

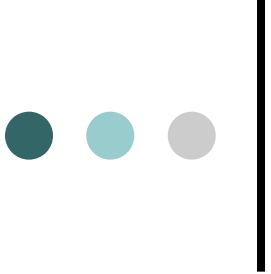


Analysing child deaths and serious injury through abuse and neglect: what can we learn?

A biennial analysis of serious case reviews 2003-5

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Research questions for 2003-5 Biennial Review

- What are the themes and trends across reviews reports?
- What can we learn about ecological transactional factors? (inter-acting risk factors)
- What are the lessons for policy and practice? (and can these types of cases be prevented/reduced)



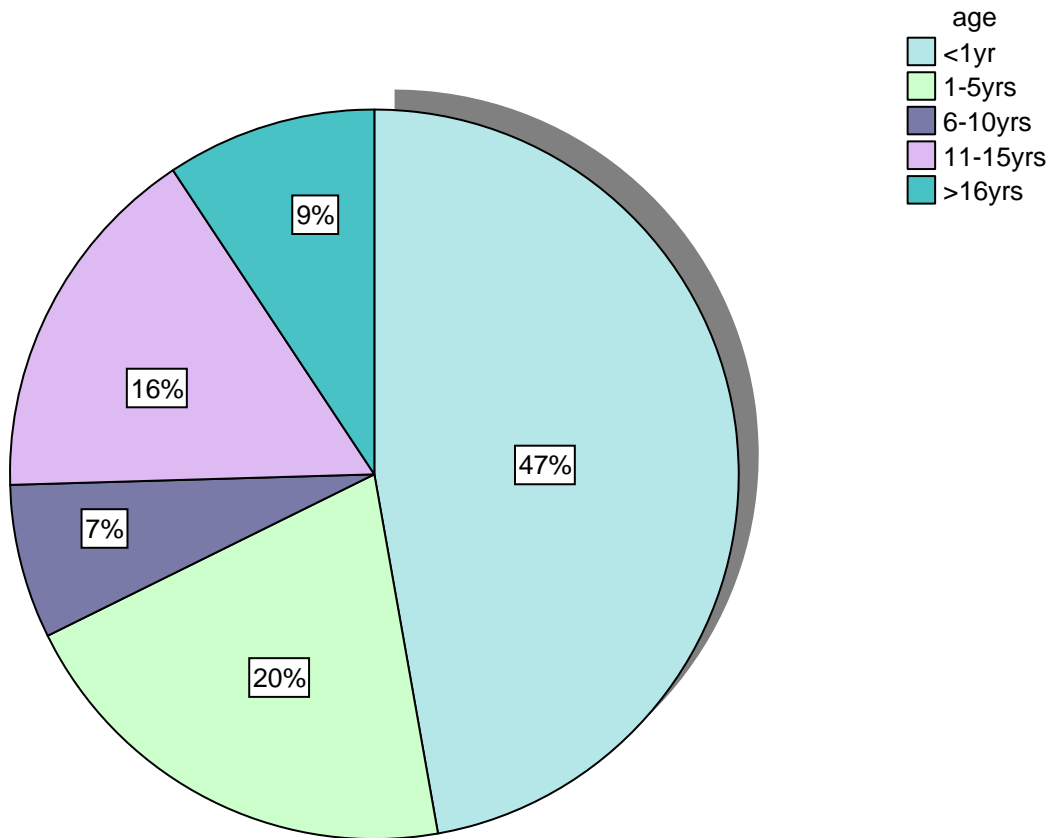
Methodology

Layer 1- Mostly Quantitative
Basic information from 'notification' database
-161 cases.



Layer 2 – Mostly Qualitative
Purposive sub-sample of 47 cases,
information from full reviews

Child's age at time of death/incident





Layer 1 cases (n=161)

- Case Example: *Cause of death is still unknown. Post mortem identified historic rib fractures. Inconclusive evidence that the baby had been shaken. No known concerns about care of other children. Minimal previous involvement of children's social care.*

(Only 12% were listed the child protection register (ie known concerns for safety and only 55% known to SSD at t.o.i.). 16% of cases were head injuries to babies – 17:25 incidents resulted in serious injury rather than death).)

- Case Example: *The child died following the inhalation of smoke from a house fire. The child had been known to multiple agencies over time. Issues of drug misuse and neglect were indicated. Poor living conditions.*

(21% of 161 cases featured neglect including house fires, accidents and illness; poor living conditions in 30% of cases)



Layer 2 cases (n=47)

- [The child's mother] *had a series of violent partners... suffered with mental health problems, anxiety and depression and was misusing alcohol. The family changed address frequently ... and all three children witnessed serious domestic abuse...* [The child's mother] *failed to attend a number of medical appointments with the children* (suicide of child aged 15)

(Caregiver problems: 66% domestic violence, 55% mental ill health, 57% substance misuse – co-morbidity of all 3 in 1:3 cases. In 32:47 cases there was lack of cooperation or overt hostility from families to workers)



Categorisation of Layer 2 cases (n=47)

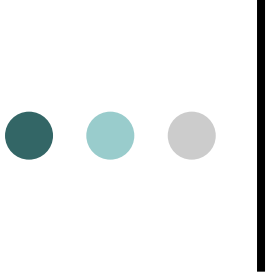
Stage 1

Child factors and experiences	Family and environmental factors	Practice/professionals, agency factors
<p>Very young babies (prematurity, admissions to hospital, types of injury)</p> <p>Older child, hard to help (self neglect, chronic illness, sexual exploitation, 'going missing', bullying, suicide)</p>	<p>Co-morbidity of Domestic violence, Substance misuse, Mental ill health</p> <p>Fathers, hostility, criminal convictions</p> <p>Patterns of hostility and cooperation eg disguised compliance</p> <p>Family History, eg neglect, previous child death,</p> <p>Poverty, poor living conditions, Frequent house moves, accidents</p>	<p>Agency context, capacity and 'organisational climate'</p> <p>Preoccupation with thresholds e.g. CP threshold not met</p> <p>Professional anxiety and reluctance to act and challenge</p> <p>Supervision Ethnicity challenges Understanding and dealing with neglect, 'start again syndrome'</p> <p>Keeping track of families Child not seen/ heard</p>



Categorisation of the 47 Layer 2 cases - Stage 2

- **1:3 = Neglect** (known to many agencies, long term cases 'start again syndrome')
- **1:3 = Physical assault**, (known to few agencies, most shaken baby cases, context of known volatility and family violence in 87%)
- **1:3 = Agency neglect** (Older children over 13 years, long agency history, self neglect including suicide, assault of others, hard to help, agencies have given up).



Conclusions - Knowledge

- Most cases were too complex for serious injury or death to be predictable
- The co-existence of domestic violence, parental mental ill health and substance misuse increase the risks of harm to children but **do not** predict death or serious injury
- Family volatility and a history of previous admission to A&E for the child present warning signs of abuse.



Messages: Inter agency working

- **Level 1 & 2**

Early intervention and working with early needs *is* part of the safeguarding continuum and not a separate sphere of activity.

- **Levels 3 & 4**

Arguing over thresholds and finding ways to avoid providing services leaves vulnerable children cast adrift. LSCBs have a remit to consider thresholds.

- **Neglect**

Risks of recurring maltreatment are higher with neglect than other types of abuse. Practitioners need support to stop them becoming overwhelmed and to help them think and act systematically to avoid the 'start again syndrome'.



Selected Sources

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