

Serious Case Reviews in Child Protection Historical Reflections



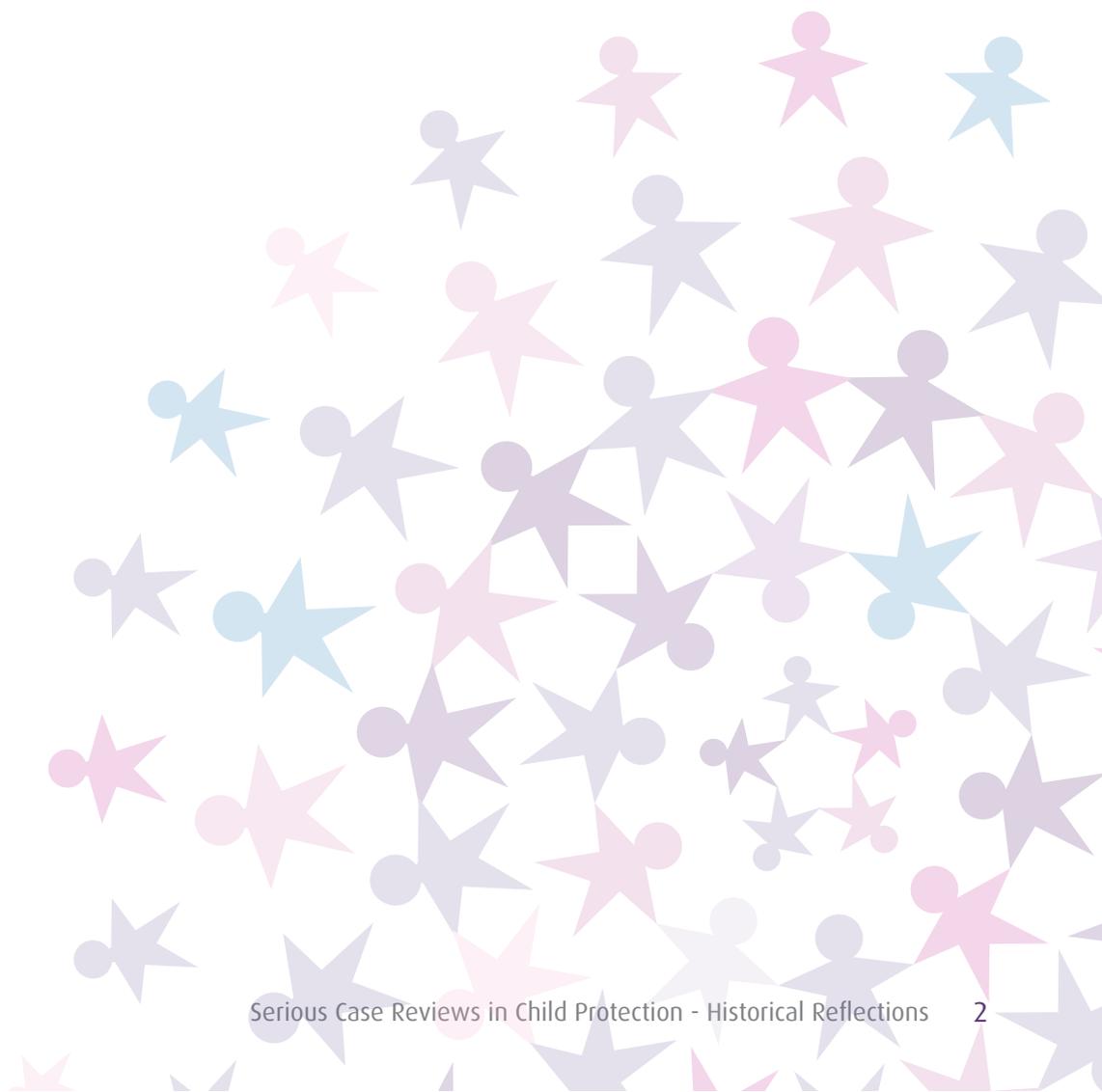
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Serious Case Reviews in Child Protection – Historical Reflections¹

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This brief historical reflection on serious case reviews (SCRs) of child protection incidents aims to set the current debates and tensions in an historical context. It does not provide a systematic review of all the child protection reviews, which have taken place.

The purpose of the paper is to consider whether the history of SCRs provides any insight into understanding and improving current practice in the conduct and management of SCRs. It is equally relevant to ask questions about the characteristics of ‘serious cases’, especially deaths from child abuse: incidence, causation, prevention, intervention. However this paper is NOT concerned with those questions. It is focused on the process of reviewing ‘serious cases’ and the management of public interest.

Whilst the main focus is on the ‘routine’ process of reviewing ‘serious cases’ as defined in Working Together 2015 and earlier guidance, it is not possible to undertake a historical review of SCRs without considering public inquiries, legal cases and other review mechanisms that existed before and in parallel with these arrangements. It is also worth noting that, whilst there is a specific professional and political focus on the process for undertaking SCRs in cases of child death, there are parallel concerns about risk management in other fields, where recognition of the need for systematic reviews of tragedies or apparent service failures has also been evolving.

What are serious case reviews?

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB’s function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(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. (Her Majesty’s Government, 2015).

Other processes can also be used to review cases where there are grounds for concern, including formal criminal or civil legal processes (for example for negligence), professional conduct hearings by regulatory bodies, formal inspections and public inquiries, which may be held in public or private.

1 This paper was prepared for the Task and Finish Group: Serious Case Reviews convened by the Virtual Staff College, drawing on my earlier work on child protection policy and SCRs.

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What pushes a 'serious case' into the public domain?

Most 'serious cases' (ie in this context, cases involving children who suffer death or serious consequences as a result of child abuse) do NOT attract sustained public and political interest. Nobody has successfully developed a 'theory' to explain which cases attract political and media attention and progress to a formal enquiry or public review, although Drakeford and Butler (2005) have systematically reviewed the evidence. This would be a useful area of further study.

"Scandals do not just happen. They are made. They are constructed out of such everyday tragedies as the small carelessnesses and institutional brutality of the long stay hospital, the abuse of children or the violent deaths of innocent bystanders" (Butler and Drakeford, 2005). A number of factors may be expected to contribute to the process, possibly including:

- the type of cases (although similar cases can have a very different public profile – severity and death do not always lead to public outcry).
- the 'response' of the local agencies – how they handle the case in public.
- how the response is perceived by 'the public' – whether this is credible or 'defensive' – increasingly whether there is a sufficiently sincere apology.
- other news taking news space on the day of publication – some cases are 'squeezed out' or sink from view because of lack of media capacity, although this may become less likely as the scope for diverse social media develops.
- local politics and whether local politicians see scope for political advantage.
- national political context - whether national politicians see scope for political advantage or ministers feel vulnerable and need to 'hit back'.
- state of professional knowledge – the existence of a 'claims maker to expose the bad practice' (Butler and Drakeford, 2005) and to propose an alternative and better response. It may be that for a scandal to 'run' there needs to be at least the potential of an alternative 'response'. For example, Maria Colwell's case came soon after publication of Henry Kempe's 'Battered Baby Syndrome' and the launch of a specialist service by the NSPCC – a better way of dealing with such cases could be seen which facilitated criticism of the handling of that specific case.
- a narrative tension – 'like a morality tale between good and evil' (Butler and Drakeford, 2005).

The vulnerability of public services to 'scandal' and criticism is not new and will not disappear; in her brief history of social work, written at the end of the 1970s, Eileen Youngusband (1981) referred to the significant impact of scandals on the history and development of the profession. The issue, therefore, is how we handle the cases which do blow up and what can we learn from past experience.

'Scandals' and 'serious cases' do not exist in a vacuum. They have to be seen within their political and social context. It is self-evident that all deaths from child abuse, for example, do NOT attract significant and sustained media coverage and political attention. For a serious case to attract more than professional attention, it must generate sustained political interest or generate public outrage, the two often being related.

'Scandals' have been used by campaigners both to criticise and denigrate and to promote and improve public services. Public enquiries, serious case reviews and other review processes have provided a significant commentary on the provision and quality of public services in general over many decades. It is arguable that such reviews have had a more significant impact on the shape and delivery of public health and welfare services than any other single influence. In short, politicians, the media and the general public often appear to be more influenced by a powerful story of an individual tragedy or dramatic account of a collective tragedy than by other more systematic forms

of evidence, such as rigorous research, considered policy development, international comparisons or systematic inspection.

Case reviews can focus on an individual case or a group of similar cases or a particular service provider. Whilst SCRs in this context usually involve one or a small number of children (usually siblings), it is informative to include consideration of such reviews as the Cleveland (1988), Orkney (1991) and North Wales inquiries (Waterhouse, 2000) and, more recently, the child sexual exploitation cases in Rochdale (2013), Rotherham (Jay, 2014) and Oxfordshire (Bedford, 2015), all of which involved a group of young people.

Apparent poor practice, scandals and inquiries are not new. The current debates about SCRs show exactly the same elements and processes as reviews and 'scandals' in early periods. This should inform our understanding of the contemporary controversies.

Victorian welfare services – scandals, inquiries and reform

Throughout the Victorian period there were several inquiries and reports on 'scandals' in Poor Law institutions (the main welfare services of their time), the 'natural history' of which bears an uncanny resemblance to contemporary experience.

For example, the Haydock Lodge scandal (1846-1852) involved the transport around the country of large numbers of 'paupers' with mental illnesses and learning disabilities, moving from public workhouses to a private institution in Lancashire, where large numbers died. It later emerged that 2 senior officials of the Poor Law Commission had a financial interest in the institution and therefore in the admissions. This became public, resulting in Parliamentary inquiries and the resignation of the officials and, in combination with the Andover workhouse scandal, precipitated a change in the structure of services: the replacement of the Poor Law Commission by the Poor Law Board (Hirst, 2005, Roberts, 1991).

In a different example, the publicity about the death of Timothy Daly, in St Bartholomew's Hospital in December 1864 as a result of 'death from exhaustion from bed sores and rheumatic fever' whilst in the workhouse, followed by the death of Richard Gibson from neglect in another infirmary, had a national impact. They were not atypical cases but were seized on by campaigners and highlighted in the media. The cases resulted in the intervention of Florence Nightingale, articles in *The Lancet*, *British Medical Journal* and popular press, publication by Florence Nightingale (1865) of the 'ABC of Workhouse reform' and the eventual establishment of an influential Commission of inquiry by *The Lancet*. This led to government action including legislation, a change in the inspection system and 'guidance' from professional bodies and researchers. The 2 individual cases resulted in implementation of changes in practice and administration within a 2 year period, in contrast to a long history of inaction during the preceding period, despite growing evidence of major problems (Farnell, 1866, *Lancet*, 1865, *Lancet*, 1867, Nightingale, 1867, Rivett, 2005, Smith, 1866, Hardy and Johnson, 1981).

Serious case reviews since 1945

Individual cases, as explored in public and other formal inquiries and Serious Case Reviews, have had a defining impact on the evolution of child care policy in the United Kingdom. It is frequently possible to trace key legislative changes to a specific incident. In recent years, politicians have tended to refer to a tragedy to justify changes in legislation or guidance, even when there is clear evidence that the changes were already under consideration prior to that case making news. For example, the Cabinet Office and professional bodies had been working for some time on major reforms to children's services (Department for Education and Skills, 2003) prior to the publicity about the death of Victoria Climbié. The inquiry into her death by Lord Laming proceeded in parallel to that work and was published around the same time as the policy proposals (Laming, 2003). The subsequent attempt to marry the recommendations from the two processes created some of the

discontinuities and tensions in the safeguarding system, such as the apparent overlap of roles and membership of Children's Trusts and LSCBs (Department for Education and Skills, 2004), which have continued to challenge those who have to make them work.

The 1948 Children Act emerged from the experience of the 1939-45 war and especially the evacuation of large numbers of children. However the death of Dennis O'Neill, later discussed by his brother Tom O'Neill (2000), and the Monkton inquiry, which followed (Home Office, 1945), had a dramatic impact on the political process. In sharp contrast to the timescales for more recent reviews, the inquiry opened at Newport Civic Centre on 10 April 1945 and reported on 28 May 1945, a mere 7 weeks: within six months of Dennis' death, the inquiry had been completed and the report published. The report led to the establishment of the Care of Children Committee (Chairman: Myra Curtis) – the Curtis Committee (1946), which shaped the 1948 Act and the creation of Children's Departments and led directly to changes in Boarding Out Regulations. For example, evidence from the inquiry that unqualified staff had been sent to do an assessment but had been ineffective helped to support the case for strengthened social worker training. The report criticised both councils involved, but did not name any specific individual(s) and acknowledged that the failings were not deliberate.

Whilst a small number of children continued to die at the hands of their carers in subsequent years, the next inquiry, which had a major impact on policy and practice, took place in the early 1970s.

The inquiry into the death of Maria Colwell (Department of Health and Social Security, 1974) provided a clear watershed leading directly to the development of child protection and safeguarding guidance eventually known as 'Working Together' (Batty, 2004, Jones et al., 1987, Jones et al., 1979, British Association of Social Workers, 1980). The public inquiry into her death at the hands of her stepfather highlighted a serious lack of coordination within child protection services. The report resulted in changes in legislation and highlighted the importance of multi-agency working, leading firstly to guidance on joint working and eventually to the development of Area Child Protection Committees (ACPCs), the precursors of Local Safeguarding Children Boards (LSCBs). Their primary role was to coordinate the work of agencies responsible for ensuring the safety of children at risk and to provide training. They later took on responsibility of overseeing child protection registers. The public inquiry lasted for several weeks and attracted major national news coverage. It can be said that it created the political precedent for the response to 'child abuse tragedies' for the following decade (Stevenson, 2013, Parton, 2004, Butler and Drakeford, 2011).

This inquiry attracted significant media coverage and political interest over several months; the social worker was 'mobbed' as she entered the location of the inquiry to give evidence. This set the tone for a sequence of 'tragedies' and public inquiries of different kinds. Judges seemed to feel obliged to make comments about service failures at the end of court cases, especially those involving child deaths, even though court procedures were not designed to explore the service issues in any systematic way. If a judge called for an inquiry, it seemed that this became almost inevitable. There were also examples of other agencies, especially the police, making critical public comments about social work practice, which tended to fuel the public thirst for an inquiry.

However, it is self-evident that the vast majority of child abuse cases and child deaths did NOT result in a public inquiry or public report; at that time there was no other formal mechanism for reviewing cases or requiring multi-agency cooperation in a review process. Cases, which did not go to formal inquiry, were often ignored and there was no systematic attempt to analyse mistakes or learn lessons.

Some of the more significant cases and inquiries are listed in Appendix 1.

There was a growing unease in the professions and within government during the late 1980s and early 1990s about the mounting costs of enquiries and the damaging effect they were

having on public perceptions and professional morale. Professionals increasingly felt driven to seek legal representation³. The inquiries frequently produced long reports with many detailed recommendations, indeed this output was perhaps seen as the primary justification for the expense involved. The cost of each inquiry, even in the 1980s, was constantly rising and said to run to several millions, with the costs of individual representation in addition, often met by unions or professional bodies. At that stage there was already an emerging question about whether all this expense resulted in new learning and was cost effective.

In this context, the Department of Health (the lead department) began searching for an alternative, politically acceptable, less costly and more systematic approach to handling reviews (Gilroy, 2004). My recollection is that there was explicit discussion about the need to develop a credible, robust and cost effective inquiry system, which would convince politicians, the media and judges that there was a robust system of review and therefore that public inquiries were not necessary. The creation of the Part 8 duty on LSCBs to undertake formal inquiries into serious cases arose from that debate⁴.

Government guidance

The first government guidance on ‘Battered Babies’ was published in 1970 (Department of Health and Social Security, 1970), with further guidance being published after the Maria Colwell inquiry (Department of Health and Social Security, 1974) and a major revision in 1980 including statutory guidance on child abuse registers (Department of Health and Social Security, 1980). Working together: a guide to arrangements for interagency co-operation for the protection of children was first published in 1986 (Department of Health and Social Security, 1986) as central government statutory guidance (i.e. mandatory), with revisions published in 1988 on the same day as publication of Public Inquiry into the Cleveland sexual abuse cases (1988). Part 9 of the guidance introduced a system of senior management ‘case reviews’ to be overseen by the Area Child Protection Committees.

Working Together (1991) followed the Children Act 1989 and introduced ‘Part 8’ setting out the following duty: *“Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the ACPC”*. The purpose of case reviews (which became known as Part 8 Reviews) carried out under this guidance was to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence, and
- to improve inter-agency working and better safeguard children.’

Working Together (1999), published at the same time as the Social Services Performance Assessment Framework (Department of Health Social Services Inspectorate, 1999), continued and strengthened the Part 8 guidance:

“When a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies should ... consider whether there are any lessons to be learnt from the tragedy about the way in which they work together to safeguard children...”

3 David N Jones gave evidence as BASW General Secretary and an expert witness to the Cleveland Inquiry. He comments: “It seems that I was unusual in being accompanied only by a solicitor (rather than a barrister), who was expected to lead me through my evidence. The inquiry panel of four (a judge, an eminent Professor of Paediatrics, a leading Director of Social Services and a Chief Constable) sat in front of a circle of around 10 barristers, some of whom were supported by juniors or solicitors, all of whom could question witnesses. Similar arrangements were seen in the Orkney inquiry and several others.

4 See appendix for table comparing the guidance in successive iterations of Working Together.

ACPCs should always consider whether a review should be conducted where a child sustains particularly life-threatening injury or serious and permanent impairment of health and development or has been subject to particularly serious sexual abuse; and the case gives rise to concern about inter-agency working to protect children.

The guidance was explicit that ‘case reviews are not enquiries into how a child died or who is culpable; that is a matter for Coroners and Criminal Courts respectively to determine, as appropriate.’

Working Together (2006) followed the Laming Inquiry into the death of Victoria Climbié (Laming, 2003), implementation of the Children Act 2004 and the introduction of a major new strategy for children’s services: Every Child Matters: Change for Children (Department for Education and Skills, 2004). Case Reviews become Serious Case Reviews and the guidance was further extended: ‘When a child dies, and abuse or neglect is known or suspected to be a factor in the death, local organisations should ‘consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a serious case review into the involvement with the child and family of organisations and professionals. Additionally, LSCBs should always consider whether a serious case review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about inter-agency working to protect children from harm.

Working Together (2010) strengthened the guidance further, taking account of inquiry by Lord Laming following the death of Baby Peter (The Lord Laming, 2009), whilst reflecting the growing concern that SCRs were becoming fault finding enquiries. The chapter on SCRs extended to 23 pages and reiterated that the purposes of SCRs carried out under this guidance were to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

“SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a SCR indicating that disciplinary action would be appropriate, such action should be undertaken separately from the SCR process and in line with the relevant organisation’s disciplinary procedures. SCRs may be conducted at the same time, but should be separate from disciplinary action. In some cases (for example, alleged institutional abuse) it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children.”

Working Together (2013) marks the first significant departure from the trend of evolving guidance since the 1991 guidance, radically reducing the length and specificity of the safeguarding requirements. SCRs were identified as one element within the wider framework of learning & improvement. Whilst in most cases the criteria for holding an SCR did not change, there was one significant change which strengthened the requirements. The former requirement remained (Regulation 5(2)b (ii)), namely an SCR must be convened *“where 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”, but adding ‘unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR’.* (This was further strengthened in 2015 – see below.) In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children’s home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

“Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.”

A serious case is one where:

(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.

The 2013 guidance was more permissive than all previous guidance about the way that SCRs should be conducted and was significantly shaped by the recommendations from the review of child protection undertaken by Professor Eileen Munro (2011, 2010) and her earlier research (Munro, 2004b, Munro, 1996). However publication was made mandatory in all but a few scenarios. An independent Expert Panel was established to advise the DfE and LSCBs on publication and aspects of SCR procedure; the areas of expertise of Panel members included family law, aviation disasters, civil service and voluntary sector management and journalism.

The 2015 revised guidance reflected the recommendations of the first annual report of the National Panel of Independent Experts on Serious Case Reviews (2014) by introducing greater specificity in the definition of ‘serious harm’ and by making explicit the expectation that, ‘even if a child recovers, this does not mean that serious harm cannot have occurred’.

The 2015 guidance strengthened the reference to the conditions which apply to Regulation 5(2)b (ii): *“unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB must commission an SCR.”*

The guidance also states that *“if an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review. The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded.”*

Developments in other sectors

SCRs are not evolving in a vacuum. Other sectors are also developing mechanisms to review services, which appear to have 'gone wrong'. The aviation industry process has been widely cited (e.g. Munro, 2005, Dale and Mills, 2013, Gawande, 2010), with positive comments about the systems approach adopted and the focus on learning rather than blame. The health service systematically applies root cause analysis to examine health service 'failures' (see below).

Those working in child protection frequently feel that other sectors do not appear to attract the degree of public and political interest which continues to focus on child protection, although individual cases of medical, engineering and other professional 'scandals' do occasionally attract significant media interest.

There is a general trend to 'hold professionals to account', possibly a consequence of the general decline in deference and demand for greater accountability. It nevertheless appears that child deaths do exert a greater emotional pull and will therefore attract what may at times seem a disproportionate level of political and media interest in comparison with other perceived service failures.

National Health Service

The NHS, like other health and social services around the world, has been subject to an inexorable rise in complaints and legal actions for failures of care. The cost of legal actions against the NHS for errors and poor care has become an increasingly significant element in the budget.

The 1997 White Paper *A New NHS: Modern; Dependable* (Department of Health, 1997) sets out a 10 year modernisation strategy for the NHS, which included the comment: *"Past performance on quality has been variable, and the health service has sometimes been slow to detect and act decisively on serious lapses in quality"* (para 7.13).

In 2000 the Department of Health published *An Organisation with a Memory* (Department of Health, 2000). This introduced systems thinking to the act of incident review, drawing on experience of the aviation industry in particular. The foreword by the Secretary of State stated: *"Too often in the past we have witnessed tragedies which could have been avoided had the lessons of past experience been properly learned. The task of the Expert Group was to advise the Government on the steps that can be taken to ensure that the NHS learns from its experiences, so that the risk of avoidable harm to patients is minimised."*

"This report examines the key factors at work in organisational failure and learning, a range of practical experience from other sectors and the present state of learning mechanisms in the NHS before drawing conclusions and making recommendations. Its recommendations include the creation of a new national system for reporting and analysing adverse health care events, to make sure that key lessons are identified and learned, along with other measures to support work at local level to analyse events and learn the lessons when things go wrong." (pvi)

"When things go wrong, whether in health care or in another environment, the response has often been an attempt to identify an individual or individuals who must carry the blame. The focus of incident analysis has tended to be on the events immediately surrounding an adverse event, and in particular on the human acts or omissions immediately preceding the event itself." (p viii)

"It is of course right, in health care as in any other field, that individuals must sometimes be held to account for their actions – in particular if there is evidence of gross negligence or recklessness, or of criminal behaviour. Yet in the great majority of cases, the causes of serious failures stretch far beyond the actions of the individuals immediately involved. Safety is a dynamic, not a static

situation. In a socially and technically complex field such as health care, a huge number of factors are at work at any one time which influence the likelihood of failure.”

“Activity to learn from and prevent failures therefore needs to address their wider causes. It also needs to stretch beyond simply diagnosing and publicising the lessons from incidents, to ensure that these lessons are embedded in practice. The distinction between passive learning (where lessons are identified but not put into practice) and active learning (where those lessons are embedded into an organisation’s culture and practices) is crucial in understanding why truly effective learning so often fails to take place.” (p ix)

The government set up the National Patient Safety Agency (Butler, 2002) in 2001 to coordinate learning activity, and promote use of Root Cause Analysis (Nicolini et al., 2011) as a methodology for review of serious incidents in the health sector. This method is still used to review ‘serious untoward incidents’ within the NHS.

Meanwhile, within the safeguarding and child protection system, Lord Laming had been inquiring into the death of Victoria Climbié (Laming, 2003). Children’s health services had also been challenged by a review into children’s heart surgery at the Bristol Royal Infirmary 1984 -1995 which identified weaknesses in the arrangements for monitoring and reviewing the deaths of children receiving health care (Kennedy, 2001). The government’s response, *Keeping Children Safe* (Department of Health, 2003) proposed a new system for review of unexpected child deaths (eventually leading to the creation of Child Death Overview Panels) and also recommended that the current SCR system would benefit from more of a ‘systems approach’, as was recommended in the health service. The Children Act 2004 established statutory LSCBs responsible for the conduct and commissioning of SCRs and for supporting Child Death Overview Panels.

Social Care Institute for Excellence (SCIE)

SCIE was involved in professional discussions across different sectors about service improvement and reviews of serious cases, drawing very heavily on the theoretical work of Eileen Munro (Munro, 2005), who became directly involved with SCIE around this time. SCIE Guide 06: *Managing risk and minimising mistakes in services to children and families* (Bostock, Bairstow, Fish & Macleod, 2005) used research into practice to advocate the development of a routine culture of review, reviewing cases that could have resulted in serious harm (safeguarding incidents) but managed to avoid this – rather than only reviewing cases once something had gone badly wrong. It used the systems concepts of ‘active’ and ‘latent’ failures in a child safeguarding context, echoing the Department of Health recommendations about patient safety in ‘An organisation with a memory’ (see above).

SCIE published Guide 24: *Learning Together to safeguard children: developing a multi-agency systems approach for case reviews* (Fish, Munro & Bairstow, 2008) and in 2009/10 piloted case reviews in 3 LSCBs in the North West, funded by the Regional Improvement and Efficiency Partnership (RIEP) and supported by the Government Office North West. Further pilots were undertaken in the South West region and London during 2010/11. 3 training cohorts were run for LSCBs in England during 2011/12 and in 2012/13 1 training cohort was run with North East Scotland Child Protection Committees. The SCR approach was piloted with 4 Safeguarding Adult Boards in England.

Part 8 reviews/serious case reviews

The responsibilities for child protection transferred from the Department of Health (DH) to the Department for Children, Schools and Families (DCSF) in 2003, including responsibility for overseeing serious case reviews. Almost immediately a number of serious cases hit the headlines, including Victoria Climbié. The new Department had to rapidly engage with the political and administrative challenges of high profile child protection tragedies. Secretaries of State came to experience the unique and complex challenges, which arise in such cases and the unpredictable outcomes of case

reviews, which can affect reputations for years afterwards (Parton, 2014, Jones, 2014, Observer Editorial, 2010).

Working Together established a requirement for LSCBs to undertake reviews of ALL 'serious cases'. Anecdotal evidence from discussions with Social Services Inspectorate (SSI) and Ofsted colleagues suggests that there were significant differences between local areas in the ways in which they decided to interpret this requirement. SSI had responsibility for monitoring LSCBs and local review processes and for briefing Ministers (Gilroy, 2004). This was done in a largely low profile way, with most reviews receiving little if any public attention unless other factors raised the profile. Ofsted took over the responsibility for monitoring local child protection arrangements in 2007 (Department for Education and Skills, 2005) and it soon became evident that there were significant regional differences in the approach taken to monitoring SCRs. It also became clear that some reviews were taking a significantly long time, far exceeding the statutory guidance; some reviews were taking several years to complete, with little likelihood of the findings having any impact on practice. Delays were sometimes but not always related to criminal proceedings or other formal processes.

Ofsted decided to implement a more systematic process for tracking, monitoring and evaluating SCRs. The new arrangements were implemented with some urgency and limited consultation. Ofsted decided to apply its standard four point judgement to each SCR, which also provoked considerable disenchantment. This approach involved the publication of the Ofsted judgement, which inevitably became the standard to which report writers referred. The Ofsted judgements on SCRs were resented, especially those applied to the backlog of 'old' reports which had not been written to the new criteria. A criticism rapidly emerged that reports were being written to 'tick the Ofsted boxes' rather than to learn lessons. I was personally involved in evaluating some SCRs and providing feedback to LSCBs, so had an inside view of the process. It seems clear that the evaluations were implemented at a time of pressure, without full consultation and without 'buy-in' from agencies. However it was also evident that the standard of reviews was highly variable; the frequently lacked challenge and determined inquiry.

In the context of several high profile cases, the election of a new government (and a change of name for the responsible Department), the pressure began to build for SCRs to become more open (Loughton, 2006). In the wake of the first Baby P SCR, there were media campaigns for more transparency and explicit Ministerial threats to implement tougher regimes, including mandatory publication of SCR reports (Gove, 2012). Ofsted and ADCS resisted political pressure to publish the full SCRs, on the grounds that this was a breach of family confidentiality and also that it would provoke defensive behaviours among the professionals whose work was being reviewed and thereby undermine scope for learning. Under sustained media and political pressure, publication eventually became inevitable and is now required by guidance, although exceptions are allowed.

Following criticism from Eileen Munro and others (Munro, 2004b, Munro, 2005, Munro, 2008, Munro, 2010, Munro, 1996, Munro, 2004a), the Ofsted responsibility for evaluation of reports and the grading system was removed. However the Department for Education (DfE) became more directly involved in monitoring the outcome of SCRs. Working Together 2013 introduced an Independent Panel to review all published SCRs. DfE continues to take an active interest in SCRs and intervened publically and directly with press briefings and Ministerial letters in the Pelka and Khan cases, when it was not satisfied with the perceived outcomes. Working Together 2015 refined the criteria for SCRs in response to experience and the observations of the National Panel in their first annual report (see above).

DfE has also taken steps to widen the pool of SCR authors, funding a new training programme and seeking to introduce report writers with differing backgrounds. There has been discussion about the need for a national database of authors and a more formal process for selecting authors than the current informal system of networking. The Association of Independent LSCB Chairs now maintains a database of independent authors which can be accessed by Chairs to widen the field of choice of authors (www.lscbchairs.org.uk).

The arrangements for Serious Case Reviews in Wales followed the same arrangements as England during the early period covered by this account. However, a very different approach has been launched by the Welsh Government (2013). There are also different arrangements in Scotland (Vincent and Petch, 2012, Vincent et al., 2007). Northern Ireland also has similar arrangements. Nigel Parton and colleagues (2011) published a comparative analysis of SCRs in the UK, although this is inevitably already dated.

Learning from serious case reviews

A few, individual serious cases have had a massive and very public impact on child protection policy and practice and the names of the children are etched on the public consciousness. However information from other cases has also informed our understanding of family dysfunction and multi-agency working. The government recognised the need to draw together the findings from individual SCRs and commissioned a series of biennial reviews. These provided systematic reflection on the findings and issues, forming a substantial evidence base about the characteristics of families where serious abuse occurred and also about multi-agency working practices (Brandon et al., 2009, Brandon et al., 2012, Brandon et al., 2014c, Brandon et al., 2008b, Rose and Barnes, 2008, Sinclair and Bullock, 2002, Vincent, 2012). The research team also published a number of academic papers with further analysis of findings from SCRs (Brandon et al., 2008a, Brandon et al., 2002, Brandon et al., 2005, Brandon et al., 2014b, Brandon et al., 2014a). This series of publications was not continued by the Coalition Government. However, a decision was made in 2014 to commission a further series of retrospective reviews.

The Association of Independent Chairs of LSCBs (AILC) and NSPCC have jointly promoted a repository of SCRs which, has resulted in easier access to local reports but also a series of papers on specific elements arising from reviews (http://www.lscbchairs.org.uk/SCR_repository). SCRs have also been studied by academics (Gupta, 2008, Manthorpe and Martineau, 2011, Rawlings et al., 2014, Reder et al., 1993) and most LSCBs provide an information service in their locality, which includes findings from SCRs around the country.

Many have commented that SCRs seem to continue to reach similar conclusions, namely that there were failures in information sharing and multi-professional/inter-agency working, there were errors in evaluation of evidence of risk and professionals lacked a sufficiently inquisitive approach to gathering evidence about risk. These issues are discussed in more detail in the section on organisational learning within the main document, but raise the need to explore whether these findings are more descriptive than analytical and that there is a need to better understand the human processes which contribute to the apparent repetition of flawed practice. There is clearly a need to have a more informed understanding about organisational and human dynamics, as has been found in other sectors such as aviation (see above).

International experience

There is indisputable evidence that the UK experience of child protection ‘tragedies’ is not unique to this country and our systems but is also seen in other English speaking countries and (possibly to a lesser extent) on the European mainland; *“in many countries child protection and child welfare has taken on a high political profile due in large measure to intense media coverage”* (Gilbert et al., 2011).

Comparative and reliable studies of different child protection systems, which go beyond basic descriptions of one or two countries, are rare. Child Protection Systems (Gilbert et al., 2011) is a comparative study of the social policies and professional practices that frame societal responses to the problems of child maltreatment in ten countries: USA, Canada, England, Sweden, Denmark, Finland, Belgium, the Netherlands, Germany and Norway. Focusing on the developments in policy and practice since the mid-1990s, the findings highlight the changing criteria that define child maltreatment, professional responses to allegations of maltreatment, and the level of state

responsibility for child and family welfare, providing an in-depth understanding of the different ways modern welfare states assume the sensitive responsibility of balancing children's rights and parents' rights.

The book demonstrates that the character of child protection systems worldwide is changing rapidly reflecting dramatic and rapid organisational, policy, and legislative changes; the expansion of child welfare systems; the rise of formal procedures and evidence-based initiatives; the increased challenges posed by race and ethnicity. A key variable seems to be the extent to which countries adopt either a child protection or a family service approach to child abuse. The directions in which services are heading are analysed, such as movements toward privatisation and devolution of child welfare service delivery. Against this backdrop, the authors argue that a third approach begins to emerge - a child-focused orientation - that aims to promote and improve children's development and well-being. The book maps contemporary trends and policy issues in the design of child protection systems and illustrates why child protection has become so politically sensitive and the different ways in which countries respond to and inquire into 'tragedies'.

Multidisciplinary child fatality review teams (CFRT) have existed in the United States (USA) for almost 30 years; the products of the review process, however, remain unexamined and have not been systematically used to shape improvements in practice. Douglas and Cunningham reviewed reports from CFRT throughout the USA to compile and evaluate the identification of problems and recommendations by professionals concerning child maltreatment fatalities. Team- and state-level data were also used for analysis to better understand the context in which recommendations are made. Over 300 recommendations for change from CFRT were grouped into 11 macro categories. The frequency of each type of recommendation and examples from each category are provided. The authors provide recommendations of their own for improvements in CFRT outputs (Douglas and Cunningham, 2008).

Enquiries over several years by the Edmonton Journal in Alberta, Canada, resulted in an open public and political discussion about deaths of children in public care or living at home under supervision (Kleiss and Henton, 2013). The deaths of more than 400 children in public care were discovered; not all had died as a result of abuse or neglect, but many had undergone no formal review process. This led to a political decision to subject all such cases to a formal review process and to require the children's services authority to publish in future the names and photographs of those who died in such circumstances (Kleiss, 2014). The press campaign, the findings and the reforms which followed are documented extensively on the newspaper's website (Kleiss, 2015).

In British Columbia, Canada, the Representative for Children and Youth who is a designated member of the British Columbia Legislative Assembly, has a statutory duty to report on reviews and investigations of critical injuries and deaths of children receiving reviewable services (Representative for Children and Youth Act, Section 16). A recent report into the death of a learning disabled, aboriginal girl aged 19, who had spent most of her life in care and died apparently of a drug overdose, attracted considerable publicity (Turpel-Lafond, 2015, Hunt, 2015).

Inquiries in other countries can take many forms. Some have formal mechanisms similar to SCRs or confidential inquiries. In some situations, legal proceedings provide the theatre for the inquiry, including actions for civil damages and professional misconduct hearings.

It is clear that the challenges within the child protection system in the UK are mirrored in other English speaking countries, which tend to share the same family culture. However there are also examples of tragedies and systems failures in other European cultures and worldwide. It therefore seems unjustified to see the dilemmas in the English child protection system as uniquely reflecting service delivery problems in this country. There is a need for a wider appreciation of the inherent challenges and conflicts in preventing and responding to child protection in all countries and cultures.

A number of countries have comparatively recent experience of case reviews of historic/'non-recent' child abuse cases, especially relating to abuse within institutions and by the church. Australia established a Royal Commission into Institutional Responses to Child Sexual Abuse (2015), to systematically review abuse within schools, residential homes and other institutions. There have been many calls for a formal review of abuse of aboriginal children within residential schools in Canada (Gough et al., 2009). A number of inquiries have been held in Ireland, including inquiries into allegations against priests, (O'Meara, 2010, O'Brien, 2012b, Commission to inquire into child abuse, 2009, Gaughan and Garrett, 2012, Powell et al., 2012, Murphy, 2005). These have resulted in major reform of the statutory services for children and families (Wayman, 2014). The UK has seen a number of public inquiries relating to abuse by people in authority, celebrities, and within institutions (Scott-Moncrieff, 2015, Lampard and Marsden, 2015, Her Majesty's Inspectorate of Constabulary, 2013, Morris, 2014).

A selection of case reviews from other countries, which have attracted media coverage in those countries is listed in Appendix 2.

Conclusion

This overview of the history of Serious Case Reviews in England with some comparative evidence from other English speaking countries, has shown how all countries are facing the pressures of child protection arrangements, with high and increasing public expectations that public services and others will always protect children and young people and prevent all distress in a context where professional certainty about risk is frequently illusory, evidence to support risk assessment is frequently absent and human judgement is fallible. Most English speaking countries have also faced different degrees of austerity and constant pressures to reduce expenditure and improve efficiency.

Open democracies properly require transparency in delivery of public services and the performance of state employees and other professionals. In such situations, some form of review of cases, which appear to have 'gone wrong' is inevitable and appropriate.

This analysis has shown how the English system has evolved, the constant tension between 'learning' and allocating responsibility or blame, the difficulty of getting real insights into the complexity of multi-agency service delivery arrangements and practice and the frustration that similar findings are frequently repeated with no real explanation or understanding as to why this happens.

England is not unique in grappling with these challenges. Indeed it is arguable that our structured and formal systems, which have called forth considerable professional and academic enquiry and energy, are more robust, effective and consistent than those of many (even most) other countries. Despite this, there is professional, political and public frustration with the outcomes of many reviews and therefore a clear need to explore more effective ways to understand the dynamics within organisations and between individuals, including family members and children themselves, and why these sometimes result in tragedy but much more frequently provide positive support to people in profound and difficult circumstances.

'Why did this happen?' is inevitably a legitimate question and one which demands a credible answer through the Serious Case Review or whatever alternative process is used.

Appendix 1

Inquiry reports and serious case reviews⁵

- 1973 Graham Bagnall
- 1973 David Lee Naseby
- 1973 Maria Colwell
- 1974 Max Piazzani
- 1975 Auckland family
- 1975 Richard Clark
- 1975 Lisa Godfrey
- 1975 Stephen Meurs – death from neglect and starvation
- 1976 Neil Howlett
- 1977 Wayne Brewer
- 1977 H family
- 1978 Paul and L. Brown
- 1978 Stephen Menheniott
- 1978 Simon Peacock
- 1979 Lester Chapman
- 1979 Darryn James Clarke
- 1980 Paul Stephen Brown
- 1980 Claire Haddon
- 1980 Carly Taylor
- 1981 Maria Mehmedagi
- 1981 Malcolm Page
- 1981 Christopher Pinder/Daniel Frankland
- 1982 Jason Ceasar
- 1982 Lucy Gates
- 1984 Shirley Woodcock
- 1984 Heidi Kosedá – death from starvation
- 1985 Jasmine Beckford – moved in & out of care – murdered by stepfather – focus on the apparent lack of concern for the needs of the child
- 1985 Reuben Carthy
- 1987 Tyra Henry – murdered by father who had a previous conviction – finding that white social workers were indecisive and anxious not to be seen to be racist by criticising child-rearing practices in a Black family
- 1987 Cleveland – 121 child sexual abuse cases ‘identified’ by doctors resulting in a crisis for and divisions between health, police and social services – long public inquiry
- 1990 Orkney – allegations of ‘satanic abuse’ – public inquiry criticised police and social work department and especially the assessment techniques
- 2000 North Wales children’s homes - Lost In Care - The Waterhouse Report (Webster, 2005)
- 2001 Caleb Ness – baby shaken and murdered by father
- 2003 Victoria Climbié – hidden from agencies – multiple moves between London boroughs focus on the professionals’ fear of the parents and lack of systematic inquiry – failings in police, health and social services
- 2006 Michael McGarrity – 3 year old discovered close to death after being locked for 6 weeks in a flat with the body of his mother who died of a drug overdose
- 2007 Baby Peter – an ‘invisible child’ – found to have 50 serious injuries at death – intimidating parents – another resident adult was not known (SCR)

⁵ This list is not complete – inclusion or omission does not imply any judgement about significance.

- 2009 'J' children – 'Edlington' – Doncaster SCR
- 2010 Khyra Ishaq – starved and beaten
- 2012 Edlington case - A Review by Lord Carlile of Berriew CBE QC (2012) (Gove, 2012)
- 2013 Daniel Pelka – child's failure to thrive being investigated as a medical condition – other siblings seen to be thriving – lack of referral by school (SCR)
- 2013 Hamzah Khan – child found at home having died on 15th December 2009 but his body was not discovered until September 2011 (SCR)
- 2013 Operation Pallial (North Wales police inquiry) interim report
- 2013 Operation Yewtree (Jimmy Saville) Giving Victims a Voice (Gray and Watt, 2013)
- 2013 Rochdale – sexual exploitation of a group of young women
- 2013 HMIC's review into (police handling of) allegations and intelligence material concerning Jimmy Savile between 1964 and 2012
- 2014 Rotherham 1997-2013 - Independent inquiry into child sexual exploitation
- 2015 Oxfordshire – sexual exploitation of a group of young women
- 2015 Independent oversight of investigations into matters relating to Jimmy Savile at schools and children's homes: independent report
- 2015 Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile



Appendix 2

International case examples

Ryan Report (Ireland, 2009)

The publication of the Ryan Report during 2009 was a seminal event in the vindication of the human rights of survivors of child abuse in Irish reformatory and industrial schools and public truth-telling. There were seventy-one industrial schools and ten reformatories established in Ireland during the second half of the nineteenth century. Most of the reformatories soon closed because there were not enough children to put in them. The Ryan Report was 2,600 pages in length and composed of five volumes. It contains the testimony of over 1,500 witnesses. However the alleged perpetrators of abuse (living and dead) have been given anonymity following legal action (Powell et al., 2012).

Director defends Montana's child protection efforts (Montana, USA, 2011)

A series of recent high-profile child abuse cases in Montana has led some people to question the efficacy of the state's child protection systems. Child abuse and neglect in the state aren't as easy to identify and address as people would like to believe, according to officials and experts. But the difficulty in determining whether abuse occurred doesn't mean Montana is failing to do its job in protecting children, according to the Director of Fieldwork.

Federal guidelines require that states have in place child death review teams and citizen advisory boards. In Montana, the Fetal, Infant and Child Mortality Review teams examine all regional and local deaths of children younger than 17, and determine if policies need to be changed or advocate for better legislation. In addition, the state is required to have a citizens review board, known in Montana as the State Advisory Council, which Costello said meets quarterly. Regional citizens review boards report to the State Advisory Council (Cates and Bennion, 2011).

Social workers could've saved boy who starved to death (Colorado, USA, 2011)

The wrongful-death lawsuit against two social workers involved in the Chandler Grafner case will go forward. A judge this week dismissed the defendants' request to dismiss the case. The 7-year-old weighed only 31 pounds when he died of dehydration and starvation in 2007, the Denver coroner said. Grafner's legal guardians, Jon Phillips and his girlfriend Sarah Berry, were charged with murder. Phillips is currently serving life in prison without the possibility of parole, plus 49 years. Berry was sentenced to 48 years in prison. Grafner's biological mother and father are suing Margaret Booker and Mary Peagler, two social workers involved in the case. The court order said Booker was head of Investigation of Child Maltreatment and Intake Services at the Denver County Department of Human Services and Peagler was a case record supervisor at DCDHS during the relevant time.

The judge ruled that *"Plaintiffs have sufficiently alleged facts showing an affirmative link between the failure to investigate the April 17, 2007 referral and the death of Chandler."* The judge said Grafner's injuries, by their nature, occurred over a period of time. *"Had Defendants properly exercised their professional judgment in response to the April 17, 2007 referral, these injuries may well have been avoided,"* the judge wrote. *"The Court has little trouble finding that a reasonable person in Defendants' positions would have known that the failure to investigate the April 17, 2007 referral was a violation of Chandler's constitutional rights."*

In 2010, then-Gov. Bill Ritter signed legislation that dramatically changed Colorado's child welfare

system. One law created a state ombudsman - a representative operating outside of the normal system that anyone can call to report a child in danger or a child whose case is being mishandled by a county agency. Another law requires counties to notify mandatory reporters of child abuse – teachers, doctors and counselors – of how their complaints are being handled (Stanley, 2011).

Director needs plan for child fatalities (North Carolina, USA, 2012)

A North Carolina Child Fatality Review Team has released a report in 2012 regarding the death of a 2-month-old Salisbury boy in 2009. Fayko, who replaced Sandra Wilkes as director at the beginning of May, said many of the review team's recommendations are already in place at the social services department. The review concerned the death of Jy'hime Bacon, the son of Latoyia Niccole Myers. Myers pleaded no contest to involuntary manslaughter in September 2011. The original charge was second-degree murder. She was given a sentence of time served after spending more than two years in the Rowan County jail. The review team noted that two infants died in Myers' care because of unsafe sleep environments. Another son, 29-day-old Zy'marion Myers, was found dead in Nov. 2007. His autopsy said the cause of death as suffocation, while Jy'hime's was listed as 'undetermined'. Authorities said Myers and Zy'marion slept together, with the infant on top of a pillow.

The team also found that there was inconsistent contact with the family and insufficient communication between the social worker and supervisor in 2007. This resulted in the inaccurate assessment of the family's risk, safety and well-being needs, according to the release (Minn, 2012).

Washington workers could have done more before Josh Powell's killing of boys; lawsuit looms (Washington, USA, 2012)

Social workers tasked with protecting the children of Josh Powell did not consult with law enforcement or explore his potentially violent past before allowing him to host supervised visits at his home, a panel found Thursday. Powell violently killed his kids during one such visit earlier this year. Now the state faces a lawsuit over the handling of the case. To kill his children, Josh Powell locked his front door in the face of a social worker, then used a hatchet on his boys inside and torched the home to kill himself and the two children.

The report issued by a task force convened after the deaths, concluded that the Washington Department of Social and Health Services should 'make concerted efforts' to check with detectives prior to making changes in parent-child contacts when there is an active investigation. Authorities have been investigating the 2009 disappearance of Powell's wife, Susan Powell, from the couple's Utah home. Josh Powell had been locked in a custody dispute at the time of the killings, and a judge had recently ordered him to undergo an intensive psycho-sexual evaluation. The child fatality review committee also concluded that social workers should immediately reassess visitation policies when someone is ordered to undergo a psycho-sexual evaluation.

While the social workers did follow the law, there were signs that should have led them to be more vigilant, the panel found. In one finding, the committee concluded that the disappearance of Susan Powell in Utah should have prompted the workers to further explore the potential of domestic violence. Detectives in Utah had shared little about their Powell investigation and had never even publicly labeled Josh Powell a suspect in the case. That was despite the fact that authorities found blood in the family home and a hand-written note in which she expressed fear about her husband and her potential demise. The child fatality panel said that the information Utah authorities had kept private could have helped reassess the length, location and supervision of Powell's visitation rights (Washington Post, 2012).

Shannon Report (Ireland, 2012)

The independent report into the deaths of children in contact with social services over a 10-year period, by child law expert Geoffrey Shannon and Barnardos director of advocacy Norah Gibbons, raised serious concerns about poor social work practice, a lack of co-operation between State agencies and a crisis-driven approach to child protection (O'Brien, 2012a).

Don't let Phoenix's death be in vain: foster mom (Manitoba, Canada, 2013)

Phoenix was tortured and killed by her mother, Samantha Kematch, and stepfather, Karl Wesley McKay, in 2005 at Fisher River First Nation. Her death wasn't discovered until March 2006. Several people had seen signs of abuse but didn't report it. Some suspected and reported abuse to CFS but a social worker never saw Phoenix. A public inquiry was set up and reported in 2013. There was almost daily coverage in the local newspaper (Sanders, 2013).

After receiving a call that Phoenix was being locked in a bedroom and possibly abused by Kematch, Christopher Zalevich was sent to check out the complaint. He took along a senior social worker for his own personal safety but didn't go inside the suite because Kematch said she had company. The social workers didn't see Phoenix but spoke to Kematch in the hallway while she held her seemingly happy, healthy baby, whose dad was McKay. There's no note of Zalevich asking to see Phoenix or her whereabouts. In his records, he notes he mentioned to Kematch that the lock on the door was a fire hazard, then left. His supervisor, Diva Faria, testified earlier she agreed with him closing the file without seeing Phoenix because there were *"no known protection concerns."*

Union Co. DSS ordered to reopen past cases of child abuse (North Carolina, USA, 2014)

Department of Human Services Director, Richard Matens, who oversees DSS, told Channel 9 that a team of state officials visited DSS three times since December and randomly selected more than 50 cases dating back three years to review. Some of those cases were overseen by Wanda Larson, a former Child Protective Services supervisor who has since been arrested on child abuse charges after a child under her guardianship was discovered handcuffed to her front porch with a dead chicken tied around her neck. State reviewers found problems with social workers' documentation, including what Matens called inconsistencies and discrepancies in handwritten and electronic intake reports. State officials said 'some of the complaints about possible neglect or abuse were taken by employees not properly trained to handle the process. Larson and her long-term boyfriend Dorian Harper, remain in jail on multiple criminal charges. (Burcham, 2014)

Swain DSS director put on leave (North Carolina, USA, 2012)

The director of the Swain County Department of Social Services was suspended pending the outcome of a police investigation into the death of a toddler who was under the agency's care. The newly appointed DSS board placed Tammy Cagle on paid investigative leave after meeting for a little more than an hour Monday night. County commissioners had called for the suspensions to allow for an unimpeded investigation into the death of 15-month-old Aubrey Littlejohn. She died after spending the previous day strapped into a car seat for 12 hours and receiving only bites of a hot dog and sips of soda, according to a search warrant filed by the State Bureau of Investigation. Social worker Craig Smith, who visited Powell's home five months before Aubrey died, has already been suspended with pay pending the outcome of the investigation. He was at the home acting on a tip that Aubrey fell down a set of stairs from an unbuckled car seat. Smith told police he later falsified records after the child's death to show he had made sure she was seen by a doctor for injuries from the fall, according to investigator's statements in court papers. He told investigators his supervisor instructed him to fix the records. A preliminary autopsy found Aubrey had a broken arm that had healed before her death.

Aubrey was a member of the Eastern Band of Cherokee Indians, though living in Swain County. The tribe has since requested that the social workers named in the investigation no longer work on the reservation — a move the state agreed with.

The SBI raided the DSS offices in Bryson City on Feb. 22, seizing records and computer hard drives. An SBI raid on a state office could signal high level of interest from prosecutors in the case. District Attorney Michael Bonfoey has declined comment (Ostendorff, 2011). A police probe later found that social workers falsified documents to make it appear as if a thorough investigation had been launched into reports that the little girl was being mistreated.

Officials with the state Division of Social Services said they're changing the way they review the deaths of children who were involved with the social services system. Urgent, high-profile cases like Littlejohn's will be taken up first, rather than taking cases in chronological order, in hopes of learning whether systemic flaws contributed to the deaths (Weiss and Breen, 2012).

Paige's story: abuse, indifference and a young life discarded

A 19-year-old aboriginal girl who died of a drug-overdose on Vancouver's Downtown Eastside two years ago was treated with shocking indifference by social workers and other professionals, whose inaction contributed directly to her death, a new report says. Representative for Children and Youth Mary Ellen Turpel-Lafond said 'Paige's Story' is one of the most troubling reports she has ever released.

"If a parent in B.C. had treated their child the way the system treated Paige, we may be having a debate over criminal responsibility," she said, asking if "this is the face of institutionalized racism and a system that discounts the value of some children's lives in B.C." The 76-page report says social workers repeatedly returned Paige to her drug-addicted mother and permitted her to live in places that workers were afraid to visit. Educators failed to keep the bright young girl in school.

The health system discharged her without follow-up after abortions or detox, and police and lawyers neglected to notify social workers in cases where she was found passed out or incoherent. *"One police officer told Crown counsel that Paige needed 'some form of intervention, hopefully by the court, or she may be hurt or killed while on a binge," Turpel-Lafond said. "Unfortunately, the courts never provided that help."* (Kines, 2015, Turpel-Lafond, 2015)

Appendix 3

Evolution of working together guidance

Working together timeline

1988	Working Together first published as central govt guidance on same day as publication of Public Inquiry into Cleveland. Part 9 of the guidance introduced a system of senior management 'case reviews' as responsibility of ACPCs to oversee.
1991	First revision following implementation of Children Act 1989.
1999	Second revision – coinciding with publication of Assessment Framework. Case Reviews ACPC responsibility in Part 8 of the guidance.
2006	Third revision – updated following the Laming Inquiry into the death of Victoria Climbié, Children Act 2004 and the introduction of Every Child Matters: Change for Children. Case Reviews become Serious Case Reviews.
2010	Fourth revision – updated following Laming's second review and death of Baby P. Chapter on SCRs now 23 pages long.
2013	Fifth revision – updated following Munro review. SCRs one element within a wider framework of learning & improvement. Publication mandatory. Expert independent Panel established.

Part 8 – Case Reviews	Working Together 1991	Whenever a case involves an incident leading to the death of a child where child abuse is confirmed or suspected, or a child protection issue likely to be of major public concern arises, there should be an individual review by each agency and a composite review by the ACPC. This includes cases where a child was accommodated by a local authority in residential setting or with foster carers...'
	Working Together 1999	When a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children at risk of harm who need safeguarding (e.g. siblings, other children in an institution where abuse is alleged). Thereafter, agencies should consider whether there are any lessons to be learnt from the tragedy about the way in which they work together to safeguard children... ACPCs should always consider whether a review should be conducted where a child sustains particularly life-threatening injury or serious and permanent impairment of health and development or has been subject to particularly serious sexual abuse; and the case gives rise to concern about inter-agency working to protect children."
Regulation 5 LSCBs Serious Case Reviews Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely: 5 (1) (e) undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned. (2) For the purposes of paragraph (1) (e) a serious case is one where: (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, its board partners or other relevant persons have worked together to safeguard the child.	Working Together 2006	When a child dies, and abuse or neglect is known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (e.g. siblings, or other children in an institution where abuse is alleged). Thereafter, organisations should consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a serious case review into the involvement with the child and family of organisations and professionals. Additionally, LSCBs should always consider whether a serious case review should be conducted where: <ul style="list-style-type: none"> • a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or • a child has been subjected to particularly serious sexual abuse; or • a parent has been murdered and a homicide review is being initiated; or • a child has been killed by a parent with a mental illness; or • the case gives rise to concerns about inter-agency working to protect children from harm.
	Working Together 2010	The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations. Reviews vary in their breadth and complexity but, in all cases, where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed.
	Working Together 2013	Cases which meet one of [the Regulation 5] criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b) (ii) above) must always trigger an SCR. In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.
	Working Together 2015	'Seriously harmed' in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following: <ul style="list-style-type: none"> • 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. <p>This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.</p>

Resource material

Historical overviews of child protection include the following publications, details of which are included in the bibliography below: (Batty, 2004, Bilton, 1998, Stevenson, 1998a, Thoburn et al., 2008, Stevenson, 1998b, Burnham, 2012, Parton, 2004, Parton, 1985, Parton, 1991, Parton et al., 2011, Butler and Drakeford, 2005, Daguerre, 2000, Munro, 2004b, Corby, 2006, Jones et al., 1987)

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