases. Dingwall (1995) notes that sensitivity and specificity tend to have an inverse relationship, so a high sensitivity might imply a low specificity. This would draw low risk families into greater surveillance and possible interventions than they truly needed (Dingwall et al. 1995).

In practice, CAFCASS reports show that there was a large increase in the numbers of children coming into formal child protection procedures following the two recent Laming reports (Laming 2009, Laming 2003a, CAFCASS (Child and Family Court

Advisory and Support Service) 2009). This suggests that either previous unaided professional risk assessments have included a large number of false negative cases which have now been reconsidered in the light of the Baby P case, or that these subsequently increased referrals represent false positives (Haringey Local Safeguarding Children Board 2010). Given that unaided assessments are open to bias and error, as described in the successive reviews of serious child abuse cases (Blom-Cooper 1987, Blom-Cooper 1985, Brandon et al. 2009, Brandon et al. 2008, Butler-Sloss 1988, Reder and Duncan 1999, Reder et al. 1993, Rose and Barnes 2008), this would support the use of well designed, evidence based tools to assist professional decision making.

Despite lack of specificity information, the FRAAN assessment appears to be broadly compatible with information held in British child protection case records. The lack of information on men in the family in such reports (see paragraph 9.2 below) has been noted in other studies (Brandon et al. 2009, Sidebotham et al. 2011). Better information on the actual family and those caring for children is essential for effective safeguarding of vulnerable children and would improve risk assessment accuracy.

The external validity of the FRAAN risk assessment itself cannot be supported by the external studies of Serious Case Reviews undertaken by Brandon et al (2009) or Ofsted (2010) because neither of these reviews has adequate data on cases and families to provide a full comparison with the data from the T.C.S. cases. This rests on the existing work undertaken in North America on the original Michigan FRAAN assessment and the more recent California Family Risk Assessment (Baird 2002, Baird et al. 1999a, Baird and Wagner 2000, Baird et al. 1995, Baird et al. 1999b, Johnson 2004, Shlonsky and Friend 2007, Shlonsky and Gambrell 2001, Shlonsky and Wagner 2005).

The actuarial basis for these two related assessments could lead to different emphases and different weighting of risk factors if an assessment developed for one culture was applied in a very different social setting, or if new risk factors emerged

over time. In the USA, one example of this might be the use of methamphetamine, which was not so readily available previously to its widespread synthesis for the illegal market.

8.5 Hypothesis 2: Identifying High Risk Cases with a Risk of Fatal Maltreatment

The second hypothesis states that FRAAN scores can differentiate between those cases which ended in the death of a child from abuse or neglect and those where children survived. This is not supported by the T.C.S. data since there was no overall difference between the scores for the two outcome groups. Indeed, the results are strikingly similar and the Spearman's Rho correlations confirm that FRAAN would be a poor tool in identifying those high risk cases likely to child homicides. Even considering the effect of individual FRAAN risk factors, few of them were able to discriminate between the two groups.

Those that appeared helpful were:

N5 – Primary caretaker unable/unwilling to control impulses

N9 - Primary caretaker currently has a substance abuse problem

A2 – One or more prior abuse allegations and/or findings

Since FRAAN was designed from large scale North American studies of family characteristics and child outcomes, the rarity of child abuse across populations could be reduced by including only those families where there had already been a child protection referral and child protection teams needed to estimate further risks to children if they remained with their parents. However, the nature of the outcomes of that abuse (including death or serious injury) was not part of the risk assessment, simply the likelihood of any further neglect or abuse (Baird et al. 1999a). Since serious harm and death are very rare outcomes from neglect or abuse, they would not be recorded frequently enough to register on a statistical process which looked at the whole range of child protection cases (Grygier 1966). Only smaller studies

focused on high risk cases, such as reviews of Serious Case Reviews and known child homicide cases, are likely to identify any useful risk factors for child deaths and serious injuries.

The presence in the household of a child with a developmental disability or a history of delinquency appeared to act as factors which diminished risks, possibly because such problems tend to result in additional supportive services to families and modify the risks.

Non-FRAAN risk factors in the T.C.S. reports which did significantly distinguish those families where children died were instead derived from overlapping combinations of factors and from detailed studies of cases of child homicide (Cavanagh et al. 2007, Friedman et al. 2005, Kauppi et al. 2010, Pritchard 2004, Pritchard and Bagley 2001, Resnick 1969, Stroud 2000, Stroud and Pritchard 2001) .

These factors were:

- Parental mental health problems, especially when combined with domestic violence
- Substance abuse by either or both carers, especially when combined with parental mental health problems
- Chaotic families with evidence of child neglect.

Child homicide is a rare phenomenon and the number of child deaths in the T.C.S. cases represents a very special group of cases, even within child protection work. The importance of these three risk factors is supported by the fact that they were also major findings in the Intensive sample of child protection cases reviewed by Brandon et al (2009) and were even highlighted as major factors in the limited detail provided by the Ofsted study (Ofsted 2010).

The Wessex study of child homicides represents a rare UK study of a cohort of child killers and the quality of the data is more detailed in relation to adult assailants than

the child protection studies (Pritchard and Bagley 2001, Pritchard 2004, Stroud and Pritchard 2001, Stroud 2008). The Wessex findings in relation to adults with mental health problems who kill their children enables a link with the evidence from psychiatric studies on mothers with mental illnesses who require child protection interventions to safeguard their children.

There are some difficulties in comparing data between studies of adults and reports on children, plus child homicide studies cannot consider the children whose deaths are not directly and proximally related to their maltreatment, but result from failures to obtain medical attention for illnesses or those ‘near miss deaths’ where children survived because of modern intensive treatment, but only with catastrophic brain damage, blind and permanently disabled. The advantage of the Wessex data is that it is drawn from case data recorded in relation to convictions for homicide and detentions under mental health legislation and these sources are likely to be of good quality to enable perpetrators to be treated justly.

Given that the second hypothesis that the risk scores would be different between the Deceased and the Survived cases was not supported, the fatal abuse cases would be expected to show some differences not covered by the main FRAAN child protection risk assessment criteria. The FRAAN risk factors are actuarially developed and would have to feature in a large number of cases to satisfy the statistical requirements for inclusion. The rarity of child killings means that the special factors of such cases could not be identified by this kind of process. For this reason, child homicide studies are valuable sources for such special risk factors, but these cases are still too rare to include such risks in screening populations where there may or may not be any risk of abuse, let alone fatal abuse (Grygier 1966).

In spite of these difficulties, the social and political pressures and public concern which follow maltreatment deaths create an expectation that child abuse ought to be prevented and abuse leading to a child’s death should certainly be preventable. The tendency of Serious Case Reviews to focus on child protection agency failures and individual professional inadequacies leads to a powerful blame culture, reflected

in the increasingly directive policy responses to the case of Peter Connolly in Haringey (Department for Children Schools and Families 2009, Department for Children Schools and Families 2005, Department for Children Schools and Families 2010, Laming 2009).

The information derived from child homicide studies of adults who had killed children form an important source of possible factors because they deal with the rare types of adults who kill children, as opposed to those who neglect or abuse them. This includes extrafamilial killers, but in the T.C.S. study all the adults in the Deceased cases were either family members or very closely involved with the family.

The effect of socioeconomic circumstances would be unlikely to be a sole or main causative factor in child homicide because many families live with poverty, poor housing, unemployment and a wide range of social needs, so it is unsurprising that the Wessex study risk factors relate to the parents/carers and their particular vulnerability to life stresses that other families may survive. There are some factors which appear to place such parents in a very special group, quite different from those risks faced by families who are at risk of 'normal' child neglect and abuse rather than homicide (Pritchard 2004, p.118-121).

Most of the deaths in the T.C.S. cases were those of very young children, but this reflects the youth of the index children as a wider group, where 76% were under five years old and 55% under a year old. The perpetrators responsible for the Deceased cases were predominantly male. A recent study of British fathers and stepfathers who killed children found that all these intrafamilial victims had been under four years old when they died (Cavanagh et al. 2007). Previous abuse of the child who died had occurred in all but one of the twenty six cases. Domestic violence was also a striking feature of the Cavanagh et al (2007) cases. Many of the men involved had histories of family breakdown and school failure during their own childhoods and more recently, alcohol and drug abuse and prior criminal convictions (not all for violence offences) (Cavanagh et al. 2007). They showed unreasonable expectations

of the young children in their lives and were noted to display jealousy and resentment of them. This study adds to the evidence of the child protection and earlier UK homicide studies in emphasising the importance of child protection agencies working more closely with men in families. The paucity of detail on men's roles and experiences in families in the child protection cases is highlighted by the strong evidence that violent men are identified as perpetrators in violent assaults on very young children, uncommon though such cases may be.

It is interesting to note that the FRAAN risk factors also relate more to individual adult and child circumstances rather than to broader socioeconomic factors, again suggesting that although poverty, unemployment and poor housing add to the stresses of bringing up children, especially for lone parents, they are not in themselves significant risk factors for abuse and neglect unless additional stress is present. There are additional personal circumstances which affect maltreating families and it is in this area that risk assessment operates.

8.6 Effects of Violence in Serious Case Review cases

Police management reviews which were included in the T.C.S. Serious Case Review reports listed any pre-existing parental criminal history, but it was not clear whether or not these circumstances were known to child protection agencies before the index event. In practice, most child protection teams share information relating to recent serious domestic violence between adults because of its likely effects on children in the home who may witness it. It is less likely that older histories of violent convictions would be shared in the absence of any proximal threat to children, especially if they occurred outside the area where the family are living and if the adult partnership is recent or informal in character. Where men with violent convictions do not actually live full time with the family and are not the biological father of any of the children, it is difficult to see how any risks they may present could be known to child protection teams. Violence to previous female partners or

their children which did not result in a formal conviction for a violent offence is also unlikely to be known in a new area after a man enters a new relationship.

The importance of domestic violence in assessing the risks of child maltreatment is emphasised by other studies (Casanueva et al. 2009, Shlonsky and Friend 2007). Casanueva et al (2009) found that mothers living with domestic violence were twice as likely to have more than one report of abuse or neglect of their children. Violence to children and previous child injuries and deaths might also not be known to new partners and agencies in a new area. In some cases, factors were concealed by new cohabiters, for example in Case 13, where a previously violent male partner gave a different date of birth and his past records were not identified.

Men with convictions for violent offences were identified as important features of the cases studied by earlier reviewers (Brandon et al. 2008, Department of Health 1991, Reder and Duncan 1999, Reder et al. 1993). These studies were more qualitative in approach and they did not seek to weight the importance of such factors in relation to the outcomes for children. In this study, a more quantitative approach made such trends more visible.

The attitude of male carers in the current study towards the children or the services provided for the family was not always recorded and cooperation (or lack of it) with care plans could only be determined from the actions of parents and carers in response. Sometimes attitudinal issues emerged in the behaviour of either carer in refusing or limiting access to the children by service providers, failure to attend appointments (especially antenatal care appointments) or failure to give essential treatments prescribed for children. This was noted in fifteen of the fifty eight study cases (Cases 19, 31, 33, 35, 37, 41, 42, 45, 52, 54, 56, 57, 59, 60 and 63). In Case 54, a domineering father insisted on a premature infant being delivered by himself at home and locked the emergency services out of the home. Such behaviour is so unusual and threatening that it must have alarmed professionals, but in the absence of a focus on risk to the child, the effect may frighten service providers and inhibit them from challenging it.

Brandon (2009) was able to identify whether the mental health problems of carers were current or past problems, but noted that there was limited information on parental mental health and that the numbers affected may have been an underestimate because such details were generally unavailable. This is a caveat in this smaller T.C.S. study too, for similar reasons.

The link between domestic violence, mental illness and substance abuse is supported by a large study of violence among 34,653 American adults with mental health problems, which found that the incidence of violence was higher for people with severe mental illness, but only significantly so for those with co-occurring substance abuse (Elbogen and Johnson 2009). The combinations of some factors may operate synergistically and appear to be more powerful than they are individually. A review of UK homicides by adults with mental illness showed an overall drop in the numbers of homicides perpetrated by mentally ill adults since the 1970s (Large et al. 2008).

A lack of detail on men in the families where abuse occurred was common to all the child protection reviews (Brandon et al. 2009, Brandon et al. 2008a, Ofsted 2010, Rose and Barnes 2008b). In this respect the Wessex child homicide study was more helpful, although most of perpetrators were mothers in this cohort. These problems in acquiring the breadth of family information from the Review reports has its roots in professional practice in contributing agencies. Many family welfare agencies such as maternity services and health visiting take an approach based on the mother/child dyad. Whilst this acknowledges the increased number of single parent families, men seem to have been tolerated rather than included by midwives and health visitors. The evidence from this study and others that men in the family were the most frequent abusers is important. It suggests that their parenting abilities and their understanding of the needs and vulnerability of young children and the pressures of family life need much more attention by universal child and family services. It is surprising to note that some of the cases in the study recorded almost nothing about men whose violence and substance misuse must have been major

daily issues for the children and their mothers. Their care of previous children with other partners was rarely mentioned and then tended to relate to domestic violence, but if children in a family are neglected, fathers and male carers are surely as responsible for that neglect as mothers. None of the other reviews mentioned male carers as perpetrators of neglect and the issue was not recorded alongside neglectful mothers in the child homicide data. A more balanced approach to gender roles cannot start at a Serious Case Review stage, but needs to begin at the beginning. This has training implications and an increasing emphasis on men in the family within the Framework for Assessment of Children in Need and their Families (Brandon et al. 2009, Department of Health et al. 2000a, Sidebotham et al. 2011).

In twelve of the fatal T.C.S. cases, children died from violent assaults, often resulting in severe head injuries (39% of the deaths) and this was the most frequently recorded cause of death in T.C.S. and Sidebotham et al's recent study (Sidebotham et al. 2011). There were many reports of domestic violence in the T.C.S cases and in the comparator studies (Brandon et al. 2009, Ofsted 2010). It was significant factor in distinguishing between the Deceased and Survived cases. The Wessex study did not record domestic violence reports, but men with convictions for violence emerged as a statistically significant risk group for child homicide.

One problem is that domestic violence is a private, domestic crime, not always reported, let alone successfully prosecuted. Violence of any kind in the general population is rare, but cases which result in prosecution are subset of all violence and formal convictions may not be the best way of identifying men who may pose a risk to young children, despite their prominence in child homicide cases (Brandon et al. 2009, Department of Health et al. 2000a, Sidebotham et al. 2011) . Violence is perhaps an iceberg phenomenon, where the hard facts of court convictions are only a small part of the underlying issues. The nature of the offence itself may also minimise its importance within families. For example, the Criminal Statistics

Annual Report for 2009 showed that there were 43,426 convictions for violence against the person in England and Wales in 2009. This is quite an inclusive category and some will involve token or minor acts of violence which did not result in injury. The most serious prosecutions for violence resulting in imprisonment were just 14,084 in the entire population of England and Wales during 2009 (Ministry of Justice 2010). Serious violence is very unusual and perpetrators will have crossed a kind of social barrier which prevents most adults acting on feelings and anger and frustration. Such feelings are common in dealing with the tiring demands of young children and the men in the T.C.S. cases who killed children also felt able to use such violence against them, resulting in eighteen of the deaths (58%) due to violent assaults or deliberate/overt homicides. The nature of these individuals is poorly described in Serious Case Reviews, probably reflecting a limited interest in men among children's services professionals.

Studies looking at men who kill children are more useful in illuminating the nature of these unusual cases and demonstrate the violent nature of some of the males involved. Cavanagh et al (2007) shows that 20% of the father and 44% of the stepfathers in a study of 26 child homicides had actual convictions for serious assaults including attempted murder, grievous bodily harm, actual bodily harm and aggravated assault. In addition, the cases showed high levels of domestic violence and previous abuse of the child victims and a low level of commitment to relationships with either the children or their mothers (Cavanagh et al. 2007). Statements from the court proceedings are used to argue that the men involved were resentful of the demands of young children and behaviour they saw as not giving them proper attention, so that the violence was a means of enforcing what they saw as their authority in the relationships (Cavanagh et al. 2007). Similar mental processes have been suggested to underlie domestic violence by men against women and the high levels of domestic violence in all the child protection studies suggest that men who require such enforcements should alter child protection agencies to the risk they pose to children too (Antle et al. 2007, Brandon et al. 2009, Devaney 2008, Humphreys 2007, Irwin and Waugh 2007, Ofsted 2010, Shlonsky and Friend 2007).

One of the limitations in the studies looking at child homicides is the problem of ‘near miss deaths’ where a child suffers profound, lasting and life limiting disabilities, but given modern critical care, they survive their abuse. There were seven such cases in the T.C.S. sample and these showed similar injuries to those who died following serious physical assaults. Although the legal consequences for abusers are different in such cases, they show similar features to the Deceased cases.

8.7 Effects of Parental Mental Illness and Substance Misuse

The T.C.S. Case Reviews contained limited detail about specialist psychiatric and substance misuse service inputs to support parents. This is acknowledged as a weakness of this study and of child protection records, but Falcov (1995) identified a range of barriers to improved communication, including the difficulties in diagnosis of mental illness. Only one of the T.C.S. cases included a full psychiatric report on a parent with a severe mental illness who killed his daughter and this report revealed that his wife had frequently expressed fears for the children and herself due to his illness and frightening behaviour. The sense of isolation and fear was palpable in this report, but the conclusions stated that the murder could not have been predicted. It did seem as if the particular timing could not have been predicted, if only because the event seemed likely to happen at any point over several years. It is easier to look back at events with hindsight, but with this case the risks appeared more obvious than with some of the others because the threat was longstanding and not a sudden impulsive action.

The importance of maternal mental health is obvious when *‘approximately one-quarter of the women referred to psychiatric services have a child under age 5 years’* (Freidman et al (2005), citing Mowbray et al 2001). In addition, the authors note a lack of studies on women who kill their children, but who do not appear to have any mental illness. The evidence is also limited in relation to child related

factors such as prematurity, colic, constant crying or others problems which make caring more difficult.

The significant parental characteristics of the Wessex study of child homicides also emerged as significant distinguishing characteristics between the Thirteen Counties Deceased and Survivor Groups (Pritchard 2004, Stroud and Pritchard 2001). The Wessex cases included greater numbers of men with formal convictions for violence, which may be under recorded in Serious Case Reviews but was available for adults convicted of child homicides. The most significant risk factors in the T.C.S. child death cases were parental mental illness, chaotic neglectful families and substance misuse by parents. Substance misuse appears to increase the existing difficulties in families where there is a mentally ill parent and also where domestic violence is experienced, as demonstrated by the overlapping combinations of factors in the T.C.S. cases. There are also co-morbidities in mentally ill adults which are likely to affect their behaviour and the outcomes of their illness (Batki et al. 2009, Bolton et al. 2009, Elbogen and Johnson 2009, Merikangas et al. 2008, Volkow 2009).

A recent exploratory study also found that risk assessments for neglect and abuse failed to pick up those cases where there was a potential for child homicide, but also states that there were relatively few factors which were significantly linked to a fatal outcome (Graham et al. 2009). Family factors relating to carers' mental health and substance misuse are very important, but although this has been studied before and work made available to child protection professionals and agencies, this has not yet led to new service responses (Cleaver et al. 2007). Cleaver et al (2007) identified that services are still working in isolation and that information sharing between agencies and across geographical areas remains a weakness. The T.C.S. findings suggest that this particularly affects the most serious abuse cases.

The findings of the T.C.S. study show that the most frequently recorded factors in fatal cases were parental mental illness, domestic violence in the home and substance misuse. These factors have been extensively recorded in studies of child homicide and there is good evidence that they are important correlates of violence and child homicides. For example, in terms of mental health and child homicides, mothers with severe mental illnesses, particularly psychotic illnesses such as schizophrenia, have been shown to be at greater risk of harming or killing their children, quite apart from the way in which mental illness can affect bonding with a new baby and parental ability to care for the infant (Friedman et al. 2005, Howard et al. 2003, Liem and Koenraadt 2008, Schnitzer and Ewigman 2005, West et al. 2009, Wilczynski 1995).

Child protection reviews of serious cases have tended to treat such family related factors as an elephant in the room, ignored in their recommendations for policy and practice, but overwhelmingly present and consistently mentioned alongside the agency and professional failures in the cases. The focus of child protection reviews on communication, processes and procedures tends to expose professional agency related problems such as poor communication about risks posed by adults to children, but fails to highlight these complex individual and family related factors which are important factors in serious neglect and abuse (Brandon et al. 2009, Brandon et al. 2008, Brandon et al. 2002, James 1994, Laming 2003, Ofsted 2010, Rose and Barnes 2008, Sanders et al. 1999).

In countries with infanticide legislation, killing of a child by a mother may be regarded as deserving a psychiatric response, rather than imprisonment, irrespective of whether there is a diagnosed mental illness or not (Friedman et al. 2005a). Falcov (1996) identified that relatively few of the mothers in his review of fatal Serious Case Review reports were recorded as having a diagnosed mental illness, but this may depend on the criteria used for mental illness and the perceptions of the assessor where diagnosis may be uncertain (Falkov 1995). Child protection review reports frequently mention mental health problems using non-specialist terminology. This means that although such problems are highlighted as major factors in the cases

reported by both Ofsted and the Brandon team, (Brandon et al. 2009, Ofsted 2010), this not based on detailed information about diagnoses. Similarly, few of the T.C.S. case reports recorded that a mother or father was under the care of a mental health team suffering from a diagnosed psychotic or affective mental illness. The criterion for recording them as having mental health problems in this study was simply that it had been reported in the case review, without specific services or diagnoses being in mentioned. Much mental illness is treated by family doctors without specialist referrals or admissions. Personality disorders form a debatable diagnostic group among mental health specialists, although there are links with child maltreatment (Howard et al. 2003, Conroy et al. 2009). The link between mental illness and self medication with alcohol or street drugs is important because substance misuse can disinhibit behaviour and make violence more likely (Elbogen and Johnson 2009).

8.8 Implications for Knowledge and Evidence Based Practice in Child Protection

Risk assessment in North America has drawn upon a large body of published research which began in the early 1990s, much of which measured outcomes of cases and focused on the most significant factors (child, family and socioeconomic) which could predict future recurrences of maltreatment (Baird 2002, Baird et al. 1999a, Baird and Wagner 2000, Baird et al. 1995, Baird et al. 1999b, Browne 1995a, Browne and Saki 1988, Camasso and Jagannathan 2000, Cash 2001, Cooper 2003, Cooper et al. 2003, DePanfilis 1996, DePanfilis and Scannapieco 1994, DePanfilis and Zuravin 2001, DePanfilis and Zuravin 2002, DePanfilis and Zuravin 1999, Johnson 2006, Johnson Forthcoming, Jonson-Reid et al. 2003, Kahn and Schwalbe 2010, Milner 1994, Schnitzer and Ewigman 2005, Schwalbe 2008, Shlonsky and Friend 2007, Shlonsky and Gambriell 2001, Shlonsky and Wagner 2005, Sledjeski et al. 2008, Steadman et al. 2000, Stith et al. 2009, Taylor et al. 2008, Wald and Woolverton 1990, Yampolskaya et al. 2009, Zelenko et al. 2001, Zuravin et al. 1995). Although there have been some British studies, with the exception of Browne's work on risks across populations and detailed studies on child homicides

(Pritchard and Bagley 2001, Pritchard 2004, Stroud and Pritchard 2001, Sidebotham et al. 2011, Stroud 2000), these have taken a more theoretical, and ethical and less empirical approach (Browne 1995b, Browne and Saki 1988, Munro 1996, Munro 1999, Munro 2010, Munro 2004, Parton 1998, Ryan et al. 2005, Rzepnicki and Johnson 2005, Sidebotham and Golding 2001). This is largely because large scale child protection case data is not centrally collected or available for researchers. Even major child cohort studies do not include the parental and socioeconomic data which would match the scope of Belsky's aetiological factors and they deal with populations rather than known risk groups of families (Belsky and Vondra 1989). Conversely, child protection agencies tend not to hold detailed information about parental mental health, substance misuse or violence.

Population wide studies of child protection outcomes present difficulties because serious child abuse cases are very rare on this basis. The work of Browne and colleagues in the 1980s found that risk assessment for child neglect and abuse across whole populations was unacceptably inaccurate (Browne 1995a, Browne 1995b).

To add to the difficulties of UK research on risk assessment, local access to archived case material is difficult because of data protection concerns (see the Office of the Information Commissioner guidance to local authorities http://www.ico.gov.uk/for_organisations/sector_guides/local_authority.aspx). Some of these barriers were encountered in gaining access to data for this study. There are also some fundamental professional controversies about how acceptable evidence based practice may be in a system with a strong caring ethos which is focused on the individual parents and children and their particular needs (Gambrill 2011, Pollack 2010). This difficulty is highlighted by examples from the risk assessment literature published in the 1990s, a peak time for such research.

The UK and US appear to have diverged during the 1990s and 2000s in terms of the research emphasis on quantitative studies of the socioeconomic and family factors underlying child maltreatment in the US. This was not matched by a similar volume of work over the same period 1990-2000 in the UK (see Appendix D for a list of

relevant studies published during this period in both countries. The third interim report of the current Munro review of child protection in England will consider risk assessment, but the form this will take remains to be seen. This study can contribute by demonstrating the usefulness of North American actuarially based risk assessment in British child protection cases. An effective reference group for such major national reviews is likely to have identified some of the literature cited in this study.

8.9 Implications for Policy on Serious Case Reviews

The T.C.S. reports formed a cohort of cases dating from 2000-2008, but the full expected cohort was incomplete, firstly because there were substantial numbers of overdue reports which had not been submitted within the prescribed time frame and secondly, because some of the files had missing report sections and this reduced the access to possible risk factors so that the cases could not be included in the study.

Two recent reports (Munro 2011, Rose 2009) have highlighted the increased workload involved in producing Serious Case reviews and in the thirteen counties more than fifty cases were undergoing or awaiting review. Child Safeguarding Boards currently cover quite small local authority areas and the time and attention needed to complete a Serious Case Review is substantial, even for experienced reviewers who are familiar with the process. The current guidance is quite substantial in volume, but the mixed quality of the reports and the omission of details about key family members and the child themselves are important. The focus remains on lessons about agency communications and following procedure rather than the family and the child.

A new form of review is proposed to enable analysis of agency processes would involve detailed local fault tracing, rather on the lines of an airline crash investigation (Munro 2011, Fish 2009). Piloting has suggested that the process may be more inclusive of frontline multi agency child protection staff. This is a good way to involve staff who work within organisations in reviewing cases and this

appears useful. However, there remain two problems with the proposed approach using root cause analysis: firstly, the focus still appears to be on agency processes and secondly, it does not appear that such a process would reduce the workload involved to review a case. Apart from the use of a detailed multi agency chronology of events and several pages of questions, there are few positive structured guidelines for staff preparing to tackle a Serious Case Review.

The workload issues are known factors in preventing reviews being completed and an incomplete review is unlikely to contribute to learning lessons from the case (Munro 2011a). The intra-agency focus on staff performance and management issues should not have to wait for a child to die before any fundamental problems are addressed. Competent team leaders and managers should be aware of problems through normal oversight of work and staff supervision.

Lessons need to be learned about the professional and service issues contributing to serious child abuse, but many of these lessons arise from understanding what has happened in the *family* rather than the social worker's office or the paediatrician's clinic. The obvious differences in detail obtained by the FRAAN data compared with the less structured approach used by the Brandon team and Ofsted enables this different focus on case reviews (Brandon et al. 2009, Brandon et al. 2008, Ofsted 2010, Rose and Barnes 2008). FRAAN and its successors can contribute to analysis of this area and the use of such methods to analyse cohorts of cases can identify valuable general themes and insights missing from current reviews of reviews

This study set out to assess the feasibility of using the Michigan Family Risk Assessment for Abuse and Neglect (FRAAN) in the context of British child protection cases (Baird et al. 1999b, D'Andrade et al. 2008, Gambrill 2008, Gambrill and Shlonsky 2001, Gambrill and Shlonsky 2000). It was clear that the risks identified in the T.C.S. reports could be assessed, provided those reports contained enough data to populate the risk assessment. The reports were of mixed quality and not all risk factors may have been recorded. In dealing with a new case,

professionals would be likely to seek any information required for a risk assessment, so this is partly due to working from records made for other purposes.

The quality and completeness of the main review reports was variable, a fact noted in other studies using Serious Case Reviews (Brandon et al. 2009, Brandon et al. 2008, Ofsted 2010, Rose and Barnes 2008), Data extraction also drew on factors identified from the text of the review report, accompanying documentation such as case correspondence, individual agency reports, transcribed record chronologies, press coverage of court hearings and any additional material from child protection agencies. Some studies have drawn on summary documentation alone, including a recent study of 276 fatal child abuse reports dating from 2005-2009 (Sidebotham et al. 2011). This study draws on précis reports where the data was extracted by others:

‘Anonymised data on each case were made available to the research team. These data included basic descriptive and demographic information on the case and a short free text narrative of the case. The research team did not have access to the full Serious Case Review reports, nor to any of the primary case records. ‘

(Sidebotham et al, 2011, p. 6)

This problem with access to full data means that larger studies like Sidebotham et al (2009) tend to be based on summaries, which are even less complete than the full Reviews and if those summaries are drawn by individuals not in the research team, the unknown quality of the summaries may affect the findings.

The 276 deaths in the Sidebotham et al (2009) study also included 41 teenage suicides (15% of the deaths). Suicides were excluded from the T.C.S. cases because the reports (which were complete reports in the T.C.S. study) gave very little background on the family and child protection concerns and instead focused on immediate events around the time of the suicide, including arguments with family and friends and any prior use of drugs and/or alcohol by the child themselves (see

Section 9.4 below). Any links between earlier child neglect or abuse and the later suicide were consequently difficult to establish in the suicide reports.

The quality of data in the summary reports was not always adequate to identify the nature of the child's death in the Sidebotham et al (2011) study and 30 cases (11%) could not be categorised. However, the number of deaths which did not specify causes in the T.C.S. cases was larger (7 cases (23%) of the Deceased cases). This suggests either that the original cases used by Sidebotham et al (2011) were better prepared than the T.C.S. reports, or the data extraction and précis reports were able to draw on additional sources besides the case report.

8.10 How the FRAAN Risk Assessment could incorporate risk factors for serious neglect, abuse, and child homicides

The FRAAN risk assessment is structured in three parts (see Appendix A). There are two main sections comprising actuarially derived and weighted risk factors for Neglect and Abuse respectively, forming the basis for the feasibility study, plus a brief third set of 'Mandatory Override factors' which are unweighted and derived from professional opinion about factors most likely to result in later episodes of abuse or neglect of the case child/ren (Baird et al. 1995, Baird and Wagner 2000). When applied, these factors raise the score to Intensive Risk immediately. In addition, the assessment allows for possible additional factors to be added as free text by the user, but this aspect was not considered for this study because such decisions are not required by the risk assessment and there are no criteria for the free text entries.

The current mandatory factors are mixed group of risks:

1. Sexual abuse cases where the perpetrator is likely to have access to the child victim
2. Cases with non-accidental physical injury to an infant

3. Severe, non-accidental, physical injury requiring medical treatment or hospitalisation and that seriously impairs the child's health or physical well-being.
4. Death (previous or current) of a sibling as a result of abuse or neglect

These appear to be more in the nature of actual failures to protect a child than potential risk factors. Each in itself is a fully developed undesirable situation, not a risk factor for neglect or abuse.

In contrast, parental mental health problems, a parent or carer with a history of domestic or other forms of violence and substance misuse act as risk factors which may or may not result in an adverse event like a further episode of neglect or abuse.

8.11 Implications for child protection practice

The lack of professional attention to men in vulnerable families emerged from the T.C.S. case reviews, but has been demonstrated by other reviews (Brandon et al. 2009, Sidebotham et al. 2011). This is gap in the work of professionals who currently work with women and children, including maternity services, health visiting and social work which cannot be justified in the light of evidence that fathers and male carers for children have a major influence on the care of children and family wellbeing. This study has demonstrated the worst influences, but a more balanced approach to men as co-parents would also show the better contributions of men as parents and support their role with young children.

The experiences and concerns of young men who find themselves in a parenting role are clearly important when violence in the home and inappropriate expectations of very young children emerge from the T.C.S. cases and other previous work (Brandon et al. 2009, Pritchard 2004, Stroud and Pritchard 2001, Sidebotham et al. 2011, Cavanagh et al. 2007, Stroud 2008). Frontline staff and their managers should not be reluctant to engage with young fathers and those in a *de facto* step parent role,

both in a positive supportive role and with the awareness of the importance of men's reactions to young children around them. Their understanding of children and their experiences of child care are likely to be as diverse as those of mothers, but the traditional focus on mothers and children by female midwives and health visitors may not meet the needs of young men (Taylor and Daniel 2000, Fägerskiöld 2008, Featherstone and Peckover 2007). In addition, histories of conflict and violence (including domestic violence) and the use of alcohol and/or drugs by all carers cannot be taboo subjects if the risks to children are to be addressed. These matters are not easy, but informed professional approaches are essential for child protection.

8.12 Handling Self Inflicted Child Deaths

The study is concerned with cases of children who suffered serious harm or died as the result of abuse or neglect. However, following changes to the Serious Case Review criteria in 2006, the number of Serious Case Reviews and agency internal management reviews has increased significantly from the numbers undertaken during the previous period after the revised guidance was issued in Part 8 of 'Working Together under the Children Act 1989'.

In the relevant time period covered by data collection for this study there were twenty three suicides among children and young people within one local authority alone. In practice, most of these deaths involved young adults whose ages ranged into their late twenties and these cases were not reviewed. Within the reports on youth suicide cases there were non-specific references to family problems including rejection, neglect and abuse in these cases, but review reports focused on the young person's immediate personal circumstances and personal risk taking behaviour as teenagers than on their backgrounds. These immediate factors related to drug use, sexual behaviour, peer relationships and indicators of mental health problems rather than the nature of their families.

The FRAAN risk assessment tool assesses family related maltreatment risks based on Belsky's model of factors underlying child maltreatment (Belsky 1993). It does

not encompass the broader range of risk factors for these adolescent suicides where internal family, peer group, educational, substance misuse and wider external risks were involved. There is no evidence that the FRAAN risk assessment would be helpful in identifying risk factors for older children and young adults who would be likely to self harm or commit suicide, although there are links between childhood abuse and adolescent suicide (Bruffaerts et al. 2010).

The inclusion of suicides alongside cases of abuse means that these qualitatively different cases are reviewed using unsuitable methods which are designed for child abuse. The suicide of a child deserves a full and respectful review and it did not appear that the child protection guidance or child protection risk assessment offered a suitable model. There are common factors to some cases, but this area requires further consideration rather than simply fitting under an existing process like Serious Case Reviews.

Chapter 9

Conclusions

This study proposed to find out whether North American developed actuarial risk assessment questionnaire tools can be used to identify risk to children in British child protection cases, using data derived from Serious Case Review files. It also concerned risk assessments for the most serious cases resulting in the death of a child could be predicted from their risk scores. The evidence shows that the FRAAN risk assessment tool does appear to be useable for the identification of risks in UK cases. The sensitivity of the tool was high. The specificity could not be calculated using cases which were all high risk, but future research should consider a larger group of closed cases which better represent the mix encountered by local child protection teams and the risks to the children at referral and at case closure would enable a better mix of outcomes to be studied.

The FRAAN entirely failed to differentiate between the fatal and non fatal cases among the high risk group. An actuarially developed tool would naturally include those factors found most frequently in cases of abuse. Child homicides are very rare and a sample of child protection cases would have very few of this type. The external comparison with the English study of child homicides by Pritchard and his colleagues was valuable because it identified the risk factors most common to such cases (Pritchard 2004, Stroud and Pritchard 2001). In the fatal abuse cases in this study, the same factors of parental mental illness and violence were also significant findings.

There are caveats in recommending the use of such factors for a more mixed outcome group of cases such as might be encountered by a local authority department. The rarity of child homicide means that there will be cases of parental mental illness and violent homes where children may be at high risk of harm, but the use of such risk factors to identify risk of homicide is unlikely, unless the case is

already one of the relatively few where risks are already very high, as measured by risk assessment.

9.1 The practical value of the study

The value of this study lies in the evidence it provides on the potential usefulness of US risk assessment tools to support professionals working with families where children have already suffered some maltreatment and decisions have to be made about their safety to return home and allocation of limited support and resources to the most vulnerable families and children.

Previous studies of Serious Case Review reports have reflected the requirements laid down in government guidance since 1991 (Home Office et al. 1991). However well intended, this has limited Reviews to considering interagency communications and joint working. Whilst this allows discussion of the concerns within services under pressure (Brandon et al. 2009), it fails to allow lessons to be learned about the circumstances and pressures in families where children are seriously abused. It is a matter of concern that factors in the published reviews commissioned by central government departments repeatedly include adult violence, mental illness and previous abuse and neglect within families, but these remain marginal findings and fail to influence policy.

The results of using formal risk assessments with such cases would enable the identification of unmet needs and the risks they entail of further maltreatment. While data on unmet need arising from risk is not always politically comfortable information, it should not be ignored. It can also prevent high risk cases being overlooked by less experienced professionals who may be less competent at making such judgements without formal assessments. It can contribute to better interagency discussion of risks to children and more focused child protection planning to mitigate those risks.

9.2 Contribution to knowledge

The value of using accurate risk assessments was also demonstrated in relation to gaining greater understanding of families in difficulties from Serious Case Reviews. The purpose of such reviews was always to enable lessons to be learned from tragic cases in hope of preventing others in future. In the most recent reports, the focus of this learning process is rather on the difficulties of organisations and professional teams than on the problems of families and dangers to children (Brandon et al. 2009, Brandon et al. 2008a, Ofsted 2010).

The use of the FRAAN assessments in this study highlighted the nature of the recurrent problems in families where there is serious neglect and abuse and the external validation studies served to confirm the fact that these were common to other reviews conducted by expert teams on a larger scale than this study. Whilst the proposed new approach to such reviews is using systems approaches to track errors, both the current and proposed methods say too little about the child, the family and factors that contributed to maltreatment. Both the systems approach and the analysis of the risks present in the families themselves have much to contribute to better understanding of these tragic events.

The nature of much of the child protection research differs between the UK and US, and much of the quantitative work is undertaken in North America because of the availability of hard data from cases for research. This is not limited to the US, because there are also excellent quantitative studies derived from Scandinavian case data. This approach could yield better information for practice and policy if UK Serious Case Reviews were approached as data sources for studies of families and their problems in relation to child maltreatment.

Qualitative and exploratory studies are illuminating and increase understanding of the issues around child protection, but cannot serve to inform practitioners about what approaches are most effective in terms of assessment and intervention.

9.3 Contribution to policy development

The current assessment materials used by child protection teams have a limited empirical basis, but the use of standardised assessment tools for specific purposes alongside the Framework for Assessment is already established. This study suggests that if further research on mixed outcome cases showed that the FRAAN could allow the classification of cases by risk, it would enable a further useful assessment to be added to the existing set to support effective practice.

Commissioning of reviews of serious child protection cases needs to be revised to enable government departments to draw more useful lessons from such cases and inform future central government guidance and professional practice in child protection.

Child protection registers are a mandatory requirement for local authorities, but the criteria for inclusion are variable. If effective risk assessment were available to child protection teams and their managers, such registers could reflect the actual needs of children and their families and justify placing children in substitute care, either during work with birth families or permanently if their families are likely to continue to present risks of significant harm.

Data protection policy and guidance needs to offer more specific advice for the management of personal data and anonymous data derived from cases. At present, there is uncertainty and with the abolition of the plans to develop national registers of individuals who should not care for children, adult mental health, probation services, domestic violence teams and substance misuse agencies deserve clear practical guidance from the Office of the Information Commissioner on sharing their highly sensitive information with child protection teams.

9.4 Future research directions

This study has yet to be published and the issues which it raises relate to a number of future areas for research. These include the theoretical possibilities of risk assessment in child protection and further feasibility testing on archived original children's case records, as opposed to the digests produced for Serious Case Reviews. This study is only the beginning of a full feasibility study by a single researcher, but there are barriers to accessing case records in adequate numbers which still remain to be overcome.

Professional practice in child protection is required to comply with a range of structured assessment and recording documents which are required in all local authorities in England (Department of Health et al. 2000a). These documents do not include a formal risk assessment tool. If there is no move to abolish the current Framework for Assessment and related documents, the addition of a suitable risk assessment tool may be helpful. Despite the favourable results of this study, further large scale testing with low risk cases is essential before any implementation of an English version of FRAAN can be recommended.

Further research in this field is unlikely to attract commercial sponsorship because it relates to welfare services in the public sector. To achieve the time frame and scale of work which will inform this area of practice, central government funding seems to be the best source. Coherent programmes of research should be considered to bring examples of the best work to the attention of UK professionals and services and enable studies to be replicated and findings tested for UK child protection services. A robust empirical basis is important for any area of professional practice and under the auspices of the ongoing Munro Review (Munro 2011a), there is an opportunity to begin this with studies of Serious Case Reviews on a much larger scale than a single doctoral study.

Practice is only as good as the knowledge base that informs it and the practice of child protection needs more research into effective tools and interventions to build on the impressive UK history of universal child and family welfare.

APPENDIX A: Chronology of Child Care Legislation and Policy

1948-2008

- 1948 **Children Act 1948**, based on the report of the Interdepartmental Committee on the Care of Children (Curtis Report) in 1946 following the Monkton Inquiry (1945) into the death of Denis O’Neill, abused by his foster father. Tripartite structure introduced for personal social services:
- Health departments - public health, health visiting and some social care;
 - Welfare departments - providing residential care and support for elderly or disabled people;
 - Children's departments - child care, incl. receiving children into care if suffering from neglect or abuse.
- The Committee sought to improve the care of children who could not be raised in their own family homes. Underpinned by contemporary theories such as those of Bowlby on infant monotropic attachment to single adult, usually the mother. Links between early maternal deprivation & later delinquency/social maladjustment, education failure and even psychopathy. Families might be the source of many children’s problems, but they were also important to their development, so social workers needed to work with the whole family rather than the child in isolation (Parton 1991).
- The Poor Law systems previously providing services to families were abolished.
- 1952 Local authorities empowered to investigate neglect of children.
- 1956 **Sexual Offences Act**. Re-codified existing sexual offences legislation including unlawful sexual intercourse with under 16s (Unless man aged under 24 and first offence), abduction, all homosexual acts between males & incest.
- 1960 **Ingleby Committee report**. Set up in 1956 to consider the problem of juvenile delinquency. Concerned about the judicial/welfare functions of the juvenile court, and recommended that the age of criminal responsibility in England

and Wales be raised from 8 to 12 years.

Their work was published as the '*Report of the Committee on Children and Young Persons*' and emphasised preventative role of social services. Children's Departments were recommended to promote the welfare of children and to prevent family breakdown.

1962 **Battered Child Syndrome:** Publication of article by Henry Kempe, an American paediatrician, describing the 'Battered Baby Syndrome' as a medical condition affecting children aged < 3 years who were injured by an adult care taker (usually a parent) and suffered serious childhood disability or death (Kempe et al. 1962b).

1962 **Health Visiting and Social Work (Training) Act 1962** established the Council for the Training of Health Visitors (CTHV) and the Council for Training in Social Work (CTSW) to regulate training and set standards for professional practice.

1963 **Children and Young Persons Act**, based on findings of Ingleby Report – emphasis on social work with the family forming a 'consistent, trusting, professional relationship' to nurture inadequate or immature parents so that they can care better for their children (Parton 1991, p.22-3). Social workers empowered to investigate neglect, but state and parents seen as working in partnership. Social workers given discretion to deliver services appropriately.

The Act also raised the age of criminal responsibility to 10 years. Family breakdown blamed for juvenile crime. S.16(2) provides that in any proceedings for an offence committed or alleged to have been committed by a person of or over the age of 21, any offence of which s/he was found guilty while under the age of 14 is to be disregarded for the purposes of any evidence relating to her/his previous convictions.

1965-1968 **Seebohm report** – Seebohm

Committee was tasked "to review the organisation and responsibilities of the local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service" (Seebohm, 1968, p.11). Child care work to be in partnership with families because children live in families. Creation of generic rather than specialist child care social workers

- 1969, implemented 1971 **The Children and Young Persons Act 1969** removed the distinction between young offenders and neglected or abused children and allow both to be received into care. Implementation of Place of Safety Orders granting authority to detain a child or young person and take him or her to a place of safety for not more than 28 days, because of the child's actual or likely ill-treatment or neglect or other urgent need to leave present accommodation. Foster placements, small group homes and larger Assessment Centres provided care for children and Community Homes with Education on the Premises (CHEPs) replaced the old system of Approved Schools.
- 1970 **Local Authority Social Services Act LASSA** helped to implement some of the Seebohm recommendations for integrated child and family services and generic social workers in order to replace the 'stigma' of separate children's services.
- Introduction of Area review Committees to bring agencies together to work on child protection, plus the first UK Child Protection Registers designed to share information on children at risk, building on previous less formal 'at risk' registers. The Registers were made a more formal requirement after 1974.
- 1973 **Inquiry report into the case of Graham Bagnall.**
- 1973 onwards **Responses to child death inquiries:** 'Political and professional consensus around child welfare' threatened by successive reports from inquiries into child deaths and resulting media criticism of social workers and systems (Parton 2006b).
- 1974 **Inquiry report into the case of (Brandon 2001) Colwell** - review of the death of an abused child returned to her birth parents from a secure foster home. Formal inquiries were used to investigate high profile child deaths from abuse and neglect. The following were introduced:
- *Area Review Committees* (re-titled *Area Child Protection Committees in 1988*) which would be responsible for developing local procedures and training
 - A system of multi-disciplinary Case Conferences
 - The establishment of Child Abuse Registers

- 1974
- Inquiry report into the case of David Naseby**
 - Inquiry report into the case of Max Piazzani**
 - Inquiry report into the case of Susan Aukland**
- 1975
- Inquiry report into the case of Stephen Meurs**
 - Inquiry report into the case of Lisa Godfrey**
 - Inquiry report into the case of Richard Clark**
- 1976
- Inquiry report into the case of Neil Howlett.**
- 1977
- Inquiry report into the case of Wayne Brewer**
- 1978
- Inquiry report into the case of Karen Spencer**
 - Inquiry report into the case of Stephen Menheniott**
 - Inquiry report into the case of Malcolm Page**
 - Inquiry report into the case of Simon Peacock**
- 1979
- Inquiry report into the case of Darryn James Clarke**
 - Inquiry report into the case of Lester Chapman**
- 1980
- Inquiry report into the case of Claire Haddon**
 - Inquiry report into the case of Paul Brown**
 - Inquiry report into the case of Carly Taylor**
 - Inquiry report into the case of Darren Cooper**
- 1981
- Inquiry report into the case of Maria Mehmedagi**
 - Inquiry report into the case of Emma Hughes**
 - Inquiry report into the case of Christopher Pinder /Daniel Frankland**
 - Inquiry report into the case of Malcolm Page**

- 1982 **Inquiry report into the case of Jason Caesar**
- Inquiry report into the case of Richard Fraser**
- Inquiry report into the case of Lucie Gates**
- Inquiry report into the case of Gerard Fenlon**
- 1984 **The Short Report** proposed changes in child care law, arguing that Family Courts rather than SW discretion should be responsible for major decisions on rights and duties of parents and local authorities in the ‘best interests’ of the child, although child care teams remained responsible for their day to day decisions. Place of Safety Orders replaced with Emergency Protection Orders, to be used only when required as the only likely way to protect a child thought to be at immediate risk, rather than a starting point for care proceedings (Parton 1991). Evidence should be given on oath. Care Orders to be time limited. Supervision Orders to ensure awareness of child’s current whereabouts & to monitor child socially and medically as well as direct education. Intervention justified on likelihood of harm to the child in short term and continuing risk, but orders based on justification to magistrate rather than departmental decision. Underpinned by ideas from Bronfenbrenner’s ecological model of children & families in socioeconomic context (Parton 1991). Recognition that most neglect and abuse was linked to poverty and unsupported families (Packman et al. 1986) and the report recommended increasing access to social security benefits for lone parent families.
- Inquiry report into the case of Shirley Woodcock** published October 1984
- 1985 **Review of Child Care Law 1985** instituted by Department of Health and Social Security (DHSS) to consider the recommendations of the Short Committee and a number of research studies funded by DHSS and ESRC research funding to provide empirical evidence for policy changes.
- Jasmine Beckford inquiry** report (December 1985) prompted increase in the use of Place of Safety Orders (POSOs) in child protection cases where children could be removed from home for 28 days on a magistrate’s order. Emphasis was placed on statutory role of social workers in removal of children when thought necessary and the report discouraged optimism about family’s abilities to cope. Social work was framed in laws which gave them responsibilities in the private sphere of the

family. Social workers criticised for ‘rule of optimism’ in allowing children to stay in unsafe homes because of a tendency to interpret parental behaviour too positively and assume that natural parental love would protect them from harm. More authoritarian approach and pessimism about family abilities to change based on Kempe’s ‘disease model’ of abuse with Greenland’s risk indicators in parental histories, social circumstances and behaviours. (Kempe et al. 1962b, Greenland 1987).

Inquiry report into the case of Reuben Carthy (September 1985)

Inquiry report into the case of Gemma Hartwell

1986 **Inquiry report into the case of Heidi Koseda**, published March 1986.

Inquiry report into the case of Charlene Salt, published October 1986

1986 **Childline was established**, a telephone help line for children funded by voluntary organisations.

1987 **Inquiry Report on the case of Kimberley Carlile** (December 1987) showed that child protection efforts by social workers and health visitors had been effectively frustrated by the family, especially the mother’s violent partner.

Inquiry Report on the case of Tyra Henry (1987) indicated that family foster arrangements with grandmother failed to protect a child subject to a Care Order. Child killed by violent father previously convicted of child cruelty.

1987-8 **Cleveland child sexual abuse inquiry** published July 1988 increased concerns about the management of sexual abuse through POSOs when a large number of children were taken into care over a short period following medical referrals following suspicions of sexual abuse. The cases raised issue of family rights to privacy versus intervention to protect children. Increased public awareness of sexual abuse of children was met with disbelief and denial, plus the harassment of professionals (doctors in this case) concerned with child protection interventions and the removal of children from home against the wishes of parents.

This inquiry added to critical judicial and media comments on social workers involved with child care following the inquiries into the deaths of Jasmine Beckford, Tyra Henry and Kimberley Carlile. Changing attitudes emerging towards domestic violence and the role of men in families (Parton 1991). Abiding concerns remained about the issue of sexual abuse of children, the rights of parents accused of such offences and the powers and accountability of agencies in protecting children (Donaldson and O'Brien 1995).

1988

Inquiry Report on the case of Gavin Mabey

Inquiry Report on the case of Jason Plischkowsky

Inquiry Report on the case of Sukina Hammond

1989

Children Act 1989 – separate management of children who are taken into care on account of neglect or abuse from those who have committed offences. Local authorities given specific preventative duty to safeguard and promote the welfare of 'children in need' for any reason. Children in need of protection seen as a subset of wider needs for family support, etc. Admission to care based on the welfare of the child, his or her needs, but the child should be suffering, or at risk of, 'significant harm', i.e. 'ill-treatment or the impairment of health or development', or is deemed to be beyond parental control.

Principles of the Children Act 1989 were:

- The child's welfare is paramount
- Delay is not in the child's interest and should be avoided
- Courts should make no order unless it is in the interest of the child to do so.

1989

Inquiry report into the case of Karl John McGoldrick, published June 1989.

Inquiry report into the case of Doreen Aston published July 1989.

Inquiry report into the case of Liam Johnson, published November 1989.

Inquiry report into the case of Stephanie Fox.

- 1989 **UN Convention of the Rights of the Child ratified by the UK government.** The Convention was the first binding international human rights treaty dealing with the needs and rights of all children (aged 17 and under). The UK signed the convention on 19 April 1990, ratified it on 16 December 1991 it was implemented in the UK on 15 January 1992. There are reports to the UN on the ways in which it is being implemented. The USA and Somalia have never ratified the Convention.
- 1991 **‘Working Together under the Children Act 1989’** - new child protection guidance for agencies introducing Area Child Protection Committees (ACPCs) to replace Area Review Committees. These ACPCs tasked with Part 8 Reviews into cases which had led to the death of serious harm to a child and with reporting such cases to central government. This replaced the earlier legally led inquiries. Part 8 reports were never published and this reduced public profile of abuse until concerns arose in relation to extrafamilial institutional abuse in children’s homes and similar settings (Parton 2006b).
- 1991 **‘Looking After Children: Assessing Outcomes in Child Care’** published. Concerns about ‘looked after children’ in the public care system ending up socially excluded, unemployed, poorly qualified and sometimes within mental health or prison settings. New guidance focused on developmental needs of children. Policy recognition that the care system presented a range of risks for children and that these risks continued to add to public costs and burdens. In England and Wales, the ‘Quality Protects’ initiative is launched to improve services in childcare, plus the need for a better qualified and regulated social care workforce.
- 1991 **Orkney Inquiry.** Public inquiry into children removed from Orkney families following allegations of organised abuse with ritualistic or Satanist connotations. Social workers criticised in relation to interviewing techniques which were suspected to direct children to ‘disclose’ satanic abuse.
- 1992 **‘Memorandum of Good Practice on Video Recorded Interviews with Child Witnesses for Criminal Proceedings’:** new joint guidance by Department of Health and Home Office

on interviewing children where abuse is suspected

Inquiry report into the case of Leanne White.

1994

Inquiry report into the case of Rikki Neave.

1995

Department of Health publication ‘Child Protection: Messages from Research’ emphasised working in partnership with parents to help children in need and to intervene early with emotionally neglectful families who tended to provide care with little warmth and excessive criticism. The aim was to prevent abuse rather than just react to incidents.

1996

Hague Convention on the Protection of Children – reflecting increased movement within the European Union to protect children subject to cross-border 'protection' measures including care proceedings and contact cases.

1997

First Utting report ‘People Like Us The Report Of The Review Of The Safeguards For Children Living Away From Home’ published following allegations of child abuse in children's homes and foster care in North Wales. Concerns about ‘looked after children’ in the public care system ending up as socially excluded, unemployed, poorly qualified and sometimes within mental health or prison settings.

‘Looking After Children: Assessing Outcomes in Child Care’ focused on developmental needs of children.

‘Quality Protects’ initiative was launched in England and Wales to improve services in childcare, plus the need for a better qualified and regulated social care workforce, including in residential care.

1997

Sure Start programme announced to address social deprivation affecting children and their families.

1999

Protection of Children Act 1999 created new statutory lists of people deemed unsuitable to work with children or young people to prevent their employment in positions where they would have unsupervised access to children. Criminal conviction not required, but subjects must have been dismissed or left organisations where there were grounds for dismissal related to their behaviour to children.

2000

Waterhouse report ‘Lost in Care’ published. Public inquiry

report into alleged abuse at children's homes and psychiatric settings in north Wales

Inquiry report into the case of Lauren Wright following violent assault by her stepmother

2000 **Children (Leaving Care) Act 2000** required local authorities to make provision for children leaving care and moving into adult life.

2001 **Inquiry report into the case of Caleb Ness**

Inquiry report into the case of Chelsea Brown

2001 **Department of Education and Science** took on government policy for children's services from Departments of Health and Education & Employment.

2002 **Inquiry report into the case of Ainlee Labonte/Walker**

2002 **Soham murders:** schoolchildren Holly Wells and Jessica Chapman were murdered by the caretaker at their school, Ian Huntley, who had a history of sexual offences against women and children. The case was investigated and this resulted in the Bichard Report.

2002 **Education Act 2002** required local authorities, schools and further education colleges to safeguard and promote welfare of all children aged <18 years.

2003 **Inquiry report into the case of Victoria Climbié. First Laming report** following the public inquiry into the murder of Victoria Climbié made 108 recommendations with timescales for implementation.

2003 **Green Paper 'Every Child Matters' published,** partly in response to the first Laming report on the Inquiry into the death of Victoria Climbié. The overall objective was to integrate services around children. Proposals include protecting children at risk within the context of universal services for children and families.

Five outcomes:

- being healthy
- staying safe
- enjoying and achieving
- making a positive contribution
- economic well-being

This initiative is also seen as the UK implementation programme for the UN Convention on the Rights of the Child.

2004 **The Bichard Report** was published looking at the case of a child murderer, Ian Huntley. It made recommendations to safeguard children through a vetting and barring scheme to prevent similarly unsuitable people obtaining work with children.

Independent Safeguarding Board under the Safeguarding Vulnerable Groups Act 2006 implemented.

2004 **Children Act 2004** – increase effective partnership between agencies & clarify accountability for contributing to policy and local strategy (Children and Young People’s Plan) and sharing information, but also within Children’s Trusts to achieve the 5 outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution, achieving economic wellbeing. Specific provision comprises:

- a Children’s Commissioner to champion interests of children and young people;
- a duty on Local Authorities to make arrangements to promote co-operation between statutory agencies and other appropriate bodies (such as voluntary and community organisations) in order to improve children’s well-being plus a duty on key partners to participate;
- a duty on key agencies to safeguard and promote the welfare of children;
- a duty on Local Authorities to set up Local Safeguarding Children Boards and on key partners to take part;
- ContactPoint: provision for indexes or databases containing basic information about children and young people to enable better sharing of information;
- Requirement for a single Children and Young People’s Plan to be drawn up by each Local Authority;
- Local Authorities must appoint a Director of Children’s Services and designate a Lead Member;
- Integrated inspection framework and the conduct of Joint Area Reviews to assess local areas’ progress in improving outcomes; and
- Provisions relating to foster care, private fostering and the education of children in care.

Every Child Matters: Change for Children programme introduced a national framework to support the joining up of services..

The ten key elements of the national framework to achieve the 5 outcomes for children are:

1. The duty to cooperate to promote the well-being of children and young people
2. The duty to make arrangements to safeguard and promote the welfare of children and young people
3. The development of statutory local safeguarding children boards (LSCBs) to replace non-statutory area child protection committees (ACPCs)
4. The appointment of local directors of children services
5. The National Service Framework for Children, Young People and Maternity Services
6. The Outcomes Framework
7. The development of an integrated inspection framework
8. The appointment of a Children's Commissioner
9. The development of a Common Assessment Framework

10. Workforce reform to help develop skills and ensure staffing levels

2005 **England's first Children's Commissioner (Professor Al Aynsley Green, a paediatrician) was appointed.** Wales appointed a commissioner following the Waterhouse report in 2000.

2006 **'Working Together to Safeguard Children'** - new national guidance for England and Wales on interagency working for child protection. Area Child Protection Committees become Local Safeguarding Boards. *Child protection* defined as a 'process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse or neglect'.

2006 **Safeguarding Vulnerable Groups Act 2006** designed to implement further vetting and barring schemes to protect against unsuitable adults working with children or vulnerable adults and hold lists of individuals considered unsuitable to work with children or vulnerable adults.

2006 **Childcare Act 2006:** regulated childminders and nurseries and other early years care services for children.

2007 **Death of child Baby P** (later identified as Peter Connolly) in Haringey.

- 2007 The **Department for Children, Schools and Families (DCSF)** took over policy lead for children's services in England from Department for Education and Skills.
- 2007 **ContactPoint** - a new national database on children under Children Act 2004 Information Database (England) Regulations 2007, Statutory Instrument 2007 No. 2182.
- 2008 **Second Laming Report** ordered following concerns raised by OFSTED reports about Haringey and other Children's Services departments in England.
- Serious Case Review into the case of Khyra Ishaq** who died of starvation and neglect May 2008.
- 2008 **The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)**, led by Christine Davies, established in July 2008 to identify and disseminate effective practice in children's services.
- 2008 **Local Safeguarding Children Boards (LSCBs)** made responsible for investigating all unexpected child deaths in their area, not just those where abuse or neglect was involved.
- Child Death Overview Panels (CDOPs)** set up to look at ALL child deaths except stillbirths and legally terminated pregnancies, including expected deaths. The CDOP must consider whether the death was preventable, using appropriate medical expertise to do this. National minimum data set introduced on deaths.
- 2009 **Second Laming Report** recommends :
- Overhaul of child protection social work training;
 - Strengthened management accountability;
 - A national Safeguarding Unit
 - New safeguarding targets;
 - Student SWs to specialise in children's social work after the first year of their degrees;
 - A new postgraduate qualification for experienced children's social workers;
 - A review of the 'Working Together' guidelines;
 - Serious case reviews should publish executive summaries;
 - Local safeguarding children boards to be independently chaired;
 - Social Work Taskforce to establish guidelines on

2009

guaranteed supervision time and maximum caseloads

- Integrated children's system to be nationally co-ordinated to end inconsistencies between local areas.

The Protection of Children in England: Government response to second Laming report includes following actions and policies:

1. Appointment of Sir Roger Singleton as first independent Chief Adviser on the Safety of Children to advise the Government on strategic priorities and the effective implementation of policy and report annually to Parliament on safeguarding progress, including the action plan and delivery of the recommendations from Lord Laming's report, guidance issued by professional bodies;
2. A Chief Adviser's Expert Group to advise the Chief Advisor;
3. A more rigorous OFSTED inspection programme with better qualified inspectors for Children's Services;
4. Care Quality Commission (CQC) to monitor performance of local NHS trusts;
5. Her Majesty's Inspectorate of Constabularies (HMIC) to monitor safeguarding through annual 'Rounded Assessments' from November 2009;
6. Her Majesty's Inspectorate of Probation (HMI Probation) to use seconded inspectors from OFSTED to support HMI Probation inspectors on safeguarding;
7. An Apprenticeships, Skills, Children and Learning Bill, to strengthen Children's Trusts with Boards on which the partners and the local community are represented and subject to statutory guidance;
8. Children's Trusts to have responsibility for producing a local Children and Young People's Plan & scrutiny of service outcomes, but being themselves under scrutiny by LSCBs;
9. Clarifying roles of Directors of Children's Services, Lead Members of local authorities, Chief Executives and Council Leaders, with a leadership programme for Directors of Children's Services & service managers;
10. Consultation of local communities on Children and Young People's Plan and appointment of two lay members drawn from the local community to the LSCB;
11. A new National Safeguarding Delivery Unit (NSDU) to focus on:
 - better, more consistent practice
 - strong, co-ordinated cross-Government monitoring and reporting on progress on safeguarding children and

- increasing public and professional confidence in arrangements for safeguarding and protecting children in England.

13. Regional Government Office staff will work as part of the National Safeguarding Delivery Unit to support and challenge Local Safeguarding Children Boards (LSCBs) on Serious Case Reviews, including :

- following up implementation of recommendations and assessing impacts of change;
- regional dissemination of learning from Serious Case Reviews;
- challenging the quality of local needs analysis, alignment of that analysis with local Children and Young People's Plan priorities & assessing adequacy of commissioning of services;
- negotiation with local authorities on appropriate targets for safeguarding, to be set out in the Children and Young People's Plan. These will have a statutory framework.
- helping LSCBs secure an adequate and high quality supply of Serious Case Review chairs and authors; and developing stronger local advice on safeguarding.

2009	Borders, Citizenship and Immigration Act 2009 S.55 required UK Border Agency to safeguard and promote the welfare of children.
2010	'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (HM Government 2010)- new child English protection guidance.
2010	National Safeguarding Delivery Unit (NSDU) disbanded. Post-Bichard report plans for those planning to work with children and vulnerable adults to register with an Independent Safeguarding Authority (or Independent barring Board) were halted. The proposed Vetting and Barring Scheme will now be scaled down.
2010	ContactPoint information database switched off and records of children already entered to be destroyed.

- 2010 **Commissioning of a review of child protection in England by Eileen Munro.**
- First report : The Munro Review of Child Protection: Part One: A Systems Analysis**
- 2011 **Second Interim Report from Munro Review: Interim Report: The Child's Journey**
- 2011 **Final Report from the Munro Review: A Child-Centred System.**
-

**APPENDIX B: The Michigan Family Risk Assessment for Abuse and Neglect
(FRAAN) Risk Assessment Tool**

	NEGLECT	Score		ABUSE	Score
N1	Current complaint and/or finding includes neglect a. No b. Yes	0 2	A1	Current complain and/or finding includes mental injury a. No b. Yes	0 2
N2	Number of prior assigned neglect complaints and/or findings a. One or less b. Two or more	0 2	A2	Number of prior assigned abuse complaints and/or findings a. None b. One or two c. Three or more	-1 0 1
N3	Number of children in the household a. Three or less b. Four or more	0 1	A3	Age of youngest child a. Seven years or older b. Six years or younger	0 1
N4	Primary caretaker's social support a. Appropriate and available social support b. Limited or negative support (check all that apply) • No or limited supportive relationships with relatives/friends/neighbours • Relative/friends/neighbours have negative impact	0 1 1	A4	Number of children in the household a. Two or less b. Three or more	0 2
N5	Primary caretaker is unable/unwilling to control impulses a. No b. Yes	0 1	A5	Either caretaker was abused and/or neglected as a child a. No b. Yes	0 1
N6	Primary caretaker provides inadequate physical care and/or inadequate supervision for child(ren) a. No b. Yes (check all that apply) • Provides inadequate physical care • Provides inadequate supervision	0 1 1	A6	Secondary caretaker has low self esteem No secondary caretaker (check if applicable) a. No b. Yes	0 0 1
N7	Primary caretaker currently has a mental health problem a. No b. Yes	0 1	A7	Either caretaker is domineering and/or employs excessive and/or inappropriate discipline a. No neither caretaker b. Yes (check all that apply) • Domineering • Inappropriate discipline	0 1 1
N8	Primary caretaker involved in harmful relationships d. No e. Harmful relationship(s) or one of more domestic violence incident f. Multiple (2 or more) domestic violence incidents	0 1 2	A8	Either caretaker has current or a history of domestic violence a. No, neither caretaker b. Yes	0 1
N9	Primary caretaker currently has substance abuse problem a. No b. Yes	0 1	A9	A child in the household has one or more of the following characteristics No child has any of the characteristics below Yes (check all that apply and indicate the highest score) • Developmental disability • History of delinquency • Mental health issue • Behavioural issues	0 1 1 2 2
N10	Family is homeless or children are unsafe due to housing conditions a. No b. Yes (check all the apply) • Family is homeless or about to be evicted • Housing is physically unsafe	0 2 2	A10	All caretakers are motivated to improve parenting skills a. Yes, all caretakers motivated or improvement not needed b. Yes, caretakers are willing to participate c. No, one or both caretakers needs to improve parenting skills but will not participate	-1 -1 0
N11	Primary caretaker able to put child's needs ahead of own a. Yes b. No	0 1	A11	Primary caretaker views incident less seriously than department a. No	0

			b. Yes, views incident less seriously	1
	TOTAL NEGLECT RISK SCORE	TOTAL ABUSE RISK SCORE

SCORE RISK LEVEL:				MANDATORY DISCRETIONARY OVERRIDES					
Assign the family's scored risk level based on the highest scores on either the neglect or abuse score using the following chart:				<u>Mandatory</u> : Override to intensive risk. Tick appropriate reason.					
Neglect Score		Abuse score		Risk level					
<input type="checkbox"/>	0-2	<input type="checkbox"/>	-2 - 0	<input type="checkbox"/>	Low				
<input type="checkbox"/>	3-6	<input type="checkbox"/>	1-3	<input type="checkbox"/>	Moderate				
<input type="checkbox"/>	7-9	<input type="checkbox"/>	4-6	<input type="checkbox"/>	High				
<input type="checkbox"/>	10+	<input type="checkbox"/>	7+	<input type="checkbox"/>	Intensive				
				<input type="checkbox"/>	1.	Sexual abuse cases where the perpetrator is likely to have access to the child victim			
				<input type="checkbox"/>	2.	Cases with non-accidental physical injury to an infant			
				<input type="checkbox"/>	3.	Severe, non-accidental, physical injury requiring medical treatment or hospitalisation and that seriously impairs the child's health or physical well-being.			
				<input type="checkbox"/>	4.	Death (previous or current) of a sibling as a result of abuse or neglect			
				<u>Discretionary</u>					
				<input type="checkbox"/>	5.	Reason			
								
								
OVERRIDE RISK LEVEL		<input type="checkbox"/>	Low	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	High	<input type="checkbox"/>	Intensive

Supervisor Review/Approval of Discretionary Override Date

APPENDIX C: ACCESS TO SERIOUS CASE REVIEW REPORTS

This Appendix comprises three documents:

1. Application to the Welsh Assembly Government Children's Health & Social Services Directorate.
2. Ethical clearance
3. Permission to access Serious Case Review reports.

1...Research proposal to develop a Risk Assessment Instrument to assist in Child Protection decisions.

Proposal: To test the feasibility of using an actuarial based Risk Assessment Instrument via a retrospective, non-intrusive study of Child Protection Serious Case Reviews, in order to contribute to improving Child Protection risk assessment decisions in future.

Proposed output:

Feasibility testing report on a Risk Assessment Instrument to assist professional decision-making in the safeguarding of children.

Outline of the Study:

There are few more onerous responsibilities than taking decisions to safeguard children. Both legally and ethically, the activity is fraught with multi-complex problems, as the rights of the child to protection are balanced against the right to maintain the child within their family wherever possible. This was dramatically demonstrated in the high profile media case of 'Baby P', whose mother, her boyfriend and another man, were responsible for his death. Because of the ongoing involvement of the local Social Services, the media were hugely hostile. A case arising at the time Baby P was being reported - the two Mulling-Sewell children killed by their psychotic mother – led to more kindly treatment of services by reporters. Current research on the child protection-psychiatric interface however provides firmer predictive evidence of the absolute fatal risk to children by a mentally ill mother, than 'ordinary' neglect cases (Pritchard, 2004; 2006; 2009).

The current Framework for Assessment of Children in Need and Their Families is a structured assessment process, facilitating inter-agency collaboration but some day-to-day practice and professional decisions are essentially about 'predicting risk' for the child and that is not specifically the task of the Framework. Risk prediction occurs not only in child protection (Baird et al 1988, Onderersma et al, 2005; Craissati & Beech,

2006; Allan et al, 2007; Becker & Grilo, 2007; Guenther et al, 2008) but in a number of related human care service fields, e.g. education, medicine, criminology and psychiatry (Ayer et al, 2008 Lung & Lee, 2008; Pritchard & Williams 2009). However, all face the problems of false negatives or false positives and most fall short of real practice significance.

The most dominant and it might be argued, successful form of risk assessment is not carried out by the human welfare services but by insurance companies, who cover a multitude of risks, essentially using actuarial models (e.g. Ayer et al, 2008; Lung & Lee, 2008). Risks are based upon statistical analysis of behaviour over time in a large cohort of child protection cases and actuarial models use regression and discriminant analysis to identify the most powerful risk prediction factors.

Perhaps for many in social work, an actuarial risk assessment may seem to be a denial of the essence of their work, namely the specific consideration of the individual within their personal and social circumstances. Yet in studies on the accuracy of predicting risk in Child Protection, the predominately used consensus based models [based upon theoretical models of human personality allied with in-depth discussions and case analysis by experienced practitioners in the field] versus actuarial models' [based upon statistical analysis of key inter-related factors] the actuarial approach has been demonstrated to be significantly superior compared to the consensus model (Milner 1994, Meehl 1954, Grove and Meehl 1996, Grove et al. 2000, Shlonsky and Wagner 2005, Doueck et al. 1993, DePanfilis 1996, DePanfilis and Scannapieco 1994, Camasso and Jagannathan 1995, Leschied et al. 2003, Ryan et al. 2005b, English and Pecora 1994, Browne and Saqi 1988).

The practice implication suggests that if we had an reasonably reliable established actuarial Risk Assessment Instrument, decisions surrounding cases like 'Baby P' and the Mullings-Sewell children would be made easier, as it would be possible to contrast a prediction score based upon the specific case, enabling the panel to make better informed decisions.

In an attempt to improve Child Protection decisions, the researchers seek a partnership between the Bournemouth University's Department of Social Work and the Welsh

Assembly Government in order to explore the potential to develop a Risk Assessment Instrument that will be practitioner-user friendly, which if it proves feasible, could be developed for national use. To this end Bournemouth University, will provide a Ph.D. student as a research assistant, under the supervision of the Social Work professors. There will be no financial cost to the Welsh Assembly Government.

Background to the Study

There is evidence that the Child Protection services of England & Wales have contributed to the improved reduction of the violent deaths of children [0-14] over the period 1974-2002. Indeed, currently the UK has some of the lowest violence-related deaths in the Western world (Pritchard, 2002; Pritchard & Butler, 2003; Pritchard & Sharples, 2008a, b). However, those children who have experienced adverse psycho-social-economic disadvantage are over represented in a range of physical, social and psychological ‘pathologies’ in adolescence and adulthood, as the problems of the accumulative impact of neglect and abuse remains (Utting 1997, Farrington 2003; Watson et al 2006). New and expanding neuro-biological research into the release of stress hormones in maltreated children, impacts upon the child’s neurological development, interacting with any poverty or/ and poor or adverse parenting upon the developing infant’s brain (Perry & Pollard 1998; Dawson et al, 2000; Ornoy, 2003; Breslau et al, 2006; Lee et al, 2005; Dahl et al 2006; Howe, 2008). What is often not appreciated, that there is relatively a greater degree of brain and neurological development in the first 18-24 months of life than at any other time, so that a child growing up in adverse circumstances, adds physiological impairment to the linked psycho-social development and social disadvantage (Lupie et al, 2001; Flinn, 2006; Sourander et al, 2007; Kishiyama et al, 2008), to the extent that although overt physical neglect or abuse may not reach current thresholds of ‘significant harm’, these early adverse situations can and do impair the child’s physical and especially neurological development (Ornoy, 2003; Srivastava et al, 2003; Bradley et al, 2008).

This gives a new urgency to understanding the medium and long-term impact of these factors upon children, and not as it were merely the extremes of ‘physical/sexual’ abuse but severe emotional abuse, associated with later adolescent and adult psychopathology, which gives a further twist to the cycle of deprivation and child neglect and abuse (Lipman et al, 2001; MacMillan et al, 2001; Schubert et al, 2005; Grover et al, 2007; Sourander et al, 2007; Burton, 2008; Kisiyama et al, 2008; Stirling et al, 2008).

A key problem facing practitioners, therefore, concerns children experiencing psychosocio-economic difficulties and raises the question, '*Can their parents be helped to meet the child's developmental needs in the time the child requires and if so, how?*' If not how can the risk of 'substantial harm' be predicted accurately?

We are confident there is a considerable amount of effective social work done with children and families on the Child Protection Register [CPR] as seen in the lowest ever rate of violent deaths of children in the UK (Pritchard & Sharples, 2008a, b) so it should be possible to identify measure what factors contributed or inhibited a good outcome, thus distilling further elements of good practice (Howe, 2005; Pritchard, 2006; Crosston-Tower, 2007; Pritchard & Williams, 2009). However, as we know, in a minority of cases, the accumulative deficits in the family situation are such that the problems may never be wholly resolved, possibly because the insurmountable nature of the problems goes unrecognised, or perhaps over-optimistically assessed. Making changes in care in a timely fashion to avoid effects on the development of young children requires these interactive risks to be assessed, and often under time pressures. Can these *de facto* 'risks' be predicted and practitioners supported in this difficult situation?

This result of these problems may lead to having their neuro-biological development impaired, and to further under-developed cognitive and social skills (Teicher et al, 2003; Flinn, 2006; Byung-Joo et al, 2007; Sourander et al, 2007; Kishayama et al, 2008). If 'looked after' there can be a *staccato* placement history and disrupted attachment experiences (Howe, 2005), with cumulative damage that makes it more difficult to foster or adopt the child successfully, should that be, ultimately, the agreed plan (Parker, 1991; Jackson & Thomas, 1999)]. A secondary outcome, in these minority cases, will be increases in the already substantial costs incurred to provide adequate placements, and along with associated educational-under-achievement, which may in adolescence and adulthood, produce costs associated with criminal careers, anti-social behaviour and a range of other psychosocial problems over the course of adult life (Dawson et al 2000; Home Office, 2001, Pritchard, 2004, Dahl et al 2006; Watson et al 2006; Pritchard & Williams, 2009). The problem remains therefore how

to assess contemporaneous data from child protection cases to identify factors contributing to risk levels over time.

Critique of the Assessment Framework and Risk Prediction

Risk is a key factor in making major decisions, especially in the unenviable role in removing a child from their family, and whilst the actual decision rests with the courts, they depend on accurate expert advice of child protection teams.

Ethically, risk and decision-making is a difficult area in effect involving the prediction of events which may or may not occur in a complex, dynamic family context where the central needs of the child change as he or she develops over time. Any assessment tool which aims to quantify risk cannot measure the variations in human behaviour and volatile emotions over time (Goddard et al, 1999) and many factors may influence practitioner judgement, and often they appear to rely on naturalistic decision making, drawing on their own past experience whilst maintaining a vulnerable child or children as the focus of their work.

The quality of decision making on future risks underpins the quality of the legal action which may follow, as well as the quality of future management of cases where children are at risk of further neglect or abuse. The process is often undertaken where the information on which to base risk assessment may be incomplete, or in practice deliberately hidden by family adults involved. In an effort to gain a degree of inter-agency comparability the Framework was launched in 2000 to build a clearer picture of the needs of the child, the capacity of their parents and the circumstances of the family (Department of Health, Department for Education and Employment and Home Office, 2000). This drew on the ecological model of child development in context developed earlier by Belsky and Vondra (1989) and required data to be grouped under a new set of related domains, with the child and their developmental progress at the centre of the assessment process. It was not intended as a tool for child safeguarding work, but as a framework for assessing every child considered to be in need. This sets child neglect and abuse on a continuum of child needs, rather than maintaining them as a separate category of 'at risk' children. It marked a change from the earlier Department of Health guidance

'Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment' (Department of Health, 1988)

Cooper (2003) analyses how the framework for assessment of children in need copes with the issues of risk in child safeguarding. Risk is seen as an interaction between components of value and probability. Checklists tend to restrict risk assessment to the factors which form the listed components of any given tool (Cooper 2003). In addition, risk assessments need to be based on sound statistical models to be valid in these terms. Cooper (2003, p.103) however strongly criticises existing published risk assessment models on the grounds that none of them provide a 'sufficiently detailed and systematic child-focused structure facilitating the identification of 'risk relations' to guide the assessment.' They fail to analyse risks and benefits or strengths of the factors symmetrically and are unable to bring the risks of specific factors together in a valid way to identify asymmetries which may pose a risk to the child concerned. In terms of the Framework, factors would have to be assessed in terms of their symmetry on the three separate dimensions being assessed – the child's needs, the family's capacity and the environmental circumstances, would give rise to a very complex risk calculation which is not included in the Department of Health publication on assessment. Cooper (2003) uses three dimensions of assessment based on these domains to map the risk to children in relation to the possible deficits in these parameters, relative to acceptable family and environmental factors and to normal child development.

The issues Cooper identifies which underpinned the development of the Framework lie in social work practice and the nature of the circumstances under which child and family assessment has to be carried out (Cooper 2003) and cites Beach (1997) in relation to research on naturalistic decision making by professionals such as fire fighters and ambulance personnel *in situ* which requires the practitioner to recognise the situation as familiar and as one for which they have been trained to set particular goals and expectations and to give an appropriate response (Beach, 1997).

This type of pattern recognition based decision making is not a formal analytical process, but it does have advantages in familiar situations when there are time pressures and decisions have to be reached quickly. If the situation is not familiar, the model requires the practitioner to gather further information in the hope of recognising the type of situation presenting itself and being able to envisage appropriate goals and adapt existing solutions to the specific circumstances. According to earlier work Beach suggests that between 40% and 80% of decisions in some circumstances involve recognition in the earlier stages, recognition increases as the practitioner becomes more experienced in their area of practice, but beyond this description of a behavioural pattern how the worker finally decides remains opaque (Beach, 1997, p. 146). This builds on the critically reflective and analytic skills that social workers develop and hone within their work.

For Cooper, the pressure to move away from excessive use of child protection processes to manage cases of children in need and the lack of structure offered by the Orange Book to practitioners, meant that decision making tended to be of poor quality and haphazard. Successive reviews, such as that of Utting (1997), demonstrated a need to provide a framework for practice which fitted with the naturalistic decision making patterns of practitioners under pressure by providing a basic set of cues, but did not use complex risk assessment tools. For many practitioners working with human beings, the idea of mechanistic processes of risk factors leading to predictable outcomes is difficult; partly this is because there is so much effort put into casework towards risk mitigation and reduction. At the same time, the consequences of failure to protect a child are so severe for social workers that they may become unable to move from a risk averse perspective and not register a family whose risk factors suggest extreme vulnerability to poor outcomes.

Laming (2003) identified the need to ensure that agencies communicated information which they previously held within their own records systems, so that there was a single core assessment of any child in need. The Climbié report, like many child abuse reviews before it, identified the difficulties of bringing together multi agency information to clarify risks to the child and need for family support.

The need to ensure that a child receives all the welfare and universal services is also supported by the Framework and subsequent Common Assessment Framework developed under Every Child Matters.

Whilst Browne (1995) is critical of the use of checklists such as the tools used to bring together risk factors for neglect or abuse, Cooper defends them as ‘indispensable guides to alertness and informing our judgement on risk issues.’ (Cooper, 2003, p. 111). It is essential that practitioners have a reasonable understanding of how such checklists. They are drawn from *post hoc* frequencies of adverse outcomes and not designed specifically as reliable predictive tools for the particular new case circumstances in which they are applied. In addition, factors (or interactions between factors) not identified in screening tools may affect the outcome for the child, including resilience or the ‘buffering’ effect of secure family relationships when the family comes under stress (Browne 1995b), Rutter 2007). The importance of record keeping is highlighted here in that it is the practitioner’s only way of objectifying their judgements and the evidence on which they have drawn in making them, a distinct improvement on theoretical approaches which preceded the Framework’s introduction (Cooper, 2003, p. 114).

Both Browne (1995) and Cooper (2003) emphasise the need to use empirically derived tools to assess some of these factors, rather than expecting screening tools to do the work of prediction, for which in essence they were not designed. Precey (2003) believes the Framework contributes little to the specific task of *risk* assessment and prediction, although it contributes to multi-agency knowledge and cooperation. It does not frame risk factors as a specific element. In addition, the 35 day time frame for a core assessment may be either too long to allow action to protect the child, or too short to allow for a complex investigations (Precey, 2003, p 307-8), with limited scope to record details of the mother’s own history, which is often significant in the child protection-psychiatric interface (Pritchard, 2004; 2009). Precey (2003) also criticises the lack of a requirement for a genogram or a detailed chronology of events such as medical interventions, family changes e.g. frequent home moves etc where the parents may seek to avoid.

Decision making in social services and child welfare depend on a number of factors around the process of making decisions. These are summarised by Gambrill (2008) as follows:

- Goals and the conflicts which may arise between them
- Situational awareness
- Affective reactions
- Reconstructive memories selectively recall past successes rather than failures
- Influences we are unaware of at the time
- Individual decision making styles differ
- Various biases: over interpretation, overconfidence, cognitive conservatism, certainty of hindsight, tendency to impose higher standards of evidence on dissonant claims than consonant ones, incoherence in subjective probability judgements
- The use of heuristics – simplifying strategies
- Errors due to systems factors, rather than one person or one environmental characteristic
- Lack of domain specific knowledge and skills to make decision

Actuarial Models

Actuarial risk assessments differ from consensus or rationally derived tools in that they are based on statistical methods (Hilton and Harris 2005). Actuarial risk assessment tools are used in a number of settings where accurate risk of violence is important, notably in assessing risks of violence in mental health care settings and in predicting repeated spousal violence (Hilton and Harris 2005); (Cooper et al. 2007). Even in these established settings, the use of such empirical predictive tools is relatively recent (Hilton and Harris 2005). The purpose behind their use is to increase the likelihood of professionals coming to an accurate assessment of risk, although it is readily acknowledged that actuarial tools may also lead to false

negative or false positive judgments, but they have been demonstrated to do so less often than consensus models (Hilton & Harris 2005). This is because actuarial approaches reduce the number of factors to the minimum required to predict the outcome effectively. Whilst some factors will have stronger predictive effect than others, all of them may be features of the situation in real life.

Actuarial tools in professional decision making have a long history in psychology and also in risk prediction in forensic settings where they have been used to assess the likelihood of future violent behaviour in previously violent offenders (Milner 1994, Meehl 1954, Grove and Meehl 1996, Grove et al. 2000, Gambrell and Shlonsky 2000).

Grove and Meehl (1996) provide a useful outline of the arguments for the use of actuarial tools for general clinical and other human decision making situations and a criticism of the arguments raised against the use of them in clinical practice. The fundamental difference between consensus tools such as the Framework and actuarially based methods lies in the theoretical understanding of the phenomena being considered. Grove and Meehl (1991) point out that using ‘softer’ intuitive decisions have a poorer level of success and recent meta analytic work relating to human behaviour demonstrates this difficulty in situations which relate to prediction of risk in child protection (Grove and Meehl 1996, p. 296; (Aegisdottir et al. 2006).

Cooper et al (2007) review the changes in offender risk assessments techniques since the 1960s and groups them into three types:

- Traditional clinical assessments;
- Actuarial assessments;
- Combined adjusted actuarial approaches with structured clinical judgments – the conditional and tree-based actuarial models;

On follow up, the first generation traditional clinical assessments showed poor predictive power with only one in three cases assessed predicted correctly. There

were a high number of false predictions which led to individuals being detained for long periods past the point at which they could have been allowed to return safely to the community. The reasons suggested for this are:

- Forensic psychiatric patients form a very heterogeneous population in terms of mental disorder and this may have underpinned the variability of outcome;
- Although there were high rates of past violence among the offenders when first detained, samples for research were drawn from those who had low rates of violence and were being considered for return to the community;
- Base rates for violence were estimated from arrest rates, which excluded those who had not been arrested following subsequent violent episodes;
- Only mentally disordered offenders from long term custodial settings were studied, so that their responses could not be predicted for the very different circumstances they would encounter in the wider community ;
- The methodology used was that of subjective clinical opinion, rather than a more structured approach. The mechanism of decision making is intuitive and based on professional experience.

Some of these do not apply to child safeguarding risks, but the very poor predictive power of the ‘expert’ assessments of professionals in mental health suggests that those seeking to establish risks to children may be exposed to similar difficulties.

The ‘second generation’ of risk studies in the typology proposed by Cooper et al (2007) uses actuarial approaches to overcome the problems of subjectivity. They are based on statistical relationships identified through empirical research between specific risk factors and the probability of an undesirable outcome.

The advantages of actuarial methods are that they are more accurate in predicting risk and do not rely on subjective opinion, however, Cooper et al suggest that there is more to the prediction of violence in future than can be summed up in an algorithm alone (Cooper et al, 2007, p. 14).. There is also a problem with the static nature of some of the initial actuarial risk factors in predicting the outcomes of lives

lived in dynamic and changing circumstances, and to an extent, can only be seen as reasonably valid close to the time of assessment. This leads Cooper et al to review the evidence for the third generation of risk assessments – the adjusted actuarial approach which allows the combination of different mental health comorbidities in the prediction of violence (Cooper et al. 2007).

Much of the work is based on previous large scale actuarial studies undertaken by the MacArthur Violence Risk Assessment project in the USA (Steadman et al. 2000). Unlike the purely actuarial models based on regression analysis, this one enables clinicians to combine empirically derived actuarial factors together with specific rare, but highly significant clinical findings (e.g. psychopathy, schizophrenia, responses to treatment, lifestyle changes) in a decision tree which predicts the risk of violence for the individual patient circumstances. Such clinical guidelines and decision support tools endeavour to bring together the best of both worlds, but the validity of such mixed methods is more difficult to establish.

Actuarial tools for assessment of child maltreatment risk

In the field of child safeguarding, there are a number of actuarial tools in use, all of which originated in the USA and a major study (Baird et al 1999) reviewed the inter-rater reliability of three such tools:

- The Washington Risk Assessment Matrix (WRAM)
- The California Family Assessment factor Analysis (CFAFA)
- The Michigan Family Risk Assessment of Abuse and Neglect (FRAAN) - attached as **Appendix A** to this document.

The tools were assessed using scenarios based on 80 selected case records rather than randomly selected case records, to ensure that there was adequate information presented to reviewers to enable all of the tools to be used. Identifying data was also removed to protect the privacy of families. Sites were selected for the case readers to test the tools in a wide geographical range sites, including a range of ethnic

groups and a mix of urban and rural settings, with the raters undergoing detailed training in their use. Measures of reliability between raters were their percentage agreement into high, medium and low categories, with Cohen's kappa used to measure agreement adjusted for random concurrence. The tools themselves have different numbers of data categories, so the CFAFA tool with the fewest categories was compared against the combined results from the more complex FRAAN and WRAM scores.

In no cases was there a 100% agreement between raters, but the FRAAN assessment tool showed the highest level of inter-rater reliability than both the WRAM and CFAFA. Kappa thresholds were set at 0.3, with anything below this being considered as too low a level of reliability. This test showed a marked difference between the scoring, with the FRAAN emerging as the only tool with adequate reliability and it was concluded that only the FRAAN was acceptably reliable for child protection work. Accordingly, it is intended to use FRAAN as a template for this proposed study, to test its validity in a British setting and modify accordingly. It has to be acknowledged that there has been adoption of actuarially based tools in the USA and other countries (Baird et al, 1999) but limited application in the UK, hence the need to explore their use on British case-records. Nonetheless, the better actuarial assessment tools in mental health field show much higher reliability ratings than consensus based models

Proposal

This study proposes a retrospective analysis of Serious Case Reviews submitted between 1995 and 2008 using the FRAAN factors to identify factors associated with such high risk cases at a stage before the Review episode of significant harm. This assumes that there is currently extant data within the Serious Case Review reports, which could be used to enable us to explore the potential for testing the feasibility of the Risk Assessment Instrument in decision making. The aim of this research is to identify a valid and reliable actuarial risk assessment tool to make services to children and families more effective, as well as more efficient on the longer term by reducing

some of the costs linked to significant harm, protracted family breakdown or long exposure to adverse developmental conditions.

Methodology: The study is a non-intrusive retrospective Serious Case Review based project. It is hoped to be able to examine all Welsh Serious Case Reviews submitted between 1995 and 2008.

It is recognised that such analyses can be demanding but the research team already have quite substantial experience of such studies and analyses (Pritchard & Williams 2001; Pritchard 2004; Randall & Parker, 1999). A major advantage of a Serious Case Review approach lies in avoiding intrusion into the lives of vulnerable and troubled families and testing risk assessment on known high risk cases. Data will be kept secure according to Data Protection legislation and will be un-attributable and wholly anonymous. As required by the university research ethics policy, the proposal has been submitted for scrutiny and approval to the appropriate research ethics committee. Utilising the FRAAN as a template, each Case Review Report will be examined to see to what extent the FRAAN factors emerge during the history of the case.

The Methodological Process.

In an effort to minimise bias, initially the researcher will only know of the Serious Case Reviews submitted between 1995 and 2008.

The FRAAN will be applied to the 1995-2008 Reviews at each stage of the case where data can be extracted to populate the risk assessment tool. These earlier risk scores will be compared with later scores during the case duration and at the point where significant harm occurred. The quality of the case review report will affect the data available.

This will achieve three goals:

- To test the feasibility of populating a US based risk assessment tool;

- to determine how accurately FRAAN scores can identify risk in known high risk Welsh cases;
- to consider whether the FRAAN can be applied to high risk cases in Wales.

The Serious Case Review reports will be analysed by the researcher to identify key risk factors during the earlier stages of the case, with inter-rater checks using one of the professors to examine the reliability of the ratings.

Outputs:

The research would provide an analysis of the recorded high risk factors contributing to outcomes of cases with serious outcomes for children and their families, based on established evidence based risk assessment tool.

A report for the Assembly will be compiled and papers in peer-reviewed academic journals and the professional press will be submitted.

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DATA PROTECTION ISSUES : ACCESSING SERIOUS CASE REVIEW REPORTS FROM GOVERNMENT RECORDS

What is the purpose of accessing Serious Case Review reports?

Access to the reports is necessary to identify the extent of contemporaneous information child protection teams had available to make their decisions about children involved in past cases where risks were known to be high. If the Review information includes enough detail, the risk assessment tool developed in North America will be used to assess the risk of further neglect or abuse to the child/children at that point in the case history. The risk assessment will be used again to reassess cases at significant points in the case history to see how risk levels changed over time. Any later allegations or episodes when neglect or abuse was suspected will also be noted, together with any re-referrals on grounds of children being in need of protection.

Information recorded about the child's developmental and school progress will be noted at the time of first referral and again during the time covered by the case history to identify any points in time where risk or neglect or abuse of the child/ren might have been identified as high if child protection professionals or their managers had had access to a suitable risk assessment tool.

Child protection Serious Case Review reports are submitted to the Welsh Assembly Government by multi agency teams throughout Wales. The Assembly and the local authorities share the data in the reports for joint follow up of action plans. Other agencies including the NHS and police are required to cooperate with child protection processes, but the lead remains with local authorities with child protection responsibilities, together with the responsibility for retaining and safeguarding the original case records for a legally prescribed period. Serious Case Review reports will contain information on the child or children and also third parties such as those caring for them, other family members and possibly neighbours or friends who are not part of the family. Named child protection professionals ought not to be recorded in files, nor foster carers or other workers from the local authority, child care and educational settings, the NHS, police or voluntary sector service providers. If the child's name or that of an adult convicted of crimes in relation to the case is recorded, this will only be because this information is already in the public domain.

What use will be made of the data?

The anonymous Review report data will be used to test whether Serious Case Review reports contain the kind of information required to use US actuarial risk assessment tools. If this level of detailed information is available, the tools will be used to retrospectively assess risks at various points during the case history chronology in order to see whether access to such risk assessments might be helpful for child protection teams in 'live' case management situations.

Ethical issues and how they will be managed

The ethical and research governance procedures required by the Welsh Assembly Government and Bournemouth University will be followed at all times and approval for the study will be sought through the relevant Research Governance Committee. The researcher will offer to work subject to an honorary contract with the Welsh Assembly Government and to comply with their requirements for access to their premises, as well as being supervised and accountable to the University through Professors Colin Pritchard and Jonathan Parker. All the University staff involved directly with this study will produce valid current Criminal Records Bureau clearances and provide copies of these.

The study will also adhere to the Bournemouth University research ethics and formal academic consent to proceed will be obtained before access to any case file material.

Legal advice relating to the Data Protection Act requirements for this type of sensitive personal information has been sought and used by the researcher to prepare this application.

Collection and storage of research data

Data will be collected on the premises designated by the Welsh Assembly Government using a laptop computer and stored using a separate encrypted hard disk.

The investigator will work under an honorary contract to the Welsh Assembly Government and will be subject to their procedures for handling and storing confidential case files, as well as the research requirements of the University.

Ensuring anonymity, privacy and confidentiality

Source material will consist of Serious Case review reports and any accompanying documentation. This will only be accessed on Welsh Assembly Government premises or using encrypted material supplied by them. All data from the reports will be entered into a database of material for the research, excluding any personal identification data which could possibly identify any individual client, family or any professional or organisation working with them. All data collected will be kept anonymous at source, with a key to case file numbers for tracing data back. The files used for the research will be encrypted using secure password protected TrueCrypt software installed on a portable hard disk. Two copies will be kept of this disk and the researcher is responsible for the safety and secure storage of the disks at all times.

No paper notes, audio tapes or other files will be used during this study.

Should there be any loss of data due to corruption or damage to a disk, the disk will be physically destroyed and a fresh disk prepared from the second disk copy. If the disk is ever mislaid, there will be no risk of access to the data without the extended password details to unlock the encrypted files.

Data security at the end of the study

On completion of the research, the anonymous material used will be lodged with the School of Health and Social Care and kept securely for 5 years following completion of the study as evidence of the academic work analysing the material obtained from the files. No client or professional identification will be included in any retained material.

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Bournemouth University

Appendix A

RISK ASSESSMENT OF NEGLECT OR ABUSE

Adapted from original documentation from Michigan Department of Human Services, March 2008

	NEGLECT	Score		ABUSE	Score
N1	Current allegation and/or finding includes neglect? c. No d. Yes	0 2	A1	Current allegation and/or finding includes psychological harm c. No d. Yes	0 2
N2	Number of prior assigned neglect allegations and/or findings c. One or less d. Two or more	0 2	A2	Number of prior assigned abuse allegations and/or findings d. None e. One or two f. Three or more	-1 0 1
N3	Number of children in the household c. Three or less d. Four or more	0 1	A3	Age of youngest child is: c. Seven years or older d. Six years or younger	0 1
N4	Primary caretaker's social support is: c. Appropriate and available d. Limited or negative support (circle all that apply) • Unavailable or limited supportive relationships with relatives/friends/neighbours • Relative/friends/neighbours have negative impact	0 1 1	A4	Number of children in the household c. Two or less d. Three or more	0 2
N5	Primary caretaker is unable/unwilling to control impulses c. No d. Yes	0 1	A5	Either caretaker was abused and/or neglected as a child c. No d. Yes	0 1
N6	Primary caretaker provides inadequate physical care and/or inadequate supervision for child(ren) c. No d. Yes (circle all that apply) • Provides inadequate physical care • Provides inadequate supervision	0 1 1	A6	Secondary caretaker has low self esteem No secondary caretaker (circle if applicable) c. No d. Yes	0 0 1
N7	Primary caretaker currently has a medical health problem c. No d. Yes	0 1	A7	Either caretaker is domineering and/or employees excessive and/or inappropriate discipline c. No neither caretaker d. Yes (circle all that apply) • Domineering • Inappropriate discipline	0 1 1
N8	Primary caretaker involved in harmful relationships g. No h. Harmful relationship(s) or one of more domestic violence incident i. Multiple (2 or more) domestic violence incidents	0 1 2	A8	Either caretaker has current or a history of domestic violence c. No, neither caretaker d. Yes	0 1
N9	Primary caretaker currently has substance abuse problem c. No d. Yes	0 1	A9	A child in the household has one or more of the following characteristics: No child has any of the characteristics below Yes (circle all the apply and indicate the highest score) • Developmental disability • History of delinquency • Mental health issue • Behavioural issues	0 1 1 2 2

NEGLECT	Score	ABUSE	Score
N10 Family is homeless or children are unsafe due to housing conditions		A10 All caretakers are motivated to improve parenting skills	
c. No	0	d. Yes, all caretakers motivated or improvement not needed	-1
d. Yes (circle all the apply)		e. Yes, caretakers are willing to participate	-1
• Family is homeless or about to be evicted	2	f. No, one or both caretakers needs to improve parenting skills but will not participate	0
• Housing is physically unsafe	2		
N11 Primary caretaker able to put child's needs ahead of own		A11 Primary caretaker views incident less seriously than department	
c. Yes	0	c. No	0
d. No	1	d. Yes, views incident less seriously	1
TOTAL NEGLECT RISK SCORE		TOTAL ABUSE RISK SCORE	
.....		
...		...	

SCORE RISK LEVEL:

Assign the family's scored risk level based on the highest scores on either the neglect or abuse score using the following chart:

Neglect Score	Abuse score	Risk level
<input type="checkbox"/> 0-2	<input type="checkbox"/> -2 - 0	<input type="checkbox"/> Low
<input type="checkbox"/> 3-6	<input type="checkbox"/> 1-3	<input type="checkbox"/> Moderate
<input type="checkbox"/> 7-9	<input type="checkbox"/> 4-6	<input type="checkbox"/> High
<input type="checkbox"/> 10+	<input type="checkbox"/> 7+	<input type="checkbox"/> Intensive

MANDATORY DISCRETIONARY OVERRIDES

Mandatory: Override to intensive risk. Tick appropriate reason.

- 1. Sexual abuse cases where the perpetrator is likely to have access to the child victim
- 2. Cases with non-accidental physical injury to an infant
- 3. Severe, non-accidental, physical injury requiring medical treatment or hospitalisation and that seriously impairs the child's health or physical well-being.
- 4. Death (previous or current) of a sibling as a result of abuse or neglect

Discretionary

- 5. Reason

OVERRIDE RISK LEVEL Low Moderate High Intensive

Supervisor Review/Approval of Discretionary Override Date

1) Student: Heather Wood

Title: A prospective case-record based study to identify factors contributing to the successful or unsuccessful protection of children on the Child Protection Register 2002-2006.

Reviewers: 2 senior academics

Report prepared by: Martin Hind

Date: 15.05.09

Dear Heather

Thank you for submitting your study to the research governance review group (RG2). Before you proceed with your study the review panel identified a number of issues which will require your attention. You are advised to discuss these issues raised with your supervisory team and respond to us at RG2 (by re-submitting all documents) about each of the following stated points;

1. The proposal document would benefit from proof reading to ensure consistent terminology. In its present form the review panel found it confusing to follow. For example is it appendix or annex?; also your links to annex's are mixed up (Eg. Annex B is mixed up in the proposal in relation to exactly what is in that annex). You are advised to use the more conventional term 'appendix' and to make sure that the correct appendix no is properly stated within and throughout the proposal document. NB. Making these amendments will enhance the overall coherence of your submission documents.
2. There is a disparity between the Application for Ethical Approval document (around six months) and the Information Sheet for Informed Consent (between 6-9 months). The review panel would like to see an overall and consistent project plan identifying key milestones throughout the entire study.
3. The proposal states that ethical and research governance procedures required by the Children's Department will be followed, but the ethical implications are not discussed. This discussion should be in the proposal document.
4. The panel were unsure why you plan to select 200 cases. How has this figure been determined?, and what will happen if you fail to meet the required sample?. Please provide more clarity, in the proposal document, about your sampling intentions.
5. It is not very clear who will be contacted for consent and by implication whose records are being used? Is it the child's records? and if so is consent being sought from the child, or the person with parental responsibility?; or is the person who has/had parental responsibility consenting to their own records being used? If it is the child's records and the child is being asked, and they are still under 16 (or even 18), then the issues around their consent needs further consideration. If it is the person acting with parental responsibility giving consent to use the child's records, given the complexity of parental responsibility for some children who are placed on the at risk register, this needs much greater clarity. For example, is it assumed that whoever had parental responsibility in 2002-4 still has it because this may not be the case and they may no longer be in a position to consent on the child's behalf?. If the person (adult) who had parental responsibility is consenting to their own records being used, then that needs to be made much clearer. We appreciate that this is a complex issue, because the records pertain to the child, we assume, but the assessment in many respects pertains to the person who was their parent or who had parental responsibility at the time. The review panel would like much more certainty, expressed in the proposal document, around this important issue.
6. The review panel requires further clarification concerning the purpose of the study. The use of the risk tool for assessing the likelihood of neglect and abuse is clearly identified in the Application for Ethical Approval under the heading *purpose of the study*, but this is not matched in the Information Sheet under *purpose of the study* and is even less prominent under the study heading. This should be addressed in the documentation (as per point one above).
7. As you will have honorary contract with the local authority you are advised to consider with your supervisory team about any potential conflicts of interest when recruiting and collecting and analysing the data. These considerations should be evident in your proposal document.
8. It is not clear how you plan to analyse your data. The intention seems to be to identify which children were placed on the *at-risk* register that would have been identified as at risk of further abuse by your tool and whether these predictions would have been an accurate reflection of what actually happened. However, apart from a general suggestion that statistics will be used, the review panel require far greater clarity on how you plan to manage and analyse the data. I.e. what type of statistics (descriptive and, if relevant inferential) will you plan to use?. A proposal of this nature should have more certainty in respect of planned statistical analysis and the review panel would like more clarity, in the proposal document, about your intended data analysis.
9. The review panel were not sure that the potential distress to families/ children from being invited to participate, albeit only by their records, has been adequately thought through. Whilst there is no invitation for face to face contact, the fact of being asked about the study may recall what, for some individuals, was a very distressing experience, and being reminded of it, and that it is held on record may be difficult for some people. This does not mean the study should not be undertaken, but it would be expedient to consider how being reminded of a past child protection case in the mail, along with regular post, might be like for some people. The review panel would like to see evidence, in the proposal document, of this issue being considered.

10. If the last known address is being used to communicate, there is a risk that a new resident at an address will open post, despite it not being addressed to them and be provided with a name, and information that this person was involved in social services viz a viz child protection. This could be a serious breach of confidentiality. This potential scenario needs to be fully considered and steps taken to ensure this scenario could not happen. The review panel would like a full account, in the proposal document, of how this scenario will be avoided.
11. Given that the researcher also provides (as is required) their own contact details, there should be evidence of awareness of self protection; some people who are still angry about such events might take it upon themselves to vent their feelings on the researcher. The review panel would like to see this consideration in the proposal documentation and/or on a standard university risk assessment form.
12. The covering letter must explicitly refer the participant to the Information Sheet for reading before asking them to sign the form.
13. The following issues were identified in relation to the supplied Participant Information Sheet (PIS);
 - a. 200 case files identified in Application for Ethical Approval are not mentioned in the PIS.
 - b. The PIS requires an entry stating that "taking part in the research is entirely voluntary".
 - c. Managing the risk of dealing with confidential records and loss of data are considered but not clearly identified as risks in the PIS. This must be made more obvious.
 - d. It is not clear if Annex B: Compliance with the Data Protection Act 1998 is part of the information to be shared with participants.
 - e. A clear statement on the PIS is needed in relation to how the results will be used and this should include all potential written expressions (ie. Dissertation and future publication)
14. Permission has already been granted by a local authority providing Children's Services and the consent of former clients to access their records will be sought in writing, using the last previous addresses known to Children's Services. Please ensure that we receive a copy of that approval letter for our own RG2 files
15. The review panel are uncertain if NHS REC approval is needed. The Department of Health document entitled '*Research Governance Framework for Health and Social Care*' states that

***Social care research involving human participants to whom
the NHS has a duty of care (or their organs, tissue or data)
must have a favourable opinion from the relevant NHS REC.
(DH 2005 3.12.3)***

It is therefore necessary for you, in view of this uncertainty, to write to the relevant NHS REC and enquire if they would expect to be involved in the ethical review of a study of this nature and purpose. NB. This should be in writing and a copy of the response supplied for our RG2 files. This approach should be made after the study has completed its passage through RG2 as evidence of RG2 approval may have a favourable influence on the NHS REC opinion.

That concludes the RG2 review report. We appreciate this feedback is quite lengthy but we will require a re-submission of your proposal documents that have addressed all of the points raised in this report before the study can be approved. If you require any clarification about any aspect of this report then please do not hesitate to contact me at RG2@bournemouth.ac.uk

Yours sincerely

Martin Hind RG2 Co-ordinator

References

DH 2005 Research Governance Framework for Health and Social Care Second edition: www.dh.gov.uk

Keith Ingham
Cyfarwyddiaeth Iechyd Plant a Gwasanaeth Cymdeithasol
Directorate for Children's Health and Social Services



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Eich cyf . Your ref
Ein cyf . Our ref

19 November 2009

Dear Heather,

Application for Research Access to Serious Case Reviews

Thank you for your letters of 21 September and 12 October. My apologies for the delay in replying, however as you will appreciate it was necessary for us to seek legal advice regarding your request to access confidential information held by the Welsh Assembly Government.

I am pleased to be able to inform you that we are able to offer you access to our files in order to undertake your research, provided that you can satisfy the exemption provided for in 33 of the Data Protection Act 1998, which allows the processing of data subject to certain conditions.

I enclose an agreement which will need to be signed by yourself and your main supervisor, Professor Jonathan Parker, and returned to this office before any access can be allowed.

You have suggested that you could visit the Assembly Government in Cathays Park to access the files and we believe that this would be the most sensible option. We can then arrange access and ensure that the files are stored securely when not in use.



BUDDSODDWR MEWN POBL
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Once the agreement has been signed and returned I would suggest that you contact Stephen Gear – the Head of the Children's Safeguards Team – to make the necessary arrangements for your visit. Stephen can be contacted by telephone on 02920 826535 or by e-mail at stephen.gear@wales.gsi.gov.uk

Yours sincerely



Keith Ingham
Director
Children's Health and Social Services
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DATA PROCESSING AGREEMENT TO ALLOW ACCESS TO WELSH ASSEMBLY GOVERNMENT FILES CONTAINING CONFIDENTIAL INFORMATION REGARDING SERIOUS CASE REVIEWS UNDERTAKEN IN WALES

Between:

(1) The Welsh Assembly Government of Crown Buildings, Cathays Park, Cardiff ("WAG")

and

(2) Heather Wood, Postgraduate Student, School of Health and Social Care, Bournemouth University, and Professor Jonathan Parker, School of Health and Social Care, Bournemouth University ("the Researchers").

We, the Researchers confirm that in being allowed access to confidential information being held on Welsh Assembly Government files regarding serious case reviews that have been carried out, will adhere to all of the conditions set out in Section 33 of the Data Protection Act 1998 which exempt certain data from the obligations of the Data Protection Act 1998 if certain research conditions are met, and in particular will ensure that:.

- I. The personal data will be used exclusively for research purposes (including statistical or historical research purposes). The personal data must not be used for any other purpose, not even for incidental use.
- II. The personal data will not be used to support measures or decisions relating to any identifiable living individual (not just the data subject but anyone who may be affected by the research).
- III. The personal data must not be used in a way that will cause, or is likely to cause, substantial damage or substantial distress to any data subject.
- IV. The results of the research activity, or any resulting statistics, must not be available in a form that identifies in any way a data subject. With respect to this condition, then if the circumstances of any individual are described in sufficient detail so that it is possible for

—

someone to identify that individual, (even by implication), then this condition will not be met.

In addition, the following conditions shall apply:

1. Without prejudice to the application of the Official Secrets Acts to any confidential information, the Researchers acknowledges that any confidential information obtained from or relating to WAG, the Crown, and its or their employees, servants, agents or sub-contractors, is the property of WAG or the Crown as the case may be.
2. The Researchers shall:
 - a. maintain in confidence any information or materials provided to it directly or indirectly by WAG under, or in anticipation of this Agreement, taking such reasonable security measures as it takes to protect its own confidential information and trade secrets;
 - b. treat all confidential information obtained as secret and confidential and safeguard it accordingly, and only use it for the purpose of this piece of research as set out in the letter dated 21st September 2009 from Heather Wood to Keith Ingham;
 - c. not disclose any confidential information to any other person other than those who have accepted obligations of confidentiality equivalent to these conditions and who need to have access to such information or materials in connection with the preparation of the feasibility testing report on a Risk Assessment Instrument, to assist professional decision making in the safeguarding of children.
3. Without prejudice to condition 2c of this agreement the Researchers shall not disclose any confidential information to any other person whatsoever without the prior written consent of the Party supplying it.
4. The Researchers shall provide all necessary precautions to ensure that all confidential information is treated as confidential and not disclosed (without the WAG's prior approval in writing) or used other than for the purpose for which it has been made available.

5. Where it is considered necessary in the opinion of the WAG, the Researchers shall ensure that any other person engaged by it in connection with the research shall sign a confidentiality undertaking in a form specified by the WAG.
6. The provisions of these conditions shall not apply to any information which:
 - is or becomes public knowledge (otherwise than by breach of this agreement); or
 - which is in the possession of the receiving Party, without restriction as to its disclosure, before receiving it from the disclosing Party; or
 - which is received from a third party who lawfully acquired it and who is under no obligation restricting its disclosure; or
 - which is independently developed without access to the confidential information; or
 - which must be disclosed pursuant to a statutory, legal or parliamentary obligation placed upon the Party making the disclosure including any requirements on the Welsh Assembly Government for disclosure under the Code of Practice on Public Access to Information published by the Welsh Assembly Government, the Freedom of Information Act 2000 or the Environmental Information Regulations 2004 and pursuant to Condition 27 (Freedom of Information).
7. Nothing in these conditions shall prevent the Researchers:
 - disclosing any confidential information which is required to be disclosed by an order of court or other competent tribunal or required to be disclosed by any applicable legal requirement; or
 - disclosing such confidential information as is strictly necessary for the purpose of obtaining legal advice or for the examination or preparation of the accounts of the Researchers to their legal advisors and accountants, provided that such legal advisors and accountants are bound by a professional duty of confidence.
8. Nothing in these conditions shall prevent the Researchers from using any techniques, ideas or know-how gained during the performance of

the research in the course of its normal business, to the extent that this does not result in a disclosure of confidential information or an infringement of Intellectual Property Rights.

9. In the event that the Researchers fail to comply with these conditions, the Client reserves the right to terminate this agreement by notice in writing with immediate effect.
10. The information requested will only be made available on the WAG'st property in Cathays Park, Cardiff and by prior arrangement with the Children's Safeguards Team. No attempt should be made to photocopy any of the documents or to remove any of the documents from the premises.
11. In order to ensure that the WAG is satisfied that no individual can be identified from any of the information contained in the final report, a copy of the final document must be submitted to the Children's Safeguards Team for approval before it is made public. The Assembly Government reserves the right to prevent the publication of this research and prevent its wider dissemination, if it believes that individuals can be identified or any of the conditions above have been breached.

Signed:

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Name and Position:	Heather Wood Postgraduate Student Bournemouth University	Professor Jonathan Parker School of Health and Social Care Bournemouth University

Date:

Appendix D

Publications on Risk Assessment in Child Protection in North America and Britain during the 1990s

These publications are roughly contemporaneous with the studies summarised in 'Messages from Research' published by Department of Health in 1995. They reflect the relative interest in the USA in the use of large scale databases on child protection cases and the development of formal risk assessment tools. In contrast, 'Messages from Research' uses largely qualitative sources and explore the concepts around child abuse and neglect and the ways in which services respond to families.

Of these published papers relating to the risks of child maltreatment, nineteen are UK studies and forty one are North American.

NOTE: Most of these publications are in American journals, but those published in the UK are indicated in **bold** text. The order is chronological, not alphabetical.

1. Dawer, R.M. & Faust, D. (1989) Clinical versus actuarial judgment. *Science*, **243**(4899), 1668.
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5. Pecora, P.J. (1991) Investigating allegations of child maltreatment: The strengths and limitations of current risk assessment systems. *Child & Youth Services, 15*(2), 73-92.
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7. Doueck, H.J., English, D.J., Depanfilis, D. & Moote, G.T. (1993) Decision-making in child protective services: A comparison of selected risk-assessment systems. *Child Welfare, 72*(5), 441-452.
8. Nasuti, J.P. & Pecora, P.J. (1993) Risk assessment scales in child protection: A test of the internal consistency and inter-rater. *Social Work Research & Abstracts, 29*(2), 28.
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10. Danoff, N.L., Kemper, K.J. & Sherry, B. (1994) Risk factors for dropping out of a parenting education program. *Child Abuse & Neglect, 18*(7), 599-606.
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14. Hegar, R.L. & Zuravin, S.J. (1994) Factors predicting severity of physical child abuse injury. *Journal of Interpersonal Violence*, **9**(2), 170.
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16. Milner, J.S. (1994) Assessing physical child abuse risk: The child abuse potential inventory. *Clinical Psychology Review*, **14**(6), 547-583.
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19. Dingwall, R., Eekelaar, J. & Murray, T. (1995) *The protection of children: State intervention and family life*, Avebury, Aldershot.
20. Dore, M.M., Doris, J.M. & Wright, P. (1995) Identifying substance abuse in maltreating families: A child welfare challenge. *Child Abuse & Neglect*, **19**(5), 531-543.
21. Falkov, A. (1995) **Study of Working Together 'Part 8' Reports: Fatal child abuse and parental psychiatric disorders an analysis of 100 area child protection committee case reviews conducted under the terms of part 8 of Working Together Under The Children Act 1989.** Department of Health, London.
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Appendix E: Case List

No.	Case details
1	<p>Parents had both been considered as Children in Need with troubled histories, mother not bonded with baby girl. Mother was the only child of family of five not to be taken into care. Father adopted as young child. Neglect observed. Mother ate very little. She was 16 when the baby was born, vulnerable and without family support. There was a history of domestic disputes during the pregnancy and mother also presented as depressed, unwell & withdrawn with bruising noted to forearms. She appeared unable to grasp what motherhood would mean & both parents hostile to professionals. She had a history of cannabis use. Becks Depression Index score = 21 – moderate depression. Midwives observed most of care & feed given by male partner and mother appeared uninterested in her. Baby developed problems at <1 month of age, said to have apnoeic attacks, breathing with grunting sounds & wheezing. She was admitted to hospital and then discharged. The parents continued with male partner doing most of care. They received an eviction notice for non payment of rent. Allegations were made by mother's aunt that she was rough with the baby and that the father was violent and the baby showed widespread bruising, which mother attributed to the way in which she'd been picked up and also to grasping her hand whilst 'walking' her, while father said they were caused during dressing the baby 2 days previously. The bruising was attributed to accident but the mother and child subsequently failed a number of appointments and could not be contacted at home or by phone. Child admitted to hospital with serious injuries including a broken arm attributed to her pushing herself against father's chest. Fracture considered non accidental, but radiologist and paediatrician disagreed on this & consultant refused to do a skeletal survey, later argued with designated doctor & discharged baby home. Parents had been reluctant to allow the baby to stay in hospital, father v aggressive and insistent about taking baby home. Again parents failed appointments following discharge & refused to attend multi agency meeting on case. S47 investigation - noted to have graze on back of head. No explanation, mother reluctant to undress baby or feed her, refused examination until threatened with court order. Parents separated, and same day baby brought to hospital by ambulance with respiratory arrest, died of brain damage following severe hypoxia, skin bruising noted. Multiple healing fractures found on skeletal survey. Parents did not visit in hospital while in PICU. Examination showed 15 rib fractures, old spinal & arm fractures, both retinas detached, brain dead, child died. Parents charged with cruelty.</p>
2	<p>Two children aged 3 and 5 years old smothered by mentally ill father and placed in the bath to make it look as if they had drowned whilst their mother was out. Mother was a former child in need, with alleged abuse to her, history of domestic violence & mental health problems & solvent abuse, own violent behaviour. Father with criminal history inc. arson, under-age sex, substance abuse plus bipolar disorder & threats to partner & children. Both children found dead in bath, father jailed for their murder.</p>
3	<p>Massive multivolume report on sexual abuse within a family with 4 siblings and other children involved.. Case notified October 2006. The High Court dismissed the care order application when the children had lived away from their parents for 2 years. The case centred on the fact that the children had been considered to have been sexually abused by other children and that their parents had failed to protect them from that abuse. 5 year old girl alleged to have been found while being sexually abused by 11 year old unrelated boy with learning disabilities, alleged other older children, possibly Schedule 1 offender because the medical evidence suggested that the child's indications of sexual abuse could not all have resulted from the contact with the 11 year old. . Medical concerns suggested chronic abuse, denied by parents. History of paternal violence towards mother and he also had a history substance abuse (prescription drugs). Accounts and medical evidence were very contradictory throughout the investigation of the case which contributed towards a complex report.</p>

7	<p>Case notified 5/12/05. Incident involves a very premature baby boy (24 weeks gestation) on SCBU aged 4 months since birth, with major developmental delay. Child found to have sustained a spiral fracture of his femur & bruising whilst on the Unit, considered non accidental. Abdominal bruising had been seen previously, but had been considered accidental. Baby is the youngest of 3 children and mother was aged 20. She had been in relationship with father since she was 16 and her own family were well known to social services. She was suffering with unspecified emotional difficulties at the time of the incident and was under strain due to long distance travel to visit the baby when she had young children already. . Father was aged 31 with history of many convictions 5 severe sexual and 5 violent offences mostly against children but also some adults, plus public order & property offences. He had another child by another partner and was not always resident in the household with this family due to child protection plan for the 2 older children but he was allowed to return because of mother's 3rd pregnancy and need for his support. There were allegations from children and the girl herself in the family of physical and sexual abuse of his older daughter, aged 3 years and physical abuse of the younger daughter aged 1 year. All the children were on Child Protection Register at risk of sexual abuse. Baby boy was born at 24 weeks gestation, still on neonatal intensive care unit and injuries identified immediately after a family visit. Perpetrator not identified, father initially accused hospital staff of harming the child and had a history of verbal aggression with hospital staff whilst mother was very quiet and compliant with advice. Hospital staff had witnessed father threatening mother & pulling her hair during visits, but both parents denied domestic violence. Baby was discharged to foster care & care proceeding for all 3 children, although the 2 older children remain at home with mother.</p>
8	<p>Case notified 8/11/04. Girl aged 2 years 3 months died of a subdural haematoma. She was on Child Protection Register at the time and was the youngest of 3 children of her mother. The incident was explained by mother and her husband of five months (not father of any of children) as resulting from him tripping & falling whilst holding child. Hospital noted other extensive bruising & impetigo, other injuries found on examination including a 'branding' burn to left foot, a broken arm and a crushing injury to her right hand. The family had been known to social services in relation to domestic violence by mother's previous partner & chaotic lifestyle. The house was used for drug taking and was very noisy with behaviour that neighbours found unacceptable. Both mother and her partner were heroin users and mother had suffered substantial domestic abuse (including head injuries) from a previous partner and had a history of convictions for ABH & possessing an offensive weapon. She had poor relationships with former neighbours and had been served with an ASBO. The second child and third child had behavioural problems at school with violence to other children. She also had a history of depression. Her first 2 partners had served prison sentences and the 2nd partner had physically abused the two older children leading to Child Protection Register registration. Surviving children now subject to care order and placed with foster carers. 2nd partner had experienced feelings of paranoia and had been involved in the theft of a car which was then used to run down and kill the car's owner. Mother convicted of child cruelty and partner with cruelty, wounding and manslaughter. Both parents failed to seek medical attention for the case child and prevented professional access.</p>
9	<p>Sexual abuse of 16 year old boy by adult whom he knew through Boys Brigade. Perpetrator had been grooming the vulnerable boy and was on license following convictions for other similar offences and was convicted in this case too. The boy concerned was vulnerable in that his mother had suffered numerous episodes of mental ill health and he had been brought up mostly by his maternal grandmother. He is described as borderline dyslexic and autistic. He had lost significant adults in his life: his grandfather when he was 11 and his uncle when he was 14. He had experienced bullying at school and is described as depressed, almost suicidal at time received counselling and was being referred to the youth psychiatric services. He was vulnerable to grooming from the adult sex offender. He collapsed following a blackout which was investigated for epilepsy and he had attended A&E following an assault and bruised testicle with dysuria. He made allegations against the offender at his college.</p>

10	<p>Unexplained severe injury to male infant aged 38 days, child brought to hospital with respiratory arrest, no history of trauma disclosed. Skull fracture, subdural haematoma and injuries consistent with shaken baby syndrome, non accidental. Taken to GP with reported apnoeic episodes & unconsciousness, GP very concerned & called ambulance. At hospital, additional injuries found on admission including old fractures. Child left blind and permanently disabled in consequence of brain injury. Mother blamed the baby's delivery for the brain injuries and later blamed her older school aged son for his handling of the baby. This was mother's second child, the first having a different father. There was a history of domestic violence. Mother had history of neglecting half sibling, previous partner had convictions for violence & she had been evicted because of noisy parties and men frequenting the house. The older half sib remained in mother's care but the injured baby was placed in foster care.</p>
12	<p>Case notified 19/01/07. Mother took 3 year old boy to a minor injuries unit with genital bruises, bite marks and a life threatening abdominal injury after return from staying with his father (non resident). The child required emergency abdominal surgery, but survived. He was the older child of two with a one year old half sibling. Previous anonymous referral when he was one year old for bruising and lack of care. On examination, the child was found to have bruising to head, injury to scrotum, & pubic bruising which was explained to have resulted from a fall. He had previously been treated for injuries at an out of area hospital including a laceration to his mouth, eyebrow, head, nose & ear and these were all attributed by father to falls from an upstairs window, a bunk bed and a fall in the day nursery toilet. He had a hearing defect & language delay. Father of the second child was not resident with the family but the children stayed with him sometimes. Mother was 15 when she became pregnant with her first child and she had a history of domestic violence perpetrated by her brother. The file doesn't say whether children remained with their mother.</p>
13	<p>Assaults on female infant aged < 1 year, second child of mother with a 4 year old sister. Mother considered to be at risk of depression following birth of baby and her previous partner (baby's father) was in prison remanded on a charge of attempted murder. She began the relationship with the perpetrator during her pregnancy and he had just been released from prison. He had a previous conviction for an offence against a child & domestic violence. He had had a previous child removed together with the children of his previous partner. Infant taken to minor injuries unit, then hospital in England, with a broken arm. Skeletal survey was undertaken, but the child left hospital before the results were received, but they were later found to show a fracture to the right arm, contemporary with the left arm fracture. Different explanations were given for the cause of the fracture, to the hospital and to the police. A subsequent episode of domestic violence was alleged. Checks were undertaken, but the new partner had given an incorrect date of birth. These checks revealed a history of 7 convictions for violent offences and domestic abuse. The baby was brought to hospital again with bruising to her face and neck consistent with non accidental injury. Mother then confessed that she had lied about the earlier injuries. Mother convicted of neglect & attempting to pervert the course of justice, male partner convicted of Grievous Bodily Harm and Actual Bodily Harm.</p>
15	<p>Case notified 3/11/07. 3 month old child who was placed with relatives (no details) sustained non accidental significant physical injuries and a fit. He was found to have a subdural haematoma, a fractured rib & clavicle, neck scratches and retinal haemorrhage. He was the only child of his parents. He had been cared for by his father during the previous day. Parents were unable to explain the injuries. Father was unknown to social services but mother had been involved as a teenager when she ceased attending school to work in a pub and was alleged to have stolen money from pub safe. Father had previous unsubstantiated allegation of elder abuse against a grandparent, but there is no detail on his history. Injuries considered non accidental and to have been inflicted over a period of time & likely to impair his development.</p>
16	<p>Case notified 2/08/07. 10 year old girl suffered persistent sexual abuse by the 19 year old adopted son of the family where she was fostered. The girl and her brother had been placed in care due to neglect and abuse by their mother and had been fostered since she was 6 years old,</p>

	<p>suffering abuse throughout the 4 years. No agency was aware of the risks posed by the teenaged adopted son, who had come into care following physical abuse by his parents and sexual abuse of his sister. Adopted child detained for public protection, expressed no remorse but pleaded guilty and was imprisoned. Disclosure by victim's brother, who witnessed the abuse. The adopted boy was known to Youth Justice agencies for offences including theft and burglary, common assault. Considered to be emotionally immature and manipulative. Risk of sexual abuse not realised. The family included an 18 month old foster child, an older brother and sister of the perpetrator and another older unrelated adopted child. The foster mother also had 2 of her own children and a 9 year old granddaughter living with her. She was a single parent, separated from her partner. Not all these children were resident during the whole 4 years of the offences. One further grandchild of the foster mother was killed on the railway line bordering her land, aged just 15 months. The foster mother had problems with her emotional health and coping with all the children, the home was in a chaotic condition and there were few boundaries and rules for the children, who appeared neglected at times. The adopted son had fathered a child himself with a girlfriend, but took no interest in this infant. He was sentenced to 12 years imprisonment.</p>
<p>18</p>	<p>Infant aged 2 months died following collapse, non accidental brain injuries suspected while in care of father. Considered to be natural causes until birth of 2nd infant, who was taken to hospital at 11 weeks old with facial injury. Subsequent review of cases led to 2nd child on Child Protection Register, father charged with murder of 1st infant & mother with failure to protect. Father died in custody before he came to trial. Father had convictions for dishonesty, but not violence. He had a history of anxiety/depression and had taken serious overdose. Case notified October 2007. Both children lived with their married parents. The older child was admitted to hospital aged 2 months after father described him having uncontrollable hiccups. The baby was resuscitated but died. Brain injuries (subarachnoid haemorrhage), bruising to abdomen, jaw, base of neck were found on postmortem suggesting severe trauma and some of which occurred prior to the day he died, and not to resuscitation efforts. Despite this, the Coroner recorded an open verdict, death by natural causes. The younger brother was taken to A&E with facial injuries, explained by father as due to him tripping and kicking a toy against the baby's head as he lay on the carpet. The consultant neurologist referred the case as one of child protection because injuries were not consistent with explanations. He was placed with foster carers on discharge from hospital and later with his maternal grandparents on a Care Order. Exclusion orders were made to forbid father and mother from entering the home area of grandparents. Father was charged with shaking the older boy causing the injuries leading to his death. The case of the younger child was considered to be due to injuries inflicted by the father but that the mother had failed to protect him. Father died in custody before coming to trial.</p>

21	<p>4 month old male child taken to hospital by father following a head injury said to have been sustained when he hit his head on the hearth after trying to sit up unaided. Investigations showed 2 swellings to head, linear and bilateral skull fractures considered to be non accidental. The baby was the only child of parents with troubled background. Mother had history of emotional& conduct problem, overdoses, depression & self harm. She abused drugs and alcohol, including during her pregnancy and smoked heavily. . Father had history of conduct problems & Attention deficit hyperactivity disorder, misuse of drugs and alcohol, self harm unsure that he was the baby's father. His flat was verminous and dirty. Convictions for 39 offences dating back to when he was aged 13, including assault, public order, threatening behaviour. He had served a custodial sentence for racially aggravated abusive behaviour. He had been assessed as posing a low risk to children, but there were concerns about the care of a dog at his property. History of domestic violence during mother's pregnancy which led to her moving into a refuge and raised concerns about the safety of the unborn child because mother had a metabolic problem which affected blood clotting. She suffered a number of injuries during pregnancy following accidents including whiplash injury and falling downstairs. In the later stage of pregnancy she demanded an induction and threatened to take castor oil if refused. There were concerns about the mother's mental health after birth because of postnatal depression & concerns about the lack of plans and support to care for the baby. Mother also moved house many times due to homelessness during the early months of child's life and had no safe permanent accommodation. Child protection concerns were raised in relation to her moving in with father. Mother told health visitor that she hated the child and was unable to cope with his care. The maternal grandmother stated that father had thrown the child onto the sofa more than once. Case closed by social services.</p>
22	<p>Baby girl aged 3 weeks died while in homelessness hostel, causes were not determined although a number of injuries were found at postmortem. Mother and her partner had both used drugs and alcohol on the previous night. . Father had history of convictions for criminal damage, shoplifting, and drugs. Mother was aged 17, came from an abusive home and had a history of aggressive behaviour, depression, substance abuse & self harm. She was the eldest of 5 children and had suffered an assault by her partner in early pregnancy.</p>
23	<p>Baby aged 8 months hospitalised for fractured skull, other older injuries found. Non accidental injury suspected. Previous referrals for child protection concerns had occurred with the baby was just 1 month old due to a bruise on his arm for which there was no explanation. No further action was taken. 2 weeks later when the baby was 6 weeks old, he was again referred following a domestic violence episode when his mother was assaulted and the baby was thrown onto a sofa by his father. A further referral was made for the same concerns the following month. Parents had separated before these domestic violence incidents. Mother had a daughter aged 5 years by a previous partner who had suffered unexplained head injury when she was 3 months old and had subsequently gone to live with her biological father. Home had been used for drug misuse, many men visiting and serious property damage had occurred. Previous referrals from NHS and police had been made in relation to concerns about possible physical abuse of the baby and physical abuse by mother's partner, putative father of the 2nd baby.</p>

25	<p>Child was admitted to hospital aged 4 months following episode whilst in the care of his maternal grandfather described by him as spontaneous screaming and convulsions. On examination, injuries determined as non accidental – bruise to left ear, two subdural haemorrhages, retinal haemorrhages. No history of trauma reported by family. On examination he had a bruise on his left ear, two subdural haemorrhages and retinal haemorrhages. No family member reported a history of trauma. He was placed in foster care but later returned to his parents' care after court hearing. He was an only child and his mother and her boyfriend lived with maternal grandparents. During pregnancy a rare abnormality was discovered affecting the child's leg development Child was initially placed with foster carers, but later returned to his parents. Injuries likely to result in permanent physical and mental disabilities and thought to be due to shaking. Child was born with limb abnormality of left leg and right hand due to intrauterine problem, only child of mother and her boyfriend who lived with maternal grandparents. Family history revealed that this infant's uncle, a child of the maternal grandfather had died aged 7 months in the care of the maternal grandfather. Described as a 'cot death'. Neither the child nor the family had had any prior contact with social services.</p>
26	<p>Baby aged 17 weeks, born 3 months prematurely, 1st child of 18 year old mother & partner, in neonatal ICU since birth. Had only been discharged home (on oxygen!) to parental care for 18 days before he died of head injuries related to shaking, both parents denied knowledge of incident. Parents had shown limited interest in visiting or caring for baby in hospital before discharge and resented requests to visit more frequently, verbally aggressive & declined help. Threatened with social services referral and visiting improved. No home assessment was done due to problems accessing home and visiting the baby. Bruising to the baby's face noted a few days before death and parents reported blue marks on face, facial swelling, and breathing problems, similar to anaphylaxis. Parents did not seek medical help. Marks consistent with bruising. Admitted days later to hospital, not breathing, no pulse and bleeding from nose. Died 16 days later. Injuries consistent with non accidental head injury, subdural bleed and multiple retinal bleeds. Parents described as detached and father controlling. Very little information on parent's backgrounds and extended family in this report.</p>
27	<p>Baby was on Child Protection Register at time of death from physical abuse. Postmortem findings showed both arms broken plus non accidental head injuries and bruising. Boyfriend (not father) who killed baby had history of assault & petty crime as well as substance abuse. Mother had 3 previous children all in care in other part of UK, history & current indications of injecting drug use and alcohol abuse and self harm. She had health problems related to hepatitis and her own mother had died of alcohol related accident when she was aged 13 & she had come into care. Placements frequently broke down due to mother's behaviour. Her first partner had an alcohol problem and all three children were taken into care with signs of neglect when this relationship broke down and father returned to Belfast & mother was admitted to hospital. Home conditions described as very poor. Mother lived in very inadequate & dirty accommodation, unsafe & unsuitable for young children, with frequent visits by Partner 2 (a Schedule 1 offender with a conviction for violent offences against his previous partner & history of physical abuse of daughters), so 3 children stayed in care until better housing could be found. Mother then failed to keep access appointments with her children while they were in care. There was substantial domestic violence between mother and partner 2 and relationship ended when mother moved in with new Partner 3 and left the area. Oldest child expressed unwillingness to go home & leave foster care. All 3 older children effectively abandoned in care & freed for adoption. Mother returned >2 years later and sought help with drug abuse, but left the area again & moved twice. She admitted to mental hospital with drug abuse problems, health then deteriorated seriously and she again became homeless and pregnant having left baby's father. Failed to keep antenatal appointments, went missing & sleeping rough. Boyfriend/ possibly father of baby had convictions for violent offences, no access to his children from previous relationship. After baby's birth, mother kept in hospital due to existing health problems & father's behaviour unacceptable to hospital, mother disclosed violence, his alcohol problems & fear that he will kill her. Rehoused in refuge. Mother rehoused to temporary accommodation, but found to be leaving child with different men when she went</p>

	<p>out. Baby taken to hospital, dead on arrival with multiple bruises & marks to face & head. One episode of bruising to child's eye noted one month before death. Boyfriend convicted of manslaughter.</p>
30	<p>Baby aged 6 months suffocated in pushchair under older brother, who had been placed on top of her. Both children on Child Protection Register for neglect at the time. Mother with learning disabilities had a long history of sexual and physical abuse & behaviour problems. Vulnerable family exploited by local drug users.</p>
31	<p>Premature infant (26 weeks) born after mother admitted with obstetric emergency due to assault. Died in hospital aged 2 days. Father had a history of mental health problems with paranoia and serious domestic violence when older sibling was present. He also had a long criminal history relating to drugs, stolen property, and violent assault. He had a history of depression with persecutory ideation and substance abuse. Mother also thought to have been violent towards father. Mother had a history of depression and had had psychiatric input since she was 14 years old and a long history of injuries with vague explanations. She had many failed appointments with baby clinics. This was the second of two children; the first being 22 months old at the time of the death of the second infant, though the father had disputed his paternity of this older child. The parents were unmarried & not living together and the father had a previous child aged 6 years old. Neighbours had complained about noise, nuisance and abusive language and damage to property by father. He was charged with Actual Bodily Harm towards mother, but she withdrew from the prosecution. Police notified a child at risk following this and the couple separated but father continued to harass mother & violence continued. Mother refused emergency rehousing; children's social services appear to have taken no action. Mother's family had been known to social services and her parents had divorced and remarried. Father was one of 5 children, with a history of adult psychiatric involvement, during which he had expressed thoughts that he could kill someone. Following the death of the baby, the older child continued to live with mother and was not on Child Protection Register. Father was convicted of manslaughter of the baby and Grievous Bodily Harm to mother in December 2000.</p>
32	<p>Girl aged 8 disclosed abuse of self and siblings when in day care. Chaotic family, seen as 'vulnerable'. Physical and sexual abuse, severe neglect of younger children, children are dirty & rejected by peers, many minor injuries and poor home conditions & environmental health concerns, complaints from neighbours about noise and rats. There was an anonymous child protection referral 4 years previous to case review. Child 4 failing to thrive hospitalised for under feeding, chronic cardiac condition, developmental delay, special needs. Father main carer, deteriorating with mental health problems & alcohol abuse. Mother epileptic, not compliant with treatment. Domestic violence suspected. Mother declined parenting support. Eldest girl disclosed sexual abuse by many adults (intra and extra familial) despite threats to her by mother to kill her pet hamster. Children were observed at family support nursery to have bruising extensively and to be poorly dressed for cold weather and hungry. Other children rejected than because they were smelly and had bad breath due to poor dental hygiene & decayed teeth. They used bad language and swore at staff and demonstrating sexualised behaviour.</p>

33	<p>Two boys found to be seriously neglected and malnourished too weak to stand or walk when admitted to hospital in 2004 aged 4 years and 20 months respectively. The 4 year old was still in nappies and had neglected and excoriated skin due to urine and faeces on dirty clothing, both, cold and smelly, severely underweight. Both children were placed in foster care immediately. They were the middle two of four children and one older sister (living with her paternal grandparents) and a younger 2 month old baby sister. Mother convicted of child neglect & cruelty. The 3 older children had different father from the youngest child. Family known to feature domestic violence, criminality, consistently failed appointments at home and with services, non cooperation. The home was consistently in poor condition, with rubbish and dirty clothes & bedding, smelling of urine and drug paraphernalia lying around including needles, considered unsafe for young children. There had been 9 previous child protection referrals (five from the police) but the last was in 2004. This was an anonymous referral stating that the children were confined to a bedroom and fed through a safety gate and evidence of padlocked doors was found. The resulting SW visit led to the boys being admitted to hospital for medical assessment against mother's wishes (reluctant consent): she refused to accompany them to the hospital. The mother's partner was involved in crime and had convictions for theft, burglary & supplying Class 2 drugs. Oldest child living with paternal grandparents, different father from other two following a divorce, and all 3 older children had lived with their father and their mother, and 2 further partners of their mother - multiple carers. The father of the youngest child was not contacted about the case. Mother had a history of sexual assault by 3 boys at her school when she was 14 but had been considered able to protect herself. She had a history of depression.</p>
34	<p>13 month old toddler killed by mother's partner, 50 other injuries found as well as serious head injury, previous mistreatment allegations & domestic violence, suspected drug misuse. Ambulance crew called because child not breathing noted severe facial bruising. Explanation of child 'going floppy' while mother's partner feeding him. Mother stated that child had fallen from settee & landed on head. Other inconsistent explanations offered. 3 weeks before his death, child had been taken by mother to hospital with an arm injury, but mother did not wait for him to be seen. There was an anonymous referral stating that the child had bruises and that mother's partner was a drug user. Social services involvement very limited and following the anonymous referral, they wrote to mother asking her to come to the offices and discuss the allegations, but the letter was sent to wrong address. The same anonymous caller rang again to ask about action taken but there was change in plan. Male partner had mental health problems, history of self harm and made attempt to hang himself. He had a history of severe physical abuse and neglect as a child and both he and his siblings were on Child Protection Register and had been in care. He had convictions for theft, burglary, criminal damage, threatening behaviour & violence including Grievous Bodily Harm and had a history of domestic violence with previous partner when he broke into her home whilst she and their child were asleep. He assaulted a friend of previous partner and served a custodial sentence.</p>
35	<p>Case notified 2004. 14 week old baby found unresponsive at home in early evening, taken to hospital and resuscitated but died of catastrophic head injury. Baby was the 2nd of 2 children with an older sibling aged 17 months living with mother and putative father. Mother had a history of paracetamol & alcohol overdoses (aged 14 & 16) and depression (Child and Adolescent Mental Health Services (CAMHS) and adult mental health services involvement) there was evidence of past domestic abuse at a time when mother and children were living with maternal grandmother. She had herself been on the Child Protection Register as a child following abuse by extra familial but neighbourhood person (no detail. She attended the hospital emergency department with a facial injury caused by a boyfriend at age 16 and later following a physical assault by her uncle. Father had previously been cautioned for a violence related assault (domestic) towards mother. Baby was found dead face down on sofa at home with both parents present. Mother's 2nd child, late booking for antenatal care and baby had a history of weight loss. History of failed appointments with both children. Mother had history of self harm and was discovered to be a Schedule 1 offender in relation to a child on child assault when she was in her teens. She served a sentence in a Young Offenders Institution. She also dropped out of school and failed to attend the alternative provision offered. She declined some services and failed appointments and had a number of convictions relating to drink & theft. Father had a history of offences including violence, plus a history of mental</p>

	health problems, overdoses & alcohol abuse. Father admitted killing the child.
36	<p>11 year old girl was placed on Child Protection Register in June 2006 after alleged prolonged serious sexual abuse by her stepfather since she was 3 years old, and by her 16 year old stepbrother (staring when he was aged 13 and she was 7, but he denied continuing). The man's own 18 year old daughter also made similar allegations, having demonstrated behaviour problems since she returned from living in Germany with her mother. Her grandmother had also reported to police that she would not go home or speak to her family on her phone. Child protection investigation led to mother stating that she would separate from stepfather and not allow access to child. No action was taken in relation to the stepbrother who remained at home. But stepfather found not guilty of charges against his own daughter and he returned to the family home. The stepdaughter made further allegations of sexual assault at school and this was substantiated by investigation. Stepfather later admitted charges, stepdaughter removed from the home into care of maternal grandmother. Biological daughter had also made allegations at school that her stepfather had sexually abused her since she was 3 years old. Stepfather later convicted having admitted offences. The stepbrother was to be placed with her paternal grandparents and not to return to stepmother's home. Stepfather had been charged with sexual assault on a woman 8 years prior to this case but he had been acquitted in Crown Court.</p>
37	<p>Twin died aged 1 month, brought to hospital by father at 5am, history of being in bed with father and lifeless when he woke; death confirmed. When health visitor visited same day, surviving twin found in bed in poor condition with breathing problems & cyanosis, a grubby baby: hospitalised & needed resuscitation. Older children quiet & subdued. Skeletal survey of dead twin showed fracture to skull, 2 tibial fractures of differing ages & signs of rough handling. One of 4 children of parents aged 2 years, 1 year and twins aged 4 weeks, but mothers of father's other previous children have made allegations about his abuse. Mother was of Asian origin, father white British. Father dealt drugs and there was domestic violence, mother had a history of depression following birth of 1st child (she refused psychiatric referral) and the child was stated to be small for his age & underweight with a small head circumference at age 8/52. Mother discharged her 2nd child against medical advice from maternity ward & the baby had no name for > 1 month. Many failed clinic appointments for antenatal and postnatal care, minimal antenatal care for twin pregnancy & twins born small for dates, father showing little interest in them & not supportive, noted to handle them very clumsily. Other families with children on Child Protection Register staying at house plus other adults. Previous serious child protection concerns about 2 older children handled as child in need. Parents then refused support plan and no further SSD involvement until child died. Two previous child protection referrals in relation to family after neighbours expressed concerns re. 2 year old wandering streets unsupervised and adults screaming about 'can't belt a baby like that. Father's involvement with drug dealing,, plus state of house ('cesspit', according to police) and garden, people sleeping in cars in the garden and the severe neglect of the family's dog. A previous dog had been removed by the RSPCA seriously emaciated. Nursery places offered, but refused by parents (they cited 'legal advice' that they didn't have to accept it) and social services withdrew after decision making process not followed. The police had raided the house but there was no liaison between police and social service. Father very domineering, but mother had hit oldest child in front of midwife. Children generally seen to be 'nicely presented' but birth of twins seen as difficult for family to cope with. Nursery staff visited and were concerned at state of home. Two months later, one twin died and a child protection procedure was launched. The other children were immediately placed with foster carers 19.12.01, surviving twin in hospital with decision that mother was not to be left alone with surviving twin or be allowed to remove baby. All contacts with children to be at nursery & supervised.</p>
38	<p>Abuse & homicide of 7 month old infant (head injuries with inconsistent & contradictory explanations) by mother who had previously assaulted an older baby (at age 9 months) leading to bruising of face and unspecified fractures. Older child had been wary of adults, weight falling rapidly across growth chart percentiles. The older child was returned to mother's care</p>

	<p>following a specialist assessment that she had a 'theoretical ability to parent' but there was uncertainty about who caused injuries to older child. Social services appear to have downgraded risks to children in this case. The baby that died had previously been placed in foster care at birth and was placed with mother for the first time in her life. Long multi-generational history of family sexual abuse and neglect had led to mother and maternal grandmother both being in care. Mother had been in care herself as a child after sexual abuse of her older sister by their father, she also had a history of repeated self harm, alcohol & drug abuse and had also contracted hepatitis C, very depressed and suicidal, placed in a Secure Residential Unit after she had jumped from the roof of her previous unit & broken bones including vertebrae. All her siblings had been in care. She was referred again later at age 13 years 11 months after going missing with a 20 year old boyfriend. She alleged rape by a family friend & violence from her own father, but case was later closed. She left care at age 16 to live with an older brother, but the self harm continued. She had a miscarriage aged 17. During her pregnancy with the older child, she failed appointments for psychiatric support. She continued to be depressed and unwilling to care for the baby (taking little part in his care) and responded to child's crying by placing a hand over his mouth. He was found to have facial bruising. She stated that she did not want to care for the baby & requested that he be accommodated and later terminated a subsequent pregnancy. Day care and respite was offered instead, but mother then assumed childcare for neighbours child! The case children had different fathers. Second baby's father's history included a conviction for rape, involvement with drugs and fraud. Paternal grandmother had care of 2 other grandchildren, following concerns about their care she reported to social services. Concerns had been raised about the mother's ability to parent a young child from professional and many other sources who knew the mother dating back to her first full term pregnancy. Previous child had been neglected and physically abused. Mother seen as primary client of social workers, father of 2nd infant refused to be assessed. Surviving child remained in care after death of baby.</p>
39	<p>4 month old female baby found dead in parents' bed. Third child of her parents, born in another part of UK, middle child had died aged 5 weeks, just 12 months before birth of this baby and there was a 2 year old sister. Cause uncertain – labelled SIDS. This child died whilst sleeping in parents' bed. The case infant was born 3 weeks premature with withdrawal symptoms requiring weaning off opiates. The new baby and the surviving older sister were placed on Child Protection Register. Parents refused detox. programme and claimed to be drug free by own efforts. Baby discharged to the care of paternal aunt, but the baby then returned to her parents' care 3 days before she died, although they had previously had little involvement with her care since birth. Both parents had disturbed childhoods and had been in care and there had been domestic violence between them. Their involvement with drugs had led to violent attacks on their home in England before the move to Wales. Baby died of unknown causes aged 16 weeks having been born addicted to opiates & still on medication. Previous infant had died at 5 weeks old, 12 months prior to this death. 1st child recorded as Sudden Infant Death. Both parents were dependent on drugs, refused detox. programme, and case child and a toddler sister were both on Child Protection Register for neglect. When parents claimed to be drug free, they were allowed to care for index child although she had been in voluntary care of a paternal aunt previously & parents had had little contact with her. 3 days after she returned to parental care, infant was found dead. Drug use paraphernalia found all over house.</p>

40	<p>Case concerns 15 year old girl reported missing and found 2 months later in shallow grave. Stepfather convicted of murder. Stepfather had lived with family for most of her life and there were 2 younger half siblings. Murdered girl had run away from home on a number of previous occasions & had poor school attendance and achievement, Education Welfare officer involvement led to referral to social services. Previous history suggested possible long term sexual abuse. She had been on pill and involved with much older boyfriend who took an overdose to persuade her to continue the relationship.</p>
41	<p>Female child died of suspected uncontrolled epileptic fit aged 5 years without medical attention. A taxi driver refused to take her to school on the day she died because she looked so ill, but mother insisted. Driver later reported incident. She was born prematurely & suffered lasting disabilities resulting from her prematurity - cerebral palsy & hydrocephalus & epilepsy controlled by drugs. She had been in hospital for 5 months after birth. She was not growing well, although she gained weight well in hospital. She was prescribed dietary supplements, but parents did not give these. Mother expressed very negative feelings about her disability and there is evidence of scapegoating. 5th of 8 children, 2 of whom in care following physical abuse and not in touch with mother. Father of some of children not always living in the house & relationship was volatile. Died aged 5 years. Concerns from birth re poor maternal attachment & parenting skills, neglect. Mother had a long history of abuse as a child, was in care herself, had been excluded from school and had a history of sexual assaults against other children when she was 12 and violence involving threats with a knife. She had many convictions including violence. Her first 2 children were already in care following abuse. Diagnosed as having a personality disorder & mental health problems, but was only in intermittent contact with psychiatric services. Both parents misused drugs and there was domestic violence by mother. The existing children were seen to be at risk of neglect and emotional harm and there was a Case Conference before baby returned home. They exhibited intimidation by mother, challenging behaviour and some did not want to return home, one refusing to get out of the car on arrival. School attendance was poor for all the children and there was poor dental hygiene, behavioural problems. A previous head injury had not led to the mother seeking medical attention for child. Child protection concerns before child's death – neglect, failure to seek medical attention following a fall and resulting head injury with vomiting for 3 days, bruising to cheek (blamed on other children), intimidated by mother, challenging behaviour by children and epileptic drug prescriptions had not been collected and her anti epileptic medicines or diet supplements (for failure to thrive) had not given for months. Cause of death attributed to uncontrolled prolonged fit. Parents were not prosecuted.</p>
42	<p>Twin died aged 1 month, fractured skull and two tibial fractures found & head injuries found. Other twin seriously ill with bronchitis. One of 4 children of parents, but mothers of father's other children have made allegations about abuse. Father dealt drugs and there was domestic violence, mother had a history of depression and many failed clinic appointments for antenatal and postnatal care other families with children in Child Protection Register staying at home and other adults. Previous serious child protection concerns about 2 older children 'converted' into child in need. Parents then refused support plan and no further social services involvement until child died. Two previous child protection referrals in relation to family after neighbours expressed concerns re. 2 year old wandering streets unsupervised and adults screaming about 'can't belt a baby like that. Father's involvement with drug dealing,, plus state of house ('cesspit', according to police) and garden, people sleeping in cars in the garden and the severe neglect of the family's dog. A previous dog had been removed by the RSPCA seriously emaciated. Nursery places offered, but refused by parents (they cited 'legal advice' that they didn't have to accept it) and social services withdrew after decision making process was not followed. The police had raised the house but there was no liaison between police and social service. Father very domineering, but mother had hit oldest child in front of midwife. Children generally seen to be 'nicely presented' but birth of twins seen as difficult for family to cope with. Nursery staffs visited and were concerned at state of home. Two months later, one twin died and a child protection procedure was launched. The other children were immediately placed with foster carers 19.12.01, surviving twin in hospital with decision that mother was not to be left alone with surviving twin or be allowed to remove baby. All contacts with children</p>

	to be at nursery & supervised.
43	Mother cut her wrists and child found in a severely neglected state when police forced entry to home. Concerns previously expressed by extended family member. One of 2 children, parents not together. Mother with mental health problems, previously involved with Child and Adolescent Mental Health Services and Social Services, accommodated during own childhood. Mother pregnant at 15. Domestic violence within parental relationship involving police & housing department & allegations of red marks on older child's neck.
44	13 year old child with a long history of repeated sexual assaults and sexual activity dating from age 8 years, also child had special needs & hearing loss and a history of self harm, substance abuse & petty crime. Fearful of being left alone at night. No assessment occurred because the sexual assaults were deemed to be extra-familial and that mother was capable of protecting her. Mother was a young single parent with her own history of drug use and depression. Home conditions unsatisfactory and child had not always been adequately dressed for school and not well fed
45	Mother had Asperger's syndrome & mild learning difficulties, failed appointments in pregnancies, behaviour erratic and parenting ability uncertain. Boyfriend is alcoholic baby's father convicted of robbery. Mother threatens suicide after argument when baby one month old. Previous maternal overdose history, mental health act powers considered. Mother depressed & not eating properly stressed re baby having colic, crying inconsolably, later requests child be taken into care as she cannot cope – to foster care but later returned to mother despite professional concerns. Mother failed to take up support services. Head injuries x2 over short period of time, homelessness, mother raped, further overdose. Child A died aged 2 years. Mother pregnant with 2nd child, takes further overdoses & reports seizures herself. Mother and new partner increasingly resistant to engagement with services & risk to new baby B. Mother collapsed from alcohol & overdose, partner alleges baby is unsafe in her care. Family members allege neglect of child B, Children and Family Court Advisory and Support Service involved. Mother continues with chaotic behaviour, sometimes leaving child B alone in bathtub & house very cold. Mother failed to engage with Community Psychiatric Nurse & became homeless. With poor relations to previous family support. Rehoused, but child B unsafe & unsupervised in new home, Non accidental injury suspected.
46	3 rd of 5 children of parents heavily involved in crime and drug dealing and frequent violence. Children neglected and parenting poor, home conditions very poor with much antisocial behaviour & criminal involvement. Parents intimidating of services and hard to engage with. Child excluded from school due to severe behaviour problems & attacks on other children & staff. He also has a long history of involvement with the police for a large number of offences. Substance abuse and violence involving parents and children. Child took an overdose of a mix of drugs and is in a persistent vegetative state due to severe brain damage.
48	Child drowned in bath by mother who had a long history of mental health problems including overdoses. Child was born 10 weeks prematurely and mother's mental health deteriorated postnatally. The child was diagnosed with cerebral palsy, which was mild in its effects. Mother's relationship with her partner broke down and she drank heavily but homicide risk not suspected.
50	8 weeks old baby admitted to hospital following domestic violence at home between parents. Baby pronounced dead. Extensive history of violence and alcohol abuse and mother had had a previous child adopted. An older child lived with her and fled the house during the violent episode. One family member attacked with axe and mother threatened with a knife. Home conditions were poor.

51	<p>Child aged 12 stabbed by father with mental health problems (paranoid schizophrenia with strong and persistent delusions) dating back many years, previously detained under Mental Health Act and many admissions in UK and USA. Mental health team were well aware of his home circumstances. He had expressed ideas to his psychiatrist 5 years previously of doing away with his family and had stabbed himself in the past (9 stab wounds to chest in one episode. His wife had expressed concerns for the safety of the children and fears about being in the house with him and the children, but at the time of the attack on the child the father considered the previous threats to be historic and delusory. Father found not guilty by reason of insanity and detained indefinitely. No child protection referral ever made.</p>
52	<p>Child presented at hospital with multiple injuries of different ages. She had presented at many hospitals on many previous occasions with history of minor injuries due to falls, inc head injuries & feeding problems. Skeletal survey revealed multiple fractures. Child survived & she and a premature infant sibling still in care. Mother and male partner (not child's father) convicted of assault, neglect & ill treatment. The biological parents had separated before the child's birth and there was no information on child's father. Mother had been registered in relation to emotional and sexual abuse as a child herself and both she & her sibs had been in care. She was concerned that her mother would wish to take over the care of this child too. She also had a history of mental health problems including severe depression and 'relationship problems' including taking an overdose during pregnancy & had discharged herself and her child from hospital against medical advice on a number of occasions. Male partner came from a traveller family with many moves & insecure accommodation, behaviour domineering and locked mother & child into home on occasions, plus there was evidence of domestic violence history. The family had multiple social problems over several generations. Case child had been born with talipes and had been on Child Protection Register for risk of physical harm following being left in the road during a domestic argument, she had also been taken by her mother to the local social services department and later to a police station before being placed for several months with mother's partner's parents, also travellers. Domestic violence history known plus itinerant lifestyle staying with various relatives & living in caravan on insecure sites. Some child health records were lost in this process.</p>
53	<p>Mother cut her wrists and was found with 3 year old younger child of two in a severely neglected state when police forced entry to home. Concerns previously expressed by extended family member. One of 2 children, parents not together, unsupported mother isolated and refused access to services. Mother with mental health problems, previously involved with Child and Adolescent Mental Health Services and social services, accommodated during own childhood. Mother pregnant at 15. Domestic violence within parental relationship involving police & housing department & allegations of red marks on older child's neck. Mother convicted and imprisoned, Schedule 1 offender.</p>
54	<p>Father with a history of depression and suicide attempts and sexual offences against his own sister and other children – Schedule 1 Offender. Both his children by his first marriage were on Child Protection Register and subsequently subject to Care Order, although they were both returned to the family under Supervision order. Son fell downstairs, no medical attention sought. Concerns re. Safety of children and wife accusing father of physical and sexual assault. She moved to a refuge and he was charged with buggery & carrying offensive weapon. 3rd child stillborn. Supervision order lapsed. Marriage ended with son remaining with father, daughter with mother, 2nd relationship with woman of low intelligence with one previous daughter led to birth of 2 more children, one of whom was placed on Child Protection Register for emotional harm. Domestic violence in this relationship although father disabled due to injury leaving him with mobility and continence problems & depression. Son of 1st marriage accommodated following accusations of physical assault, but moved between both parents, known to have ADHD. Second child born prematurely at home at parental insistence & before midwife or ambulance present, ambulance crew refused access to mother and baby by aggressive father. Case baby aged 1 month admitted to hospital with suspicions of neglect & cruelty, suffered breathing problems & died. Both parents charged with Child Neglect, but mother subsequently found dead at home (suicide) so father convicted of wilful neglect.</p>

	Family movements between areas impeded early access to full history of father's offences.
55	Nine year old girl admitted to hospital after collapse, needed resuscitation. History of poor health, poor growth by all the children and hygiene noted by school. Noted to be underweight, poorly nourished and with poor hygiene. Found to be suffering a rare inherited immunological condition. Family had history of harassment by neighbours, poor home conditions including rat infestation. Children bullied at school, one sib deaf from birth. All 5 children noted to have consistent poor hygiene. Mother & father both felt to be incompetent parents but agency support for children in need very limited.
56	2 year old child taken into care with abused baby half brother. Stressful relationship between mother and new partner, so offered day nursery. Mother had trained as a nursery worker, but had not completed her course. Child 1 had previous hospital admission with bruising following alleged fall caused by dog. Partner had convictions for violent assaults on police, domestic violence and motoring offences. 14 week old baby admitted to hospital with multiple fractures & other injuries. Weight gain failed before injuries found, admitted to hospital and found to have an ulcerated throat. Mother stated did not feed well. Had an X ray at that time, but no fractures detected. Mother had a history of abuse as a child and as an adult she moved address very frequently.
57	Child admitted to hospital with evidence of sexual abuse, subsequently disclosed abuse by her paternal uncle. Child's name & that of her sister placed on Child Protection Register prebirth due to risk of sexual abuse by uncle, but removed from register & most agencies unaware of registration. Family regarded as strange by others. Child had been described by mother as suffering from premature ageing and experiencing menstruation at age 3 years. Not allowed by mother to change for sport but came with kit on under day clothing. Learning difficulties and frequent absences from school noted, including failure to present for school medical examination. Mother had history of criminal convictions & intergenerational abuse and had an eating disorder, depression and suicidal ideation. She was socially isolated with no family support and domestic violence was suspected. Father has convictions for a number of offences including burglary, attempted rape and sexual assault and earlier convictions for sexual offences against children (a Schedule 1 offender. Uncle has convictions for offences including burglary, arson & rape and is a registered sex offender. Uncle refused to cooperate with rehabilitation programmes post conviction. Convicted of offences against child.
58	Long standing neglect of six children by parents who were seen as poor parents, but despite support & many child protection conferences, the children suffered from poor growth which was interpreted as constitutional small stature rather than failure to thrive. Home conditions consistently described as appalling and children as thin, pale, dirty and poorly dressed. Not offered regular meals. Father reported to have hit children but when challenged stated that he had the right to do as he pleased. Children seen with minor injuries and marks on many occasions, crying and upset. One child noted to use sexualised language and they were allowed to roam around the neighbourhood unsupervised. Speech delay and behaviour problems noted.
59	Infant born prematurely to 17 year old mother with history of delinquency, sexual abuse and domestic violence during her pregnancy. Died at home due to a ruptured liver, found to have injuries consistent with physical abuse. Mother's boyfriend (not child's father) convicted of murder. Mother had a history of paracetamol overdoses and was homeless during pregnancy due to notice to quit from her own mother. Failed to comply with antenatal and postnatal care and had a history of sexual abuse herself. Boyfriend on probation at time of child's death for theft and motoring offences.
60	Brought to hospital dead on arrival, skull fracture and displaced ankle fracture, bruising. Repeated beating by mother's boyfriend. One of twins born prematurely. SCBU care, but mother visited only rarely & demonstrated a lack of interest. Mother had a history of misusing alcohol and drugs and there was domestic violence. Both twins observed to be bruised at times, thought to be accidental. Mother's boyfriend under probation and treatment for drug

	dependency. No full report on file, only correspondence and action plan documents.
61	<p>Mother & baby aged 10 months both strangled by baby's putative father whilst on license from prison following a domestic row. He was a persistent offender (not violent convictions though he had been violent at school & charged with Grievous Bodily Harm. He had absconded from foster care, stealing carer's car. Rejected by his family. Mother had been supplied by father & had injected heroin during her pregnancy. At one stage, mother had requested termination of this pregnancy and ambivalence about relationship with father, who was actually in prison during most of child's life. She suffered from depression after 2nd child was born and admitted snapping at the children, especially her older child. She had weight loss and poor sleep and started taking benzodiazepines. She admitted to suicidal thoughts between father's release from prison & the murders. There had been domestic violence and threats and the relationship between the parents had apparently ended, although they continued to attend Drug and Alcohol team appointments together. Father convicted of both murders. The mother had an older girl child born 1997, who lived most the time with maternal grandmother. The two children had different fathers. Father of 2nd child supplied heroin to mother during her pregnancy. Mother had been injecting heroin user. Mother had a conviction for assault when aged 16 & had 1st child at age 17. Maternal grandmother concerned about care of older child and sexual activity in front of child, who later left to live with her because she did not want to return home (not a placement. Grandmother expressed fears about when 2nd child's father came out of prison. Father of 2nd child had been involved with social services since he was 14 through his offending & mental health. He was referred to Child and Adolescent Mental Health Services following self harm and depression, but failed to comply and the case was closed. He lost control of himself when angry & was violent. He abused farm animals and killed animals and admitted to arson. He had low self esteem & hard to engage properly so that many agencies failed to see him as a danger to others. Agencies failed to exchange information, but father had been rejected by own family & awareness of his dangerousness was low. 12 days before murders, he strangled mother to unconsciousness & said that if relationship was over, nobody else would have mother & baby.</p>
62	<p>17 month old girl reported to have died while in mother's arms, unresponsive when mother woke, with vomit on clothing. Was not on Child Protection Register. Mother was aged 22, single & unsupported except by maternal grandmother, and had been out drinking with the child and friends known to be substance abusers the previous evening, 'very drunk' and left by friends to sleep on sofa. Mother involved with Drug and Alcohol Team and on methadone programme because she had used drugs since the age of 15, also known to use benzodiazepines & dihydrocodeine as well as other opiates, but was reported as buying methadone only urine samples from others to prevent detection of her other drug use. Child noted to have petechial marks below left ear & over temporal mandibular joint. Co-sleeping with mother regarded as cause of a 'cot death', but SIDS descriptor is only used for infants aged <1year. There were no criminal charges in relation to the child's death. The baby was born with neonatal abstinence syndrome and required treatment to wean her off drugs at birth, she was small for her age and her head was small. Mother had a long criminal record with 19 previous convictions including assault and a custodial sentence. She was on probation at the time the child was born and had a history of failing to comply with programmes and non attendance at appointments. She had been arrested for being drunk in charge of a friends 3 year old child, but not convicted. Lifestyle chaotic. She had been harassed by neighbours who had broken a window in her property. She had no cooker and this presented problems in that child was fed only sweet things, but mother did not see diet as a priority.</p>
63	<p>Case notified 06/12/07. 8 weeks old baby girl died after sleeping in her mother's bed with her and the 7 year old brother. Mother had been drinking and there had been a domestic incident earlier that day which was attended by police. The family had recently moved to the area and there had been four police reports of attending domestic violence incidents in the four weeks they had lived there, one of which had led to the arrest of the of child's father. The home was chaotic without enough bedding for the whole family. There was a history of similar incidents in their previous home area. The father also had a history of attacking mother's foster</p>

	<p>brother with an axe during a fight. Father had many previous convictions including violence, drugs and public order offences. Mother had been raised by her own grandparents and had a social worker as a child. She had been living with her own mother prior to moving after failing to pay the rent on her previous home. The older boy had a different father who lived in Scotland. Mother's pregnancy with him had been concealed with no antenatal care. Mother had had a previous child who had been adopted.</p>
64	<p>Case notified 8/10/08. Child aged 1 year found in bath, taken to hospital but later died. She had 2 half brothers aged 5 and 9 years. Mother had a history of domestic violence & alcohol abuse with 2 convictions for Actual Bodily Harm. She was also convicted of supplying drugs. The house was cluttered and dirty. Mother also had a history of depression. Allegations of neglect and leaving the 2 older boys alone had been made by neighbours. The baby girl had been noted to have facial bruising at age 8 months. The school had noted the boys being collected late from school.</p>
65	<p>Case notified 14/05/08. An 18 day old baby boy was admitted to hospital with a head injury reported to have occurred accidentally when he was being fed by his father. The child had been seen in the same hospital earlier that day and considered to have a minor head injury. At this stage he was discharged with advice to his parents, Non accidental injury not considered. The second admission 7 hours later revealed acute bilateral subdual haematomas and retinal haemorrhages considered to be due to non accidental injury. Father had a history of abuse in his childhood and had spent time in care following parental separation with frequent changes of placements. His history included suspected sexual abuse by his own father and by a foster brother and physical abuse. At the age of 13 he was considered to pose a sexual risk to others. He had been known to the Child and Adolescent Mental Health Services services at age 9 and as an adult he had twice taken drug overdoses while in relationships with previous partners. He had a child with a previous partner who was on the Child Protection Register following bruising, but he had no contact with this child since she was 4 months old. Both parents had a history of domestic violence in previous relationship.</p>
66	<p>Case notified 07/07/09. Infant living with her mother and father in a small flat with a bull terrier pet. Parents had good family support network with young child. At age 8 weeks the child presented at routine clinic with bruising to hips, knees & legs and abdomen. Mother had told health visitor previously that baby bruised easily (no clotting abnormality). Referred to local hospital where further bruising found to face and hairline. X rays showed fractures to ribs and right collarbone, considered non accidental. Baby was placed in foster care. Parents denied causing injuries and offered no explanation. Parents and grandmother arrested. Father had a history of convictions for burglary, common assault, public order offences, handling stolen property, Actual Bodily Harm and breach of community rehabilitation order. Mother had a history of depression. She had been treated for a cut to her forehead caused by a bottle on the previous new year's eve. The baby was placed in foster care</p>
67	<p>Baby girl aged 8 weeks was admitted to hospital with multiple injuries including bruising, multiple rib fractures, healing rib fractures, fractures to right femur and right thumb and bilateral subdural haemorrhages. Explanation incompatible with the extent of her injuries and they were considered non accidental. Her mother had become pregnant early in her relationship with child's father, but had previously lost a baby in stillbirth and suffered from epilepsy. Child had been born 4 weeks prematurely with a rare abnormality of the lower bowel which required a temporary colostomy, plus other congenital abnormalities of her spine and heart. Her mother's history included behavioural problems resulting in referral to CAMHS services, including anxiety and speech problems. She had alleged sexual abuse by her older brother when she was aged 12. She was threatened with school exclusion on account of her behaviour. Father's background included severe domestic violence between his parents, plus physical and sexual abuse of his sister by his father. He had attempted suicide.</p>
70	<p>Baby born 28.08/06 died 11/10/06. Local agencies determined that the case did not meet the criteria for Serious Case Review. The child was a 6 week old infant who was found dead in bed with his parents when they awoke. The child had been alive and had been fed some 2</p>

	<p>hours earlier. Father usually did night care. Both parents drug users, father on methadone which he was accustomed to take after the baby's early morning feed. The baby had been on the Child Protection Register since birth owing to mother's inability to take care of her first child, who was removed. The baby was felt to be at risk of neglect, but no evidence of neglect was found and no circumstances to identify the death as other than Sudden Infant Death.</p>
71	<p>Child born 15/11/99 Review notified 18.10.2000. Correspondence makes reference to injuries and physical abuse and an admission to hospital, but no report was ever submitted. Internal paperwork states that the girl was 11 months old when she suffered physical abuse which required her admission to hospital and transfer to a specialist paediatric unit suffering from 'catastrophic' brain stem injuries consistent with shaking. She was left blind. Mother's partner (not the baby's father) had recently joined the household and was charged with causing Grievous Bodily Harm to child. He was babysitting while mother worked in a hotel. In public domain, mother's boyfriend convicted of Grievous Bodily Harm following picking the 11 month old baby up by her arm causing a fracture and shaking her severely when she cried. Child left blind and spastic tetraplegic with severe brain stem injury with limited life expectancy.</p>
72	<p>Child born 18/07/04 and male sibling born 24/05/97. Case notified 22/06/09. Case involved the homicide by suffocation of a 4 year old girl by her mother 19/06/09. The mother was found by her daughter's body with serious injuries. The older son aged 12 called the ambulance. Mother is a single parent whose children had both been on Child Protection Register May 2007-Sept 2007. There was a history of domestic violence which led to the family moving to a refuge when they moved to area from London in May 2007. They had received family support services until April 2008 when the case was closed. The family had previously been known to social services in London where there were concerns about the mother's mental health. Mother is now on remand charged with her daughter's murder and is detained under the Mental Health Act in a secure psychiatric unit. No review report has been completed yet.</p>
73	<p>Male child born 23/03/93 died 8/01/09 aged 15 years. Case notified 10/07/09. The boy was stabbed to death by his stepfather, receiving 18 stab wounds in the attack whilst he slept. The stepfather also attacked & injured his wife, the boy's mother, and his stepdaughter (born 03/04/90) aged 18 years. There were a further seven children living in the home, biological children of the index child's stepfather. Stepfather convicted of murder and attempted murder of his wife and stepdaughter. Stepfather was not mentally ill but was described as possessive, controlling and manipulative and had banned his wife from speaking to her own parents and controlled her movements and mobile phone calls and mileage on the family car. He banned the stepchildren from contacting their father's family including grandparents. He had refused to feed the stepson or talk to him for months before the attack and had encouraged the other children to assault him. He drank heavily on the day of the assault, went to the boy's bedroom with a kitchen knife and killed him, then attacked his wife and stepdaughter outside the bedroom. The court refused to accept a defence of diminished responsibility and considered that his jealousy and previous threats to kill his wife if she left him made him a serious risk and he should serve at least 16 years in prison.</p>

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