Learning from Cafcass submissions to Serious Case Reviews

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This version of the report has been adapted for sharing with external agencies, and case examples have been anonymised to protect identities (November 2017).

Contents

List of tables

List of figures

Executive summary

Introduction

This is the fifth study into the learning derived from Cafcass submissions to Serious Case Reviews (SCRs). This report presents data in relation to:

- The 15 most recent SCRs between December 2015 and December 2016 (referred to as 'the 2017 study');
- The 97 SCRs to which Cafcass has contributed since 2009, taken from the five studies.

The caveats we have expressed in previous studies bear repetition. Firstly, 97 cases represent a tiny fraction of the total number of cases that Cafcass has worked with between 2009 and 2016: approximately one case per 4000 or 0.025% of our total caseload. Tragic outcomes are extremely rare.

Secondly, SCRs have added to our understanding of risk and of our practice strengths and weaknesses, but they have no predictive value. They do not tell us which children are going to die, how, or when. We cite examples in this report of cases where the overt risk was derived from one adult but the fatal or serious harm was perpetrated by somebody else. We also provide data showing that the 'index incidents' (the fatal/serious abuse that triggered the SCR) took place during proceedings in just over a third of cases.

Context

Section 1 provides a description of the context in which this study is published, notably the passing of the Children and Social Work Act in April 2017 which sets out new arrangements that will replace SCRs. We expect that SCRs will continue to be convened until the new arrangements are implemented, at a date to be confirmed.

Under the new arrangements there will be two different types of multi-agency reviews, one national and the other local. At a national level a Child Safeguarding Practice Review Panel will be established to identify cases that are complex or of national importance and arrange to have these reviewed under its supervision. Cases that do not meet these criteria will be subject to a Local Child Safeguarding Practice Review. These will be the responsibility of the safeguarding partners – the local authority, police and health – who will be responsible for setting up the arrangements that currently fall to Local Safeguarding Children Boards (LSCBs). Further details will be set out in regulations and *Working Together*.

Methodology

Section 2 describes our methodology which is, a few minor refinements apart, the same as that used in previous studies. We analyse SCR submissions, looking at the children and families involved, the index incidents, and risks identified in the cases.

Findings from SCR submissions in 2017 study

Section 3 sets out findings from the 15 submissions we made to SCRs between December 2015 and December 2016, relating to 21 children. Key findings include:

- Five of the index incidents took place during proceedings. Twelve were public law cases and three were private law cases.
- Five involved the death of a child: four of these children were aged two or under and their deaths were caused by fatal maltreatment; the fifth was a teenager who died of a health condition but who was found to have sustained severe neglect.
- Physical abuse, both fatal and non-fatal, accounted for the highest number of incidents.
- Concerns prior to the index incident were examined as risk factors. Neglect featured in all of the public law, and one of the private law, cases. Many of these cases also featured parental vulnerabilities such as learning difficulties, and the child had previously been the subject of a child protection plan. Domestic abuse was another common feature.
- Risk ratings (the total rating obtained from 13 risk factors, each rated at high, medium or low) were higher in public law cases than they were in private. This does not mean that private law cases are intrinsically safer: it may reflect the higher level of inter-agency scrutiny of cases that are in care proceedings.

Learning from SCR submissions

Section 4 sets out learning derived from the 15 SCR submissions included in the 2017 study.

There are three mechanisms by which Cafcass generates learning and takes action to improve practice:

1) the Significant Incident Notification review that is conducted within a working day of the notification;
2) the Individual Management Review (written report to the SCR) that refines our learning;
3) independent scrutiny/challenge by SCR.

SCRs rarely produce new learning, other than when they ‘break new ground’, for example when we contributed to SCRs on child sexual exploitation some years ago. For the most part their value lies in telling us what we already know about what distinguishes strong practice from weak.

We present a number of examples of how the quality of service is raised or lowered by attention to front-loading of the work, planning, sound recording, systematic attention to the needs of the child, and a crisp analysis.

Actions taken at a national level in light of learning gained from our SCR submissions (and other sources) include:

- Revision of the core induction training module ‘Risk and Harm’:
- Development of eLearning on MySkills in relation to Special Guardianship Orders;
- Delivery of case recording workshops;
- Sharing of learning on diversity matters via the ambassador network.

Analysis of SCR submissions between 2009 - 2016

Section 5 sets out findings from the 97 cases we have researched since the first study that was published in 2012. The cases span the period from 2009 to the end of 2016. We set some of our findings against those found in the recent Department for Education Triennial Review of serious case reviews (2016).

The key findings are:

Incidents involving the death of a child

- About 60% of SCRs have been triggered by the death of a child as opposed to serious harm. The most common index incident is a physical assault but children have died in other contexts including homicides (the deliberate killing of a child), neglect and suicide.
- Both this study, and the Triennial Review, found that equal numbers of fathers and mothers are responsible for deliberate homicides. We have coded 14 cases as homicides, about two per year, nearly all in private law. We have noted how fathers known to us who have killed their children had histories of domestic abuse and control; and how fragile the mental health of some of the mothers seems to have been.

Involvement in family court proceedings

- Public law cases slightly outnumber private law cases but the pattern has changed over the years, with private law cases more prevalent in the early studies and public law in recent studies.
- In 36% of cases Cafcass was involved with the child at the time of the index incident. In a further 39% of cases we had previously known the child. In 25% of cases we did not previously know the child but knew another family member or proceedings were started in respect of the child after the serious harm that triggered the SCR.

Source of harm

- We have found, as did the Triennial Review, that a substantial majority of incidents were known or thought to have been perpetrated by family members. Fathers form the group that has been most frequently identified as the suspected perpetrator, but mothers or groups (one/both parents and others) were also often suspected perpetrators.
- In eight of our 97 cases the known or suspected perpetrator of the index incident was a member of the extended family, some of whom were Special Guardians.

Risk factors

- Domestic abuse was the most common risk factor in SCR cases, present at varied risk levels in 71% of the SCRs. Domestic abuse is very ‘gendered’ in our sample: that is, it is frequently perpetrated by the father or male partner. However, in 48% of cases featuring domestic abuse, the person thought to have killed or harmed the child was not the alleged domestic abuse perpetrator.

Section 1: Introduction and context

1.1 Introduction

This is the fifth report about the learning derived from Cafcass submissions to Serious Case Reviews (SCRs). Across the five studies we now have data relating to 97 SCR submissions involving 174 children. This report (referred to as 'the 2017 study') presents data in relation to the 15 most recent SCRs[1] (December 2015 – December 2016) in respect of three broad areas: children and families; index incidents and risk; and practice learning. This is then followed by an analysis of the 97 SCRs to which Cafcass has contributed since 2009, taken from the five reports.

Table 1: Number and timeframe of SCR submissions per Cafcass study

Study	Timeframe	Number of Cafcass SCR submissions
2012	2009 - March 2012	23
2013	April 2012 – July 2013	10
2014	August 2013 – September 2014	26
2015	October 2014 – November 2015	23
2017	December 2015 – December 2016	15
Total	**2009 – 2016**	**97**

1.2 Context

SCRs convened by LSCBs

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 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.

Cafcass contributes to SCRs convened by LSCBs when they involve a family currently or previously child known to Cafcass. The number of SCRs convened by LSCBs dropped by 19% in 2015-16 but is still substantially higher than was the case between 2011 and 2013 (see Table 2).

[1] One review was configured as a multi-agency learning review rather than an SCR.

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

Timeframe	SCRs convened by LSCBs	SCRs to which Cafcass contributed
2011-12	55	15
2012-13	81	11
2013-14	189	30
2014-15	174	26
2015-16	146	25[2]

The future of SCRs

In line with the Children and Social Work Act (April 2017) SCRs will cease, though it is anticipated that they will continue to be convened until the new arrangements, described below, are refined within regulations and a revised *Working Together*.

The new Act follows the publication by government in May 2016 of the *Review of the Role and Functions of Local Safeguarding Children Boards* (LSCBs) conducted by Alan Wood, and of the government's response. Wood described SCRs as a 'discredited model' and was critical of a number of elements including: time; cost; flaccid recommendations; and an over-emphasis on establishing 'who has made a mistake'.

The new arrangements are as follows:

- A Child Safeguarding Practice Review Panel will be established by government.
- On being notified of child deaths or serious harm it will identify cases that are complex or of national importance and arrange to have these reviewed under its supervision.
- Where cases do not meet these criteria they will be subject to a Local Child Safeguarding Practice Review. The detail of how these reviews will operate is not yet available but Wood recommended that they should be completed in three months. The Act states that the reviews are to focus on improvements to practice that can be made.
- The local reviews will fall to the safeguarding partners – the local authority, police and health – who will be responsible for setting up the arrangements that currently fall to LSCBs.

[2] This number does not correspond to the number of SCR submissions set out in Table 1. The figures are based on different timeframes and some SCR submissions are very brief and unsuitable for inclusion in the study.

Section 2: Methodology

Each case is different both in terms of: the nature of the incident and the child's circumstances; the nature and timing of Cafcass' involvement with the children; and 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.

The report presents data gathered principally from Cafcass' written submissions to SCRs. These reports take different forms according to the SCR model but are commonly Individual Management Reviews (IMRs) and/or chronologies. Data was also gathered from:

- the Serious Incident Notification (SIN) reviews undertaken by the National Improvement Service (NIS) upon notification of the death of, or serious harm sustained by, a child;
- Case plans, particularly in respect of risk factors.

The methodology replicated that of the previous studies, analysing SCR submissions made since the last period of analysis ended (November 2015). The details of each submission were added to a dataset containing the information from the previous samples, allowing for comparison between and aggregation of data since 2009, logging: information regarding the child and family; the index incident; Cafcass' involvement in the case; and risk factors according to 13 categories:[3] child protection plan; physical abuse; emotional abuse, sexual abuse, neglect, child vulnerabilities; domestic abuse; parental mental health; substance misuse; parental vulnerabilities; antagonism to/non-engagement with professionals; parental experience of abuse; other.

The risk data presented in this report relates to the *case* rather than the suspected perpetrator. So, for example, risks derived from the parents are included even if the child was killed or harmed by a foster parent. The authors of this report worked collaboratively to agree the level of risk to assign to each category for each case.

Data from the 2017 study is presented alongside data from the previous studies.

It is important to bear in mind that SCRs represent a tiny fraction of the workload of Cafcass and other agencies. Their tragic outcomes commonly entail a degree of chance in line with the inherent unpredictability of much human behaviour, rather than a predictable or preventable external factor.

[3] Methodology repeated from previous years except two categories were amended: 'child putting self at risk' to 'child vulnerabilities'; and 'parental self-harm, suicide' to 'parental vulnerability'. These have extended relevant risk factors in the 2017 study sample to include vulnerabilities relating to disabilities (and for children very young age), as well as behaviour previously included in the categories.

Section 3: Findings from SCR submissions in the 2017 study

3.1 Case details

Cafcass made submissions to 15 SCRs between December 2015 and December 2016. The majority of these cases came from public law proceedings, although three related to private law proceedings. For each case we recorded the latest date of our involvement with the index child (or children), for which there is variation within each category (Table 3).

Table 3: Case types and involvement in proceedings at time of incident

Cafcass' involvement with index child (or children)	Public law	Private law	Total frequency
Prior to incident only	7	1	**8**
At the time of the incident	3	2	**5**
Following the incident only	2	0	**2**
Total	**12**	**3**	**15**

Cafcass was involved with the child at the time of the incident in five cases.

- One was a fatal incident in a public law case, where the child remained with the mother under an interim supervision order. The child was under one year old and was smothered while both mother and child were asleep.
- Two other public law cases involved non-accidental injuries to two children, both under one year old. Both had been removed from their mothers and subsequently placed with their respective fathers during proceedings, one pending further assessments, and one under an interim supervision order.
- Both private law cases involved the respective fathers' application to spend time with the child. Both children were presented at hospital having been in the care of the mothers; one had multiple injuries; the other was at high risk of death from malnutrition, caused by neglect.

Cases where our involvement had ceased prior to the incident comprised:

- A private law case where the incident happened a day after the case was closed, while the child was with the resident parent. Concerns in the case focused on the non-resident parent, who had applied to spend time with the child.
- Four cases where incidents happened within nine months of being placed with the perpetrator (either parents or special guardians) following care proceedings;
- Two incidents that happened several years after being placed with the perpetrators following care proceedings: one under a Special Guardianship Order three years previously, and one placed with mother over four years previously;
- In one case a child perpetrated an incident 12 months after placement in foster care.

In two cases Cafcass did not know the children at the time of the incident but was asked to contribute to the SCRs on the basis of our subsequent involvement. The care proceedings revealed the long standing nature of the abuse suffered by the children, which prompted the convening of the SCRs.

3.2 Children and families

Children

21 children were the subjects of 15 submissions to SCRs.

- **Number of children involved in the SCR.** The majority (12) of SCRs involved only one child. A further four children were the subjects of two SCRs involving concerns about sexual abuse, and five children were involved in a case involving concerns about neglect.

- **Gender of children involved in the SCR.** Twelve children were female and nine were male. Two girls and two boys were subjects of sexual abuse; five girls and four boys were subject to neglect; four girls and three boys were subject to physical abuse; and one girl was the perpetrator of an incident.

- **Age of children involved in the SCR**. The majority (16) were young children (under six years old). All incidents featuring physical abuse occurred within this group. Incidents involving sexual abuse occurred for children aged between one and 10; two index teenagers suffered neglect and one was the incident perpetrator.

Figure 1: Age and gender of children involved in index incident (2017)

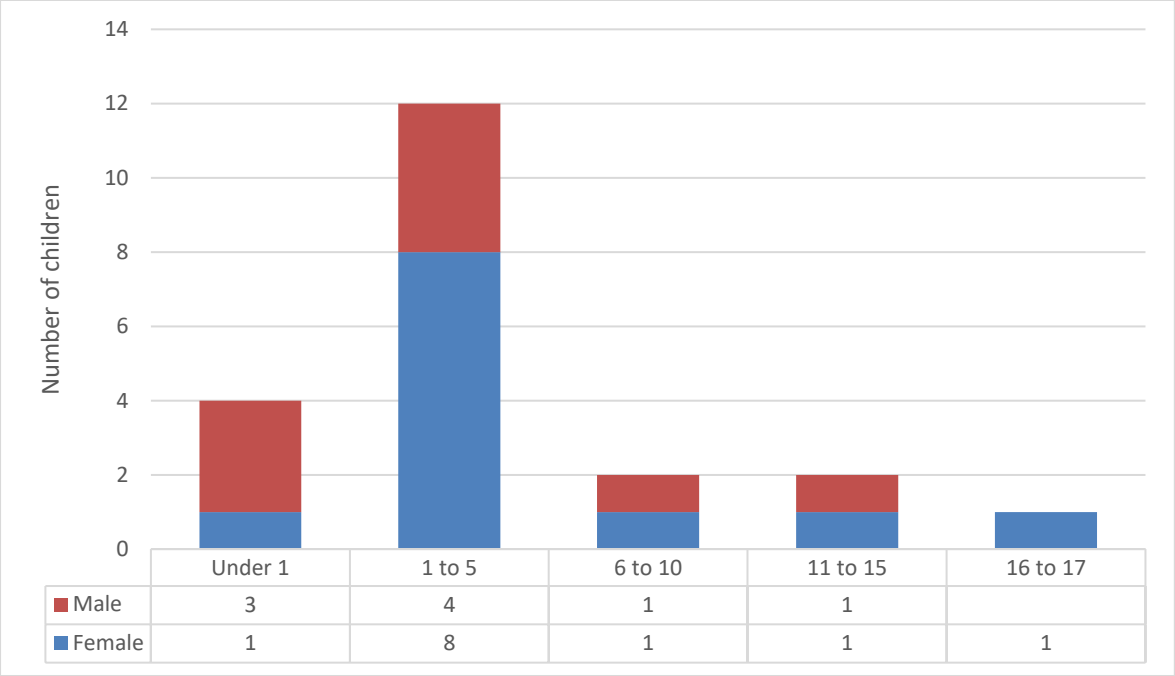
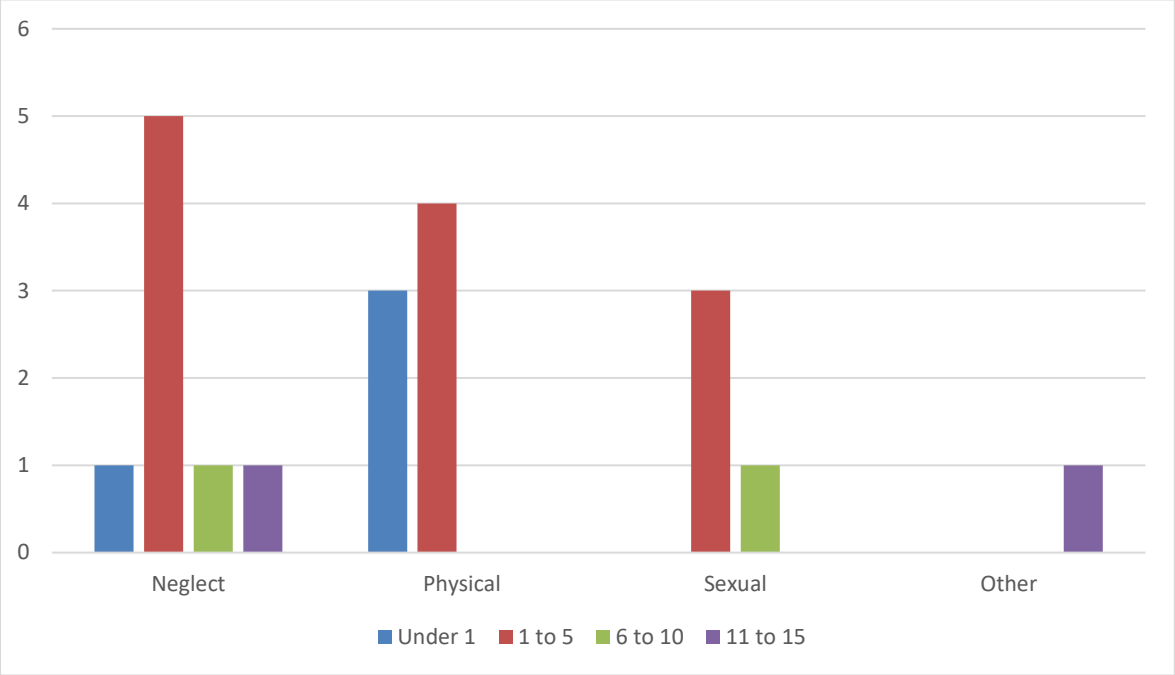


Figure 2: Type of harm suffered in index incident by age of child (2017)



Parents

As in previous studies, the majority of cases involved mothers who were young at the birth of their first child, and fathers tended to be older.[4] In three cases there had previously been removal of older siblings from the care of the parents.

Table 4: Age profile of mothers and fathers at birth of first child (2017)

Age	Mothers	Fathers
Under 21	8 (53%)	2 (13%)
21-25	4 (27%)	5 (33%)
26-30	1 (7%)	2 (13%)
Over 30	1 (7%)	5 (33%)
Unknown	1 (7%)	1 (7%)
Total	**15**	**15**

3.3 The index incidents

The breakdown of types of 'index incident' (the incident with which the SCR was concerned) is set out below. Physical abuse, both fatal and non-fatal, accounted for the highest number of incidents.

Five incidents involved deaths of children, aged: 1 month, 1 year, 1 year, 2 years, and 16 years old. Two resulted from physical abuse, one from neglect, one from co-sleeping, and another was linked to a congenital health issue after which evidence was found of severe neglect.[5]

[4] Data showing the age of fathers at the birth of their first child is less reliable as SCRs may only include information about the father's children with the mother in the case.
[5] Included in category 'neglect (non-fatal)', as the neglect is not thought to have caused the death.

Serious maltreatment (non-fatal) incidents included five instances of physical abuse, three of neglect, two of sexual abuse, and one 'other' where the incident was perpetrated by the child.

3.4 Risk types and ratings

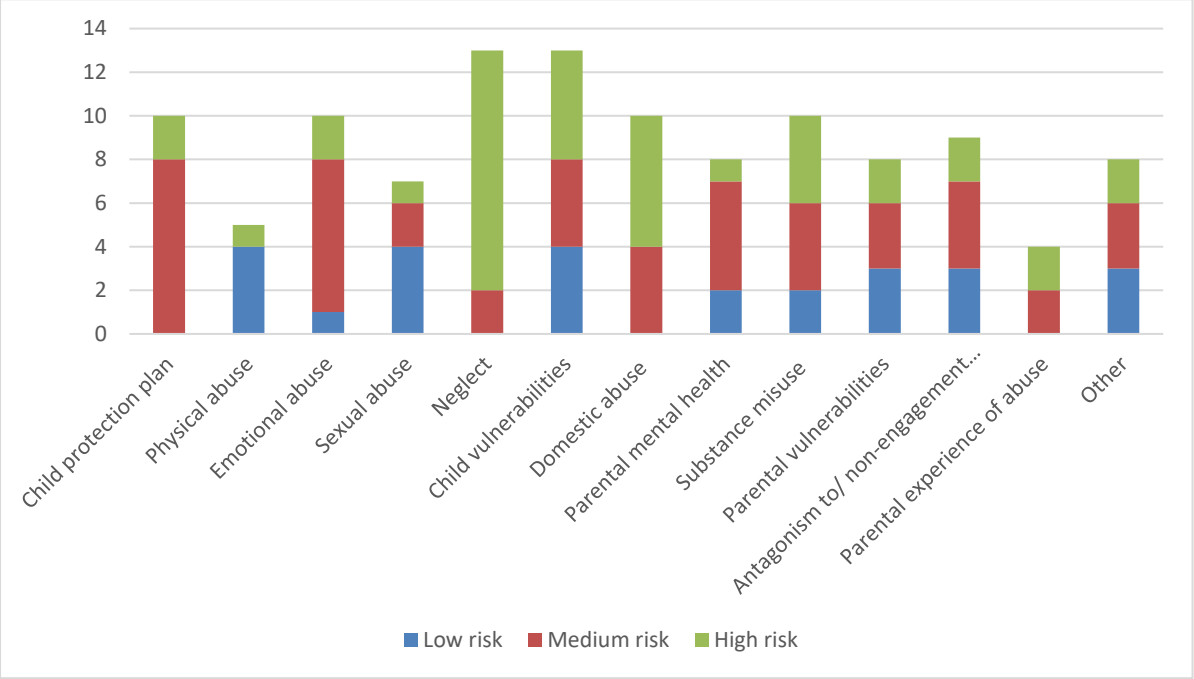
Each case was accorded risk ratings against 13 risk factors, with ratings of 'high', 'medium' or 'low' based on how recent the concern was, together with the frequency and the severity.[6]

- 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. 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. This is also true of ratings of low or medium.
- Risks relate to all case participants, not just risks specific to the placement in which the child lived at the time of the incident.
- Protective factors are not accounted for in the risk ratings.

3.4.1 Risk types

The level of risk in each category within this sample is set out in Figure 3. All cases feature risks under more than one category.

Figure 3: Risk types and levels for cases (2017)



[6] 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.

Neglect featured in all public law cases and one private law (n=13); the majority of these were high risk (n=11). High risk of neglect featured in seven of the eight cases involving **parental vulnerabilities**[7]. The children in almost all of these cases were on or had been subject to a **child protection plan**, or had been removed at birth. In the one exception (a private law case) the local authority had been involved with the family in respect of an older sibling following allegations of neglect.

Child vulnerabilities also featured in the majority of cases (n=13); risks involved children with severe disabilities, developmental delay, specific medical needs, or very young age. In some cases these risks combined with lack of experience of parenting (counted under '**other'**).[8]

Domestic abuse and **emotional abuse** (linked risks) featured frequently, although it was common for allegations and patterns of abuse to be disputed by both alleged perpetrators and, in some public law cases, alleged victims. Of the three private law cases, two featured high risks of domestic and emotional abuse, which were the key concerns during proceedings. The alleged perpetrator of domestic abuse in all cases except one was male; in the one case, the mother was alleged to be both a victim and perpetrator.

In eight cases the child had previously been on a **child protection plan.** Five of these cases involved physical abuse index incidents perpetrated by a parent or family member. However, physical abuse risks prior to the incident were only present in two of these cases, both at low risk.

Out of all eight cases which involved a **physical abuse** index incident, only three involved a known risk of physical abuse, reflecting that a lack of known history does not necessarily mean that there is no such risk. In the one case involving high risk of physical abuse, this related to risks posed by the father, but he had no contact with the child at the time of the incident.

Risk factors about parental capacity often combined, such as **antagonism or non-engagement with professionals** and risks noted under '**other'** such as previous removal of other children, parental ambivalence and anger issues, and lack of parental experience or of a positive support network. In all but one of the eight cases featuring **parental mental health** risks, both **substance misuse** and **domestic abuse** risks also featured.

3.4.2 Risk ratings

The overall risk rating for each case is determined by converted ratings of 'low', 'medium' and 'high' to scores of 1, 2 and 3 respectively across each of the 13 risk factors. These overall risk ratings per case are then averaged across all cases involved in each Cafcass SCR submission study; in Table 5 we present these 'average risk ratings' for the 2017 study against the previous years of study, separated by case type.

[7] Updated category in 2017 to include personality and learning difficulties, as well as self-harm or suicide attempts

[8] See research by the NSPCC which explored the key issues around disabled and deaf children in SCRs. 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.

Table 5: Overall risk rating by case type (and number of cases in each category)

Case type	Average risk rating (2017)	Average risk rating from previous studies (2012 – 2015)	Overall average risk rating
Public law – s31 only	17.6 (12)	17.1 (29)	17.3 (41)
Public law – others	-	13.3 (8)	13.3 (8)
Total public law	**17.6 (12)**	**16.3 (37)**	**16.6 (49)**
Private law – WTFH[9] only	-	7.1 (17)	7.1 (17)
Private law – WTFH & WAFH[10]	11.3 (3)	10.2 (21)	10.4 (24)
Total private law	**11.3 (3)**	**8.8 (38)**	**9.0 (41)**
Public and private	**-**	**17.3 (7)**	**17.3 (7)**
All case types	**16.3 (15)**	**12.9 (82)**	**13.1 (97)**

The average risk rating in the 2017 study was slightly higher than previous years. This may be due to wider applicability of the updated 'child vulnerabilities' risk factor.[11] It should be noted that the 2017 study involved fewer cases (n=15), so individual cases affect the total ratings more than in previous years.

- The majority (n=10) of cases were rated between 11 and 20.
- The lowest risk rating was nine in a private law WAFH case (where the child suffered near-fatal neglect while living with mother but the case had focused on risks relating to the applicant father).
- The highest risk rating was 24 in a s31 public law case (where a very young child was placed with their father during proceedings).
- Three cases, including the highest risk rating case above, had very high risk ratings of over 20. Two involved accepted risks of placement with parents either during or after s31 proceedings; the other involved the anomalous case where the majority of the risks related to the child's family but the child was the perpetrator of the incident.

[9] Work to first hearing (WTFH) is limited to filing a safeguarding letter reporting on checks undertaken with the police and local authorities, and any welfare concerns raised by adult parties. It does not involve meeting with the child.
[10] Work after first hearing (WAFH) denotes cases where Cafcass is ordered to complete further work after the first hearing, usually including filing a welfare report containing an assessment of what is in the child's best interests, based on interviews with adult parties, meetings with the child, and any other relevant enquiries.
[11] Previous risk category 'child putting self at risk' was amended to 'child vulnerabilities'; in the 2017 study sample this also includes risks relating to the child's very young age or disability.

- Public law cases on average had higher risk ratings than private law (public law range 11-24; private law range 9–15); this is similar to previous years and may partly reflect lesser known risks in private law cases rather than intrinsically safer cases.[12]

[12] Public law cases involve a high level of risk as this is prompts the local authority's application to court. The practitioner therefore has access to detailed risk information provided by the local authority. The local authority involvement and, in many cases, the fact that the children are placed outside of the home during, and sometimes after, 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, this may not indicate such cases are intrinsically safer: less may be known about these cases, and there may be fewer protective factors as Cafcass is often the only safeguarding agency involved.

Section 4: Learning from SCR submissions

4.1 How Cafcass learns from SCRs

There are three mechanisms by which Cafcass has the opportunity to learn in respect of most SCRs:

The Significant Incident Notification (SIN) review that is conducted by the National Improvement Service (NIS), commonly within a working day of the notification of the fatal/serious maltreatment of a child known to Cafcass. This is generally limited to a file review but it produces the vast majority of learning derived from the case. Its obvious benefits are speed and NIS experience, in that strengths and vulnerabilities are identified in a very timely manner at individual, service area and national level – and action taken to remedy shortfalls.

The Individual Management Review (IMR) that is also undertaken by NIS, generally within six to eight weeks of the SCR being convened. This commonly entails interviews with the FCA(s) and line-management, as well as dialogue with the Assistant Director (who signs off the report) around recommendations. It is a more in-depth process than the SIN review as it explores, for instance, how the practitioners saw the case at the time, or the context in which the work was undertaken. It is rare that the IMR substantially changes our view of practice in the case as gained by the SIN, but it does commonly elaborate it. As NIS are centrally involved in Learning and Development it provides opportunities for learning from other mechanisms to be integrated with that derived from the IMR, and for opportunities to be identified for promoting the learning, such as through the production or amending of training modules.

Scrutiny/challenge by the reviewers and SCR panel: this has the benefit of independence but the time required to complete an SCR commonly exceeds the timeframe stipulated in *Working Together* – within six months of initiation – sometimes by a year or more.

4.2 What we have learnt from this year's SCR submissions

A point we have made in previous studies – but which bears repetition – is that SCRs rarely produce new learning. More frequently they tell us what we already know about what distinguishes strong practice from weak.

IMRs or SIN reviews illustrated the merits of front-loading the work, planning, sound recording and systematic attention to the needs of the child – or the problems that ensue if these are overlooked. They reflected comments on:

- Timeliness of reviewing the case file, speaking to relevant professionals, reading the expert reports, and meeting the family and children.
- Child-centred work that reflects a good understanding of the safeguarding issues, analysing the needs and vulnerabilities of each child, avoiding the assumption that children are likely to be affected in the same way despite factors of age, resilience, experiences in the family etc.
- Detailed observations of individual children and parents, and analysis of those observations.

- Systematic attention to risk factors, and how these might be mitigated within a reasonable timeframe, including the age and experience of parents, availability of family support, and histories of poor mental health or substance misuse.
- Timely and clear case recording.

4.3 How this learning is taken forward

The following are examples of actions that have been taken at a national level following our SCR submissions. In some cases the actions are a direct consequence of the learning gained from the reviews. In others the actions are more directly derived from other sources of learning (audits, Area Quality Reviews) with the actions being refined in light of our SCR work.

- The following learning point was cascaded to the organisation via the learning log: the need to give careful consideration as to when to undertake an observation of young children (who cannot verbalise their wishes and feelings) to inform the guardian's assessment and advice to the court.
- The core induction training module 'Risk and Harm' was amended in January 2017 to strengthen advice to FCAs regarding changing the advice/recommendations to court when giving evidence in court. All new starters attend this course in the first six months of service.
- The development of eLearning on MySkills[13] in relation to Special Guardianship Orders. This will be reviewed before the end of 2017.
- Case recording workshops have been developed and are being delivered across Cafcass in 2017. These look at the need for case files to contain all relevant information to reflect defensible decision-making. It also addresses practical barriers to case recording and explores new models of working to facilitate case recording when practitioners are in court or on the move, such as through case recording via smartphones.
- The commissioning of a three day course on attachment and parenting capacity from Dr David Shemmings from the University of Kent Centre for Child Protection. To date over 300 staff have completed this course.
- The sharing of learning via the diversity ambassador network for discussion in local teams.

[13] Electronic learning platform available to all staff

Section 5: Analysis of SCR submissions between 2009 – 2016

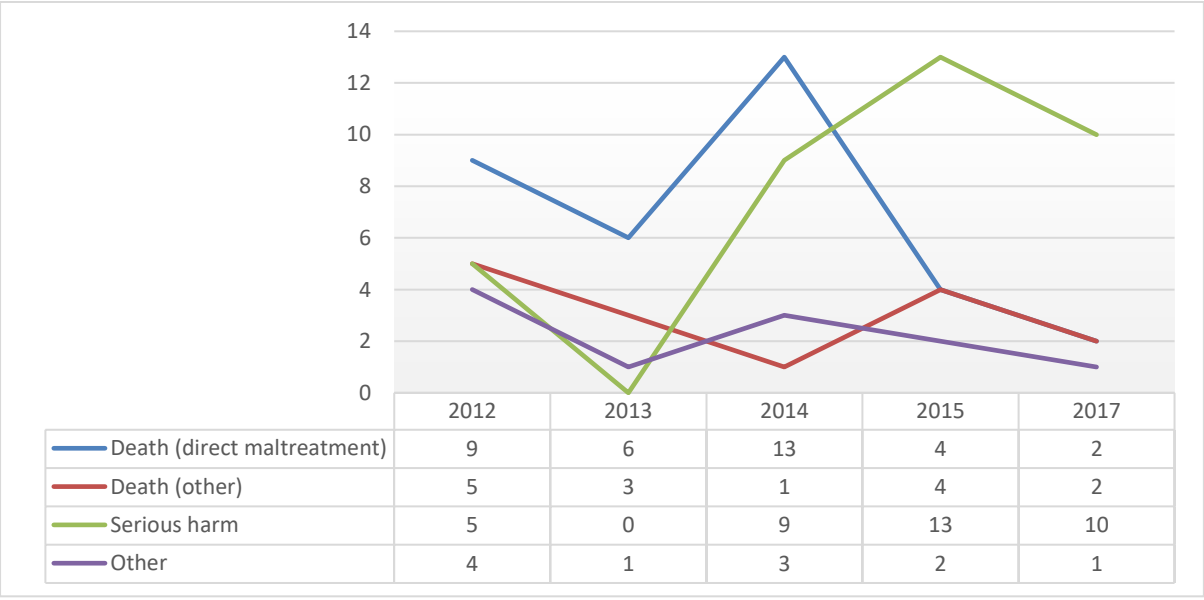
Our experience of SCRs suggests that there is no 'typical' case that ends up in a review. Some index incidents occur during proceedings; others years later. Our early studies on SCR submissions were formed mostly of private law cases; our more recent studies feature rather more public law cases.

They can involve apparently innocuous cases, or the risk may come from someone who is considered safe rather than someone who has a history of posing risk. Others involve acknowledged risks but protective factors that in other cases led to positive outcomes for parents and children, or low levels of risk which take on particular significance with hindsight. Although in some cases it is possible to identify areas where more scrutiny of risks was warranted, it is no coincidence that only a very small minority of SCRs have concluded that the fatal/serious harm was predictable or preventable.

Analysis relating to the 97 SCRs to which Cafcass has contributed since 2009 is set out below. The recent DfE Triennial Review of serious case reviews (2016) also considered findings across a long time period (2004 – 2014). Cafcass contributes to only a small proportion of all SCRs: those where the family was known to us through family court proceedings. Nonetheless, some of the themes identified in the Triennial Review are relevant to this study and we therefore set some of its findings against our own.

5.1 Index incidents

Figure 4: Index incident type per year of Cafcass SCR submissions study



	2012	2013	2014	2015	2017
Death (direct maltreatment)	9	6	13	4	2
Death (other)	5	3	1	4	2
Serious harm	5	0	9	13	10
Other	4	1	3	2	1

We have seen an increase in SCRs involving serious harm incidents since the 2012 study, which involves a higher number of sexual abuse and child sexual exploitation cases (Figure 4). Deaths due to physical abuse or homicide[14] have been low in the last two years, and cases where deaths did not involve physical maltreatment have remained stable.

This is approximately in line with what the Triennial Review found in a much larger sample. It found that the number of child deaths from *direct* maltreatment (physical assaults and homicides) is stable, but that SCRs into serious harm and cases where maltreatment was a factor but not a direct cause of death had increased.[15]

Cafcass was involved with the child in ongoing proceedings at the time of the incident in 36% of cases (n=35). 39% of incidents (n=38) occurred after family court proceedings had ended. In 25% of cases (n=24) we did not previously know the child but knew another family member or proceedings were started in respect of the child after the serious harm that triggered the SCR.

There have been a similar number of SCRs relating to private and public law (see Table 6).

- Interestingly, given that neglect is more commonly associated with public law applications than it is with private law, both law types feature similar numbers of neglect index incidents resulting in deaths and serious harm.
- Differences between law types include a higher number of homicides relating to private law proceedings, and a higher prevalence of sexual abuse relating to public law cases.

Table 6: Index incident type by type of proceedings

Incident type		Public	Private	Public and private	Total
Death					
Direct maltreatment	Physical abuse	8	11	1	**20**
	Homicide	1	12	1	**14**
Other	Neglect	5	4	0	**9**
	Co-sleeping	4	2	0	**6**
Serious harm					
	Physical abuse	8	4	0	**12**
	Neglect	5	4	1	**10**
	Sexual abuse	10	2	3	**15**
Other					
	Suicide	5	2	0	**7**
	Accidental fatal drug overdose	2	0	0	**2**
	Other	1	0	1	**2**
Total		**49**	**41**	**7**	**97**

[14] There is a fine (and perhaps semantic) distinction between the two but we use the term homicide to denote the deliberate killing of a child. It is often associated with the suicide, or attempted suicide, of the perpetrator.
[15] Triennial Review, p. 52

5.2 Source of harm

The variety of contexts in which the fatal/serious harm takes place presents significant challenges for those charged with safeguarding children. Our dataset contains numerous examples of professional attention being appropriately focused on protecting the child from known risk – but the child subsequently suffering fatal/serious harm in an alternative placement where no such risk factors were known, or where protective factors were in place. The following two examples from public law cases illustrate the point.

In one, the children were provided with kinship care as their parents were unable to meet their basic care needs. Despite no identification of sexual or physical harm risks as concerns for the carers, such abuse was later reported. In another, the child was looked after at birth. Despite background risks, positive assessments were made of father and the child was placed with him with local authority support. The child suffered a serious injury shortly after.

5.2.1 Suspected perpetrators

The suspected perpetrators of all 97 incidents are set out in Table 7. We emphasise the term 'suspected' as it is not for the SCR to determine who perpetrated the harm. Sometimes it is made clear by findings in the criminal or family courts. Otherwise we have made a judgement on the evidence available.

The evidence available shows that the vast majority of the incidents (75%) were thought to have been perpetrated by parents and/or other family members. This is similar to the Triennial Review findings that most incidents occurred within the family home involving parents or other close family members (65%).[16] The few exceptions we have seen are mostly cases of child sexual exploitation.

Table 7: Suspected incident perpetrator

Suspected incident perpetrator	Frequency	%
Father	22	Familial: 75%
Mother	16	
Both parents	8	
One/both parent(s) and others[17]	9	
Mother and partner	5	
Mother's partner	5	
Extended family[18]	8	
Young person him or herself [19]	10	Child: 11%
Subject child was perpetrator	1	
Extra-familial	4	Extra-familial: 7%
Child's ex-boyfriend	2	
Foster carers	1	
Not known	6	Unknown: 6%
Total	**97**	

[16] Triennial Review, pp. 66-67
[17] Commonly another family member
[18] Includes, but not restricted to, family members that became Special Guardians
[19] Includes known/suspected suicides plus drug overdoses which were unlikely to be suicides

The Triennial Review found equal numbers of fathers and mothers responsible for deliberate homicides. This is in line with Cafcass findings, albeit our sample is half the size of the Review's (14 cases compared to 28). The Triennial Review suggests that fathers and mothers may have different motives; the former being driven by a loss of control and a need to exact revenge, the latter by 'altruism', such as a belief that the child's suffering must end.[20]

This is an area where much caution needs to be exercised in interpreting motive – for the most part we cannot know for certain what any parent was thinking or feeling. However, subject to that caveat, our view is aligned with that of the Triennial Review. We have noted how (the few) fathers known to us who have killed their children had histories of domestic abuse and control; and how fragile the mental health of some of the mothers seems to have been.

Further, the Triennial Review found that physical assault (harm or serious injury) was most likely to be perpetrated by a father or father figure, whereas the mother was more likely to be the prime source of harm in co-sleeping and neglect deaths, reflecting her role as the main carer.[21]

Our data shows that involvement in the fatal physical harm to the child does not have a clear gender difference: fathers were involved in at least 12 cases, and mothers in at least 10. However, in line with the Triennial Review findings, more mothers were involved in deaths following neglect and co-sleeping (at least nine compared to four).

Table 8: Suspected perpetrator by type of index incident[22]

Suspected index incident perpetrator	**Death**		**Serious harm**		
	Physical abuse and homicide	Neglect and co-sleeping	Physical abuse	Neglect	Sexual abuse
Father	11	2	4	1	4
Mother	7	7	1	1	0
Both parents	1	2	1	4	0
One/both parent(s) and others	3	1	0	1	4
Mother and partner	2	0	1	2	0
Mother's partner	4	0	1	0	0
Extended family	2	2	1	0	3
Extra-familial	0	0	1	0	3
Child's ex-boyfriend	2	0	0	0	0
Foster carers	0	0	0	0	1
Not known	2	1	2	1	0
Total	34	15	12	10	15

[20] Triennial Review, pp. 56-57
[21] Triennial Review, p. 66
[22] Table excludes incidents where the young person him or herself was responsible for the incident.

5.2.2 Special Guardianship

Harm perpetrated by Special Guardians has been the subject of media attention upon the publication of recent SCRs. This follows wider sector concerns around Special Guardianship, such as those articulated in the DfE-led review (2015) to which Cafcass contributed.

In eight of our 97 cases the perpetrator of the index incident is known or thought to have been a member of the extended family, some of whom were Special Guardians. It is important to state that no IMR prepared by Cafcass regarding a Special Guardianship Order (SGO) has concluded that the children's guardian made the 'wrong' recommendation: indeed positive practice was identified in some, regarding advocating for fuller assessment or a stronger support plan. Likewise, we are not aware of any SCR overview report that has concluded that an SGO should not have been made.

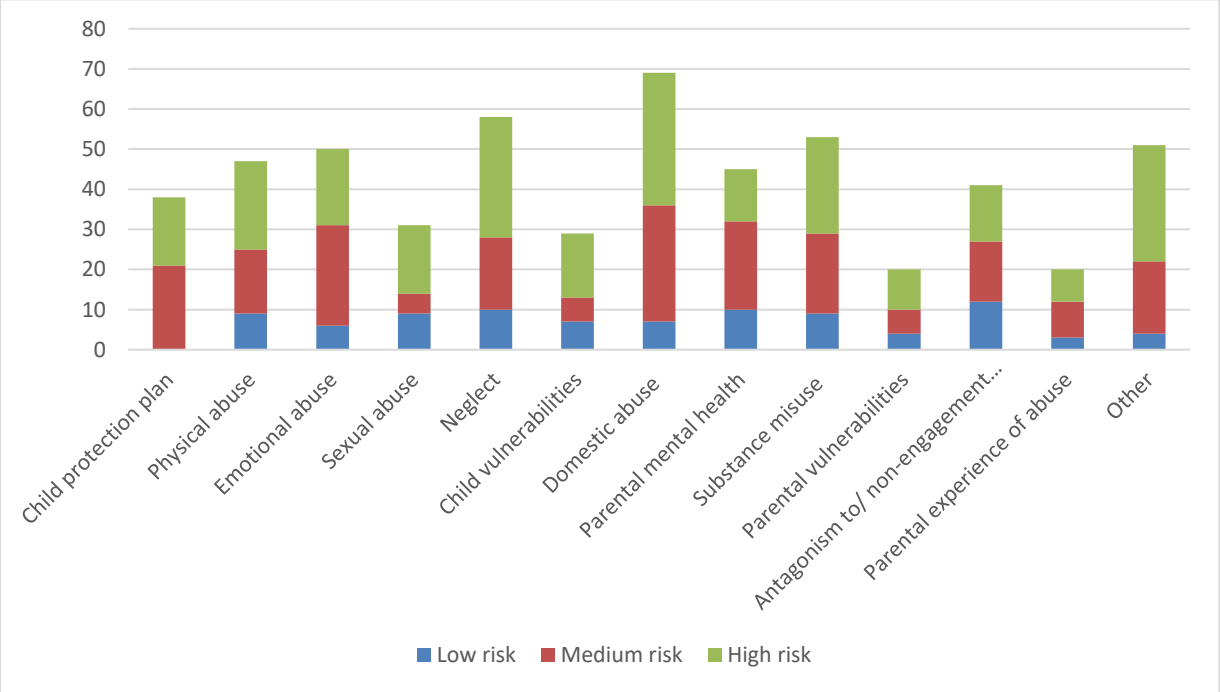
Recent reforms regarding practice in Special Guardian assessments include:

- Amendments to regulations so that assessments of prospective Special Guardians should address their capacity to: meet the child's current and future needs, including those derived from harm that has been suffered; protect the child from any risk of harm posed by parents or others; and bring up the child to the age of 18.
- The Viability Assessment practice guide developed by the Family Rights Group.
- Guidance on assessments of special guardians from ADCS and Cafcass.

In a recent article *Special guardianship orders: are they being used safely?* Professor Judith Harwin (who is conducting a longitudinal study of SGOs making use of Cafcass data) usefully reminds us that adverse outcomes in Special Guardianship cases occur in a 'minority of extreme cases'.

5.3 Risk factors

Figure 5: Risk types present in SCR submission cases



5.3.1 The 'toxic trio'

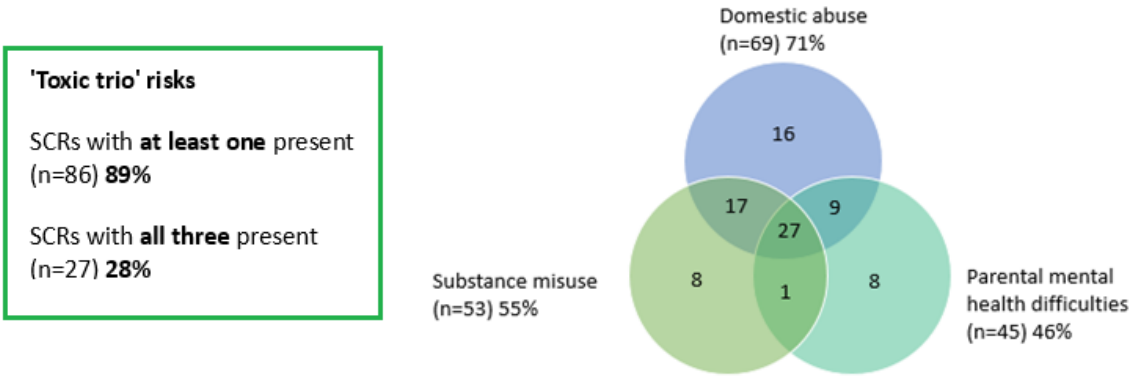
The cumulative risk of harm when domestic abuse, substance abuse and mental health problems co-exist (the 'toxic trio') is well known in social work practice. The risks are borne out in our study, which found:

- 28% of cases involved all three toxic trio risk factors (see Figure 6);
- At least one of the toxic trio risk factors was present in each case that entailed fatal or physical maltreatment by one or both of the parents.

Eleven Cafcass cases did not feature any of the 'toxic trio'. In these cases the index incidents were: fatal or physical harm caused by other family members; extra-familial child sexual abuse or exploitation; and likely accidental drug overdoses by teenagers.

The proportions of cases featuring at least one factor, and all three factors, are higher than those found in the Triennial Review (89% compared with 47%; 28% compared with 22%).[23] Domestic abuse was also more present in our study, featuring in 71% of cases rather than in 54%.[24] These differences may again reflect the subset of SCRs which involve the families known to the family justice system, where proceedings may be prompted by these concerns.

Figure 6: 'Toxic trio' of risk factors in SCR cases



5.3.2 Domestic abuse

Domestic abuse was the most common risk factor in SCR cases, present at varied risk levels in 71% of the SCRS (n=69) (Table 9). The levels and nature of disclosure also varied between law type (Table 10). Domestic abuse was more commonly alleged in private law cases, where one partner (generally female) accuses the other partner, who often denies it; in public law the allegations are sometimes denied by both parents who dispute the local authority's assessment of risk derived from domestic abuse.

[23] Triennial Review, p. 76
[24] Triennial Review, p. 75

Table 9: Prevalence and risk level of domestic abuse by law type

Domestic abuse risk rating	Public	Private	Public and private	Total
High	16	14	3	33
Medium	10	15	4	29
Low	3	4	0	7
Total cases featuring risk (% of overall number of cases)	**29** (59%)	**33** (80%)	**7** (100%)	**69** (71%)

Evidence of domestic abuse and the risk derived from it also varied between cases. One case example demonstrated multi-faceted domestic abuse perpetrated by the father with a number of associated acute risks, and clear evidence of psychological harm to the child, who was described as 'brutalised' and provided a graphic account of his father being systematically violent to his mother. Conversely, in another example the Cafcass practitioner's inquiries raised domestic abuse concerns, but did not provide definitive evidence to support or refute them. The mother, the alleged victim of abuse, killed the child and herself.

Table 10: Alleged perpetrator of domestic abuse by law type

Alleged perpetrator of domestic abuse	Public	Private	Public and private	Total
Father/male partner	18	25	3	**46** (67%)
Mother/female partner	0	1	0	**1** (1%)
Reciprocal	4	4	1	**9** (13%)
Unknown or insufficient data	7	3	3	**13** (19%)
Total	**29**	**33**	**7**	**69**

In cases featuring domestic abuse, the alleged perpetrator was most commonly male (66%; see Table 10). In fewer cases the abuse was alleged to be reciprocal, that is the data suggested that the man too had been the victim of physical aggression by the woman (13%). However, as noted above the issue of who perpetrates fatal/serious abuse is rather less 'gendered' (see Table 7 and Table 8).

Of the 69 cases featuring domestic abuse as a risk factor:

- In 52% of cases (n= 36) the person thought to have perpetrated the index incident was also thought to have perpetrated domestic abuse. This was the father in 20 cases, the mother in six cases, both parents in six cases, and mother's partner in four cases.
- In 28% (19) of cases, the person thought to have perpetrated the index incident was not the alleged domestic abuse perpetrator (this number excludes incidents where the source of harm was the young person themselves).

In some cases where index incidents were perpetrated by the mother, SCRs found that the mother's history had not been sufficiently analysed, concerns about her being overshadowed by concerns about the father or other male. It is interesting to note that such SCRs do not show a simple relationship between male domestic abuse and the fatal/serious maltreatment of children. In one example the risk posed by the very violent male was thought to have

masked other less evident risk factors connected to the mother (self-harm, her volatility and outbursts of anger, possible drug misuse) and the child (the impact of witnessing domestic abuse and her anxiety in the company of men).

5.3.3 Extent of neglect

Risk of neglect was present in 60% of SCR cases reviewed (n=58), which is slightly higher than the Triennial Review estimated (55%).[25] The higher rate may be linked to our involvement in public law cases, for which neglect is commonly the concern that drives the s31 application, even if it is less often the directly cause of the index incident (see Table 6: 15% of index incidents involved fatal neglect/co-sleeping, 10% involved non-fatal neglect).

Neglect was also found to be present in a number of private law cases. In one example safeguarding concerns focused primarily on the applicant father, as there were allegations of domestic abuse towards the mother and child. The child lived with mother and did not spend any time with the father. During the case, the child was admitted to hospital at high risk of death, thought to be due to intentional neglect.

Table 11: Prevalence and risk level of neglect by law type

Neglect risk rating	Public	Private	Public and private	Total
High	26	3	1	**30**
Medium	9	6	3	**18**
Low	4	6	0	**10**
Total	39	15	4	58

5.4 Characteristics of children and parents involved

The Triennial Review looked at whether there was anything about the children, their families or their wider social environment which set them apart, and that could help prevent maltreatment if it was better understood by professionals.[26]

5.4.1 Age of children

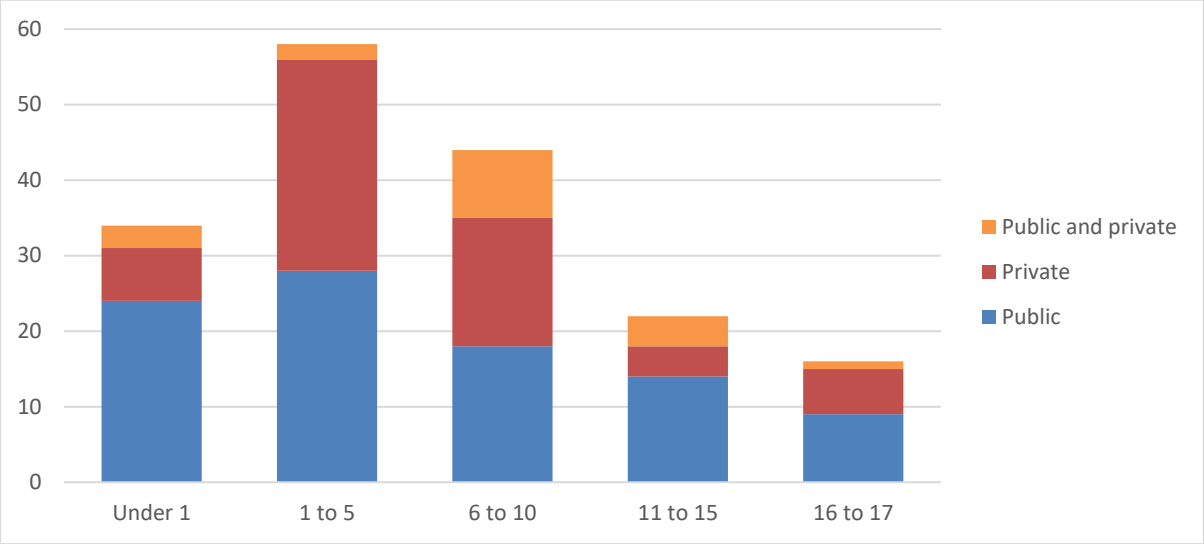
The Triennial Review found that two age groups were particularly vulnerable to suffering serious harm: young infants, and adolescents. The largest proportion of SCRs they reviewed related to children aged under one year, relating to known child protection risks linked to the extreme physical vulnerability of the very young, and pressures on parents which come with having infants. It also found the numbers increased again at mid- to late-teens mainly relating to suicide.[27]

However, the profile of children in our study is subtly different which may reflect that the Triennial Review includes incidents with children involved in child in need or child protection processes who are not known by Cafcass. Children aged under one represented a smaller proportion of our cases (20% compared to 41%). Similarly, the number of teenagers was much

[25] Triennial Review, p. 43
[26] Triennial Review, p. 68
[27] Triennial Review, p. 35

lower (9% compared to 28%). The most prevalent age group in our cases was between one and five years, which was higher than the Triennial Review (33% compared to 22%).

Figure 7: Age of children at time of incident



5.4.2 Gender of children

The Triennial Review found that between 2005-11 slightly more boys featured in SCRs than girls (53%), but that this trend was reversed in the 2011-14 period where 55% of cases involved girls.[28] Our data reflects different reporting periods so cannot be directly compared, but is similar to the more recent trend identified in the Review: a slightly higher proportion of SCRs concerned girls (56%) than boys (44%).

Table 12: Gender of child by year of Cafcass SCR submission study

Gender	Frequency 2012	Frequency 2013	Frequency 2014	Frequency 2015	Frequency 2017	Total frequency
Female	27 (50%)	17 (59%)	16 (50%)	26 (68%)	12 (57%)	**98 (56%)**
Male	27 (50%)	12 (41%)	16 (50%)	12 (32%)	9 (43%)	**76 (44%)**
Total	54	29	32	38	21	174

5.4.2 Age of parents

The Triennial Review found that young parenthood was a factor in many SCRs; in over half (54%) of cases involving families with only one child, the mother was aged nineteen or under.[29] This is in comparison with the average age of first time mothers in England and Wales of 28. Young parenthood also often combined with lack of support from the mother's own parents or an unstable relationship with the father.

[28] Triennial Review, p. 38
[29] Triennial Review, p. 73

Our data shows a similar pattern, although we have recorded the age of the mother at the birth of her first child, not at the time of the incident. [30]

- The majority (41%) involved mothers who had been aged under 21 at the birth of their first child.
- Based on the information available,[31] fathers are typically older at the birth of the first child than mothers. A small proportion of fathers were under 21 (19%); the majority of fathers (31%) were aged over 30, compared to 14% of mothers.

Table 13: Age profile of mothers and fathers at birth of first child[32]

Age	Mothers	Fathers
Under 21	26 (41%)	12 (19%)
21-25	15 (23%)	14 (22%)
26-30	11 (17%)	12 (19%)
Over 30	9 (14%)	20 (31%)
Unknown	3 (5%)	6 (9%)
Total	64	64

[30] Ages of parents have been collected for Cafcass SCR submissions studies since 2014.
[31] Data showing the age of fathers at the birth of their first child is less reliable as SCRs may only include information about the father's children with the mother in the case.
[32] Ages of parents have been collected for Cafcass SCR submissions studies since 2014.