Learning from Cafcass Individual Management Reviews (IMRs)

Case Dynamics: Executive Summary

November 2013

Introduction

This summary sets out learning about the case dynamics derived from 35 Individual Management Reviews (IMRs) undertaken between 2009 and 2013 and data provided by serious incident notifications, specifically in respect of incidents of child and parental suicides from 2009 to 2013.

Context

There was previously a requirement, set out in *Working Together to Safeguard Children* (2010), that IMRs must be produced by agencies that contribute to Serious Case Reviews (SCRs). The revised version of *Working Together,* published in March 2013, delegated the decision as to what methodology to use in conducting a SCR to Local Safeguarding Children Boards (LSCBs). The early indicators are that LSCBs are using different models. Some have chosen to commission IMRs as they were previously required to do. Others have chosen to adopt 'systems models' that typically consist of the following elements: chronologies; very succinct bullet-point summaries; multi-agency discussions; and a thematic overview report.

A SCR is mandatory where (a) a child dies and abuse or neglect is known or suspected to be a factor in the death, or (b) where a child has been seriously harmed and there are concerns about the quality of multi-agency working.

Methodology

Data was extracted from all IMRs completed by Cafcass between April 2012 and July 2013, however only the findings from IMRs from April 2012 – July 2013 are considered in detail.

Where quantitative data is presented in this report we typically set out the numbers relating to the sample for the years 2009-12 (herein referred to as the 2012 sample), the 2013 sample and the total sample (2012 and 2013 data combined). However we only discuss the qualitative detail of the 2013 sample. IMRs have facilitated a detailed and forensic inquiry into a small number of cases, and as such have made an important contribution to learning within Cafcass. However, it is also important to note that thirty-five cases is a small sample when set against our stock of cases – approximately 34,500 as of 1 July 2013. In preparing the annual Cafcass safeguarding report (2013; unpublished) we estimated that a child currently or (more usually) previously known to Cafcass dies as a consequence of abuse/neglect in approximately one case per 3,800.

Findings from IMRs from April 2012 to July 2013

This section looks at findings from the 12 IMRs completed by Cafcass between April 2012 and July 2013. It is divided into two sections: the first looks at the 10 cases which involved intra-familial abuse; the second at the two cases of child sexual exploitation.

1. Intra-familial Abuse

In respect of the 10 cases:

- Seven were private law cases, of which six were Work to First Hearing (WTFH) only, and one was Work after First Hearing (WAFH).
- Three were public law cases, of which two were s31 applications and the other an application for an Emergency Protection Order.
- The index incident (the fatal abuse/neglect) took place in three cases where there were current proceedings. In the other seven cases there had been previous proceedings, four relating to the index child/ren, and three relating to non-index children i.e. in these latter three cases the child/ren who died had never been in proceedings, but Cafcass had previously been involved with another family member.

In respect of the 16 index children who sustained fatal abuse:

- Nine of the 16 index children were boys, and seven girls.
- One child was Asian, the others known or believed[1] to be White UK.
- One child was known to have a serious disability.

Age of children (at index incident)

As set out above, a total of 16 children sustained the fatal abuse/neglect that triggered the SCR. The age frequencies of the children are set out in table 1 below: the 2012 sample; the 2013 sample; and the total sample (2012 and 2013 combined). As point of comparison, data from one of the latter biennial reviews (Brandon et al; 2009) is also provided.

Table 1: The age of children, at index incident

	2012 sample (n=30)	2013 sample (n=16)	2012 & 2013 samples (n=46)	Biennial review (n=83)
Under 1	2 (7%)	5 (31%)	7 (15%)	39 (47%)

[1] The data presented in this report is derived from Cafcass IMRs, not the SCR overview reports, and may therefore be partial.

1 to 5	14 (47%)	4 (25%)	18 (39%)	20 (24%)
6 to 10	5 (17%)	4 (25%)	9 (20%)	5 (6%)
11 to 15	6 (20%)	2 (13%)	8 (17%)	11 (13%)
16 to 17	3 (10%)	1 (6%)	4 (9%)	8 (10%)

The age of parents (at birth of first child)

Table 2: The age of parents at birth of first child (2013 sample only)

	Type of Case	**Age of mother when first child born**	**Age of father when first child born**
1	**Private law – WTFH only**	24	28
2	**Private law – WTFH only**	16	Unknown
3	**Private law – WTFH & WAFH**	19	27
4	**Public law – s31**	36	33
5	**Public law – s44**	17	26
6	**Private law – WTFH only**	17	26
7	**Public law – s31**	20	20
8	**Private law – WTFH only**	18	18
9	**Private law – WTFH only**	19	24
10	**Private law – WTFH only**	20	21

Eight of the ten (80 per cent) mothers were 20 or under at the birth of the first child; and two fathers (20 per cent) were 20 or under.

2. The index incidents

Table 3 below sets out the index incident in respect of all ten cases, together with the following data:

- The type of case – private or public law
- Whether the index child died
- Whether the index child was in proceedings currently (at the time of the index incident), previously or never.
- The probable identity of the perpetrator of the index incident, where known.
- The level of risk.

The level of risk was determined, by identifying known risk factors and by then identifying the degree of risk in respect of each risk factor – low (one point); medium (2 points); high (3 points). Thus each case has a level of risk score, the lowest possible score being 0 (no

known risks) and the highest 36 (all risks present at a high level). It should be borne in mind that the data is taken from IMRs and that IMRs reflect what was known to practitioners at the time. Thus the level of risk reflects contemporary knowledge on the part of the Family Court Adviser, and not the knowledge that may have been gained subsequently through multi-agency review, care proceedings of surviving siblings, or criminal trials.

Table 3: The index incident, and additional case information (2013 sample only)

	Type of case	Category of index incident	Child death	Child in proceedings?	Perpetrator	Level of risk
1	**Private law – WTFH only**	Suicide	Yes	Yes, previously	Self	11
2	**Private law – WTFH only**	Neglect (fatal)	Yes	Yes, currently	Mother & Father & other	10
3	**Private law – WTFH & WAFH**	Physical abuse (fatal)	Yes	No	Father	4
4	**Public law – s31 only**	Neglect (fatal)	Yes	Yes, currently	Father	11
5	**Public law – s44**	Physical abuse (fatal)	Yes	Yes, previously	Father	7
6	**Private law – WTFH only**	Physical abuse (fatal)	Yes	No	Probably father or mother	4
7	**Public law – s31 only**	Neglect (fatal)	Yes	Yes, currently	Maternal Aunt	7
8	**Private law – WTFH only**	Neglect (fatal)	Yes	Yes, previously	Mother	12
9	**Private law – WTFH only**	Spite/revenge killing	Yes	Yes, previously	Father	8
10	**Private law – WTFH only**	Physical abuse (fatal)	Yes	No	Father	2

- Four of the incidents involve a fatal physical assault upon a child: three within private law cases and the other following an application for an Emergency Protection Order that was refused by the court. A fifth case also involved fatal assaults on two brothers followed by the suicide of the father/perpetrator. The key factor in this case may have been the father

learning that his ex-wife had recently formed a new relationship, which lends weight to categorisation of this case as a spite killing.

- Four cases involve deaths of a child or children in the context of neglect.
- The levels of risk of many cases within the 2013 sample are notably lower than those in the 2012 sample. The range is 2-12, whereas the range in the 2012 sample was 1-26.
- The highest risk score in the 2013 sample was 12, compared to five scores of between 23 and 26 in the 2012 sample. This could be taken as a reminder that whilst fatal abuse/ neglect sometimes occurs within the context of high risk, this is not always the case. Some deaths occur when there is little known risk or even 'out of the blue'.
- A further reflection is that the 2013 sample contains six cases that were WTFH only, one public law case that was an EPO application only, and two s31 cases that were of much shorter duration than many of those that formed the 2012 sample, which was characterised by many WAFH private law cases, and some public law cases that had very lengthy durations. The identification, and recording, of more risk factors within the 2012 sample may be derived in part from our more substantial involvement in those cases.

Table 4: The categories of index incidents (2012 and 2013 samples)

Category of incident	2012 sample n = 23	2013 sample n = 10	2012 & 2013 samples n = 33
Neglect (fatal)	4 (17%)	4 (40%)	8 (24%)
Physical abuse (fatal)	3 (13%)	4 (40%)	7 (21%)
Spite/ revenge killing	5 (22%)	1 (10%)	6 (18%)
Suicide	4 (17%)	1 (10%)	5 (15%)
Physical abuse (non-fatal)	4 (17%)	0	4 (12%)
Neglect (non-fatal)	2 (9%)	0	2 (6%)
Other	1 (4%)	0	1 (3%)

In respect of the above table:

- Fatal physical assaults account for 13 of the 33 cases: seven fatal assaults and a further six spite killings. The latter group are distinguished from the former in that there is an intention to kill the children, with the motive being in many cases to cause distress to the surviving spouse. In a study of 'family annihilators' Yardley et al (2013) found that the primary motivation was family break-up in 66 percent of such killings; and that just under 80 percent of cases entailed the suicide, or attempted suicide, of the perpetrator.
- The Yardley et al (2013) study only looked at male perpetrators of spite killings. One of the six spite killings subject to a Cafcass IMR was perpetrated by a woman. We have recently been notified of another SCR into a case in which the mother is thought to have killed her child shortly after the Cafcass FCA recommended change of residence to the father (not included in the sample).
- There were a further four physical abuse cases in the 2012 sample which did not have a fatal outcome. None of these feature in the 2013 sample which seems to confirm a widely-held view that LSCBs are by and large only convening SCRs that meet criterion (a) – see section 1 - where a child has died and abuse/neglect is known/suspected.

- Neglect accounted for ten cases, of which eight had a fatal outcome, commonly in situations where children were left unattended, or in co-sleeping/overlaying incidents where substance abuse is typically a factor (Cuthbert et al, 2011).
- In five cases the index incident was a child suicide: four in public law and one in private law. All of the children who committed suicide were aged between 11 and 17 years old, four of the children being males and one female. The subject of suicide – child and adult – is explored further within the notifications section.

3. Prevalence of risk factors

Private law

Table 5 sets out those risk factors which were prevalent within private law cases across both samples together with their overall risk rating (the sum of the frequency with which a risk occurs together with its level of risk – low, medium or high). Domestic violence and, to a lesser extent, substance abuse are very prevalent; parental mental health much less so. Across the entire sample the 'toxic trio' occurred in combination in seven of the 21 cases (33 per cent).

Table 5: Risk factors prevalent within private law cases (2012 and 2013 samples)

Risk	2012 sample n = 14	2013 sample n = 7	2012 and 2013 samples n = 21	Overall risk rating
Domestic violence	12	7	19 (90%)	45
Substance abuse	12	4	16 (78%)	32
Neglect	7	1	8 (38%)	15
Mental health	5	2	7 (33%)	15
Physical abuse	3	4	7 (33%)	12

Public Law

The 2013 public law case sample is very small – just three cases. Within the total (2012 and 2013) sample of 14 cases the most common risk factors were:

- Antagonism/non engagement with services – 12 cases (86 per cent)

- Neglect - 11 cases (79 per cent)
- Domestic violence – 9 cases (64 per cent)
- Substance abuse – 8 cases (57 per cent)

4. Child sexual exploitation (CSE)

Cafcass contributed to two SCRs on the subject of CSE, between April 2012 and July 2013, comprising five young women known to us. A further such SCR is in train comprising six young women known to Cafcass.

A striking feature of these cases is how young the victims of the CSE were when they gave birth to children who were then subject of s31 care applications.

The fact that all the young women were victims of CSE was already known when the care proceedings started, and Cafcass did not receive any new 'disclosures' i.e. the victims did not share any information with the Children's Guardian that was not already known to children's services. Self-evidently, all the young women were extremely vulnerable. We do not yet have all the findings from the on-going SCR but the fact that four of the six were subject of s25 applications indicates their vulnerability and, no doubt, the harm caused by the CSE.

The completed IMRs have identified the importance of trying to establish the identity of the father of the children with due consideration of the possibility that: coercion, control and violence may be influencing a young person's reluctance to disclose this; the identity may not be known where there has been sexual assault perpetrated by a number of men; there may be 'cognitive distortions' formed by the grooming process (e.g. perpetrators seen as boyfriends) and very strong feelings of shame.

A training module is being created for Cafcass staff, which will set out key learning from literature, research and our IMRs in relation to CSE.

Serious Incident Notifications

Cafcass staff are asked to make notifications where a family is known to Cafcass and: a child dies under any circumstances; an adult dies as a consequence of domestic violence or suicide; or a serious incident occurs. The notification describes the family composition and index incident, together with the nature, and the start/end dates, of Cafcass' involvement.

This sample includes all notifications received between April 2011 and July 2013; a total of 152 notifications over a 28 month period. The notifications were codified into three categories: child deaths; child serious incidents; and adult deaths. They were then further codified into sub-categories of the above, as set out in the left hand column of table 6. The results were as follows:

Table 6: All notifications received between April 2011 and July 2013

		Number			
Notification	**Code**	**11/12**	**12/13**	**Apr – July 2013**	**Total**
Child deaths (CD)					
Abuse/neglect known/suspected	CD1	8	10	4	22
Suicide	CD2	4	4	0	8
Natural causes/ accident	CD3	9	9	1	19
Cause n/k	CD4	2	0	0	2
CD1 plus adult suicide	CD5	2	1	1	4
CD1 plus homicide of parent	CD6	1	0	1	2
Child Serious Incidents (CS)					

Sexual abuse/exploitation	CS1	4	3	3	10
Physical abuse	CS2	16	7	2	25
Child missing	CS3	4	7	5	16
Concern re foster placement	CS4	0	0	1	1
Neglect	CS5	3	0	1	4
Other	CS7	0	2	1	3
Suicidal behaviours	CS8	3	4	0	7
Adult Deaths (AD)					
Domestic homicide partner	AD1	5	4	2	11
Domestic homicide other	AD2	0	1	2	3
Adult death natural or n/k	AD3	1	1	2	4
Parental Suicide	AD4	8	3	0	11
Total		70	56	26	152

The data in the table above is unlikely to be a precise account of the serious incidents that took place in families subject to proceedings. What is notified to the safeguarding team, and thus appears in the table, hinges on a number of factors, including:

- the operational service being informed of serious incidents where these occur after Cafcass has ceased its involvement ;
- the extent of adherence to the requirement to notify; and
- the interpretation of what constitutes a serious incident.

It is important to bear in mind that 152 notifications, over a period of 28 months, represents on average about 5.5 per month. During the same period Cafcass received, in total, over 120,000 applications. This means that a serious incident notification is made in approximately one case per 800, or 0.0013% of cases. Serious incidents are mercifully rare.

The notifications made most frequently are as follows:

- Physical abuse (not fatal) of a child (n = 25)
- Death of a child where abuse/ neglect is known/suspected (n = 22)
- Death of a child entailing natural causes or an accident (n = 19).

In total 23 suicides were notified. These 23 incidents are explored in greater detail in the following section.

Section 6: Suicides

The research team looked into the 23 suicides identified within the serious incident notifications ('notifications') between 2011 and July 2013.

The 23 suicides comprised:

- 11 suicides of a parent;
- four suicides of a parent where the parent was also known, or believed to have, killed a child; and
- eight suicides of children.

Self-evidently we cannot be certain that the child or adult intended to commit suicide in every case. The cause of death or the context in which it occurs is determinative in some cases. For example, where a child or adult jumps to his/her death from a bridge we can conclude that it was indeed a suicide. Likewise, where the bodies of a parent and children are discovered, in the context of highly adversarial residence/contact disputes, we can reasonably infer that these were homicides/suicides. We cannot be so sure where, for instance, an adolescent dies of an overdose in the context of lengthy substance misuse. We do not have access to data derived from the Coroner's Court. For that reason we took the pragmatic decision to categorise as suicides all notifications where the data available to us suggested that it was at least a strong possibility.

A decision was taken to interrogate the notification of suicides from an earlier period, incorporating 2009/10 and 2010/11. This revealed a further:

- three suicides of a parent
- three suicides of a parent where the parent was also known or believed to have killed a child; and
- nine suicides of children.

Table 7: The total numbers of identified suicides, April 2009 to July 2013.

		2009/2010	2010/2011	2011/2012	2012/2013	2013 to date	Total
Child suicide	CD2	5	4	4	4	0	17
Child homicide plus adult suicide	CD5	1	2	2	1	1	7

Parental suicide	AD4	0	3	8	3	0	14
Total		6	9	14	8	1	38

Child suicides

We interrogated the data further in respect of the child suicides, establishing: gender; age; whether the child was in proceedings at the time of his/her death; (if not currently in proceedings) how much time had elapsed since proceedings concluded; and the sections of the Children Act (1989) under which applications had been made to the court. The data is set out in table 8.

Table 8: Case information on child suicides

Case No	Gender	Age	Current proceedings	How long before the death did proceedings conclude?	Section
361	Female	17	No	11 months	25 & 31
354	Male	9	No	5 years	31
356	Male	17	No	1 year	8
318	Male	12	No	1 year	8
291	Male	13	No	1 year	8
258	Female	17	No	10 months	31
243	Male	17	N/A	N/A	N/A
222	Male	17	No	11 years	31
213	Male	21	No	8 years	31
201	Female	17	N/A	N/A	N/A
196	Male	10	N/A	N/A	N/A
169	Male	12	No	6 years	31
156	Male	11	No	1 year	31
118	Female	14	No	2 months	25
121	Male	11	Yes	N/A	31

123	Female	13	No	1 year	31
111	Female	15	No	11 months	25

In summary:

- 11 of the suicides were males and six were females.
- Six children – three males and three females – died aged 17.
- There were six male suicides aged 12 or under. The youngest child to die thus was a boy aged 9. The youngest female to die was aged 14.
- Three of the children who died were never subject of an application, but were siblings, or a close relative living within the same family, of a child who was the subject of an application.
- Only one child died during proceedings, a pre-adolescent, who was subject of a s31 care application.
- A further three children died within a year of the conclusion of proceedings.
- Eleven of the 14 cases in which the child was/had been in proceedings entailed either care (s31) and/or secure accommodation (s25) applications, with just three being private law (s8).

The cause of death was notified in 13 of the 17 cases.

Suicide of a parent

We interrogated the data further in respect of the 21 parental suicides, establishing: who died; whether the proceedings were on-going; whether there were prior proceedings; and the sections of the Children Act (1989) under which applications had been made to the court. The data is set out in table 9. The parental suicides are set out first, followed by the homicide/ suicides with the identity of the victim(s) in parentheses. The notes column adds some contextual detail.

Table 9: Data in respect of parental suicides

No.	Who died	Current proceedings	Prior proceedings	Section	Notes
341	Mother	Yes	No	31	Two days before final hearing.
302	Father	Yes	No	8	Just after making of s8 order
282	Mother	Yes	No	31	Long-standing mental health problems. Child due to be presented to

					adoption panel.
267	Mother	Yes	No	31	Day of final hearing.
298	Both parents (different incidents)	Yes	No	8	Just after making of s8 order.
266	Father	Yes	No	8	Long-running contact dispute.
254	Mother	Yes	Yes	31	Heroin o/d 3 days after placement order.
249	Both parents (together)	Yes	No	31	Unclear whether double suicide or suicide & homicide.
226	Father	Yes	No	8	Day after hearing.
227	MGM	Yes	No	31	Children recently removed from MGM's care .
214	Mother	Yes	No	31	Suicide on day of final hearing – history of suicidal ideation/behaviours and addiction.
176	Mother	Yes	No	8	Mother suicide whilst children on contact with father.
168	Mother	Yes	No	31	Early stages of proceedings; mother had suffered psychosis.
237	Father	Yes	Yes	8	Contact application but not having contact.
No.	Who	Current proceedings	Prior proceedings	Section	Notes.
368	Mother (and children)	No	Yes	31	Shortly after split from partner.
330	Father (and	No	Yes	8	During contact.

	children)				
252	Father (and child)	Yes	Yes	8	Shortly after mother made application.
264	Father (and mother and child)	No	Yes	31	Only perpetrator known to Cafcass.
212	Father (and mother and children)	No	Yes	8	Only mother known to Cafcass.
182	Father (and child)	Yes	No	8	Father had interim residence.
151	Father (and child)	No	Yes	8	Father survived (but motive very probably suicide).

There were 14 cases in which a parent committed suicide, and a further seven homicide/ suicides. In respect of the 14 suicide cases:

- There were 16 deaths (if we classify case 249 as a double-suicide), comprising nine mothers, six fathers and one grandmother who had cared for the children.
- Eight were public law (s31) cases; the other six were private law (s8).
- All 14 took place during proceedings, unlike the child suicides.

In respect of the eight public law cases the proximity of the suicide to a milestone event within the proceedings is striking. Two parents killed themselves on the day of the final hearing (one in view of the court building). A further two suicides took place within three days of the final hearing. Other notifications referred, for example, to an amendment to contact arrangements, or an impending adoption panel.

In respect of the seven homicide/suicides:

- Six were perpetrated by the father, and one by the mother.
- Five involved the killing of a child or children.
- Two involved the killing of a child and partner.
- Five were private law and two public law.
- Five took place after the proceedings had concluded.

Homicide/suicides are particularly horrifying, as is reflected in the language that is sometimes employed to describe these – ‘family annihilation’, ‘family wipe-out’ etc. The spite killings (see above) are also very distressing. Indeed, some of the cases feature in both our

spite killings and homicide/suicide cohorts, though not all as there are some distinguishing features between the two categories. These include:

- The spite killings do not always entail the suicide of the perpetrator.
- Some homicide/suicides are characterised by severe mental illness or 'altruistic' motives e.g. 'the child cannot possibly live a happy life if I am dead'. Conversely, some of the features of spite killings we have seen in our IMRs include: a telephone call to the mother to say that the children are about to be killed; a message on an explosive device left for the mother.

In the light of the particularly chilling quality of these incidents it is important to set out some key learning derived from the literature, notably Berry and Cliff (2013) and Yardley et al (2013):

- It is thought that there are on average, in England and Wales, about four killings of a child per year followed by the suicide of the perpetrator. It is a very infrequent occurrence, about 0.05 per 100,000 population.
- Most perpetrators are male, estimated to be 86 per cent.
- Few perpetrators have a history of offending, or input from children's or mental health services.

Key Learning Points

The following are the learning points derived from the aggregation of the 2012 and 2013 cohorts of IMRs, and the inclusion of data in the 2013 study only derived from serious incident notifications, principally in respect of suicides.

1. Abuse-related deaths of children are mercifully rare within both public and private law cases. Good safeguarding practice will, very often, identify which children are at high risk, and in some cases mitigate the risk, but it is rarely possible to predict which children will die, nor foresee the circumstances in which they will die (by whom, how and when).
2. The level of risk, identified prior to the incident that triggered the SCR, in the 2013 sample was notably lower than in the 2012 sample. This may simply be attributable to the small sample sizes. However, it serves as a useful reminder that fatal abuse does not always occur within the context of recognised high risk indicators. Indeed, in the 2013 cohort the fatal physical assaults, and the one spite killing, all took place in cases where there were relatively few known risks.
3. When the data from the two cohorts is aggregated, the most common cause of death was neglect, typically overlaying (where substance abuse is implicated) or a child left unattended.
4. Domestic violence is the highest risk factor within both cohorts.

5. Approximately four children per annum take their own lives. This entails: more boys than girls; more older children (17 being the most common age); and more public law applications. There are, however, exceptions to all of these 'rules'. The most striking finding is that only one of the 17 children that has died thus since 2009 committed suicide during proceedings. This may simply reflect the point made above – most child suicides occur amongst the older age group who are under-represented in proceedings. Or it may imply that proceedings represent a period of hope that things may change for the better – hopes that are sadly not realised in every case.
6. There were a similar number (16) of notifications of adult suicides in the same time period, the difference being that all took place during proceedings. A striking feature of the public law cases is the proximity of the death to a milestone event in the proceedings, with half taking place on, or within three days, of the final hearing. Notwithstanding the very low numbers, compared to the number of S31 applications per annum, Children's Guardians should be alert to any indicators of suicidal ideation or behaviours, and to pass this information promptly to the local authority.
7. There were a further seven homicide/suicides since 2009, in which a child is deliberately killed prior to the perpetrator taking his/her own life. In line with the research into this phenomenon, we found that most such killings are perpetrated by men. We do not have sufficient data to identify motive in each case. Mental illness may be a feature of some, and 'altruism' a feature of others, but some were explicitly committed in order to cause the maximum degree of distress to the other parent.

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