Learning from Cafcass Submissions to SCRs

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Section 1: Introduction and Context

This report follows a similar study published in 2013, entitled *Learning from Cafcass Individual Management Reviews: Case Dynamics*, about the learning derived from Cafcass submissions to Serious Case Reviews (SCRs). SCRs are convened by Local Safeguarding Children Boards (LSCBs) whose statutory duty it is to initiate and conduct a SCR 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.

The study seeks to build on the previous one by presenting data on three areas: children and families; index incidents and risk; and Cafcass' involvement in the case. It also inquires separately into cases where child sexual exploitation was a feature, as this has been subject to considerable media and professional scrutiny following high-profile reviews in Rochdale, Rotherham and elsewhere.

This study is based on 28 submissions to SCRs provided by Cafcass between August 2013 and September 2014, whilst the previous study was based on learning derived from 35 Individual Management Reviews (IMRs) undertaken between 2009 and 2013 (these are described as two samples 2012 and 2013). Across the two studies we now have data relating to 63 SCR submissions.

The number of SCRs that Cafcass has contributed to has risen greatly, from an average of one per month from 2010 – July 2013 to double this figure at 28 submissions in the past 14 months. This is in line with a steep increase in the total number of SCRs that have been convened i.e. not restricted to those SCRs to which Cafcass has contributed. Ofsted (2014) suggests that this rise may be attributable to LSCB decision-making regarding those cases where a child has been seriously harmed and there are concerns about the quality of multi-agency working (henceforth 'type B' cases), as opposed to cases of fatal maltreatment ('type A' cases). According to Ofsted 'type B' SCRs almost trebled in number in the past year, from 24 to 69, whereas the number of 'type A' cases remained broadly static. In the former, type B cases, LSCBs have a greater degree of discretion regarding whether the case meets the criteria to hold a SCR.

The other factor that may have encouraged LSCBs to convene more SCRs was the decision of the government[1] 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 which 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 an 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

[1] *Working Together* (March 2013)

likely to make use of source documentation. 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. It soon became apparent that many LSCBs are using elements of different models and 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 1: 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.

The differing and evolving methodologies used by LSCBs can pose a challenge to Cafcass as a national organisation. 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; now the two roles are commonly fulfilled by the same person. More recently, a small number of LSCBs have begun to ask for an analysis to be provided at the point that the LSCB is still setting the terms of reference for the review, whereas, traditionally, only factual information was sought at this point, with an analysis being provided later in an IMR. This allowed the author more time to make thorough enquiries.

Section 2: Methodology

This section provides a summary of the detailed methodology found in Appendix A.

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. Two of these cases were excluded from the analysis (see Appendix A for further details).

The following information in respect of each case was recorded: the child and family; the index incident; Cafcass' involvement in the case; and risk factors. The methodology used in the 2013 study for assigning 'risk ratings' for each case was repeated for this sample. The 13 categories of risk used are set out in Appendix B. Assigning the ratings was a subjective

process and the categories used were more suitable to some cases than others. More information about this and the other limitations of the methodology are set out in Appendix A.

As noted in the introduction, this study also looks at child sexual exploitation (CSE). A sample of CSE cases was formed from previous SCR submissions involving CSE and notifications from operational staff of other children known to Cafcass who were victims of CSE.

Section 3: Findings

The findings of the study have been broken down into five subsections. Firstly, *case details* (3.1) sets out Cafcass' involvement in each case. This is followed by a description of the profiles of *children and families* involved in the cases (3.2), and then the index incidents that make up this year's sample (3.3). Finally, *risk ratings* and *risk types* (3.4 & 3.5) look at the different levels and types of risk associated with different cases.

3.1 Case details

Cafcass was involved, currently or previously, in cases concerning 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[2].

The Cafcass casework in the cases which are subject to SCRs sometimes took place several years ago. The earliest involvement began in 2005 and the most recent, 2013. Our involvement in half (13/26) of the cases began in 2010 or earlier. The duration of Cafcass involvement[3] (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 2, in the majority of cases (17) the total duration of Cafcass involvement was 24 months (two years) or less.

Table 2: 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

There are two distinct case types in which Cafcass is involved: public law cases; and private law cases. Public law cases commonly entail an application by the local authority for a Care

[2] Our coding and analysis regarding these cases are based on the proceedings in which Cafcass was involved, even though these did not relate to the index child.
[3] 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.

or Supervision Order (s31)[4], or a Secure Accommodation Order (s25). In these cases Cafcass practitioners are appointed by the court as children's guardians to represent the child. Private law proceedings commonly entail applications by parents (or occasionally by others) under s8 of the Children Act 1989 to the court to decide the arrangements for the child regarding with whom the child is to live and/or to spend time with. In such private law cases, Cafcass completes a safeguarding letter to court before the first hearing setting out any safety issues. This stage of work is referred to throughout this report as Work to First Hearing (WTFH). Following the first hearing, the court may ask Cafcass to complete further work, such as a report under s7 on the child's welfare. Such work is referred to as Work after the First Hearing (WAFH). In other cases, Cafcass' role ends following the first hearing.

Table 3: 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[5]	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.

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.

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.

[4] All sections cited in this paragraph refer to the Children Act (1989).
[5] Two of these involved s31 and s25 secure accommodation applications and the other case involved s31 applications and applications to discharge a care order.

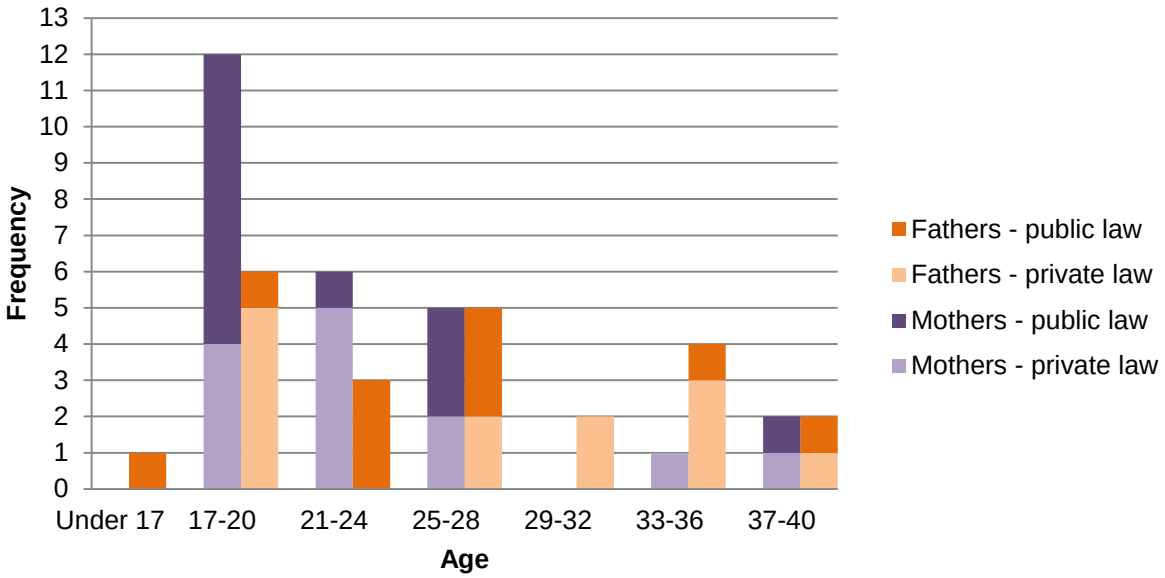
Table 4: Children's ages

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 the 2013 report. 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.

- 46.2% of mothers were aged 20 or under at the birth of their first child. The average (mean) age of the mothers was 23, 5 years younger than the national average.[6]
- 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.
- Young parents, particularly mothers, are a feature of both the public and private law cases in the sample.

[6] 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

- While many cases involved two young parents, in some cases there was a significant age gap between the parents.

3.3 The index incidents

The following table breaks down the cases by incident type and draws a comparison with the two previous samples.

Table 5: 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. Both cases that we have classified thus in this year's sample were evidently homicides and 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 was involved in the proceedings to which the index child was subject at the

time of the incident. 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.

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.

The **non-fatal neglect** cases were equally spread between public and private law. The **fatal neglect** case occurred in s31 proceedings.

The majority (eight, including the non-fatal case) of the **physical abuse** cases were private law cases. The four other cases occurred in public law s31 cases. In three cases Cafcass was currently involved in proceedings to which the index child was subject at the time of the incident. In two cases, Cafcass had not been involved with the index child at any point (but had had 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.

The **perpetrator**[7]**,** or one of the perpetrators, in 10 of the 26 cases was either known or presumed to be the child's mother, whilst the child's father was the perpetrator or one of the perpetrators in seven cases.

3.4 Risk ratings

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. Please see Appendix A for a detailed description of the methodology and Appendix B for a list of the risk factors. Importantly, it should be noted that the ratings were completed on the basis of the information within the Cafcass submission to the IMR and a score of zero under any particular category may simply mean that there was either no information on this risk type within the submission or no information about the risk was known to Cafcass, it does not necessarily mean that such a risk was not present in the case. 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[8] in a public law s31 case. Table 12 sets out the average risk rating by case type.

[7] Please note perpetrator is sometimes presumed rather than established through criminal proceedings.
[8] Note the 2013 IMR research report erroneously stated this to be 36

Table 6: 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.
- 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[9] 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.

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

Furthermore, 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.

We provide some case examples below 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 died after sustaining serious non-accidental injuries. Risk factors in this case included the child being the subject of a child protection plan; the mother's learning difficulties; and the mother's mental health and lifestyle.

Case example 3 – high risk (22) public law

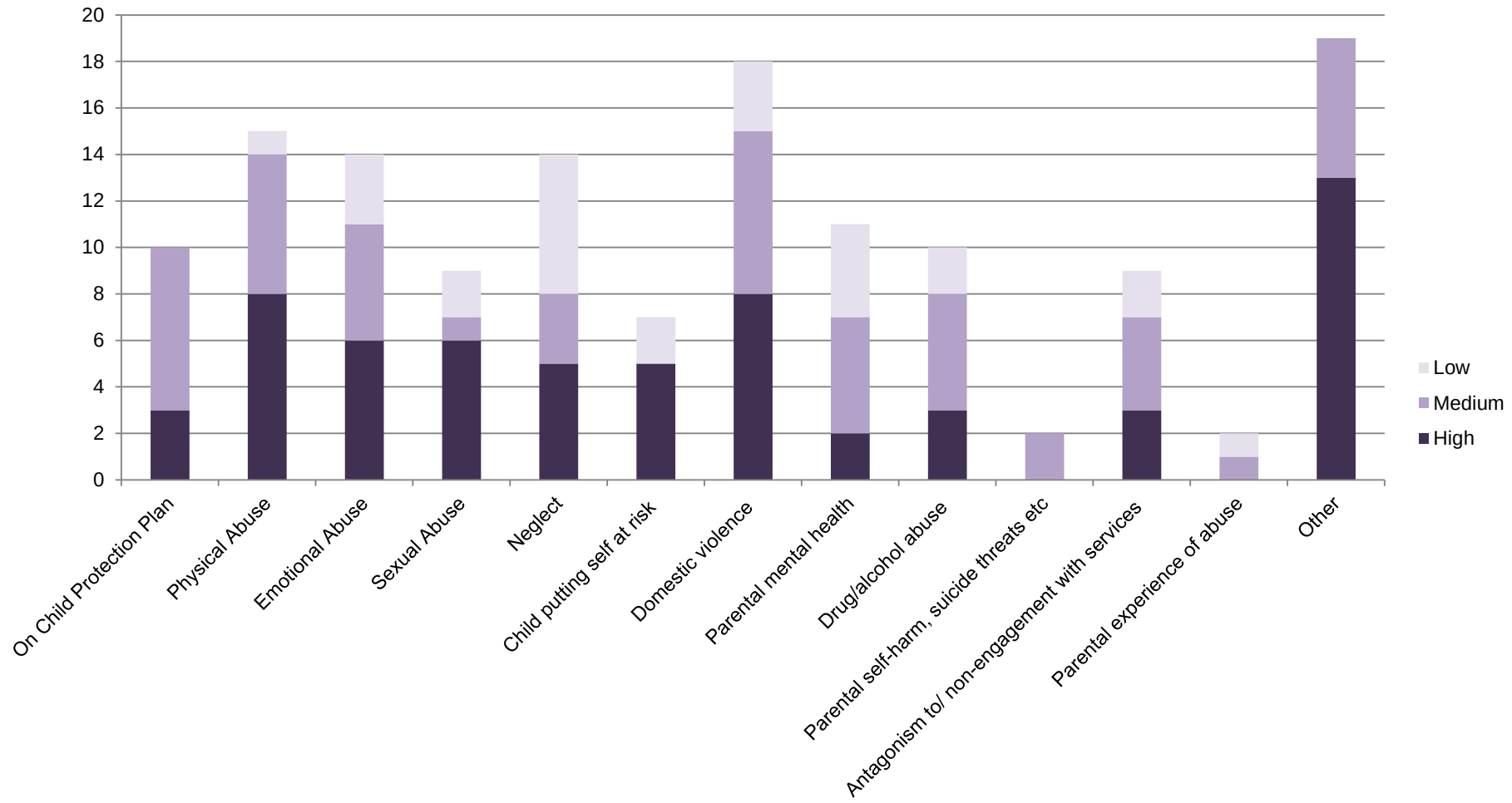
Following care proceedings the child was placed with her father under a residence order. The child subsequently died as a result of injuries perpetrated by the father. Risks in this case included the child's behavioural, health and developmental problems; the father's mental health problems and criminal history; serious concerns regarding domestic violence; 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.

3.5 Risk types

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

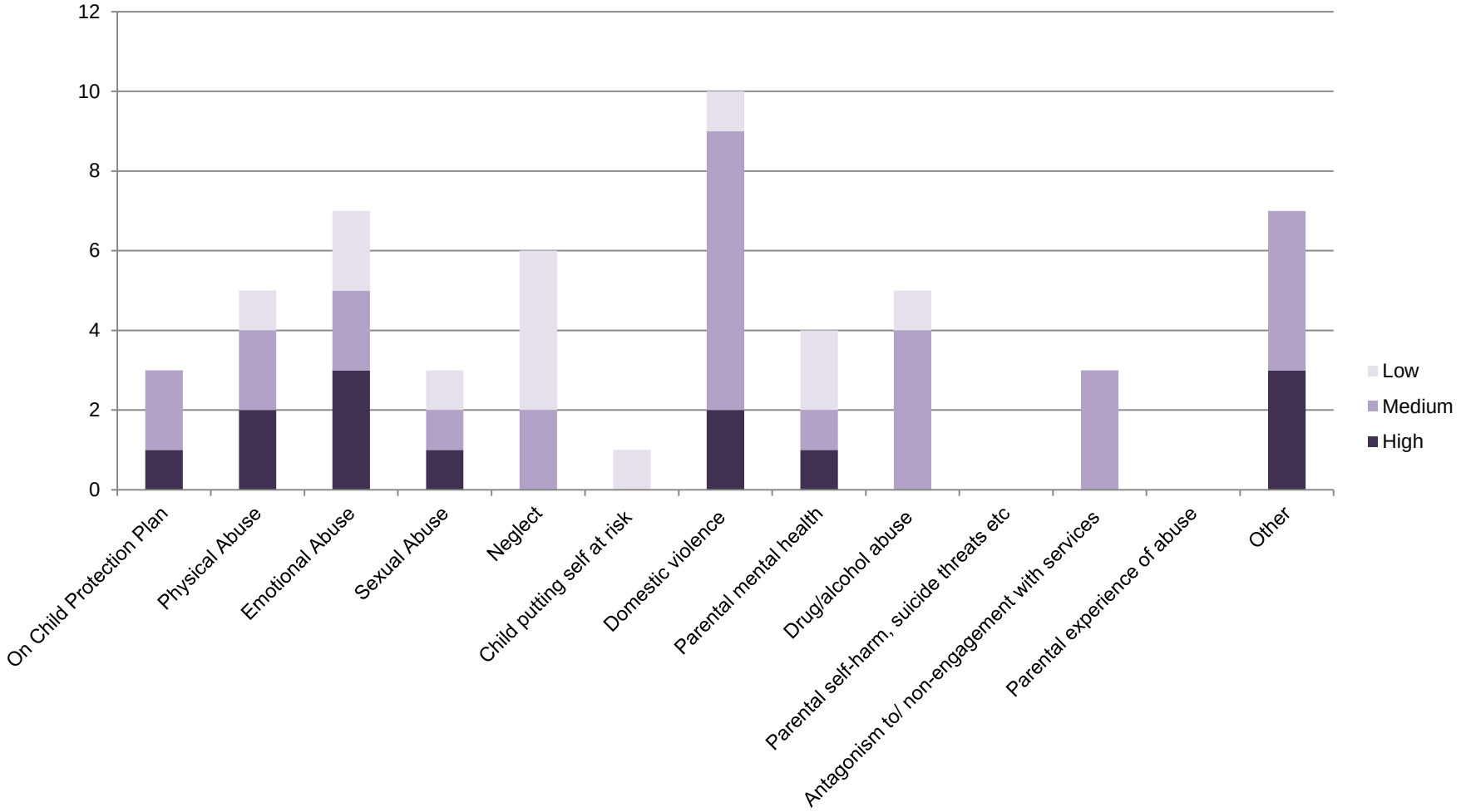
Please note that most cases involved risks under more than one category.

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



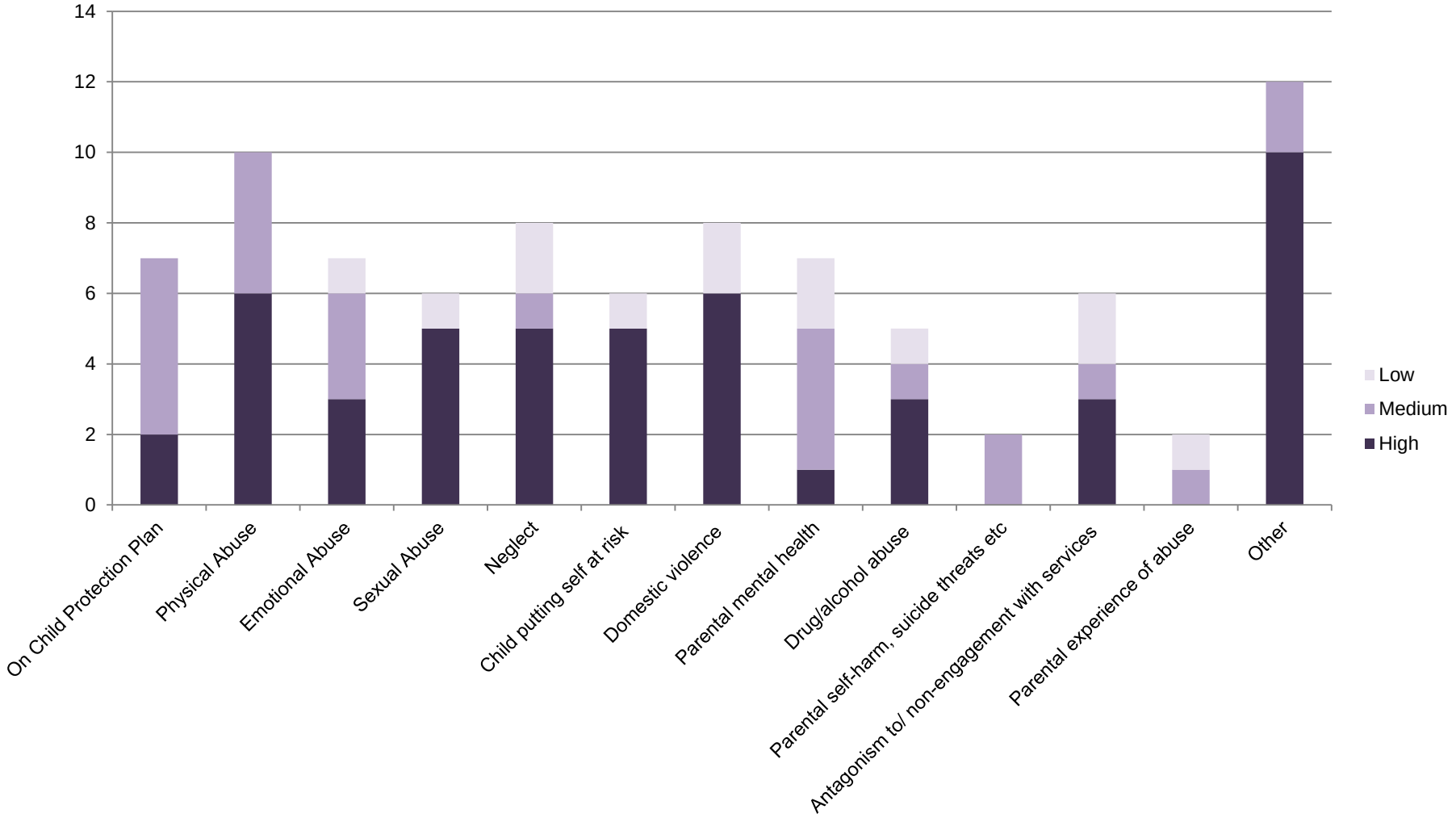
Note that for the category on child protection plan the scores high and medium correspond respectively to: on child protection plan at time of index incident; and on child protection plan prior to index incident; there was no corresponding 'low' value.

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[10].
- 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) was **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**.
- There were a high number of risks, particularly in public law which did not easily fit into any particular category and were classed as other. Such risks which arose in more than one case included: child's drug or alcohol misuse; parental history of violence or other criminal activity; parental learning difficulties; children's health/behavioural problems (including mental health) which may have increased their vulnerability; parents' previous children having been taken into care.

Analysis

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. Conversely, it is important to bear in mind that this research is concerned with the very few 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.

[10] 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.

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 Cafcass practitioners.

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, indeed, it is not possible to establish how many such cases there are. 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 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 7 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 7: 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.
- 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

We analysed the age of the victims (a) when first known to Cafcass and (b) at the most recent application.

- 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 a substantial number of 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. We give the following examples[11] as an illustration of these points.

[11] Details of the cases have been changed to protect identities

Case 1: There were concerns around parental drug and alcohol use and the victim had a history of absconding, including being found with older men in a public park. She had been in several foster placements and had a history of self-harming and low engagement with support services. She disclosed having had sex with men for money but presented this as being consensual.

Case 2: The victim's family had been known to the local authority for many years prior to the making of the s25 application. Sexualised behaviour was identified from a young age, 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.

The vulnerabilities that feature commonly in the cases that form this study 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. 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.

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: Key learning points

In this section we first set out how Cafcass learns from its inputs to SCRs and then conclude with the key learning points derived from the analysis.

5.1 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 8: 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. Firstly, the problem identified by the SCR may have already been resolved prior to the SCR commencing (for example where the case work dates back several years). Secondly, the problem may have been resolved at the point we were notified of the incident or during the SCR process; file reviews, which are carried out by Cafcass' National Improvement Service when we receive notifications of child

deaths/serious incidents and an ongoing dialogue between the IMR author and relevant Senior Managers allow for problems and opportunities to take swift corrective action. Finally, Cafcass has developed a Learning Model (see Appendix C) which sets out the mechanisms by which learning from each SCR submission is disseminated, at a local and national level.

5.2 Key Learning Points

We conclude this report in the same way as the previous report of 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 17 fatal incidents were fatal physical assaults, 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. 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 has reduced the need to make formal recommendations, as has the development of the Learning Model (see Appendix C).

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Appendix A: Methodology

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 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; and risk factors.

The methodology used in the 2013 study 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.

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 therefore 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 time 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.

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.

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 also 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 the Policy Team 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.

Appendix B: 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 C: Learning Model