Learning from Cafcass Submissions to SCRs

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Section 1: Introduction and Context

This is the third report about the learning derived from Cafcass submissions to Serious Case Reviews (SCRs). It is published at a time of considerable change, as the number of SCRs convened has risen and as many different models of review are being employed. This has posed many challenges for Cafcass as a national organisation, notably in meeting the increased demand and in responding to the plethora of different ways in which SCRs now establish factual information, gain practitioner input, identify learning and so on. We set out the current context below. We recognise that this entails a great deal of esoteric detail. However, we are aware that:

- SCRs can appear rather opaque, and rather intimidating, to those who are unfamiliar with them.
- Many Cafcass staff are involved in SCRs in one capacity or another, including: providing information/views to reviews; providing written accounts and analyses of Cafcass' work; representing Cafcass on panels; participating in Local Safeguarding Children Board (LSCB) sub-groups that have the responsibility of making recommendations to LSCB chairs regarding the convening of SCRs; attending LSCB meetings where SCR reports are ratified; embedding findings from our SCR submissions into staff training; reporting data and findings to the Executive and Board etc.
- Operational staff – traditionally those who have found SCRs to be particularly opaque – are much more likely to be *directly* involved in an SCR than was previously the case, as new models of SCRs are employed which make use of 'conversations' between practitioners and SCR lead reviewers. (This is described below.)

This section is therefore intended to serve as an introduction to the current state of SCRs, as well as a brief introduction to the research.

1.1 Context

We published two similar studies, entitled *Learning from Cafcass Individual Management Reviews,* in 2012 and 2013. The studies form one element of the Cafcass Board-mandated research programme. The 2012 study was based on 23 Individual Management Reviews (IMRs) undertaken between 2009 and March 2012. The 2013 study was based on a further 12 IMRs completed between April 2012 and July 2013. This study is based on 28 submissions to SCRs provided by Cafcass between August 2013 and September 2014. Across the three studies we now have data relating to 63 SCR submissions – a substantial dataset. As set out below, submissions to SCRs have not, since the publication of the revised *Working Together to Safeguard Children* (March 2013), entailed the completion of an IMR in every case. We have, therefore, amended the title of this study to *Learning from Cafcass Submissions to Serious Case Reviews.* We do, however, use the terms IMRs and SCR submissions inter-changeably in this report, as a substantial agency report is submitted to most reviews and as the vast majority of the data presented in this report is taken from those agency reports.

Table 1 below sets out the above data relating to the number of Cafcass submissions featured in each of the three studies and the timeframes i.e. the periods during which the submissions were completed by Cafcass.

Table 1: Submissions by study and timeframe

Study	Timeframe	Number of Cafcass submissions
2012	2009 – March 2012	23
2013	April 2012 – July 2013	12
2014	Aug 2013 – Sept 2014	28
Total		63

Between 2010 and July 2013 Cafcass submitted on average about one IMR per month. It is apparent from table 1 that Cafcass made 28 submissions to SCRs between August 2013 and September 2014, a period of 14 months. This represents about double the rate of submissions made during the three preceding years. The rise in Cafcass SCR submissions is in line with a substantial rise in the number of SCRs being convened by LSCBs whose statutory duty it is to initiate and conduct a SCR where either:

(a) A child dies and abuse or neglect is known or suspected to be a factor in the death (henceforth 'type A cases'); or
(b) A child has been seriously harmed and there are concerns about the quality of multi-agency working (henceforth 'type B cases').

The data regarding the number of SCRs that have been convened is rather confusing, not least because different timeframes are under consideration and the numbers provided by different sources do not seem to tally precisely. However, the following data points to a steep rise in the number of SCRs:

- The Parliamentary Under Secretary of State for Children and Families stated, in a written response to a question asked in Parliament (HC Deb, 03 April 2014, c 786W), that 114 SCRs were convened in 2013/14 against 55 in 2011/12.
- The *First Annual Report of the National Panel of Independent Experts on Serious Case Reviews* (July 2014) reported that 189 SCRs had been convened since its formation in June 2013. The precise dates when data collection started and concluded are not set out but this seems to be approximately a 12-month period. This is approximately twice as many SCRs as the 184 that were convened in a two-year period between April 2009 and March 2011 (Brandon et al, 2012).
- Ofsted published figures in September 2014 showing that 143 SCRs were initiated in the year April 2013 to March 2014, a 53% rise on 2012/13 when there were 93.

The recent rise in SCRs follows a sharp fall around 2010/2011, which was thought to relate to the government's decision in mid-2010 that SCRs should be published in full.

Why should the number of SCRs have risen so steeply of late? Ofsted (2014) suggests that the rise may be attributable to LSCB decision-making regarding 'type B' cases (see above – those cases that entail serious harm to a child and concerns about inter-agency safeguarding). Ofsted has reported that 'type B' SCRs almost trebled in number in the past year, from 24 to 69, whereas the number of 'type A' (fatal maltreatment) cases remained broadly static. Self-evidently, LSCBs have a greater degree of discretion around 'type B' cases as the interpretation of the criteria entails a higher level of subjectivity than is necessary for 'type a' cases. The other factor that may have encouraged LSCBs to convene

more SCRs was the decision of the government, set out in the revised *Working Together* (March 2013), to delegate to LSCBs the discretion about how they conduct SCRs. Previously, there was a mandated model (henceforth 'the traditional model') used in all SCRs.

The traditional model was 'top-down' in nature, in that managers in participating agencies identified the strengths and weaknesses of practice, established what steps needed to be taken to remedy weaknesses, and reported to the SCR panel through a (commonly lengthy) IMR and chronology. A number of alternative models have been developed but the one which received most professional attention, having been advocated by the *Munro Review of Child Protection* (2011), was a 'systems approach', such as the 'Learning Together' Model that was then being developed by the Social Care Institute for Excellence (SCIE). The SCIE model involves a 'bottom-up' approach in which 'conversations', between practitioners who were actively involved in the case and the lead reviewers, form the principal methodology. IMRs are not commissioned from the managers of individual agencies, as lead reviewers are more likely to make use of source documentation, such as local authority assessments and, section 7 reports. Recommendations are derived by the reviewers from the conversations, and from their consideration of key episodes in the case under review.

We sought to code the 28 SCRs which feature in this study to establish which models were used by the LSCBs. This was not straightforward. It soon became apparent that many LSCBs are taking a 'pick and mix' approach (using elements of different models) and 'playing things by ear' (amending the methodology as the SCR progresses). However, we looked at the dominant features of the methodologies and coded each SCR as follows: traditional; hybrid (where the method was explicitly identified as being derived from the traditional and systems models); SCIE; and unclear (not yet determined by the LSCB). The results are as follows:

Table 2: SCR type

Type of SCR	Number
Traditional	18
Hybrid	7
SCIE	1
Unclear (to date)	2
Total	28

It is noteworthy that so many SCRs have made use of the traditional model, and so few the SCIE model, though the influence of the latter is evident within the hybrid reviews and, sometimes, within the traditional model e.g. when a practitioner event is held towards the end of the review to debate draft findings.

We started this section by stating that it is challenging for a national organisation to understand and adhere to the methodologies being used. At the start of each review (and sometimes, during the course of a review) we cannot be certain what methodology will be used. The 'old rules' do not necessarily apply. For example, prior to the publication of the revised *Working Together* (March 2013) it was expected that the author of an IMR would not also act as the representative of that agency on the SCR panel; if the IMR author attended a panel meeting, it was generally by invitation to present his/her report. Now the two roles are

commonly fulfilled by the same person. More recently, a new challenge has emerged, derived from the practice in a small number of LSCBs of asking for an analysis to be provided at the point that the LSCB is still setting the terms of reference for the review. Traditionally, only factual information was sought at this point, with an analysis being provided later, set out in an IMR. This allowed the author to make proper enquiries of involved practitioners and to provide an evidence-based analysis. Cafcass is monitoring these trends.

1.2 The report

This study seeks to build on the two previous ones by presenting data around three broad areas: children and families; index incidents and risk; and practice. In the 2013 study we looked in more detail at some areas which had been the subject of discussions in the Cafcass Board, namely notifications of deaths and serious incidents to the Safeguarding Team, and child and adult suicides. In a similar vein, this report inquires in more depth into two matters:

- Child sexual exploitation – as this has been subject to considerable media and professional scrutiny following very high-profile reviews in Rochdale, Rotherham and elsewhere.
- Learning derived from our submissions to SCRs – as our inputs to SCRs represent a significant use of our resources, it seems timely to consider what we have learned from these inputs, and how.

The following section – Methodology – sets out in detail how we have undertaken this study.

Section 2: Methodology

The methodology used replicated that of the 2013 and 2012 studies. Twenty eight Cafcass submissions to SCRs were made in the 14 month period between the start of August 2013 and the end of September 2014, the period of analysis for this research.

As in the 2013 study, two cases were removed from the analysis as they did not fit with our methodology. One of these cases could not be included as it involved multiple children from different families subject to individual applications. The second involved two children from the same family but could not be included in the sample as, in this case, Cafcass had only submitted a summary of involvement to the SCR which did not provide sufficient information for the purposes of this research. Both of these cases, however, were subject to the analysis found in section 4 of this report (see below) relating to 27 children known to Cafcass who have been the subject of child sexual exploitation.

The details of each case were entered into a spreadsheet containing the information from the 2012 and 2013 samples, allowing for comparison between and aggregation of the three samples. The details entered into the spreadsheet consisted of: information regarding the child and family; the index incident; Cafcass' involvement in the case; risk factors; and positive and negative Cafcass practice as identified in the IMR.

The methodology used in the 2012 and 2013 studies for assigning 'risk ratings' for each case was repeated for this sample. The 13 categories of risk used are set out in appendix A. This year, at least two and, for most cases, three members of the team worked collaboratively to reach consensual views on the level of risk in each category for each case. While this promoted reliability between the risk ratings assigned to different cases and therefore allowed for comparisons to be made between cases, it should be kept in mind that this was still a subjective process.

The level of risk assigned was based on the information available to Cafcass at the time of our involvement in the case. This was ascertained through reading the Cafcass submission to the SCR. One limitation to the research is that it is possible that some risk-related information which was available to Cafcass at the time we were involved with the case may have been omitted from our submission. In particular, there were ten cases where Cafcass had not submitted an IMR at the time of the analysis for the research. In these cases we relied upon a chronology or other summary document which may not have contained all the risk information known to Cafcass at the time we were involved in the case. The limitations to the risk ratings will be discussed in greater detail in section 3.4 and 3.5.

Each case is different both in terms of the nature of the incident and the child(ren)'s circumstances; the nature and timing of Cafcass' involvement with the children; and, as has been discussed above, the extent of Cafcass' contribution to the SCR. For these reasons, the methodology we have used will be more appropriate to some cases than others.

Separately, information was collected from all 2012, 2013 and 2014 samples regarding the number and nature of recommendations made in each IMR. The information derived is presented and discussed at section 5.

As mentioned above, two of the cases for which Cafcass made a submission to an SCR in 2014 involved child sexual exploitation (CSE). This had also featured in two of the 2013

IMRs and was subject to a short discussion in the 2013 report about learning from IMRs. This year, the Cafcass Policy Team was notified by operational staff of additional children (not subject to an IMR or SCR submission) known to Cafcass who were victims of CSE. Given the current media and professional interest in CSE, we decided that an analysis of all CSE cases notified to Policy would be a valuable exercise. This comprised: IMRs from the 2013 study; IMRs included in this study; and notifications from operational staff. This formed a total sample of 27 children and the findings derived from the analysis of this sample are set out in section 4.

Section 3: Findings

3.1 Case details

The table below shows the number of cases (n=26) in which the index child was in proceedings in which Cafcass was involved: at the time of the index incident; prior to the index incident; or not at all. As is apparent from table 3 Cafcass knew, currently or previously, 24 of the 26 index children. In the two cases where there was no current or previous involvement, Cafcass' contribution to the SCR was on the basis of our knowledge of another family member. In respect of these two cases it should be noted that our coding and analysis are based on the proceedings in which Cafcass was involved, even though these did not relate to the index child.

Table 3: children in proceedings at time of incident

Involvement	Frequency
At time of incident	10
Prior to incident	14
None	2
Total	26

The Cafcass casework in the cases which are subject to SCRs sometimes took place some years ago. This is important to keep in mind when reviewing Cafcass practice in those cases. The tables below, 4 and 5, show respectively the dates in which Cafcass' involvement in each case began and ended. In more than half of the cases (14/26) there was more than one period of Cafcass involvement and in one case there were five periods. In these cases we have not recorded continuous involvement, but simply the dates at which we were first, and last, involved.

Table 4: Start date of Cafcass involvement

Year involvement commenced	Frequency
2005	1
2006	1
2007	3
2008	1
2009	4
2010	3
2011	1
2012	6
2013	6
2014	0
Total	26

Table 5: End date of Cafcass involvement

Year involvement ended	Frequency
2008	2
2009	0

2010	0
2011	2
2012	4
2013	7
2014	11[1]
Total	26

The duration of Cafcass involvement[2] (that is, the sum of the duration of each period of involvement) varied widely between cases; from a minimum of two months to a maximum of 69 months (5 years and 9 months). As shown in table 6, in the majority of cases (17) the total duration of Cafcass involvement was 24 months (two years) or less.

Table 6: Total duration of Cafcass involvement

Total duration (months)	Frequency
0 to 12	9
13 to 24	8
25 to 36	5
37 to 48	2
49 to 60	1
60 to 72	1
Total	26

Table 7: Case types

Law type	Frequency
Private law – WTFH & WAFH	7
Private law – WTFH only	5
Private law total	**12**
Public law – s31 only	9
Public law – others specify[3]	3
Public law total	**12**
Public and private	**2**
Total	**26**

The numbers of public and private law cases were equal in the 2014 sample. In respect of the two cases which featured public and private law proceedings, one of these has at some points in the analysis in the following sections been categorised as public law and the other has been categorised as private law. This is because in both cases one law type related only to historical proceedings whereas the other law type was the more recent or current case at the time of the incident.

[1] This includes ten cases which remained open at the time of the research analysis (September 2014)
[2] It should be noted that this is the duration of Cafcass involvement taken at the time of the research analysis (i.e. September 2014) and not the date of the incident. In those (10) cases where the case remained open following the incident the duration of involvement up to the incident may have been shorter.
[3] Two of these involved s31 and s25 secure accommodation applications and the other case involved s31 applications and applications to discharge a care order.

3.2 Children and families

Children

There were 30 index children in the 26 submissions to SCRs. Sixteen index children were involved in public law cases and 14 in private law. Sixteen children were female and 14 were male. Eighteen of the children died as a result of the index incident and 12 children survived the incident. Data on the ethnicity of 17 children was not available within Cafcass' IMRs. Data on the ethnicity of the remaining children is shown in the table below.

Table 8: Children's ethnicity

Ethnicity	Not specified	White British	Mixed other	Asian or Asian British Indian	Mixed White & Black African	White other	Mixed White and Asian	Asian or Asian British Other
Frequency	17	7	1	1	1	1	1	1

The age profile of the 30 index children was similar to that of the 46 index children from the 2012 and 2013 samples, as shown in the table below.

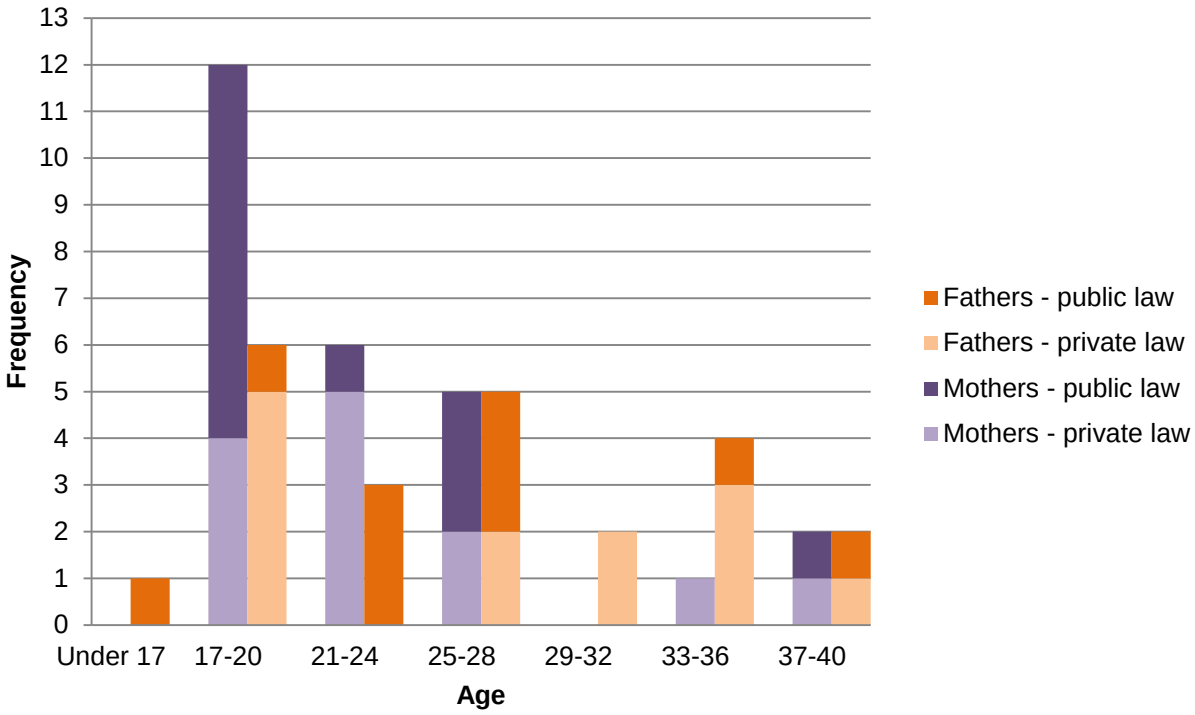
Table 9: Children's ages

Age	Frequency 2012 and 2013 samples (%)	Frequency 2014 sample (%)
Under 1	7 (15.2%)	3 (10%)
1 to 5	18 (39.1%)	11 (36.7)
6 to 10	9 (19.6%)	9 (30%)
11 to 15	8 (17.4%)	3 (10%)
16 to 17	4 (8.7%)	4 (13.3%)
Total	46	30

Parents

The age of the parents was considered in both the 2012 and 2013 IMR research reports. The data on parents' ages from the 2014 sample is shown in chart 1 below.

Chart 1: Ages of parents at birth of first child by law type



Data in respect of three fathers was missing; for one of whom we did not have a date of birth and two fathers' identities were unknown.

In the 2014 sample, 46.2% of mothers were aged 20 or under at the birth of their first child. This is a lower percentage than the 2012 and 2013 samples in which 78% and 80% respectively of mothers were 20 or under at the birth of their first child. Fathers were older than mothers on average with a mean age of 26 and there was a lower percentage of very young fathers, with 30.4% being 20 or younger. This is similar to the 2012 and 2013 samples within which 31% and 20% respectively were 20 or younger.

The average age of the mothers in the sample at the birth of their first child is lower than that of the general population at 23 years; the Office for National Statistics (2013) reports that in 2012 the average age of mothers at the birth of their first child was 28.1. The chart above also shows that young parents, particularly mothers, are a feature of both the public and private law cases in the sample.

While many cases involved two young parents, with the father being around the same age or only a few years older than the mother, in some cases there was a significant age gap between the parents. For example, one case of severe neglect and possible sexual abuse involved a mother who had been 18 at the time her first child was born and a father who was 38 at that time.

3.3 The index incidents

The table below provides information on the type of case, the category and a brief description of each incident and Cafcass' involvement with the subject child at the time of the incident. The risk ratings, which will be discussed in detail in the next section, are also displayed.

Table 10: The index incidents

	Type of case	Category of index incident	Description of incident	Child in proceedings	Perpetrator[4]	Risk rating
1	Private law – WTFH & WAFH	Spite/revenge killing	Mother thought to have killed child and then fled the country.	Yes at time of index incident	Mother	4
2	Public law – s31 only	Physical abuse (fatal)	Non-accidental injuries (NAIs) but unclear who the perpetrator was.	Yes at time of index incident	Unknown	13
3	Private law – WTFH only	Physical abuse (fatal)	Mother and child killed by mother's boyfriend (not father of child).	No	Mother's partner	2
4	Private law – WTFH & WAFH	Physical abuse (fatal)	Child believed to have been killed by mother and mother's friend	Yes at time of index incident	Mother and mother's friend	8
5	Private law – WTFH & WAFH	Physical abuse (non-fatal)	Child admitted to hospital with NAIs. Child's mother and mother's partner convicted of criminal offences related to the injury and neglect of the child.	Yes previously	Unknown	10
6	Private law – WTFH only	Physical abuse (fatal)	Two children died three months apart in the context of neglect with the local authority believing the mother to have deliberately suffocated both children.	Yes previously	Mother	9
7	Private law – WTFH only	Neglect (non-fatal)	Child admitted to hospital suffering from fits. On medical examination child was discovered to be severely malnourished.	Yes previously	Mother and mother's partner	12
8	Private law – WTFH & WAFH	Physical abuse (fatal)	Child taken to hospital with serious head injuries and died two days later.	Yes previously	Step-father and step uncle	14
9	Public law – s31 only	Suicide	Child hanged herself in residential home	Yes previously	Suicide	22
10	Public law – s31 only	Physical abuse (fatal)	Child was found collapsed at home and later died from head injuries.	Yes previously	Father	16
11	Public law – others specify	Drug overdose (fatal)	Child was found dead from a drug overdose which was unlikely to have been suicide.	Yes at time of index incident	Child died from drug overdose	8
12	Private law – WTFH & WAFH	Sexual abuse	Video evidence found of child being sexually abused.	Yes at time of index incident	Father	7
13	Public	Sexual abuse	Child sexually abused by	Yes at time	Father	18

[4] Please note perpetrator is sometimes presumed rather than established through criminal proceedings.

	law – s31 only		father.	of index incident		
14	Private law – WTFH & WAFH	Physical abuse (fatal)	Mother's partner physically assaulted child causing major internal injuries which resulted in the child's death.	Yes at time of index incident	Mother's partner	11
15	Public law – s31 only	Neglect (non-fatal)	Three children severely neglected and possible sexual abuse.	Yes at time of index incident	Mother and father	25
16	Public law – s31 only	Sexual abuse	Rape and sexual abuse by a number of men.	Yes previously	A number of men	14
17	Private law – WTFH & WAFH	Physical abuse (fatal)	Child was strangled and killed by her ex-boyfriend.	Yes previously	Child's ex-partner	11
18	Public law – s31 only	Neglect (fatal)	Aunt and two other adults co-slept with twin babies. Index child was found not breathing and, following resuscitation in hospital, child subsequently died.	Yes at time of index incident	Aunt and 2 additional adults	20
19	Public law – s31 only	Physical abuse (fatal)	Child taken to hospital with serious injuries, perpetrated by the father, and later died.	Yes previously	Father	22
20	Private law – WTFH only	Neglect (non-fatal)	Severe neglect of child.	Yes previously	Mother	0
21	Public and private	Sexual abuse	Repeated sexual abuse to the index child by the index child's half-brothers.	Yes previously	Both half-brothers	17
22	Public and private	Spite/revenge killing	Mother set fire to house, killing both self and child.	Yes at time of index incident	Mother	17
23	Private law – WTFH only	Physical abuse (fatal)	Mother jumped from first floor of house with child. Child died, mother survived.	Yes previously	Mother	3
24	Public law – s31 only	Physical abuse (fatal)	Child found dead at home, post-mortem revealed non-accidental injuries suspected to have been perpetrated by parents	No	Mother and father	15
25	Public law – others specify	Drug overdose (fatal)	Child found dead, post-mortem results showed child died from opiate toxicity (unlikely to have been suicide).	Yes previously	Child died from drug overdose	6
26	Public law – others specify	Neglect (non-fatal)	Severe neglect and emotional abuse of two children.	Yes previously	Mother and father	12

The following table breaks down the cases by incident type.

Table 11: Index incident type in 2012, 2013 and 2014 samples

Index incident type	2012 sample (%)	2013 sample (%)	2014 sample (%)	Total (%)
Physical abuse (fatal)	3 (13.0)	4 (40)	11 (42.3)	18 (30.5)
Neglect (fatal)	4 (17.4)	4 (40)	1 (3.8)	9 (15.3)
Spite/revenge killing	5 (21.7)	1 (10)	2 (7.7)	8 (13.6)
Suicide	4 (17.4)	1 (10)	1 (3.8)	6 (10.2)
Neglect (non-fatal)	2 (8.7)	0	4 (15.4)	6 (9.2)
Physical abuse (non-fatal)	4 (17.4)	0	1 (3.8)	5 (8.5)
Sexual abuse	0	0	4 (15.4)	4 (6.8)
Fatal drug overdose (not suicide)	0	0	2 (7.7)	2 (3.4)
Other	1(4.3)	0	0	1 (1.7)
Total	23	10	26	59

Percentages may not add to 100 due to rounding

Key observations:

- Non-fatal incidents made up 34.6% of the 2014 sample in contrast to 18.1% of the 2012 and 2013 samples combined. This supports the hypothesis set out in the introduction that the overall rise in the number of SCRs being convened nationally is due to a greater willingness by LSCBs to review cases where a child had been seriously harmed and where there are concerns about the quality of multi-agency working.
- Fatal physical abuse accounted for the highest number of index incidents in 2014 (42.3%). The percentage of fatal neglect incidents in the sample was considerably lower than in both the 2012 and 2013 samples though the percentage of non-fatal neglect cases is higher.

Analysis

Two of the 2014 cases have been classified as **spite killings**. However, it should be noted that this is inevitably a very tentative classification (other than in respect of those cases where the perpetrator makes it explicit that the motive was to cause maximum distress to the other parent), as it requires a judgement being made about the motivations of the perpetrator. One case is clearly a homicide and the other is clearly a homicide/suicide. The context - extensive private law proceedings and extreme hostility to the other parent – suggests that spite may have formed at least part of the motive. In both cases, Cafcass had been involved in the proceedings to which the index child was subject at the time of the incident. In one case the child's death occurred in the context of a Cafcass recommendation that residence be changed to the father. In both cases the perpetrator was the mother of the child. This contrasts with the six spite killings in the 2012 and 2013 samples, five of which were perpetrated by men. In the 2014 sample there was also a further case, classified as fatal physical abuse in the above table in which the mother apparently jumped from a first floor window with her child as a result of which the child died; in this case we had too little information to form a view about the mother's motivation.

Sexual abuse did not feature as an index incident in the 2012 sample; nor in the 2013 sample, with the exception of the two CSE cases excluded from the sample. In the 2014 sample, four index incidents (15.4%) were sexual abuse (and in addition there were two CSE cases which were removed from the sample). This may also be accounted for by the national rise in SCRs convened as a result of a child being seriously harmed where there are concerns about the quality of multi-agency working. Two of the four sexual abuse cases were s31 care proceedings, one was s31 proceedings and historical private law proceedings and the remaining case was private law WTFH and WAFH. Cafcass was involved with the index child at the time of the incident in one of the s31 cases and in the private law case. In the remaining cases Cafcass had been previously involved with proceedings to which the index child was subject.

The **non-fatal neglect** cases were equally spread between public and private law: two cases were private law WTFH only; one was s31 proceedings only and another was s31 proceedings and an application to discharge a care order. The **fatal neglect** case occurred in s31 proceedings. In the two s31 neglect cases, Cafcass was currently involved in proceedings to which the index child was subject at the time of the incident. In the remaining three cases Cafcass had previously been involved with the index child.

The majority (eight, including the non-fatal case) of the **physical abuse** cases were private law cases, five WTFH and WAFH and three WTFH only. The four other cases occurred in public law s31 cases. In three cases, two private law WTFH and WAFH and one s31 care, Cafcass was currently involved in proceedings to which the index child was subject at the time of the incident. In two cases, one private law WTFH only and one s31 care, Cafcass had not been involved with the index child at any point (and was therefore asked to contribute to the SCR on the basis of our involvement with another family member). In the remaining seven cases, Cafcass had been previously involved with the index child.

Both of the children who died from **drug overdoses** had been subject to secure accommodation orders and, at the time of their deaths, had recently been released from secure accommodation. This suggests that being released from secure accommodation is a critical time for children, particularly those who have been abusing drugs prior to their admission. Cafcass was currently involved in the s31 proceedings to which one of these children was subject at the time of the incident and had previously been involved in s31 and s25 proceedings for the other child. One of these cases is summarised below.

Case example 1 – drug overdose in s25 secure accommodation case

The child, who was 15 years old at the time, had been accommodated under s20 for one year in residential homes when he absconded and took an overdose of heroin and cocaine. Following this incident he was placed in secure accommodation under a Secure Accommodation Order which was renewed a number of times. The local authority also made an application for a Care Order and an Interim Care Order was granted. After six months in secure accommodation, the child was returned home to his mother. Within two months the child tested positive for cocaine and heroin use and was placed in a rehabilitation unit. The child continued to misuse drugs and abscond from the placement and, after one month, the local authority made a further application for a Secure Accommodation Order which was granted. The child remained in secure accommodation for the next three months until a final Care Order was granted and he was moved to an open residential placement in accordance

with the local authority's care plan. The child absconded from the placement on the day he moved there and was found dead a few days later as a result of a heroin overdose.

3.4 Risk ratings

As set out in the methodology, each case was accorded ratings of 'high', 'medium' or 'low', which were converted to scores of 3, 2 and 1 respectively, against 13 risk factors. The scores given were based on how recent the concern was, together with the frequency and the severity. For the category of 'on child protection plan', the ratings were: 'yes, currently'; 'yes, previously'; and 'no'. These corresponded to scores of 3, 2 and 0 respectively. A score of zero in respect of any risk factor does not necessarily mean that it was not present; rather it means that no risk of that type was indicated from the information available within the Cafcass submission to the SCR. A score of zero may therefor indicate either a) that there was no risk of that type in the case; b) that risk of that type was present but it was not known to Cafcass at the of our involvement in the case, or; c) that such risk factors were known to Cafcass at the time of involvement but are not included in Cafcass' submission to the SCR. This is also true of ratings of low or medium.

The lowest risk rating was zero in a private law WTFH case, the highest was 25 out of a maximum of 39[5] in a public law s31 case. Table 12 sets out the average risk rating by case type.

Table 12: Average risk rating by law type – for 2012, 2013 and 2014 samples (number of cases in each law type/sample are indicated in brackets)

Law type	Average risk rating combined 2012 and 2013 samples (number of cases)	Average risk rating 2014 (number of cases)	Overall average risk rating (number of cases)
Public law (s31 only)	18 (9)	18.3 (9)	18.2 (18)
Public law (other)	16.7 (3)	9 (3)	12.8 (6)
Total public law	**17.7 (12)**	**16 (12)**	**16.8 (24)**
Private law (WTFH only)	6.9 (9)	5.2 (5)	6.3 (14)
Private law (WTFH and WAFH)	9.5 (10)	9.3 (7)	9.4 (17)
Total private law	**8.3 (19)**	**7.6 (12)**	**8 (31)**
Public and private law	18 (2)	17 (2)	17.5 (4)
All case types	**12.3 (33)**	**12.2 (26)**	**12.2 (59)**

Key observations:

- Consistent with the 2012 and 2013 samples, the cases in the 2014 sample which involved both public and private law have the highest average risk score (17). The number of such cases is, however, very low.
- Public law cases have an average score of 16, which is also congruent with the previous samples and s31 cases have a higher score than 'public law (other)' cases.

[5] Note the 2013 IMR research report erroneously stated this to be 36

- The private law WTFH cases had the lowest average risk score (5.2); this was also the case in the 2012 and 2013 samples (at 6.9).
- WAFH cases in the 2014 sample have an average risk score (9.3) that is lower than public law but higher than private law WTFH; this was also the case in the 2012 and 2013 samples (at 9.5).
- The overall risk score for 2014 private law cases was lower than public law (at 7.6).
- The overall risk score for the 2014 sample was 12.2; this was almost the same as the 2012 and 2013 samples at 12.3.
- The range of risk scores in private law was from a minimum of 0 to a maximum of 17[6] and in public law, 6 to 25.

Analysis

The difference in the average scores between case types can be explained by a number of factors: the duration of Cafcass' involvement; the scope of Cafcass' role and the reasons behind the applications.

Public law s31 care applications are only made where the local authority believes the child has suffered or is likely to suffer significant harm and therefore are likely by their nature to involve greater risk than the vast majority of private law proceedings. In addition, the most recent *Three weeks in November* (Cafcass, 2014) study found that 82% of cases were known to Children's Services prior to the s31 application being made. In these cases the Children's Guardian is likely to have access to extensive safeguarding information. Further, in care proceedings Cafcass is involved for the duration of the proceedings, unlike in private law where involvement may end at the first hearing or following the completion of a discrete piece of work within the proceedings.

Two of the three 'public law (other)' cases involved both s31 care applications and s25 secure accommodation applications and adolescent index children. Cafcass' role in s25 proceedings is time-limited and narrower in scope than s31 proceedings. In addition, the low risk scores in both of these cases (8 and 6) and thus, the 'public law (other)' category as a whole, can be further explained by a combination of two other factors: the absence of information within the IMR about the child's early history which may have been unknown or not covered by the period to which the SCR related; and the gearing of the methodology towards parental characteristics rather than child characteristics which are often more relevant in cases of older children.

We provide some case examples below of cases in public and private law cases that have low and high risk scores. These illustrate the important point that risk factors are not always accurate predictors of serious/fatal maltreatment as some children die in the context of apparently low risk, as well as in circumstances where the risk is known to be high.

Case examples

Case example 2 – low risk (13) public law

The child had been placed in foster care under an Emergency Protection Order following a referral to the local authority from the hospital where the child had presented with significant injuries, some of which were deemed non-accidental. The local authority then made a s31

[6] The case with a score of 17 involved historical care proceedings. Excluding this case the highest score was 14.

care application, an Interim Care Order was granted and the child was placed with foster carers. Three months later the child died as a consequence of the non-accidental injuries received prior to being taken into local authority care. Risk factors in this case included the child being the subject of a child protection plan; the NAIs to the child; the mother's learning difficulties; the mother having previously concealed the pregnancy; and the mother's mental health and lifestyle.

Case example 3 – high risk (22) public law

Following care proceedings the child was placed with her father under a residence order. The child subsequently died as a result of injuries perpetrated by the father. Risks in this case included the child's behavioural, health and developmental problems including Foetal Alcohol Syndrome; the father's ADHD; the father's violent criminal history; serious concerns regarding domestic violence, both between the father and the mother and the father and his current partner; the mother's drug and alcohol misuse; mother's lack of engagement in the court proceedings; mother's mental health; and the child and siblings having previously been the subject of Child Protection Plans

Case example 4 – low risk (4) private law

Private law proceedings were instigated by the father to prevent the mother removing the child from the jurisdiction and to make arrangements for contact. The mother subsequently applied for leave to remove the child to her home country and the father made an application for residence. A Cafcass Guardian was appointed under rule 16.4 early in the proceedings. Following the Guardian making a recommendation that residence be changed to the mother, the child was found dead. It was believed that the mother had fled the country. The risk factors in this case were limited to a low level of concern around the mother's mental health and a high level of 'other' concerns including the risk of abduction and the animosity between the parents.

Case example 5 – high risk (14) private law

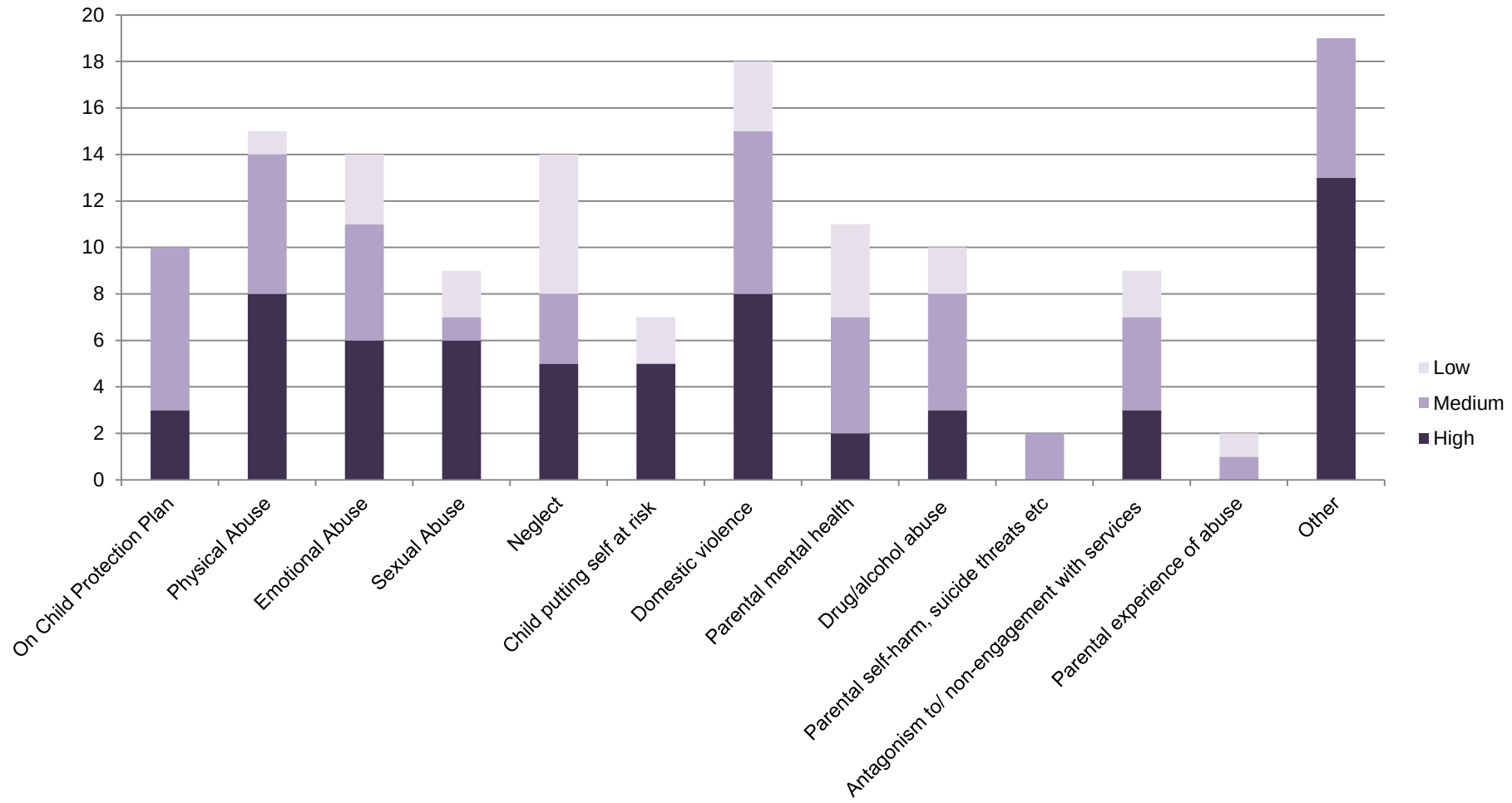
Cafcass became involved in this case in 2007 when a prohibited steps order was made preventing the father from removing the child from the mother's care. Shortly afterwards the mother made an application for a residence order. Local authority checks revealed significant concerns of domestic violence both between the mother and father and the mother and her current partner. Other risk factors included: allegations that the father had physically abused the child; both parents' drug use; the child's poor school attendance; allegations that the mother's current partner had hit the child; an incident which took place before a planned observation of contact by the FCA involving a violent altercation between the father and the mother's partner in which the latter threatened to stab the former. The child died three years after Cafcass' involvement had concluded, following injuries sustained whilst in the care of the mother's partner and his brother.

3.5 Risk types

The charts on the following pages show the level of risk in each category for: all cases (chart 2); public law (chart 3); private law (chart 4).

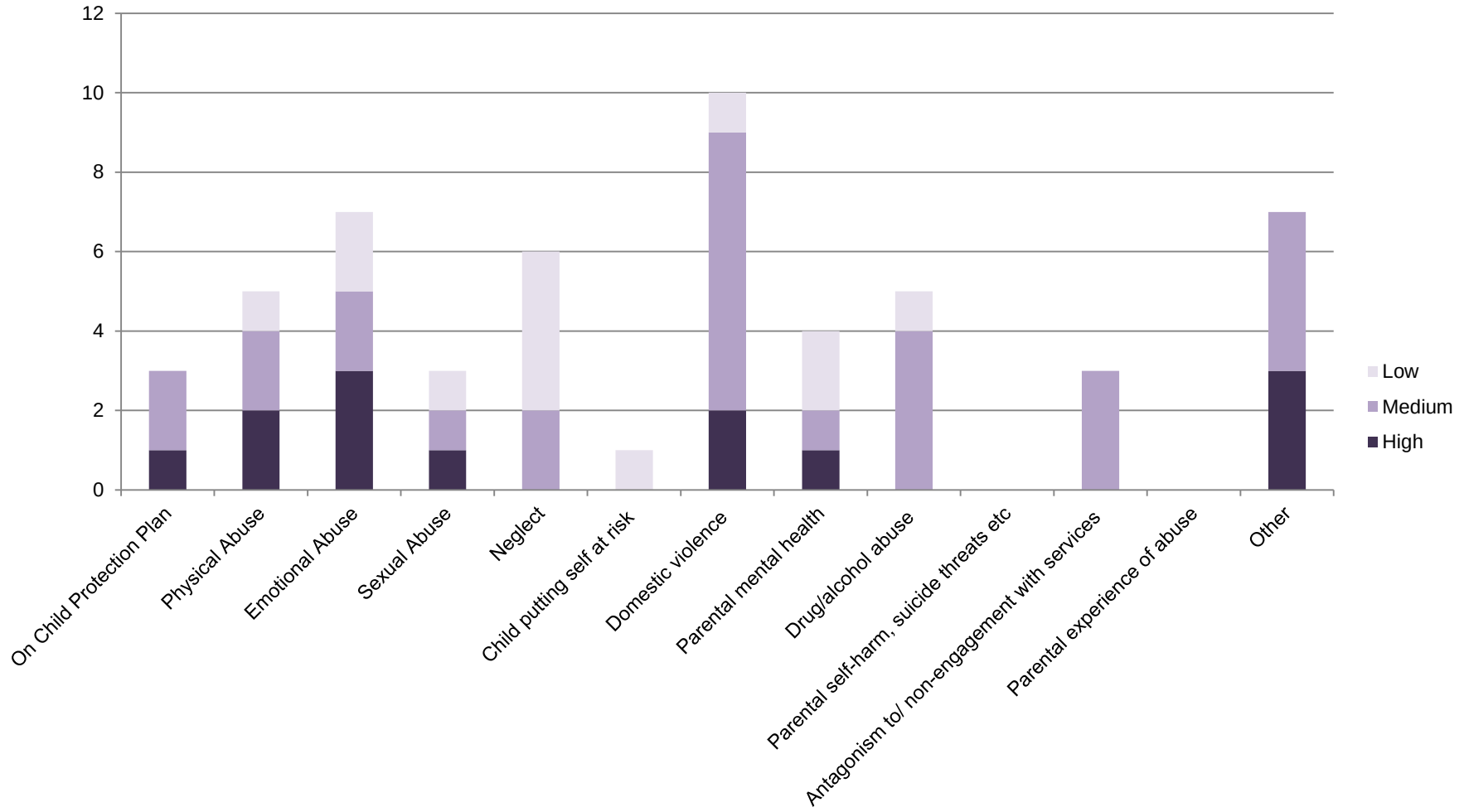
Please note that most cases involved risks under more than one category.

Chart 2: Risk types in all case types (number of cases = 26)



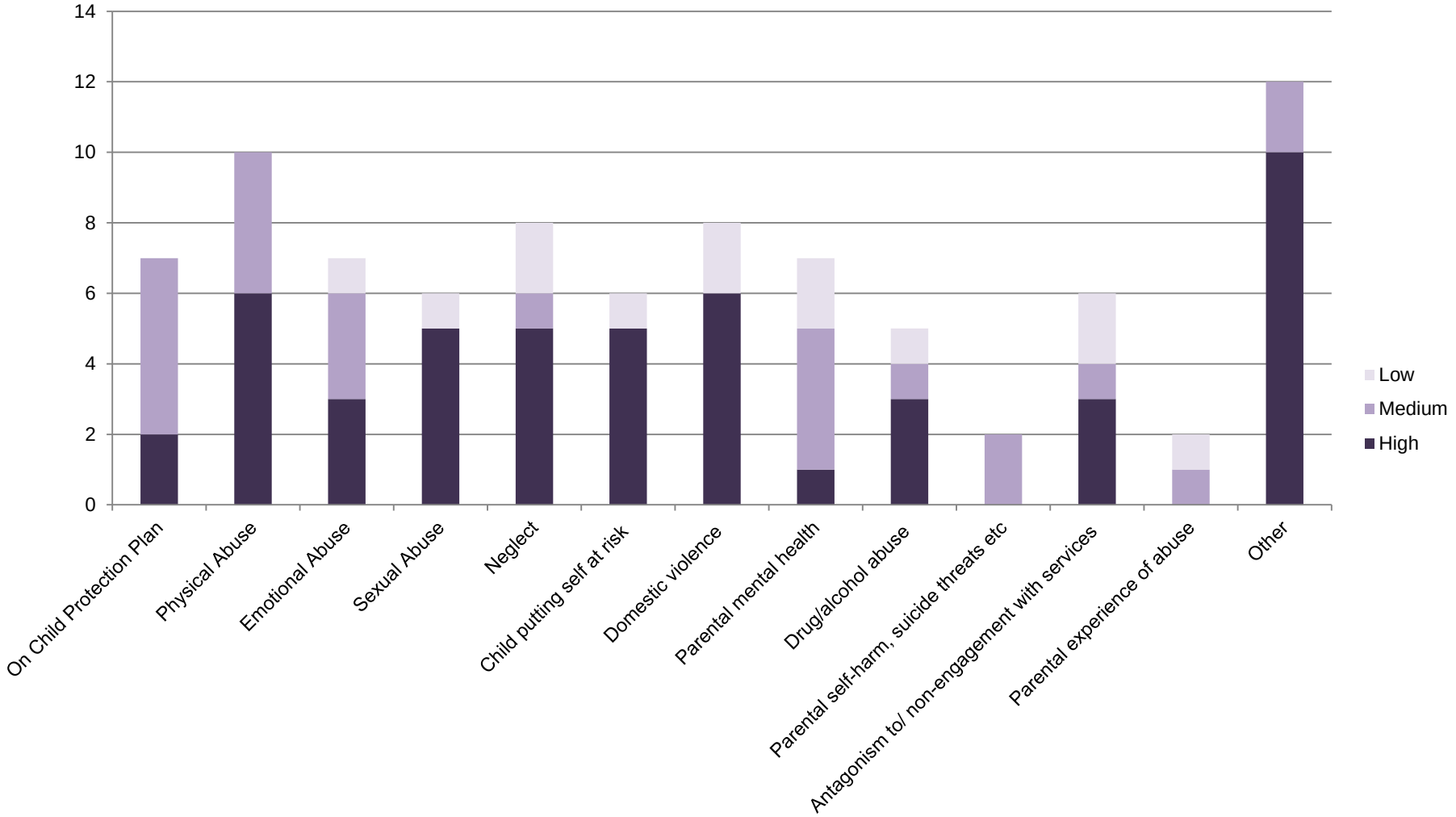
Note that for the category on child protection plan the scores high and medium correspond respectively to: on child protection plan at time of index incident; and on child protection plan prior to index incident; there was no corresponding 'low' value.

Chart 3: Risk types in private law cases (number of cases = 13)



For the purposes of this chart one case with both public and private law has been included here as the public law element was historical whereas the private law proceedings were on-going at the time of the index incident

Chart 4: Risk types in public law cases (number of cases = 13)



For the purposes of this chart one case with both public and private law has been included here as the private law element was historical whereas the public law proceedings had taken place close to the time of the index incident

Key observations:

- **Domestic violence** was the most common risk factor identified in the private law cases, featuring in more of the private law cases, 10 of 13, than public law, 8 of 13 cases, though there were fewer 'high risk' domestic violence cases in private law (two) than public law (six).
- The second most common risk factor in private law cases was **emotional abuse**, this featuring in seven cases and being assessed as a high risk in three of these.
- In public law the most common risk factor (excluding the 'other' category) was **physical abuse**, featuring in ten of the 13 cases.
- Concerns around **neglect** featured in eight public law cases and six private law cases, though in the private law cases the risk level was assessed as lower.
- **Parental mental health** featured as a concern in seven of the public law cases; the majority of the concerns were assessed as 'medium' and 'low' risk[7].
- The **child putting themselves at risk** was a concern in six public law cases and only in one private law case. This may be a reflection of the different age profile in the public law cases, where five of the 16 index children were 13 and over in contrast to only one of the 14 private law children.
- In only three cases, two in public law and one in private law, did information in the IMR indicate that the index child (or children) **currently subject to a child protection plan** at the time of the incident. However, in seven cases, five public law and two private law, the child(ren) had **previously been the subject of a child protection plan**.

Analysis

The high number of medium and high scores in the 'other' category, particularly in public law, may indicate that the risk categories used could have been more comprehensive; i.e. a large number of risks did not fit in any particular category. As a consequence, in cases where there were a range of 'other' risks not covered in any category except 'other', the total risk rating score may not fully reflect the level of risk apparent in the case, in relation to other cases. For example in one case which was assigned a risk rating of six, risks in the 'other' category included the child's emotional and behavioural difficulties, drug addiction, previous suicide threats and medical problems associated with drug use. These were not captured by the methodology which was designed principally to rate cases based on parental characteristics. Other risk factors which did not easily fit into any particular category and arose in more than one case included: parental history of violence or other criminal activity; parental learning difficulties; children's health/behavioural problems which may have increased their vulnerability; parents' previous children having been taken into care.

It is worth noting that the types of risks evident and the people they relate to in many cases do not directly relate to the index incident; that is the incident occurred as a result of a risk which was not evident to Cafcass at the time of our involvement. This is another important reminder that such incidents are not predictable. This is illustrated in a case example below. Conversely, it is important to bear in mind that this research is concerned with the very few

[7] The researchers found that where mental health was mentioned in IMR reports the information was not often detailed (as such detail is not always required for the purposes of an IMR) and therefore the 'low' and 'medium' scores in this category may in some cases reflect a lack of information to justify a 'high' rating.

cases in which a child dies or is seriously harmed; in many cases, protective interventions are effective in ensuring that children do not die and are not seriously harmed at the hands of their parents/carers, such cases never become the subject of SCRs.

The following is an example of fatal maltreatment perpetrated after Cafcass' work concluded by a man who was not involved in the child's life during our involvement.

Case example 6 – risk and index incident

The mother made an application for a non-molestation order, a prohibited steps order and a residence order. The father made a cross-application for contact. There were significant concerns about domestic violence perpetrated on the mother by the father. There were also allegations that the father had been physically aggressive towards the child and the mother's other child; had threatened to remove the child from the jurisdiction and had threatened to kill the mother's other child. The father's contact was restricted to indirect contact and he was ordered to attend a DVPP. The child died whilst the proceedings were on-going as a result of a physical assault perpetrated by the mother's current partner.

Section 4: Child sexual exploitation (CSE)

Child sexual exploitation (CSE) is defined as involving '*exploitative situations, contexts and relationships where young people … receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities*' (Department for Education, 2009).

As set out in section 2, the 27 CSE cases that form the sample for this aspect of the study are derived from two sources: two-thirds are taken from IMRs (dating back a number of years); and the other one-third from cases notified to the Policy Team by FCAs at the behest of the Cafcass Operational Management Team (OMT). The principal purpose of OMT's request was for Policy to hold a database of known CSE cases to facilitate the sharing of information and experiences among operational staff. Research was a secondary purpose. However, the recent publication of the inquiry into CSE in Rotherham (August 2014) alerted us to the possibility of making use of this data within this report.

In respect of those cases in the sample which had been the subject of a Cafcass IMR, the data presented in this section is taken from the IMR. In the other cases the data was taken from the electronic case file, largely from the local authority application and any supporting documents (such as statements and chronologies) compiled by the local authority. Reference was also made to the Cafcass contact log.

It is essential to set out a caveat derived from our 'opportunistic' methodology, namely that it should not be taken as representative of all CSE cases that come to Cafcass' attention and certainly not of CSE cases in general. The numbers are very small and we have not systematically considered every Cafcass case in which CSE features (which would be practically impossible as such data cannot be retrospectively established from ECMS or its predecessor). Notwithstanding this caveat, we hope that the data presented here will provide helpful information about the profile and histories of children who have suffered CSE and who are or have been subject to a family proceedings application.

4.1 Gender

We were notified (by FCAs and SCRs) of 27 girls/young women who were victims of CSE, but received no notifications of male victims. Recent research (Barnardo's, 2014) found that nearly one in three victims that had been supported by Barnardo's were male – a much higher figure than found by previous studies. The inquiry into CSE in Rotherham (August 2014) did not provide a precise breakdown of victims by gender beyond stating that six of the 51 cases held by the CSE team in May 2014 involved males, and suggesting that the exploitation of young males was probably under-reported.

4.2 Applications

Table 13 sets out the most recent application in each case. We have distinguished in the table between those cases where the victim of CSE was the subject of the application, and those cases where, aged under 18, she was the respondent in s31 proceedings.

Table 13: Application type

Application	CSE victim subject of application	CSE victim respondent in application
s25	9	0
s31	8	5
s25 and s31	3	0
s8	1	0
Other	1	0
Total (n=27)	**22**	**5**

In respect of the above table:

- Almost all cases in which the victim was the subject of the application were public law, entailing an application for a Secure Accommodation Order (s25), a Care Order (s31) or both.
- The number of public law applications (s25 particularly) hints at the extreme vulnerability of these girls/young women. It is apparent that some were targeted whilst looked after, such as the girl who, aged 15, absconded with another resident of the home and was brought to hospital intoxicated by an unknown male, and found to have been raped.
- The only exceptions were one private law case, and one 'other' in which the exploited child was the sister of the child subject to the application.

4.3 Age

The tables below set out the age of the victims (a) when first known to Cafcass and (b) at the most recent application.

Table 14: Age when first known to Cafcass

Age when first known to Cafcass	Number of victims
2	1
3	-
4	-
5	-
6	1
7	-
8	1
9	-
10	-
11	-
12	-
13	3
14	5
15	7
16	2
17	3

Unknown	4
Total	27

Table 15: Age at most recent application

Age at most recent application	Number of victims
13	3
14	5
15	7
16	6
17	3
Unknown	3
Total	27

In respect of the above tables:

- All of the most recent applications were made in respect of teenage girls (aged 13-17).
- The vast majority of CSE victims had not been previously known to Cafcass, the most recent application being the first.
- Where Cafcass had been previously involved there were substantial histories of proceedings involving the CSE victim and, sometimes, siblings as well. One girl had been subject to nine s25 applications, as well as a s31 application.

4.4 Vulnerability

The most striking feature of all of the CSE victims, including those five who were respondents in s31 cases, is their extreme vulnerability. Notwithstanding the fact that the sample only includes children known to Cafcass and therefore subject to family law proceedings, this is not surprising. First, it is well-established (see, for example CEOP, 2011) that those who are minded to perpetrate sexual abuse/exploitation of children will carefully select vulnerable children, who are more likely to be successfully 'groomed', and less likely to disclose immediately or be protected by adults. Secondly, the CSE is itself likely to be extremely damaging. Thus there are both pre-disposing vulnerabilities, and further vulnerabilities derived from the exploitation. The following examples illustrate these points:[8]

Case example 7

The victim was one of many siblings who sustained systematic maltreatment in, and were removed from, parental care. She has extensive mental health problems: an attachment disorder; post-traumatic stress disorder; emerging borderline personality; extensive self-harming. She is described as having autistic traits and borderline learning disability. There are many behavioural problems, some of which have led to criminal convictions, including

[8] Some details have been omitted or amended to protect the victim's identity.

violence and sexualised behaviour. There have been no fewer than 15 care placements, culminating in secure accommodation. She disclosed having had sex with men for money but presented this as being consensual. She is thought to have been raped whilst absconding.

Case example 8

The victim's mother has significant mental health difficulties, did not report that her daughter was missing and would not engage with professionals. A further concern was the severe domestic abuse perpetrated by the victim's boyfriend, who lived in the family home. The victim was reported to be engaging in underage sex, selling sex and being beyond mother's control. The s31 application was in respect of the victim, then aged 16, but it was noted that she herself was pregnant at that point.

Case example 9

In this case the victim was, aged just 17, the respondent in a s31 application. She had been accommodated by the local authority having alleged sexual abuse by a family member. She absconded frequently and was found in the homes of different men. She had been in six foster placements and had a history of self-harming and low engagement with support services; she had continued to smoke and use alcohol and drugs when pregnant.

Case example 10

There were concerns around parental drug and alcohol use. The victim went missing repeatedly from home, associating with other young girls at risk from CSE, and sustaining a physical assault by a male but denying sexual activity. She twice sustained serious physical assaults by her boyfriend, being found on the second occasion in an abandoned house, held against her will and badly beaten.

Case example 11

The victim was beyond parental control. Her parents are from Eastern Europe and speak little English. The child disclosed past heroin use but denied CSE, whilst saying that she had come under peer pressure. There was some sexualised behaviour towards a male resident of the secure unit in which she was placed.

Case example 12

The victim's family had been known to the local authority for nine years prior to the making of the s25 application. The victim has a history of drug and alcohol use and self-harming, from the age of 10, including several A&E admissions. The victim has significant mental health concerns and a history of absconding, including being found at a train station with an older male, and with older men in a public park. Sexualised behaviour was identified from the age of nine, towards school pupils and online. She reported being forced into sex by her teenage boyfriend and made allegations of rape by other teenagers, which were later withdrawn. At the time of the s25 application the victim had been charged with soliciting.

These are six examples but there are many others that are equally striking. The vulnerabilities that feature commonly in these, and other, cases include:

- Highly unstable backgrounds within their families exacerbated, in some instances, by the care history.
- Maltreatment in the family.
- Severe child mental health/emotional and behavioural problems. It is noteworthy that some of the victims were admitted to a psychiatric unit. Many had been referred to CAMHS.
- Being hard-to-engage.
- A parental incapacity to provide protection. In some cases this was derived from parental mental illness, disability or language barriers; in others there seems to have been an element of parental indifference.
- Substance abuse and/or violence in the family.

4.5 Implications for Cafcass

One of the striking aspects of many of the cases is the ambiguity around the status of the men. Some victims, having presumably been extensively groomed to believe that they were entering into consensual relationships, commonly described perpetrators as boyfriends. This is very likely to be true in some of the examples set out above. One of the key features of CSE, as highlighted in the literature and research, is the likelihood that victims will not see themselves as such (CEOP, 2011). This may explain why the degree of victim co-operation with the authorities was, initially at least, commonly low. There are also indicators in some of the accounts that the authorities may have misunderstood the coercive elements of the interactions with men and failed to enquire sufficiently. In retrospect (if not necessarily at the time) there were clear indicators that some of the girls were being sexually exploited: being provided with money and/or gifts in exchange for sex; frequently absconding; flagging down unknown cars; the high number of men with whom they said they had had sex; an unwillingness/inability to identify the father of their child.

In this respect, it is important to clarify that, to the best of our knowledge, no victim made a first or substantial disclosure of CSE to a Cafcass officer. In many cases the CSE was known before Cafcass became involved: indeed the CSE acted as a 'trigger' for the application in some cases, notably the SCRs that feature in this sample. However, the exploitation was not necessarily set out explicitly in the application. It is evident that in some cases information regarding CSE was received, or elaborated upon, after the proceedings started. In a small number there are signs that the CSE continued after the proceedings started, but no effective protection was put in place. We illustrate the point with the following example:

Case example 13

This concerns a girl who was described (within professional reports) as having been 'sexually active' from the age of 11 (notwithstanding the fact that a child of this age cannot legally consent, and that this would constitute statutory rape). Aged 13, and looked after, she had a 'boyfriend' who was much older and who was arrested for a sexual offence against another child. She went missing numerous times from the placement (not all of which were

notified to the Children's Guardian). This was framed as 'involvement in prostitution' rather than exploitation, and there does not seem to have been any concerted effort to counter this.

That being the case we suggest that there may be some learning points for Cafcass, as follows:

1. The victim may not have provided a full and accurate account of the CSE. She is likely to have been systematically groomed to believe that she is acting consensually, and to have been threatened.
2. The CSE may not have ended and the child may not be safe.
3. The victim may not have entered freely into an equal relationship with her 'boyfriend'. He may be a perpetrator of CSE.
4. Descriptions of the victim's behaviour such as 'sexually active' or 'involved in prostitution' are likely to mask the power and control exercised by the perpetrators of the CSE, and the extreme vulnerability of the child.
5. Whilst all victims of CSE notified to the Policy Team to date are female, and all but one was the subject of public law applications, not all victims necessarily fit this profile. It is intended that ECMS will be able to capture cases where CSE is a feature as of February 2015, thus allowing the collation of more robust data.

Section 5: Learning

We look at two matters in this section: *what* have we learned about our practice from this year's SCR submissions; and *how* does Cafcass learn from its inputs to SCRs?

5.1 What has Cafcass learned?

In our 2012 study we wrote the following regarding private law practice:

'*No fewer than 11 of the 14 private law cases were weak in respect of the obtaining and screening of safeguarding checks. Unfortunately, this had a 'knock-on' effect on the quality of the provision of advice to the court…Perhaps the most concerning manifestation of systemic failure was those cases where there seemed to be a prevailing culture in some courts, and some Cafcass services, of the 'real' function of both being to expedite a swift outcome to as many cases as possible…It may be significant that many of the IMRs identified massive backlogs in Cafcass' services at the time'.*

To place these comments in context, some of the IMRs had been submitted three years previously (around 2009) and thus not all of the practice was contemporary. Nonetheless, the findings highlighted a number of systemic failings (by which we mean that they seem to relate principally to the governance, policies or culture of the organisation, rather than to the work of individual practitioners) that impeded the provision of a consistently high-quality service, notably in private law. The findings from the public law IMRs suggested that there were fewer systemic problems in that area, though we noted difficulties in the allocation of FCAs and drift in cases of long duration. We speculated that there might be an inverse relationship in some public law cases between case duration and the quality of work i.e. the longer a case lasted; the more likely it was that the quality of practice would drop.

In this study, in line with our work on the previous studies, we looked at all SCR submissions, recording positive and critical comments about the practice. We then sought to code the comments to establish whether there were any aspects of our practice that were consistently strong or weak. Unlike the 2012 study, quoted above, few clear patterns emerged, but we note the following:

- Direct work with children, and the setting out of the child's needs, wishes and feelings, were consistently cited as being a strength.
- Connected to this, there were also positive comments about the understanding and reporting of the child's diverse needs.
- Liaison with the local authority was generally strong; though there were examples, within private law cases, of data provided by local authorities in response to safeguarding information requests, not being followed up; and within public law of liaison with the Independent Reviewing Officer being weak.
- Recording was mixed, and occasionally very poor. The principal consequence of this is the potential to compromise safeguarding, but it may also mean that good work is not identified within the SCR.
- Where comment is made about the management of services or cases, this is commonly positive.

In respect of **private law** we present very succinct summaries of the strengths and weaknesses of two cases, both of which have been redacted to protect the confidentiality of those involved. In both of these cases, and others in the sample, the safeguarding work is fundamentally sound but there is room for improvement. A strong impression in both cases is that raising the standard of the work would not have required substantially more practitioner input; but rather that a bit more attention to detail or a follow-up action or a more timely intervention would have made a big difference.

Case example 14

The need for a child protection referral was identified and made in a timely manner. The safeguarding letter clearly identified numerous safeguarding issues, informed the court of the referral to the local authority and provided appropriate advice to the court, including the need for further assessment of specific issues. The WAFH case plan was strong, identifying the key issues: the outcome of the child protection referral, enhanced police checks; the impact of domestic violence/coercion by father and mother's ability to safeguard the children in her care.

Important safeguarding information contained in the application was apparently overlooked in the initial screening. The parties were not contacted until just before the FHDRA, this being a fairly common practice at the time within a culture of 'just in time' working to filing dates rather than working more steadily across the whole period between receipt of a new application and the FHDRA. The recording was patchy, which is particularly unfortunate in a case to which several FCAs contributed, and there was delay in establishing the outcome of the child protection referral.

Case example 15

The safeguarding checks were undertaken and accurately reported to the court. There is a coherent record of a planned and purposeful intervention, which facilitated the collation of important information from the parties and agencies that knew them. The direct work with the children was good and strengthened by the use of assessment tools. Management oversight led to a re-evaluation of the risks to the children derived from domestic violence and parental attitudes to the children, and a child protection referral was then made to the local authority.

There are gaps in the recording. Whilst the initial case plan was strong, the reviews were less so, as they were not used to reflect upon the significance of emerging information. Some of the risk factors were not sufficiently explored in the referral to the local authority or the report to court, and the latter was rather 'sloppy' with numerous spelling and grammatical errors.

In respect of **public law** we present two more summaries, appropriately redacted. Self-evidently, the practice in one case is much stronger than it was in the other. The former evidences a determination to understand and represent the child's needs, together with strong analytic skills. The latter does not:

Case example 16

The Guardian considered the needs of each child individually, ensuring that they were consulted at each stage of the proceedings and that their voices were listened to and

understood by the court. The specific needs of and risks to the children (derived from age, history and disability) were assessed and set out for the court. There was effective challenge to the local authority's application to dismiss the direction for expert assessment. Guardian recognised that (one child) would be especially vulnerable to abuse in the future and ensured that the necessary therapeutic interventions were provided.

Case example 17

There was insufficient analysis of the risks posed to the child by father. The child's special needs, and the long-term risks derived from these, were not addressed. The father's denial of domestic violence was not checked against the accounts of his ex-partners. This was compounded by an erroneous belief that he was not the perpetrator of an assault. There was too little analysis of, and too much reliance on, a superficial expert assessment.

There were a few examples in the sample of cases that formed this study of systemic challenges being identified as follows:

- Is the Cafcass approach to child sexual exploitation, and practitioner understanding of the same, sufficiently strong (see section 4)?
- Is the requirement to undertake WTFH telephone interviews with adult parties understood and implemented by Early Intervention Team practitioners, irrespective of current local authority intervention? (More than one IMR has revealed the erroneous belief that telephone interviews are not required if the local authority is involved in the case, and has agreed to provide a section 7 report.)
- Whilst the management and quality assurance of staff is fundamentally sound as evidenced by, for example, Ofsted inspections, is there an area of weakness around staff whose performance is erratic?

We repeat a caveat that we have made in previous studies in this series: cases that are subject to SCRs are not necessarily representative of practice as a whole. That said, there are two striking differences between the findings of the 2012 study, quoted above, and the findings of this study:

- There is now a much more encouraging balance of positive findings alongside the more negative ones.
- The failings rarely reveal widespread vulnerabilities across the organisation.

5.2 How has Cafcass learned?

We start by setting out in table 16 the mean number of recommendations per IMR from 2010 to 2014, together with the range of recommendations (the lowest and highest number).

Table 16: Recommendations by year

Year	Number of IMRs	Mean number recommendations per IMR	Range
2010	11	5	1 - 9
2011	9	6	2 - 17

2012	6	4	2 - 6
2013	11	1.3	0 - 3
2014	13	1.5	0 - 6

It is apparent from the above table that the mean number of recommendations has dropped in the last two years. Prior to 2013 Cafcass made at least one recommendation in each IMR. In the last two years (2013 and 2014) Cafcass has made no recommendation in nine of the 24 IMRs.

There are essentially three reasons for these changes:

1. The problem identified by the IMR has already been resolved. A recent example is an IMR that looked at a public law case dating back three years in which the case was not promptly allocated due to a backlog. In such instances we are able to cite current MIS data demonstrating current prompt allocation across the organisation.
2. The problem was not identified or resolved at the point that the index incident occurred but is resolved, or at least in hand, now. The Cafcass National Improvement Service (NIS) now completes an immediate file review when a child dies which enables swift corrective action to be taken, and IMR authors discuss their emerging findings with the Head of Service and National Child Care Policy Manager, which presents further opportunities for such action to be taken. Examples include: an audit to establish the timeliness of responses to the receipt of safeguarding information and early contact with parties; promoting adherence to the Supervision Policy through enhanced dip-sampling, observations of supervision and audit.
3. The development of the Learning Model (see Appendix B). This sets out the mechanisms by which learning from each SCR submissions is disseminated, at a local and national level. These include; team discussions; the learning log; training modules; LSCB events and this research. The principle behind this model is that learning is not restricted to management action, but also entails the provision of knowledge and opportunities to reflect, individually or in groups. The development of the model means that where there are no actions stemming from an SCR submission, this does not mean that there has been no learning. In this respect it is noteworthy that it is very rare for LSCBs to challenge SCR submissions, in instances where we make no recommendations, from which it can be inferred that our model is seen as robust.

Section 6: Key learning points

We conclude this report in the same way as the two previous reports of 2012 and 2013, by setting out the key learning points derived from our analysis:

1. Cafcass has contributed to 28 SCRs in the 14 months (August 2013 to September 2014 inclusive) that forms this study. This is approximately twice the rate of SCR submissions over the previous three years. The increase in Cafcass SCR submissions is in line with a substantial increase in the total number of SCRs being convened by LSCBs.
2. Seventeen of the 26 index incidents (that were subject to analysis) entailed a child fatality. Eleven of the 15 incidents entailed a fatal physical assault, which is the most common index incident in all three samples combined. Ten of the 26 incidents took place whilst the proceedings were on-going.
3. The average age of the mothers at birth of first child was about five years lower than the national average age of mothers at the date of their first birth.
4. The known risks are, on average, much higher in public law cases than in private law cases. However, fatal/serious maltreatment occurs in the context of low, as well as high, risk cases. This acts as a useful reminder that risk factors might be a crucial practice tool in identifying that significant harm has occurred, or is likely to occur, and thus guiding professional practice; but that they are of little or no value in predicting which children will die as a consequence of maltreatment.
5. As in the previous studies, domestic violence was the most common risk factor.
6. The most striking feature of the child sexual exploitation (CSE) cases considered in the research was the extreme vulnerability of the young women. It is evident that they had many vulnerabilities derived from their family lives (which may explain why they were identified as suitable for exploitation); and that the CSE had significantly added to their vulnerability.
7. It appears that some of the young women were still being sexually exploited after proceedings began and that the men referred to as their 'boyfriends' were in fact perpetrators of CSE.
8. Descriptions of the victim's behaviour such as 'sexually active' or 'involved in prostitution' can mask the power and control exercised by the perpetrators of the CSE.
9. The scrutiny of Cafcass practice identified few clear patterns, though we noted that direct work with children remains a strength together with reporting of the child's diverse needs. In private law the quality of practice could have been considerably improved by very little extra work e.g. bit more attention to detail or a follow-up action or a more timely intervention.
10. In 2014 Cafcass made, on average, 1.5 recommendations per SCR submission, compared to an average of 6 in 2011. The timely identification and resolution of problems following notification of the incident (facilitated by a file review conducted by the National Improvement Service) has reduced the need to make formal recommendations, as has the development of the Learning Model (see Appendix B).

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Appendix A: Risk categories

1. Child subject to CPP?
2. Physical Abuse
3. Emotional Abuse
4. Sexual Abuse
5. Neglect
6. Child putting self at risk
7. Domestic violence
8. Parental mental health
9. Drug/alcohol abuse
10. Parental self-harm, suicide threats etc.
11. Antagonism to/ non-engagement with services
12. Parental experience of abuse
13. Other – specify

Appendix B: Learning Model