



# Child fatality or serious injury through maltreatment: Making sense of outcomes

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## ABSTRACT

There is a moral and a legal imperative to learn the lessons from the outcomes of child fatality or serious injury through maltreatment to prevent or at least reduce their reoccurrence. A conclusion of a study, funded by the English Government, of a full cohort of 161 'serious case reviews' of child death and serious injury through abuse, was that most of these worst outcome cases were mostly too complex to be predictable or preventable. Limitations to learning from these high profile cases, which often dominate policy and practice internationally are illustrated by this study. Three groups of cases are identified: 'serious physical assault of young babies', 'neglect', and 'older, hard to help young people'. Learning is offered about safer practice and better recognition of abuse across three levels of intervention – universal services, known maltreatment risks, and late intervention which may have some cross-national implications. Professional judgment, based on a sound theoretical understanding, is argued to be a better route to safe practice than over adherence to performance indicators. Findings from in-depth studies of small populations of worst cases can be misrepresented and learning from these idiosyncratic studies needs to be linked more clearly to large population studies.

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## 1. Introduction

The murder of a child attracts more public outrage and media attention than perhaps any other crime (Davies & Mouzos, 2007). During November 2008, an English newspaper (The Sun) collected over a million signatures calling for the sacking of social workers deemed responsible for a child who was killed by his mother, her partner and a household lodger. The Prime Minister, Gordon Brown, has said that such cases must never happen again, but is the outcome of death through abuse indeed preventable, and is it wise to base policy on these worst outcome cases?

Child welfare outcomes can be interpreted through the three strands of policy, practice, and research. Perspectives on outcomes from these domains will be different: "Policy makers will associate outcomes with figures about (cost) effectiveness and decisions about budgets, professionals with realising good practices and serving best interests, children and families with being given voice, belonging and being helped, researchers with designing studies, conceptualising change over time and looking for evidence" (Grietans, 2007:7). Media and public concern need to be added to this list as does the understanding of outcomes from their national and cultural context. Outcomes appear, not as uncontested 'facts', but as concepts and ideas that can permeate policy debates and influence practice (Tilbury, 2004:228).

Many states and countries conduct studies or reviews of child deaths through abuse and neglect and in some instances these reviews also include cases of the most serious maltreatment. All four parts of the

United Kingdom have separate, but similar, legally mandated national review systems into child death and serious injury through abuse (Vincent, 2008). However, there are inconsistencies in methodology and sample size, problems with access to accurate data, and duplication of review processes within government departments (Joint Chief Inspectors, 2008). This paper considers the contributions that can be made from such reviews to national and international policy and practice to keep children safer by illustrating and analysing the process and findings of the latest national biennial study from England (Brandon et al., 2008).

Death though abuse is the appalling outcome for only a very small number of children. Yet inquiries into single, high profile child deaths are used as a major source of learning and policy formation for child welfare and child protection in many states and countries. Fish, Munro, and Bairstow (2008), among others, question the value of inquiries into single deaths (and by implication analyses of groups of deaths) since they repeatedly identify the same problems in practice and make similar recommendations. The levels of child death through abuse in comparable wealthy countries (which are known to be underestimates) remain largely stable with only minor decreases and shifts in numbers and rankings (Gilbert, Widom et al., 2008; WHO, 2008).

Attempts to determine potential preventability have sought to discern more of the 'missed' maltreatment deaths attributed to poor investigation, incorrect diagnosis, and improper or incomplete recording on death certificates (Covington, 2007; Sidebotham, Fox, Horwath, Powell, & Perwez, 2008; Unicef, 2007). Child death review teams, initially established in the US in the 1970s, are now in existence throughout much of the US, in many states in Australia, and since 2007, in England (Hochstadt, 2006; Sidebotham et al., 2008). Many child

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death review teams have extended their remit from considering the prevention of death through abuse at the micro, family level, to a better understanding of how to prevent all child deaths, including non-abusive deaths from the macro level, societal and environmental causes. There is, however, not always a good connection between learning from child death review teams and learning from inquiries into smaller numbers of maltreatment deaths or serious injury.

It has been argued that child homicides overall, occur too infrequently to effectively measure their impact on child welfare services and policies (Trocmé & Lindsey, 1996). Also, they may not in fact represent the endpoint of a continuum of violence to children since many deaths arise as a result of a single outburst of violence or through incidents connected to parental mental illness (Janson, 2005; Unicef, 2003). More nuanced understandings of the causes of child death will not come from statistical analyses of homicide. Instead, arguably, outcome measures should tap the broader mandate of improving the circumstances and well being of children (Trocmé & Lindsey, 1996).

Policy that takes account of children's well being has been developing, in some countries, over the last decade or more. In a comparison of outcome indicators between England, Australia and the United States, Tilbury points out that only England has welfare-based outcomes (Tilbury, 2004). This policy direction represents a partial shift in emphasis, in many European countries and many states in Australia and New Zealand, from protecting children from maltreatment, to ensuring that robust protection systems sit alongside better support services to families through earlier intervention. But there has been little decline in homicide rates in most of these countries (except, to some extent, Sweden and other Scandinavian countries, Janson, 2005), despite improvements in child protection policy and systems and better early intervention provision (Gilbert, Widom et al., 2008).

English well being outcomes are used as performance indicator targets for local authorities. As part of the broadly interpreted 'staying safe' outcome, the latest UK government's Children's Plan for 2008/9 expects a drop in the number of hospital admissions caused by unintentional and deliberate injuries to children and a reduction in preventable child deaths (and not just deaths from abuse; HM Government, 2007).

The next part of the paper considers what can be learned from a more in-depth and nuanced understanding of the profiles of children killed or seriously injured through abuse. The illustration comes from the third biennial analysis of all England 'Serious Case Reviews' from the period 2003–2005 (Brandon et al., 2008). Serious Case Reviews are undertaken when a child dies (including by suicide) or is seriously injured and abuse or neglect are known to be a factor (HM Government, 2006). The purpose of the biennial analysis of these reviews is to draw out themes and trends so that lessons learned can inform policy and practice (HM, 2006). The underlying, challenging, question from a policy and practice perspective was whether these types of cases with the worst outcomes can be prevented or at least reduced.

## 2. Methodology

Mixed methods were used, employing primarily quantitative methods for the collection and descriptive analysis of limited data from the total of 161 serious case reviews (Full Sample). A grounded theory, qualitative approach was used for the documentary analysis of a sub-set of a sample of 47 case reviews (Intensive Sample).

## 3. Analysis and theoretical approach

The overall analysis was underpinned by an ecological transactional approach which addressed inter-acting risk and protective factors. This informed the way that data about the children and their family circumstances were categorised and conceptualised. The approach builds on the ecological model of Bronfenbrenner (1979) and specifically on the work of Howe (2005) and Cicchetti and Valentino (2006).

It takes account of carers' experiences of being parented themselves and the history of their own relationships with family, peers, partners and professionals which influence their sense of themselves and others. The approach prompts a deeper grasp of carers' states of mind and the way they understand and interpret the needs and behaviour of their children and can, or cannot, keep them safe (Howe, 2005).

## 4. Limitations and interpretability of this and similar studies

There are a number of research difficulties involved in studying this population of 'worst cases'. Transferring the learning is problematic since 'hard cases make bad laws' (Dingwall, 1989; Sinclair & Bullock, 2002). Evidence based practice seeks solutions from success, and from what works, rather than from what has gone badly wrong (Zeira et al., 2007). The high level of emotion and shock that children can be harmed and killed (usually by their parents and carers) can arouse a climate of tragic anecdote rather than rigorous evidence based scrutiny (Fordham University, 2006). Thus a careful methodology is needed to provide a clear, theory driven, objective, analysis. For this study it was felt important to collect information about *all* known serious case reviews rather than to allow the analysis to be driven by learning from a few, often high profile cases, which may not have been representative of the whole cohort. This study is the first UK analysis of a near total sample of a relatively large number of serious case reviews.

Studies which combine both death and serious injury (as here) do not have neat comparison groups and cannot be compared straightforwardly with either child homicide or serious abuse studies. In-country comparisons can be made but a purely in-country focus can be parochial. Comparisons can be made with either child death/homicide studies, or child maltreatment or 'near miss' studies but like cannot be compared with like in these circumstances. The same issues arise internationally and a better comparison might be large population studies of both homicide and abuse.

Although the decision to call a serious case review in England is based on criteria from national guidance (HM Government, 2006) it is subject to local variability. All child deaths through abuse must be reviewed, in accordance with the Human Rights Act 1998 (Rose & Barnes, 2008). However, certainty about the interpretation of the links between death and abuse is complex and subject to similar underestimates and uncertainties that beset homicide studies. A degree of local discretion also exists about which serious injury cases meet the wide range of criteria for inclusion. As such the sample reflects those cases which local areas *choose* to subject to a thorough review and are a sample of some, but not all, cases from the serious end of the child abuse continuum.

The full sample of 161 cases and the intensive sample of 47 cases were compared. Application of statistical tests ( $\chi^2$ ) shows broad comparability on key characteristics (see Table 1). Since the information sources for the full sample were often minimal, with many missing values, the intensive sample is, arguably, a *better* reflection of what is known about the cases.

To consider the extent to which this, and other equivalent international small scale studies, might have more generalized learning, some findings are contrasted with results from studies of larger populations and systematic reviews. Case examples are provided from researcher notes from the serious case reviews.

## 5. Findings

### 5.1. The children's ages and types of death/injury/harm (from the full sample)

The age profile showed high numbers of very young, developmentally vulnerable children and almost half of the children were less than 12 months old (see Table 1). The age distribution of this combined

**Table 1**

Sample characteristics: full sample vs. intensive sample (\*full sample  $n = 161$ , intensive sample  $n = 47$  unless otherwise stated).

	Full sample	Intensive sample	<i>P</i> value
<i>Age</i>			
<12 months	76 (47%)	22 (47%)	0.75 (N/S)
1–5 years	33 (20%)	6 (13%)	
6–10 years	11 (7%)	4 (9%)	
11–15 years	26 (16%)	10 (21%)	
16–17 years	15 (9%)	5 (11%)	
<i>Gender</i>			
Male	88 (55%)	20 (43%)	0.14 (N/S)
Female	73 (45%)	27 (57%)	
<i>Ethnicity</i>			
	$n = 136$	$N = 39$	
White/White British	101 (74%)	31 (80%)	0.64 (N/S)
Mixed	8 (6%)	3 (8%)	
Black/Black British	17 (13%)	2 (5%)	
Asian/Asian British	8 (6%)	3 (8%)	
Other ethnic groups	2 (1%)		
<i>Incident type</i>			
Death	106 (66%)	35 (75%)	
Serious injury	55 (34%)	12 (26%)	0.27 (N/S)
<i>Type of injury/death</i>			
Shaken baby	25 (16%)	8 (17%)	0.90 (N/S)
Sudden infant death	<6	1 (2%)	
Overlying	6 (4%)	3 (6%)	
Physical assault	57 (35%)	14 (30%)	
Neglect (including house fires, accidents and illness)	33 (21%)	10 (21%)	
Poisoning/overdose	7 (4%)	1 (2%)	
Suicide	14 (9%)	4 (9%)	
Sexual abuse	6 (4%)	2 (4%)	
Gone missing	6 (4%)	4 (9%)	
Other	<6	–	

\*Numbers of less than 6 are not displayed for the full sample of 161 (to prevent identification) and are indicated as '<6'.

group of children killed (two thirds) or seriously injured (one third) does seem to parallel the findings of national and international child homicide studies, with two peaks for the youngest children aged under 1 year and for older children (Finkelhor, 2008).

In terms of the cause of death or injury, severe physical assaults were mostly inflicted on the very young children, with only 14 'assaults' in total for all children aged 6 years and over. The kind of harm more often reported for the older children included neglect, sexual abuse and being missing from home, which contributed to a lower proportion of deaths. Older children often experienced multiple forms of maltreatment and deaths and suicide in the older age group may be a reaction to previous maltreatment and not directly caused by it.

The types of death and serious injury of these children occur, broadly, in the three ecological niches outlined by Finkelhor, namely: a pre-school, family-based early development niche, a middle childhood mixed school and family niche and an adolescent, risk-exposed transition to adulthood niche. The types of death (and serious injury) are related to the nature of the children's dependency or autonomy and to the stage of their integration into the adult world (Finkelhor, 2008:40). For example "Actions such as running away, attempting suicide, abusing substances, causing deliberate self-harm, and engaging in promiscuous sexual activity are noted as behavioral responses to victimisation that tend to be limited to adolescents" (Finkelhor, 2008:83) (Table 2).

## 5.2. Agency responses (full sample)

Only 55%, of the total of 161 cases, were known to children's services at the time of the death or incident and there were current child protection plans for only 12% of the 161 children. Although

**Table 2**

Death or serious injury by age group.

Age group	Full sample ( $n = 161$ )		Intensive sample ( $n = 47$ )	
	Death	Serious injury	Death	Serious injury
<1 year	44 (58%)	32 (42%)	16 (73%)	6 (27%)
1–5 years	26 (79%)	7 (21%)	5 (83%)	1 (17%)
6–10 years	6 (55%)	<6	4 (100%)	–
11–15 years	16 (62%)	10 (39%)	6 (60%)	4 (40%)
16+ years	14 (93%)	<6	4 (80%)	1 (20%)

maltreatment about the 'known' children was missed, maltreatment was also not being recognized for almost half of the children who were out of the orbit of children's services. This reflects the national and international picture of most children's abuse not being recognized (Woodman, Lecky, Hodes, Taylor, & Gilbert, in press). Higher levels of children known to protective services are apparent in other similar reviews, for example in some Australian states, but cases under scrutiny are often confined to children *already* known to protective services, thereby missing community level abuse (for example Victorian Child Death Review Committee, 2006). Frederick provides a helpful analysis of the differences in reviews of child death throughout Australia (Frederick, 2007).

There was evidence of domestic violence in two thirds of the Intensive Sample families and parental mental ill health and parental substance misuse in 55 and 57% of the cases respectively. A third of the children had been living in families with all three characteristics. This potentially toxic trio of parental behaviours increases the risks to children's safety and well being (Cleaver, Nicholson, Tarr, & Cleaver, 2007). While many parents were known to specialist adult services like substance misuse services, or adult mental health services, links were not made with children's services.

## 5.3. Typology of cases

In depth analysis of the 47 intensive sample cases revealed an even clustering into three broad but somewhat overlapping groups (Table 3). These were 'physical assault in young children' ( $n = 17$ ), 'neglect' ( $n = 15$ ), and 'hard to help' older children who experienced neglect from helping agencies ( $n = 15$ ). The 'physical assault' and 'hard to help' categories fit into the ecological niches of dependent babies and older young people, while neglect spans all age groups. The findings from these groups produce learning about safer practice and better recognition of abuse across three levels of intervention – universal services, known maltreatment risks, and late intervention which may have some cross-national implications.

## 5.4. Physical assault in young children

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

This example of the death of a very young baby was typical of many of the inconclusive cases where physical assault (including head injury) was (probably) the most common cause of death or type of injury. The key feature in the profile of these families was the presence of 'volatility', which tended to erupt into violence. Domestic violence was present in the families of 86% of these 'physical assault' cases.

### 5.4.1. Engagement with agencies

These families tended to have had the least, or the briefest, contact with children's services. Involvement was mostly with universal services, or services to meet early needs. The police were the agency

**Table 3**  
Themes from the intensive sample cases ( $n = 47$ ).

Death/serious injury – physical assault $n = 17$	Death/serious injury/harm – neglect $n = 15$	Death/suicide/serious injury – older 'hard to help' (child 13 years or over) $n = 15$
Mostly young babies Illness in babies 'Volatility' Domestic violence Some parental mental ill health Little contact with children's services, low level agency involvement Repeat visits for emergency medical treatment Little focus on the child Families difficult to engage	Wide spread of children's ages Domestic violence, substance misuse, mental ill health often in combination History of neglect Fathers, hostility, criminal convictions Poor living conditions, frequent house moves Patterns of hostility and compliance Professional anxiety and reluctance to act 'Start again syndrome' Preoccupation with thresholds e.g. child protection threshold not met Accidents	Older adolescent young people Bullying  Self-harm, suicide Sexual exploitation Going missing Long history of severe maltreatment and rejection History of living with domestic violence Substance misuse and mental ill health (child and parents) Assessed as 'not mentally ill, no suicidal intent'  History of high level involvement with many services over many years 'Hard to help' resistant to services Agency neglect

which responded most often to the 'volatility' and domestic violence. Some parents had mental health difficulties and past, but rarely current, involvement with children's services. Links with criminal justice and mental health agencies were more frequent than links with children's services. Many, but not all, families were 'difficult to engage' with many missed health appointments.

There was sometimes a lack of awareness among health staff, and the police, to the link between domestic violence and the risk of harm to the child. Family 'volatility' and a history of previous emergency treatment for injury for the child appeared to have presented potential warning signs of abuse in many of these cases. Repeated presentation of babies for emergency treatment was a potential indicator of abuse in a systematic review (Woodman et al., in press).

There was little evidence of shared expertise between specialist services like substance misuse services or domestic violence units and children's services. Professionals from different agencies rarely looked beyond their individual specialism and did not make children, as well as adults, a priority in services primarily for adults (Cleaver et al., 2007; Office of the Deputy Prime Minister, 2004).

### 5.5. Neglect

The six year old child was seriously injured as a result of a house fire. The child had been known to several agencies over time. Issues of parental drug misuse and neglect were indicated. Poor living conditions.

Table 1 shows that 21% of the 161 cases featured neglect as the *prime* concern in the case, although in numerous other cases it was one of many concerns and neglect has, arguably, the most detrimental impact on the child's development (Gardner, 2008; Gilbert, Kemp et al., 2008). Information about fathers was largely missing but many men in families were hostile and violent. A common profile of the child's mother included many combinations of the following: a history of emotional and/or physical neglect, past sexual abuse; multiple pregnancies with many losses due to termination, miscarriage, or compulsory removal of other children. Many parents and carers suffered with mental ill health; self-harm, substance misuse and demonstrated strong ambivalence to helping agencies.

#### 5.5.1. Engagement with agencies – and implications for 'known risks'

These neglectful families had been well known to children's services over many years, often over generations. Family histories and family dynamics were complex, confusing, and often overwhelming for practitioners. One common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by

the families, was to put aside knowledge of the past and focus on the present, adopting the 'start again syndrome'. In families where children had already been removed because of neglect, parental history was not fully analysed to consider their current capacity to care for this child safely. Instead, agencies supported the mother and family to 'start again'.

Families tended to be ambivalent or hostile towards helping agencies, and staff were often fearful of violent and hostile men. Parents often avoided agencies, but agencies also avoided or rebuffed parents by offering a succession of workers, closing the case, losing files or key information, by re-assessing, referring on, or through initiating and then dropping court proceedings. There was systemic failure to engage with the parents' fundamental problems in parenting and the child's experience of direct or indirect harm. These problems were exacerbated by the lack of a shared understanding of definitions and thresholds for neglect, leading to confusion and delay of key decisions (Gardner, 2008; Horwath, 2007).

### 5.6. 'Hard to help' older children, late intervention

Gemma was discharged home from residential care at the age of 15 because of persistent running away. She was one of six siblings most of whom were placed in out of home care. Since Gemma's birth there had been serious concerns about her mother's parenting ability. At home Gemma had experienced long term neglect and sexual abuse. She had numerous placements and had exhibited serious self harm, suicidal behaviour, substance misuse, and violent and threatening behaviour from the age of 13, when she was first placed away from home. Gemma was assessed as 'not mentally ill with no real suicidal intent' numerous times. (Suicide age 16).

The theme of older adolescent children who were very difficult to help emerged powerfully. A common profile, for all but two, of the young people emerged demonstrating the long term impact of living with abuse. All (but two) had extensive contact with agencies, a history of rejection, loss and usually severe maltreatment and neglect over many years. The young people's parents had their own history of abuse and rejection, and often misused substances and had mental health difficulties.

By adolescence most young people were typically harming themselves, neglecting themselves, and misusing substances. It was difficult to contain them in school and in placement. There were numerous placement breakdowns featuring running away. Going missing increased the risk of sexual exploitation and risky sexual activity. This catalogue of risk factors reinforces the view that it is the cumulative interaction between these difficulties that produces the

most harmful effects (Rutter, 1979; Unicef, 2003). Risk of suicide also increases with the accumulation of multiple adversities (Afifi et al., 2008; McHolm, MacMillan, & Jamieson, 2003).

### 5.6.1. Engagement with agencies

State services rarely supported these young people fully and latterly, agencies had 'neglected' these young people's needs. The causes of, for example, running away were not properly addressed. Persistent running away sometimes led to discharge from out of home care (usually back home). At the time of the incident which prompted the serious case review, most of the young people were receiving low level services only. Agencies had run out of helping strategies and mental health services were reluctant to assess these young people as mentally ill and/or with suicidal intent. Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the services needed. A lack of coordination of services for these young people 'in transition' to adulthood was coupled with a failure to respond in a sustained way to their extreme distress, which occurred in parallel to their risky behaviour.

## 6. Discussion

Child death and serious injury through abuse affect a minority of the child population but are of significant research interest and have a high level of impact on policy, practice and the voting public. Child homicide studies and measures of serious injury are difficult and slippery outcomes beset by problems of definition, reporting and administrative data gaps and inaccuracies. The English study examined here exemplified a number of these problems whilst trying to offer a deeper understanding of the circumstances of these worrying cases than a wholly quantitative study could achieve. In depth studies of small populations of worst cases only reveal part of the picture however. Findings can be misrepresented or over stated and policy changes made on the basis of single cases that do not reflect trends or common practice.

However the findings from this single cohort do suggest some similarities and parallels with larger population studies and the two do need to be combined more effectively. For example the analysis of longitudinal data by Johnson-Reid, Chance and Drake (2007) suggests that low-income children who survive a first incident or reported maltreatment have twice the risk of death before age 18 than those who were not maltreated. The more nuanced background information offered here can help to explain more about the context of the vulnerability of babies, and offer more understanding about the heightened risks to children posed by the co-existence of parenting difficulties like domestic violence, substance misuse and mental ill health. Findings from these types of reviews can never establish causal relationships between aspects of parental behaviour and serious child abuse or neglect because of their idiosyncratic nature.

Inspection systems in England now rank the performance of serious case reviews themselves (Ofsted, 2008). This is contributing to the drop in staff morale that scrutiny of these worst cases engenders. Outcome measures and targets can impinge on good, safe practice with children (Cooper, Hetherington, & Katz, 2003; Henricson, 2007). The availability of services, budgetary restraints and lack of good staff support and supervision all have an impact on staff's ability to recognise and understand the dynamics of abuse (Brandon et al., 2008; Gilbert, Kemp et al., 2008).

Indeed the analysis of the reviews revealed that the numbers of factors which interact and increase or decrease the risk of harm to children are extremely complex. Even if the 'whole picture' of family circumstances had been known, it would not have been possible to accurately factor in and compute a clear outcome for the children at the centre of most of the reviews. Similarly, it is not possible to anticipate with any certainty the effects of interventions, even though

they can be planned and evaluated more systematically (McCauley et al., 2006; Zeira et al., 2007). The complexity of many of the reviews studied means that most cases of serious harm may be essentially unpredictable. Thus living with uncertainty and risk is at the core of practice with children and families.

## 7. Using research and theory for practice

Although serious abuse to the children was not necessarily predictable, the 'neglect' and the older 'hard to help' young people's cases, did offer evidence of known childhood adversities which should have been taken into account. These difficulties echoed many of the key indicators for the recurrence of maltreatment which were not brought together (Hindley, Ramchandani, & Jones, 2006).

Although predicting serious abuse to children is not straightforward, it is crucial for professionals to feel that they have done their best for the child. Having confidence in a theoretical framework, for example an ecological transactional perspective, helps practitioners (and managers) to be more aware of how factors are playing out in family and child dynamics and dynamics between professionals and families. Thinking critically and systematically helps to avoid over reaction, often prompted by media and public opinion, which is extremely dangerous. It is important to remember that the majority of children living with high levels of adversity, will not necessarily be subject to serious abuse. There is not a straightforward link between these adversities and serious abuse to children. It is essential that professionals are alert to the way in which difficulties interact if they are to understand the child's experience of day to day care and have a better appreciation of how harm might arise, and not just in children's services.

There appears to be an important inter-relationship between measuring and understanding child death and serious injury through abuse. The study illustrated here makes a modest contribution to the body of knowledge in this area, not least by underlining the caution to be exercised in interpreting the findings for use in policy, research and practice.

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