

NSPCC

Policy Practice Research Series

What Really Happened?

Child protection case management
of infants with serious injuries
and discrepant parental explanations

by Peter Dale, Richard Green and Ron Fellows

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The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children.

The NSPCC exists to prevent children from suffering abuse and is working for a future for children free from cruelty.

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NSPCC TM
Cruelty to children must stop. FULL STOP.

Foreword

What Really Happened? Child protection case management of infants with serious injuries and discrepant parental explanations recounts and analyses, in a qualitative way, cases of severe injury in babies and young children where there are discrepant parental explanations. This concept of analysis by discrepant information is not one that is well established but could form an important part of the future analysis of injuries. I was particularly interested in the different accounts that many parents may give for these injuries.

These are terrible stories where severe injuries have been diagnosed in children but they have been sent home unprotected, sometimes to their death. I challenge anyone who reads these accounts not to be seriously moved and concerned by them. This book provides vital information for all those involved in the child protection process. However, there are also lessons not only for professionals and policy makers but for society as a whole.

This information will not come as a surprise to many who have long voiced concerns about the dangers to babies from abuse (National Commission of Inquiry into the Prevention of Child Abuse, 1996; Speight and Wynne, 2000). As a paediatrician and from my research and that of others, I know that these dangers are present with subdural haemorrhages (Jayawant et al., 1998), with non-accidental suffocation (Davis et al, 1998; McClure et al, 1996) and, indeed, with abuse as a whole (Sibert et al., 2002). Recently our research has shown that a third of babies sent home after confirmed physical abuse are re-abused (Ranton et al., 2002). In this report Dale, Green and Fellows also emphasise that very young babies may be at particular risk. This again is known to paediatricians (Sibert et al., 2002), where we found that sub-dural haemorrhage, fractures, bruises and burns are much more common in the first six months of life than in the second half of their first year.

The issues that may predispose to this abuse are described well in *What Really Happened?* These include parental mental health, domestic violence, and alcohol and substance misuse. These are substantial matters for all practitioners.

How common is abuse?

How common is child abuse is another theme of *What Really Happened ?* In fact, we have surprisingly very little information on this. We know how many children are entered on child protection registers but those figures measure process and not the numbers of actual abused children. The work by Dale, Green and Fellows adds to the evidence that we urgently need to develop systems through which we can know and understand how many children are abused rather than just those needing child protection plans.

Child Protection Services

What Really Happened? rightly emphasises the many difficulties in the child protection process, particularly in the context of Messages from Research and the Framework for Assessment. The authors demonstrate that the present concept of professionals seeking to work in partnership with parents in all cases, despite serious injuries, may result in disaster for the child. That is a conclusion from our work too. These must be matters of serious concern to society as a whole.

Dale, Green and Fellows suggest that “*although it is impossible to ‘prove’, it is our view that several children in the assessment sample are alive today who otherwise would not be if alert and skilled social services, police and health professionals had not intervened in diligent ways.*” Professionals have succeeded in protecting many thousands of children. However, as the authors point out, there have been no headlines in mass circulation newspapers informing readers that “Social Services Prevented Fatal Child Abuse”. The work of the National Commission of Inquiry into the Prevention of Child Abuse (1996) also highlighted the media’s role in reporting horrific child abuse stories and in ignoring the successes of child protection.

Nevertheless, there has been a change in the handling of severe child protection cases following the Children Act 1989. Prior to the implementation of the Act in 1991, nearly all such cases were immediately made the subject of civil court proceedings, usually via wardship. However since 1991, it has become typical for social services to lead the management of these cases outside of the court setting.

There must be reservations about the value of the Assessment Framework in certain complex situations. In the documentation, there are very few specific references to serious physical abuse of babies and infants. Consequently attention is not drawn to the specific assessment and case management challenges in situations where there are serious injuries to babies. These are serious concerns that need to be addressed at the highest level.

Conclusions

Professionals in all disciplines need to address these issues. The failures in child protection were not just by social workers. In one example a paediatrician got it wrong when coagulation studies were misinterpreted. The Courts may give confusing and contradictory judgements. Solicitors may be idiosyncratic. The Guardian ad Litem may advocate for the parents and not the child.

To deal with these situations Dale, Green and Fellows advocate the need for National Standards for Child Protection, particularly in child protection case management. The inter-agency nature of case management has been a central component of UK child protection procedures over the past three decades. At the practice level this occurs predominantly through strategy meetings, child protection conferences and core groups. However, today, the volume of required child protection activity is such that gaps inevitably occur. The authors suggest that there needs to be a computerised system for the management of cases.

The system would be firmly evidence-based through the infrastructure of continually updated research and policy hyperlinks. This would present information and guidance to minimise the occurrence and impact of inappropriate professional judgements. There also could be triggered warnings built into the computerised system so that when required actions are not undertaken alerts would be displayed to professionals concerned.

The better protection of babies and very young children is of vital importance for a humane society. *What Really Happened?* and the work of other practitioners and researchers suggest that present guidelines may result in too much emphasis on working with parents and not enough on the safety of children. We must do better.

Jo Sibert

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Executive summary

Clinical and evaluation experience of child protection assessments over a twenty year period indicates that there is a particular group of cases that present significant challenges to child protection systems and courts in relation to decision-making about future risks. These involve babies who have sustained serious physical injuries, and where there are discrepant parent/carer explanations regarding the cause of the injury. For brevity we refer to these cases by the acronym SIDE (serious injury – discrepant explanation).

There has been very little research which focuses upon child protection assessment and case management in these situations. This book reports on a study which examined child protection system assessment and case management of SIDEs in 38 families involving 45 seriously–or fatally–injured children (aged 0–2 years) from two perspectives:

- a clinical assessment sample of 21 SIDE cases involving 26 babies and young children;
- an analysis of 17 Part 8 Review reports of SIDE cases that culminated in the deaths of 17 (and serious injury to two other) babies and young children.

Drawing from analysis of both samples, we describe the types of injuries that these children sustained, explanations that were provided, and the family circumstances in which they occurred. We review the child protection system initial responses and subsequent case management, highlighting factors of effective and detrimental practice. We conclude that many (but by no means all) of the deaths, and occurrences and recurrences of serious injuries, were preventable from the perspective of reasonable expectations of informed professional practice.

Within this context, we make recommendations for improvements in the quality and consistency of child protection system processes and outcomes, which we believe could lead to a reduction in the incidence of SIDE cases. We highlight some principles of evidence-based assessment practice intended to reduce the occurrence of aberrant judgements regarding a child's safety.

At the prevention level, we call for **National Standards for Child Protection** to be developed by central government. Such standards should specify quality process and outcome requirements at each key stage of the progress of a child protection referral.

Existing Area Child Protection Committees (ACPCs) should be charged with the responsibility to implement and audit the operation of National Child Protection Standards, and to achieve specific targets for decreased incidence and improved outcomes. We make proposals for the steps that each ACPC should take to develop a strategy for a reduction in fatal and non-fatal SIDE cases each area over a five-year period.

In addition to their retrospective role in reviewing cases that have adverse outcomes, operational case-tracking responsibilities of Area Child Protection Committees (ACPCs) should be significantly strengthened. ACPCs should provide an expert consultation and monitoring role to current cases involving high-risk infants.

Public confidence in child protection services is possibly at an all time low. The public is much less aware that child protection systems, which have developed over the past 30 years, do work well for thousands of children each year. Out of sight, skilled and diligent professionals arrange vital protection for vulnerable children, and provide or organise effective support for their parents and wider families. Without this level of successful, but hidden, child protection practice, rates of serious and fatal child abuse in the UK would undoubtedly be substantially higher than they currently are.

However, it remains unfathomable to the general public that children continue to die as a consequence of basic child protection failures. In response, it is imperative that child protection practice in the UK becomes subject to consistent explicit quality standards, supported by more sophisticated evidence-based protocols to assist professional judgements. Also, that services are sufficiently resourced to enable these standards to be achieved, sustained and continually improved.

1 Introduction

The very short life of a baby girl we shall call Bianca highlights concerns about child protection assessment and case management that we address in this book:

Extensive bruising to baby Bianca's face and body was noticed when she was two weeks old. She was admitted to the local children's hospital the same day where the consultant paediatrician formed a firm view that the bruising was non-accidental. However, contrary to the advice of the paediatrician, Bianca was returned to the care of her parents while criminal and child protection enquiries continued. During the next few weeks she was seen by professionals to have further facial bruising. Medical opinion was not sought. At the age of eight weeks, Bianca was re-admitted to hospital by ambulance with extensive bruising to her body and severe head injuries from which she died. (Synopsis from a Part 8 Review).

This tragic and preventable death illustrates a type of case that often promotes confusion within child protection systems. These are cases where babies have sustained serious physical injuries and where parental/carer explanations are absent, inconsistent or discrepant with expert medical opinion. By 'serious' we mean any, or combinations of:

- head and brain injuries
- fractures
- burns
- severe bruising
- adult bite marks
- poisoning
- suffocation.

By 'discrepant explanations' we mean where the parents/carers (either or jointly) provide:

- no explanations
- inconsistent explanations
- conflicting explanations
- explanations that are not accepted as plausible by expert medical opinion.

For brevity we shall refer to these cases by the acronym SIDE (serious injuries with discrepant explanations).

This book reports on a study that examined child protection system assessment and case management of SIDE cases from two perspectives:

- a clinical assessment sample of 21 SIDE cases involving 26 seriously injured babies/infants aged 0-24 months;
- an analysis of 17 Part 8 Review reports of SIDE cases that culminated in the deaths of 17 babies/infants aged 0-24 months.

Drawing from analysis of both samples, we describe the types of injuries that these children sustained, explanations that were provided, and the family circumstances in which they occurred. We review the child protection system initial responses and subsequent case management, and highlight factors of good (effective) and poor (ineffective or damaging) practice. Finally, we make recommendations relating to improvements in child protection system management for this very challenging type of case. These improvements are aimed to facilitate more consistent and evidence-based assessments of initial safety and future risk of re-abuse of these particularly vulnerable children. We also make proposals for child protection system policy that we believe could lead to a reduction in the incidence of SIDE child abuse.

Research and practice context

Each year in England and Wales the deaths of approximately 30 infants under the age of one year are officially recorded by the Home Office as being due to homicide. Creighton (1995) noted that this figure has remained remarkably stable over the past 20 years, while Wilczynski (1997) estimated the actual rate of fatal child abuse to be at least double the *homicide* rate.

In the year ending 31st March 2000, 9,500 children in England and Wales were placed on child protection registers in the category of physical abuse. Unfortunately child protection registers in the UK do not classify cases in relation to severity of abuse or record rates of recurrence of abuse. Consequently, there are no reliable official records to inform us how much serious physical abuse of babies/infants is taking place. Also, more crucially, we do not know whether this is an increasing or decreasing problem – or what proportion of these children are subsequently re-injured. Recent research indicates that this is not an insignificant problem. A population-based incidence study in Wales concluded that 1:880 babies were seriously physically abused in the first year of life (Sibert et al., 2002).

NSPCC practice experience (e.g. gained through assessment, consultation, audit/evaluation services, chairing child protection case conferences, membership of Part 8 Reviews) suggests that serious injuries to babies/infants is an unremitting national problem, and that these cases present complex assessment and case management challenges. Risks are high and outcomes can be fatal. On some occasions, as in the case of Bianca, the death can be directly associated with child protection system failure.

Government guidelines on assessment practice such as the '*Orange Book*' (DoH, 1988a), *Assessment Framework* (DoH, 2000) and *The Child's World* (Horwath, 2000) do not include a specific focus on serious physical abuse to babies. Consequently they do not assist greatly with the interpretation of complex SIDE situations. We hope that this book will support the development of an evidence-based context to complement the *Assessment Framework*, and assist multi-agency assessment of these challenging cases.

As we shall discuss later, a volume of research focuses on the occurrence and diagnosis of serious injuries to babies. Few studies, however, have addressed in detail the child protection assessment and case management challenges in situations involving serious injuries to infants with discrepant explanations. Krugman (1985) reported a sequence of 24 fatal cases of child abuse that all involved 'discrepant histories' and delay in seeking help. Inconsolable crying in infants less than one-year-old, and toileting events in older infants were the major identified trigger factors. Head injury was the cause of death in 70% of the cases. Kasim, Cheah & Shafie (1995) and Hicks & Gaughan (1995) reported similarly on samples of 30 and 14 infant fatalities respectively.

More recently Miller, Fox & Garcia-Beckwith (1999) in the USA reviewed 30 infants/toddlers who had suffered severe injuries, the vast majority involving discrepant

explanations. Methodology involved a file analysis and telephone follow-up interview with social workers nine months later. Initially, all but one child had been removed from parental care. In over 50% of the cases of severely injured infants under the age of five years, the identity of the perpetrator remained unknown. At follow-up, 16 (52%) of the children had been returned home, including ten to homes where the identity of the perpetrator remained unknown. One child was known to have suffered another serious injury post-rehabilitation. The authors expressed their concern about the application of family preservation principles in these severe cases.

Diagnostic research

Much more research has been undertaken in relation to the challenges involved in medical diagnoses of physical injuries. A study of subdural haemorrhages in 33 infants noted the difficulty in determining between accidents and abuse (Jayawant, et al., 1998). The authors concluded that 82% of the subdural haemorrhages were highly suggestive of abuse. A clear history of shaking was eventually obtained in fourteen cases (42.5%) – although this was never the first explanation offered.

Wilkins (1997), in an aptly titled paper “Head injury – abuse or accident?” reviewed the complex uncertainties in medical diagnosis. He remarked upon the continued potential for disagreement between doctors, noting tendencies in some of a resistance to diagnose abuse, and in others an over-enthusiasm to do so. David (1999) provided a succinct overview of key issues and uncertainties relating to medical diagnosis of abuse (or not) in cases of childhood head injuries. These are important papers (and valuable sources of further references) which should be read by professionals who have a role in child protection assessment and case management of physical abuse.

The impact on families and the child protection system of serious physical injuries (often life-threatening, sometimes fatal) to a baby is immense. At a time when parental reactions are commonly those of acute shock, numbness, denial and disbelief, urgent professional decisions need to be made about the immediate protection needs of the baby and any vulnerable siblings. The process of determining the likelihood of injuries being the result of accidents or other non-abuse causes is a real challenge to all of the disciplines within child protection systems. The difficult task is to identify and ensure sufficient protection for children who really are in danger, whilst maintaining fair process for parents whose children have been injured (accidentally or otherwise).

Method

Our interest in cases of serious injuries with discrepant explanations developed primarily in the course of providing an independent assessment and consultation service in the South of England between 1986 and 2000. The service was accessed across several Local Authorities areas. Most cases arose from seaside towns and rural villages, reflecting a mix of significantly deprived and affluent communities.

Clinical assessment sample

Over 15 years, assessments were undertaken with 203 families where all forms of serious child abuse had occurred. Of these, 38 fell into the category of serious injuries with discrepant explanations, and 21 of these involved injuries to 26 babies/infants between the ages of 0–24 months. In this book we shall focus on the issues arising from this 0–2 year-old assessment sample (a further publication is in preparation which will include additional issues arising in relation to older SIDE children).

All of these families had one white British parent. Five of the families additionally had a second parent with either Eastern European, South American, West Indian, Afro-Caribbean or Chinese family backgrounds.

The 0–24 month assessment group of SIDEs is a convenience sample arising from a clinical setting. We do not discuss the assessment practice in the clinical service in relation to these cases (further information about this can be found in Dale & Fellows, 1999). Rather, the analysis stems from extensive information derived from the comprehensive NSPCC files on each case. Typically, files included combinations of: sets of child protection case conference minutes; police statements by parents and professionals; medical reports regarding opinions of injuries; reports from social services, Guardians ad Litem and medical staff to conferences and courts; other assessment reports e.g. psychologist, family centre; NSPCC assessment case notes and reports; court judgements; and miscellaneous professional correspondence.

A file analysis instrument was developed which captured data across nine sections covering: referral information; family and children information; injuries and other concerns; explanations for injuries; professional interventions; professional disagreements; NSPCC assessment issues; subsequent events; and summaries of key themes. Each substantial file was read separately by two researchers. The first reader completed the detailed instrument, while the second read the file and the completed instrument, providing an additional thematic commentary which was appended to the instrument. The combined instrument and comments were then all read by the third researcher who added further comments.

In accordance with principles of qualitative data analysis (Bogdan & Taylor, 1975; Denzin & Lincoln, 1994), memos were continually developed in relation to emerging questions, themes, issues and hypotheses. These memos served as the basis for the development of the initial categorisation system. This system continually evolved through successive versions, with amendments, additions and integration of categories as further cases were analysed. A parallel quantitative analysis recorded the number and nature of all injuries; nature of parental explanations for suspicious injuries; and the nature of other recorded factors of concern.

This is an exceptionally rich source of data with extensive descriptions and impressions of cases from the multiple perspectives of the many professional groups involved, as well as detailed accounts of the views of the parents and other family members. Such documentary analysis has significant methodological advantages in the sensitive field of child protection research due to its non-intrusive nature. Also, this data and analysis stems from a clinical setting – a perspective that Ratiner (2000) noted is often lacking in child protection research. Consequently we hope the material will indeed speak to the “clinician’s plight in the trenches” (Ratiner, 2000).

Part 8 Review sample

Separate from the clinical assessment sample, we also analysed 17 Part 8 Review reports which focused on 19 children who suffered SIDEs (17 fatal, two non-fatal). Part 8 Reviews are undertaken by Area Child Protection Committees under government guidance contained in successive versions of *Working Together* (DoH, 1988b, 1991, 1999).

This was an opportunity sample of Part 8 Review reports (dated between 1996 and 2001) obtained mostly via NSPCC membership of seven Area Child Protection Committees in the Home Counties of England. The Part 8 Review reports contained significantly less detailed information than the extensive files in the assessment sample. For example, it was not possible to record ethnic origin with any confidence. The reports ranged from two to 42 pages in length and varied considerably in the quality of exploration and analysis of

relevant events and issues. The documentary analysis of the reports involved identification of key themes and noting similarities, differences and exceptions in relation to the categorisation of significant issues developed from the analysis of the assessment sample.

In chapters 2–5 that follow, we report on key findings of the research in relation to:

- injuries and explanations
- contextual concerns
- child protection system responses
- outcomes

Chapters 6–7 locate these findings in the context of:

- diagnostic issues
- assessment practice
- social policy dilemmas

Finally, in chapter 8, we outline our conclusion that a proportion of SIDE cases are preventable; and make recommendations accordingly for child protection system practice and policy.

2 Injuries and explanations

In this chapter, we draw on the analysis of material from both the assessment and Part 8 Review samples and focus in turn on the types of injuries and nature of parent/carer explanations.

Combined sample

Taken as a whole, the research focuses on 45 infants (0–2 years) from 38 families. Gender characteristics can be seen in Table 1.

Table 1 Gender characteristics of samples

	No. of families	Infants aged 0–2 years		
		Male	Total	Female
Assessment sample	21	17 (65%)	26	9 (35%)
Part 8 Review sample	17	14 (74%)	19	17 (26%)
Total sample	38	31 (69%)	45	14 (31%)

These figures illustrate the disproportionate vulnerability of males to serious and fatal injury in infancy. This has been reported in other studies (e.g. Wilczynski, 1997), and there is no generally accepted understanding as to why this gender imbalance exists.

Injuries: assessment sample

The following section gives information about the children, injuries and families involved in the assessment sample, in age-ascending order:

AR206 Girl First SIDE presentation: age 2 weeks

Injuries: fractures to both legs (tibia x 2, fibula x 1)

Parent context: two natural parents (together)

SIDE child position in family: first and only child

History of known previous injury concerns: none

Significant combination of other contextual concerns: no

Parental explanation for the injuries was that father had caused these accidentally whilst passing the baby to mother for a feed in the middle of the night. This was firmly discounted by the paediatrician.

After a few days in hospital the baby was discharged home to her parents' care, ahead of the child protection conference. The day after the child protection conference the baby sustained a further injury, a bruise to the cheek, whilst in her father's care. The explanation was again deemed inadequate by the paediatrician. This time she was removed from her parents' care and placed with extended family under an Interim Care Order.

Conflicts emerged within the professional network, specifically around whether child protection intervention was counter-productive. Within six months the baby was rehabilitated with her parents under the terms of a Supervision Order.

Follow-up information: No known subsequent reports of child protection concerns.

AR53 Boy First SIDE presentation: age 3 weeks

Injuries: laceration to inner lip

Parent context: two natural parents (together)

SIDE child position in family: first and only child

History of known previous injury concerns: none

Significant combination of other contextual concerns: yes

Parental explanation was that the baby had rolled off a changing mat. Paediatric view was that this was not developmentally possible. Baby was placed on child protection register and remained at home with parents.

Follow-up information: At the age of 11 months the baby sustained another SIDE - a fractured leg. Explanation given was that father had accidentally injured the baby when he fell over a wall (while holding the baby). This generated some professional uncertainty, but the parents were given the benefit of the doubt.

Over the course of the next two years the boy received occasional suspicious bruises and one minor burn. Matters came to a head when he and his younger brother were found to have bruising to the face and lower limbs and both were removed briefly on Police Place of Safety Orders. These were allowed to lapse and the boys made subject to Supervision Orders. Concerns about borderline and minor injuries continued for several years.

AR9 Boy First SIDE presentation: age 6 weeks

Injuries: 14 fractured ribs (of at least three different ages), fractured fibula, bilateral retinal haemorrhages

Parent context: two natural parents (together)

SIDE child position in family: first and only child

History of known previous injury concerns: none

Significant combination of other contextual concerns: no

Baby taken to hospital unwell. No external signs of injury. Diagnosis of NAI made a week after hospital admission upon review of x-rays. Baby placed with foster parents under an Interim Care Order. Early in the NSPCC assessment father admitted that he had caused the injuries but maintained that this was 'accidental'. Shortly afterwards, his wife left him and made a statement to the police which acknowledged she had been aware of his maltreatment of the baby. Father then committed suicide. Following assessment (which included a mother-baby residential component) there was consensus that mother was able to provide proper care for her son. Seven months after the original hospital presentation he returned to her care under the terms of a Family Assistance Order.

Follow-up information: no known subsequent reports of child protection concerns.

AR51 Boy First SIDE presentation: age 6 weeks

Injuries: fractured femur

Parent context: two natural parents (together).

Position in family: youngest of two

History of known previous injury concerns: none

Significant combination of other contextual concerns: yes

No initial explanation from parents for the injuries. At the conclusion of the initial inquiry an extended family member suddenly claimed to have caused the injury accidentally. The mechanics of this explanation were discounted by the paediatrician. Later (during separations) on two occasions father claimed that the mother had caused the injury. Each time he retracted this upon their reconciling. An application to court for an Interim Care Order was refused.

A second injury (with no explanation) occurred at age 7 months (torn frenulum) and this time the boy was made subject to an Interim Care Order. Subsequent assessment revealed major problems within the family including chronic reciprocal domestic violence.

Delay in fixing a final court hearing led social services to place the infant back at home with parents ahead of the final hearing. Thereafter the parents ceased to co-operate with agencies. The boy subsequently was subject to an extensive series of bruising and bite injuries which parents explained as being caused by his elder sibling.

Follow-up information: within a year of his return home the child was found dead. The pathologist's eventual conclusion that death was due to acute pneumonia. The body also had clear signs of chronic neglect, extensive bruising and several bite marks.

AR193 Boy First SIDE presentation: age 6 weeks

Injuries: multiple fractures (ribs, arm and leg – different ages). Significant facial bruising.

Parent context: parents recently separated, child living with mother

SIDE child position in family: first child

History of known previous injury concerns: about 10 days before the index injuries came to light the baby had been observed by a social worker to have bruising to his temple. This had not been subject to medical examination.

Significant combination of other contextual concerns: yes

A number of explanations were offered by the parents for the injuries. Domestic violence featured prominently in these with the baby being both 'caught in the crossfire' and subject to a physical 'tug of war' between the parents. Also, mother claimed that father squeezed the baby too hard when drunk. Mother admitted fracturing his arm, initially claiming this was accidental, later admitting it was done in anger. The boy was removed from his parents' care and made subject to a Care Order. He was left with serious disabilities – profoundly deaf and partially sighted.

Follow up information: it is thought that the baby was adopted. The mother was charged with GBH, outcome not known.

AR44 Boy First SIDE presentation: age 8 weeks

Injuries: multiple fractures, of different ages, to femur, clavicle and ribs

Parent context: natural parents (together)

SIDE child position in family: youngest of three

History of known previous injury concerns: see below

Significant combination of other contextual concerns: no

A paediatrician and forensic pathologist diagnosed NAI. The parents offered a number of explanations, including the injury being caused either by a boisterous elder brother or hospital staff holding the baby down to complete a medical procedure.

A retrospective examination of medical records uncovered previous injuries to elder siblings, at least one of which (a fractured ankle at age 6 months) was also thought to be an uninvestigated potential NAI.

The index child was placed with extended family for several months under a Residence Order while several assessments took place. Further medical opinion was sought by parents who contested the SSD's application for a Care Order. This opinion was that the injuries were caused by 'temporary brittle bone disease'. This diagnosis was disputed by paediatricians and was rejected by the judge who made the boy subject to a Care Order. Further assessment work was undertaken following the care proceedings. The baby was returned to parents' care.

Follow up information: parents subsequently separated. No known subsequent reports of child protection concerns.

AR56 Boy First SIDE presentation: age 8 weeks

Injuries: fracture to tibia

Parent context: natural parents (together)

SIDE child position in family: first child

History of known previous injury concerns: observed bruise to abdomen age 4 weeks.

Significant combination of other contextual concerns: no

There was a significant difference of medical opinion as to whether the initial SIDE injury was NAI. Parental explanations were that this had been self-inflicted by the baby in his cot. Against the advice of the consultant paediatrician and other professionals, he was returned home by social services with no assessment having taken place.

At age 17 months he was readmitted to hospital with a fracture of the humerus. Parents again claimed that the injury was self-inflicted as a consequence of the infant's boisterousness. Significant disputes occurred between expert medical witnesses regarding the possibility of accidental explanations. Ultimately, the judge ruled that both injuries had been NAI but that, nonetheless, the boy should return to his parents. No criminal charges were brought due to the improbability of proving which parent was responsible.

Follow-up information: father is known to have died. No known subsequent reports of child protection concerns.

AR11 Boy First SIDE presentation: age 10 weeks

Injuries: 5 fractures to ribs and pneumonia

Parent context: single mother

SIDE child position in family: seventh child (but only child in mother's care)

History of known previous injury concerns: yes

Significant combination of other contextual concerns: yes

History of longstanding child protection and neglect concerns regarding 4 elder siblings. One of these siblings had died suddenly at 3 months (recorded as sudden infant death syndrome, SIDS) in circumstances which appear to indicate significant lack of appropriate care.

At the time of the index SIDE injury mother and baby were living together alone. The baby was admitted to hospital with pneumonia which was thought to be connected to neglect. At this point 5 fractured ribs were discovered and a clear diagnosis made of NAI. Mother initially blamed the father. Subsequently she admitted that she had caused the fractures by squeezing the baby too hard 'accidentally'. She later retracted this admission.

Lengthy care proceedings ensued with concomitant multiple assessments culminating in the baby being made subject to a Care Order and placed with father and stepmother.

Follow-up information: this placement was not successful and it is believed that he subsequently was brought up in care of the local authority.

AR81 Girl First SIDE presentation: age 11 weeks

Injuries: bleeding from nose

Parent context: single parent

SIDE child position in family: only child

History of known previous injury concerns: none

Significant combination of other contextual concerns: yes

Teenage single mother gradually admitted attempting to smother her baby by holding her face down in the cot mattress for between 3-5 minutes. No explanation regarding motivation. The baby was adopted.

Child protection system re-involvement precipitated by rapid subsequent second pregnancy. Assessment question regarding protection of new baby at birth.

The new baby was removed at birth and made subject to a Care Order. Assessments pointed to both parents' capacity to mature, to work cooperatively with agencies and to care appropriately for the baby. Major social problems significant at time of birth of first baby substantially resolved. Contact was increased leading to the baby being placed at 'home on trial', followed in turn by revocation of the Care Order.

Follow-up information: direct information over more than ten years – eventual parental separation. No other subsequent reports of child protection concerns.

AR2 Boy First SIDE presentation: age 16 weeks

Injuries: fractured femur

Parent context: single mother

SIDE child position in family: only child

History of known previous injury concerns: by the age of 6 weeks the baby had sustained two bites on separate occasions to his arm and shoulder, which mother admitted inflicting. No child protection action was taken.

Significant combination of other contextual concerns: yes

The spiral fracture of the femur at aged 4 months was diagnosed as NAI. Mother claimed that this must have occurred accidentally whilst she was either cuddling him or lifting him onto the bed.

Care proceedings and residential assessment ensued, at the conclusion of which the baby was rehabilitated with mother subject to a Care Order.

Follow-up information: following another bite incident at age 16 months the infant was removed again and adopted. A subsequent baby was removed at birth and adopted. Mother was convicted on two counts of cruelty relating to the earlier bites and served a probation order. No charges were brought in relation to the fracture or subsequent bite.

AR1 Boy First SIDE presentation: age 16 weeks

Injuries: bilateral subdural haemorrhages (permanent brain damage)

Parent context: mother & boyfriend (step-father)

SIDE child position in family: only child

History of known previous injury concerns: five previous hospital admissions including near fatal pneumonia. Also severe apnoea episode. (It later transpired that mother's cohabitee had served a prison sentence for attempting to smother his own baby.)

Significant combination of other contextual concerns: yes

Mother eventually came to admit that she had shaken the baby once but insisted that this was not sufficiently severe to cause the brain damage. She also stated that she had left her son in the care of her cohabitee and had returned to find him 'limp'.

The baby was adopted. Mother became pregnant again (by a different man) giving birth approximately a year later. This child, a girl, was removed at birth and a Care Order obtained. Assessments identified some positive changes within mother, including emotional maturation, greater understanding of her mutually violent relationships with men, a degree of reconciliation with her mother and more productive relationships with professionals.

The girl was rehabilitated gradually with her mother and the care order eventually revoked.

Follow up information: outcome mixed. No known subsequent reports of child protection concerns regarding index child. However, a subsequent child received a SIDE fracture injury at age 30 months.

AR108 Girl First SIDE presentation: age 6 months

Injuries: two incidents of attempted suffocation

Parent context: natural parents (together)

SIDE child position in family: only child

History of known previous injury concerns: two previous hospital admissions for apnoea reported by mother.

Significant combination of other contextual concerns: yes

The mother of a 6 month old baby informed her health visitor that she had held a pillow over her daughter's face the previous evening. Medical examination revealed confirmatory petechial haemorrhages. Mother claimed she was drunk at the time and was unclear how long the event had lasted or what her motivation was.

The local authority sought Interim Care Orders on the baby and her elder sibling but the court made Supervision Orders. A pattern of domestic violence, heavy drinking, separations and reconciliations, and associated concern about the emotional welfare of the children continued over a long period. No further known apnoea or injuries.

Follow-up information: parents long separated. Mother coping well alone with the children. No known subsequent reports of child protection concerns.

AR13 Girl First SIDE presentation: age 8 months

Injuries: multiple fractures (femurs, tibia, radius and ulna). Extensive bodily bruising. Injuries of different ages.

Parent context: mother and boyfriend (step-father)

SIDE child position in family: youngest of two

History of known previous injury concerns: bruising to temple observed at age 7½ months.

Significant combination of other contextual concerns: yes

Paediatric opinion was of 4 discrete non-accidental injuries occurring on at least 3 occasions. Child and sibling were taken into care for protection and assessment. Initial explanations were given by mother, boyfriend and extended family member of various accidental causes. Paediatric opinion was that these were mechanically insufficient to cause the nature and extent of the injuries.

Mother and boyfriend were tried on charges of cruelty but acquitted on the judge's instruction as it was impossible to determine which was responsible. Mother then separated from her boyfriend. Following assessment the children were returned to mother's care.

Follow-up information: mother subsequently voluntarily placed the sibling (not the SIDE child) for adoption. No known subsequent reports of child protection concerns to the SIDE child.

AR7 Boy First SIDE presentation: age 9 months

Injuries: fractures to skull, brain and retinal haemorrhages

Parent context: parents recently separated, child living with mother

SIDE child position in family: only child

History of known previous injury concerns: the boy had been presented to hospital some 3 weeks prior with vomiting. The explanation then, as with the index injury, was that he had fallen and hit his head.

Significant combination of other contextual concerns: yes

Paediatric opinion was that the injuries were consistent with the boy having been shaken and that the skull fracture suggested impact e.g. with a wall. Both parents were initially charged with GBH but CPS did not proceed as it was thought impossible to establish in a court which parent was responsible. The boy was accommodated within the extended family for almost a year. An adult psychiatric report (no formal psychiatric illness) was influential in the decision to rehabilitate the baby with mother.

Follow-up information: no known subsequent reports of child protection concerns.

AR46 Baby girl No injuries: age 9 months

Concerns re: query failure to thrive and history of her father

Parent context: (inadequate information regarding relevant deceased children)

SIDE child position in family: only child in current family

History of known previous injury concerns: yes

Significant combination of other contextual concerns: regarding role of father in deaths of two previous babies.

Care proceedings were brought in respect of a girl of 9 months when it was learned that the child's father had been charged with the murder of a baby of a previous partner. The child who died had suffered one suspicious injury at 6 weeks (second degree burn to mouth and cheek) and then died just two weeks later. She had brain and retinal damage, the paediatrician's view being that she had died as a result of being shaken. Another child of this man had suffered a cot death some years prior to these events.

He was subsequently acquitted of manslaughter. A charge of Actual Bodily Harm in respect of the first suspicious injury to the baby was left on file.

The baby girl of 9 months was made subject to a Care Order. The judge made explicit the expectation that she would be rehabilitated with mother and her partner. The query failure to thrive was resolved with a medical explanation. Following assessment (with a residential mother-baby component) the child protection system concluded that parenting was satisfactory and the family reunited.

Follow-up information: no known subsequent reports of child protection concerns. It is believed that the parents eventually separated.

AR43 Girl First SIDE presentation: age 10 months

Injuries: ingestion of poison

Parent context: natural parents (together)

SIDE child position in family: only child

History of known previous injury concerns: 4 prior hospital admissions and mother's 'odd' presentation.

Significant combination of other contextual concerns: no

This baby was admitted to hospital very sick and was found to have a potentially fatal level of anti-epilepsy medication in her bloodstream. The parents' eventual explanation was that the infant had picked up and swallowed a tablet that had been accidentally dropped on the floor. Child protection agencies were firmly of the view that this had been a deliberate poisoning by the mother and (in the context of the nature of the four previous hospital admissions) suspected Munchausen's Syndrome by Proxy. This discrepancy was never resolved.

A number of social and psychiatric assessments ensued over a long period of time with the girl placed with extended family. Eventually, in a context of continuing significant professional differences about future risk, the girl was rehabilitated with the mother who had separated from the father.

Follow-up information: soon after this both parents died in separate accidental circumstances. The girl went to live with maternal grandparents. She is known to be doing well.

AR74 Boy First SIDE presentation: age 21 months

Injuries: Fractured tibia, fractured humerus (different ages). Facial bruising.

Parent context: mother and boyfriend (step-father)

SIDE child position in family: second child

History of known previous injury concerns: none

Significant combination of other contextual concerns: yes

At a pre-arranged appointment with their GP mother raised concern about her son's leg. Hospital examination revealed fractures with paediatric opinion of NAI.

The parents had recently separated. Mother had started a relationship with their lodger who looked after the children whilst she worked. Initially, both mother and lodger denied all knowledge of the injuries. During the police enquiries the lodger 'remembered' handling the boy violently. Over time, mother acknowledged being concerned about his handling of her son. Mother and lodger separated immediately after the injuries came to light and she resumed her relationship with her husband. The assessment came to a positive view of their parenting and they were able to resume care of both children under the terms of a Supervision Order. The lodger faced trial for GBH but the jury was unable to reach a verdict. It is not known whether a retrial took place.

Follow-up information: no known subsequent reports of child protection concerns.

AR114 Three siblings: Boy age 16 months; Girl age 3 years 1 month; Girl age 6 years 2 months

Injuries: first SIDE presentation: severe bruising to buttocks of boy. Severe bruising to face of 3 year old girl. Bite mark to same girl and query fracture to wrist.

Parent context: mother and boyfriend (step-father)

SIDE child position in family: youngest of 3

History of known previous injury concerns: eldest girl: fracture to arm 3 months previously. Severe bruising also noted two weeks later.

Significant combination of other contextual concerns: yes

When the eldest child received serious bruising (together with concerns about neglect) all 3 children were removed from home on a Place of Safety Order. However, they were returned 2 weeks later when their mother pledged to cooperate with social services. Within 5 days the two younger children had suffered severe bruising, a bite mark and a possible fractured wrist.

The children's accounts suggested that both mother and cohabitee were implicated. Mother severed contact with her children and professionals. She pleaded guilty to cruelty charges and was imprisoned. Her cohabitee pleaded not guilty and the outcome of his trial is not known.

The birth father of the two younger children resumed care for them under a Residence Order. The eldest child (not his) was subject to a Care Order and placed with a foster family long-term.

Follow-up information: direct information - one further child protection report. Father notified social services that he had smacked his son causing a bruise. This was interpreted as well-intentioned over-chastisement and no further action was taken. No known subsequent child protection reports.

AR61 Boy First SIDE presentation: age 20 months

Injuries: hypothermia

Parent context: single mother

SIDE child position in family: youngest of 5

History of known previous injury concerns: sequence of extensive hospital contacts. Query MSBP.

Significant combination of other contextual concerns: yes

The fifth child in this family was born prematurely and spent the first three months of his life in hospital. Over the course of the next two years he had more than 40 presentations at hospital with a range of symptoms including apnoea, bruising, minor burns, choking and hypothermia. Over time the injuries became more serious including razor lacerations to his knees and, finally, serious iron burns to his legs.

Professional opinion inclined towards medical or accidental explanations for most of this period until a full inquiry into the circumstances surrounding the burns led to the boy and his siblings being removed into care. The mother served a prison sentence for inflicting the burns and in time acknowledged that she had done this deliberately.

Follow-up information: the boy returned into the care of his natural father. A further child protection report occurred when he sustained minor bruising (considered to be over-chastisement) whilst in his father's care.

Mother later had another child by a new partner. She has since been charged in relation to further serious burn injuries to a subsequent child.

AR69 Boy First SIDE presentation: age 23 months

Injuries: severe spiral fracture of the femur, old fractures to the collarbone and forearm (probably of different ages) and extensive bruising

Parent context: mother and boyfriend (step-father)

SIDE child position in family: youngest of two

History of known previous injury concerns: two other injuries within the past few months: a facial injury and burns to the hands.

Significant combination of other contextual concerns: no

Mother's boyfriend was alone with the boy at the point all injuries occurred. Explanations given such as falls off sofas were not congruent with the injuries. The boyfriend was convicted of GBH and sentenced to four and a half years imprisonment. For a prolonged period mother and her family vigorously asserted the boyfriend's innocence.

Both the boy and his elder sister were made subject to Supervision Orders and placed with extended family. A significant change occurred with regard to the family's view of the boyfriend's responsibility, and mother ended her relationship with him. The children were returned to her care.

Follow-up information: direct knowledge that rehabilitation of the children with mother was successful. No known subsequent reports of child protection concerns.

AR57 Boy pre-birth assessment

Injuries: N/A

Parent context: (inadequate information regarding relevant injured children)

SIDE child position in family: no other children in current family

History of known previous injury concerns: two previous boys (by another father) had been removed from mother's care 3 years previously and placed permanently elsewhere after one of them had received unexplained injuries to an eye at 17 months.

Significant combination of other contextual concerns: yes

Mother's new partner (the unborn baby's father) also had convictions for cruelty and assault on a child. The parents attempted to conceal the birth of the referred child by giving false names to the hospital and discharging him immediately. This led to immediate protective action and care proceedings. The boy was later adopted.

Follow up information: enquiries were received from around the country in relation to this man who moved in with other families resulting in child protection concerns. Mother known to be destitute for a period of time.

This represents a sizeable catalogue of serious injuries to very young children. As a whole, we believe that these cases are characteristic of the challenges that SIDE cases present to child protection services.

Child and family characteristics: assessment sample

As sufficient information was not available about the circumstances of previously injured children in two families, information about family structure at the time of the first SIDE injuries is presented in relation to 19 families in the assessment sample as follows:

- In 8/19 cases the injured child was living with both natural parents, and in six of these cases was the only child in the family;
- In 6/19 cases, the mother was living as a single parent;
- In 5/19 cases the natural mother was living with a boyfriend who was not the father of the child;
- In 11/19 cases the injured child was the only child in the family;
- In every case with more than one child in the family it was the youngest child who was injured.

Types of injuries

In the assessment sample there were 146 discernable documented injuries to 26 babies and infants across the 21 cases. Table 2 shows the nature of injuries:

Table 2 Numbers of injuries by type (assessment sample)

Type of injury	occurrences
Fractures	58
Serious bruises	46
Lacerations	10
Suffocation/apnoea	10
Burns	8
Bites	6
Retinal haemorrhages	4
Brain haemorrhages	3
Poisonings	1
Total injuries	146

The number of separate injuries ranged from a single event, to one child with an extraordinary sequence of 23 injury incidents. The most common were bone fractures (71% of cases). Fifteen babies sustained a total of 58 fractures, including four babies with a total of 28 rib fractures between them.

A striking feature was the very young age at which SIDE injuries occurred. Just under half of the cases (9/21) involved at least 18 fracture injuries to babies who were between two and 12 weeks old. The earliest was three fractures (femur and x 2 tibia) to a baby girl aged two weeks. Another baby in this highly vulnerable age group suffered bilateral retinal haemorrhages and brain damage from shaking at age eight weeks.

One-third (7/21) of the cases involved injuries that had been recorded at the time to be life-threatening or the cause of permanent disability. These involved brain damage (three

cases), suffocation (three cases) and poisoning (one case). Lack of follow-up information (especially regarding developmental problems that would only become apparent over time) means that this is almost certainly an under-recording of abuse-related permanent disability.

There had been four child-fatalities in the past in three families within the assessment sample, two of which had been classified as cot deaths. However, retrospective analysis of the circumstances, including subsequent serious abuse to other children in the family, raised queries about this judgement. A third suspicious death occurred two years after a six-week-old baby had sustained serious SIDE injuries and a court had returned the baby home against the recommendation of social services. The fourth case involved assessment of a family where the father of a new baby had in the past been charged (and acquitted) of the murder of an eight-week-old baby.

Injuries: Part 8 Review sample

The Part 8 Review sample involved 17 families with 19 children, of whom 17 died. The other two children suffered permanent serious disabilities from their injuries. Table 3 outlines numbers of families and children involved in the assessment sample:

Table 3 Families and children in Part 8 Review sample

	Part 8 Review 0-2 years
Families	17
SIDE children	19
Male	14
Female	5
Siblings	9
Male	6
Female	3

These figures portray sad brief lives of children, and prolonged consequences for the families (and professionals) concerned. Given the poignancy of the tragic events, it is with some reluctance that we distil information about these infants in what might appear to be a somewhat detached 'Table' format. However, there are important factors behind these deaths (many of which in retrospect that can be seen as preventable) that require analysis to develop understanding regarding psychological, systemic and social processes.

Information regarding the SIDE injuries in the Part 8 Review sample is given in Table 4 (overleaf).

Table 4 Injury information in Part 8 Review sample

Ref No.	Sex	Age at first SIDE injury	Age at fatal SIDE injury	No. of injury episodes	Nature of fatal injuries
P8.2	M	11 weeks	11 weeks	1 presentation – but fractures of different ages	Extensive retinal haemorrhages, flame haemorrhages and intra-retinal haemorrhages. Multiple rib fractures of different ages. Skull fractures. “Death due to head injury consistent with being shaken and impact of head on edge of a firm object. Bruising to scalp consistent with having been caused by gripping the head whilst head injury inflicted. Numerous healed fractures of ribs consistent with being caused by a compressive force applied to the chest.”
P8.3	M	18 weeks	18 weeks	1 presentation – but fractures of different ages	Fatal neck fracture – fracture of cervical spine due to violent whiplash effect, consistent with shaking the child whilst the neck was unsupported. Also a number of other injuries (not specified) of an older age than the fatal injuries.
P8.6	M	6 weeks	6 weeks	1 presentation – but fractures of different ages	“Extensive bruising to chest and buttocks, fractures to seven ribs plus a brain injury leading to subdural haemorrhaging.” (Most likely from shaking)
P8.7	M	4 weeks	4 weeks	1	Baby brought to hospital with cardio-respiratory arrest (had been dead in bed with heroin-induced sleeping parents).
P8.8	M	3 weeks	7 weeks (non-fatal)	At least 2	Right sided parietal fracture and bilateral subdural haemorrhages
P8.9	F	3 weeks	6 months	At least 2	Bilateral retinal haemorrhages (no signs of external bruising or trauma). Serious brain swelling/head injury consistent with forceful impact onto a firm surface plus ? shaking.
P8.10	F	15 months	15 months	1	Extensive subdural haemorrhage – probably caused by shaking.
P8.11	F	9 weeks	10 weeks	2	Extensive skull fracture and brain damage.
P8.12	M	18 months	18 months	1	Mother reported finding child not breathing and no pulse. No evidence of significant trauma. 8mm contusion (blue) L forehead and 2mm scab R temporal area. Toxicology revealed caffeine in urine.
P8.13	M	11 weeks	6 months	2	Cause of death given as infection – staphylococcaureus. Post-mortem also revealed number of injuries of varying ages consistent with NAI. Numerous fractures of differing ages involving ribs, collapsed vertebral bodies and left tibia. Also retinal haemorrhages.
P8.14	M	7 weeks	7 weeks	1 presentation – but fractures of different ages	Extensive fractures to ribs – of varying ages.
P8.15	F	8 months	8 months	1	Extensive injuries to body that in the main thought to be NAI. But no specific cause of death. Mysterious needle puncture marks to her feet.
P8.16	All M	Not known	3 children: i) 16 months ii) 6 weeks iii) 5 weeks	Not known	All 3 children believed to have been suffocated.
P8.17	M	3 months	4 months non-fatal	At least 2	Baby brought into hospital vomiting and fitting. Bilateral retinal haemorrhages. Emergency CT scan showed generalised brain atrophy consistent with fresh intracerebral bleeds.
P8.18	F	2 weeks	8 weeks	At least 4	Post-mortem examination revealed: linear fracture of skull (L. parietal 3.8cm) Extensive bilateral retinal haemorrhages. Sub-dural and sub-arachnoid haemorrhages = 2 separate injuries with force of RTA.
P8.20	M	4 weeks	4 weeks	1	Fatal dose of heroin and distalgic.
P8.21	M	5 weeks	2 yrs 3 months	Too many to record	Acute form of pneumonia – but extensive additional NAIs.

As with the assessment sample, the vulnerability of babies in the very first weeks of life is strikingly apparent. The most frequently recorded injuries were (figures reflect number of cases with this feature): subdural haemorrhages (7); retinal haemorrhages (5); skull fractures (4); rib fractures (4); other fractures, including neck (2); and poisoning (1). Although it is difficult to draw exact comparisons (because of the differences in ways data has been recorded in the two samples), there may be one distinguishing characteristic between the predominantly fatal sample and the non-fatal sample. While the extent of fractures was similar, there was a higher proportion of brain injuries in the fatal group. This indicates that while both groups of children suffered violence sufficient to break bones, the infants in the fatal group were more likely to have experienced impact injuries to their heads and/or to have been severely shaken as part of the assaults.

Child and family characteristics (Part 8 Review sample)

Across the 17 families in the Part 8 Review sample, there were a total of 28 children. Nineteen (14 male, 5 female) received SIDE injuries and 17 of these were fatal. In every case (bar one) it was the only child, or the youngest child in the family who sustained the SIDE injuries. Family structure was as follows:

- 13/17 comprised two natural parents and (as far as is known) their natural child(ren);
- Three were single mothers each with a single child (two girls, one boy);
- Only one of the 17 families involved any natural parent and step-parent combination.

In summary, child and family factors for both samples are presented in Table 5:

Table 5 Child and family factors (both samples)

	Assessment	Part 8 Review	Total
SIDE Children (0-2 years)	26	19	45
Sex	Male 17 (65%) Female 9 (35%)	Male 14 (74%) Female 5 (26%)	31 (69%) 14 (31%)
Only child in family	11	11	22 (49%)
Family (at time of SIDE assessment or fatal review)	19 (Not N=21 because of 2 cases with no injuries to current child)	17	36
2 natural parents	8 (42%)	13 (68%)	21 (58%)
2 natural parents with only child	6 (32%)	7 (37%)	13 (36%)
Mother and boyfriend /cohabitee	5 (26%)	1 (6%)	6 (16.5%)
Single Mother	6 (32%)	3 (18%)	9 (23%)

Ages of parents

In neither sample were the parents particularly young. Table 6 presents information regarding parental age (at the time of the index SIDE injury) and relationship to the injured child.

Table 6 Ages of parents

Assessment sample	Ages			
	Mothers	Fathers	Step-fathers/ boyfriends	Total
Assessment sample N=19 families				
number	N=19	N=8	N=5	N=32
mean	24	26	21	24
mode	23	21	-	23
median	23.5	25	22	24
range	16-40	21-40	17-23	16-40
Part 8 Review sample N=15 families				
(Two non fatal Part 8 Review cases omitted)	N=15	N=11	N=1	N=27
mean	22	26	-	24
mode	26	24	-	26
median	20	25.5	-	25.5
range	17-29	17-38	33	17-38

These figures suggest that serious and fatal abuse to children aged between 0-2 years predominantly occurs in households containing both natural parents who are in their early to mid-twenties. Contrary to a popular stereotype, step-fathers had little presence and involvement in this particular form of child abuse. This is consistent with other fatality reviews such as Reder et al. (1993) in the UK, and Levine et al. (1994) in the USA, both of whom reported similar findings in relation to parental age and family structure.

Explanations for injuries

The defining characteristic of SIDE cases is the nature of parent/carer explanations which are absent, inconsistent, implausible or discrepant with expert medical or forensic opinion. These features complicate assessment and case management. Material in this section on explanations for injuries is drawn from the detailed case records in the assessment sample only. (The Part 8 Review reports contained no information about parental explanations for injuries.)

In the assessment sample, types of recorded parent/carer explanations (or lack of them) were reviewed from the documents in relation to each injury. In two-thirds (14/21) of cases, at the point of initial investigation, *no explanations* regarding any untoward event were forthcoming. Most commonly parents/carers asserted that the baby had suddenly become seriously unwell.

When initial explanations were provided, these were mostly based on some form of reported accident. These were split roughly equally between those involving the parent and those that did not. Two examples stated inadvertent parental involvement as follows:

A two-week-old baby girl sustained three leg fractures (both tibia and one fibula). Her young parents maintained that the injuries had occurred accidentally while the baby was being passed between them during the night.

The parents of an eight-week-old baby maintained (after initially offering no explanation) that the multiple rib fractures must have been caused inadvertently by the mother in a hospital while she was

holding the baby for eye drops to be administered.

Both of these cases generated strongly held different views between professionals regarding the extent to which the explanations were feasible. The fact that these were also what would be considered to be ‘middle class’ families with few apparent significant social stresses, added to the complexity of assessment and case management.

In six situations parents/carers insisted that the injuries must have been self-inflicted accidents:

A six-week-old baby boy sustained a spiral fracture to his tibia. Parents stated that this must have been caused by the boisterous baby trapping his leg in an awkward position while sleeping.

This child was re-injured at age 17 months having sustained a fractured humerus. In response to the second injury, his parents were again adamant that he had caused this himself by “doing acrobatics” in his cot.

The fourth most common type of explanation was where one parent (either immediately or subsequently) accused the other:

In a family where a previous baby had died (in circumstances that we consider suspicious), a ten-week-old baby lived with both natural parents. Shortly after the father left home, the baby sustained five fractured ribs. Mother claimed that these must have been caused by the baby’s father during contact. During an assessment interview she subsequently tacitly acknowledged that she must have caused the injuries by “squeezing him too hard”. She later withdrew this explanation.

In a small number of cases, parents stated that a boisterous elder sibling must have caused the injuries. One remarkable case involved a grandmother who threw the child protection system into further confusion by suddenly asserting in the middle of a child protection conference that she had caused the injuries inadvertently. This was subsequently discounted as not being physically possible in the manner described, and amounted to an unusual *false-confession* (presumably to distract the focus of suspicion).

A notable pattern (7/21 of cases) was for a lack of initial explanation to be followed by the emergence of a *sequence of different accounts* as criminal and child protection enquiries continued. Explanations evolved as (depending on interpretation) parents strove either to identify the unknown actual cause of the injuries, or endeavoured to concoct a plausible explanation that the child protection system would accept, without implicating themselves criminally.

In only four cases, did admission of responsibility emerge over time that could be construed as being fairly explicit:

■ *A five-week-old baby was found to have multiple fractures of different ages and bi-lateral retinal haemorrhages. Both parents initially denied having any knowledge how these injuries had occurred. Several weeks later in an assessment interview the father acknowledged that he might have ‘unintentionally’ caused the injuries. He committed suicide a week later.*

■ *In a police interview the mother of a four-month-old baby who sustained serious brain damage stated: “I said to the baby ‘I always get it in the neck when you cry’. He kept on crying so I shook him...”*

We noted in a small number of cases a process that we construed as the development of tentative or *tacit admissions* – as if the parent/carer was attempting indirectly to clarify the consequences of making a confession prior to committing herself/himself to this. One mother, for example, stated in an assessment session: “*Whoever did it, knowing how serious it was, would be unlikely to do it again...*”

Parents who are responsible for injuries may be inhibited in giving full accounts for a number of reasons. Hypothetically these include :

- Shame (aware of responsibility and wanting to conceal this);
- Denial and selective amnesia (genuinely held, but mistaken, belief in their non-involvement). This has been discussed in an adult murder context by McSherry (1998);
- Memory impairment related to alcohol, drugs or a neurological condition;
- Family repercussions (forced separations, extended family disapproval and conflicts);
- Social repercussions (impact on status, reputation, employment, standard of living);
- Criminal repercussions (prosecution, costs of defence, sentence, publicity);
- Child protection repercussions (loss of child at worst, child protection surveillance at best).

It is likely that some parents genuinely, yet naively, believe the false but plausible assurances of their partner that he/she was not to blame. In other situations there may be abuse explanations that are genuinely unknown to the primary caretakers – such as a child’s sibling, other relative, carer, or friend having accidentally or maliciously caused harm to the infant.

These issues are particularly complicated in that there is no reliable way to distinguish accurately the behaviour of a parent who genuinely denies responsibility when wrongly suspected, from a parent who denies in an attempt to avoid detection for actual culpability. As we shall address in chapter 6, this complexity is augmented as there can be rare accidental and medical explanations for injuries that appear strongly to be abuse-related. In such cases, before this has been established, child protection professionals have often viewed parents’ protestations of ignorance and innocence with deep suspicion.

It was uncommon for ‘confessions’ to emerge during the course of child protection system involvement. The exact circumstances of the injuries remained in most cases, poorly understood years later. There are few incentives for parents to acknowledge responsibility when they have caused an abuse-related serious injury, and many reasons (psychological, social and legal) to adopt and reinforce a stance of denial. Remaining silent is likely to thwart criminal prosecutions and convictions in both non-fatal and fatal cases, especially if both parents were present in the home when the events occurred. This is illustrated by a recent UK survey of 492 children who had been unlawfully killed or seriously injured by their carers revealed that only one-third of these cases resulted in criminal prosecution – and the conviction rate would be even lower (BBC, 24/1/02).

In the next chapter we examine the family and social contexts within which these injuries and deaths occurred.

3 Contextual concerns

In this chapter, we report on the significance of common child abuse risk indicators in relation to fatal and non-fatal SIDE cases. The file review instrument logged 26 ‘other recorded factors of concern’ (additional to the index injuries) in each case. Within the 21 assessment cases (for which considerably more detailed information was available than for the fatal sample), records identifying combinations of contextual factors of concern ranged from one family with 19 factors, to one family with only one recorded factor (mean 9.5). However, not too much emphasis should be placed on the actual numbers of recorded factors in each case. These are subject to great inconsistencies as to what issues professionals had become aware of, how they interpreted them, and how well they were recorded. Specifically, sums of contextual concern factors should not be used as a crude quantitative check list to calculate levels of risk.

Table 7 presents the 26 recorded factors of concern from the original analysis of the assessment sample case records:

Table 7 Recorded factors of concern from assessment sample case records

	Current concern	Historical	Extent/significant features	Document source
Previous suspicious injuries				
Parental mental health problems				
Domestic violence				
Alcohol abuse				
Drug/substance abuse				
Parental conflict				
Conflict in broader family				
Parent abused as child				
Poor care received by parents (disrupted childhood/adolescence)				
History in LA care (parents)				
Parental criminal convictions (involving children)				
Parental criminal convictions (other)				
Lack of support systems				
Finances				
Housing				
History of aggression				
Young parents				
No. of young children				
Conflict with agencies				
Child’s behaviour				
Child’s health				
Child premature				
Child development				
Attachment concerns				
Neglect				
Emotional abuse/ neglect				

The grid was developed by use on pilot files to capture and reference key information. It is by no means a comprehensive and exhaustive itemisation of all associated child abuse factors. However, as a file analysis instrument, it served effectively to identify key themes and locate material from sizeable files, thus facilitating the on-going analysis. It is not possible in a book of this length to present information and analysis in relation to all of the items in the grid. A further publication is in preparation that will do this more fully. Consequently we have selected five major categories for detailed discussion. These are:

- Previous suspicious injuries
- Parental mental health
- Domestic violence
- Alcohol/drug/substance misuse
- Cases where there are few recorded classic factors of concern

Table 8 shows the recorded distribution of these factors across both samples:

Table 8 Selected categories of concern

	Assessment (N=21 families)	Part 8 Review (N=17 families)	Total (N=38 families)
Significant classic factors of concern	15 (71%)	13 (76%)	28 (74%)
Previous suspicious injuries	13 (62%)	12 (71%)	25 (66%)
Domestic violence	12 (57%)	4 (23.5%)	16 (42%)
Parental mental health	9 (43%)	9 (53%)	18 (47%)
Alcohol/drug abuse	2 (9.5%)	4 (23.5%)	6 (16%)
None/few classic factors of concern	6 (28.5%)	4 (23.5%)	10 (26%)

Patterns of factors of concern

There were two main clusters observable from the grid registering recorded contextual factors of concern. First (as might be expected in cases of serious suspected child abuse), the majority of cases (15/21 in the assessment sample and 13/17 in the fatal sample) had several (sometimes many) recorded factors of concern. Second, there was a smaller number of cases (6/21 and 4/17), where there were very few traditional factors of concern recorded. These were mostly (but not all) what would be widely construed as white, middle class, articulate parents with supportive and often resourceful extended families. We shall discuss child protection interventions with this particular group later in this chapter.

Previous suspicious injuries

At the time of the index or fatal injury, 13/21 and 12/17 of the children in the two samples (66% of the total sample) had been noted by a professional to have had one or more previous injuries. Interpretation of such injuries (especially when they are minor) is a challenging task, particularly for health professionals who have daily routine contact with large numbers of young children. These can be critical moments and dangers arise from both under -and over-reactions.

In the assessment sample, in 13/21 cases (and 4/9 of cases where fractures occurred to babies younger than 13 weeks old) the serious injury precipitating child protection system intervention had been preceded by a relatively minor injury. This was most commonly a small bruise to the face or trunk which had been observed and recorded by a professional. Such precursor bruising was noted within a month prior to the SIDE injury in five cases, and between one and two months in another five cases. Records indicated that the professionals observing these bruises appeared to accept parental explanations (e.g. baby lying on dummy or rolling onto a toy) or lack of explanation very readily. Sometimes there was a record of puzzlement, but by and large, such bruises were interpreted as benign, unusual and unexplained events rather than as a potential indicator of mounting parental tension and possible rough handling.

This is important, as precursor injuries may be specifically brought to a health worker's attention in an indirect help-seeking approach. For example, one mother pointed out to her health visitor a bite mark she had inflicted on her six-week-old baby. The child protection system interpreted this as illustrating a need for even greater family support, rather than a communication from the mother that she was struggling to contain her hateful feelings regarding the baby. A further bite rapidly followed, with a similar response. The baby was subsequently removed into protection (from hospital) having sustained a fractured femur, ten weeks after the initial bite.

Similar responses occurred with professionals' observations of babies in the very early weeks of life who were reported by parents to be constantly crying and sleeping/feeding poorly. In a number of these cases we can retrospectively infer that the fractiousness of the baby was a consequence of serious injuries already sustained. This is especially so with rib fractures and brain damage from squeezing and shaking, which can often occur with no visible external signs.

Parents who have abused their children are often implicitly or explicitly criticised by child protection systems for not seeking help. Professionals, however, can be insufficiently attuned to the underlying significance of injuries to babies—whether these are directly presented for attention or concealed. One common factor in many of these situations was recorded professional comments, notwithstanding the concerns, that the parents 'love' the baby. This attribution of love was assumed to be a protective factor. We urge caution about this. Is there sometimes an idealistic professional assumption in operation that all parents do automatically love their children?

The impact of decades of psychodynamic and attachment theory should warn child protection professionals that this is not necessarily so. In some of these cases (as in the example of the bites just given), it seemed that professionals were projecting idealised notions of love onto the parent and child about whom they had concerns. Such attributions of 'love' can create a dangerous false reassurance. Also, parents in this position may attempt to 'fake good' (faking love) in attempts to deny to themselves (and family/professionals) the reality and implications of underlying powerful feelings of ambivalence, rejection and resentment of the child. Also, even when present, 'love' is not necessarily a sufficient protective factor in its own right. In certain circumstances parents who genuinely love their child do cause serious harm.

Patterns of escalating threat and harm

In 5/17 of the fatal cases the fatal injury was the first known injury incident. However, in contrast, two-thirds of cases (12/17) involved situations where infants had previously been treated for SIDE injuries. These children were subsequently re-injured, sometimes on several occasions, ultimately with fatal consequences.

In many of the Part 8 Review cases (with the perspective of hindsight in the context of tragedy) it is difficult to understand why more assertive child protection interventions were not instigated by health and social services. Retrospectively, patterns of escalating threat and harm are very apparent. For example, one family context included combinations of serious pre-natal concerns, parental mental health problems and domestic violence:

Domestic violence erupted graphically at the earliest stage in a baby's life as the parents had a furious row in the hospital delivery room during labour. This culminated in father punching a hole in the wall. At age three weeks the baby was failing to thrive and was admitted to hospital. At five weeks mother reported to the Health Visitor and GP that the father had lost his temper with baby, putting his hands round his throat on a couple of occasions. Social services were informed. Two days later father told the GP that he has "bad thoughts" about the baby, saying he wished him dead sometimes. No psychiatric or child protection responses were initiated. Father was ultimately charged with murder following the death of the baby one week later.

This case illustrates the process of rapidly escalating concerns with a very young baby, and highlights the missed need on several occasions for an urgent assessment of the baby's immediate safety.

In other situations, concerns escalated less vividly over a longer period of time. One review noted a "significant number of events and concerns during baby's life that should have triggered formal child in need and/or child protection assessment". Instead health and social services focused predominantly on practical matters e.g. baby's weight and family housing needs, rather than the mother's (increasingly disturbed and despairing) state of mind. The report revealed a catalogue of medical and social services errors which resulted in the failure to take necessary protective action on the numerous occasions that acute concerns were expressed for the safety of the baby.

Parental psychiatric/mental health concerns

Significant concerns about parental mental health were recorded in 9/21 cases in the assessment sample, and 9/17 of the fatal sample (47% of whole sample). The relationship between mental health concerns and formal psychiatric disorder is mired in diagnostic and definitional problems. There was no evidence of parental mental illness (according to strict formal psychiatric criteria) recorded in any information that we reviewed in the assessment sample. However, when a broader concept of *parental mental health concerns* is adopted, it is striking that this was a major associated factor in 9/21 cases in the assessment sample. Concerns included:

- lack of impulse control (frequent physical and verbal aggression)
- depression
- suicide attempts and self-harming
- 'unusual' personalities and personality disorders
- alcohol and substance misuse.

These factors clearly impacted negatively on adult and parenting relationships and also contributed to domestic violence.

That so few formal psychiatric diagnoses should exist is surprising in the context of the study of Part 8 Review cases by Falkov (1996) which revealed evidence of psychiatric morbidity (principally psychosis) in a third of cases. This raises two questions worthy of further consideration. First, is there any difference in formal psychiatric status between parents whose infants die of SIDE injuries and those who survive? Second, does the low

recorded incidence of formal psychiatric diagnosis in parents of SIDE infants in our sample say anything about the accessibility and quality of adult psychiatric services in the relevant areas?

In the fatal sample, parental mental problems were recorded factors in 9/17 of the families. Unfortunately, little detailed information is available from the Part 8 Review reports. There are three references to mothers with post-natal depression. In two cases there were references that fathers had been hearing voices and hallucinating prior to the fatal assaults. One report described a young mother with a long history of suspected factitious illness and hypothesised about possible Munchausen's Syndrome by Proxy (MSBP) underlying the repeated hospital attendances of her baby prior to the baby's death at age eight months in mysterious circumstances that remain unexplained. However, the majority of descriptions of parental mental health concerns in the Part 8 Review reports relate mainly to known histories of serious violent behaviour by parents of both sexes.

Across both samples there appeared to be a distinct lack of interaction between adult psychiatric services and inter-agency child protection practice. Despite the prominence of parental mental health concerns, adult psychiatrists played a negligible role in inter-agency child protection assessment and case management. The standard contribution in the seven assessment cases in which adult psychiatrists were involved was to have a minimal contact with the parent and then report that "there are no signs of formal psychiatric disorder". On several occasions this opinion was given in relation to parents who were manifesting vivid personality and behavioural problems. One mother had set herself on fire in front of her children. One father was a patient in a medium secure psychiatric facility, whose behaviour became so violent on the ward that the police were called to evict him. He was returned home to his wife and children.

Attempts to elicit opinions from adult psychiatrists regarding risks to children that disturbed parental behaviour might present were generally fruitless. When obtained, such reports were of limited value. For example, one report from a forensic psychiatrist (in a case where a baby had sustained a fractured skull) concluded "in the absence of admission (of causing injury) no comment can be made about the risk of repetition".

One worrying effect of such limited adult psychiatric opinions can be that child protection systems construe this as a false reassurance that the children are not at risk. On this basis, infants were returned home from protective placements, and children's names removed from the child protection register. Also, such opinions may be used as the rationale for decisions that are in reality resource-driven – such as not providing support services or inappropriately closing cases. However, as Falkov (1996) and Reder & Duncan (1999) emphasised, it is parental behaviour and its impact on children – rather than presence or absence of formal psychiatric diagnosis that is significant for children, and upon which their needs for protective and support services should be based.

Domestic violence

Domestic violence was a more frequently recorded contextual factor of concern in the assessment sample (12/21 cases) than in the Part 8 Review sample (4/17 cases). It is unclear whether the lower reporting in the fatal sample represents any real difference between the contexts of fatal and non-fatal SIDE cases. It is likely that the subsequent information from professional interventions (characteristic of the assessment case files) revealed and recorded the presence of domestic violence to a greater extent.

The association of domestic violence with SIDE injuries sometimes promoted confusion in child protection case management. The safety needs of injured children could be misjudged by virtue of a professional belief that domestic violence inherently involves the

unidirectional physical and psychological victimisation of ingenuous women by habitually persecutory and violent men. We do not suggest that this is not an actual domestic violence scenario. At least four of the twelve cases in the assessment sample where domestic violence was an identified significant factor were predominantly of this nature. SIDE injuries in this context occur either by direct male attacks on the baby as well as the mother, or by the baby being injured during an attack on the mother.

However, other cases illustrate that there are different contexts of domestic violence where SIDE events occur which involve female violence. On occasions there was inadequate professional recognition and understanding that women can and do initiate serious violence to their children – SIDEs occurring in single parent (mother) families being the most obvious example of this. A number of cases revealed aggressive behaviour of mothers in relationships with partners where both initiated assaults and retaliated violently. Several mothers had had serial mutually aggressive relationships with men who had established violent reputations.

In domestic violence contexts, one child protection error is to assume that the child will be safe if the male partner is persuaded or forced to leave. Undoubtedly this is an appropriate short-term solution in certain situations. However, some of these cases highlight that adult conflicts can continue and escalate during separations, and that in these circumstances a child can become the focus of violent maternal anger. Three examples illustrate this:

■ *A ten-week-old baby sustained multiple rib fractures while in the sole care of his mother. Father (we will call him Dave) had recently left the home to live with another woman. In the days before the injury, mother remarked to a social worker: “I’ll show Dave...”*

■ *A suffocation incident occurred in a domestic violence context when the child protection system had wrongly assumed that the baby would be safe with mother following father’s temporary departure.*

■ *A baby of four months had suffered brain damage from being shaken. In one of the rare cases where an explicit self-implicating explanation emerged the mother said during an assessment interview: “(Partner’s name) told me to “fuck off”. I think a lot of him and it hurt me so I took it out on the baby.”*

In at least three cases we were struck by the possibility of mothers deriving degrees of covert gratification from violent atmospheres, acts and threats. With one couple, it was difficult not to visualise them as a ‘Bonnie and Clyde’ combination, with the mother encouraging and taking satisfaction (and sub-cultural status) from her partner’s high level of violent activity in the community and his very threatening and violent behaviour to child protection workers. When the focus of his violence, she complained little and denied any abuse. The repeated separations and reconciliations of another couple (where the mother acknowledged she was the primary instigator of violence) hinted at an emotional (and perhaps sexual) self-reinforcing arousal cycle. It is very rare to get access to such potential underlying dynamics in the context of child protection interventions (although it is not uncommon in general therapeutic work with some adults).

In the fatal sample it was also notable that serious domestic violence involved mutually provocative and retaliatory behaviour by both parents, including repeated separations and reconciliations. These reconciliations are often mystifying and dismaying to child protection workers when they have invested considerable commitment and resources in attempting to assist mothers to separate from violent partners and to establish themselves as single parents. For children, it results in highly disturbed lifestyles and confused attachments in unpredictable violent environments to which, sometimes, social workers appear to have become resigned or desensitised.

As we become more speculative in our attempts to understand the varied nature of the

domestic violence relationships of the parents in the samples, it is clear that more research is needed to understand this phenomenon more clearly. Generally, research on domestic violence (see Tomison, 2000 for a thorough review) tends to ignore the type of situation where women have a central role in either initiating, reciprocating or escalating physical expression of conflict in relationships, although Archer (2000) has recently drawn attention to this. As we have noted, the 'helpless female–aggressive male' scenario can be a limited perspective for fully understanding both how female violent impulses impact on relationships, and how they contribute to the highly disturbed parental relationships that are very significant in many serious child abuse cases. We reiterate our view that an ideologically derived limited perspective on domestic violence can seriously compromise some child protection assessments.

Alcohol/drugs/substance abuse

In the assessment sample, parental abuse of alcohol/drugs/substances was a recorded feature in only 2/21 cases. This is almost certainly an underestimate based on inaccurate client self-reports and under-recording by professionals at the time. In the fatal sample, note was made that abuse of drugs/substances was a feature in 5/17 cases. In three of these, parental drug usage appeared to be incidental to the main circumstances of death. In two, parental drug usage was a significant factor:

■ *A four-week-old baby was found dead in bed by a family friend next to both parents who were deep in heroin-induced sleep. The baby had been born with opiate withdrawal symptoms and had only been home in parents' care for two days following discharge from hospital. Official cause of death was given as Sudden Infant Death Syndrome (SIDS) which seems questionable given the context of major concerns (especially parental drug usage) revealed in the Part 8 enquiry. The Part 8 Review concluded that this death was preventable and social services had failed to act protectively despite expressed medical concerns. The case had been designated as 'child in need'.*

■ *At age four weeks a baby boy was found dead by his parents. Initial post-mortem findings were indicative of cot death. Several weeks later toxicology reports revealed large amounts of heroin and distalgesic in the baby's blood. Both parents were charged with murder and eventually (half-way through trial) pleaded guilty to manslaughter. The baby had been placed on the child protection register at birth in relation to serious pre-natal concerns including parental mental health issues, domestic violence and emotional neglect of two siblings. However, care and development of the baby prior to death was consistently noted to be good throughout regular observations, and agencies had no knowledge or suspicion of parental use of non-prescribed drugs.*

The recorded incidence of drugs/substance abuse in the combined samples was 7/38 (18%). We suspect that this does not fully recognise the significance of this factor in many cases of serious and fatal child abuse because of specific enquiries not being made, inaccurate parental self-reports, and lack of recording. Effects of substance misuse relevant to child welfare and abuse can include:

- parental disinhibition and poor impulse control (e.g. poor tolerance of frustration, violent outbursts);
- distorted parental perceptions and cognitions (e.g. lack of awareness of impact on child, lack of empathy);
- parental mood dysfunction/swings (ranging across depression, agitation, panic, manic to euphoria);
- impact on parental memory (e.g. poor recall of behaviour and events – including violence – when intoxicated);
- parental preoccupation with immediate adult needs (e.g. lack of attention to child's needs and routine);

- inadequate supervision of child (e.g. child left alone, supervised by unsuitable others, or parent(s) unconscious);
- parental preoccupation and dependence on drug/alcohol sub-culture (e.g. exposure of child to disinhibited, disturbed and criminal behaviour of a range of adults);
- dangerous criminal activity and high-risk prostitution to obtain money for supplies;
- degeneration of parental self-care which affects care of child and household;
- deliberate or accidental ingestion of parents' drugs by child (e.g. through lack of supervision or intentionally administered to subdue the demands of the child).

Much of this behaviour and its effects can be concealed from child protection workers. The plausibility of parental denials of the extent and effects of their substance misuse can contrast markedly with reality. This is a very difficult issue to assess from a child protection standpoint. Children of many parents who use, and misuse, substances do not come to great harm. Substance misuse in itself does not accurately predict serious child abuse. However, when it is known to have been a factor in previous abuse, it must be taken very seriously as a potential indicator of risk of recurrence.

In chapter 4 we review the child protection system responses to these complex fatal and non-fatal SIDE cases.

4 Child protection system responses

The cases in the assessment sample occurred over a time period from 1986 to 2000; and those in the fatal sample between 1994 and 2001. During these periods there were several major developments in child care law and government guidance regarding inter-agency child protection work. Of particular significance were the implementation of the assessment guidelines known as the ‘*Orange Book*’ (DoH, 1988a), the *Children Act, 1989* (implemented in 1991), successive versions of ‘*Working Together*’ (1988b, 1991 & 1999); and developments in local Area Child Protection Committee (ACPC) *Child Protection Procedures*. The effect of these legislative changes and guidance amendments was to produce significant changes to the style and context of inter-agency child protection practice across all functions of investigation, assessment, monitoring and prevention. As we shall note further in Chapter 7, such changes reflect the continual tension inherent in the parallel social policy intentions of providing services that *both* protect children *and* support families.

Each particular child protection era is significant in relation to our analysis of responses to SIDE cases. For example, management of SIDE cases was very different before and after the Children Act, 1989 (see Speight and Wynne, 2000 for a critical commentary on the impact of this change). Prior to the implementation of the Act in 1991, virtually all such cases (certainly in the areas from which our sample has been drawn) were quickly made subject to civil court proceedings, usually via wardship. Post-1991, under the influence of the Children Act and subsequent government guidance (stemming from *Messages from Research* in 1995) promoting the need for a “lighter touch”, it became typical for a time for case management to be led by social services outside of any court arena. In this context the problematic dichotomy of social services categorising referred children as being *either* ‘in need’ or ‘at risk’ also developed.

It is the misfortune of human services (and perhaps social work in particular) that the positive outcomes of effective protective and preventive work have far less impact on public impressions of services than cases with adverse outcomes. Case studies of inadequate interventions and very poor outcomes are always more graphic than those with appropriate interventions and good outcomes. This is particularly so in relation to preventive work, where good outcomes mean that nothing happens! The next sentence is emboldened as we wish to make the point strongly that: **Although it is impossible to ‘prove’, it is our view that several children in the assessment sample are alive today who otherwise would not be if alert and skilled social services, police and health professionals had not intervened in diligent ways.**

The assessment sample included cases where there had been excellent child protection practice by individuals and the whole local inter-agency child protection system. Effective practice included combinations of:

- systematic attention to immediate safety needs of the injured baby;
- subjecting parental explanations to thorough scrutiny in an open-minded way;
- following child protection procedures;
- respecting opinions of specialist colleagues;
- establishing neutral yet supportive relationships with parents;

- commissioning independent assessments;
- involvement of civil court proceedings for judicial endorsement of child protection plans following assessment.

Yet there have been no headlines in mass circulation newspapers exclaiming: “*Social Services Prevented Fatal Child Abuse*” or “*Child Protection Workers Spotted Risks, Communicated Well, Effectively Helped Child and Family, And Now All Is Well*”. As we have said, case examples of good practice and ‘success’ are rarely gripping, nor do they remain in individual or social consciousness as long as images and emotions related to ‘failures’.

Notwithstanding this, there are a number of areas of problematic practice which require comment. Our hope is that in doing so, this research will draw professional attention to key issues associated with child protection failures so that their incidence and adverse outcomes can be minimised.

Inadequate child protection responses

In 13/17 of the fatal cases, the baby had died prior to the child protection system formally becoming involved with the family. The equivalent figure for the 18 applicable cases in the assessment sample at the time of the first SIDE injury was 11/18. This signifies that serious and fatal abuse to babies, on occasions, can erupt ‘out of the blue’ in families where there have been few or no previously recorded relevant significant concerns. However, in all but two of the 13 Part 8 Review cases, the reports stated (or intimated) that the level of concerns known to professionals **should have led** to child protection procedures being invoked to assess the safety needs of the children prior to the fatal incidents. In some situations, a quite inappropriate level of professional tolerance of observed harm or threat to babies/infants without child protection interventions being triggered was apparent.

In these contexts, it is not surprising (given the purpose of Part 8 Reviews) that the analysis of the fatal sample identified problematic child protection system case management involving inadequate implementation of procedures and poor professional judgements. It was unusual for a Part 8 Review to conclude that local child protection procedures were at fault. Instead, it was the failure to implement basic well-established procedures by professionals from all agencies that was repeatedly highlighted as being the significant factor in relation to deaths that were considered to be preventable.

The major failings in professional judgements identified by the Part 8 Reviews involved the absence of appropriate assessment of situations of concern, and the practice of social services in categorising contexts of serious concern as ‘child in need’ rather than ‘child at risk’. Absent or inadequate assessment was mentioned or apparent in 9/17 of the fatal cases. It is clear that in some social services offices ‘child in need’ referrals did not receive a priority response – if indeed, they received any response at all. We hope that the implementation of the new *Assessment Framework* (Department of Health, 2000) will end this artificial and inappropriate dichotomous categorisation: identification of needs does not allay risks.

Deaths in the context of serious child care concerns

Six out of 17 fatal cases involved deaths that occurred in the context of already identified serious child care concerns.

One young mother had been in care as a child with a very disturbed childhood and adolescence including suicide attempts and cutting herself. An unwanted pregnancy occurred shortly after leaving care aged 16. She booked a termination of pregnancy then withdrew from this. She called social

services twice during pregnancy asking them to look after her baby when born. A high post-natal depression score was associated with immediate concerns (including repeated episodes of apnoea – temporary cessation of breathing) about the care of baby. Referrals from health professionals to social services were responded to by a letter to the mother from social services asking if she wanted any help (this with a young woman who was known to have antagonistic feelings about social services following her own experiences in care). At the age of eight months the final reported apnoea episode proved fatal. The Part 8 Review noted major SSD and Health failings regarding assessment, support and protection. Specifically, it was concluded that there were a significant number of events and concerns during the baby's life that should have triggered formal child in need and/or child protection assessments.

Another case reflected similar frustrations felt by health professionals in trying to get social services to treat their concerns with sufficient seriousness:

The known background was that the mother had a disturbed childhood in care, becoming involved in drugs and prostitution. She was convicted of a violent offence and gave birth to her first child in prison. The baby is recorded to have died from cot death aged ten weeks. She lived with the father of her second baby in circumstances that gave rise to significant concerns for health professionals (unsanitary home conditions and presence of dangerous pets). Serious reported incidents of concern (such as a member of the public calling the police having observed the father kicking the pram over, resulting in the baby falling out) were not responded to with child protection enquiries. Attempts to get social services actively involved were unsuccessful. The baby died shortly afterwards, aged seven weeks, from injuries to heart and chest. The father stated to police that he had tripped and fallen over the family dog and landed with the full weight of his knee into the chest of the baby who was lying on the floor.

However one interprets the plausibility of this explanation of the fatal events, post-mortem examination revealed an extensive number of fractures to the baby's ribs caused at varying dates from the injuries that caused death. Both parents were acquitted of child cruelty and the father was acquitted of murder. In accordance with the rules of evidence in criminal proceedings, it is likely that the jury would not have been aware of the context of concerns and the other suspicious injuries to the baby. Findings were, however, subsequently made against the parents in civil proceedings relating to a surviving sibling.

One significant factor regarding these cases and others like them, was that on a number of occasions, in response to referrals expressing acute concern, babies were formally classified by social services as 'children in need' (not requiring a formal inter-agency coordinated plan), rather than as 'at risk'. From one perspective it could be argued that social services were attempting to put into operation the government policy of a 'lighter touch' (stemming from *Messages from Research*, DoH, 1995), notwithstanding how manifest the risks to the babies appear to be in retrospect. Consequently, this could be framed as well-intentioned attempts to work in partnership with parents, using minimal levels of intervention, while offering family support.

However, in respect of these particular Part 8 Review cases, this interpretation is not convincing. Designations of referrals as 'children in need' seemed to be pragmatic resource-saving 'no further action' disposals. The reasons for this are difficult to discern in individual cases, but are likely to include professional rationalisation based on the impact of the strong 'steer' from *Messages from Research*. Also, parlous social services organisation factors (such as those graphically illustrated in the 2002 Laming Inquiry into the death of Victoria Climbié) including continual reorganisations, high vacancy rates and turnover of social work staff, poor supervision, inadequate management oversight and staff support are likely to have been significant contributory factors in some of the cases.

As noted, some referrals indicating high risk (but designated as ‘child in need’) received no further action. Others were responded to by letters from social services to parents (in one case illiterate parents) advising them to contact the Department if they required advice or assistance. This is a particularly inappropriate response in cases where concerns have been expressed about a child. From the perspective of social services, it may demonstrate that the information received about the concerns has not been ignored. But putting the ball in the parents’ court in this way is a gesture that is predominantly indicative of inadequate resources and agency self-protection. To offer parents ‘support and advice’ by letter when serious concerns have been expressed about the welfare of their children (and to close the case when there is no response) is not effective child protection.

In effect, ‘child in need’ designations virtually guaranteed that no assessment of the child or family would occur, and may have falsely reassured other professionals (particularly Health) that the welfare of the child about which they had expressed concerns would be looked into.

Health management and misjudgements

In almost half of the Part 8 Review cases (7/17), serious pre-natal concerns had been recorded regarding the future care of the baby once born. Reports indicated that levels of concern in these cases often evaporated inappropriately as responsibility continually shifted between different professionals at different stages.

Inadequate health service and medical management was a feature in 7/17 cases. All of the fatally abused babies had been subject to normal health service screening, although there were several occasions when this was noted to have been less than adequate. Medical examinations may be routine, or requested because a baby is ‘off colour’, not sleeping, feeding poorly, or is ‘whingey’. In such circumstances, experienced GPs, health visitors and even paediatricians may not detect (or suspect) underlying abuse-related injuries, even when it later becomes apparent that babies were already seriously injured at the times of these examinations. In 4/17 cases, it was evident from post-mortem reports that the deceased baby had a range of older serious injuries that must have been present during routine health contacts and medical examinations in the period before death. These post-mortems revealed old (healing) rib fractures, skull fractures, limb fractures and brain damage due to subdural haematoma.

It is well known that serious injuries can have occurred without any marks on the child being apparent. For example, Krugman (1985) noted that in a sample of 24 infant fatalities, 10/16 with abuse-related brain damage had no visible external signs of injury. Consequently, some of the review cases correctly noted that it was virtually impossible to detect underlying child abuse in the course of such examinations. Others, however, concluded that the contextual concerns were so serious, and the distress of the baby so apparent, that further urgent medical examinations in relation to the possibility of child abuse should have been undertaken.

One example of this was the erroneous judgement of a consultant paediatrician which was identified as being a very significant factor in relation to the death of a baby. At the age of 11 weeks (having been home from hospital for just two weeks) the baby was admitted to the paediatric unit with a history of vomiting, being ‘whingey’, high-pitched crying, diarrhoea and a bruised cheek. The mother indicated to hospital staff at the time her concern that the father may have caused bruises while winding or bathing the baby. Crucially, the paediatrician misunderstood the opinion of a consultant haematologist in a phone conversation. As a result of this, the paediatrician believed wrongly that the bruising was due to a blood disorder and immediately discharged the baby home without consultation with any other professional colleagues. Less than three months later the baby was fatally re-abused.

In addition to concerns about medical failures to recognise abuse, another factor (notable in 7/17 of the Part 8 Review reports) was of *poor medical management* of children where child abuse was suspected. In one case, an abused baby was simply discharged home from hospital by mistake (and was subsequently fatally re-injured). In another, parental behaviour and capabilities were significantly adversely affected by medical condoning and facilitating the chronic misuse of prescribed medication.

Child protection assessments

There can be few more demanding tasks in the field of human services than that of undertaking initial investigations into the circumstances of babies who have sustained serious physical injuries; or assessments of new babies in families where a previous child has died in SIDE circumstances. Enquiries take place in highly charged atmospheres, as parents, other family members and professionals alike attempt to understand what has happened, and what are the necessary and appropriate next steps. Babies who have been seriously harmed will be admitted to hospital. In addition, urgent decisions will need to be taken in relation to assessment of the safety of any siblings. This is also the case for siblings of babies who have suddenly died in circumstances where abuse is a possible factor.

In several cases it was evident that initial assessments did not sufficiently and systematically consider the immediate safety needs of the injured babies. Individual and collective judgements of professionals at this stage were inconsistent. Although the official onus is on ‘working together’ – in reality this involves the challenging expectation that professionals from different disciplines with wide degrees of knowledge, experience and beliefs (not to mention personality and status differentials) will somehow interpret immediate risks to injured babies in similar ways. While this can and does happen (and there are several examples in our assessment sample of this nature), it is also clear that unfortunate combinations of inter-agency miscommunication, role confusion, differences of opinion, unilateral actions (and inactions) can arise.

Absent or conflicting explanations for SIDEs (with varying degrees of plausibility) present very difficult dilemmas for professionals in child protection systems. By definition, the assessment challenge occurs in a context where significant information is missing. Either there are no explanations offered – or explanations emerge involving descriptions of accidents, misdiagnosed illnesses, self-infliction of injuries, or accusations against others. In four cases in the assessment sample, significant disputes between doctors occurred as to whether parental explanations/hypotheses of the cause of injuries were plausible. In three of these cases, parents’ solicitors and Guardians ad Litem appeared to ‘shop around’ until they were able to find a doctor who was willing to give credence to an unlikely parental explanation, or to provide a controversial medical explanation. Indeed, certain doctors had a national reputation for this practice as ‘hired guns’ – and one appeared in two cases in this sample.

One of the key child protection tasks following a suspicious serious injury to a child is to attempt to estimate the risk of further injuries if the child is returned to the parents/carers thought to be responsible. This is particularly challenging in SIDE cases where doubts remain regarding the cause of the injuries or exactly who was responsible. There is considerable professional uncertainty and inconsistent practice in this area. Most pertinently, in some cases babies/infants *were* returned home explicitly because there was no further clarification of how the injuries had occurred. In other essentially similar cases, babies/infants *were not* returned home explicitly because there was no further clarification of how the injuries had occurred. Application of this contradictory principle was apparent throughout case conference decisions, Guardian ad Litem recommendations, and court judgements.

Legal systems contributed to difficulties in effective resolution of complex and contentious cases. One problem involved delays in sufficient court time being available to hear cases. This was a significant factor in two fatalities. In one, a court had declined to hear a contested application for an Interim Care Order following the birth of a baby about whom there were serious pre-natal concerns. By the time the court was able to schedule a hearing, the baby was dead. Judicial decisions were also not immune from being inconsistent and occasionally bewildering. In one case, two judges hearing the same case in sequence gave contradictory rulings about the seriousness of risk. The second judge overruled the first, and refused to make a Care Order on an infant who subsequently died in suspicious circumstances with clear physical signs of further chronic abuse.

The role of solicitors was also a significant factor. There can be a major chance element regarding whether parents are represented by a solicitor whose preferred strategy is to aggressively challenge the child protection system; or by one who attempts to influence it in a more conciliatory and diplomatic way. (Both of these styles can be seen to have advantages and disadvantages). Solicitors also have an idiosyncratic impact. In one case, a single mother became much less committed to an assessment following a change in solicitor. Exploring the reasons for this, it became clear that her new solicitor had introduced her to the evangelical church that he attended. Subject to this influence, the mother took the view (for a time) that the assessment was now irrelevant, as God would protect her children from her in the future. (We would add that idiosyncratic influences apply across all professional groups).

Other legal system issues related to the role and influence of Guardians ad Litem (GAL). The quality of the work of GALs varied considerably, reflecting (at the time these cases were current) their self-managed professional status. In some cases, the GAL influence was very positive, particularly in facilitating assessment services, and challenging where social services had prematurely adopted a very pessimistic view regarding parents' ability to change. In contrast, on other occasions, the GAL impacted negatively on child protection processes and outcomes. This was most notably so when the GAL took on the role of single-mindedly advocating for parents. GALs have now been integrated into the new CAFCASS agency, and, it is argued, this will result in more consistent standards and greater accountability (Poyser, 2001). Many GALs believe the opposite: that this will reduce their effectiveness in independently promoting the best interests of children.

Family-Child Protection System dynamics

The relationship between families and child protection systems takes different forms and can change over time. The degree of openness and consistency within family and professional systems varies considerably. How open, consistent and trusting are professionals with families – and what influences this? Also, what influences families' perceptions of how reliable and trustworthy professionals can be? Clearly, some professionals view some parents/families as being inconsistent, uncooperative, unreasonable, unpredictable, unreliable, divided, devious, deceitful and manipulative. (And, it has to be said, some parents have exactly the same view of child protection professionals.) However, even when such professional perspectives of parents have some reality base, they are not *necessarily* indicative of high risk or poor prognosis. The extent to which they are specifically contextually based, and the capacity for them to change and become sufficiently stable to allow child safety have to be carefully assessed.

Consequently it is important that families are not stereotyped or outcomes predicted on the basis of what may be very context-specific attitudes and behaviour. For example, hostility, lability, confusion or passivity may equally be reactions of a parent wrongly accused of child abuse who has become ensnared in the perceived nightmare of child protection services, as they can be of a parent who is determinedly lying by denying that

abuse has occurred. On the other hand, analysis of examples of extreme cases (e.g. samples of public inquiries and Part 8 Reviews) shows the extent to which some parents can hide the truth and successfully mislead entire professional groups (Munro, 1999; Reder, Duncan & Gray, 1993; Reder & Duncan, 1999).

Some parents view some professionals in very negative ways. While child protection workers must anticipate a range of emotional parental reactions, families have the right to expect that the professionals they encounter will be respectful, competent, consistent, transparent, and well informed. This is by no means always the case. Child protection workers (as with professionals in all fields) have their fair share of personality variations and stress responses that can affect clients' perceptions of their competence, humanity and humility. Child protection systems as a whole are also idiosyncratic. Like any complex group process, they develop inconsistencies, internal conflicts, hidden agendas, biases—compounded in many areas by the chronically undermining impact of seriously inadequate resources.

Partnership, passivity, compromises and conflicts

In retrospectively tracking child protection case management we noted four types of relationships between families and child protection systems. These manifested predominant characteristics of partnership, passivity, compromise and conflict. Each process affected the potential for effective collaborative working and illustrated a different pathway toward eventual case closure.

Effective partnerships

In their study of the operation of a number of child protection systems, Farmer & Owen (1995) noted that effective understanding and partnership between parents and professionals was most likely to occur when there was no disagreement about the cause of injuries and who was responsible. By definition, these criteria do not apply in SIDE situations. Nevertheless, there were examples where characteristics of consistency and transparency became mutually apparent in the relationship between families and child protection agencies.

There were several illustrations of excellent practice by local authority social workers in facilitating highly effective partnerships with family members. To achieve this requires considerable professional skill and reflective personal qualities. This partnership always involved the social worker commissioning services that made a significant contribution to helping parents with their own problems. Attending to parents' own needs was noted as a key factor in successful outcomes by Farmer & Owen (1995). It goes without saying that this requires a good level of local resources. Successful partnerships between parents and social services are less likely to develop when resources are scarce, and where social services are not perceived as being a valuable conduit to other effective services.

It is notable that (notwithstanding efforts) such effective partnerships did not occur to any great extent with any of the families where the person considered most likely to have caused the injuries remained in the household where the injuries occurred. In contrast, with the departure of this significant person, it was often possible for the other parent and extended family to work openly and consistently with the key agencies in assessments. Change in family composition following injury incidents and consequent child protection system intervention is not uncommon: other research has noted that a high proportion of such parenting relationships did not survive over a two-year period (Cleaver & Freeman, 1995).

Passivity

Some parents/carers demonstrated little ability or motivation to have an influence on the child protection system process. What are the psychological underpinnings of apparently non-distressed enigmatic personalities that are particularly characteristic of some mothers in these cases? Such presentations can be difficult to interpret and need to be carefully assessed. We raise a number of questions about this:

- Does passivity indicate a temporary psychological state of confusion and helplessness in the face of sudden disorientating events? Shock reactions need to be taken into account.
- Is this passivity a strategic superficial form of cooperation – attending without communicating anything significant – so that reports will say that all sessions were attended?
- Are these mothers still effectively in a relationship with the previous male partner (while pretending to the child protection system that they are now separated)?
- Is the previous male partner continuing to control the woman's non-responsiveness from a distance through intimidation?
- Is passivity a form of communication that indicates parental recognition of their emotional rejection of the child – or their poor prospects of coping with parenting adequately and consistently?
- Does passivity reflect detachment or despair as a consequence of the fundamental power imbalance between parents and the 'system' – for families that are often already the most disadvantaged in terms of all forms of resources (intellectual, social, financial and extended family support)?

Parents who, for whatever reasons, respond passively to the child protection system seem less likely to eventually have their children returned than parents who 'fight' or challenge the system. A social class element does seem to be a factor. In situations where babies received very similar injuries, we noted different child protection processes and outcomes between middle-class families who had the resources and resilience to challenge the child protection system (via obtaining second opinions, independent assessments or well-articulated complaints), as opposed to poorer families without such resources and motivation. It can appear on occasions that working-class parents have to give more convincing explanations than middle-class parents for injuries to achieve the same outcomes.

Middle-class parents also demonstrated another significant advantage in that they were invariably able to negotiate/demand far higher levels of contact with their child in care than were working class parents. On occasions this could be a striking differential. In one middle-class case, a court ordered extensive daily contact between parents and their child who was in a foster placement. In contrast, in a concurrent case, a very poor, learning disabled, single mother who suffered from epilepsy, was only allowed brief contact once a week.

As well as being intrinsically inconsistent and unfair, great variations in levels of contact in SIDE cases can have a major bearing on outcomes. With high levels of contact maintained, it becomes far more difficult for the child protection system to recommend permanent separation on the basis of continued risk, as the counter-argument of damage to sustained attachments can be made forcefully. On the other hand, when contact has been set at low levels during the child protection assessment process, parental attachments can be construed as having already been weakened, making permanent separation a more justifiable course of action.

Compromises

Child protection processes characterised by compromise involve situations where parents/carers and the 'system' informally endeavour to broker agreements about how injuries may have occurred, and what level of acceptance of responsibility is sufficient for an agreed outcome (invariably the return home of the child) to be reached. In this context we noted that some parents' explanations for injuries tentatively evolved over time in ways that were either a genuine search for the 'truth', or tacit attempts to negotiate plausible 'no blame or consequence' compromises that child protection systems were willing to accept as the basis for the child returning home.

This process resonates with the social work principle of attempting to develop a 'partnership' relationship with parents. We believe that unknown numbers of SIDE cases in general must have been resolved on such a basis with good outcomes – although, unfortunately, there is little published evidence of case studies to confirm this. While worthy in principle, such 'partnership' resolutions can also go badly wrong. Several cases in this study showed clearly that some parents were far more skilled and effective in negotiating the basis of the compromises than were the over-adaptive and sometimes credulous professionals. This had led to some parlous child protection decisions with adverse outcomes (e.g. re-injuries and deaths).

Sustained conflicts

In contrast to the compromise process, contest scenarios involve explicit battles between parents/carers and the child protection system for one version of 'truth' to prevail over another. In atmospheres which generally include significant mistrust, antagonism and hostility, parties (parents, social services, Guardian ad Litem) briefed opposing expert witnesses and prepared for lengthy and costly adversarial court hearings.

This antagonism also intensifies into contests and formal complaints by parents/carers regarding the quality, consistency and appropriateness of the practice of child protection agencies. The complexity of regulations governing each agency's practice in child protection cases provides fertile ground for complaints when procedures are not followed to the letter, and (even minor) decisions are perceived to be unfair. Formal complaints about these matters can consume significant agency resources and distract attention from the main child protection issues. This may apply both when significant malpractice has occurred (as does happen); and also as a challenging retaliatory strategy by vexatious or litigious parents/families.

Sustained conflicts were particularly likely to occur with families (often middle class) where there were few recorded indicators of significant contextual concerns. In the absence of familiar factors of concern, SIDE cases present particularly difficult challenges to child protection systems, and judgements and established processes can go awry. In particular, a marked reluctance on the part of some professionals to query and probe positive (and possibly idealised) self-reports of middle class parents was apparent. This was reflected explicitly in recorded biases about abuse not being possible in such 'nice' and 'normal' families.

For example, in one case where a two-month-old baby had received several fracture injuries of different ages, the Guardian ad Litem (GAL) advocated aggressively for the parents who were described in the GAL report as "normal, hardworking and worthwhile". The report went on to argue that the baby should be returned home, as the "separation was causing distress to the parents". Their distress was undoubtedly genuine, but to allow it predominant status over the safety of a seriously injured baby is suggestive at the least of a questionable child protection perspective.

Perplexingly, in these mostly middle-class homes violent events appeared ‘out of the blue’ to babies/infants who were developing appropriately and seemed well cared for. There is little knowledge about this phenomenon whereby severe injuries occur within a context of otherwise apparently unremarkable personalities and relationships. To what extent is this a particularly well-concealed form of child abuse with explosive personality and relationship factors subsumed beneath a façade of middle-class respectability? Or, are there as yet little known medical explanations for severe injuries that have all the traditional hallmarks of abuse? We shall return to this question in chapter 6.

Difficulties can arise for practitioners in responding constructively to the highly articulate, resourceful and influential characteristics of some of these families. Such families do not expect to become subject to child protection systems interventions. They invariably make very clear their deep resentment of this occurrence. Practitioners may feel great sympathy with the parents, or be intimidated by them. Either way, it can be difficult to achieve and sustain a confident, neutral yet supportive stance without becoming subject to dynamics that promote an over-identification with the parents at one extreme, or mutual antagonism at the other. Consequently, the goal of ‘partnership’ can become problematic and distorted, with child safety needs being ultimately compromised.

In circumstances where the child protection system process has become conflictual and reached a stalemate, independent assessments can be particularly valuable and effective. Independent assessments can help diminish negative emotional intensity and provide opportunities for families to reflect on their situation in a neutral yet supportive environment. In an independent child protection assessment service involving more than 200 cases, there was evidence of an important therapeutic benefit for many parents, helping to promote positive change and sometimes enabling recommendations to be made which all parties were able to accept without losing face. When this occurs, the painful process and significant expense of a lengthy contested court hearing can often be avoided (Dale & Fellows, 1999).

Having focused a great deal on issues related to child protection system problems, it is now timely to remember that ultimately it is parents/carers who have killed and seriously injured the children in the cases reported in this book – not the professionals, who overwhelmingly were doing their best in complex, confused and very uncertain circumstances.

In chapter 5 we present the best information about ‘what really happened?’ in these cases, alongside discussion of outcomes.

5 What really happened, and what happened next?

To what extent is it possible to clarify retrospectively how the injuries and deaths to these children really occurred – and which person(s) was responsible? We have already noted, that as a general rule, very little subsequent information becomes available (at least to child protection agencies) to answer this question. Invariably Part 8 Reviews do not consider this issue, focusing solely on the actions (and inactions) of professionals and agencies. Given that there is little systematically gathered information available from the current structure of formal enquiries into the circumstances of these deaths and serious injuries, we shall offer our own best judgements from the documents we have analysed from both samples as to the tantalising question of responsibility. Table 9 shows our conclusions in relation to responsibility for the injuries/deaths in both samples:

Table 9 Likely responsibility for SIDE deaths and injuries

Researcher's judgements regarding responsibility for SIDE deaths					
	Either or both parents	Natural father	Natural Mother	New male cohabitee	Remains too mysterious to categorise
Assessment sample	7/21 (33%)	3/21 (14%)	7/21 (33%)	2/21 (9.5%)	2/21 (9.5%)
	Total involving natural parent: 17/21 (80%)				
Part 8 Review sample	9/17 (53%)	5/17 (29%)	2/17 (12%)	0	1/17 (6%)
	Total involving natural parent: 16/17 (94%)				
Total sample	16/38 (42%)	8/38 (21%)	9/38 (24%)	2/38 (5%)	3/38 (8%)
	Total involving natural parent: 33/38 (87%)				

There are a number of points to be made from these figures. First, we reiterate the subjective nature of these judgements – although they are based on a systematic review of extensive information and more than 75 accumulated professional practice years between the three authors. The ascriptions to the categories of ‘natural father’, ‘natural mother’ and ‘new male cohabitee’ have been made with some confidence on the basis of known dispositions of cases. Where there is little dispositional information we have ascribed the injuries/deaths to the ‘either or both parents’ category (when it is clear that one or both must have been responsible) and to the ‘mystery’ category when it is not possible to make a judgement with any confidence. For example, in one such case a baby had been cared for by a number of relatives and friends – as well as by parents – in the crucial period within which it was determined that the injuries must have been inflicted.

Merging the categories where we are significantly uncertain who was responsible (e.g. the ‘either or both parents’ and ‘remains mysterious’ cases) shows that responsibility remained uncertain in 9/21 cases (42.5%) in the assessment group, and in 10/17 (59%) in the Part 8 Review group. Across both samples the combined figure is 19/38 (50%). This is the same as found in similar research conducted in the USA (Miller et al., 1999).

Over the two samples, it can be seen from Table 9 that 87% of the injuries and deaths are adjudged (by ourselves as researchers – not judicially) to have been caused by either, or both, natural parents. A step-parent (step-father of male cohabitee) is seen as being

responsible in only 3/38 (8%) of the whole sample. This is a much lower figure than traditional child abuse wisdom would predict, but is in line with recent research that has highlighted the low rate of abuse inflicted on children by step-parents (Cawson et al., 2000; Reder et al., 1993; Levine, et al., 1994).

Bystanding and failure to protect

Returning to the role and responsibilities of parents/carers for the deaths and serious injuries to the children in this research, there is a crucial issue (and one that is not necessarily in accord with recent social work orthodoxy) that needs to be highlighted. This is the role of parents in *bystanding* or *failing to protect* their child when they are aware of another parent ill-treating the child – or in some cases systematically and sadistically abusing the child over a period of time. In much social work thinking, the notions of the ‘abusing’ and ‘non-offending parent’ have become a commonplace distinction. In our view, in the context of these SIDE cases, this can be an artificial dichotomy and a potentially dangerous misconception. The behaviour, attitude and potential roles of each parent/carer require an open-minded and careful assessment focus.

We can note four main scenarios of significant failure to protect:

- Where natural parents together, or separately, ill-treat their babies, inflicting single or sequences of injuries. They deny having done so, and cover up for each other (joint enterprise).
- One parent mistreats a baby, with the knowledge and condonation of the other (vicarious assault).
- One parent mistreats a baby and the other does not take action, despite opportunities, to prevent it recurring (bystanding).
- Failure to seek medical help when a child is known to have been injured and is in pain.

Delayed help-seeking is a characteristic feature of many SIDE cases and is well-reported in the general physical child abuse literature (e.g. Krugman, 1985). A fairly graphic example of not seeking medical help was outlined in one Part 8 Review case. Police interviews with a father noted his account of the events:

“...He said he was angry and shook the child three times. During the third shake, Mr X stated that his son went limp and his breathing became unusual: “He made this groaning noise. It sounded like he was in pain. I didn’t do nothing about it...” Mr X went on to say that he had checked the baby every 45 minutes and that he was fitting at those times. He took no action, considering that it was more important to get the decorating finished...”

In another fatal case it was believed strongly in the child protection system that the mother had regularly abused the child. Following the death, on viewing the body, the father was overheard by a coroner’s officer to say: *“I knew you had it coming son...”*

The dynamics of vicarious assaults, bystanding and delayed seeking of medical assistance in cases of fatal and non-fatal SIDEs (and the reluctance of some professionals to accept their significance) are issues that need to be carefully considered by all professionals involved in child protection assessments. Failing to protect has been described throughout much of the child abuse literature of the last 30 years, including in some detail by one of the present authors from a previous sample of 26 children nearly two decades ago (Dale et al., 1986). However, the psychology of the ‘failing to protect’ parent is poorly understood and requires further research. This behaviour, its implications and susceptibility to change are fundamental features of child protection assessment in SIDE cases.

Reunification and re-injuries

Systematically gathered long-term follow-up data specifically about SIDE cases is virtually non-existent. Outcome evaluations of case management from clinical specialist treatment centres indicate that over time, varying proportions of seriously abused children are returned home. Reported reunification rates include: 95 % (Baher et al., 1976); 88 % (Lynch and Roberts, 1982); 65 % (Dale et al., 1986) and 52 % (Miller et al., 1999). Unfortunately none of these samples was subject to extended follow up, so that rates of re-injury and general welfare outcomes over a long period of time are not known.

Recent research has more systematically evaluated re-abuse outcomes from general child protection system case management. These findings (incorporated in the *'Messages from Research'* conclusions) indicate that between one-third and one-quarter of children were known to have been re-abused after they had come to the notice of child protection agencies (Cleaver & Freeman, 1995; Farmer & Owen, 1995; Gibbons et al., 1995). (Follow up periods ranged from 20 months to ten years). These studies also noted that when re-injuries did occur, the proportion that were severe was very low.

In Table 10 we provide known outcomes information from the assessment sample. A proviso regarding this data is that it has not been gathered through a formal follow-up procedure. Rather, it represents the outcomes that became known over time (sometimes long periods of time) to the clinical service. (However, all re-referrals into the child protection system would have been automatically notified to the service.)

Table 10 Known outcomes from the assessment sample

Case ref	No reunification following index SIDE	New child assessment	Reunification with same parents/carer	Reunification with one parent or extended family	Re-injury?	Permanent separation following re-injury?
206			x		moderate	No
53			x		serious	No
9				x	None known	NA
51			x		fatal	No (sibling)
44				x	None known	NA
56			x		serious	No
11	x				NA	NA
2			x		moderate	Yes
108			x		None known	NA
13				x	None known	NA
7			x		None known	NA
43			x		None known	NA
74				x	None known	NA
114				x	moderate	No
61				x	Serious (subsequent sibling)	Not known
69				x	None known	NA
193	x				NA	NA
	2/17		8/17	7/17		
			Total reunification 15/17			
			Re-injury 5/8	Re-injury 2/7	7/15	2/7
			Total re-injury 7/15			

From these figures a number of summary statements can be made:

■ In 15/17 cases, the children were reunified with some combination of family members. Just over half (8/15) were returned to the same parental combinations as at the time of the injuries. An almost equal proportion (7/15) returned to a household which had changed by the departure of a parent/carer; or to stay with close relatives.

■ In only 2/17 cases was the injured child permanently separated from parents/carers and extended family.

■ Re-injuries occurred in seven of the 15 cases where children were reunified with parents/carers/extended family. This happened to a greater extent when children returned to homes with the same combination of parents/carers as at the time of the original injuries (5/8 cases). Reunification with changed parenting arrangements resulted in a lesser number of known re-injuries (2/7 cases).

■ The extent and severity of re-injuries was mixed. One child died (cause of death officially recorded as natural, but body badly bruised and neglected). Three children sustained further bone fractures; and a further three significant bruising.

■ In only two cases (to our knowledge) did any of the reunifications end on child protection grounds. One child who had been returned to a single natural mother was permanently separated following a re-injury of moderate severity. A subsequently born sibling was seriously injured in another family where a child had been returned to a changed household. (In a third case, a mother who had had her three children returned to her care, subsequently voluntarily placed two of them for adoption.)

In four cases, the child protection task was related to assessment of unborn or new babies where there were histories of serious and fatal SIDes with previous children. The outcomes of these cases can be seen in Table 11:

Table 11 Child protection outcomes with unborn/new babies given previous SIDes

Case ref	New child assessments	Removal at birth prior to assessment	Reunification	Permanent separation	Re-injury?	Permanent separation following re-injury?
1	x	x	x		Serious (to subsequent sibling)	No
46	x	Residential assessment	x		None known	NA
81	x	x	x		None known	NA
57	x	x		x	NA	NA

Three out of four of these cases involved the removal of the baby from the mother at birth on the basis of an emergency court order. In one of these cases this was only effected after the parents were caught by the police, having absconded from the hospital with the baby shortly after giving birth. In one case, the child was already nine months old at the time it was learnt that the father had been implicated in the death of a previous baby elsewhere in the country. In this case, a residential placement was obtained, thus preventing the detrimental impact of separating the baby from her mother.

The outcomes of these four cases were that three of the children were reunified at some

stage with their natural parents (two cases) and single mother (one case). In the other case (the absconding parents) the baby was placed for adoption. Re-injuries are known to have occurred in one of these cases: a subsequent sibling to the baby of the single mother sustained a SIDE injury several years later.

In the assessment sample as a whole, a substantial proportion (18/21) of the children were returned home. In comparison, a study in the USA of SIDE-type situations found that 52% (of 30 injured infants) had been returned to their carer (Miller et al., 1999). While some of these were infants who returned into circumstances that clearly caused the researchers considerable alarm, only one child was known to have suffered another serious injury post-reunification at nine-month follow-up.

These figures should not be used as the basis for supporting recommendations about future risk or reunification in any individual case. Both samples are small, and have less than ideal follow-up information. They are also context specific. It is clear in the American study that significant psychotherapeutic and parent education resources were offered to the parents involved. In our assessment sample, most of the cases had arisen in areas that (at the time) were well resourced in terms of the quality and variety of assessment, therapeutic and family support services. Also, generally speaking (there were a few exceptions) the culture of inter-agency child protection case management was to allow sufficient time for parents to derive benefit from the therapeutic opportunities that independent assessments offered.

In any interpretation of the figures we have presented for reunification and re-injury from this assessment sample, these factors relating to service context must be taken into account. We have wondered, on many occasions, what the outcomes would have been for many of these children and families if, by chance, they had been living in areas of the country with far fewer resources.

Even in systems with relatively favourable resources, risk assessment is an uncertain and inexact science. In the following chapters 6, 7 and 8, we place the findings reported so far into a broader theoretical and practice context.

6 Abuse and non-abuse explanations

In this book so far we have reviewed issues that have arisen from a study of 38 families where infants have been subject to suspicious fatal or non-fatal injuries, and where parent/carer explanations have not been in accord with professional opinions regarding the cause of the injuries. For convenience we have referred to these types of cases by the acronym SIDE (serious injuries with discrepant explanations).

In this chapter, and chapters 7 and 8, we place some of the key findings about injuries, explanations and outcomes into a wider theoretical and research context. In particular, we explore material relating to:

- medical diagnostic factors for physical abuse;
- non-abuse explanations for serious injuries;
- principles of evidence-based assessment practice;
- the social policy challenge to prevent abuse and protect children whilst minimising 'false positive' child protection system interventions into family life.

Medical diagnostic factors for physical abuse

A high proportion of fatal and non-fatal SIDEs occur to an only or youngest child in a family. In such circumstances parents tend to be inexperienced and perhaps unprepared for the incessant demands of babies. However, as the occurrence of serious harm to children in general is very rare in these circumstances, these contextual factors serve better to explain the possible triggering of abuse than its cause.

The cases of serious and fatal injuries with discrepant parent/carer explanations reported in this book highlight the vulnerability of very young babies to severe physical abuse in the first few weeks and months of their lives. Most homicides of children occur in the 0–12 months period. The younger the child, the more likely that the force of an assault will result in more serious injuries. Nine of the 17 deaths in the Part 8 Review group were of infants aged less than three months. In the predominantly non-fatal assessment sample, one-third of cases involved fractures to babies less than three months old; and at least the same proportion suffered serious permanent damage. The extent and severity of injuries in non-fatal SIDE cases seems broadly similar to that evidenced in fatal case reviews where babies have died. Research on child abuse fatalities suggests that relatively few parents who are violent to their babies actually intend to kill (Falkov, 1996; Resnick, 1969; Stroud & Pritchard, 2001; Wilczynski, 1997). Factors of *chance* (also noted by Levine et al., 1993 and Reder & Duncan, 1999) and, in all likelihood, the extent to which babies have been shaken during assaults, play a major part in respect of whether serious abuse proves fatal or not.

One of the key complications in the assessment and child protection case management of SIDEs is that medical diagnosis of abuse or non-abuse can be uncertain and sometimes conflictual. Studies in the USA of Emergency Room (Accident & Emergency) treatment show that accidental injuries do occur on a significant scale to babies and infants. Reece & Sege (2000) determined the accidents-to-abuse ratio to be 81% and 19% respectively. Rivara et al. (1988) reported that three-quarters of presenting injuries were unintentional (accidental) and one-quarter were the result of abuse.

Rivara et al. (1988) also noted important differences between the characteristics and contexts of the two groups: accidental injuries were predominantly single injuries, were less serious, and rarely resulted in permanent disability. A feasible explanation was forthcoming in all cases of accidents. In contrast, the injuries that were considered to be the result of abuse tended to be multiple, much more serious, with a 25% rate of consequent permanent disability. No explanation was forthcoming in 36% of these cases. The authors concluded that unintentional injuries to infants are common and also invariably minor. In contrast, closed head injuries, fractures to ribs and lower extremities and abdominal injuries are suggestive of abuse (Rivara et al., 1988).

International reviews (e.g. American Academy of Pediatrics, 1993; Carty & Ratcliffe, 1995; David, 1999; Wilkins, 1997) also highlight key factors relating to injuries and combinations of injuries that are highly indicative of abuse. Fatal injuries to infants from abuse invariably involve brain damage resulting from impact injuries to the head, shaking, or both. It is common that there are no external observable signs of injury (Krugman, 1985). The classic combination of injuries that is often stated to be a definitive marker of abuse is brain damage, retinal haemorrhages and fractures of skull, ribs or limbs.

Brain damage typically involves two significant types: haemorrhaging and the shearing of nerve connections. Bleeding from the rupture of veins within the different membrane layers covering the brain gives rise to epidural, subdural and subarachnoid haemorrhages. The shearing or swelling of connective nerve endings within the structure of the brain is known as diffuse axonal injury (DAI) and results from abnormal movement of the brain inside the skull as a consequence of rapid rotational acceleration and deceleration motion (such as shaking). David (1999) notes that DAI injuries are particularly significant, as they are probably responsible for immediate effects (unconsciousness) and long-term neurological damage in non-fatal cases.

Retinal haemorrhages involve bleeding that occurs in front of, within, or beneath the retina. It is common for babies to be born with retinal haemorrhages and while most have disappeared by eight days, in some cases they persist for longer (David, 1999). Studies have consistently shown that it is unusual for retinal haemorrhages to be caused by accidental severe head injuries (although there are some recorded exceptions to this). However, retinal haemorrhages are commonly found in infants who have subdural haematomas from impact injuries, and this raises the suspicion that shaking associated with the head injury causes the retinal haemorrhages.

A triad of injuries involving subdural haematoma, diffuse axonal injury and retinal haemorrhages is generally (but not universally) held to be firmly diagnostic of abuse to infants caused by an impact to the head and shaking (especially where there are associated grip-type injuries such as fractured ribs, a fractured long limb used as a 'handle', and finger tip bruising). Opinion is more divided about abuse when subdural haematoma, diffuse axonal injury and retinal haemorrhages have occurred with no external signs of injury.

This scenario has become known as 'Shaken Baby Syndrome' (SBS) which most often affects babies younger than six months of age. Signs and symptoms of SBS are neurological and present on a spectrum from minor to immediate death. Minor symptoms include irritability, poor feeding, lethargy and vomiting. With no external signs of injury, these subtle symptoms can easily be mis-interpreted on medical examination as infant colic or mild viral illnesses (American Academy of Pediatrics, 1993). It has often been noted that babies' crying can be particularly problematic during the 6-week to 4-month age bracket, and that this is also the peak incidence of SBS.

After a shaking incident, parents may put their baby to bed hoping that he/she will recover. However some babies slip into unconsciousness rather than sleep and are later found dead. Otherwise, as brain damage intensifies (due to haemorrhaging and swelling)

emergency help is finally sought when the baby is convulsing or comatose. The outlook for SBS infants is poor, especially when medical attention is delayed. Approximately 60% of babies who are critically ill in this way at the time of medical attention being sought, die or are left with permanent profound disabilities (American Academy of Pediatrics, 1993).

There is an unresolved disagreement between international medical experts as to the severity of impact and the severity of shaking required to cause subdural haematoma and retinal haemorrhages (Wilkins, 1997). Furthermore, a team led by a London neuropathologist has recently reported that non-severe shaking (but still greater than normal events) can cause a cessation of breathing and massive brain swelling that previously has been indistinguishable from the type of brain damage (known as diffuse axonal injury) that is associated with severe shaking (Coghlan & Le Page, 2001; Geddes et al., 2001). The Geddes research is likely to become important in adjudications of future (and appeals regarding past) cases of serious injuries to infants with discrepant explanations.

The seriousness of brain damage caused by shaking has led to “Don’t Shake Your Baby” public information campaigns. However, there is another campaign developing to highlight that in certain cases, the typical SBS combination of injuries may have non-abuse explanations.

Non-abuse explanations

Given the complexities and uncertainties regarding diagnoses of child abuse, it is not surprising that some injuries thought to be a result of abuse can turn out to have non-abuse explanations. Male et al. (2000) reported on three children presenting with possible physical abuse injuries who in fact had a form of rare organic disease. Care proceedings on the grounds of suspected abuse had been initiated on a three-month-old baby with an ‘unexplained’ transverse fracture of his right fibula. Investigation subsequently revealed that this was due to a benign tumour arising from surrounding tissue. Abuse was also initially suspected with a three-year-old girl who had ‘finger-print’ type bruising, until a type of leukaemia was eventually confirmed. In the third case, abuse was suspected with a two-year-old girl who had a two-week history of bruising under her eye, a swollen cheekbone and reluctance to walk. Sadly, the real cause was confirmed as a terminal cancer (Male et al., 2000).

The anguish for parents of being wrongly accused of child abuse through being unable to explain injuries in these circumstances is difficult to imagine.

Leventhal (2000) discussed the challenge of diagnosing child abuse when a child has a medical condition such as demineralised bones or abnormal blood clotting. Are the fractures/bruising due to the underlying condition, abuse, or a combination of both? Leventhal, a Professor of Paediatrics with substantial experience of child abuse diagnoses, stressed that unusual events do happen to children. He gave an example of a five-month-old baby with two skull fractures indicative of two separate impacts. The baby’s mother could only explain one incident – the baby falling from the settee. Child protection enquiries began, and later the elder sister revealed that she had dropped the baby – and had not said so before because she was not allowed to hold the baby. Consequently, Leventhal urged: “*Do not automatically disbelieve a history because it seems strange: the child’s injuries may be consistent with this unusual history.*” (Leventhal, 2000 p.144). However, to highlight the complexity of these situations (whilst not doubting the veracity of this particular account), some readers may have had experience of siblings in families being tutored to provide similar **false** explanations. (We shall discuss older children’s explanations of discrepant injuries in a subsequent publication.)

Brittle bone disease (osteogenita imperfecta) is a rare serious condition which causes regular fractures of bones, and affects around 6,000 people in the UK. It has characteristic other signs that makes diagnosis fairly straightforward. The notion that a temporary form of brittle bone disease can cause fractures in babies and infants has been expounded by Dr Colin Paterson (a consultant in biochemical medicine) in many child protection court cases. His belief is that a number of cases of suspected serious non-accidental injuries to babies do not involve abuse, but rather a poorly recognised condition of temporary brittle bones that fades over time during infancy.

In a clinical sample of 128 children referred with fractures over a 21 year period, Paterson reported that of the 65 he diagnosed with temporary brittle bone disease, 48 were returned to their parents. Two subsequently died in circumstances that he does not associate with child abuse. For 43 of the remaining 46 children, Paterson states that his follow-up information over a total of 248 patient years (range from 1 – 11 years, mean 5.8 years) reveals no evidence of any subsequent non-accidental injury. Data in respect of three of these children is not given (Paterson, 1997).

Paterson's views are highly controversial. While not without support (e.g. Miller, 1999) they have attracted significant criticism within the paediatric and judicial community. Methodologically, many questions can be asked about the data, the analysis and conclusions. For example, Dr Paterson was publicly criticised by a High Court Judge for including within his temporary brittle bone research sample cases where judgements have been made in the High Court that the injuries were non-accidental (Wall, 1995). Also, it is not clear how systematically the follow-up data was gathered. If this was largely on the basis of Paterson remaining in contact with parents he had championed in contested court hearings – then the self-reports of these parents regarding no further child abuse concerns could possibly be unreliable without independent verification. Nevertheless Paterson's criticism of the view that *"the failure of parents to come up with an explanation for fractures found radiologically is ipso facto evidence for non-accidental injury"* (Paterson, 1997 p. 648) and by implication non-rehabilitation of the infants concerned is important.

Other challenges are occurring to the prevailing orthodoxy surrounding the precision of diagnosis of Shaken Baby Syndrome from a particular combination of symptoms. A vigorous campaign is underway in the USA, arguing that catastrophic reactions to vaccines (and associated medical mismanagement) is the real cause of severe and fatal brain damage in some cases that have been misdiagnosed as SBS child abuse resulting in serious miscarriages of justice. The argument is that there is growing evidence to indicate that adverse reactions to vaccinations in vulnerable babies can result in brain swelling and bleeding that is indistinguishable from that caused by mechanical injuries (Buttram & Yazbak, undated; Scheibner, 1998).

Parents' perspectives

There is very little research which specifically elucidates the experiences and perspectives of parents who killed or seriously harmed their children, yet who denied being responsible at the time. In contrast, parents and carers who believe that they have been wrongly accused of causing serious, or fatal, injuries to their young children understandably express strong views about erroneous medical opinion and child protection system interventions. Such cases are regularly reported as feature articles in the media.

A study commissioned by the now defunct PAIN organisation (Parents Against Injustice) explored the experiences of 30 families who claimed to have been wrongly accused of child abuse. Prosser (1992) reported in detail on ten of these families, three of which involved child protection system responses to concerns about serious injuries to infants

with discrepant explanations. In each case there was significant disagreement between the opinions of examining doctors. The PAIN research graphically conveys the impact on families of child protection system interventions. Parents described arrogant and insensitive responses of doctors making routine assumptions that abuse must be the cause of the injuries. They were particularly disconcerted by a Kafkaesque scenario presented by social services in which they were required to confess (falsely) to inflicting the injuries to stand any chance of having their children returned.

The overall impression, from the parents' perspective, was of the unfairness (and impossibility) of a system where the onus was firmly upon them to prove their innocence. Ultimately, in 29 of the 30 families, charges were either dropped or courts eventually ruled in the parents' favour. In one case, a medical cause for the injuries that precipitated extended child protection system intervention was eventually discovered (Prosser, 1992).

This highlights the complexity and significance of the issues at stake as practitioners attempt to walk the fine line between protecting children who genuinely urgently require it, while not damaging children and families by intervening unnecessarily or inappropriately. While this raises key technical issues of assessment and judgement in individual cases, it is also a significant matter of social policy. Given that errors are inevitable in all attempts to predict human behaviour, what proportion of child protection errors in which direction (false positive or false negative identifications) is socially and politically acceptable? We shall return to this issue later.

7 Evidence-based assessment practice

Recent research studies into the processes and outcomes of referrals into child welfare systems (e.g. Farmer & Owen, 1995; Ferguson & O'Reilly, 2001; Gibbons et.al., 1995) have had a significant impact on child protection policy and practice developments. In England and Wales this includes the introduction of new government guidance relating to assessments – the *Framework for the Assessment of Children in Need and their Families* (Department of Health, 2000). The *Assessment Framework* (likely to become known as the 'Lilac Book' in the tradition of its 1988 orange predecessor) provides guidance regarding an ecological approach to be followed in multidisciplinary assessments of children in need. The influence of *Messages From Research* (DoH, 1995) is apparent in that a child potentially at risk of abuse or re-abuse is subsumed within an overarching 'needs' assessment (on the basis of needs for protection).

Many readers will be familiar with the triangular concept central to the *Assessment Framework* which provides three assessment domains of i) Child's Developmental Needs, ii) Parenting Capacity and iii) Family and Environmental Factors. The aim of providing a research-based theoretical perspective for assessments is a welcome advance on the information-hoovering multiple question format in the 'Orange Book'. We support the stated intention that "*the combination of evidence-based practice grounded in knowledge with finely balanced professional judgements is the foundation for effective practice with children and families*" (DoH, 2000, p.16).

However, we have reservations about the general utility by itself of the *Assessment Framework* in certain complex situations. The rationale of the *Assessment Framework* stems predominantly from the collection of studies known as '*Messages From Research*' (which highlighted unnecessary child protection systems interventions rather than attention being paid to child need). In contrast, the body of research which focuses on inadequate child protection system performance in child abuse fatalities (e.g. James, 1994; Munro, 1999; Reder, Duncan & Gray, 1993; Reder & Duncan, 1999; Sanders, Colton & Roberts, 1999; Stroud & Pritchard, 2001) is not currently well integrated into the *Assessment Framework*.

For example, the *Assessment Framework* and its companion Reader *The Child's World* (Horwath, 2000), contain very few specific references to serious physical abuse of babies and infants. In contrast to other overseas frameworks, there is no domain relating to exploring and understanding the circumstances of serious events. Consequently, attention is not drawn to the specific assessment and case management challenges in situations where there are serious injuries to babies with discrepant parent/carer explanations. The technical, ethical, legal and human rights issues involved in the assessment of SIDE cases (to minimise the likelihood of both false positive and false negative identifications) are hardly addressed.

SIDE assessment challenges

As we have reported in this book, one finding from our research is that when attempting to assess safety needs and risks of re-injury in SIDE cases, child protection systems can become confused by the multiplicity of factors which generate contradictory opinions, conflicting plans and heightened emotions. A good deal of assessment practice is problematic. In the fatal sample, assessments were either completely absent or seriously

inadequate. Sometimes, in this context, incomprehensible and contradictory decisions are made. Essentially similar situations are handled in very different ways: we have noted that in one case **a baby was returned home** explicitly because there was no further clarification of how the injuries had occurred. Yet in a very similar case, another baby **was not returned home** expressly because there was no further clarification of how the injuries had occurred.

One explanation for these inconsistent processes and outcomes is the lack of a structured evidence-based assessment protocol to focus judgements of risks of further maltreatment against the possibility of false positive predictions of further harm. As we shall shortly discuss, one of our recommendations from this research is that computerised decision support technology (Sheets, 1996) be developed in relation to child protection case management of SIDEs to complement assessments of need undertaken in accordance with the *Assessment Framework* format.

Apart from the specific difficulties stemming from the uncertain cause of injuries, assessment in SIDE cases is challenging in relation to interpretations of associated factors of concern in families where SIDEs have occurred. The assessment sample revealed two clusters. In approximately three-quarters of families, there were records of high proportions of traditional child abuse indicators. The assessment challenge is to establish to what extent these are contextual (and possibly transitional) factors with predominantly social exclusion-type origins (as in the 'Messages' model). Or, to what extent they represent degrees of deep-rooted individual psychopathology and seriously enmeshed mutually provocative and violent adult relationships, where infants become the focus of explosive and sadistic impulses.

In contrast, approximately one-quarter of the assessment sample registered virtually no traditional child abuse indicators. Yet in circumstances that remain obscure, serious and fatal violence to babies apparently erupted from nowhere. As we have noted, these tend to be middle-class or otherwise apparently stable and resourceful families who assert themselves strongly in challenging the child protection system process. The typical signs are very difficult to interpret. To what extent are the low levels of recorded concerns accurate? Or, are real concerns present but not recorded because of a lack of previous involvement with child welfare agencies? To what extent do major psychological disturbances and relationship problems exist beneath façades of normality and respectability? Or to what extent can the lack of recorded contextual concerns be taken as a supportive indicator in favour of a non-abuse explanation?

Authentic responses of parents who have been mistakenly accused of child abuse (e.g. anger, challenging and lack of cooperation) are largely indistinguishable from defensive behaviour of parents who vigorously, yet untruthfully, deny being responsible for serious abuse. How to distinguish between the two? The signs that are presented by these very different scenarios can appear to be superficially similar. This is a key area where professional presumptions and prejudices can lead to significant errors of judgement.

Sources of assessment bias

The formation of individual and group clinical judgements about risk in child protection can be a highly subjective process. Some argue that the socially constructed nature of concepts such as 'abuse', 'risk' and 'assessment' render professional judgements inherently meaningless and invalid. Such perspectives tend to derive from academic discourse well out of range of the responsibilities of front line child protection practice.

However, the socially constructed or subjective nature of risk is an issue of concern. Outline the circumstances (and limited options) of a vulnerable young child to a multi-

disciplinary sample of professionals, and there will be considerable variation in judgements about that child's 'needs' and 'best interests'. Undertake this activity in a group setting – or for real in a case conference – and other biases from group dynamics will arise to affect perceptions and judgements. A principle of evidence-based practice requires that the impact of the subjective experiences of practitioners be more consistently recognised, and explicitly compensated for, as part of the process of weighing evidence and forming judgements. What are some of the key factors that can result in judgements made in good faith being so varied?

We shall briefly describe some key factors and dynamics that influence perceptions and judgements in complex human situations, highlighting the impact of emotions and cognitions on professional interpretations.

Emotions

Emotional factors play a crucial role in the interpretation of information and formation of judgements. These influences stem from personal past experiences (including childhood experiences ranging from privilege to abuse), present circumstances (satisfactions, dissatisfactions, stresses) and future expectations (aspirations and fears). These influences are invariably complicated by less conscious processes of projection, transference and counter-transference which can impact strongly as sources of bias. Limitations in training can mean that social workers do not develop sufficient knowledge to recognise these dynamics. They can consequently often become entangled in them – rather than, for example, acquiring the practice skills to constructively 'surf' clients' transference reactions.

Emotional status, counter-transference and mood can have a major impact on professional perceptions, behaviour and judgements. Elevated moods potentially give rise to (over) optimistic interpretations and vice versa with depressed mood states. An enthusiastic and idealistic practitioner may invest a great deal more energy attempting to engage with a difficult family, and may draw conclusions about potential for change that are very different from that of a long-serving battle-scarred practitioner recently emerged from the trauma of being subject to a Part 8 Review following the death of a child. Impressions and judgements in the former scenario may tend toward unrealistic optimism and naïveté; the latter may incline toward a pessimistic, if not cynical, response. In any individual case, the conclusions of either of these caricature practitioners may be right or wrong. The random nature of which of them is allocated to a case will, however, play a major part in the subsequent child protection system process.

Cognitions

Cognitions are thinking processes of the 'Is the glass half full, or half empty?' variety that affect how the world is interpreted. Cognitive styles, belief systems and levels of knowledge affect what a person notices and ignores, how such observations are construed, and the degree of importance that becomes attached to each interpretation and its implications. A powerful source of bias lies in the operation of selective interpretations in favour of a confirmatory hypothesis. 'Evidence' is only observed and incorporated when it supports a pre-existing belief or inclination. Evidence that does not support the interpretation is either not noticed, ignored or is discounted. It is our impression that confirmatory bias – selective interpretation of evidence in favour of presuppositions – is widespread in many child protection assessments.

Belief systems also introduce significant sources of bias. One example is divergent views regarding parental potential for change. The same set of circumstances can be interpreted from one perspective as reflecting a 'one-off, out of character' incident with little risk of repetition. Or, they can be interpreted from another perspective, as being a clear

illustration of a fixed 'once an abuser, always an abuser' pattern, with a corresponding very pessimistic view regarding recurrence.

Prejudices (attitudes) can be a major influence on interpretations and contribute to biases and discriminatory behaviour. First impressions are particularly likely to influence erroneous judgements. This is important to note in the field of child protection, when first impressions are formed of parents and children at an unusual time and often in very poignant, unexpected circumstances. Parents who have just been informed that their baby's serious condition is thought to be due to child abuse may react in a range of ways. There may appear to be little reaction. The reaction may be one of acute distress and panic. It may be one of challenge, criticism, blame and even threat toward professional staff.

While such reactions may ultimately be seen to convey real meaning about an individual or a couple, they cannot automatically be assumed to do so. A passive response to such news may indeed reflect an underlying lack of care and attachment with the baby, but it may equally be a transient response of a deeply shocked, introvert personality type. Similarly, volatile, unpredictable and inconsistent behaviour can be the response of innocent parents to traumatic shock. This can be indistinguishable from the behaviour of parents who are attempting to conceal responsibility for actual abuse.

Prejudices arise in relation to an almost endless list of personal characteristics and contexts. They represent stereotypical responses (negative or positive) to a type, regardless of the unique factors and circumstances of an individual. Commonly recognised prejudices relate to ethnicity, gender, class, culture and disability. Less well noted, but significantly influential reactions also occur in respect of factors such as intellect, dialect, linguistic ability, levels of power and authority, social/financial status, profession/occupation, political/moral attitudes, extrovert/introvert characteristics, and perceived personal attractiveness. The latter has been noted to be a potent factor in psychotherapy (Schofield, 1964) where therapists have been seen to be particularly motivated to pay positive attention to clients who fit the YAVIS (young, attractive, verbal, intelligent and successful) acronym. It is likely that there is an equivalent similar constellation of client factors in child protection work that influence positive and negative practitioner responses in relation to levels of interest, motivation, judgement and commitment.

The impact of less conscious psychological processes like these makes the formation of interpretations even more complex. The dynamics of projection, transference and counter-transference involve the mis-perception of a person or a situation influenced by personal experiences and emotional state. This dynamic has the potential to affect all child protection professionals who, for example, invariably bring into their work the continuing reverberations of their own childhoods; and, for many, their positive and negative experiences of being a parent. Whatever the nature of their personal backgrounds (whether a stable and happy family life, or an upbringing with unhappiness and sometimes abuse), the particular lens formed by individual histories and needs is a potential significant influence on professional interpretations of current child protection cases and the 'needs' and 'best interests' of the children concerned.

It is not difficult to caricature some possible scenarios. How do the cognitive and emotional schemas stemming from satisfactory or unsatisfactory childhood affect perceptions of the 'needs' of a child who has been chronically neglected, or seriously physically/sexually abused? To what extent do personal historical influences have a part to play in respect of whether a child needs to be permanently 'rescued'— or whether the parents need support in their efforts to care? To what extent do personal experiences affect views as to whether abusers need help, punishment (of what severity) or both?

The significant impact of personal emotions and cognitions on professional perceptions, interpretations and opinions has long been recognised in the fields of psychotherapy and counselling. Specific measures are applied during training, and are required throughout practice, so that therapists maximise their self-awareness and minimise the negative impact of such distortions. Given the significance of decisions that have to be made in cases of serious injuries to children, the fact that the key agencies and professions involved in child protection work rarely have the commitment or resources to monitor and supervise such potentially damaging influences on practice is a matter of serious concern.

Some principles for containing bias in assessment practice

One impact of *Messages from Research* (DoH, 1995) has been to encourage a predominant view of abusing parents as being helpless and poor – doing their best in difficult circumstances. While much relatively minor child abuse undoubtedly occurs in situations where over-stressed parents react to the multiple and cumulative negative effects of social deprivation and absence of effective family support services, the serious injury cases in this research seem qualitatively different. Notwithstanding the conclusion by Gibbons et al. (1995) that a single abusive incident rarely caused long-term difficulties for children, by definition in SIDE cases this is not so, and consequences are severe.

Attention to detail

The *Assessment Framework* promotes holistic assessments of child need and discourages an exploration of the details of injury incidents. In our view this stance is disadvantageous to all parties in SIDE cases. A detailed understanding of what exactly happened, when and where, who was present, and what happened next can be a vital key to establishing the roles of parents/carers, assessing the veracity and consistency of accounts, and the probability of explanations. Our emphasis on the importance of this supports the views of Macdonald (2001), Munro (1999) and Scott (1998), all of whom, from different perspectives, have noted that a neutral and systematic approach to the generation and testing of hypothetical explanations is often lacking in child protection practice.

Munro's work is of particular relevance to this discussion (Munro, 1999, 2002). She draws attention to failures in professional reasoning in child protection practice, noting that the lack of a scientific basis in the training of social workers tends to incline them as a group to interpret situations on an intuitive and emotional basis rather than from informed systematic analysis. As Scott (1998) also noted, further exploration on this basis tends to be 'verificationist' – that is when only information that supports the existing view is sought, recognised and remembered. Evidence that would disconfirm the preferred explanation tends not to be sought, recognised; or is discounted.

In this context of the potential for powerful biases on professional child protection judgements, we suggest several evidence-based principles that should be followed in initial safety and risk of recurrence assessments in SIDE cases. Assessments need to be *neutral, systematic, probabilistic and structured*.

Neutral and systematic

As we have emphasised throughout this book, one defining characteristic of SIDE cases is the uncertain nature of what has actually happened and alternative explanations as to who was responsible. Over-certain professional opinions and single-minded advocacy (for or against a parent) are indicators that professional perspectives may have lost their grounding in neutrality. When neutrality is lost, parents experience some professionals being 'on their side', and others who are 'against' them. Such dichotomy and polarity is not helpful to a constructive process of child protection case management and rarely culminates in satisfactory outcomes.

The principle of neutrality involves the open-minded and systematic exploration of alternative hypotheses regarding the cause and circumstances of a serious, suspicious injury to a child. This is a highly skilful activity that elicits detailed descriptions of events, respectfully asks focused questions, probes answers; and invites responses to feedback regarding discrepancies, incongruities and alternative hypotheses. **To explore rigorously the details of serious injury incidents and family factors is not inherently an anti-partnership approach.** It is in the interests of the children and their parents/carers that all explanations are thoroughly considered. Not only is this most likely to reduce false-positive identifications by identifying non-abuse causes, it also establishes detailed records of incidents in cases where subsequent, or multiple, injuries occur and where a retrospective analysis of patterns of injuries can be confirmatory of abuse.

To illustrate the range of hypothetical explanations to be considered, we can illustrate from practice experience a variety of situations in which confirmed serious abuse injuries to infants and children occur. These include:

- Mishaps stemming from lack of proper supervision (e.g. toddler falling out of a window or on to a fire). The context may include significant and chronic neglect, chaotic parental lifestyles, alcohol and drug dependence.
- Children injured in the context of serious domestic violence, caught in violent 'crossfire', or intentionally hurt in a revenge attack against the other parent.
- Single serious outbursts of violence – momentary loss of control (guilt). Violence erupts in the context of otherwise good parenting where there are often identifiable recent significant stressors. Control is quickly regained, guilt feelings are immediate and strong, and help is quickly sought.
- Single serious outbursts of violence – momentary loss of control (denial). Violence erupts often in the context of otherwise good parenting. There are often signs of long-standing family tensions and stresses below the surface of happy family presentation. Immediate response to the violent incident is denial or displacement onto others (e.g. blaming injured infant's sibling or medical misdiagnosis). Parents (and sometimes whole extended family) unite against child protection agencies. To what extent can memory be impaired for such events (e.g. through alcohol/drugs) resulting in a parent genuinely not remembering what happened?
- Sustained outbursts of violence (male). Serious (and sometimes serial) abuse to children occurs in households where the male is habitually violent. These fathers or step-fathers tend to abuse others (including partners) and may have psychopathic and sadistic tendencies. Mothers may be terrified and terrorised into passivity (rather than collusion).
- Sustained outbursts of violence (female). Rarer, but similar to above. Either single parents, or male partner colludes or bystands.
- Sustained outbursts of violence (both parents jointly). Serious serial abuse to children in households where both parents are habitually violent to the children. Attacks on children occur jointly, and separately with collusion. Parents may have psychopathic and sadistic tendencies.
- Psychosis: serious and fatal attacks on infants and children can occur as a consequence of parental delusions resulting from psychotic illness. A child may be psychotically misperceived as a threat or evil influence, and the parental attack represents a deluded defence against such attack. Or the attack (often fatal) on the child may stem from a psychotically depressed altruistic motivation – that it is an act of love to kill the child to protect him/her from an evil world or other specific imagined misfortune. When psychosis clears, guilt is likely to be great.

■ **Revenge attacks:** usually occur in the context of seriously enmeshed and conflictual parental relationships with established patterns of mutual provocation and retaliation. The child may be killed (perhaps with perpetrator suicide) in a final raising of the stakes in the bitter parental dispute.

■ **Munchausen's Syndrome by Proxy:** these are situations where a parent (almost always a mother) secretly and deliberately induces illness in her child and repeatedly presents the child for medical attention. A pattern of increasingly serious presentations develops, resulting in a sequence of unnecessary medical procedures. Fatalities occur.

These (by no means exhaustive) clinically well-established situations illustrate the range of potential psychological, parental and family dynamics that may lie behind a SIDE injury. It is important that assessments are open to all possible explanations. In turn, the evidence to support the existence of one scenario over another must be searched for and considered in a detailed exploration of significant events. This hypothesis-testing neutral stance avoids the communication of judgemental (or sometimes persecutory) professional attitudes to accused parents and – equally damaging in many ways – inappropriate reassurances to parents that the professional does not believe that they were responsible. 'Siding' with parents and advocating for them can, at the stage of assessment, be damagingly counter-productive (Wall, 1995). As Korbin (1989) noted from a study of incarcerated mothers who had killed their children, it can also close down a process of gradually taking responsibility for what really happened – as confessing responsibility then requires the betrayal of a committed supporter.

Probability versus possibility

By definition, assessments of SIDE cases invariably become focused on confusions and conflicts relating to the 'what really happened' and 'whodunit' questions. Rather than tackling these cases by contests over proof, or by side-stepping the issue such as the 'Resolutions' approach (Essex, Gumbleton & Luger, 1995), we support the view that the focus should be on systematically establishing a level of *probability* in relation to an injury being caused as described (Kemp et al., 1998; Macdonald, 2001; Ruscio, 1998). To do so requires detailed consideration of the injury event and context.

For example, it is not possible to say with *absolute* certainty that a six-week-old baby did not accidentally self-inflict a fracture to his tibia while alone in his cot. But, in the absence of brittle-bone disorder, it is possible to assert with confidence that this, if true, would be an extremely unlikely occurrence. An ethical expert witness who argued (in a contest over 'truth') that this was possible, would, in a cross-examination over probability, have to concede that this must be an exceedingly rare event. This opens up discussion about relative probability regarding other hypothetical explanations associated with known contextual factors. Given that a self-inflicted fracture to a six-week-old baby may conceivably be possible but extremely unusual – how probable are alternative explanations?

Effective and consistent assessment in SIDE cases requires evidence-based systems of analysis relating to *probability* to supersede (often conflicting) opinions regarding *possibility*. How probable is it that one exasperated parent has caused the injury without the knowledge of the other parent and wishes this fact not to be known? How probable is it that one parent has caused the injury and (from some mechanism of impaired consciousness or memory) genuinely does not remember doing so? How probable is it that one parent caused the injury, the other is aware of this, and both decide to attempt to conceal the event? How probable is it that both parents have caused the injury and unite together to attempt to conceal this? A number of further hypothetical possibilities could be developed.

Also, how probable is it that professional suspicions of abuse are wrong, and that an unusual event or medical condition does explain the injury?

Social policy dilemmas – protection or prevention?

Many years ago, the Director of Broadmoor Special Hospital remarked that only 5% of his patients would kill again if released, and added that he would be delighted to release the other 95% if someone would tell him – reliably – who they were. A similar dilemma arises in child protection practice. For SIDE cases as a whole, the proportion of children who would be re-injured or killed if returned home is not known. The professional difficulty is how to distinguish those who would be seriously re-harmed from those who would not. The social policy question is what margin of error and type of risk is preferable and acceptable. Is it erring on the side of risks of further injuries (and sometimes death) from a tendency toward rehabilitation? Or is it facing risks from permanent separation with children who could have been safely returned home? What is the optimal balance between these two tendencies towards error? This is a dilemma that is longstanding in all human risk-prediction fields.

False positives and false negatives

Ideally, the desired outcome of the child protection system is to prevent abuse and re-abuse. Family needs and stresses are identified at an early stage, and effective interventions are offered which prevent these early identified difficulties escalating into episodes of child abuse. This requires the provision of easy access, non-stigmatising family support and therapeutic services. Children at acute risk of significant harm, and those who have been harmed, are quickly identified. Their circumstances are promptly and competently investigated and assessed. Inter-agency protection plans are instigated which secure children's safety either in their own homes or, if necessary, in appropriate substitute care. This is the '**true positive**' position: the system prevents children from re-experiencing serious and escalating abuse. Risk is real and protection is effective. Successful outcomes are largely invisible.

False negative outcomes arise when the system fails to recognise, underestimates, or ignores classic warning signs of risk to children. It is erroneously assessed (or simply assumed) that the chance of occurrence or recurrence of serious injury is low. False-negative errors are highly visible. When fatal they often attract significant negative publicity. Subsequent enquiries invariably focus on professional inexperience and naïveté about the danger that some parents can present.

Ideally, child protection systems should not pursue actions in respect of children who are not in need of external protection. To do so creates undesired **false positive** outcomes. These are less demonstrable but occur when it is wrongly adjudged that recurrence of risk is high, reunification with parents is not allowed, and permanent alternative care arrangements are enforced. Infants and young children who could have been safely and successfully returned to the care of their parents/natural families, are instead diverted permanently to substitute carers, often via adoption. The incidence of false-positive errors is largely hidden and unknown.

Little is known about the long-term outcomes of unnecessary separation from their natural families for such children. We do not know to what extent they are damaged by inadequate provision (including multiple placements) throughout their careers in the care system. Children can also be neglected and abused in foster and adoptive homes and in residential placements. The effects of this are compounded by inadequate contacts with natural families and poor educational provision.

The level of future risk to infants who have suffered unexplained serious injuries with discrepant explanations is uncertain. There is no research on long-term outcomes which provides a basis for estimating the likelihood of injury recurrence in any individual cases. From our own research, the argument can be made both ways. From one perspective, the

assessment sample shows that most of the reunified injured children had reasonable outcomes (we do not know the outcomes for the permanently separated children in this sample). In contrast, the Part 8 sample provides evidence of preventable occurrence and recurrence of injuries with fatal consequences.

The problem of false positives and negatives is not only a significant technical challenge to improve reliability in risk-assessment practice. It is also a fundamental issue of social policy and politics. It is salutary to recognise that SIDE and fatal non-accidental injuries to infants are not entirely preventable. Because of the rare incidence rate, and the general unpredictability of human behaviour, no risk assessment system will ever be able consistently to identify in advance all such cases. It is unrealistic to expect that injury recurrence in SIDE cases (including a certain level of fatalities) can ever be totally prevented without a policy stating that no SIDE baby/infant can ever be reunited with parents/carers. Such a policy would be unacceptable, due to the unknown proportions of such children who would undoubtedly have negative experiences within long-term 'care' systems, and also because of the disproportionately high level of false-positive identifications that would result.

8 Conclusions and recommendations

In this final chapter we present practice and policy recommendations that we believe would reduce the future incidence of fatal and non-fatal SIDEs.

National standards for child protection

Public confidence in UK child protection systems is low. Haunting images of a relentless succession of dead children gaze at the public from their morning newspapers and television screens. Attention is drawn repeatedly to the poignant fates of chronically and systematically abused children (Lauren Wright and Victoria Climbié most recently) who have died in the context of failures of inter-agency child protection practice. It can appear to the public that child protection services are both naïve and incompetent. And that nothing ever changes to improve systems for detecting abuse and protecting children.

In this dismal context it is now essential that the quality of professional practice and inter-agency working together in relation to child protection case management in the UK becomes subject to specific national standards. National Standards for Child Protection should specify quality requirements (including timescales) for child protection interventions at each key stage of the child protection case management process:

- categorisation and response to initial referrals
- assessment of initial safety needs
- assessment of risk of recurrence of maltreatment
- assessment of need and provision of appropriate family support and therapeutic services
- continual assessment and monitoring of child and family progress
- decisions regarding re-unification, de-registration and case-closure
- continual audit and evaluation of child protection services.

National child protection standards would promote consistency and evidence-based practice on the specific decisions that need to be taken at each of these stages. Consequently, the child protection process would become more predictable and transparent, resulting in better scrutiny and fairer process for children, parents and families.

Child protection case management

The inter-agency nature of case management has been a central component of UK child protection procedures over the past three decades. At the practice level, this occurs predominantly through strategy meetings, child protection conferences and core groups. The policy level operates via the Area Child Protection Committee (ACPC) structure. Regulations for inter-agency child protection work at both levels stem from *Working Together* and ACPC *Child Protection Procedures*.

We have reported that in responding to SIDE cases, child protection case management can become confused and inconsistent. Poor practice in the samples studied involved inadequate investigations, failure to follow child protection procedures, absence of any

form of assessment, and inconsistent (and occasionally incomprehensible) decision-making. Judged by this sample as a whole, effective ‘working together’ remains a significant inter-agency challenge. Communication problems, role confusions, rivalries, and conflicts of opinions, purposes and personalities were apparent, presenting a worrying picture of randomness of response to children at risk.

Assessment of initial safety needs

At the point of initial criminal and Section 47 enquiries, there were notable inconsistencies in the thoroughness of enquiries and judgements that were made about the immediate safety needs of the injured infants. It is particularly concerning that essentially similar serious and urgent situations are responded to by child protection systems in very different ways. Child abuse fatalities – treated as suspected murders – are subject to far greater systematic and forensic investigation procedures than cases of serious injuries to babies that are not fatal. While this is understandable in the interests of focusing limited police resources on the legally most serious offence, we concluded that several of the police investigations into the SIDEs in this sample were either under-resourced or pursued with insufficient investigative commitment.

If you are thought to have murdered your baby, police enquiries will continue in many simultaneous directions, notwithstanding your silence and professed lack of knowledge of how the injuries were caused. If your baby has been seriously injured – but has survived – maintaining silence or professing ignorance is likely to result in these enquiries coming to a halt fairly quickly with no charges being brought. Despite the high number and proportionate severity of injuries to the babies/infants in the assessment sample, only four of the cases resulted in a criminal conviction for any assault. Police resources need to be sufficient so that serious injuries to babies and infants can be consistently investigated with the level of commitment that is applicable in cases of suspicious deaths.

Structured child protection assessment and case management

Child protection assessment and decision-making has traditionally been based on ‘clinical judgement’ models in the UK. Such judgements emerge from combinations of wisdom, knowledge, experience, ideology, intuition, ignorance, misunderstanding, bias and prejudice of each unique professional and idiosyncratic group. Although clinical judgement is often seen as the defining nature of professional activity, and defended as a precious commodity, research shows that it is a poor process to rely on for accurate prediction of risks (Baird & Wagner, 2000; Dawes, Faust & Meehl, 1989; Fluke, et al., 2001; Ruscio, 1998).

Research also indicates that groups of professionals interpreting the same child protection scenarios form significantly inconsistent judgements about risks and thresholds, e.g. acceptable versus unacceptable degrees of neglect; or levels of concern that warrant removal of a child from parental care (Rossi, Schuerman & Budde, 1996). We have already discussed the wide range of powerful influences that can bias professional (clinical) judgements; and cases in this book highlight the tragic consequences of error.

Today, such is the volume of required child protection activity, gaps in professional education and staffing problems in many areas, that especially in over-stretched social services departments, the resources (e.g. sufficient time and professional knowledge and experience) necessary to formulate considered judgements can be lacking.

When adverse outcomes result from child protection practice (especially deaths of children from re-abuse) enquiries repeatedly highlight significant professional errors relating to assessment and case management. Invariably, Part 8 Reviews and public inquiries reveal an absence of assessments, or ‘clinical’ judgements that appear

incomprehensible. Professionals endure the trauma of being held significantly responsible for a preventable child death. Careers are ruined as individuals are privately disciplined or publicly pilloried (or both) as a consequence of their misjudgements. Agencies face significant embarrassment, and increasingly the prospect of litigation. Public confidence in child protection practice declines further. In turn, agencies find it increasingly difficult to recruit and retain skilled and experienced staff who are prepared to work in the child protection field. In this context, one conclusion from the research in this book, is the need in the UK for a more structured, evidenced-based approach to assessment and child protection case management, linked to proposed national standards for child protection.

In North America, and two states in Australia, structured decision-making (SDM) protocols are a central component of child protection assessment and case management practice (e.g. Hetherington, 1999). A range of Risk Assessment Instruments (RAIs) have been developed to provide evidence-based contexts for the path each case will take through a 'decision-tree' toward intended desired outcomes. In some models, 'incident' and 'strengths-based' domains are also incorporated into general child protection assessments (Turnell & Edwards, 1999).

In association with various risk assessment instruments, SDM protocols focus practitioners on specific criteria that must be addressed in the decision-making process. Evaluations of SDM and RAIs report that the reliability and validity of these systems are significantly in excess of the vagaries of individual professional 'clinical' judgements (Baird & Wagner, 2000). However, there is an on-going debate about the benefits and drawbacks of manualised structured decision-making protocols (Goddard et al., 1999; Wald & Woolverton, 1990).

Existing overseas SDM models are not of a form (or culture) that could be imported directly into UK child protection systems. However, given the current public crisis in confidence in UK child protection services (exemplified by the Laming Inquiry into the death of Victoria Climbié, and the Scottish child protection system review following the death of Kennedy McFarlane), a radical step forward would be for the Government to make a commitment to the development of an appropriate model of computer assisted decision-making for child protection case management in the UK (Sheets, 1996).

In such a system, for example, every child referred because of child protection concerns would generate a new record in a computerised case management programme. The programme would prompt and record necessary actions at each stage of the child protection intervention (including the initial enquiry and assessment of the child and family). The programme would contain hyperlinks to policy and research material to inform practitioners and managers of key issues relating to the type of case and its stage of management. The system would be firmly evidence-based incorporating the existing three domains of the *Assessment Framework* (alongside additional 'incident' and 'strengths' domains) into an infrastructure of continually updated research and policy hyperlinks. On-screen information and guidance-prompts would inform the development of professional judgements, and provide alerts if required actions were not recorded. Such computerised child protection case management technology would be particularly valuable when specialist issues have to be taken into account such as parental mental health concerns, domestic violence, or the interpretation of explanations for serious injuries to babies.

Child protection practice informed by computerised or structured protocols would not be infallible. False positive and re-abuse outcomes would inevitably still occur. However, these would be subject to adverse-incident reporting enquiries, feeding back into a continual improvement in the sensitivity of the case-management programme. This on-going scrutiny would be equivalent to other well established 'no fault-no blame' inquiry

mechanisms to non-predictable adverse outcomes in other high-risk fields such as medicine and air traffic control.

Crucially, a more structured, systematic, evidence-based assessment and case management approach would reduce the inconsistencies generated by inadequate 'clinical' judgements, thereby improving the quality of outcomes for vulnerable children. The approach would render the child protection decision-making process less arcane to parents, promoting a greater sense of fair process and justice. Also, the impact of blame for individual professionals and agencies would be diminished in situations where adverse outcomes have occurred. Where it is possible to demonstrate that child protection procedures were followed, assessments were undertaken systematically, and decisions made with reference to the appropriate evidence-base; child protection professionals and agencies could not be so readily held responsible for adverse outcomes (e.g. certain child deaths) that are beyond the ability of sophisticated knowledge systems to predict.

Role of Area Child Protection Committees (ACPCs)

Part 8 Reviews

Recommendations from Part 8 Reviews are often incorporated into revisions of ACPC Child Protection Procedures with the aim of reducing the likelihood that specific circumstances that contributed to the death of a child will recur. On this basis, over many years, ACPCs have developed sophisticated sets of inter-agency child protection procedures that are grounded in lessons learnt from professional failings in fatal cases.

Our analysis supports the findings of other reviews of Part 8 Reviews (e.g. James, 1994; Sanders et al., 1999) in that it was unusual for conclusions to be drawn that there were major inadequacies in current child protection procedures. Rather, child protection procedures appear to be largely sound. The problem lies with the inconsistent implementation of procedures. This is the major recurring factor in the failure of the child protection systems to prevent fatal abuse cases occurring. In view of this, as we shall shortly go on to suggest, the role of ACPCs needs to be strengthened in relation to case-tracking and auditing the quality and consistency of inter-agency child protection practice in current SIDE cases.

Limitations of Part 8 Reviews

A significant disadvantage of the current Part 8 Review system – also noted by Reder & Duncan (1999) – is that the focus is largely restricted to the actions (and inactions) of agencies and individual professionals. Information is usually not available from the Crown Prosecution Service, the Coroner's Office or even from ACPC member agencies regarding their subsequent involvement with the family. Unlike the structure and process of Child Death Review Teams (which operate widely in North America and Australia) which do consider such material, Part 8 Reviews are consequently very limited in the extent to which they can further professional knowledge regarding the family dynamics of serious and fatal abuse, and the best ways to provide preventive services.

Furthermore, the composition and style of Part 8 Review groups themselves are, on occasions, such that full and frank discussion of key issues do not emerge – or do not get fully recorded. There was a striking contrast in the quality of the Part 8 Review reports considered in this research. Given the limited information available, as already discussed, several were excellent in terms of quality of analysis, identification of key factors and relevance of recommendations. However, two were extremely poor, providing a disservice to professional education, and little justice to the brief lives of the children concerned.

We were left with a distinct impression that the commitment to an effective Part 8 reviewing process, and to achieving high quality standards in reviews, varies between different ACPCs. Consequently, the proposed National Standards for Child Protection should include quality requirements for Part 8 Review processes and reports. ACPCs should constitute Part 8 Review groups with independent Chairs and members. Person-specifications should be developed for Chairs to ensure that the review process is systematic, knowledgeable, thorough, and that key issues do not get minimised or omitted.

ACPC case-tracking

ACPCs should have the duty and responsibility to closely track inter-agency child protection practice to ensure appropriate monitoring and review of critical events and crucial stages in case management. For example, a sub-group of the ACPC (perhaps the existing serious case review sub-committee or audit sub-committee) should review all on-going case conference minutes and assessment reports in SIDE cases. This would provide a valuable *concurrent* expert and senior consultancy input into practice, as opposed to the limited current system of senior *retrospective* examination of cases with adverse outcomes (via Part 8 Reviews).

In such a case-tracking consultancy system, identified concerns about quality of practice or standards of case management (including those generated by professional disagreements and complaints procedures) would be raised immediately with named senior agency professionals. Such a flagging system would be a relatively simple way of ensuring that high risk SIDE cases are regularly reviewed by an 'arms-length' group of very experienced professionals.

SIDE prevention plans and professional education

Given that a proportion (but not all) of SIDE deaths and recurrences of non-fatal SIDE injuries are preventable, there is a clear opportunity for ACPCs to formulate specific SIDE prevention plans. Currently, information is not collated through the child protection registration system in relation to the occurrence and recurrence of SIDE cases. These children are amongst the most vulnerable in our communities and it is vital that the scale of the problem is identified through much better quality data. An accurate base-line of incidence is required to monitor trends as part of a strategic plan to prevent a proportion of such cases occurring in the future.

Every ACPC should set strategic targets for the reduction in incidence of fatal and non-fatal SIDEs in their areas over a five year period. To achieve this ACPCs should:

- Establish accurate figures for incidence of SIDEs in their areas.
- Undertake retrospective reviews (a local analysis report) of the whole sample of SIDE Part 8 Reviews in their areas over the past three years.
- Routinely hold Part 8 Reviews on all non-fatal SIDEs.
- Commission external audits into the quality of their Part 8 Review processes and reports.
- Revise Part 8 Review panels to include at least one independent member, and implement person-specifications for Chairs.
- Undertake an annual analysis of the findings of all Part 8 Review SIDE reports and make this widely available as a professional education document.
- Set targets based on the local analysis report for a specific reduction in incidence of SIDEs over a five year period.

This work should identify key professional issues and concerns regarding local child protection case management and appropriateness of service provision. Professionals faced suddenly by a SIDE case have to respond quickly, often in the absence of any prior similar experience or training in the issues involved. Lessons from good and bad practice in relation to assessment and case management of SIDEs are rarely collated, analysed and disseminated.

Each ACPC should publish an annual public report focused on prevention strategy and professional education. This report (along the lines of overseas Child Death Review Team reports) should highlight issues arising from Part 8 Reviews held on all fatal and non-fatal SIDE cases. With a strategic target of a reduction in the incidence of SIDE occurrences and recurrences, such reports should make recommendations in relation to child protection procedures, inter-agency case management, training, relevant agency resource issues; and identify needs for appropriate preventive, assessment, family support and therapeutic services.

Endnote

This book has focused upon babies and infants who have sustained injuries that were very serious; some life-threatening, some causing permanent disability and some fatal. Parental explanations for the injuries have been absent, inconsistent or discrepant with their nature. Our major conclusion is that many (but not all) of these SIDE cases are preventable.

We have also noted that public confidence in child protection services is possibly at an all time low. The public is much less aware that child protection systems which have developed over the past 30 years do, in fact, work well for thousands of children each year. Out of sight, skilled and diligent professionals arrange vital protection for vulnerable children and provide or organise effective support for their parents and wider families. Without this level of successful but hidden child protection practice, rates of serious and fatal child abuse in the UK would undoubtedly be substantially higher than they currently are.

However, it remains unfathomable to the general public that children continue to die in grotesque ways as a consequence of basic child protection failures. In response, it is imperative that child protection practice in the UK becomes subject to consistent explicit quality standards. It is also vital that services are sufficiently resourced to enable these standards to be achieved, sustained and continually improved.

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0808 800 5000

Or textphone for people who are deaf or hard of hearing:
0800 056 0566

Or email: help@nspcc.org.uk

Alternatively call:
NSPCC Asian Child Protection Helpline
(Mon-Fri 11am-7pm) 0800 096 7719

NSPCC Cymru/Wales Child Protection
Helpline (Mon-Fri 10am-6pm)
0808 100 2524