CHILD DEATH AND SIGNIFICANT CASE REVIEWS:

INTERNATIONAL APPROACHES

Report to the Scottish Executive

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EXECUTIVE SUMMARY

This research report from the Dartington Social Research Unit provides an international comparison of child death and significant case reviews, an issue of interest to the Scottish Executive seeking clarity on how reviews should best be conducted.

It is based on a survey of arrangements for conducting reviews in 16 countries, with information gathered from several sources, including a literature review and substantial structured questionnaire to experts in child protection in the respective countries.

While there is a large body of research on child abuse and neglect and on child death rates generally, there is very little published material on the case review process and even less on its effectiveness. Most available evidence comes from England.

Initially, it is important to understand the context in which child death and significant case reviews are conducted. All of the countries studied had strengthened their child protection policies in recent years and sought to enhance children's rights. But the extent and nature of child need differs across countries, as do the professional structures designed to meet them. Models cannot easily be transferred elsewhere. It is more useful therefore to concentrate on the conditions necessary to achieve effective reviews and apply these to particular contexts.

All of the countries surveyed had a system for reviewing child deaths and serious injuries where abuse and neglect were contributory factors. However, the approaches varied considerably. The main differences were in the predictability of a review taking place, the existence of a standing group to commission and undertake it, whether the driving force behind the inquiry was the fact of death or an attempt to understand the abuse that caused it, the criteria for cases to be investigated, whether the mandate was legal or professional, the roles of the coroner and police in commissioning inquiries, the scope of the inquiry, the relationship of abuse and neglect investigations to monitoring arrangements of other causes of harm to children, the quality of the information systems that reviews feed into, the costs of inquiries and the arrangements for publication, dissemination and handling the media.

The report concludes that while a review might be deemed 'good' as an isolated exercise, it may be less effective at contributing to service development. Twenty features of 'good' reviews are identified from the survey and literature. If reviews are to achieve their aims of improving prevention and meeting the needs of children at risk of harm, however, they are best viewed as making a specialist contribution to a continuing programme of needs analysis, service design and evaluation of outcomes of interventions with children and families.

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ACKNOWLEDGEMENTS

1. INTRODUCTION

Aims of the research

This research report is from the Dartington Social Research Unit and deals with the Research Specification issued by the Information, Analysis and Communications Division of the Education Department, The Scottish Executive regarding an international comparative study of child death and significant case reviews. The Executive is seeking clarity on how reviews should best be conducted. This concern emanates from a continuing review of child protection in Scotland. It is particularly interested in the strengths and weaknesses of procedures in other countries following child deaths and other significant events, methods of ensuring accountability and any specific approaches that may usefully inform developments in Scotland.

The aim of the research is to provide a comprehensive international overview of approaches to investigating or inquiring into child deaths and significant cases. More specifically, the objectives are as follows: (i) to describe different approaches to reviewing child deaths and significant cases in different countries; (ii) to evaluate the effectiveness of these approaches, commenting on what is considered to work well and what has failed or is considered problematic; and (iii) to include a focus on the relative costs and resource implications of different approaches (including financial cost, time and expert/other staff resources).

The intention was to explore the possibility of identifying similar approaches across groups of countries and even to develop a typology of approaches that clearly identifies the various mechanisms, structures and procedures invoked when a child death or significant case is brought to the attention of the authorities. Connected with this is the possibility of identifying approaches or systems that are different from, or unusual in comparison with, those in use in the UK; this is to assist the Review Group to think broadly around the issues of child deaths and significant cases. The study also set out to consider countries that undertake no reviews and to report on why this is so. In order to meet these objectives the research team were asked to cover a range of sources from a variety of international contexts and to consider (a) English and other language texts as well as (b) the views of experts and specialists in this field.

Context for the study

In January 2005 the Scottish Executive Education Department commissioned an international overview of approaches to child deaths and significant cases. The research is intended to feed into the work of the Child Death and Significant Case Review Group, which was established as part of the Child Protection Reform Programme following the Child Protection Audit and Review. It follows the Scottish Executive (2002) report *It's Everyone's Job to Make Sure I'm Alright*, the product of the Child Protection Audit and Review, which included a recommendation that the Scottish Executive should consider further the issue of child fatality reviews.

At present there are a number of different approaches to reviewing the deaths of children in Scotland. Fatal Accident Inquiries (FAIs) are conducted where children die in custody or where the Procurator Fiscal decides an Inquiry is in the public interest. The circumstances and agency responsibilities of all children who die while

looked after are reviewed by local authorities and the Scottish Executive, and are the subject of a statutory report to Ministers. Neo-natal deaths are reviewed where there is an unexplained death of a child under two years old, and some local areas, usually through the Child Protection Committees (CPCs), undertake reviews of professional practice following deaths of children known to agencies or where there are concerns about abuse and neglect. Additionally, agencies have internal review arrangements for significant cases or incidents. As new approaches to reviewing agency practice have developed, such as those undertaken by CPCs, the need for clarity of purpose and guidance on how such reviews should be conducted has grown.

To this end, and as part of the Child Protection Reform Programme, the Child Protection Review Team has established a Child Death and Significant Case Review Group. The role of this group is to consider broadly all the procedures, mechanisms and structures that are invoked when a child dies or a serious incident is uncovered and, ultimately, to make recommendations that relate to those instances where child protection concerns are a factor. The research undertaken for the Scottish Executive and reported in this study is intended to assist the Review Group in this role. The Review Group will consider the deaths of children and significant cases broadly in order to locate any work they undertake within the wider understanding of risks to children. The group requires an international overview of child death reviews, how these different approaches handle systems failure and accountability and any unusual or contrasting approaches.

The research team

The Dartington Social Research Unit is an activity of the Warren House Group at Dartington, a set of research and development activities based at Dartington, Devon. The other activities in the group are Dartington-i, the Centre for Social Policy, Warren House Press and DeMo Information Design. Further details can be found on the charity's website www.whg.org.uk.

In completing this work the research team sought to draw on its previous work in various ways. First are earlier publications, in particular a review of child protection research (Department of Health, 1995), a study of Serious Case Reviews that follow child deaths or serious injuries in England where neglect or abuse is thought to be a contributory factor (Sinclair and Bullock, 2002), a commentary on the role of children's services in protecting children (Bullock and Little, 2002) and an overview of research and best practice in the US, Europe and Australasia on refocusing children's services towards prevention (Dartington Social Research Unit, 2004). The messages emerging from these studies are drawn on here, mainly to set the findings in context but also to assist with the design of the survey questionnaire and with drawing out implications from the study for policy and practice. Second, the research team utilised the Dartington Unit's international network of researchers and professionals in order to help acquire information quickly from child protection experts in different countries. Third, methods used previously for comparative international studies at Dartington were drawn on, in particular a framework employed in a four-country comparison of the educational achievements of looked after children (Weyts, 2004).

2. THE RESEARCH LITERATURE

This section presents the main messages for the study from the literature. The literature search method is described in section 4 of the report 'Methodology' but essentially it involved a systematic search of various paper and electronic sources, supplemented by a question in a survey to child protection experts in various countries.

Relevant studies in the UK

While there is a wealth of literature on child protection and on perpetrators likely to murder or seriously injure children (Browne et al., 2002), there is much less on child death or serious injury reviews. Moreover, the material that is available tends to seek common themes and messages rather than scrutinise the process and its value.

The most significant tranche of studies comes from the United Kingdom. Hill (1990) was one of the first researchers to identify the benefits of child abuse reviews and highlighted many issues addressed in subsequent guidance. He warns against the process allowing society to distance itself from public responsibility for child care. He also expresses concern that too great a focus on incidents can divert attention from important wider social processes and the gender, power and social class factors intrinsic to them. He stresses what are now familiar criticisms raised in reports, namely failing to focus on the child as an individual in his or her own right, static assessments of family structures and relationships, pursuit of the 'rule of optimism' and, in some cases, a clear dereliction of legal duty. The effects of this, he argues, are to segregate abusers as 'abnormal' people, to preserve cherished values held by the majority of the population, to reinforce the social policing role of social workers, to miss possible solutions based on empowering people and communities, to divert attention from preventative practice and reinforce the belief in managerial solutions to complex problems. In short, the review process does little to 'create the social conditions and welfare systems which keep children safe'.

Munro (1996), writing in the mid-1990s after the publication of the 1991 *Working Together*, looked at 45 inquiry reports and emphasised the tardiness of social workers to alter their early judgements when evidence on risks to children accumulates (see also Munro, 1999). This problem is identified by accident investigations in all industries and was certainly a factor noted by the inquiry into the death of Victoria Climbié, where inadequate supervision for the staff concerned meant that a fresh perspective to highlight the error was missing (Munro, 2005). Although some tragedies result from poor practice compounded by these inflexible views, in many cases the incident is simply 'bad luck'.

Domestic violence was a factor particularly neglected at this time. This is taken up by Brandon and Lewis (1996) who noted that although children assessed as experiencing 'significant harm' display a range of presenting symptoms, domestic violence is a frequent background factor. Nearly half (49 of 105) of the children they studied had witnessed such violence and 28 out of the 51 children looked at intensively had been

harmed by it.

The most significant studies of child abuse inquiry reports have been commissioned by the Department of Health in England. These are the Department of Health (1991), Social Services Inspectorate (1994), James (1994), Falkov (1996), Reder et al. (1993); Reder and Duncan (1999) and Arthurs and Ruddick (2001). Another study by Owers and colleagues (1999) was commissioned by the National Assembly for Wales. The Department published overviews in 1991 and 1993 to identify the issues among which are: lack of a clear format, the inclusion of partial information, variation in length and a focus on services and compliance with procedures. Familiar administrative shortcomings are also highlighted. These include poor training, failure to share information, a plethora of unconnected recommendations and the isolation of the exercise from wider strategic planning.

Subsequent studies explored the children and families involved more extensively. James (1994) looked at 30 reviews conducted between October 1991 and December 1993, covering all regions of the country and children of every age. The reviews were found to be of variable length and have considerable gaps, especially information on the men involved in the cases. The time taken to complete the work varied enormously and the recommendations which ranged in number from four to 99 were an unsatisfactory mixture of 'core' policy and practice concerns and everyday issues. He provided much new information on the children and families involved.

Falkov (1996) scrutinised 105 review reports undertaken in 1993 and 1994 looking especially at adult mental health. He found that psychiatric disorder was detected in a third of the cases examined and that there was a distinct lack of integration between agencies providing services for the adults affected and their children. Training in mental health and child protection for the relevant professionals was seen as the best way of enhancing recognition, referral and intervention. He concluded, however, that this is unlikely to prevent individual deaths but 'to improve procedures and practices which impact on the much larger group of children who are abused but not killed and constitute the 'at risk' population from which many fatalities will arise'.

In Wales, Owers and colleagues (1999) examined 10 reports between April 1996 and December 1998 using a 'layered reading' methodology. They found that the reports were extremely diverse in the nature of their compilation and in terms of the contribution of individual agencies. Prior to the incident, assessments of need and risk were poor, practitioners received inadequate supervision and inter-agency communication was lacking. The quality of reports and the extent to which information was reviewed varied significantly. This was especially so for family histories where the absence of information on a particular factor was often taken to mean its absence in reality. There was also too much emphasis on particular incidents and a failure to identify overall patterns. They stressed the importance of national guidance but were dubious about the value of complicating the process further and making endless recommendations.

The Welsh report concluded that professional competence is the key to protecting

children. The elements of this are: knowledge, values and professional identity, skills, professional/clinical supervision and training. They conclude that Serious Case Reviews should have clear objectives and need to be part of an audit of services. These findings are echoed in another Welsh study by Sanders and colleagues (2001) of 19 reviews. They identify the key practice issues as unstructured approaches to assessment, problems in inter-agency communication, failure to accept responsibility, involvement of a large number of professionals, the peripheral role of general practitioners, insufficient training for paediatricians and radiologists, and parents being given too much choice to accept or decline services, so increasing risks of harm for their children.

In this final point, they echo Reder and Duncan (1998) who, in their study of 86 child abuse deaths, exhorted reviews to 'promote learning at different levels'. Indeed, revisions to procedures were thought likely to be more effective if they were based on these audits and not on single incidents.

Reder, Duncan and colleagues (1993; 1999) developed this theme of linking research and practice more effectively. One issue they sought to address was the assessment of accumulating risk. They argue that the most effective approach was to look at each facet of the situation and at each bit of practice in that context, including the effects of previous interventions – activity that is rarely evaluated. Echoing Owers and others, they valued training as a way of helping people interpret information such as genograms and argued for a much more testing and argumentative agenda for analysing the information, a process termed by them as a 'dialectic mindset'.

Like Falkov, these authors emphasised that as Serious Case Reviews cases are only a sample of all fatal child abuse cases, wider implications for child abuse policy have to be drawn cautiously. They saw the value of Serious Case/Part 8 reporting as limited by the restricted aims of the exercise, the narrow composition of panels, the type of information provided and the style of reporting. The focus on procedures was also a constraint. More outside experts, more material on children's personal development and past relationships, more effective participation by GPs and a standard format for presenting the material would help. Many of these points are echoed in the Bridge (2001) report *Childhood Lost*, which also offers a possible format for presenting reports, and in the 1991 report *Child Death review Teams: A Manual for Design and Implementation* published by the American Bar Association and Academy of Pediatrics.

More recent surveys of Serious Case/Part 8 Reviews support these proposals. Arthurs and Ruddick (2001), for example, scrutinised 25 reports in England conducted between April 1998 and March 2000 in a National Health Service region covering 20 local and 14 health authorities. They also analysed thirteen other potential cases that did not lead to a full review. In addition to the problems already described, such as poor communication and inadequate recording, they emphasise the importance of parental participation in the legal process, the need to maintain this involvement, the importance of ensuring that early child protection conferences set in motion a successful review process and the need in protection plans for a strategy to address failure. They pose 42 questions for Area Child Protection Committees to consider in the routine audits of local practice that their report recommends.

The most extensive analysis of cases reviews in England is the study previously referred to by Sinclair and Bullock (2002). They provided new information about the children and families affected and evaluated the effects of new Government guidance introduced in 1999 for conducting what were now termed Serious Case Reviews.

They scrutinised a sample of 40 case reviews undertaken between 1998 and 2001 - that is before and after the new guidance - with the following objectives: (1) to identify what helps and hinders the review process as revised in 1999; (2) to ascertain if the revised review processes have led to changes in practice and policy at local level; and, (3) to identify any lessons for national policy and practice guidance. Thirty-one of the 40 incidents scrutinised led to the child's death and nine to serious injury. The authors found that the 40 cases fell into 10 groups, the salient features of which are shown in Table 2.1.

Table 2.1 Features of 40 cases reviewed in England and Wales (1998-2001)

Group		Number of cases
1	Accidental/natural causes death but possible neglect	10
2	Known significant protection risks or long-term neglect	6
3	Baby 'battered' by father/step father	5
4	Teenagers living in chaotic circumstances	4
5	Murder by mentally ill father/step father (one-off incident)	4
6	No known protection risks but suspicious death/injury	4
7	Murder by mentally ill mother (one-off incident)	3
8	Dramatic change in parenting following arrival of new male	2
9	Concealed pregnancy/abandonment	1
10	Fabricated or induced illness (Munchausen by proxy)	1

This classification confirmed that within a variety of situations, clear groups can be identified. The characteristics and circumstances of the incidents in each one are different and this needs to be reflected in the development of preventative and therapeutic services.

The expected changes pre- and post- 1999 Government guidance were:

- a change in emphasis from an inquisitorial perspective to a learning one
- clarity about why the review was undertaken and what it would produce
- clearer scope of the review from the outset, with the questions to be answered and the sources of information delineated
- clearer structure of reports from the welfare agencies and the ACPC overview regarding information on key areas, such as the child's family history, family structure, previous referrals, decisions taken and work done
- a more robust action plan in which the responsibilities of each agency, the time scales and plans for implementation are specified
- well prepared plans for the dissemination of reports and handling the media
- reports undertaken and completed within time limits

- the public availability of an executive summary report
- the setting up of a serious cases review panel to consider undertaking reviews
- evidence that reviews increase awareness of child protection issues among local policy makers and practitioners.

The evidence gathered questioned many commonly held stereotypes about the circumstances surrounding child deaths and serious injuries, for instance that mothers are young, mentally ill and struggling to care for their babies with the help of social workers. Sinclair and Bullock found that for the children who are the subjects of serious case reviews, only 9 of the 40 main carers were aged under 21 when the child was born, only 18 of the 40 had mental health problems, for 16 children no concerns about their welfare had ever been expressed, only 19 of the 40 children were aged less than 12 months and in 23 cases there was no significant poverty or accommodation problem. The only majority characteristic was that 21 of mothers' 31 current partners were known to be violent.

It was also the case that while only 12 of the 40 children were not known to social services, only 12 were open SSD cases at the time of the incident. Despite their continual contact with families in 12 of the 40 cases, warning signs could have been said to have been missed in 23 of the 40 cases, although only four of these were viewed as high risk or top priority.

In most cases, the case review concluded that the child's death/injury was neither predictable nor preventable, as shown in the following table (Table 2.2).

Table 2.2 Whether children's deaths/injuries were predictable or preventable

Incident perceived as:	Highly	Weakly	Not at all	No mention	Not applicable
Predictable	3%	5%	75%	8%	10%
Preventable	8%	18%	60%	8%	8%

The six most commonly identified practice shortcomings were: inadequate sharing of information (25), poor assessment processes (23), ineffective decision making (21), a lack of inter-agency working (17), poor recording of information (15) and a lack of information on significant males (9). Other less frequent but important concerns were the influence of a dominant approach to child protection (8), poor referral procedures (5) and insensitivity to racial or cultural issues (4). Not all the comments were critical, however, and in eight cases the reports were highly complimentary about practice in these areas.

The new Department of Health guidance made some difference to the nature and quality of reports although this was not dramatic. There was more of a multi-agency perspective but gaps in information remained. There was also a better history of service involvement and compliance with procedures when the case had been previously involved with agencies.

With regard to the process of undertaking reviews, all respondents stressed their value and welcomed the 1999 guidance saying that it was helpful in its scoping

recommendations, clear terms of reference and advice on tackling difficult problems, such as following a time-table that mirrors court proceedings, when and how to involve family members and getting consistent information from each agency.

Most welcome of all was the move from an inquisitive agenda to a spirit of learning and many felt that a satisfactory balance had been struck between general prescription and sensitivity to individual variation of each case. They also liked the attention given to vulnerable groups, such as looked after children and young people with disabilities.

The local authorities participating in the study appear to have a clear mechanism for deciding when to undertake reviews and serious cases review panels are central to setting up the process and reviewing progress. One common complaint, however, is the four month time scale which, although extended from the previous guidance, is still perceived as difficult to achieve.

The interviews with the staff involved showed that action plans were usually carefully constructed and incorporated into local training as much as possible. The most difficult groups to reach in this respect were GPs and school governors. The main changes specified included:

- more conclusive child protection meetings
- better ways of gathering information on dangerous adults and mothers' partners
- exploring the effects of abuse on the child's siblings
- better identification of possible contributory problems, such as alcohol misuse or psychological difficulties
- better links between agencies, especially mental health and social services
- greater focus on the needs of women as mothers rather than as individual adults
- attention to the needs of older children and to ways of listening to what they say
- clearer definitions of boundary between culturally acceptable behaviour and child abuse
- clearer roles and re-grading for staff who record information and respond to referrals
- better training and co-operation from professionals perceived as inaccessible

The difficult issues frequently raised were:

- weak practice at the points of initial assessments, family reconstitution and case closure
- the value of using independent authors
- the involvement of family members in reviews
- the publication of reports and handling the media
- learning saturation from repeated reviews
- limited experience of those interpreting the evidence
- a lack of clarity in the role of the Social Services Inspectorate
- the priority given by DH/SSI/Joint Review inspections to case reviews

Most respondents concurred that the value of reviews was greater if they were seen as a practice audit or as another way at looking at the effectiveness of interagency work.

Three useful research and development contributions were identified in the report:

- Research into ways of better identifying in general populations children who are vulnerable to abuse and understanding the nature and interaction of significant factors
- Research into the effectiveness of different ways of introducing change in children's services
- The fashioning and research testing of practice tools designed to improve information gathering, decision making, service development and strategic planning

Relevant studies from other countries

The relevant literature from other countries is less extensive. There are numerous surveys of child deaths, many of them highly sophisticated. The most elaborate is the UNICEF (2001) analysis *Child Deaths by Injury in Rich Nations*. This looks at all child deaths due to injury in 26 wealthy nations noting variations in rates per 100,000 young people aged under 15 from 5.2 in Sweden to 25.6 in South Korea. Figures from the Baltic States and Romania are thought to be even higher – in the region of 29-38. The UK figure is the second lowest at 6.1. Within these deaths, 14% are defined as 'intentional', which implies abuse and neglect, but the report acknowledges the difficulties of gathering accurate data on this. Rates for this vary from 0.26 in Greece, 0.33 in Spain 0.5 in Italy and 0.56 in Holland to 2.74 in the US and 2.9 in Mexico. The UK figure is 0.8.

Children aged 1-4 are at much greater risk in the high rate countries but in the low rate countries, the risk is evenly spread across age groups. Boys are also at higher risk than girls but this contrast increases the higher the overall rate for that country. There is also some indication that children from lower social classes are more at risk of accidental death.

Whatever the accuracy of the figures, the important finding is that the countries with the lowest overall child death rates also have the lowest rates for 'intentional' deaths.

There are also several studies of the arrangements that exist to monitor child deaths from abuse and neglect but few of them scrutinise wider issues such as the effectiveness of different review approaches, the children and families involved and the consequences for professional development. Many of these studies can be found on the website www.ican-ncfr.org/virtuallibrary.

One of the most important studies is Durfee and colleagues' (2002) survey of 58 Child Fatality Review teams across the US which gives details of teams in terms of membership and scope. They show that most states in the US, Canada and Australia have some kind of team in place and that the core membership is fairly consistent. Most cases are selected from cases dealt with by the coroner or medical examiner or from vital statistics records through established protocols. While most reviews are conducted by local teams, state teams may review cases when the local population is small or if the case is especially complex or emotive. State teams often support local

teams through training, resources, policy development and political assistance. An increasing number of teams collect data and issue reports, often published on the Internet, allowing teams to share resources.

Based on self-report information provided by respondents, the authors see signs of maturity and growth with regard to broadening of the intake spectrum, membership and data collection and developing and following through with case management and recommended changes. Teams continue to improve multi-agency interaction and are committed to the prevention of child death and injury. An embryonic national and international system seems, therefore, to be in place. Alkcalde and Elster's (2002) extensive survey covers the same ground but stops short of wider issues by providing 'an overview of statutes and regulations in an attempt to join up and compare state approaches from across the US', while Bunting and Reid (2005) assess the advantages of introducing Child Death Review Teams to the UK.

The literature from Europe other than the UK is noticeably sparse on arrangements for child death and serious injury reviews. The Pandora Project, which studied Germany, Belgium, Hungary and France, focused mostly on the legal and ethical issues of privacy, confidentiality and disclosure rather than professional practice (Burke et al., 2000). Similarly, the comparative studies of European countries, especially France and England, by Cooper and Hetherington and their colleagues (Cooper et al., 1995; Hetherington et al., 1997) look at child protection arrangements generally rather than the reviews that interest us. Nevertheless, they describe that 'during a seminar in which French, Flemish and German practitioners presented examples of their practice to English workers, the continental workers were struck by the fact that the same question had arisen in all three groups – how many children die as a result of abuse each your in your country? Not only did they not know the answer but the question did not resonate with any of them in the way it does in England because measures of serious incidents do not function as primary indicators of professional, public or political evaluations of the efficacy of their child protection systems. However, child death in the context of the delivery of public child welfare services is by no means unknown or unrecognised in these countries' (Hetherington et al., 1997 p. 25). Later (p. 140-1) they report that the continental delegates saw themselves as 'in the business of preventative and therapeutic work for children and families and they worked in voluntary and statutory agencies, but they did not see themselves directly or solely accountable for child deaths'.

It seems, therefore, that the responses to similar problems will differ in countries depending on the historical, philosophical and professional traditions. This is illustrated by Hetherington and colleagues (p.27) by showing how responses to the common problem in child protection of balancing 'care and control' differ in Flanders and England. 'In Flanders the response to this structural difficulty in the system was two fold: to effect clearer separation of the two domains, and create an intermediate zone in which difficult cases could be assessed and managed'. In England the response, though largely unplanned, was to extend control to more and more families, via a framework of investigation regulation, procedure and through the child protection conference system, which moved therapeutic intervention to one side.'

The difficulties of drawing conclusions from international comparisons have also been highlighted by Beckett (2005). He examines a claim by the NSPCC made in 2002 that Sweden has a low rate of child abuse deaths and a major reason for this is the banning of corporal punishment. He argues that the alleged low rate of 4 child abuse deaths in 15 years may be due to the definition employed and that this figure cannot be compared to the estimate of 100 annually in the UK without considerable qualification. Moreover, this pattern prevailed before the ban on corporal punishment and is similar to some other countries, e.g. Spain, where no such ban exists. Sweden's relatively low death rate may thus be attributable to social and economic factors. Beckett also cautions about expecting a 'quick fix', such as a smacking ban to affect child deaths from abuse and neglect. It may be a symbolic gesture but the context in Sweden is quite different from the UK. Welfare expenditure is much higher and the implementation and inspection of a smacking ban in this country, whatever its other merits, could divert resources from other child protection work. He opines 'broad social/cultural/economic changes look more likely to make a difference to rates of child abuse deaths than will yet another round of tinkering with the multi-agency surveillance system.'

Many common weakness of current child protection services have been identified in these studies and it is no surprise to see that they also feature in the 2003 C*hild Protection Review in Scotland*.

Looking at all the evidence, these weaknesses can be summarised under broad headings as follows:

Inter-agency working

- Limited inter-agency co-operation and lack of service integration, especially between child and adult services
- Poor communication both between agencies and within agencies
- Health services and child protection: variable levels of knowledge, of both risks and procedures, among different groups, especially GPs and those in adult mental health services
- Need for specialist forensic paediatric pathologists
- Greater clarity of the relations between criminal proceedings and child protection

Collecting and interpreting information

- Receiving, recording, interpreting and dealing with referrals appropriately
- Using information to assess risk factors, understand triggers and interpret accumulating evidence
- Understanding thresholds, especially the importance of neglect and emotional deprivation
- Importance of comprehensive family assessments, especially histories of male figures
- Need for medical evidence to be considered within the overall context

Decision-making

- Need for shared decision-making, especially in respect of not taking action or case closure
- Moving from data collection and sharing to strategic discussions and clear plans
- Planning a co-ordinated response across professionals and agencies

Relations with families

- Seeing the child as the client, focusing on his or her protection and considering but being unduly distracted by other problems
- Dealing with hostile families or those who withdraw
- Lack of awareness of the impact of domestic violence on children and their safety.

Having looked at the findings from empirical research studies, we now turn to the context in which reviews are conducted in different countries.

3. THE CONTEXT IN WHICH REVIEWS ARE CONDUCTED

The historical and global context

Concern about the welfare of children is not new. In the UK, there is a long tradition of reports and inquiries into the circumstances surrounding situations where children are at risk. Particular issues have been salient at different times, so that the care of foundlings worried Thomas Coram, child labour horrified Charles Dickens and the destitution of street children stimulated Thomas Barnardo. This tradition has continued unabated with a major inquiry virtually every decade and numerous reports annually on children who have been killed or seriously injured.

A historical analysis of these reports shows a growing concern for the welfare of the children as individuals and greater responsibility of the state to intervene if young people are at risk of harm. While the incidents that are now included in the term child abuse and which trigger official action have never been socially approved in this country, there was a long reluctance for the state to become involved in the private lives of families. The clergyman Robert Francis Kilvert summarises this dilemma in his diary entry for Thursday 29 June 1871 describing the cruelty inflicted on Annie Corfield and her twin sisters who were all 'miserable and badly treated by their father since their mother's death. What would she say if she could see them now, ragged, dirty, thin and half-clad and hungry? How unkindly their father uses them. The neighbours hear the sound of the whip on their naked flesh and the poor girls crying and screaming sadly sometimes when their father comes home late at night. It seems that he makes the girls get out of bed and strip themselves naked and then he flogs them severely or else pulls the bedclothes off them and whips them all three as they lie in bed together writhing and screaming under the castigation. It is said that sometimes Corfield strips the poor girls naked holds them face downwards across his knees on a bed or chair and whips their bare bottoms so cruelly that the blood runs down their legs.' How noticeably Kilvert's inaction contrasts with a situation in Scotland several years ago when a father received a suspended prison sentence for smacking the bare bottom of his child when she refused to sit in the dentist's chair.

The American researcher Matt Stagner has argued in discussion with us that this process is best understood as a growing recognition of the rights of children as individuals. It is closely related to the empowerment of other disadvantaged groups whose situation was highlighted in the 1960s in discussions about the morality of the Vietnam War. This was a time of struggles about civil rights in the US and contradictions were highlighted by the Government's pursuit of a war to achieve what was denied some of their own citizens, especially African-Americans in the Southern states. Similar dissatisfactions spread among other groups, such as the disabled, women, gays and lesbians.

Stagner, who was working in Government at the time, explains that it became apparent that a viable moral basis for a modern complex society is one based on established fundamental rights for all citizens. This includes children and among the rights conferred on them was the right not to be abused. So the experience of the Corfield children would be quite different today; the state would intervene on their

behalf, they could be removed from their father's care and his access to them denied; and they could probably sue him for the psychological damage he inflicted.

So in nearly every country across the world, there is growing interest in children as individuals with rights and some kind of system in place to pursue them and so protect children from harm. As the death of a child from abuse or neglect is an extreme situation on a continuum of harm, most countries have also developed arrangements to establish the facts in such cases, to learn from the tragedy and put in place procedures to stop it recurring. Thus, arrangements for inquiry following the death of a child where neglect or abuse are contributory factors are established or being developed in most countries.

The context in each country will obviously differ. There will be different populations, different child welfare histories, different emphases on problems and different professional structures. In the United Kingdom, there is extensive multi-professional activity concerned with what is termed child protection. Indeed, in a large local authority with a population, say, of 800,000, some 7,000 people will have responsibilities in this area.

There are several lessons to be learned from these developments. First, in England and Wales, where the *Children Acts* 1989 and 2004 apply, there is no such thing as a child protection service, despite the repeated use of this term. The same services – whether family support, day care, looked after, adoption etc. – are available to all children in need, whether or not there is a protection issue. The only legal order specific to risks of abuse or neglect is the emergency protection order that enables precisely what it says.

Second, several research studies of inquiries following cases of child death or serious injury have all concluded that many of the incidents were one-off events and many others could not have been predicted. Blessed with hindsight it is easy to feel amazed at the apparent stupidity or tardiness of the professionals involved at the time but, as Munro (2005) points out, it is necessary to understand why certain courses of action seemed reasonable to those involved at the time and how their behaviour was constrained by resources and the organisational context. In the studies mentioned, while many of the children's families displayed known risk factors, it was virtually impossible to predict prospectively what would happen. Thus any claims that events might have been foreseen were unduly optimistic, insensitive to the high levels of 'false positives' found in child care predictions. Of course there were incidents of poor professional practice, but these were found in only a minority of cases. As Reder and Duncan (2002) emphasise, this does not mean that we should abandon attempts to understand the pathways that lead to these incidents but that it is a laborious task requiring extensive epidemiological evidence and analysis.

Third, the studies also showed that although child care is seen as the remit of social workers, most front-line workers in the cases studied were health professionals, with police and teachers not far behind. Thus, the problems were not those of incompetent social workers but of identification, assessment and action. Obviously, there are many different therapies for abused and neglected children and there is a healthy argument about their merits but the problems identified in child death inquiries occur before this. Hence the endless recommendations about working together, joined up services,

gathering information and communicating it to others. If there is such a thing as a child protection service, it comprises these processes rather than being a 'service' in the sense of an intervention.

The current survey of approaches to reviews in different countries

The context of all children in need

The survey of the countries undertaken for this study shows wide differences in the contexts in which inquiries into child deaths and serious injuries take place. In the United Kingdom, they are a relatively common cause of death and are taken very seriously. In some other countries, in contrast, there are other concerns about children which take the focus from abuse and neglect. In parts of the US, for instance, there is equal concern in official documents about the high number of child deaths from gunshot wounds and other causes, many of which, such as fire deaths, suicides and accidents, are associated with poverty. In South Africa the respondents all emphasised that the births of some children are not registered so their deaths could pass unnoticed and the major threat to children's welfare, consuming most of the available resources, comes from AIDS.

Similar issues arise in Eastern Europe. Discussion with a Romanian expert stressed that while child deaths from neglect and abuse were usually investigated, the major child concern in recent years has been the removal of young children from institutions. While the quality of residential provision situation in neighbouring Bulgaria is not quite as bad, here a sizeable proportion of the population, the Roma people, have been traditionally deprived of welfare services. There are also an estimated 2,000 street children in Sofia and an industry of trafficking in adolescents with associated kidnapping and murder, the amount of which is unknown. In Brazil, for example, it is alleged that homeless children are sometimes shot by gunmen hired by businessmen and property developers, by vigilante groups or even by the police.

The response from Norway is noticeably contrasting in another way, explaining that child deaths from abuse and neglect are so unusual that no extant system is deemed necessary and cases are investigated in an appropriate way when they arise. It is felt that the strong welfare tradition and policies to reduce behaviours such as bullying, domestic violence and alcohol consumption have a preventative effect. In other Western European countries, as well as in Canada, Australia and the US, child deaths and serious injury appear to be more common and a clear process has been established to review each incident.

Thus, the context of arrangements in each country not only reflects the prevailing professional structures but also the significance accorded to deaths and serious injury from abuse and neglect in the light of other perceived risks to children's welfare.

The focus of inquiries

A second contextual factor necessary to understand review processes concerns the focus of reviews and the balance and relationship between different types of inquiry. In cases of suspicious child death or serious inquiry, various professionals are automatically involved. Coroners have responsibilities for identifying the victim and

establishing the cause of death, the police for conducting criminal investigations and prosecuting perpetrators, other child welfare services for learning from events to improve their service and governments for upholding children's rights. It will be seen that the balance of activity between these agencies varies considerably across the countries studied and that there are considerable differences in the power to instigate inquiries, determine their nature, see them through and act on their findings.

The role of child reviews in the development of services

A final contextual factor concerns the role of child death and serious injury reviews in the development of services. In situations where there is no system or tradition of professional development, their function is quite different from situations where there is continuing research and evaluation into the needs of all children.

In our experience, there are at least are five models of service development. The first is to achieve change by legislation and guidance. This is highly effective but is often imposed on a cynical and reluctant workforce and may serve a hidden political agenda. The second is to fill in gaps identified in user surveys or evaluation studies. This is also effective but unlikely to be radical, leading to more of the same rather than something different. The third, is to respond to new evidence and practice experience which although slow is often positive in its effects, leading to more radical changes. For example, in recent years, there has been a considerable growth in the use of family support to protect children at risk of harm or in the use of foster care for those once deemed unfosterable.

A fourth method of service development is to respond to scandal, and it is here that reviews of child deaths and serious injury can have a major effect, whether at a national level, such as in restructuring professional relationships or amending legislation, or at the local level of practice. While the effects of these can be dramatic, there is a danger that they put in place elaborate procedures and structures for events that are relatively rare and so take resources from mainstream child care work.

Each of these approaches has its strengths and weaknesses and at different times, policy and practice developments can be seen to reflect a combination of these forces. Socio-legal considerations, practicalities, user perspectives and research evidence all interact in different ways so that one or another achieves a salience at particular moments. But, although child welfare may appear to be a consensus discipline - after all who but an ancient Spartan would think it good for children to be abused? - there are considerable tensions between the professionals involved. Policy makers, for instance, are likely to be concerned with rationing, service efficiency and consistency; practitioners with professional competence, cultural sensitivity and inter-agency co-operation; users with the consumers' voice, equality of services and practical help; and, researchers with the use of evidence, discovering the causes of social need and accounts of individual interpretation. Traditional responses to problems attempt to smooth over these difference and comprise things such as: increased resource, organisational change, attention to rights, consumer participation, better management information and greater central or local control, all of which, although important, are unlikely in themselves significantly to improve outcomes for children and families.

A fifth model of service development is more radical. It starts with the needs of children, sets desired outcomes in various areas of their life, considers the services that need to be put in place to achieve them and then considers the structures, management and training to make them work. It refocuses services in the sense of a move from a separation of services for poor and better off children to services for all children, acknowledging research evidence that all children are in need at some point in their development; it moves from an emphasis on intervention and treatment to a balance between prevention, early intervention, treatment and social prevention; it shifts the focus on process and outputs to services that prevent impairment and social exclusion and improve children's and families' quality of life. All of these not only help improve services but also increase the self-esteem of front line workers. In addition, it should reduce what Stanley and Goddard (2002) have described as the 'hostage-like' behaviour emanating from the trauma and isolation that practitioners continually experience.

Obviously, this fifth method of service development has to be supported by a set of practical procedures and instruments, such as effective referral arrangements, a common language for agencies to assess children's needs and a continuum of services likely to achieve optimal outcomes for children and families. The details can be found elsewhere (www.whg.org.uk). However, what is important in that there is no perfect and universally applicable model for reviewing child deaths and serious injury as each needs to be different according to the service development strategy that is in place.

It will also be seen later that the review models valued by policy makers and managers are often criticised by practitioners. A seemingly coherent system for reviewing child deaths can be viewed by front-line workers as somewhat forensic and unsympathetic to the situations of the families involved. The lesson for the Scottish Executive is to decide initially what model of service development it wishes to adopt and then to consider reviews of child death and serious injury in the light of this, not the other way round.

It would be expected that a children's services model developed in the way described will reduce the likelihood of child deaths and serious injury simply because it builds into daily practice the common recommendations of review reports. Unfortunately, some child deaths and serious injury will still occur for Sinclair and Bullock's study suggests that as many as 30 per cent of 100 children subject to case reviews annually in England were virtually unknown as children in need. But, when tragedies do happen, they obviously demand proper investigation with lessons learned and appropriate action, but the process does not take place in isolation. Neither can models from other countries be transferred lock, stock and barrel from one context to another.

This section has sought to alert us to the contextual factors that have to be considered if the process in place is not only to be effective in its primary task but also able to contribute to service improvement, as this will ultimately benefit the children the whole system is designed to protect.

4. METHODOLOGY

Data collection

A variety of research methods were used to investigate the arrangements for the review of child death and serious injuries in different countries. These include, in addition to the literature review just discussed, an internet search, discussions with researchers, policy makers and practitioners, and a questionnaire to experts followed-up and complemented in some cases by telephone interviews. Each method provides different kinds of information for the study. As the questionnaire and literature search were the most complex of these they need to be discussed in more detail.

Questionnaire to experts

Given the short time for the study, it was decided to send a structured questionnaire by email to selected researchers, managers, policy-makers and practitioners known as international experts and from previous work with the Dartington Unit. Respondents were also asked to alert us to interesting developments in other countries that could be followed-up and for copies of official documents regarding legislation, guidance and procedures. The questionnaire was followed-up shortly after by email or telephone call to check that respondents understood the requests and were able to assist (or point us towards someone more suitable). Returned questionnaires were analysed and, where it was necessary to clarify issues and elaborate points of particular interest, followed-up in greater depth by further email inquiries or a telephone interview.

A range of countries were selected initially (24 in total) in order to gain a good sense of the variety of review arrangements operating: Australia; Belgium; Brazil; Bulgaria; Canada; England; Germany; Ireland; Israel; Jordan; Netherlands; New Zealand; Northern Ireland; Norway; Portugal; Romania; Scotland; South Africa; South Korea; Spain; Sweden; Switzerland; US; Wales. Although these countries partly reflect existing Dartington Unit networks, they also represent different continents, developed and developing countries, a selection of non-English speaking countries and a cross-section of welfare systems. The cross-national study referred to above cautioned against making simple comparisons between countries as there is considerable variation in the context of children's services, the professionals involved and the training and values they bring to their work (Weyts, 2004). The intention, therefore, was partly to analyse the findings from the questionnaires in the context of the child welfare system operating in each country and standard attempts to classify them into a taxonomy on the basis of their welfare approach.[1]

The respondents within each country were identified on the grounds that: they were known to us personally through work on other projects and were thus more likely to respond; they work in the child welfare field, either in respected research centres or central government departments (some have worked in both) or hold senior positions

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[1] Four general welfare approaches have been delineated by international social policy analysts. These models are based on differences in the scale, entitlements and scope of public provision in capitalist societies, the differences in policy-making styles and processes, the underlying patterns of class formation and the prevailing political structures. Precise terminology varies but typically they are termed: the conservative-corporatist; economically liberal; social democratic; and Mediterranean/developing (see Esping-Andersen, 1990; Leibfried, 1994).

in provider agencies; they speak and write good English and so could provide succinct summaries of the situation in their country and assist us with translating foreign language terms as necessary; and they are well-connected in their country and so would know of other experts (so helping us to build a snowball sample). In total, completed questionnaires were received from 14 of the 24 countries, with information about another four countries gained from discussion only. Further details about the countries involved in the study and the form of their participation took are provided in Appendix A.

The questionnaire was based on previous conceptual and empirical work on the subject; for example, the questions about strengths and weaknesses drew on markers of good practice and criticisms of review systems as acknowledged in the literature. The design was circulated to several experts beforehand (including the Scottish Executive) and revised in the light of comments to ensure that the final version was comprehensible and satisfactory as a method for studying the issues (Appendix B). It explored the following areas:

(i) the boundaries of existing procedures, including approaches to the deaths of children and significant cases *broadly* but focusing on those where child protection is a factor – the types of enquiries or procedures that follow child deaths resulting from abuse or neglect and, in some countries, serious injury or other suspicious situations (it may prove useful here to use a previous attempt by this centre to categorise the characteristics and needs of children drawn into such enquiries)[2]

(ii) who orders reviews or enquiries and with what authority

(iii) who undertakes the enquiries and who else is involved – professional background, expertise, status etc.

(iv) the scope and style of the enquiries, that is their purpose and what they look at; for example, the questions that should be answered, the sources used, the required structure of reports (if any), how prescriptive the guidance is and whether reports are inquisitorial or more focused on learning and service development

(v) the administrative arrangements for conducting an enquiry

(vi) how the results of the reviews are disseminated – report formats and availability, use of the media, existence of annual or two-yearly overviews, integration into service development, Action Plans etc.

(vii) the effects of enquiries on policy, practice, legislation and guidance, training, other social work with families and subsequent reviews

(viii) the strengths and weakness of the procedures adopted, viewed from the perspectives of different stakeholders (providers, children, parents, etc.)

(ix) situations where the procedures work well and others where children are missed or poorly served

(x) an example (anonymous) of a successful review procedure and of a failed or unsatisfactory exercise

(xi) the resources invested in the review procedures in terms of finances, time, experts and other staff

(xii) whether any research has been undertaken into child death and significant case reviews in the country and if so what it found.

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[2] See Sinclair and Bullock 2002, p.36. *op. cit.*

Literature search

In order to explore the literature, standard search procedures were employed using respected scientific and practice data bases such as BIDS and the eLSC (electronic Library of Social Care). Additional literature was identified by respondents and through continuous discussions during the project with colleagues experienced in this field. A concerted effort was made to (a) link the emerging findings to other recent work undertaken for the Scottish Executive in the area of child protection (e.g. Scottish Executive, 2002) and also (b) interpret and present the findings in the context of a wider understanding of risks to children and the role of children's services agencies in addressing them. Further details of the search strategy, including the sources and search terms, are provided in Appendix C.

It was decided to conduct the literature search in two stages. Stage one was to identify relevant literature using the search terms and databases. This was to be completed rapidly initially in order to get a sense of what is available and so as not to focus unduly on any one country, with a more careful sifting of material following later. If it was necessary to narrow down the search, the option existed to add names of the countries involved in the study to any of the terms. The material identified was supplemented with sources found by other means (see above). Stage two involved coding each item of literature against key headings from the questionnaire and summarising the main points for each country. A total of over 50 relevant and useful items were identified using the various means described.

Analysis

The analysis of data from the questionnaire, interviews and literature review focused on four areas and used standard procedures for coding and organising the data thematically. The intention was to provide the following:

(i)   An attempt to describe systematically and develop a typology of approaches to child death and significant case reviews, taking into account data obtained under headings (i)-(vi) of the questionnaire as described above: the type of review and circumstances in which they are held; who orders them; who undertakes them; their scope and style; their administrative arrangements; and their dissemination and use. Approaches in each country were also scrutinised in the light of common criticisms of such reviews – their failure to focus on the child, the lack of a clear format, the isolation of the exercise from wider children's services strategic planning, etc. – and accepted good practice – taking a multi-agency perspective, including particular content (e.g. family history), emphasising clear lessons, etc. (Sinclair and Bullock, 2002, pp.12-14, 47f);

(ii)   An evaluation of the effectiveness of those approaches measured in terms of their impact on policy, practice, legislation and guidance, training and other social work with families, children and families themselves and subsequent reviews. One indicator of effectiveness is the extent to which recommendations are repeated over time (the assumption being that if they are adopted it would not be necessary to repeat them). An attempt was

made also to chart effects noted by researchers at a micro scale, for example the extent to which reviews lead to children feeling protected (subjective) or perpetrators being prosecuted (objective). To guide the analysis in this section the report draws on a model developed for measuring the impact of research on policy and practice. This focuses on (1) immediate outcomes (e.g. distribution, recognition), (2) intermediate outcomes (e.g. changes in thinking, policy, service provision) and (3) ultimate outcomes (i.e. child well-being) (Bullock et al., 1998; Knott and Wildavsky, 1981). Consideration was also given to reasons for reviews having a positive effect, for example by reflecting on the nature of recommendations (often these focus on organisational change, which tends to change the players but not the problem) (Fitzgerald, 2002);

(iii)   A closer examination of approaches or systems that are unusual in comparison with those in the UK and countries in which no reviews are undertaken. This involved repeating much of the evaluative analysis undertaken for (i) and (ii);

(iv)   The resource implications of the different approaches in terms of financial cost, time and expert/other resources.

Strengths and weaknesses

It was apparent from the outset that this study would face two main constraints: the relatively short timescale for completion and the (anticipated) relatively thin published literature on the specific subject of child death and significant case reviews, even on a global scale. The method was designed to obtain maximum benefit within these parameters. Did it succeed? This is for others to judge but certain strengths and weaknesses became apparent. The findings should therefore be considered in the light of the following observations.

First, the study obtained a good response rate. Completed questionnaires were obtained for 14 countries, supplemented by information from discussions in four other countries. This makes a total of 18 out of 24, although the analysis that follows focuses on the 16 for which the best information was available.[3] The initial distribution was followed-up for each identified respondent up to three times as necessary by email and/or telephone in order to maximise the likelihood of a response. Inevitably, though, the rapid turnaround requested (essentially 3-4 weeks for the questionnaire) meant that some people were unable to assist due to previous work or holiday commitments. The nature of the questionnaire would have played a role here in that it was fairly long, included open-ended questions that required considerable thought and therefore could not be completed rapidly. Three interviews based on the questionnaire were conducted and then translated into English on our behalf by colleagues in the relevant countries as it was easier for the respondents concerned to answer questions in their own language.

Second, many of the respondents are acknowledged experts in the area of child death and significant case reviews, not only in their own countries but internationally. This is apparent from the fact that they have published extensively on the subject, and/or

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[3] These are: Australia, Belgium, Canada, England, Germany, Ireland, Israel, Jordan, New Zealand, Northern Ireland, Norway, Scotland, South Africa, Switzerland, US and Wales.

because their name was mentioned often by others that we contacted, and/or because they hold senior professional posts in the area of study. Where this was the case they were followed-up by email or telephone interview so that key points and recommendations could be elaborated. Other respondents did not consider themselves to be experts on the topic. While to some extent this is modesty speaking, the main reason is that there has been little interest about and even less research on the topic in the countries concerned (see below); a respondent could be an expert on the indigenous child protection system without having much to say about child death and significant case reviews. Where an individual contacted in the first place knew of someone better placed to comment they told us and we pursued the contact, but often there was no-one else. It should also be noted that each expert comes from a particular perspective; one respondent, for example, commented that he was a forensic pathologist and some of the questions are arguably more the domain of epidemiologists, lawyers, politicians and paediatricians. A study with a more resources and a longer timescale would be able to canvas the views of a wider range of stakeholders (assuming they exist).

Third, the range of countries included in the study is diverse in several respects. The study includes a mixture of English-speaking and non-English speaking countries. Five continents are represented: Europe (West, Nordic and Central-Eastern), North America, Africa, Asia (Middle East) and Australasia. Different types of welfare state are also in evidence, drawing on standard typologies: liberal (e.g. US), social democratic (e.g. Norway), corporatist (e.g. Germany) and developing (e.g. South Africa). Where marked or subtle differences in the system for reviewing child deaths and significant cases are apparent *within* countries, for example between jurisdictions or ethnic groups, these too are identified; for example in Australia (New South Wales and Victoria), the US (California, Florida, Illinois), the UK (England, Wales, Northern Ireland and Scotland) and Belgium (Flanders and Wallonia). Viewed together, then, a fairly wide variety of systems and experiences is examined. With this in mind, we think that while adding further countries may enrich the study and provide additional examples, it would be unlikely to alter the main messages significantly.

Fourth, the questionnaire seemed to work well. The mixture of closed and open-ended questions meant that respondents were very focused in their answers but elaborated key points. It also provided scope for both qualitative and (limited) quantitative analysis. Some of the questionnaires were completed very fully and returned with pointers to supplementary literature; this reflected the often extensive knowledge of the respondent and the existence of an established and well-researched system in the countries concerned. Other responses were much thinner in content, reflecting either the absence of a system, or the lack of research into it, or the respondent's lack of knowledge (or, most likely, a combination of these). For instance, two questionnaires did not include any material for section B (Evaluation) because there was little in terms of a system to evaluate. The term 'inquiry' seemed to be misinterpreted by three respondents, at least initially, with the result that the answers related more to routine assessment and investigation by social workers in the case of suspected child abuse or neglect rather than retrospective reviews of what went wrong in a particularly serious case. However, in two of these cases a second opinion was available from another respondent in the country and all of the information provided was useful. (The misunderstandings themselves were telling, as they appeared to related in part to the

absence of a consistent system for reviewing child deaths and serious injuries in the countries concerned.)

Where necessary, points were clarified with the respondent directly, so minimising misinterpretation, and a draft of this report was also sent to all survey respondents for comment so that any inaccuracies that may have crept in during the process of synthesising and interpreting the material could be corrected.[4] It became apparent during the study that a complex variety of systems operate in different countries (often varying in subtle ways) and we suspect that it is easy to make assumptions about what respondents report that distort the intended meaning. While the sources and method used have hopefully minimised this, a further rationale for obtaining comments was that seeing what happens in other countries would prompt respondents to reflect further on their own countries' systems and add further insights and nuances.

Fifth, several hundred documents and reports were identified, some 50 of which related specifically to the subject area. These included books, journal articles and grey literature (unpublished reports, government guidance etc.). The fact that several of the items were identified by several search routes suggests that the main items of relevance were found. The most obvious weakness of the approach is that it was limited to literature in English, although set against that is the fact that few of the respondents for the non- English-speaking countries were aware of relevant research in their countries that focused on processes for child death and significant case reviews. Indeed, only about half of the respondents knew of research in their countries, the quality and relevance of which was varied (Appendix D); with notable exceptions, mainly from the US and UK, there is relatively little scientific research on which to draw, indicating a promising area for future studies.

Sixth, all materials were analysed carefully in order to draw out and test the key themes. Each questionnaire was read by both authors so that we had a grasp of the bigger picture and to ensure that important insights were not overlooked. The data from different sources were all examined in relation to the same framework (the main questions in the questionnaire) and greatest weight placed on the messages that could be corroborated. Isolated observations or exceptions to the rule as well as broader patterns of variety are noted in the report. It was particularly helpful for most of the countries to have information from more than one source (including completed questionnaires from more than one respondent in seven countries) as this strengthened confidence in the results and allowed points of apparent contradiction to be teased-out. A concerted effort was made also to link the findings to the broader literature on child protection and children's services (see especially sections 2, 3 and 6 of the report).

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[4] Colleagues from eight countries responded to this invitation and revisions were made to the report in order to address to their comments.

5. RESULTS OF THE SURVEY OF REVIEW ARRANGEMENTS

The main method of studying approaches to review arrangements in different countries was by means of the questionnaire described in section 4 of the report (Methodology). The results are divided into two parts, using questions from the questionnaire to organise the data. The first part charts the approaches taken in each country (or sub-section of it) to inquire into child deaths and serious injuries where abuse and/or neglect was, or is thought to have been, a contributory factor.

THE APPROACHES IN DIFFERENT COUNTRIES

Do reviews routinely take place in the event of a child death and/or serious injury/neglect? If not, why not, and what happens instead?

The variations found here centre around whether there is a predictable routine for assessing the circumstances surrounding the death of a child or adolescent and whether there is a specific group or team to do this.

In England, Wales and Northern Ireland there are both of these, with child deaths subject to a coroner's inquest and scrutiny by a standing multi-professional local committee which can decide whether to conduct a special investigation. The scope and structure of this is laid out in the guidance *Working Together* issued by central government (Department of Health et al., 1999). Occasionally, the government itself may order an inquiry in situations where there are implications for legislation and professional boundaries. In Scotland, no equivalent procedure is specified but the duty to co-operate is mandated in the *Children (Scotland) Act* 1995 and ministers can order any inquiry they think necessary.

Similarly, in New Zealand 'reviews routinely take place in the case of a child death, and in the case of serious injury/neglect. If there is a notification of child abuse or neglect an investigation by the Department of Child, Youth and Family has to take place within a specified time. All deaths are investigated by this department first but the Office of the Children's Commissioner reviews these reports and if not satisfied does its own investigation. All deaths of children in care are referred to the coroner even if not related to abuse'.

In Australia there is no uniform system across the whole country but a well-established system is found in New South Wales. The NSW Ombudsman, through the *Community Services (Complaints, Reviews and Monitoring) Act* 1993 (NSW legislation) has a responsibility to review certain deaths, using clearly specified criteria (see below). These deaths are also examinable by the NSW Coroner. The statutory department responsible for child protection and child welfare, the Department of Community Services (DoCS), may undertake reviews of the death of a child known to the department but it is not compelled to do so. The NSW Child Death Review Team Commission for Children and Young People has the role of maintaining a Child Deaths Register, analysing the data regarding causes of deaths, identifying trends and patterns relating to these deaths and making recommendations to government and non-government agencies for the prevention of further child deaths. Its role relates to all deaths of children in NSW. For serious injuries 'there is

no legislative requirement or standard approach unless deemed a critical incident by the state department but these inquiries are internal and no reports are released'. Interestingly, the NSW Commission for Children and Young People 'has the power to conduct research on trends, issues, patterns of child deaths, including deaths from natural causes.'

In the US, there is a now a well-established mixture of state and local teams: 'Local teams review cases and state teams generally support them. The exception is small states that may do both, for example Rhode Island. The most common intake seems to be all child deaths under 18 in small counties and all coroner cases under 18 in larger ones. Some teams screen cases by protocol to cut the number of reviews'.

But respondents noted that despite official policy, some cases get missed. For instance, the policy document in one Canadian province specified that the Child Death Review Unit of the Coroner's Service be committed to a comprehensive review of child deaths but the questionnaire respondent said that reviews do not routinely take place and those that do are often triggered by high profile media attention. Each province and territory in Canada has its own approach. One that undertook a careful study of non-accidental-injury (NAI) deaths found the figure to be higher than that officially recorded and investigated. This gap between prevalence and investigation seemed common everywhere ten years ago. For example, the 1995 report of the Texas Child Fatality Review Teams bemoaned that 'in Texas, over 4,000 children die annually and no single agency tracks their deaths or assesses the circumstances surrounding the deaths that are sudden and unexpected. Until now, there has been no system for co-ordination and communication among agencies that have a piece of the puzzle and this limits our knowledge about the causes of death in our children'.

Some countries do not have review systems, however. For example, a respondent in Germany commented 'as far as I understand the term 'review' a case-oriented procedure aimed to uncover problems in the child protection process is meant. This procedure should help to avoid similar problems in the future. In Germany there is no such review-procedure following the death or serious injury of a child due to abuse or neglect'.

Other countries do have systems but they are not implemented routinely: 'No, they don't take place routinely [in Ireland]. We have had only one major inquiry into a child's death (Kelly Fitzgerald, published by the government in 1996) and two other major inquiries into individual cases of child abuse (Kilkenny Incest Case, 1993; West of Ireland Farmer Case 1998) there have also been the inquiry into child abuse in sport in 1998, the Madonna House Inquiry in 1996 (residential care) and currently, the Ferns Inquiry into clerical sexual abuse. Otherwise, inquiries may be held regionally but would not be made public'. There are multi-agency case management reviews in Ireland (see next section) but 'anecdotal evidence would suggest that these reviews do not routinely or consistently happen at present as the guidelines have not been fully implemented'.

Reviews may also be convened on an ad hoc basis, as in Israel – 'when suspicion arises that the authorities themselves have been remiss, an ad hoc committee may be convened by a government minister (e.g. the Minister of Social Affairs) to investigate the matter. Usually these committees comprise representatives of the ministries of

health and welfare, legal authorities, social services, etc.). The mandatory reporting law, for example, resulted from the recommendations of one such ad hoc committee'.

This is not to say that nothing happens in countries that lack designated systems when a child dies or when abuse is suspected or identified. Routine child protection practice is ongoing, for example in Germany: 'there may be a criminal investigation against the parents as suspected perpetrators or there may be a criminal investigation against a social worker if law enforcement authorities suspect the death was preventable and the social worker had the duty and the means to do so. Moreover there may be a psychological evaluation of the family system for the family court if the child protection service seeks a termination of parental rights for the injured child or for siblings'.

Similarly in Flanders, Belgium, in cases of serious injury or neglect, the person who discovers this (i.e. the referrer) and/or the victim, have a choice. The referrer must make a decision about the acuteness of the case and about whether the case needs further investigation, which can lead in turn to prosecution of the perpetrator (if a judicial route is followed) or various supportive services (if the voluntary service input route is followed). And in Israel there is a mandatory reporting law: 'Israel has passed a mandatory reporting law. Suspicion of abuse or neglect of any kind will be examined by a child protection officer, with the aim of protecting that child from further harm and/or preventing harm to his siblings or any other children in the same situation. If suspicion arises that a crime has also been committed, a criminal investigation is conducted simultaneously. These two authorities are separate, but do cooperate. I would add that the hospitals in Israel have established special teams, which are on the alert for such cases. If they identify a case in which there is serious suspicion of abuse, they will notify a child protection officer'.

In addition, most if not all countries investigate unnatural child deaths, as in Israel: 'as in the case of any unnatural death, the death of a child will be examined – the question is by whom. Similarly, in case of severe injury, some examination will be made'. And in Flanders, Belgium, 'when a child death occurs and there are suspicious circumstances, an intervention from the courts is inevitable. If, for instance, a child dies in hospital the hospital staff will have to inform the law/justice. If this happens in the Netherlands, then a forensic investigation will automatically take place, this is not yet the case in Belgium'. Further, although reviews only happen in Belgium when the death of a child is suspicious, as in the case of non-natural death, there is a law stating that all deaths of an infant under 18 months would be followed by an autopsy (this is not yet in practice). And in Jordan, 'all the death cases in Jordan either caused by unknown causes or incidents are referred to the National Institute of Forensic Medicine where they are reviewed and autopsies are carried out regardless of the age… The following law articles in the penal code address the issue of child death: Articles 228 –331, Articles 289-290 on children neglect.'

The reasons why some countries do not have set procedures vary. In some cases, the dearth of incidents makes such procedures unnecessary. Thus, in Norway, 'We rarely have cases with child death or serious injury. If so, there will be a court case. We do not have a practice of reviews'. In other cases, there are administrative and resource difficulties. In South Africa, for example, 'reviews do not routinely take place – but where the death is suspected to be the result of abuse and/or neglect there will be an

investigation. However it is noted that in South Africa many births are not registered due to the inaccessibility of Home Affairs costs of travel to registration points and also in some instances the lack of awareness of need. A national drive is taking place at the moment to encourage birth registration. This is linked in part to access to the Child Support Grant. The project is a joint enterprise between UNICEF and the South African Government'. In Germany the lack of set procedures has been attributed to a system looking inwards and acting defensively: 'Until now the introduction of a child death review system was seldom discussed in Germany [Blűml et al., in press] which is one of many indicators of the self isolation of the Germany child protection system'.

What are the criteria for including a case in the existing procedures for conducting reviews? Do they include deaths <u>and</u> serious injuries, and do they take place if there is <u>only</u> suspicion of abuse and/or neglect as a contributory factor?

The main variation in this question concerned the motivation for the inquiry – whether it was the death or the abuse that caused it. The US child abuse expert Michael Durfee advised that 'an inclusive intake is central to looking at child death then at the cause manner and/or suspicion'. In another US state the criteria for conducting reviews are clear: 'In any case where there is a validated report of abuse or neglect or where the child is in custody or under supervision of a social services agency'. A list of the circumstances included in Georgia, US illustrates not only the range of situations but also cultural peculiarities. Investigators can examine nine categories of the death of child under 18, namely: violence, suicide, casualty, suddenly when healthy, unattended by a physician, suspicious manner, after birth or unexplained if under eight years of age, while in hospital, care or prison and as a result of death penalty execution.

Elsewhere, there are different criteria for death than for serious injury. In New Zealand, for example, 'primarily reviews are carried out in the case of death. In cases of abuse, the normal process of notification and investigation of the abuse takes place.'

New South Wales in Australia has precisely-drawn criteria. Section 35(1) of the *Community Services (Complaints, Reviews and Monitoring) Act* 1993 specifies the deaths of the following children (under-18s) as being reviewable deaths:

(a) a child in care
(b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act* 1998 within the period of 3 years immediately preceding the child's death [in other words, a child referred to the Department of Community Services]
(c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act* 1998 within the period of 3 years immediately preceding the child's death
(d) a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances

(e) a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place).

One independent commentator observed that the characteristics and needs of children for whom reviews are conducted in New South Wales resemble the situations of cases reviewed in England and Wales (see Table 2.1 in this report, above) but noted that 'these characteristics do not trigger an inquiry; these factors emerge from the inquiries into the deaths of children'. Moreover, the review may not necessarily focus exclusively on the child who died. For example, staying with New South Wales, Australia, a respondent from the Ombudsman's office pointed out that 'if serious concerns about the conduct of a government or non-government agency within the Ombudsman's jurisdiction are identified through the review process, there is capacity to investigate an investigation under the *Ombudsman Act*. The focus of investigation could include issues for surviving siblings'.

The criteria for a review are also clear in Ireland, at least for a case management review, which the respondent concerned defined as 'a multi-agency review of the response, manner and quality of services provided to children and families. It is a systems check, the purpose of which is to learn lessons from the handling of specific cases so that deficits in the system can be addressed. Health Boards will generally be responsible for instigating a case management review as part of their overall role in monitoring standards of service provision and delivery [Article 8.25.2 of *Children First Guidelines*, Department of Health and Children, 1999]'. Article 8.25.2 in *Children First* says that 'a case management review must be carried out in the following circumstances:

(i)   When the case of suspected or confirmed abuse involves the death of a child
(ii)   When the case of suspected or confirmed child abuse involves the serious injury of a child
(iii)   When a child protection issue arises which is likely to be of significant public concern

In other words, the criteria extend beyond child death. Elsewhere the criteria are much wider. In Belgium, for example, the focus is on all non-natural deaths and 'in the near future all deaths under the age of 18 months would be reviewed (including autopsy). However the parents have the possibility to reject this procedure'.

In Jordan, there are criteria for including a death incident in the existing procedures. These include:

1. Unknown causes of death
2. Death incidents with no fatal disease history
3. Unnatural causes of death as poisoning and falling from heights
4. Death incidents in institutions such as hospitals and Juvenile Institutions.

Within these categories comes suspicion of abuse and/or neglect by the Hospital Casualty Department or the assigned therapist, although some cases might not be

detected as the neglect might lead the child to suffer from chronic disease and eventually death: 'cases of death due to neglect are sometimes hard to detect'.

In other countries, there is considerable scope for professional discretion. In Canada, the criteria are 'not just suspicion of abuse or neglect but also unexplained deaths'. In Norway, 'court cases are conducted and reviews are undertaken if the authorities feel it is justified'. In Northern Ireland the chair of the Area Child Protection Committee has more responsibility than in England and Wales to decide whether or not to proceed but in Scotland there is no agreed definition of what constitutes a 'significant' case. In South Africa, 'provincial protocols on the management of child abuse, neglect and exploitation do exist but are not implemented for a number of reasons – lack of motivation and political will, lack of inter-sectoral training and awareness of the existence of the protocols and lack of resources. The child protection system is presently overwhelmed by high case loads and few resources. Many cases slip through the system'. In Germany 'there is no obligation to register cases of maltreatment to the police besides if an offence results in the death of the victim. Doctors, chaplains and lawyers exercise official discretion. The obligation to discretion can be eluded in cases of a serious danger for health or life of children and young people. Other professions, such as Socialpedagogues do not have an equivalent to the doctor-patient secrecy by law. Enquiries if there is a suspicion of endangered child welfare are the duty of the youth office due to their status as a guarantor of the child's welfare. Enquiries if there is a suspicion of a crime committed to a child are the duty of the prosecution authorities and the police'.

Criteria may also vary for practical reasons. Thus, in the US, 'We [Los Angeles County] review all cases that are notorious in the media. We emphasize homicide and undetermined [causes] because of our large size (10 million people with 150,000 births and 1,500 child deaths a year). We formed a separate team for child suicide and need another for non-intentional injuries… Smaller counties with less than 500,000 people may review all child deaths, those with less than 200,000 may meet less than monthly, those under 100,000 total population have reports; Sutter in California with 80,000 may be the smallest county with a report'.

Having considered whether reviews are conducted routinely and the criteria for holding them, it is important to comment on how they connect to other procedures for reviewing unnatural deaths and also to note any variation in approach *within* countries.

Does more than one type of review/enquiry operate in relation to child deaths or significant cases, for example for different kinds of incident, and how does this affect other answers?

There is a tension throughout this report, inherent in all international comparisons, of trying to generalise about countries that have different traditions and policies within them. For instance, the legislation of each US state is unique and 22 review child deaths from all causes while six only review deaths due to maltreatment (Webster et al., 2003).

Similarly, there is no uniform system of child death reviews in Australia. In Victoria, 'the Department of Human Services (which runs child protection) has what it

describes as a publicly accountable child death review system, which was implemented as a ministerial advisory committee in 1995 after a series of scandals. The only other states that currently have child death reviews are New South Wales and Western Australia. Other states, however, have largely medical morbidity and mortality committees. Queensland and South Australia are in the process of establishing systems for child death review. Interestingly, South Australia is considering a serious injury and child death review system, something that does not occur elsewhere'.

The respondent who made these comments noted that he was not familiar with the nature and outcome of, for example, the system in Western Australia, but identified inconsistency is an issue: 'I have argued repeatedly for a uniform Australia-wide review of all child deaths… we do not know how many children die of abuse and neglect. Unfortunately, as so often happens in the UK, it appears that scandals are necessary before there is any action'. The inconsistency is presumably related, at least in part, to the fact that the key agencies relevant to child death review – Coroner, Police, Health and Child Protection agencies – are all state jurisdictions.

Similar complications arise from the independence accorded to ethnic minority groups in, for instance, Canada, Israel and Eastern Europe. Similarly, in the UK, some aspects of the history of child care in Scotland, such as the provision of residential care, are quite different from that of England. The complexity that can arise in terms of geographical variation can be illustrated by reviewing the work of multi-disciplinary teams in each of the provinces of Canada (Table 5.1).

Table 5.1 Child Death Review Teams in Canada by Province/Territory*

Functions	Province/Territory										
	1	2	3	4	5	6	7	8	9	10	11
Multi-disciplinary child death reviews	✓	x	✓	✓	✓	✓	✓	✓	x	x	✓
Legislative mandate for review process	✓	-	✓	x	x	x	x	x	-	-	x
Case review function	✓	-	✓	✓	✓	✓	x	✓	-	-	✓
Policy development	x	-	✓	x	x	x	✓	✓	-	-	x
Provincial/Territorial child welfare membership	x	-	✓	✓	x	✓	✓	x	-	-	✓
Recommendations released case by case	✓	-	✓	x	x	x	x	✓	-	-	x
Annual Report release of recommendations	✓	-	✓	✓	✓	x	✓	x	-	-	x

* ✓=Yes, x=no, '-'=not applicable. The names of the provinces are not included as the purpose of the table is to illustrate the extent of variation between systems within one country rather than the precise arrangements in any part of Canada. The table is adapted from Table 1 in the report *Child Death Reviews and Child Mortality Data Collection in Canada* (Christianson-Wood and Murray, 1999, p.43).

What procedures operate in relation to child deaths or serious injuries where abuse/neglect are <u>not</u> (or are <u>not thought to be</u>) contributory factors?

In New South Wales, Australia, reviews cover child deaths where there is no evidence or suspicion of abuse or neglect, for example children in detention or care. In Israel 'every unnatural death of a child is examined by the Ministry of Health to rule out malpractice, infectious disease or epidemic, or other health risk', while in Switzerland there are medical reviews in cases of unclear causes of death. In Canada, 'the Coroner would always conduct an investigation in each community where a child death occurs'. The respondent from Ireland reported 'none that I am aware of, not on a national basis at any rate. Some Health Services Executive areas now employ community paediatricians but not all; one hospital I know of in the North West has a child protection liaison nurse who works between Accident & Emergency and the social work department but these are exceptions'. In Belgium, the national institute of statistics holds epidemiological data. In Jordan, 'when abuse / neglect are not contributory factors to the child's death, the cases are not transferred to the forensic medicine unless the victim appeared to suffer from remote complications of unnatural causes. The forensic medicine then takes its procedures of autopsy to indicate the cause of death'.

Germany may not have a system for reviewing child deaths but it does have data that put in context the relatively small number of children who die as a result of abuse and neglect compared to other causes: 'The UNICEF report on child maltreatment deaths in rich nations [UNICEF, 2001] is the only document found dealing with the prime subject of deaths caused by child maltreatment in Germany. It can be concluded by analysing the World Health Organisation mortality database that two children die from abuse and neglect every week in Germany'. Further, 'in Germany, more children die in childhood as a result of accidents (650 in 1999) than of cancer (335) and infectious diseases (114) together. More than 30% of all child deaths are attributable to accidents [Bundesärztekammer, 2001]'. This salutary reminder applies to other countries also, including the UK; Ferguson (2004), for example, observes the paradox of heightened concern over child death from abuse and neglect at a time when children have never been safer and when western societies quietly tolerate other forms of exploiting and harming children (for an overview of trends in child well-being in the UK see Bradshaw and Mayhew, 2005).

In South Africa there is a policy to review all deaths in-house in health facilities where the death occurred, although this is not widely implemented. In addition, suspected unnatural deaths are required to have a formal enquiry by the state pathologist (a specialist, or a GP with an 'interest' or a district surgeon), possibly leading to a police investigation. A post-mortem is conducted to establish the cause of death. In addition, there are two programmes to audit neonatal and childhood deaths. The Perinatal Problem Identification Programme (PPIP) is well-established but the Childhood Problem Identification Programme (CPIP) is in development and is criticised as being a 'superficial review with only limited attention to non-clinical data and the social circumstances of the child or infrastructure and systems within the health service'.

Thus far, this section of the report dealing with responses to the survey has described the systems operating in different countries for reviewing child deaths and serious injuries and placed them in their wider context. It is now appropriate to examine the processes involved in greater depth. The next sections therefore consider who orders and undertakes the reviews, how they are conducted and what resources and administrative arrangements are in place to enable and support the inquiries.

Who, or which type of organisation, orders reviews or enquiries and with what authority?

The main variation in this question was whether the inquiry is ordered as part of legal proceedings or whether it is a professional decision that an inquiry would be a helpful complement to other police inquiries and legal formalities.

In the UK and New Zealand, for example, there is considerable professional discretion to do more than a coroner's inquest and police inquiry. So in England and Wales, the former Area Child Protection Committee (ACPCs) – now called Local Children Safeguarding Boards – decide what is appropriate, while in New Zealand inquiries are ordered by the 'The Department of Child, Youth and Family or the Office of the Commissioner for Children. Professionals with knowledge of abuse inquiries serve on review panels. When the Commissioner for children is involved, she has independent status and reports to Parliament'. In Scotland, 'the routes through which information about a child's death may come into the public domain or alert agencies to the possibility that individual or collective practice should be reviewed are more varied. They include: investigation by government officials, a fatal accident inquiry by a legal official, a case review of a sudden unexplained death in infancy, an internal management review and a review following the death of a looked after child' (Child Protection Reform Programme, 2005).

In Norway the system is less formal but is motivated by professional concern among 'the child protection services or hospitals which may initiate proceedings that later lead to court cases'. In South Africa, an important trigger for a review is when 'a medical practitioner refuses to sign a death certificate'. In Ireland the government may order inquiries but they are not statutory: 'Sometimes the Minister for Health & Children, more often the Health Services Executive. Normally non-statutory, but for example the Ferns Inquiry into child sexual abuse has the option to be put on a statutory basis if co-operation is not forthcoming'.

In more legalistic systems, the coroner's or some other legal functionary's role is often central. In Los Angeles county, US, for example, 'teams review by the coroner's designation of cause and manner beginning with homicide and undetermined deaths. The particular circumstances come after selection and review. We may choose a case to make a point or to explore a particular problem but we do not deny review to other cases because they do not appear interesting on the outside or of interest to us that day. Inclusive intake is a central factor'. In Canada the situation varies by province but in British Colombia, 'the Coroner, Child Death Review initiates the review process by completing reviews of all sudden, unexpected and unnatural deaths and by developing investigative protocols. On January 1st 2003, the British Colombia Coroner's Service assumed the responsibilities related to child death review'. In Belgium 'the inquiries are led by the Procurator of the King after the result of the

report of a surgeon who has filled in the death certification (if there is a strong suspicion of a non-natural death the surgeon has the duty to certify that there is medico-legal objection to burying or cremation)'.

In Australia (NSW) the reviews for child deaths are prescribed in legislation. Responsibility lies with the Coroner and the Ombudsman: 'The Coroner conducts an inquest to determine the manner and cause of death. The NSW Ombudsman has legislated responsibility to monitor and review 'reviewable deaths', to review trends and patterns emerging, and to recommend changes to policies and practices that might prevent or reduce untimely deaths'.

In Germany, and bearing in mind that this does not refer to child death reviews *per se* (since such a system does not exist), the police play an important role in ordering enquiries: 'The prosecution authorities have to undertake and coordinate enquiries if there is suspicion of a crime [under section] 160 code of criminal procedure. The police have to guarantee public security and order and the duty to undertake enquiries and investigate crimes, this includes enquiries if there is a suspicion that a serious offence is committed to a child. The Police have special task forces in some of the German states to [investigate] and inform about violence against children'.

In Jordan the picture is mixed with a NGO playing a significant role alongside legal officials: 'The followings order the reviews: The Public Prosecutor (Governmental institution); The Police through public prosecution (Governmental institution); The National Center for Human Rights upon receiving complaints (Non-Governmental Organization)'.

Coroners will naturally consider as particularly important the autopsy report and it is noticeable that the 1999 guidance issued by the American Academy of Pediatrics lays out both the components of a 'complete autopsy': external and internal examination of the body, removal and examination of the eyes, microscopic examination, toxicological, microbiologic studies etc. and what else happened, rather in the manner of Government guidance.

It is generally the case that where central government regulation is low, the professional associations take a much more prescriptive and directorial role in child death and significant case reviews.

Who undertakes the enquiries and who else is involved in the process? What are their professional background, expertise and status?

Significant here is the varying role of the police in different countries. In countries where the reporting of all child abuse is mandatory, the police are likely to be involved automatically from the start. Thus, in Israel 'if no other siblings are at risk, or if there is no suspicion of malpractice or oversight on the part of the social or medical services, the examining body is usually the police. If, however, there are other siblings at risk, or if there is a suspicion that the authorities should have intervened at an earlier date to save the child, an examination is undertaken by the social services'. The coroner may also play an important role. In Victoria, Australia, for example, 'more detail comes out of Coronial investigations than from the so-called official child death reviews. The Coroner has played a very active role in some

deaths'. In Belgium 'the Procurator is leading the inquiry but the police officer works it out. Experts, e.g. forensic pathologists, are required to perform an external examination and to visit the scene of a possible delict [crime]'.

In other countries, such as the UK, the police identify a lot of abuse and neglect and prosecute serious offenders but the responsibility for the child's welfare is passed to other agencies with considerable scope to pursue options. This is not the place to argue the benefits of each approach but mandatory systems are criticised for bringing too many cases into an adversarial, forensic process and creating expensive and bureaucratic systems which exacerbate the situation for some children, whereas allowing scope for professional judgement is said to miss cases and leave children in dangerous situations (Parton, 1985, 1991).

Most countries have a standing or ad hoc review team and in some, such as England, Wales and New Zealand, the police are members rather than managers. The US authorities have developed a concept of core members, who include 'coroner, law enforcement, prosecutor, child protective services and health/public health'. Most members are public employees and mixing professions to include criminal justice and human services makes the team more vigorous'. In South Africa, 'police services and social services can order reviews after discussion with the state pathologist but the child protection system is not confined to criminal justice, it also includes health, welfare, NGOs and civil society organisations'. In Ireland the involvement of different people in reviews varies: 'In a Health Services Executive enquiry, it would normally be a multi-disciplinary team from another health board region. Public enquiries are almost always led by lawyers (judges normally) with a multi-disciplinary team of relevant experts in social work, psychology, and/or human resources'. In Jordan 'the police and the Forensic Medicine Institute undertake the enquiries, in addition to the school when abuse, neglect or death takes place at it. The Public Prosecution is also involved in the process'. In Ontario, Canada, 'Child Mortality Reviews are carried out by a group appointed by our provincial government [that] would meet on a regular basis'. Other countries have more ad hoc arrangements. For example, in Israel 'when suspicion arises that the authorities themselves have been remiss, an ad hoc committee may be convened by a government minister (e.g. the Minister of Social Affairs) to investigate the matter. Usually these committees comprise representatives of the ministries of health and welfare, legal authorities, social services, etc.'.

Most of those involved in reviews in different countries would seem to have professional qualifications but not necessarily training in child protection. In Florida, for example, a report to 800 Hot Line would be dealt with by Department of Family Service workers with or without police assistance. These workers are bachelor level graduates with Department training whereas in South Africa some members will be 'partially trained social work assistants'. In New South Wales, Australia, the work is undertaken by Senior Review Officers – specialist staff in the Ombudsman's office who 'generally have child protection backgrounds and investigative skills'. When needed, additional expert advice is sought from the Reviewable Child Deaths Advisory Committee, convened by the Ombudsman. In Belgium 'at the moment there is not a sound education curriculum for these experts but since 2002 there is a postgraduate course of 5 years to become specialist in forensic medicine'. In Jordan 'concerning the Forensic Medicine Institute, the background of the staff who receive

the incidents are qualified forensic medicine doctors, nurses and administrators who report the incidents to the Director of the Forensic Medicine to take subsequent actions'.

What are the purpose, scope and style of the enquiries? For example, are the questions to be answered, the sources of information to be used and the structure of ensuing reports set in advance? If so, by whom, in what form and how prescriptive is any guidance?

In some countries there is a fairly clear protocol regarding how the reviews be conducted, including an understanding of what data are examined and in what order. Thus, in New South Wales, Australia, 'there is a review process which begins with consideration of Coronial, Police and Department of Community Services (DoCS) information. The Ombudsman's Office has direct access to both Police and DoCs data. The Coroner provides the Ombudsman with relevant coronial information. Decisions are made as to whether the case is in jurisdiction as a reviewable death and requires further review. The Ombudsman has the power to require any relevant records from government and certain non-government agencies'. Reviews of child deaths as conducted by the NSW Ombudsman do not involve public hearings. There is a standard set of data that is collected on each death but more information is available in some cases than others. The reviews involve scrutiny of relevant records and files and other information from departments and organisations involved, which may include the departments of community services, health, education, juvenile justice and the police. The Ombudsman's team has only produced one annual report on reviewable child deaths but the Child Death Review Team has a 'fairly standard report structure'.

In Belgium, the process is also routine: 'Normally the inquiry starts immediately after the objection of the surgeon. If a obduction [autopsy] has to be performed a special judge of instruction is needed: an autopsy is normally required 24-48 hours after death'.

In Ireland the *Children First* Guidelines explain what should happen, although the focus is on objectives rather than method: '[Section] 8.25.3 says that 'case management reviews have a number of specific objectives including:

(i)   to establish facts
(ii)   to assess decision-making and interventions made in the case;
(iii)   to check whether procedures have been followed;
(iv)   to check whether services provided were adequate and appropriate
(v)   to make recommendations in the light of the findings'.

In Jordan 'questions are prepared in advance as there are comprehensive forms to be filled with information from the next of kin or parents. Thus, the forensic medicine staff furnish the report based on this structure. The form requires socio-economic information and enquiries about the death case taking into consideration the child's gender. Other report forms are available [for reporting] the process of autopsy, the results of examining collected specimen out of the dead body, the body status and finally the forensic doctor's opinion and recommendations. The forms are developed and endorsed by a board of pathologists. Interviewing the parents of the dead child

and the next of kin in addition to the crime scene are the sources of information. The process of enquiry is still inquisitorial which means relatives or next of kin are questioned and summonsed to give evidence regarding the death case. The system is not solid yet, we are thinking to establish a 'Next of kin Clinic' to interview the next of kin and obtain the information in smooth approach'.

Elsewhere, the process of conducting a review is much more flexible and ad hoc. In Israel, for instance, 'at present, the child protection officers do not work according to any protocol, nor do they have guidelines regarding what specifically to cite'. And in Belgium 'at the moment there is no strict procedural scheme as each police officer can conduct his inquiry totally freely'. In Canada there is also not really any prescriptive guidance or protocol and in California, US, it appears to be fairly flexible even if there is a basic order of doing things and expectations about what data are examined and who is involved: 'Los Angeles county reviews cases ASAP. We reviewed one case in the afternoon that occurred that morning. We have a question with each case but often end elsewhere. We present by temporal pattern of the case beginning with law enforcement that may start with the 911 [emergency] call. The coroner tells that story from the forensic evaluation and autopsy then CPS [Child Protective Services] if they have records and health, schools… The team is told the ID of cases for review before the meeting and each agency is expected to share what they know about that child and or family'. The same respondent makes an interesting point about the level at which reviews take place: 'Local teams can review in a way that state or national team cannot. They can involve the local case managers and people who actually knew and know the child and family. Records cannot replace local experience but expertise from larger populations can expand local experience and occasionally help separate case review from local politics'.

What are the administrative arrangements for conducting an enquiry? How is time made available? Who pays the cost?

The costs of inquiries are universally borne by state and government agencies, with external agencies and professionals hired as necessary. For example, in Ireland 'it varies. The Health Services Executive carry their own costs, or else the relevant government department. The practice is not established sufficiently to have a precedent'. And in Belgium 'all the costs are paid by the national department of Justice'. Certain costs, such as engaging a barrister for a long period, can increase the costs considerably. And in New South Wales, Australia 'costs are incurred and absorbed by the Government Departments involved, i.e. Ombudsman, Department of Community Services, as part of their recurrent budget'. In England, the costs of inquiries have been found to vary from £1,500 to £100,000 (Sinclair and Bullock, 2002); although it was not clear what the additional benefits of the more expensive versions were, costs tend to be higher in more complex or emotive cases and when agencies hire outside organisations to help undertake the review in order for the exercise to appear more objective.

New South Wales, Australia, seems to be unique in having a core staff to undertake the work: 'Reviews are a core function of the Community services Division of the Ombudsman's Office. We have core staff to do this work – 2 Senior Review Officers, a team leader, research officer, administration and other Ombudsman staff may assist

where necessary'. By contrast, in Israel 'the ad hoc committees engage in this work as part of their ongoing professional work and are not remunerated separately for this'.

Even on the capitalist US West coast, 'most teams maintain themselves working as a peer group that should work together anyway. Agencies and individuals take turns with minutes, mailings and arranging a room and coffee (or tea). Most teams elect or appoint a chair. That seems more effective than one agency owning the team or senior officials appointing someone. State teams are more political and may have funding for a coordinator and travel and a senior chair appointed'.

In Jordan the government pays for reviews but the precise administrative arrangements vary depending on the nature of the review: 'Multidisciplinary governmental bodies pay the cost of enquiries, [notably] the Ministry of Health, the Ministry of Justice and The Ministry of Finance. The administrative arrangements for conducting an enquiry depend on the type of enquiry. If the enquiry is a health enquiry, the case will be referred to epidemiologists. If the enquiry is judicial, the case will be referred to the Public Prosecutor. In both enquiries, autopsy is carried out and a report on the body status is generated and sent to the Public Prosecutor to hear the statements of the next of kin'.

What are the resources typically invested in the review procedures in terms of finance, time, experts and other staff?

Despite the variation noted so far, most teams and almost all members do child death and significant case reviews as part of or as an extension of their other work. Yet to be effective, all need one person as the official or understood leader, although that function can be shared. A team coordinator is essential and larger teams can pay for such a service with more than heroic effort by individuals. Only in New South Wales, Australia, was there 'a dedicated team within the Ombudsman's office to review reviewable deaths. We also have an external advisory committee made up of individuals with child protection and medical expertise'.

Elsewhere, respondents found this question difficult to answer owing to the lack of readily available information. The response in relation to Ireland is typical: 'Very difficult to know. Lawyers are terribly expensive but I am not aware of any figures. As far as I know, no specific budget is allocated'. Other responses were fairly vague, for example Jordan where 'the resources typically invested in the review procedures are the public prosecution, police, forensic medicine and schools. We look to review all children deaths by multidisciplinary professionals in fields of pediatrician pathology, forensic medicine and epidemiology. Governmental bodies pay the cost of enquiries'.

Having described the process of undertaking the reviews, and before moving on to evaluate their strengths and weaknesses as well as their impact on policy and practice, it is appropriate to reflect on the *style* of the inquiry process in different countries and on how the results are disseminated.

Does the process seek to be inquisitorial or is it more focused on practice learning and service development? What is the nature of the recommendations that follow the enquiries (e.g. regarding legislation, procedures or practice)?

In England, Wales and Northern Ireland it is likely that the Local Children Safeguarding Boards will know about all child deaths and serious injuries resulting from abuse and neglect. The guidance *Working Together* allows considerable scope for deciding to undertake a review. In Scotland, there is no single system of notification, no agreed criteria for inclusion and no national system of review. Moreover, all reviews examine agency practice rather than the personal, environmental or social circumstances of the child (Child Protection Reform Programme, 2005).

Michelle Johnson from the US National Center on Child Fatality in Michigan has proposed that the four dimensions on which approaches to reviewing child deaths and significant cases differ are as follows: the type of death reviewed; the agency composition of the review team; the size of the population covered by the jurisdiction; and the quality of the data maintenance system and its ability to consolidate information from a variety of sources. In *Keeping Kids Alive*, the Center prescribes the necessary activities for different types of child death (National MCH Resource Center, 2003). It lays out details of the facts, records needed, risk factors and services to consider, ways of improving inter-agency practice and effective preventative action and indicates sources of more information. What is unusual is that they prescribe different details according to deaths from different causes – natural, asthma, disability, suffocation, fires, burns and drowning, abuse and neglect, motor vehicle deaths, suicide and teen homicides.

Most of the official literature produced by countries and professional associations, such as the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), emphasises the need to use information from inquiries to improve the welfare of children. It is seen as an aid to practice and service development and the development of information systems as well as clarification of the circumstances of each case. The move from an inquisitorial to an enhancing approach is manifest in the differences between the 1991 and 1999 UK government *Working Together* guidance previously discussed. To summarise, these were:

  i.   a change in emphasis from an inquisitorial perspective to a learning one
  ii. greater clarity about why the review was being undertaken and what it would produce
  iii. clearer scope and structure of the review from the outset
  iv. clearer structures of final reports
  v.   a more robust action plan
  vi. plans for the dissemination of reports and handling the media
  vii. reviews undertaken and completed within the suggested time scale
  viii. public availability of an executive summary report
  ix. the setting up of an inter-disciplinary panel to consider whether a review should take place.
  x.   evidence that reviews will increase awareness of child protection issues among local policy makers and practitioners

These sentiments, in particular concerning the learning perspective, are echoed in literature from around the world. In New South Wales, Australia, for instance, reviews focus on 'identifying systemic weaknesses and developing recommendations for policy/practice change on a systems level, but this does not rule out a focus on individual matters', while an independent observer noted that 'none of the Australian reports attribute blame as such'. Rather, the focus is very much on practice learning and on ensuring the safety and well-being of other children in the family. A respondent from the New South Wales Ombudsman's office put it like this: 'The Ombudsman may also investigate matters under the *Ombudsman Act* 1974 if investigation is warranted. Investigation may extend to the circumstances of surviving siblings. The recommendations made so far – this function has been with the Ombudsman since December 2002 – have been broad ranging and systemic, focusing largely on the capacity of the Department of Community Services in regard to responding to reports of risk of harm, undertaking adequate risk assessment; closing cases on the basis of resource constraints rather than determinations that a child is safe'. Reflecting on the process described, an independent commentator wrote that 'Child death enquiries [in NSW] are professional, thorough and produce constructive recommendations for change to policy and practice. Have led to many positive changes'.

But many respondents to the questionnaire were worried by the gap between rhetoric and reality as regards the style and purpose of reviews. Writing in the context of New South Wales, Australia, an independent respondent commented that 'While most of the impacts [of the review procedures] are positive, inter-agency cooperation continues to be problematic. Public and political concern aroused by child deaths has had some negative effects in that it has increased the focus on identification and investigative aspects of child protection while the early intervention, enabling, social casework responses have not developed'. Elsewhere, the style and purpose of reviews would appear to be more clear-cut. In South Africa, for example, 'the process is more inquisitorial and not focused on practice learning and service development. Workers in the child protection field are overwhelmed by the complexity and volume of the work and are often poorly trained. Legislation does exist to protect children and criminal justice processes are also used to bring offenders into the system – however the focus is more on punishment than rehabilitation and restoration. Victim care is patchy at best'. In Belgium the nature of reviews depends, but 'once there is objection to burying, the process is inquisitorial'. Even in welfare-oriented Norway 'since we are talking about court cases, the questions concern how to prove culpability beyond reasonable doubt. Our court system is contradictory'.

Indeed, the tension between the inquisitorial and more practice learning perspectives is a recurring theme. In Ireland 'generally, it is inquisitorial in my opinion. Health Services Executive enquiries are not normally published. Others tend to recommend across a wide range of areas, mostly in terms of policy and legislation'. And in Israel 'the process is more one of practice learning, whose aim is protection of children and, further on down the road, the establishment of procedures that will benefit children. But when the need arises, punitive measures are taken'. And in New South Wales, Australia, the respondent from the Ombudsman's office noted '[Regarding criterion 8, 'emphasise clear lessons rather than attributing blame'] – overall would agree [that

this is a strength], but it is important that where individual culpability or poor practice is identified, that it is addressed appropriately by the appropriate body'.

In Florida, several factors determine the thrust of the inquiry: 'It is a matter of chance. It depends who is first on the scene – if it is the police, the inquiry is inquisitorial, to determine if a crime is to be charged. DFS [Department of Family Service] enquiries tend to be service delivery related. The law requires the removal of a child visibly injured or in the care of drug or alcohol using parents into state custody with a shelter hearing before a judge within 24 hours'. In Jordan, the process is explicitly forensic: 'The enquiries aim at revealing the cause of death… qualified forensic medicine doctors, nurses and administrators receive the incidents and report to the Director of the Forensic Medicine. The former refers the case to the Public Prosecutor who orders autopsy. A peer review takes place and a report is sent to the public prosecutor who transfers the case to the court if enough evidence was located. If not, the prosecutor orders to drop the case'. This is acknowledged as a weakness and reflected in the apparent absence of recommendations following on from the inquiries: 'The recommendations that follow the enquiries do not contribute to legislation, procedures or practice since the judicial system does not generate recommendations. We are currently trying to motivate the system to develop recommendations related to the domestic accidents'.

In other countries, the prospects for service development are more auspicious. In Canada, one respondent wrote that 'It varies… most recommendations are directed to practice and procedures' and another, regarding Ontario, commented that 'a formal inquiry would be both inquisitorial but also focus on practice learning and service development. The scope of the enquiry would be to determine what could have been done to prevent the death and to make recommendations on how to prevent the occurrence in the future'. Similarly, in New Zealand, 'the review is not usually an enquiry into cause of death or responsibility for death, which is for the prosecuting authorities to determine. The purpose is to examine whether CYF [Department of Child, Youth and the Family] departmental policies and practices were of a good standard and whether there were gaps in practice and between services'.

In California, US, the process is equally discursive, with a focus on learning lessons for practice: 'We may argue and I see that as healthy. This is not a therapy group for us although it serves that purpose also. We are also protective of each other like kids in a school that may be harsh internally but protective of peer assault by outsiders. Some coroners will not sign a case out until after review. Other agencies don't want anyone looking at their work… The case leads us to issues. We may gather types of cases like drowning or co-sleeping and look for common issues to attend to in prevention programs or to fix major problems between agencies'.

How are the results of the reviews disseminated? Is there a published report? To whom is it available? What form does it take?

Most countries welcome publication of the results of reviews but the timing and nature and content of reports vary considerably. In Ireland, for example, 'this very much depends. Sometimes there are legal reasons why the individual body cannot publish, but it can go through some kind of privileged process whereby the Government can publish it through a committee'. Normally, legal judgements pass

into reported case law and a version of each report is usually prepared for public consumption. For example, in New South Wales, Australia, 'the Ombudsman is required to produce an annual report to NSW Parliament outlining findings and recommendations arising from deaths reviewed in the previous year. The report is public… [In addition], the Ombudsman under the Ombudsman Act can make a special report to NSW Parliament on any matter within his broad jurisdiction. There has been one special report relating to a child death made since having responsibility for reviews. However, this report could have been made regardless of this [the Ombudsman's] office having a death review function – the investigation resulted from a complaint'. Research is also published: 'Reports of research by the Commission for Children and Young People into particular issues or trends in child deaths are made on an occasional basis'.

Increasingly sophisticated publishing methods mean that different versions of reports are usually prepared for different audiences, the content being judged in terms of public interest and confidentiality. Also, those disseminating the reports are given advice on handling the media at launches, radio and TV discussions and public meetings.

However, reviews may not be published. In Jordan 'the results of the reviews are not disseminated to the general public. They are only referred to the parties concerned with each case. However, dissemination takes place when conducting research. The research results are usually disseminated in local and international journals'.

Are enquiries subject to any regular or periodical overview? Are there mechanisms to integrate the recommendations into legislation, service development and practice?

As expected, this also varies considerably. The most obvious indication of this happening is in New South Wales, Australia, where the Ombudsman produces an annual report on reviewable deaths to the Parliament, incorporating the findings of his/her work in the previous year and any recommendations to prevent or reduce such deaths.[5] It is important to note that 'Recommendations made by the Ombudsman are formally monitored and progress will be reported on in subsequent annual reports'. A similar process operates in New Zealand. 'There are periodic reviews of such processes. For example there was a review of CYF [Department of Child, Youth and Family] procedures by Judge Nick Brown in 2000. The recommendations of such reviews are not always fully implemented'.

Elsewhere the picture is very different, although with slight variations between countries. In Belgium, 'at this moment there is no informative centralisation of the reviews. The information is disseminated in the many judicial departments (more than twenty!). So much epidemiological information is lost'. A similar situation pertains in Germany, reflecting the lack of a real system for reviewing child deaths, with the only real information of any relevance of a statistical nature: 'No nationwide periodical review that focuses solely on child deaths and its causes is published. Limited information can be drawn from the Police Crime Statistics and the first Periodical Security Report as well as the UNICEF report on child maltreatment deaths in rich

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[5] See www.ombo.nsw.gov.au.

nations'. In Ireland 'no, we do have a SSI [Social Services Inspectorate] which will attend to whether recommendations made by them, which may be the result of a case review (normally to do with residential care), are published. Otherwise no'. And in Jordan 'there are no mechanisms to integrate the recommendations into legislation, service development and practice. The system is not consolidated, it depends on personal initiatives'.

In Canada there is no periodical overview and no mechanisms to integrate the recommendations into legislation, service development and practice, and in Norway 'the results of court proceedings will be put into a central database, Law Data, and some, particularly from our Supreme Court, will be published anonymously in a Norwegian journal that has been established for this purpose. This is available for everybody; the database one has to pay for. There is fairly little systematic research on these cases'. Relating to the question 'Are enquiries subject to any regular or periodical overview?' a respondent from South Africa simply responded 'Not to my knowledge'.

EVALUATION OF THE APPROACHES

The questionnaire continued by exploring evaluations of the approaches adopted in different countries. Some of these comments are based on evaluative research, others are professional perspectives based on experience. The focus initially, and following on from the discussion of dissemination, concerned the extent to which the reviews had an impact on policy and practice.

What have been the effects of enquiries? Please take into account the following: policy, practice, legislation and guidance, training, other welfare work with families, children and families themselves and subsequent reviews.

Annual reports and internal evaluations from around the world claim improved practice and better protection for children at risk of harm. For example, in New Zealand 'There have been many changes in policy, practice, guidance and training as a result of reviews. Children's views are listened to and taken seriously. New requirements for the training of social workers have been introduced'. In England and Wales, the *Children Act* 2004 clearly reflects the findings of earlier child abuse inquiries as does the Laming (2003) Report, with the establishment of children's services and an emphasis on children as a community responsibility, accountability, inter-agency co-operation, improved child development, better prevention and a common language to understand the needs of children. Similarly, in Scotland the lessons of reviews are salient in the content of the 2004 *Children's Charter* and *Framework for Standards in Child Protection*.

In New South Wales, Australia, respondents indicated that there is the potential for reviews to have a positive impact, although it is too early to judge whether this will be realised. A respondent from the Ombudsman's office noted that 'We have released one annual report – December 04. The NSW Department of Community Services (DoCS) has stated acceptance, wholly or 'in principle', to all 18 recommendations made. Implementation will be monitored'. Commenting on recommendations of the Child Death Review Team, made *prior to* the Ombudsman assuming responsibility for child protection related deaths and recommendations, another respondent noted a

'major impact on legislation, policy and practice', particularly in relation to assessment, early intervention, inter-agency working and mandatory reporting, although adding a caveat that 'while most of the impacts are positive in my view, they remain to be fulfilled, i.e. improved screening and assessment, better response time, inter-agency cooperation continue to be problematic'. The respondent continued by identifying a 'strong influence on the operation of the child welfare department (DoCS) in the direction of tighter and more sophisticated procedures around screening and assessment, timing of responses, prioritising response to very young children. Has driven efforts to get better coordination between agencies through the development of Inter-Agency Guidelines for Child Protection. Has contributed to support for continuation and extension of mandatory reporting policy so that children at risk can be identified'. The Child Death Review Team work in New South Wales is also deemed to have had an *indirect* impact on funding for services: 'The public concern aroused by reporting of child deaths has also contributed to political pressure resulting in major injection of funding for more child protection and early intervention staff and services'.

Jordan is interesting because a wide range of effects is reported in relation to policy and practice, legislation, guidance and training. What is not clear, however, indeed such issues are notoriously difficult to tease out, is how far the reviews themselves contributed to these developments and to what extent other factors were at play:

'The effects of enquiries in Jordan are mild with low impact. However, enquiries in Jordan achieved the following:
Effects on Policy: developing the law of 'The Rights of Child ' which emphasizes taking into consideration the interest of the child if it is not preserved by the penal code.
Effects on Legislation: finding alternative punishments for the offenders in cases where minor abuse from the parent resulted from temporarily minor factors. Alternative punishment includes placing the offender in community institutions to obligatory serve the public instead of placing him/her in prison.
Effects on Practice: the success in establishing ' child friendly' pilot clinics for the abused children i.e. toys, to better examine the child. We used to directly take specimen from children and send them to the court. Now the examination takes place in the pilot clinics which is a better environment for the child. Also we succeeded in video taping the evidence to use it in the court room.
Effects on guidance: various actions were taken to activate the National Project for Family Protection, such as networking with the Ministry of Education to educate children – teaching children to identify whether the behaviors they encounter from adults are appropriate or not. Guidance was also provided for the preachers at the mosques to raise awareness and protect children.
Effects on training: various trainings are taking place on the 'early detection of abuse', 'reporting cases' and 'improving the suspicion level of death cases in which abuse or neglect are the major factors'. A training procedure manual was also developed for this purpose.
Effects on subsequent reviews: the National Family Protection Project was established as a result of earlier enquiries'.

Of course, different reports may have different effects. Some may instigate legislative change or trigger more resources for services; others encourage the development of

guidance or new organisations. Ireland is a good example: 'The four big inquiries held during the 1990's had a significant effect. The Kilkenny Inquiry resulted in the implementation of the *Child Care Act* 1991 and a massive development in child care services as well as the revision of procedures and other related legislation. The others all had ripple effects, particularly the Madonna House one which really led to the establishment of the Social Services Inspectorate. The sports inquiry led to the development of guidelines on child protection and good practice – overall the response has been quite strong. A lot of investment has been made in in-service training, family support services and the education of social workers and child care workers'.

Of course, policy and practice in children's services may also change despite there not being a comprehensive and routine system of reviewing child deaths. Thus, in Israel, 'despite the lack of systematic procedures, meaningful changes are occasionally made in the system. The best examples of this are the mandatory reporting law, and the establishment of the special teams in hospitals… The mandatory reporting law, for example, resulted from the recommendations of one such ad hoc committee… In a sense, the system is constantly working on improving its detection – guidelines on detecting abuse and neglect have been published and disseminated in the education and health systems – and internal procedures. For example, cooperation among the various authorities is a matter of priority, and a document to this effect has been disseminated among them'.

With regard to practice and policy, respondents identified 'improved agency responses to deaths in terms of notification, speed, information sharing, protocols with resulting changes in advocacy, litigation services, addressing abandoned infants, SIDS [Sudden Infant Death Syndrome], shaken baby syndrome, day-care licensure, smoke detectors, passenger, bicycle, water, boating, hunting and firearm safety, graduated drivers licensing, truancy, youth homicide, grief and mourning with more teams and expanded inclusion criteria, collaborative professional relationships, training, seminars, better data collection and collation, publication of reports. Increased community awareness of the value of children's lives'. Another respondent, from the US, summed this up as follows: 'The media concern is a small increase or decrease in notorious cases but the major effects may be seen in improved case managements and better criminal actions particularly for infants and toddlers with non-fatal injuries. We are just learning to work with child and family survivors issues of grief and mourning. Some authorities have expanded to look at circumstances such as death in house fires as most of the victims are infants and toddlers known to welfare agencies'.

The views from South Africa were less sanguine. One respondent argued that 'Very little evaluation of the child protection system is occurring, certainly not a comprehensive overview which is sorely needed' and another noted that 'Evaluation is minimal as no formal policy or practice exists'. And some commentators in Australia are not convinced that the reports actually change very much in the long-term: 'Many of the findings appear to be repeated e.g. lack of supervision, lack of collaboration, inadequate record keeping, unallocated cases etc. etc.'.

In addition, some of the effects of reviews and enquiries are perceived as not necessarily being in the best interests of all children. In Canada, for example, one respondent was concerned about 'the increased emphasis on risk assessment

procedures at the expense of other services'. This may be the product of other influences on policy making and practice besides evidence (including that from child death and significant case reviews). For instance, another respondent from Canada commented that 'There are mixed reviews about the enquiries. Some good recommendations that do lead to improvements and some overtly political decisions are made by governments to convince the public that the right action is being taken'. In the same vein, in Ireland 'the effects are more to do with responding to publicity about very inadequate service provision than reflexiveness or a desire to put lessons into practice!'. Meanwhile, some of the consequences of reviews are completely unexpected. In Florida, for instance, 'negative evaluations of agencies and high instances of injury and death to children in care have led to legislation that has privatised the foster care system'.

That said, Germany illustrates the problems of what can happen if cases are not reviewed properly with a mechanism for feeding the findings into practice constructively: 'Cases of child death or serious injury due to abuse or neglect continue to steer public discussion about the quality of the child protection system. Even if there is a kind of reaction by the child protection system it tends to be quite global and defensive as can be seen by a report published last year after a child fatality of a foster child due to sexual abuse [DIJUF, 2004]'. There may be another side of this coin, of course, with the respondents from Israel suggesting that 'The system is very open to learning and change. The lack of procedures and structure leave the system flexible and adaptable'.

Based on all of these observations it is hard to decide how influential child death inquiries are as agents of change. The experience of the countries studied suggests that they do produce both immediate and long-term effects but because of the dearth of robust evidence it is less clear whether these better protect all children at risk of harm. Put another way, and drawing on attempts to measure the impact of research dissemination, there is some evidence of the impact of reviews on *immediate* and *intermediate* outcomes – insofar as they shape policy, guidance, training and, to some extent, practice – but benefits for *ultimate* outcomes, measured in terms of children's well-being, are less apparent (cf. Bullock et al., 1998; Knott and Wildavsky, 1981).

Having examined the practical impact of the procedures, it is possible to stand back a little and reflect on their strengths and weaknesses, taking into account the views of different stakeholders (as far as is possible) and identifying examples of good and less good practice. Respondents were asked in the survey to indicate strengths and weaknesses in the systems pertaining in their countries for reviewing child deaths and serious injuries where abuse or neglect was suspected. In addition to providing an open-ended response they were invited to 'score' their country against markers of good and poor practice identified in previous research (drawing especially on Sinclair and Bullock, 2002, pp.12-14, 47f). The results are summarised in Appendix E. What follows describes the results in more detail but it is worth noting at the outset that there is no perfect system and different countries exhibit strengths and weaknesses in different areas. A caveat should be added to the effect that the answers (a) should be read in the light of the systems operating in each country as described elsewhere in the report and (b) indicate the views of the respondents only (others working in the field might view matters differently). We start from the positive perspective.

What are the perceived <u>strengths</u> of the procedures adopted? Please indicate your own view but also those of different stakeholders (e.g. administrators, practitioners, children and parents).

This question inevitably reveals some biases and single perspectives; as one person remarked in the Australian context, 'We have not canvassed the views of other stakeholders on these procedures. Difficult to answer this, depends on the focus – i.e. Ombudsman reviews may have different measures of 'good practice' to those conducted by the state department (DoCS)'. The variability in terms of how review procedures are enacted also make it hard to comment. In relation to Ireland, for example, 'It is difficult to comment… because practice is so inconsistent and the results of enquiries are rarely analysed or publicised to the degree that important lessons can be drawn from them'.

Even so, many of the strengths identified by respondents reflect the perceived effects of reviews previously described. One strength is that the process of reviewing child deaths and significant cases develops a child-centred protection momentum, as the following quotation illustrates: 'It seems difficult to stop teams after they have begun. Funding cuts might slow the team down but some inspired person generally gets them busy again. The passion is more important than the funding and political propriety. Thus, reviews work to prevent not only child abuse but also all accidental deaths of children'. Another strength is the use of the information gathered to improve understanding: 'A data base accumulates which helps us understand why these events occur'. This is important as good epidemiological information was identified by Sinclair and Bullock as a necessary condition to improve knowledge in this area. In addition to the direct effects on policy and practice are perceived *indirect* benefits: 'Draws public and political attention to the reality of some children's lives that are usually unseen by the community. Can be a trigger for more resources for child welfare services. Makes public agencies and departments accountable'. However, the negative effects of these developments should also be noted (see next section).

A strength is also ensuring that all cases are covered. In New South Wales the Child Death Review Team maintains a register of child deaths, classifying them according to cause, demographic criteria and other relevant factors and analysing the data to identify trends and patterns with a view to making recommendations to prevent or reduce the likelihood of child deaths. Further, in relation to *reviewable* deaths within the Ombudsman's jurisdiction, 'Where the Coroner does not identify a reviewable death, the Ombudsman reports it retrospectively. [The office is] unlikely to 'miss' a reviewable death as [it has] access to information about all child deaths in NSW'. The Israeli respondents reported similar strengths: 'The main strength of our system is that, despite a certain fragmentation, coverage is quite broad; few if any cases fall into the interstices'.

In New Zealand, the involvement of the Children's Commissioner is seen as a particular strength as staff are independent, experienced and committed to the welfare of children. The same holds in New South Wales, Australia – the mandate is important: 'The key strength from my perspective is the scope of powers associated with undertaking this work – refer to *Community Services (Complaints, Reviews and Monitoring) Act* 1993 (CS-CRAMA) and *Ombudsman Act* 1974. CS-CRAMA has its own powers and these are augmented by a link to Ombudsman Act'. Other strengths

as exhibited in New South Wales are the consistency of the process and greater accountability: 'The *Coroners Act* 1980 is also linked to CS CRAMA in that reviewable deaths are mirrored as coronial matters under s.13AB. This provides for consistency'. In Ireland it is suggested that reviews 'have certainly led to greater accountability and considerably strengthened the management layer in services'.

Florida was again more cynical: 'Not aware of any strengths and evaluation of privatisation has not occurred yet. State has provided more money to the private system process'. A respondent from Canada echoed previous views: 'My own view is that has not been helpful, it has increased reactive rather than proactive approach', although another commentator (from Ontario) noted that the catalytic function of enquiries in the sense that they often 'lead to additional funding for plans and services long recommended by the child protection system and others'. One of the South African respondents wrote 'Nil' in response to the question about the strengths of procedures.

The features of good practice specified in Chapter 8 of the 1999 edition of *Working Together* were not questioned by any respondent and these appear to be universally accepted as desirable feature of any inquiry. They are:

1 Have clear objectives
2 Require agencies to cooperate, with ability to enforce this
3 Take multi-agency perspective i.e. wide range of agencies consulted
4 Content includes family, social and developmental history of the child
5 Involve outside experts
6 Involve parents/carers, family and children
7 Form part of a broader audit of services
8 Emphasise clear lessons rather than attributing blame
9 Generate clear action plans to be integrated into mainstream work
10 Make carefully-drawn recommendations for child abuse policy
11 Present material in standard format
12 Completed within a reasonable timescale
13 Coordinated dissemination of clear messages

As well as commenting broadly on the strengths of procedures relating to child deaths and significant cases, respondents were asked to reflect on situations where the procedures work well and, if possible, to give examples of successful reviews. These questions proved harder to answer but the information that was forthcoming provides a more nuanced picture.

While the local lessons from reviews are usually taken seriously, facilities to store and analyse reports at a regional or national level are generally poor. Sophisticated data to inform research and policy is often accumulated on child deaths from causes such as cancer, meningitis or peri-natal conditions as these seem to generate more interest than other causes, such as teenagers living in chaotic circumstances or suicide in custody. In South Africa, this system is maintained by dedicated individuals rather than by a government-funded and stimulated system but even where a system claims to be in place for child protection, the reality is often quite different. In England, some Social Services Inspectorate offices had difficulty in providing the researchers Sinclair and Bullock (2002) with reports on the relevant cases for their study and

some of those eventually forwarded had the quality of bundles extracted from rarely-opened cupboards. Nevertheless, there are pockets of excellent practice. Los Angeles, for example, has a valued programme involving schools in suicide prevention and a process to link health, welfare and criminal records to identify high risk situations or collate information quickly when tragedies occur.

Again, some Southern US states have rather different criteria for success – 'the prosecution and sanctions – prison and, in some death cases, execution of offender', a salutary reminder of the varied perspectives on what a good system looks like. Similar measures of success are apparent in Jordan: 'A dead child was transferred to the forensic medicine as a result of head injury and bite marks were located on his body. The forensic medicine report indicated that the injury was not accidental. Consequently, the prosecution ordered the autopsy of the body. The investigation also revealed that the stepmother of the dead child used to hit him frequently and deliberately while the father was acquainted with this fact. Both parents were executed'.

In addition to the benefits of child death and significant case reviews for professional development, policy change and accumulation of a data bank, several examples given by respondents highlight other benefits of reviews. In one case of baby death in the US, for instance, it was unclear what happened and the parents were never charged. The review re-examined the evidence, however, particularly the timing of events, and found that it was the babysitter who was with the child at the time of death. She was later found with another injured child and was convicted.

In another US case, the review uncovered an unlikely truth. A toddler deemed to have died from head injuries inflicted by the mother was found to have died after being swung around by an older sibling who lost grip causing the child to hit the wall. The sibling put the toddler back in the crib and said nothing. The health investigators were distracted by the injuries and the fact that a child could only have caused such damage by this curious mechanism. A family with massive problems was thus saved from the misery of criminal action which would almost certainly have led to the mother's imprisonment.

A review in Ireland reflects some of the earlier points about strengths and weaknesses. 'The Kilkenny Incest investigation did not deal with a child death, it examined the response to a case of sexual and physical abuse, and was called largely because of publicity around the court case (father jailed for incest) but it appears to have had very positive outcomes in terms of service development. In terms of the process itself, there appears to have been a lot of satisfaction that it focused on lack of resources and strategies for communication rather than individual failures of practice. As there was no template, the manner in which the inquiry was conducted was largely improvised and probably reflected the approach of the individuals involved'.

Needless to say, respondents also identified aspects of the processes operating in their countries that did not work so well and/or that had various detrimental consequences. These are now discussed.

What are the perceived <u>weaknesses</u> of the procedures adopted?

Every respondent identified some weakness in their country's system. Sometimes these are administrative or practical but a few are more radical. In relation to the former, there is a general view that inquiries are under-resourced and undertaken to protect professionals rather than improve services, and that they lack standard objectives and procedures and have a tendency either to white-wash or scapegoat (with social workers more likely targets than doctors). A respondent from Canada, for instance, noted that 'governments sometimes use the recommendations to assign blame, and to adopt simplistic solutions… the enquiries have not led to an integrated system of children's services'. There are also difficulties generated by staff turnover and the failure of busy workers to attend regularly, not to mention the problems of involving important groups (especially doctors and teachers) and of implementing policy and practice changes in rigid bureaucracies.

More radical concerns are the tendency to recommend changes in isolation from other aspects of children and family services and a feeling that over-reacting to a tragedy can take resources from prevention or from help for other groups of children. Thus, in New Zealand, 'The policy that families should look after their own while, in some respects, an enlightened policy (hence family group conferences), doesn't always work to the advantage of children and puts the burden on poor families with multiple risk factors to continue caring for children, leaving children in unsafe situations'. Elsewhere, concerns were expressed that the success of the system and its ability to influence policy and practice has led to a more investigative approach to child protection, which research suggests is detrimental (Department of Health 1995a). For example: 'Public and political concern aroused by reports of child deaths [in New South Wales, Australia] has had some negative effects in that it has increased the focus on identification and investigative aspects of child protection while the early intervention, enabling, social casework responses have not been developed'.

Several commentators stress that child protection strategies have to be related to anti-poverty programmes. Van Voorhis and Gilbert (1998) note that poverty rates are a stronger predictor of child fatality rates than system reporting measures. Others are worried by the lack of robust research data. Bonner and Chafin (1998), for example, echo Hill's concern expressed ten years previously and cited earlier in the report that 'the review process does little to create the social conditions and welfare systems which keep children safe' in their frustration that 'there is still no prospective data on either risk factors or the natural course of behaviour; there are only the beginnings of empirical typologies and no actuarial risk assessment'.

While a critical mass of knowledge is essential to move the field on (Morrison, 2003), another concern was that it was better to have a good review accompanied by a lot of after-thought on a smaller number of cases than a scant and soon forgotten inquiry on all of them. Reviews can become ritualistic and the multiplicity and predictability of findings produce 'case review fatigue', a disaster for the establishment of a national strategy, interagency ownership and guidance, agreed assessments, sensitivity to ethnic and cultural factors, empirical evidence to support practice and a quality assurance framework for interventions. But a deeper analysis of each case can go beyond the platitudinous and indicate its own important lessons. For instance, Parton (2004) noted that although the Colwell and Climbié reports in England say much in

common, in the first problems derived from failure to communicate between case workers while in the second they related much more to wide-ranging and complex system failures, of which worker communication was just a part (see also Reder and Duncan, 2004). He argues that problems arise from the fact that responsibilities have broadened and intensified at the same time. In a similar vein, Munro (2005) argues for a new systematic approach to child abuse death reviews where the reasons for human error emanating from interacting factors in the practitioners, the resources available and the organisational context are more fully explored.

Again, it falls to Michael Durfee from the US to sum up this tension between depth and breadth: 'Child death is an opportunity to work together. The major hazard is becoming a political body owned by one agency or profession. We have seen this in the US with prosecutors and coroners who arrange a mandate that they must chair teams. Children known only to child welfare miss out on the system and reinforce a belief that children and family services in isolation can make children safe. Public health can lead to an obsession with data. Criminal justice can miss the value of prevention. Everyone has problems and limitations. Yet all of these professions have done superb work and demonstrate an understanding of peer support and involvement of larger professional and citizen community'.

In summary, most respondents acknowledged that the two sets of criticisms of reviews noted in the literature review applied in their country. The first concerns the quality of the reviews themselves and deficiencies such gaps in information, lack of clear format to report, too many recommendations to be useful, too much focus on incidents and compliance with procedures, isolation of the exercise from wider child care strategic planning, unrealistic timescales for completion, delays in obtaining information from some agencies, endless repetitions of recommendations in successive reviews, failure to make children feel safe and poor rates for the successful prosecution of offenders.

The other set of criticisms concerns the failure of reviews to help those children who are perceived to be at continued risk of harm. These include siblings of those children killed, children living in dangerous situations or where criminal proceedings have faltered. In South Africa, concern was expressed about poor surveillance in rural areas and among economic migrant families, while in Bulgaria it was directed to the secretive and sometimes intimidating Roma people. There was also frequent dissatisfaction with events after the review, for instance 'seriously abused children who after the inquiry remain in state care – in limbo – until they age out of the system and receive no further care or assistance' (Florida, US). In a similar vein, a respondent from South Africa commented on 'the death of a baby as a result of physical abuse by the mother's partner. The criminal justice system investigation went well and resulted in the successful prosecution of the man. However, few – if any – services were offered to the biological mother of the baby, who was also suspected of colluding in the abuse of the child. After the prosecution, the case 'died'. It is almost as if there is no 'life'/need for services after the criminal justice process is over'.

It is encouraging to note how common are many aspects of satisfaction and dissatisfaction across the countries surveyed. Despite the problems inherent in multi-culturalism and geographical mobility, few people want children to be harmed and some common standards of protection and rights can be set if effort is made. The

important lesson that emerges is to focus on the underpinning principles and outcomes and to let the process details follow from them.

6. CONCLUSIONS

How can conclusions be drawn from all this disparate evidence? So many of the procedures for conducting child death reviews are peculiar to historical and professional contexts that any generalisation seems dangerous. One thing is clear: arrangements that work well in one country may not be transferable to an other, so there is little point in searching for the 'perfect' universal model. It is better, therefore, to identify the conditions that have to be met to implement an effective system rather than suggest as series of *ad hoc* changes for Scotland.

Three approaches can be pursued. The first is to see whether there are any general patterns between the arrangements for investigation child deaths and serious injuries and other aspects of each countries' welfare systems. The second is to glean from the evidence the essential features of an effective system and the conditions necessary and sufficient for it success. These have to fairly general and the specific arrangements will need to differ in each location. The third is to avoid perceiving child death reviews as something isolated from other developments and practices and to view their function in the light of the wider child protection process and, indeed, the whole range of services for all children at risk of impairment to their health and development. These approaches are now discussed in turn.

The relationship between review arrangements and welfare systems

An attempt was made by the research team to see if the arrangements for investigation cases of child death and serious injury revealed in the questionnaires and literature were associated with particular welfare approaches. As described earlier, the classifications developed by the international social policy analysts Esping-Andersen (1990) and Leibfried (1994) were used. They delineate four general welfare approaches based on differences in the scale, entitlements and scope of public provision in capitalist societies, the differences in policy-making styles and processes, the underlying patterns of class formation and the prevailing political structures. They are termed: the conservative-corporatist; economically liberal; social democratic; and Mediterranean/developing.

The 16 countries for which adequate information was forthcoming fell into these groups as follows: conservative-corporatist (3); economically liberal (9); social democratic (1) and Mediterranean/developing (3). In subsequent analysis, however, few clear relationship emerged between the arrangements described in the questionnaires and the welfare classification.

It was found that the economically liberal systems were more likely to have a permanent system in place while, at the same time, allowing more professional discretion to commission reviews and consider child deaths from all causes whereas the conservative-corporatist models tended to be more legalistic. In the Mediterranean/developing group there was often a system in place but it was restricted in scope and rigid in approach. However, the relationships were not strong, probably reflecting the fact that the classification is based on broad economic and social factors rather than on child care variables. Indeed, other studies have found difficulty in establishing correlations between welfare systems and outcomes for children and families (Weyts, 2004).

An alternative approach was to try to develop a typology of approaches, setting out the various mechanisms, structures and procedures invoked when a child death or significant case is brought to the attention of the authorities. In order to do this the research team met together to code each country against five variables:

(1) Whether or not reviews routinely take place in the event of a child death and/or serious injury/neglect
(2) Whether such reviews are mandated by law or discretionary, that is dependent on the situation or people involved
(3) Who orders the reviews to happen, divided here between legal/police and professional bodies
(4) Whether the reviews are typically investigative/forensic, that is mainly concerned with finding out what happened and where responsibility lies for the death/injury, or focused more on drawing out lessons from the case in order to improved practice learning
(5) Whether or not the service for reviewing child deaths/injuries in the case of suspected/actual abuse/neglect is integrated with the system for reviewing unnatural deaths generally.

The results of this classification are shown in Appendix F. This analysis was difficult given the data available and the complexity of the subject and systems being studied. The pattern that emerged was only queried by one respondent when the draft report was circulated for comment but as further research is conducted on this topic internationally and understanding of the various systems improves alternative typologies will most likely emerge – something that we would welcome. Notwithstanding this caveat, an attempt was made to group countries together intuitively using these data. Various possible groupings were found. In order to check the validity of the preferred pattern that emerged, a cluster analysis was undertaken on 16 countries (those with adequate information). Cluster analysis is a descriptive, exploratory technique for producing meaningful sub-groups in selected populations according to specified factors. It measures the distance between cases on a combination of dimensions and uses this to identify groups of cases within which there is considerable homogeneity and between which there are clear boundaries. In this instance the method used was hierarchical cluster analysis. This begins by finding the closest pair of cases – in this instance countries – and combines them to form a cluster. It proceeds one step at a time, joining pairs of cases, pairs of clusters or a case with a cluster until eventually every case is in one cluster. (The method is hierarchical because once two cases are joined in a cluster they remain joined). The method generates a range of cluster solutions, in this instance from one to 16 groups; the three cluster solution most closely resembled the categorisation arrived at intuitively and is now described.

Group 1 comprised those countries with a review system in place, a group of people qualified to undertake inquiries, a process for doing so and an intention to improve policy and practice. Seven countries fell into this category: England, Wales, Northern Ireland, Canada, US, Australia and New Zealand. The US and Australia were slightly different from the other three, however, because their systems were often more legalistic in that they took place in the context of a mandatory child protection service

(in the other countries reviews are discretionary and ordered by professionals). They could actually form a separate group (so creating four groups overall).

Countries in the other two groups had no permanent system for reviewing child deaths. Those in Group 2 were distinguished from the others by their forensic or investigative focus and (Belgium, Ireland, Jordan, Norway and South Africa). The impetus sometimes came from legal officials or the police but some of these countries were able to assemble an appropriate group to conduct a review, should the need arise. In the remaining four countries (Group 3), there was also no routine system in place but the approach appeared to be more focused on practice learning: Germany, Israel, Scotland and Switzerland.

Associations between general welfare approaches and arrangements for reviewing child deaths are therefore tenuous because as the previous discussion has shown, the context of each country is so different. Nevertheless, there are some differences between countries in the existence of systems, the predictability of the review process and the scope and intended effects of the exercise.

Effective reviews of child deaths and serious injuries

If it is more useful to identify the conditions necessary and sufficient for an effective review process, what are the features of a 'good' system?

Background considerations

The first point to make is that what is deemed a 'good' child death or significant case review might not be good for children's services generally. Recommendations can create cumbersome and expensive procedures and reinforce an adversarial and forensic approach that is not helpful for the majority of child protection work. Child deaths are relatively rare and the majority of children at risk of harm present relatively low levels of abuse and neglect and are protected at home by means of family support services.

The second point is that reviews will encounter a variety of situations with some aspects in common but much that is case-specific. It is necessary to combine general knowledge, for example about risk factors and process dynamics, with an analysis of the factors peculiar to each situation. This is a difficult process as the former seeks to apply generalities to the specific, while the latter seeks generalisations from individual incidents.

The third point is to be sensible about predictions. Retrospective analysis indicates strong links between background and outcome but these are rarely borne out by 'blind prospective' forecasts where known risk factors are present but the future is unknown. Trying to predict in such situations, especially for something as rare as murder or manslaughter, is very difficult. Indeed, for child abuse generally, there will probably be some 20 wrong predictions for every correct one, even in situations where the risks are high (Sinclair and Bullock, 2002). These incorrect forecasts are termed in research parlance 'false positives'. On the other hand, it is equally important to stress that factors that increase the likelihood of harm are known and should be reiterated and

included in the assessment procedures for all children in need. Research that clarifies these should be supported.

Early decisions and organisation

Fourth, there has to be a method of deciding when to undertake an inquiry and the criteria for doing so. Is it all child deaths where abuse and neglect are known or thought to be contributory factors? Do adolescents living in chaotic circumstances qualify? What level of serious injury reaches the threshold? The factors to be considered may be varied – public interest, media coverage, professional shortcomings, system failure etc. – but these criteria should be clear.

Fifth, it is helpful to have a standing group to make decisions to undertake an inquiry and a core of people who can be drawn on to undertake it. Most countries have such a system but the weakness is maintaining the expertise and accumulating knowledge. Staff turnover is notoriously high and professionals can be exhausted by the exercise, so an individual or a stable group should be encouraged to gather and analyse the information from successive reviews in order to build up a sound knowledge base. This does not seem to be done locally or regionally and only happens patchily at a national level.

Sixth, the role of the police in reviews must be clear. They have a specific area of responsibility that can conflict with welfare considerations. Their role in the review process must be agreed at the outset if criminal investigations are not to undermine other ambitions and if collaboration is not to be perceived as collusion.

Seventh, those countries with an office providing an overview of all child welfare, such as a Children's Commissioner, allow independent scrutiny of reviews, opportunities to link the recommendations to other initiatives for children and families, external pressure to complete reviews satisfactorily and a direct line to senior policy makers and politicians if there is dissatisfaction with any part of the process.

Eighth, there must be an accurate estimate of the likely costs of the review in terms of staff time and revenue expenditure and agreement about who pays. A sudden need to consult an outside expert, for instance, can radically affect budgets and lead to acrimonious disputes. It should be recognised that some reviews will need to be very expensive, others less so. Agreed cost estimates should be related to the aims and desired effects of the review.

Ninth, it is important that the review has adequate political and professional 'clout'. It must be supported by top management and local politicians and have the power to demand participation and information. It should be recognised as a major event in developing services for children and families.

The scope and nature of reviews

Tenth, it is important that a review has a clear focus. What is it seeking to do? How does it complement and add to coroners' inquests and police criminal investigations?

In Scotland, unlike some of the other countries discussed, these will be separate and their respective functions need to be agreed.

Eleventh, the role of reviews in children's services development needs to be clear. Is their function to highlight gaps in services, make sure scandals never happen again, identify practice shortcomings or something more radical?

Twelfth, the inquiry process must be predictable and understood by all those affected. It must be clear who will be involved, that participation is compulsory and what the outcomes and effects will be, independent of the specific findings.

Thirteenth, all of the countries participating in the study appear to be moving towards the features described in the template laid out in Chapter 8 of the *Working Together* guidance for England and Wales.

Fourteenth, whatever else it considers, the inquiry should look closely at the agreed components of good child protection work to see how these have affected the case in question. These have been identified by respondents as: inter-agency work, the collection and interpretation of information, decision making and relationships between professionals and the families and children involved.

Fifteenth, to achieve its aims, the review has to be sensitive to the context of each country, its size, population distribution, the needs of all children and the professional structures in place.

Sixteenth, other groups in Scotland may be monitoring harm to children, for example from air pollution, disability, genetic and infectious diseases or road accidents, and it is important that findings about child deaths from abuse and neglect are linked to this other information as poverty is known to be an underlying factor in the deaths of and injuries to children however caused.

The aftermath of reviews

Seventeenth, recommendations made in reports following child death and significant case reviews need to be realistic, understood and helpful to front-line practitioners as well as to children and families. They should not detract or draw resources from other children's services work. They should be sensible about the extent to which abuse and neglect can be prevented. If there is bad practice it should be highlighted as such but for some cases it may be more a question of bad luck or an 'out of the blue' incident.

Eighteenth, recommendations need to be related to other child protection work and Government initiatives for children and families. For example, it is important to minimise potential conflict with government plans concerning child poverty, computerised tracking, children's centres in local communities, interventions such as Sure Start, Connexions and extended schools and strategies to deal with alcohol and drug abuse.

Nineteenth, the review findings should be published as widely as is appropriate. Dissemination will take different forms according to the audience, whether the public,

politicians, professionals, media or selected individuals, and needs to be timed carefully to avoid leaks and pre-judgement.

Twentieth, the implications and effects of review recommendations on legislation, guidance, procedures and professional practice should be made clear in the dissemination.

These 20 points drawn from the survey will not of course eliminate child deaths from abuse and neglect. But it is fair to say that reviews conducted under these conditions are likely to be more effective in achieving their aims and so lead to policy and practice initiatives that will reduce tragedies as much as possible.

The function of reviews in modern children's services

All of the countries participating in this survey are seeking to develop effective response to problems intrinsic to economically developed or rapidly changing societies. Obviously, there are issues peculiar to each country but there is also much in common driven by challenging social situations and public expectation regarding solutions.

We noted earlier that the emphasis on children's rights over the past half century has led more children to be perceived as at risk of harm and has put pressure on welfare agencies to do something about it. Other factors that increase the likelihood of impairment to children's health and development include the widening gap between rich and poor, increasing levels of family breakdown, the plethora of family structures and higher levels of drug and alcohol abuse by adults, all of which can be manifest in the poor parenting, harsh or erratic discipline, parental conflict and domestic violence and separation from biological parents that characterise children in need. The poor outlook for many of these children when they reach adolescence has been charted world-wide, and includes a lack of qualifications, involvement in crime, misuse of alcohol and drugs, teenage parenthood and accommodation problems.

Although the professional context and extent of these problems differ widely across countries, the response is generally similar – to modernise children and family services. Seven essential features of such an approach can be summarised as a service that:

- Is needs-led and is therefore consistent and equitable
- Is evidence-based
- Has clear thresholds for services
- Has a single process that leads to a continuum of interventions for all children in need
- Supports an integrated team approach and a correct balance between investigation and help for children at risk of harm
- Has a proper balance between prevention, early intervention, treatment and social prevention

Such a service has to be supported by effective:

- Knowledge about the extent of need in local communities, based on accurate epidemiological data
- Identification of all children in need and those so defined who are at risk of harm or other impairments to health and development
- An assessment of the needs of each child and family identified and the prevailing risk and protective factors
- A range of multi-agency services for children and families that are logically related to their presenting needs and current knowledge about what interventions are likely to produce optimal outcomes
- A system and methodology for aggregating data, evaluating effectiveness and using this information to enhance further service development and delivery plans
- A research programme that seeks to identify and quantify risk and protective factors for children at risk of harm, produce actuarial information on them and logically link needs, services and outcomes

This has to be further underpinned by:

- An understanding of child development and the role of risk and protective factors within it
- A common language that employs concepts acceptable and meaningful to all professionals responsible for children. This should be based on the concepts of need, service, outcome, risk and protective factors and threshold and not on vaguer concepts such as 'vulnerable' or 'disturbed' which have too many different meanings to be useful. Neither should it rely on technical terms specific to particular professions, such as 'failure to thrive' or 'conduct disorder' which tend to be misused when applied too widely across agencies.
- A system of recording information that is acceptable and useful to all professions, is accurate and up-to-date, serves clinical, management and research functions, signposts immediately key developmental data, social histories and other service involvement and comprises a single information set or file that follows the child, and which is kept by the child and family.

If such a system is in place, there should be fewer deaths and serious injuries to children who are known to services. This is because the various components of children's services are linked more effectively. One of the weaknesses found in numerous studies is that while individual service contributions can be impressive, they do not add up to a satisfactory whole and outcomes for children and families remain poor. Thus, a Victoria Climbié situation should not arise using such a system. Those children who are killed or seriously injured in 'unpredictable' incidents will also be better protected as many of them are likely to be children in need for other reasons. For those killed or injured who have never been deemed to be in need, the service has obviously failed and such cases remain difficult to reach.

However, if there is any possibility of better protecting previously unknown children, it is more likely to be achieved in this service context as the post-incident review takes place in a culture of analysis and evaluation rather than as a separate inquisition. Thus, it is more likely to recommend sober and practical conclusions and to be heard and acted on as it feeds into an auspicious context of continuing review and service development.

Advice from international experts

In the questionnaires and follow-up interviews two respected international experts provided advice that they thought would be helpful to developments in Scotland.

Michael Durfee, a psychiatrist practising in Los Angeles and ISPCAN official, and John Goad, a distinguished practitioner in the US Midwest, offer the following 13 recommendations:

- Know the total number of deaths from different causes you might expect annually. Generally, expectations in the UK can be half those from similar populations in the US, mostly because of fewer teen homicides and gunshot deaths.

- Focus especially on infant deaths including homicide, as the risk of being murdered is higher in the first year of life than at any other time and it is usually a caretaker that kills, usually with bare hands and feet. Encourage special emphasis, therefore, on the 0-5 age group.

- Have a focus: it is wrong to try and do everything. Be clear about what sorts of cases you wish to consider and develop and adhere to a sound methodology to undertake the work. Do not set the parameters too wide. The deaths and injuries will lead you if you listen.

- To get to the bottom of each case you need a systematic review process that participants can understand. Consider the level of authority in the review process. Make the reason for the review clear to all who may be affected by the recommendations. A group of qualified people is not sufficient as this can lead to a tendency to produce 'make and mend do' recommendations.

- Requiring agency participation brings some problems; agencies can still be lukewarm or not participate. Have the power to subpoena information and make this clear before the review starts. Those with most to fear will then respond and the power will not have to be used.

- The review processes may have local and distant aspects, such as court hearings, with diverse participants. It is best to have a standing group of members with different people co-opted at different points in the review. This leads to greater continuity and cumulative understanding in a situation where staff turnover is high.[6]

- Have at least one data contribution from each agency and inspire and harass to get it. Demand membership if you wish but you need each agency to participate willingly and people on the front-line understand this better than their seniors. Seniors may provide more experience but may also be protective

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[6] It is interesting to note that none of the 20 people interviewed in the Sinclair and Bullock (2002) study two or so years after being involved in a serious case review were in the same post as they had been at the time of the review.

of their agency. Line staff who know the child's family home can tell you subtleties that are not in the records.

- Children and families can inspire prevention programmes in ways that professionals cannot. But the review process also requires some separation form the world to create a forum where agencies and agents can share their failures and families can destroy that separation. The same separation I needed for politicians who may be honourable but can be a source of intimidation and leaks to the press.

- You need to address confidentiality, data gathering and protection and grief support. Protect case-specific information from the media and be careful what is released and when; this is important to avoid worry among the participants. Nevertheless, be open with the information at an aggregate level, such as in an annual report. Give statistics, synopses, explain issues etc. and pass this to the relevant politicians to publish as a public document.

- Do not forget simple resources like food, coffee, tea and 'thank-you's' for tired and frightened staff, especially those in the front line.

- We revisit our recommendations and may still fail but by commission rather than omission, most of the time. We particularly miss previous health information and so will you. Some agencies do poorly with sharing records. The most common may be social services, which has the least clarity for actions. That is a difficult job. We should pressure medicine more but teams seem to defer to doctors. Health knows infants and toddlers, their birth records and previous well-baby care and hospital injury records may tell the story better than any agency records. Friends, families and neighbours may be the most valuable and you may find most of this with law enforcement investigation. Young children need skilled interviews and toddlers can tell what happened even if they can't appear in court.

- Do not let review team members become too isolated from other work. Dealing with serious situations can distort people's view of the whole. For example, they may develop pejorative views of step-parents or paramours, even though most of these people do not harm children they come to care for. If this is not done, the recommendations agreed will either be an elaborate construction for events that may never happen again and which most professionals will never encounter or they will simply not make sense to front-line workers. Members should be reminded that most child protection work is low level neglect.

- Finally, continuous high quality research is needed to inform the prevention and treatment process. We know very little, so without that a lot of blind avenues harmful to children and families will be pursued.[7]

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[7] The Laming (2003) Report of the Inquiry into the death of Victoria Climbié and the government's vision statement for children's services in England and Wales, *Every Child Matters* (DfES, 2003), make hardly any mention of the need for research and rest heavily on assumptions that we know what best to do in these situations.

BIBLIOGRAPHY

Alcalde, M. and Elster, N. (2002) *Child Fatality Review in the United States: A National Overview*, Louisville, Institute for Bioethics.

Alexander, R. and Case, M. (2005) *Evaluation of Accidental and Inflicted Child Death*, GW Publishing.

American Academy of Pediatrics (1999) 'Investigation and review of unexpected infant and child deaths', *Pediatrics*, CIV, 1158-1160.

Arthurs, Y. and Ruddick, J. (2001) *An Analysis of Child Protection 'Part 8' Reviews Carried out over a Two Year Period in the South-East Region of the NHS,* London, Department of Health.

Axford, N. et al. (2004) 'Mapping the data needed to plan integrated services: a case study of children's services in one locality', *Journal of Integrated Care*, XII, 3-10.

Beckett, C. (2005) 'The Swedish myth: the corporal punishment ban and child death statistics', *British Journal of Social Work*, XXXV, 125-38.

BC Coroners Service (2004) *BC Coroner's Service Child Death review: Mission, Goals and Objectives*, Government of British Columbia.

Birchall, E. and Hallett, C. (1995) *Working Together in Child Protection*, London, HMSO.

Blüml H., Kindler H. and Lillig S. (in press) *Kindeswohlgefährdung und ASD – Bilanz und Ausblick nach drei Jahren Forschung*.

Bradshaw, J. and Mayhew, E. (Eds) (2005) *The Well-being of Children in the UK, Second Edition*, London, Save the Children.

Brandon, M. et al. (1999) *Safeguarding Children within the Children Act 1989*, London, The Stationery Office.

Bridge Publishing Company (2001) *Childhood Lost: Part 8 Case Review Overview Report*, London, Bridge Publishing House.

Browne, K., Hanks, H., Stratton, P. and Hamilton, C. (eds) (2002) *Early Prediction and Prevention of Child Abuse: A Handbook*, Chichester, Wiley and Son.

Browne, K. and Saqi, S. (1988) 'Approaches to screening for child abuse and neglect' in Browne, K., Davies, C. and Stratton, P. (eds) *Early Prediction and Prevention of Child Abuse*, Chichester, Wiley and Son.

Bullock, R., Gooch, D., Little, M. and Mount, K. (1998) *Research in Practice: experiments with information design*, Aldershot, Ashgate.

Bullock, R. and Little, M. (2002) 'The contribution of children's services to the protection of children' in Browne, K., Hanks, H., Stratton, P. and Hamilton, C. (eds) *Early Prediction and Prevention of Child Abuse: A Handbook*, Chichester, Wiley and Son.

Bundesärztekammer (2001) *Injuries and their Consequences: prevention as a task for doctors*.
http://www.bundesaerztekammer.de/30/Praevention/10Gesund/80Unfall/Injury.pdf
[22nd March 2005]

Bunting, L. and Reid, C. (2005) 'Reviewing child deaths – learning from the American experience', *Child Abuse Review* XIV, 82-96.

Burke, J., Thomas, T. and Katz, I. (2000) *The Pandora Project: Privacy, Confidentiality and Reporting the Disclosure of Child Sexual Abuse*, Report to the DAPHNE Programme of the European Commission.

Child Protection Reform Programme (Scotland) (2005) *Child Deaths and Significant Case Reviews*.

Christianson-Wood, J. and Murray, J. (1999) *Child Death Reviews and Child Mortality Data Collection in Canada*, LCDC Health Canada.

Cloke, C. (ed.) (2000) *Out of Sight: NSPCC Report on Child Deaths from Abuse 1973 to 2000*, London, NSPCC.

Cooper, A. et al. (1995) *Positive Child Protection: A View from Abroad*, Lyme Regis, Russell House Publishing.

Corby, B. (1996) 'Risk assessment in child protection', in Kemshall, H. and Pritchard, J. (eds.), *Good Practice in Risk Assessment and Risk Management*, London, Jessica Kingsley.

Corby, B. et al. (2001) *Public Inquiries into Abuse of Children in Residential Care*, London, Jessica Kingsley.

Corby, B. (2003) 'Towards a new means of inquiry into child abuse cases', *Journal of Social Welfare and Family Law*, XXV, 229-41.

Dartington Social Research Unit (1999) *Matching Needs and Services, Second Edition*, Dartington Academic Press.

Dartington Social Research Unit (2000) *Paperwork: the clinical assessment of children in need*, Dartington, Warren House Press.

Dartington Social Research Unit (2002a) *Going Home? Findings and Guidance to Help Professionals make Good Judgements about the Reunification of Families*, Dartington Academic Press.

Dartington Social Research Unit (2002b) *Threshold: determining levels of impairment*

to children's development, Dartington, Warren House Press.

Dartington Social Research Unit (2004) *Refocusing Children's Services Towards Prevention: Lessons from the Literature*, Research Report 510, London, Department for Education and Skills.

Dent, R. (ed.) (1998) *Dangerous Care: Working to Protect Children*, London, The Bridge Child Development Service.

Department of Health (1991) *Child Abuse: A Study of Inquiry Reports 1980-1989*, London, HMSO.

Department of Health (1995a) *Child Protection: Messages from Research*, London, HMSO.

Department of Health (2000) *Framework for the Assessment of Children in Need and Their Families*, London, The Stationery Office.

Department of Health (2001) *The Children Act Now: Messages from Research*, London, The Stationery Office.

Department of Health (2002) *Safeguarding Children: A Joint Chief Inspector's Report on Arrangements to Safeguard Children*, London.

Department of Health, Department of Education and Science and Welsh Office (1991) *Working Together under the Children Act 1989*, London, HMSO.

Department of Health, Home Office and Department for Education and Employment (1999) *Working Together to Safeguard Children*, London, The Stationery Office.

Department of Health and Children (1999) *Children First: National Guidelines for the Protection & Welfare of Children*, Dublin.

De Silva, S. and Oates, R. (1993) 'Child homicide: the extreme of child abuse', *Medical Journal of Australia* 158 (5), 300-3-1.

DfES (Department for Education and Skills) *Every Child Matters*, Cm 5860, London, The Stationery Office.

DIJUF (Deutsches Institut für Jugendhilfe und Familienrecht) (2004) *Verantwortlich handeln – Schutz und Hilfe bei Kindeswohlgefährdung*, Bonn, Bundesanzeiger Verlag.

Durfee, M. et al. (2002) 'Child fatality review: an international movement', *Child Abuse and Neglect*, XXVI, 619-636.

Durfee, M. and Titlton-Durfee, D. (1995) 'Multi-agency child death review teams: experience in the United States', *Child Abuse Review*, IV, 377-81.

Elster, N. and Alcalde, G. (2003) 'Child fatality review: recommendations for State co-ordination and co-operation', *Journal of Law, Medicine and Ethics,* Summer.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Cambridge, Polity.

Falkov, A. (1996) A *Study of Working Together Part 8 Reports: Fatal Child Abuse and Parental Psychiatric Disorder*, London, Department of Health.

Falkov, A. (1997) 'Adult psychiatry – a missing link in the child protection network: a response to Reder and Duncan', *Child Abuse Review*, VI, pp. 41-45.

Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies*, London, HMSO.

Ferguson, H. (2004) *Protecting Children in Time: Child Abuse, Child Protection and the Consequences of Modernity*, Basingstoke, Palgrave Macmillan.

Fitzgerald, J. (1999) *Child Protection and the Computer Age: Sharing Information between Agencies by Computer*, London, Bridge Publishing House.

Fitzgerald, J. (2002) 'Child Death Enquiries', Meeting of the Centre for Social Policy, Dartington, 28th-29th November.

Goddard, C. and Liddell, M. (1995) 'Child abuse fatalities and the media: lessons from a case study'*, Child Abuse Review,* IV, 355-64.

Granik, L. et al. (1991) *Child Death Review Teams: A Manual of Design and Implementation*, Child Maltreatment Fatalities Project, American Bar Association Center on Childhood and the Law and the American Academy of Pediatrics.

Greenland, C. (1987) *Preventing CAN Deaths: An international Study of Deaths due to Child Abuse and Neglect*, London, Tavistock.

Hagell, A. (1998) *Dangerous Care: Reviewing the Risks to Children from their Carers*, London, The Bridge Child Development Service.

Hallett, C. and Birchall, E. (1992) *Co-ordination and Child Protection*, London, HMSO.

Hendrick, H. (2003) *Child Welfare: Historical Dimensions, Contemporary Debate*, Bristol, The Policy Press.

Hetherington, R. et al. (1997) *Protecting Children: Messages from Europe*, Lyme Regis, Russell House Publishing.

Hill, M. (1990) 'The manifest and latent lessons of child abuse enquiries', *British Journal of Social Work*, XX, 197-213.

Hobbs, C. et al. (1995) 'Leeds inquiry into infant deaths: the importance of abuse and

neglect in sudden infant death', *Child Abuse Review*, IV, 329-39.

James, G. (1994) *Study of Working Together Part 8 Reports*, London: Department of Health.

Johnson, M. (2004) 'Preventing child deaths: lessons learned from child fatality review', *The Link*, ISPCAN, XIII (1).

Kendrick, A. (2004) 'Recent Developments in Child Protection Policy and Practice in Scotland and the UK', Lecture to ONED Coping with Child Maltreatment Conference, Paris, 15 June 2004.

King, S. (2003) 'Managing the aftermath of serious case reviews', *Child Abuse Review*, XII, 261-9.

Knott, J. and Wildavsky, A. (1981) 'If Dissemination is the Solution, What is the Problem?', in Rich, R. (ed.) *The Knowledge Cycle*, Beverly Hills, Sage.

Kovacs, K. and Richardson, N. (2004) *Fatal Child Abuse*, Resource Sheet 4, June, Australian Institute of Family Studies.

Krug, A., Pattinson, R. C. and Power, D. J. (2004) 'Why children die: an under-5 health care survey in Mafikeng region', *South African Medical Journal* 94 (3), 202 – 206.

Laming, Lord (2003) *The Victoria Climbié Inquiry*, Cm 5730, London, TSO.

Leibfried, S. (1994) 'The social dimension of the European Union', *Journal of European Social Policy*, IV, 239-269.

Little, M. and Madge, J. (1998) *Inter-agency Assessment of Need in Child Protection*, Report for NHS R&D South West, Dartington Social Research Unit.

Little, M. and Mount, K. (1999) *Prevention and Early Intervention with Children in Need*, Aldershot, Ashgate.

Little, M. et al. (2002) 'How to develop needs-led, evidence-based services', *MCC-Building Knowledge for Integrated Care*, X, 28-32.

MacDonald, G. (2001) *Effective Interventions for Child Abuse and Neglect: An Evidence Based Approach to Planning and Evaluating Interventions*, Chichester, Wiley and Son.

May-Chahal, C. et al. (2004) *The Relationship between Child Death and Child Maltreatment: A Research Study on the Attribution of Cause of Death in Hospital Settings*, London, NSPCC.

McGhee, J. and Francis, J. (2003) 'Protecting children in Scotland: examining the impact of the *Children (Scotland) Act* 1995', *Child and Family Social Work*, VIII, 133-42.

Morrison, T. (2003) 'Making a real difference or just another child death inquiry? Learning the lessons from Childhood Lost', *Journal of Sexual Aggression,* IX, 97-107.

Munro, E. (1996) 'Avoidable and unavoidable mistakes in child protection work', *British Journal of Social Work*, XXVI, 795-810.

Munro, E. (1998) 'Improving social workers' knowledge base in child protection work', *British Journal of Social Work*, XXVIII, 89-106.

Munro, E. (1999) 'Common errors of reasoning in child protection work', *Child Abuse and Neglect* 23, 745-758.

Munro, E. (2005) 'A systems approach to investigating child abuse deaths', *British Journal of Social Work* XXXV, 531-546.

National MCH Resource Center for Child Death Review (2003) *Child Death Review Process*, Okemos, MI.

National MCH Resource Center for Child Death Review (2003) *Keeping Kids Alive: Guides for Effective Child Death Reviews*, Okemos, MI.

New South Wales Ombudsman (2004) *Reviewable Child Deaths: Annual Report 2003-4*.

New South Wales Death Review Team (2003) *Fatal Assault and Neglect of Children and Young People*, Sydney, NSW Commission for Children and Young People.

Northern Ireland Office (1999, 2005) *Co-operating to Safeguard Children* and *Processing Case Management Reviews*.

NSPCC (2001) *Out of Sight: Report on Child Deaths from Abuse 1973-2000*, London, NSPCC.

Owers, M. et al. (1999) *Learning How to Make Children Safer: An Analysis for the Welsh Office of Serious Child Abuse Cases in Wales*, University of East Anglia/Welsh Office.

Parsloe, P. (ed.) (1999) *Risk Assessment in Social Care and Social Work*, London, Jessica Kingsley.

Parton, N. (1985) *The Politics of Child Abuse*, Basingstoke, MacMillan.

Parton, N. (1991) *Governing the Family: Child Care, Child Protection and the State*, Basingstoke, Macmillan.

Parton, N. (1996) 'Child protection, family support and social work: a critical appraisal of the Department of Health research studies in child protection', *Child and Family Social Work*, I, 3-11.

Parton, N. (ed.) (1997) *Child Protection and Family Support: Tensions, Contradictions and Possibilities*, London, Routledge.

Parton, N. (2004) 'From Maria Colwell to Victoria Climbié: reflections on public inquiries into child abuse a generation apart', *Child Abuse Review*, XIII, 80-94.

Parton, N. and Matthews, R. (2001) 'New directions in child protection and family support in Western Australia: a policy initiative to refocus child welfare practice', *Child and Family Social Work*, VI, 97-113.

Pritchard, C. (1996) 'Changes in child homicides in England, Wales and Scotland 1973-1988 as an indicator of effective child protection: a comparative study of baby, infant and child murder in Western Europe', *British Journal of Social Work*, XXII, 663-684.

Reder, P. and Duncan, S. (1998) 'A proposed system for reviewing child abuse deaths', *Child Abuse Review*, VII, 280-86.

Reder, P. and Duncan, S. (1999) *Lost Innocents: A Follow-up Study of Fatal Child Abuse*, London, Routledge.

Reder, P. and Duncan, S. (2002) 'Predicting fatal child abuse and neglect' in Browne, K. et al. (eds) *Early Prediction and Prevention of Child Abuse*, Chichester, Wiley.

Reder, P. and Duncan, S. (2004) 'Making the most of the Victoria Climbié inquiry report', in Stanley, N. and Manthorpe, J. (eds) *The Age of Inquiry: Learning and Blaming in Health and Social Care*, London, Routledge.

Reder, P. et al. (1993) *Beyond Blame: Child Abuse Tragedies Revisited*, London, Routledge.

Retjman, R. (1997) 'A study of Working Together Part 8 reports: fatal child abuse and parental psychiatric disorders', *Childright*, CXXXIV.

Sanders, R. et al. (1999) 'Child abuse fatalities and cases of extreme concern: lessons from reviews', *Child Abuse and Neglect*, XXIII, 257-68.

Scottish Executive (2004) *Protecting Children and Young People: The Charter*, Edinburgh.

Scottish Executive (2002) *It's Everyone's Job to make sure I'm alright*: *Report of the Child Protection Audit and Review* and *Literature Review*, Edinburgh.
http://www.scotland.gov.uk/library5/education/iaar-00.asp.

Scottish Office (1992) *The Report of the Inquiry into the Removal of Children from Orkney in February 1991*, Edinburgh, HMSO.

Scottish Office (1996) *Protecting Children – A Shared Responsibility: Guidance on Inter-agency Co-operation*, Edinburgh.

Simpson, C., Simpson, R., Power, K. and Williams, G. (1994) 'GPs and health visitors' participation in child protection conferences', *Child Abuse Review*, III, 211-230.

Sinclair, R. and Bullock, R. (2002) *Learning from Past Experience: A Review of Serious Case Reviews*, London, Department of Health.

Sinclair, R. and Little, M. (2002) 'Developing a taxonomy for children in need', in Ward, H. and Rose, W. (eds.) *Approaches to Needs Assessment in Children's Services*, London, Jessica Kingsley.

Smith, M. et al. (2004) 'A normative study of children's injuries', in Quinton, D. (2004) *Supporting Parents: Messages from Research*, London, Jessica Kingsley.

Social Services Inspectorate (1994) *Evaluating Child protection Services: Child Protection Inspections 1993/4; Overview report of 8 Inspections*.

Stanley, J. and Goddard, C. (2002) *In the Firing Line: Violence and Power in Child Protection Work*, Chichester, Wiley and Son.

US Department of Justice (2001) *The National Center on Child Fatality Review*, Office of Justice Programs.

Van Voorhis, R. and Gilbert, N. (1998) 'The structure and performance of child abuse reporting systems', *Children and Youth Services Review*, XX, 207-21.

UNICEF (2001) *A League Table of Child Deaths by Injury in Rich Nations*, Florence, Innocenti Research Centre.

Webster, R. et al. (2003) 'Child death review: the state of the nation' *American Journal of Preventive Medicine*, XXV, 58-64.

Weyts, A. (2004) 'The educational achievements of looked after children: do welfare systems make a difference to outcomes?', *Adoption and Fostering*, XXVIII, 2004, 7-19.

White, R. (1995) 'A perspective from child death reviews', *Child Abuse Review*, IV, 371-6.

Wilczynski, A. (1994) 'The incidence of child homicide: how accurate are the official statistics?', *Journal of Clinical Forensic Medicine*, I, 61-66.

APPENDIX A: LIST OF COUNTRIES

The following 24 countries were selected for the study. Those for which we received one completed questionnaire are marked by one asterisk (*) and those for which we received two or more questionnaires are marked by two asterisks (**). Countries from which we received information in the form of literature, email or a telephone discussion (but not a questionnaire) are marked with an § sign. (Information of this nature was also received for most of the countries for which a questionnaire was completed). In Israel the questionnaire was completed by two respondents working together. Over 35 people were involved in providing assistance with this study in one form or another.

**Australia
**Belgium
Brazil
§Bulgaria
**Canada
*England
**Germany
*Ireland
*Israel
**Jordan
Netherlands
*New Zealand
§Northern Ireland
*Norway
Portugal
§Romania
§Scotland
**South Africa
South Korea
Spain
Sweden
*Switzerland
**US
*Wales

APPENDIX B: THE QUESTIONNAIRE[8]

QUESTIONNAIRE FOR STUDY OF INTERNATIONAL APPROACHES TO CASE REVIEWS OF CHILD DEATHS AND SERIOUS INJURIES

The study seeks to explore approaches to and processes of enquiry following the death or serious injury of a child <u>when abuse and/or neglect is (or is suspected to be) a contributory factor</u>.

Obviously, each country will have different arrangements and limits on the types of case to be included but please answer the questions for what would happen in these situations in your country (or state/sub-region within it).[9]

Please type responses into the boxes provided (which expand as they are filled in) and return by email to rbullock@dartington.org.uk or by FAX to 00-44-1803-866783 by Monday 14th March 2005 (or as soon as possible thereafter).

A. THE APPROACHES TAKEN

A1a. Do reviews routinely take place in the event of a child death and/or serious injury/neglect? If not, why not, and what happens instead?

A1b. What are the criteria for including a child in the existing procedures for conducting reviews? Do they include deaths <u>and</u> serious injuries, and do they take place if there is <u>only</u> suspicion of abuse and/or neglect as a contributory factor?

A1c. To help summarise particular situations, please put a cross (X) next to as many of the following categories as apply in your country to help establish the characteristics and needs of children who are typically the subject of enquiries: [10]

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[8] The formatting of the questionnaire has altered in the process of adding it to this report.

[9] In some countries there is a national system, whereas in others there are differences between administrative regions, such as states or departments. Please make it clear which your answers refer to.

[10] Taken from Sinclair, R. and Bullock, R. (2002) *Learning from Past Experience: a review of serious case reviews*, London, Department of Health.

1 Accidental/natural causes of death but possible neglect	
2 Known significant protection risks or long-term neglect	
3 Baby 'battered' by father / step-father	
4 Teenagers living in chaotic circumstances	
5 Murder by mentally-ill parent (one-off incident)	
6 No known protection risks but suspicious death/injury	
7 Dramatic change in parenting following arrival of new male	
8 Concealed pregnancy / abandonment	
9 Fabricated or induced illness (Munchausen by Proxy)	
10 Death while in residential or foster care	

A2. Who, or which type of organisation, orders reviews or enquiries and with what authority?

A3. Who undertakes the enquiries and who else is involved in the process? What is their professional background, expertise and status?

A4. What are the purpose, scope and style of the enquiries? For example, are the questions to be answered, the sources of information to be used and the structure of reports set in advance? If so, by whom, in what form and how prescriptive is any guidance?

Does the process seek to be inquisitorial or more focused on practice learning and service development? What is the nature of the recommendations that follow the enquiries (e.g. re. legislation, procedures or practice)?

A5. What are the administrative arrangements for conducting an enquiry? How is time made available? Who pays the cost?

A6. How are the results of the reviews disseminated? Is there a published report? To whom is it available? What form does it take?

Are enquiries subject to any regular or periodical overview? Are there mechanisms to integrate the recommendations into legislation, service development and practice?

B. EVALUATION OF THE APPROACHES

B1. What have been the effects of enquiries in your country/state? Please take into account the following: policy, practice, legislation and guidance, training, other welfare work with families, children and families themselves and subsequent reviews.

┌───┐
│   │
│   │
└───┘

B2a. What are the <u>strengths</u> of the procedures adopted in your country/state? Please indicate your own view but also those of different stakeholders (e.g. administrators, practitioners, children and parents).

┌───┐
│   │
│   │
└───┘

Please put a cross (X) next to as many of the following features of accepted good practice in reviews of child deaths and serious cases as apply in your country/state: [11]

1 Have clear objectives	
2 Require agencies to cooperate, with ability to enforce this	
3 Take multi-agency perspective i.e. wide range of agencies consulted	
4 Content includes family, social and developmental history of the child	
5 Involve outside experts	
6 Involve parents/carers, family and children	
7 Form part of a broader audit of services	
8 Emphasise clear lessons rather than attributing blame	
9 Generate clear action plans to be integrated into mainstream work	
10 Make carefully-drawn recommendations for child abuse policy	
11 Present material in standard format	
12 Completed within a reasonable timescale	
13 Coordinated dissemination of clear messages	

Please add any additional comments on strengths here (if needed):

┌───┐
│   │
│   │
└───┘

B2b. What are the <u>weaknesses</u> of the procedures adopted, again indicating your view but also taking the perspectives of different stakeholders?

┌───┐
│   │
└───┘

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[11] Drawn from Sinclair and Bullock (2002, pp.12-14, 47f) *op. cit.*

Please put a cross (X) next to as many of the following common criticisms of such reviews as apply in your country/state:[12]

1 Gaps in information	
2 Lack of clear format to report	
3 Too many recommendations in report to be useful	
4 Too much focus on incidents and compliance with procedures	
5 Isolation of the exercise from wider child care strategic planning	
6 Unrealistic timescales for completion	
7 Delays in obtaining information from some agencies	
8 Endless repetitions of recommendations in successive reviews	
9 Does not lead to children feeling protected	
10 Does not lead to prosecution of offenders	

Please add any additional comments on weaknesses here (if needed):

B3a. Please describe situations in your country/state where the procedures relating to child deaths and serious cases work well.

B3b. Please describe situations in your country/state where children are missed or are poorly served by the procedures relating to child death and serious cases.

B4a. if you are able, please give an anonymous example of a successful review procedure in your country/state.

B4b. If you are able, please give an anonymous example of a failed or unsatisfactory review procedure in your country/state.

[12] Drawn from Sinclair and Bullock (2002, pp.12-14, 47f) *op. cit.*

C. OTHER INFORMATION

C1. What are the resources typically invested in the review procedures in terms of finance, time, experts and other staff?

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C2. Has any research been undertaken into child death and significant case reviews in your country or state? If yes, please describe briefly the method and main findings together with a relevant reference.

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C3. Please identify here the references for any official documents in your country/state regarding legislation, guidance and procedures relating to child deaths and serious cases. If possible please note a web reference or post a copy to us, indicating that you have done so: **Dartington Social Research Unit, Warren House, Dartington, Totnes, TQ9 6EG, UK**.

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C4. If more than one type of review/enquiry operates in relation to child deaths or serious cases, for example for different kinds of incident, please provide brief details here and note how this would affect any of the previous answers.

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C5. Briefly, what procedures operate in your country in relation to child deaths or serious injuries where abuse/neglect are <u>not</u> (or are <u>not thought to be</u>) contributory factors?

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C6. If we need to telephone you to discuss any of this information what telephone number should we call you on and when would be the best times to contact you in the weeks commencing 14th, 21st or 28th March?

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C7a. Please put a cross (X) in the relevant box to indicate if you are happy for us to cite your contribution in the report and attribute comments to you, if appropriate.

Yes – citation and comments	
Yes – citation only	
No	

C7b. Please put a cross (X) in the relevant box to indicate if you are happy for us to include your name in an Appendix to the report listing those who have contributed to the study.

Yes – please complete details below	
No	

Name	
Title	
Position	
Work place	
Postal address	
Telephone number	
Email address	

Thank you very much for taking the time to complete this questionnaire.

Please return the questionnaire by Monday 14th March (or as soon as possible thereafter) by email to rbullock@dartington.org.uk or by FAX to 00-44-1803-866783. Please direct any queries to Roger Bullock by telephone: 00-44-1803-862231 (Dartington) or 07714 331414 (Mobile).

Appendix C: Strategy for the Literature Search

The strategy for the literature search had two main strands. The main part involved searching various paper and electronic sources available to the research team. This was supplemented by a question in the survey requesting that respondents direct us to any research that they knew of in their own country. The results of the latter are described in Appendix D. The approach taken with regard to the former is now outlined in more detail.

The following sources were used:

> (1) Dartington Social Resarch Unit library (books);
> (2) DSRU library (grey literature – over 2000 papers and reports);
> (3) DSRU library (focusing on main journals in the field for 1995-2005);
> (4) Standard academic databases and websites (e.g. BIDS, Sosig)
> (5) Standard practice databases (e.g. eLSC, RiP)
> (6) Search engines (e.g. Google)

The review of journals in the DSRU library was done by a hand search, focusing on the following: Adoption and Fostering; British Journal of Social Work; Child Abuse and Neglect; Child and Family Social Work; Children and Society; Child Psychology and Psychiatry Review; Child Welfare; Community Care Research Matters; Development and Psychopathology; International Journal of Child and Family Welfare; International Journal of Children's Rights; Journal of Adolescence Journal of Child Psychiatry and Psychology; and Representing Children.

The databases examined were as follows: ASSIA (Applied Social Science Index and Abstracts); Caredata; IBSS (International Bibliography of the Social Sciences); Social Science Abstracts; SOSIG (Social Sciences Information Gateway); ERIC (education database); MEDLINE (medical issues); Community Care (focusing on the headings 'Best practice', 'Directory' and 'References'); eLSC (Electronic Library for Social Care); Regard (hosted by the ESRC); CEBSS (Centre for Evidence-Based Social Services); Evidencebank (hosted by Research in Practice); Making Research Count; NISW/SSRG (National Institute of Social Work and Social Sciences Research Group).

The following search terms were used for all databases:

- Child death + Reviews
- Child death + Inquiries / Enquiries
- Child + Serious case + Reviews
- Child + Serious case + Inquiries / Enquiries
- Child death + Abuse + Reviews
- Child death + Neglect + Inquiries / Enquiries
- Child abuse + Reviews
- Child abuse + Inquiries / Enquiries
- Child neglect + Reviews
- Child neglect + Inquiries / Enquiries

APPENDIX D: RESEARCH IDENTIFIED BY RESPONDENTS

Respondents were asked in the questionnaire to indicate if any research had been conducted on the system for reviewing child death and serious injuries in their respective countries. In many countries there was no research to speak of. Typical responses were 'No' and 'there is fairly little systematic research on these cases'. About half of the respondents indicated that there was but what this actually means varies widely. It is worth outlining briefly the kinds of research mentioned as it reinforces the message that, with notable exceptions, there is very little to draw on that is of direct relevance.[13]

First is robust scientific research into the nature and effectiveness of policies for reviewing child deaths. This appears to be very rare. Some research has been undertaken in the UK and in the US there are many studies of this topic, in particular by Michael Durfee (one of the survey respondents) and his colleagues at the National Centre on Child Fatality Review[14] but also Barbara Bonner at the Oklahoma Health Science Center. The main ones from both countries are covered in the literature review of this report. A study of a pilot programme for reviewing the deaths of children aged under five years was published in the South African Medical Journal in 2004. Connected with this are critiques of existing policy and practice in child protection more generally, for example the Stanley and Goddard (2002) book *In the Firing Line* in Australia and a similar publication in Germany (Blüml et al, in press).

Second is research on child deaths and child abuse *per se*, of which, unsurprisingly, there is more (e.g. de Silva and Oates, 1993; Krug et al, 2004). However, often this says little about systems of review and their value. This is illustrated by the following response from a respondent in Jordan: 'Various rsearch studies have been conducted on child death as research on patterns of injuries and domestic accidents. Need assessments, qualitative interviews and report reviews were used as data collection tools. Major findings indicated that children need empowerment and feelings of safety especially in the institutions that serve children. Different patterns of battering were identified as, for example; battering children on unapparent spots in the body'.

Third is grey literature. This includes departmental annual reports, for instance the New South Wales Ombudsman *Reviewable Deaths Annual Report 2003-2004*, which reviews the deaths of 137 children over a 12 month period, makes 18 recommendations and also reviews progress made on recommendations made in previous reports. In Ireland, Chapter 8 of the *Children First* guidelines from the Department of Health and Children in Ireland was the only known source. Also under this heading are fact sheets, providing summary figures of the prevalence of child deaths and brief descriptions of the systems in operation, for instance 'Fatal Child Abuse' by the Australian Institute of Family Studies (Kovacs and Richardson, 2004).

Fourth, respondents pointed us towards broader publications and statistics concerning child protection and child welfare policy. For example, the Israeli team advised that there was no research of direct relevance but sent us salient chapters from the *Initial*

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[13] All references are inserted in the main 'References' section of the report.
[14] See www.ican-ncfr.org.

Periodic Report of the State of Israel Concerning the Implementation of the Convention on the Rights of the Child (submitted to the UN Committee on the Rights of the Child in 2001). One of the German respondents pointed us to UNICEF figures on child deaths and abuse – in addition to studies on prevention and early intervention in child abuse (cited in the report) – and a South African respondent drew our attention to figures on the website of the *Statistics South Africa*. A report on the German child protection system was produced by a commission that was set up after the death of a foster child in Germany due to violent sexual abuse (DIJUF, 2004).

APPENDIX E: SUMMARY OF STRENGTHS AND WEAKNESSES OF REVIEW SYSTEMS

Table 1 Strengths of review systems (as reported by respondents)

Strength	Country (see below for further details)													
	Aus	Belg	Canada	Eng	Ger	Ire	Israel	Jordan	NZ	Norway	Scot	S. Africa	Switz	US
1 Have clear objectives	✓	x	✓	✓	-	✓	x	✓	✓	-	✓	x	✓	✓
2 Require agencies to cooperate, with ability to enforce this	✓	x	✓	✓	-	x	✓	✓	✓	-	✓	x	✓	✓
3 Take multi-agency perspective i.e. wide range of agencies consulted	✓	x	✓	✓	-	✓	✓	✓	✓	-	✓	x	✓	✓
4 Content includes family, social and developmental history of the child	✓	✓	✓	✓	-	x	✓	x	✓	-	✓	x	✓	✓
5 Involve outside experts	x	✓	✓	✓	-	✓	x	x	✓	-	✓	x	x	✓
6 Involve parents/carers, family and children	x	✓	x	✓	-	x	✓	✓	✓	-	x	x	✓	x
7 Form part of a broader audit of services	x	x	x	✓	-	x	x	✓	✓	-	x	x	x	✓
8 Emphasise clear lessons rather than attributing blame	✓	x	x	✓	-	x	✓	x	✓	-	✓	x	✓	✓
9 Generate clear action plans to be integrated into mainstream work	✓	x	✓	✓	-	x	x	✓	✓	-	x	x	✓	✓
10 Make carefully-drawn recommendations for child abuse policy	✓	x	✓	✓	-	x	x	✓	✓	-	✓	x	x	✓
11 Present material in standard format	x	x	✓	✓	-	x	x	✓	0	-	x	x	x	✓
12 Completed within a reasonable timescale	✓	x	✓	✓	-	x	x	x	✓	-	x	x	✓	✓
13 Coordinated dissemination of clear messages	✓	x	✓	✓	-	x	x	x	✓	-	x	x	x	✓

Codes: ✓=strength identified; x=no strength identified; '-'=insufficient information. **Note on countries:** Aus= New South Wales, Australia; Belg =Flanders, Belgium; Eng= England, Wales and Northern Ireland; US= Los Angeles County, California. **Note on codes:** The table should be read in conjunction with descriptions in the report of the respective national systems. In Germany and Norway there is no review procedure to speak of, so respondents did not complete this table. In both Australia and Canada two separate respondents completed the table; their responses have been combined (so that even if only one considered a strength to apply this was counted). In South Africa one respondent said there were no strengths, the other placed Xs in every box but noted that 'All of the above apply to accepted good practice among professionals but it does not mean that these things are happening in practice'. The US respondent used two marks (XX) to indicate a special strength, a question mark (X?) to indicate a tentative strength and a question mark by itself (?) to indicate not being sure; any X mark has been translated here into a single X and a single ? has been converted into a zero (0).

Table 2 Summary of weaknesses of review systems (as reported by respondents)

Weakness	Country (see below for further details)													
	Aus	Belg	Canada	Eng	Ger	Ire	Israel	Jordan	NZ	Nor	Scot	S.A.	Switz	US
1 Gaps in information	✓	✓	x	x	-	x	x	✓	✓	-	✓	✓	✓	✓
2 Lack of clear format to report	x	✓	✓	x	-	✓	✓	✓	x	-	✓	✓	✓	✓
3 Too many recommendations in report to be useful	x	x	✓	x	-	x	x	✓	x	-	✓	x	✓	x
4 Too much focus on incidents and compliance with procedures	✓	x	✓	x	-	x	x	✓	x	-	x	x	✓	x
5 Isolation of the exercise from wider child care strategic planning	✓	✓	✓	✓	-	✓	x	x	✓	-	✓	✓	✓	✓
6 Unrealistic timescales for completion	x	x	x	✓	-	x	x	x	x	-	x	x	✓	x
7 Delays in obtaining information from some agencies	✓	x	x	✓	-	✓	✓	x	✓	-	✓	✓	✓	✓
8 Endless repetitions of recommendations in successive reviews	✓	x	✓	✓	-	✓	x	x	✓	-	✓	x	✓	x
9 Does not lead to children feeling protected	x	✓	✓	✓	-	x	x	x	✓	-	✓	✓	✓	✓
10 Does not lead to prosecution of offenders	x	x	x	✓	-	x	x	x	x	-	✓	✓	x	x

Codes: ✓ = weakness identified; x= no weakness identified; '-'= insufficient information

Note on countries: Aus= New South Wales, Australia; Belg =Flanders, Belgium; Eng= England, Wales and Northern Ireland; US= Los Angeles County, California.

Notes on codes: In Germany and Norway there is no review procedure to speak of, so respondents did not complete this table. In both Australia and Canada two separate respondents completed the table; their responses have been combined (so that even if only one considered a weakness to apply this was counted).

APPENDIX F: SUMMARY OF THE KEY FEATURES OF SYSTEMS OPERATING IN THE DIFFERENT COUNTRIES (BASED ON QUESTIONNAIRES)

Feature	Country (see below for further details)													
	Aus	Belg	Canada	Eng	Ger	Ire	Israel	Jordan	NZ	Nor	Scot	S.A.	Switz	US
Routine system [1]	Yes	No	Yes	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Criteria [2]	M	M	D	D	D	D	D	D	D	D	D	M	D	M
Who orders [3]	L	L	P	P	L	L	L	L	P	L	L	P	L	L
Purpose/style [4]	PL	F	PL	PL	PL	F	PL	F	PL	F	PL	F	PL	PL
Integrated [5]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes

* Aus= New South Wales, Australia; Belg= Flanders, Belgium; Eng= England, Wales and Northern Ireland; US=Los Angeles County, California.

Features Codes

[1] 'Routine system' concerns whether reviews routinely take place in the event of a child death and/or serious injury/neglect (=Yes) or not (=No).

[2] 'Criteria' concerns whether such reviews are mandated (=M) by law or discretionary (=D), that is dependent on the situation or people involved.

[3] 'Who orders' concerns who orders the reviews to happen, divided here between legal/police (=L) and professional (=P) bodies.

[4] 'Purpose/style' concerns whether the reviews are typically investigative/forensic (=F), that is mainly concerned with finding out what happened and where responsibility lies for the death/injury, or focused more on drawing out lessons from the case in order to improved practice learning (=PL).

[5] 'Integrated' refers to whether the service for reviewing child deaths/injuries in the case of suspected/actual abuse/neglect is integrated with the system for reviewing unnatural deaths generally (=Yes) or not (=No).