Learning from Cafcass Submissions to Serious Case Reviews

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Summary

This is the third report about the learning derived from Cafcass submissions to Serious Case Reviews (SCRs). It is based on 23 submissions to SCRs, made between October 2014 and November 2015, relating to 37 children.

While there was an 8% drop in the number of SCRs convened by Local Safeguarding Children Boards (LSCBs) between 2013-14 and 2014-15, the number was still substantially higher than the annual rate between 2011 and 2013. Likewise, the number of SCRs to which Cafcass contributes has approximately doubled over the past two years, now at just over two per month. The rise in the number of SCRs is attributable to LSCBs deciding to hold more reviews into cases where a child has suffered serious harm, rather than to an increase in fatal maltreatment. The number of deaths of children known to Cafcass has been fairly stable over the past four years, at 22-32 per annum. In 2014-15 we received 24 notifications of child deaths, in 17 of these maltreatment was, or may have been, a feature (causal or otherwise).

In December 2015 the government announced that it intended to 'centralise' SCRs, alongside its urgent review of LSCBs. This review was published in May 2016, together with the government's response – after this report was completed.

The key findings in respect of the 23 submissions that form this study are as follows:

- The proportion of children over 10 years of age was higher than in previous years due to a substantial rise in the number and proportion of SCRs inquiring into sexual abuse; the proportion of SCRs focusing on fatal maltreatment fell sharply.
- There were three filicide-suicide cases, all private law, two of which we have classified as spite/revenge killings. Both of these were perpetrated by fathers who had displayed highly controlling behaviour. In the third case the perpetrator was the mother whose motive was less clear.
- In respect of risk ratings (by which we identify the known risks in the case and whether they are high, medium or low): public law cases had on average higher ratings than private law cases; there are broad ranges of risk within both public law (8 to 22) and private law (5 to 19) – which confirms that the known level of risk cannot be used to accurately predict in which cases incidents of serious harm or fatal abuse to children will occur; risk was higher in public law cases for all categories of risk with the exception of domestic violence and parental mental health/parental self-harm and suicide.
- Risks classified as 'other' featured in all but one case, common themes being: parental learning disabilities; parental violence; the child having behavioural or health problems.

In respect of the learning gained from our SCR submissions:

- The following were commonly identified as practice strengths: liaison with the local authority and Independent Reviewing Officer (IRO); seeking support from management; providing challenge to the local authority. In keeping with the previous studies direct work with children is commonly identified as a strength.
- There were very few cases that could be described as 'failures of safeguarding'. Where that was the case some features were: not seeing the child in a timely manner; overlooking important safeguarding information contained in the application; safeguarding information not being included in court reports; insufficient scrutiny of the father's role in the family.

Section 1: Introduction and context

1.1 Introduction

This is the third report about the learning derived from Cafcass submissions to Serious Case Reviews (SCRs).

SCRs are convened by Local Safeguarding Children Boards (LSCBs) in the following circumstances:

> (a) abuse or neglect of a child is known or suspected; and
> (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious harm is defined in *Working Together* (March 2015) as including, but not being limited to: a potentially life-threatening injury; serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

The report presents data gathered primarily from Cafcass' submissions to SCRs around three broad areas: children and families; index incidents and risk; and practice.

1.2 Context

We published similar studies in 2013 and 2014[1]. This study is based on 23 submissions to SCRs provided by Cafcass between October 2014 and November 2015. Across the three studies we now have data relating to 82 SCR submissions – a substantial dataset that, we hope, adds to the understanding of fatal/serious maltreatment within the context of family justice. The 2013 study described two samples, 2009 to 2012 and 2012-13, meaning there are four samples across the three studies. Reference to the 2012 sample is therefore drawn from the 2013 study.

Table 1 below sets out the number of Cafcass submissions[2] to SCRs that were made in each of the sample periods. Note that in 2013 and 2014 two cases were excluded from the analysis as they did not fit the methodology.

Table 1: Submissions by study and timeframe

Sample	Timeframe	Number of Cafcass submissions
2012	2009 - March 2012	23
2013	April 2012 – July 2013	12 (10)
2014	August 2013 – September 2014	28 (26)
2015	October 2014 – November 2015	23
Total		86 (82)

[1] Learning from Cafcass Individual Management Reviews (IMRs), November 2013; Learning from Cafcass Submissions to SCRs, November 2014

[2] Number subject to research analysis shown in brackets

Table 2 below sets out the total number of SCRs convened by LSCBs over the past four years, together with the number of SCRs to which Cafcass has contributed. It is apparent that the number of SCR submissions made by Cafcass, set out in table 1, does not correspond precisely with the number set out in table 2. There are two reasons for this. First, we had to exclude a few of our SCR submissions from this study as there was insufficient data to warrant their inclusion; typically, this was because the LSCB asked us to provide a chronology only. Secondly, the timeframes are different: table 2 contains annual data (April to March) whereas our SCR studies do not follow a set pattern, commonly looking at a period of 14 or 15 months, or much longer in respect of the first study.

Table 2: Number of SCRs convened by LSCBs and Cafcass submissions

Timeframe	SCRs convened by LSCBs	SCRs to which Cafcass contributed
11/12	55	15
12/13	81	11
13/14	189	30
14/15	174	26

The above table shows that the number of SCRs convened by LSCBs dropped slightly (by 8%) in 2014-15 but is still substantially higher than was the case between 2011 and 2013. The number of SCRs to which Cafcass contributes has approximately doubled over the past two years, currently standing at just over two per month, representing a substantial investment of resources.

The number of child deaths (children known to Cafcass) has been fairly stable over the past four years, the range being 22-32. In 2014-15 we received 24 notifications of child deaths, in respect of which:

- Fourteen related to open cases, and ten to closed cases.
- Eleven of the 24 deaths are thought to have resulted from maltreatment. There were a further two where it is unclear whether maltreatment was implicated in the death, and four suicides. This is a total of 17 deaths[3] where maltreatment is, or may be, a feature. The other seven deaths were 'natural causes'.

In last year's study (November 2014) we commented on the substantial changes that had taken place in the conduct of SCRs, the principal one being the use of new models for conducting SCRs, following the publication of a revised *Working Together* (March 2013) which delegated to LSCBs the decision as to how to conduct the review. We noted that some SCRs were being undertaken in line with 'systems' methodologies, notably the one devised by SCIE, but that the 'traditional' model (mandated by *Working Together* up to March 2013 and relying primarily on written submissions by each agency) was still prevalent.

[3] Suicides are included in this figure as they form one of the criteria for an SCR being convened, and as there is commonly a history of significant harm in those reviews to which Cafcass contributes.

In this study we have looked at the methodologies used by LSCBs to undertake SCRs and categorised them as follows:

- Traditional: the model that was formerly stipulated in *Working Together* and that principally relies on written reports prepared by each agency. The report, generally referred to as an Individual Management Review (IMR), is intended to identify single-agency learning with the panel assisting the independent reviewer in identifying multi-agency learning within the overview report.
- The SCIE model: this relies primarily on 'conversations' between the reviewers and practitioners around key events or periods. The emphasis is on 'learning together' i.e. multi-agency learning.
- Hybrid: making explicit use of different methods. Typically, this entails a written submission, together with one or more practitioner events that are designed to generate multi-agency learning, rather than to disseminate learning. We have included the Significant Incident Learning Process (SILP) in this category as it appears to draw from both of the above models.

The above categories are not precise; one of the clear trends in SCRs is for LSCBs to make pragmatic use of different models rather than to adhere closely to a particular one. Therefore we coded on the basis of the category that had the closest fit to the approach taken by the LSCB, the results for the past two studies being as follows:

Table 3: SCR methodologies

SCR type	Number in 2014 study	Number in this study	Total
Traditional	18	12	30
Hybrid	7	5	12
SCIE	1	5	6
Unclear (to date)	2	1	3
Total	28	23	51

The data set out in table 3 may not be representative of all SCRs, but it does imply that LSCBs continue to make extensive use of the traditional model.

In November 2015 the National Panel of Independent Experts on SCRs produced its second annual report. The panel reported that significant and welcome progress has been made, notably in respect of there being far fewer redactions in overview reports, and non-publication being exceptional. They also found, however, that serious barriers to an effective system remain, citing the variable quality of reviews, delay (the DfE reports the average timeframe being 15-20 months against the seven months stipulated in *Working Together*), and too many reports being burdened with detail. They conclude that 'there are many cases in which a proportionate, focused SCR can (be) conducted more rapidly and at less cost, with learning thereby being disseminated at a point in time more proximate to the events under consideration'.

On 14 December 2015 the Prime Minister announced the centralisation of SCRs, together with an urgent review of LSCBs.

Section 2: Methodology

The methodology used replicated that of the two previous studies carried out each year since 2013. The 2014 study considered submissions made between August 2013 and September 2014. The period of analysis of this research was therefore from the beginning of October 2014 until the end of November 2015 when work on this study began. Cafcass made submissions to 23 SCRs within this 14 month period.

The details of each case were entered into a spreadsheet containing the information from the 2012, 2013 and 2014 samples, allowing for comparison between and aggregation of the four 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 previous 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. As for the 2014 study, at least two and, for most cases, three members of the team worked collaboratively to agree the level of risk to assign to 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. This was particularly the case in the small number of cases where only a chronology or other summary document was available rather than a full, traditional IMR. The derivation of the risk ratings and their limitations is discussed in greater detail in section 3.4.

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 mentioned above, the extent of Cafcass' contribution to the SCR. For these reasons, the methodology we have used is more appropriate to some cases than to others.

Throughout this report data from the previous studies is presented alongside data from the 2015 sample, for the purposes of aggregating the data to increase our knowledge base and for comparison. These are however very small numbers of cases and any changes in the nature of the cases each year should be interpreted with caution before any conclusion about trends or wider, external changes is drawn. These are very extreme, rare cases and often their tragic outcomes entail a degree of chance in line with the inherent unpredictability of much human behaviour, rather than a predictable or preventable external factor.

Section 3: Findings

3.1 Case details

Cafcass made submissions to 23 SCRs in the period between the beginning of October 2014 and the end of November 2015.

Of these 23 SCRs: in 12 cases the index child or children were known to Cafcass at the time of the incident; in seven the index child(ren) had been known to Cafcass before the incident; in three cases the index child(ren) were not known to Cafcass at all but Cafcass had had previous involvement with other family members; in one case Cafcass did not know the child at the time of the incident but was asked to contribute to the SCR on the basis of our involvement following the incident.

Table 4: Children in proceedings at time of incident

Cafcass' involvement with index child(ren)	Frequency
Prior to incident only	7
At the time of the incident	12
No current or previous involvement	3
Following the incident only	1
Total	23

While the table above highlights the important point that Cafcass is only involved with the child at the time of the incident in just over half of the cases, it is important to note the variation within each of the above categories. For example, cases where our involvement had ceased prior to the incident ranged from s31 care proceedings where the child had been placed with the perpetrator of the incident at the conclusion of proceedings and the incident occurred shortly afterwards, to private law cases where the extent of our involvement was limited to private law Work to first Hearing (WTFH) cases many years before the incident occurred.

For each case we recorded the beginning and end dates for each period of involvement with the index child(ren) or, where there had been no involvement with the index child(ren), with the family. Note that in many cases there was more than one period of involvement. The earliest involvement Cafcass had with any of the index children was in 2003. Adding together the individual periods of involvement for each case the average total duration of Cafcass involvement was 13 months. The table below shows the distribution of the lengths of Cafcass involvement in the cases.

Table 5: Duration of Cafcass' involvement

Total duration (months)	Frequency
0 to 12	12
13 to 24	9
25 to 36	1
37 to 48	1
Total	23

There were more public law cases than private law in the 2015 sample. The table below shows the breakdown of different case types.

Table 6: Case types

	Type	Frequency
Public	Public law – s31	12
	Public law – other	1
	Total public	**13**
Private	Private law – WTFH only	3
	Private law – WTFH and WAFH	4
	Total private	**7**
Public and private		**3**
	Total	**23**

3.2 Children and families

Children

There were 37 index children in the 23 submissions to SCRs. Most (20) SCRs were in respect of only one child, one was in respect of two children, one was in respect of six children and one was in respect of nine children. Twenty-five children were female and twelve children were male. The higher number of female children can be accounted for by the high number of SCRs which related to sexual abuse which involved predominantly or exclusively female children. Ten children (27%) died as a result of the incident which the SCR was concerned with (the 'index incident'), 27 children (73%) survived.

The proportion of very young children (under 6 years old) was lower in the 2015 sample than in previous years while the proportion of teenagers and older children (over 10) was higher. The older age profile of this year's sample is largely due to the higher proportion of index incidents of sexual abuse in comparison with previous years. The children in these cases were predominantly teenagers.

Table 7: Age profile of children

Age	Frequency 2012, 2013 and 2014 samples (%)	Frequency 2015 sample (%)
Under 1	10 (13%)	4 (11%)
1 to 5	29 (38%)	6 (16%)
6 to 10	18 (24%)	10 (27%)
11 to 15	11 (14%)	10 (27%)
16 to 17	8 (11%)	7 (19%)
Total	76 (100%)	37

Parents

There were fewer very young mothers (age at birth of first child) in the 2015 sample than in previous years, with 26% aged 20 or younger, in contrast to 46% of the mothers in the 2014 sample, and 78% and 80% of the mothers in the two previous samples.

Table 8: Age profile of mothers at birth of first child

Age	Frequency
Under 21	6 (26%)
21-25	4 (17%)
26-30	6 (26%)
31-35	3 (13%)
35-39	2 (9%)
Unknown	2 (9%)
Total	23

3.3 The index incidents

The below table shows the breakdown of different index incident types in the 2015 sample and the three previous samples for comparison. The total for all samples is also given.

Table 9: Index incident type

Index incident type	2012	2013	2014	2015	Total
Physical abuse (fatal)	3 (13%)	4 (40%)	11 (42%)	2 (9%)	**19 (23%)**
Neglect (Fatal)	4 (17%)	4 (40%)	1 (4%)	4 (17%)	**13 (16%)**
Spite/revenge killing	5 (22%)	1 (10%)	2 (8%)	2 (9%)	**11 (13%)**
Suicide	4 (17%)	1 (10%)	1 (4%)	1 (4%)	**7 (9%)**
Neglect (non-fatal)	2 (9%)	0	4 (15%)	2 (9%)	**8 (10%)**
Physical abuse (non-fatal)	4 (17%)	0	1 (4%)	3 (13%)	**8 (10%)**
Sexual abuse	0	0	4 (15%)	8 (35%)	**12 (15%)**
Fatal drug overdose (not suicide)	0	0	2 (8%)	0	**2 (2%)**
Other	1 (4%)	0	0	1 (4%)	**2 (2%)**
Total	**23**	**10**	**26**	**23**	**82**

Key observations:

- The proportion of fatal incidents has fallen to 30% in contrast to 73% of the three previous samples combined.
- Sexual abuse accounted for the highest number of index incidents in 2015, making up 35% of incidents. This is a higher number and higher proportion of incidents than in each of the three previous samples.

Analysis

A much lower proportion of incidents in 2015 were fatal than in previous years, at 30% in contrast to 70% of 2012 incidents, 100% of 2013 incidents, and 65% of 2014 incidents. This change can

largely be accounted for by the much higher proportion of incidents of sexual abuse as discussed below.

The number of **fatal physical abuse** cases was much lower in 2015 than in 2014, at only two cases. One of these cases was a case of filicide/suicide which occurred in the context of private law proceedings. The other case occurred following s31 care proceedings, the outcome of which was a Special Guardianship Order. There were three SCRs concerning incidents of **non-fatal physical abuse**.

The total number of **neglect** cases was similar in 2015 to 2014, although a greater proportion of these were **fatal neglect** cases in 2015. Three fatal neglect cases were s31 care proceedings only and one was private law WTFH only. One **non-fatal neglect** case occurred after Cafcass had had previous involvement in a WTFH private law case. The other non-fatal case occurred in the context of s31 care proceedings.

The number, and proportion, of SCRs relating to incidents of **sexual abuse** was much higher in 2015 than in previous years, at eight cases, representing 35% of the SCRs Cafcass contributed to in 2015. Three of these cases were abuse within the family; two were cases of child sexual exploitation; two were perpetrated by others with a connection to a family member; and in the final case the perpetrator was unknown. Both child sexual exploitation cases were public law: one was secure accommodation; and the other, s31 care proceedings. Two of the three intra-familial sexual abuse cases were public law s31 care proceedings and the remaining case was both public and private law. Given the very small numbers of cases each year it is not possible to say whether the higher proportion of SCR incidents relating to sexual abuse is due to random variation or an external factor. We should therefore avoid drawing conclusions that the rise in the proportion of cases involving child sexual abuse reflects a rise in incidents or even a rise in reporting and professional awareness.

There were two cases which we have categorised as **spite/revenge killings**. Both cases were filicide/suicide cases occurring within private law proceedings. It is difficult to establish the intentions of the perpetrator in such cases in order to be confident that the intention is revenge or spite (as discussed in our 2014 report). However, in both these cases the father, who was the perpetrator, had previously displayed highly controlling behaviour in relationships with the child's mother. In addition the circumstances and nature of the incidents made it clear that the motive was spite/revenge. There was a third case of filicide-suicide which we have not categorised as a spite killing (it is categorised as fatal abuse). This also occurred in the context of ongoing private law proceedings with which Cafcass was involved, as rule 16.4 Children's Guardian. However the perpetrator was the mother who had claimed that the father had subjected her to domestic abuse (though there was no clear evidence that this was actually the case). The mother had ceased to engage in the proceedings, having absconded with the child and her address being unknown to the father and to the family court, and there was some evidence that the mother had believed herself to be fleeing persecution from the father. This case is therefore different in significant respects from the other two cases and it is not possible to establish the mother's motive.

The SCR categorised as 'other' concerned a child who had made many suicide attempts. There had been both private and public law proceedings in this case. There was only one suicide case in 2015, in keeping with the numbers of these cases in previous years; this was in the context of previous private law proceedings.

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 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.

The lowest risk rating was 5 in a private law WTFH case and the highest was 22 in a s31 public law case. Table 10 sets out the average risk rating by case type.

Average risk rating by law type – for 2012, 2013 and 2014 and 2015 samples (numbers of cases in each category are indicated in brackets)

Table 10: Risk rating by case type

Case type	Average risk rating 2012, 13, 14	Average IMR Risk Rating 2015	Overall average risk rating
Public law – s31 only	18.2 (18)	15.5 (12)	17.1 (30)
Public law – others specify	12.8 (6)	13 (1)	12.8 (7)
Total public law	**16.8 (24)**	**15.3 (13)**	**16.3 (37)**
Private law – WTFH only	6.3 (14)	11 (3)	7.1 (17)
Private law – WTFH & WAFH	9.4 (17)	13.75 (4)	10.2 (21)
Total private law	**8 (31)**	**12.6 (7)**	**8.8 (38)**
Public and private	17.5 (4)	17 (3)	17.3 (7)
All case types	**12.2 (59)**	**14.7 (23)**	**12.9 (82)**

Key observations:

- While there are only few such cases, cases involving both public and private law applications tend to have the highest average risk rating.
- The average risk rating was slightly higher this year than in previous years.
- Public law cases on average have higher risk ratings than private law cases.
- Although higher than previous years, the lowest average risk rating continued to be in private law WTFH cases. With regard to the rating being higher than previous years, it should be noted that there were very few cases within this category and the average risk rating was raised by one case with a very high rating of 19.

Analysis

The risk rating in each case is affected by the duration of Cafcass' involvement, the scope of Cafcass' role, and the reasons behind the application.

Public law cases typically involve a high level of risk as this is commonly needed to prompt the local authority's application to court (though it is possible for such cases to have low ratings where, for example, an infant sustains a serious injury in the context of no history of concerns). In these cases the practitioner has access to detailed information about the risk, as provided by the local authority. In public law, however, the local authority involvement and, in many cases, the fact that the children are placed outside of the home during the proceedings act as protective factors balancing the high levels of risk. Although the level of known risk in private law cases is generally lower, in these cases there may be fewer protective factors than there are in public law cases as Cafcass is often the only safeguarding agency involved. In addition less may be known about the family. For these reasons the lower levels of known risks in private law should not be taken to mean that such cases are intrinsically safer.

More revealing than the setting out of the average ratings is the variation in risk ratings between cases both within and across case types: the overall range spans from a minimum of 5 in a private law case to a maximum of 22 in a public law case; however even within private law the range is from 5 to 19 and in public from 8 to 22. This huge variation in risk ratings, particularly within categories highlights the unpredictability of these incidents.

Although many incidents occurred in cases where the levels of risk known by the practitioner were low, looking back at some of these cases with hindsight one can identify that certain risks take on a particular significance. Two filicide-suicide cases - one from the 2015 sample and another from the 2014 sample – illustrate the point. Neither case featured explicit threats but rather strong hints that the perpetrators held worrying attitudes towards the permanent loss of children. More scrutiny of these hints was warranted, though this does not mean that the tragic outcomes would have been prevented. Cafcass' experience of filicide-suicide cases is that the perpetrators do not in general have extensive histories of posing risk and none of the SCRs in relation to such cases has (to the best of our knowledge) concluded that the death was predictable or preventable.

3.5 Risk types

The charts on the following pages show the level of risk in each category in respect of the 2015 sample. The first chart shows the number of cases from all case types featuring each risk type and the second chart shows a comparison of the percentages of public law cases and percentages of private law cases featuring each risk type.

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

Chart 1 – Risk types and levels for all cases

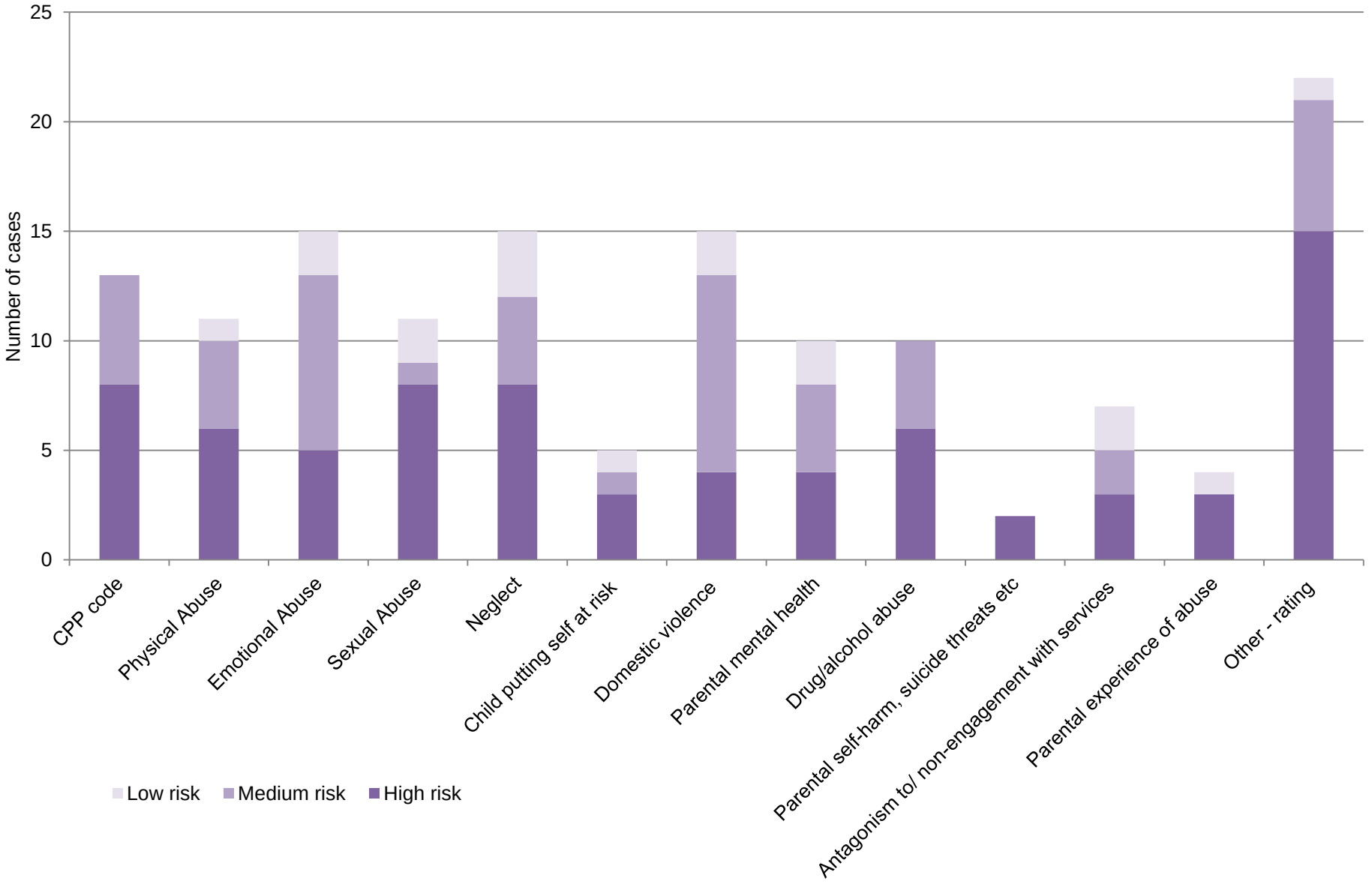
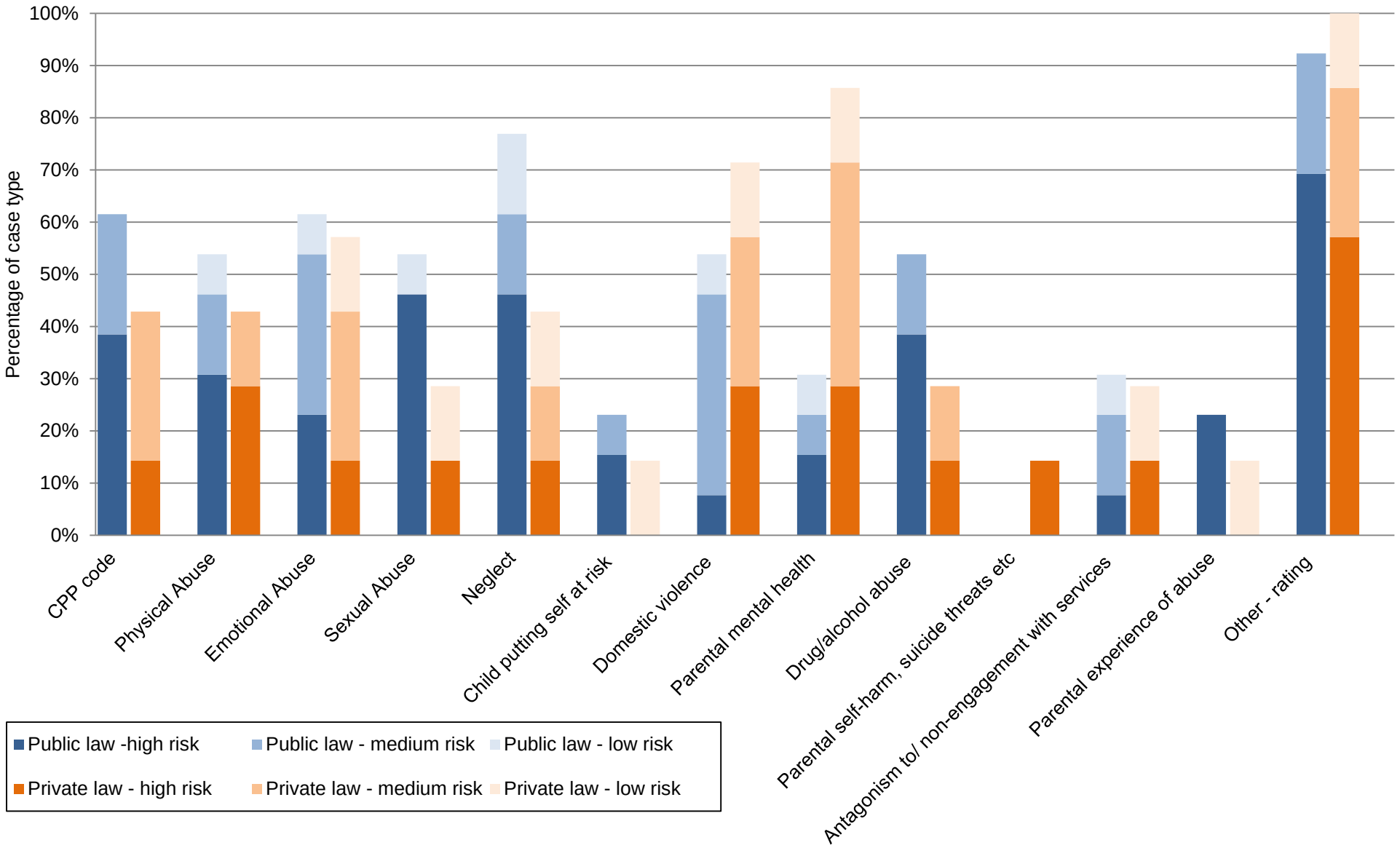


Chart 2 – risk types and levels: public (n=13) and private law (n=7) comparison[4]



[4] Note that the three public and private law cases are not included within this chart

Key observations:

- For almost all risk types, the percentage of cases featuring the risk type was higher in public law than private law with the following exceptions: domestic violence; and parental mental health.
- Neglect; emotional abuse; and domestic violence were the most common risk factors across all cases, with each featuring in 65% of cases. Neglect featured in just over three-quarters of public law cases and 42% of private law cases. Domestic violence was more common in private law cases, featuring in 72%, compared with 54% of public law cases. Emotional abuse featured in roughly equal proportions of private law and public law cases.
- Very few cases (2) featured concerns around parental self-harm or suicide, however just under half of all cases featured concerns around parental mental health, in particular, a very high percentage (86%) of the private law cases featured such concerns.
- Despite the older age profile of the index children, only six cases featured concerns around the child putting themselves at risk.
- In eight cases the child was on a Child Protection Plan at the time of the incident and in five cases the child had previously been on a Child Protection Plan.

Analysis

The charts above (on pages 14 and 15) illustrate the wide range of risk factors which were evident to Cafcass at the time of our involvement in these cases. Interestingly, a comparison of the percentages of the different risk types in public law and private law reveals that these are generally fairly similar, with some exceptions, although in public law cases the percentages of cases where the risks are present as well as the levels of risk tend to be higher.

In many cases most of the types of risks identified did not appear to have a direct, straightforward relationship with the incident which actually occurred. However, with hindsight, the interaction between such factors and other risks does appear to have some explanatory power in relation to the incident. For example in two cases there were reports or allegations of domestic violence but in neither case was the alleged perpetrator directly involved in the incident. In one of these cases the mother felt she was being persecuted by the father who she alleged perpetrated domestic violence within the relationship. The mother subsequently killed herself and her child. While the domestic violence did not directly result in the death of the child, the interaction between this factor and, for example, the mother's mental health and social isolation may have had a bearing on the outcome.

All but one of the cases had some risk factors categorised as 'other'; with these being classed as a high level of risk in the majority of cases. Common themes within the 'other' category included: parental learning disabilities; parental violent behaviour (other than domestic violence) and/or serious criminal convictions; the child having health or behavioural problems. In respect of the last of these, in some cases this appears to have been a strong factor contributing to the child's vulnerability. For example in one case, following the end of Cafcass' involvement, injuries the child had received were presented by the child's carer to professionals as being the result of the child's behavioural and health problems. Subsequently

the child died as a result of injuries inflicted by the carer. Recent research by the NSPCC has explored the key issues around disabled and deaf children in SCRs[5]. Factors identified as potentially making disabled children more vulnerable in some cases included: injuries and developmental delay being accepted as related to the disability; failure to recognise the implications of disabled children's heightened dependency on parents for care; and perceptions of disability.

[5] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/deaf-disabled-children/

Section 4: Learning

4.1 How has Cafcass learnt?

On receipt of a notification of a serious incident, Cafcass' National Improvement Service (NIS) undertakes a file review of the case. The principal reason for initiating these file reviews was to ensure that management was sighted of the strengths and weaknesses of cases irrespective of which methodology was used by LSCBs in conducting SCRs. As described in Section 1 various 'systems' models of conducting SCRs, the SCIE model included, do not entail substantial written submissions by participating agencies, relying instead on 'conversations' between practitioners and SCR reviewers. A perceived flaw in the SCIE model, in the view of the authors of this report, is a lack of clear articulation as to how learning generated in conversations is translated accurately and in a timely manner into actions by participating agencies.

However, the value of the NIS file reviews to local and national learning has been such that the reviews are now conducted on receipt of a majority of notifications, irrespective of whether an SCR is likely to follow. NIS is well-placed to conduct such reviews, being independent of line-management and experienced in conducting file audits. The review is generally conducted within a working day of notification, facilitating a swift response to any identified practice weaknesses, and summaries to Cafcass' Operational Management Team (OMT), and thence to staff, about national learning points. The process does not capture the perspective of the practitioner but opportunities are present for this to be obtained, in subsequent discussion with line-management and/or in the SCR.

It is interesting to reflect, in the light of: trenchant criticisms of many SCRs made by both reports of the independent panel of experts; and the government's stated intention to centralise SCRs (see Section 1), that a relatively simple mechanism should have provided Cafcass with its optimal learning from serious incidents, particularly when timeliness is factored into the equation alongside quality. Where an SCR is convened, the learning is refined by the more detailed scrutiny conducted first by NIS in the preparation of an IMR (which invariably includes gaining the practitioner's perspective where s/he still works for Cafcass) and later by the SCR panel.

The Cafcass file review has been brought informally to the attention of DfE and features in the formal consultation around the future of SCRs.

The other mechanisms by which Cafcass has learnt from SCRs, and sought to improve its practice, are:

- The learning log.
- Recommendations and action plans (a log of progress against actions is provided quarterly to OMT).
- Incorporation into the Learning and Development Programme (the need for eLearning on child sexual exploitation and secure accommodation was identified by SCRs, and other modules are partially informed by Cafcass SCR submissions).
- Summaries of cases provided to, and scrutinised by, the Cafcass Board.

- Annual research studies, this report being the third such publication (a redacted version of these studies is placed on the internet and has been cited in some SCRs).

4.2 Practice learning

In this section we set out a succinct overview of what the submissions to SCRs that form this study tell us about the quality of our practice. It is important to note two caveats in relation to the observations which follow. There are many variables – the application; the extent of Cafcass involvement; the role fulfilled by the FCA(s) etc – and the observations we make with regard to practice should be treated with caution given that this context is not presented here. Secondly, the practice that is scrutinised within our IMRs took place, in some cases, several years ago and may tell us very little about the quality of contemporary work.

Overall our review of the practice in these cases, based on what is recorded in the SCR submissions and in the NIS file reviews available for around half of the cases, indicates that practice is in general much stronger than it was some years ago (as evidenced by other Cafcass data derived from audits, KPIs, inspections etc). In particular, and as was noted in last year's research report, direct work with children is commonly cited as a strength, this year including a few cases where children had very complex needs and FCAs were assiduous in ensuring that the needs were identified and addressed within proceedings. The two shortcomings that feature most frequently are poor recording and planning.

Looking more specifically at cases where practice was highlighted as strong or weak, although there were very few cases which could be described as 'failures of safeguarding', in the cases where this term is appropriate, common features were:

- Not seeing the child in a timely manner.
- Overlooking important safeguarding information contained in the application, which had very unfortunate consequences as risk was under-estimated and the case 'got off on the wrong foot'.
- Safeguarding information not being included in court reports.
- Insufficient scrutiny of the father's role in the family.

Conversely, the following were common features of those cases where practice was identified as strong:

- Liaison with the local authority and IRO.
- Seeking/receiving support from management.
- Challenge to the local authority.

4.3 What has Cafcass done?

In 2015, SCR submissions have led to a range of actions aimed at improving practice and systems. Examples of such actions include the following:

- To review business processes in safe handling of court applications, with specific attention to urgent applications to ensure compliance with Child Arrangements Programme (CAP), and to ensure that these are handled safely.
- To review processes in relation to staff self-filing status and ensure that guidance is being adhered to.
- To reinforce, through OMT, the existing expectation of a higher level of management oversight of casework decisions in respect of staff who are, or have been, subject to action plans.
- To improve the effectiveness of the operational processes in WTFH to deliver safe outcomes. This includes reviewing the arrangements of the Duty Officer in responding to all applications, giving attention to 'Urgent and Without Notice' applications; FCAs to receive further briefings on seeking early outcomes on these applications; complete a review of the 10 most recent 'Urgent and Without Notice' applications against compliance with policy.