The role of parents in the *Child Death Review Process*

Lauren Devine

Abstract

This article considers whether evidential and procedural issues identified in relation to public family law social work assessment of families can be used to further understanding of the Child Death Review Process. The process is an under-researched but important aspect of statutory family assessment. Pre-litigation stages of family investigation, particularly in relation to child protection and safeguarding are undertaken within the *Framework for the Assessment of Children in Need and their Families*, set out in *Working Together to Safeguard Children*. The Child Death Review Process, also in *Working Together to Safeguard Children* is applied in cases of child deaths categorised as 'sudden' and 'unexpected'. Assessment of bereaved parents is particularly sensitive and highlights the problems of mixing investigatory assessment with measures intended to be supportive. This paper questions the function of the Child Death Review Process, asking whether it forms part of a drift towards increasingly intrusive state surveillance of families and particularly parents, or is an attempt to 'work together' with parents following bereavement. If it is an investigatory process there are ramifications for subsequent decision making, including decisions made by courts in public family law or criminal proceedings. A clearer framework for assessment and inclusion of parents as part of (as opposed to subjects of) the process is indicated. Alternatively the process should be removed from *Working Together* and carried out within the criminal justice framework, the public health framework and the Coroner's framework.

Key words

Child Death Review Process, public family law, child protection, safeguarding, BRI Public Inquiry.

Introduction

Drawing on an earlier paper from findings presented to the Sudden & Unexpected Deaths in Infancy (SUDI) Conference (Devine, 2014), the current paper discusses a number of issues in relation to the Child Death Review Process. The discussion includes: the impact of the Child Death Review Process on the justice system as a pre-litigation investigation process, its inclusion in the post-refocusing grouping of welfare and policing assessments into a general assessment framework set out in *Working Together to Safeguard Children* (Department for Education, 2013), the influence of the abuse eradication narrative, and the role of Public Inquiries and Serious Case Reviews.

Aspects of public law family assessment have become progressively more invasive into private family life since the Children Act 1989. Although the remit of the Child Death Review Process theoretically includes investigation of all circumstances surrounding a child's death, the inference is that its focus is an investigation of parental conduct by virtue of its inclusion in the English government's statutory guidance document *Working Together to Safeguard Children* (Department for Education, 2013). This theoretically places it within the remit of child protection and safeguarding with associated data sharing implications. The question, however, of where in the three domains of safeguarding, clinical/social service organisation and delivery, and public health professionals, the Child Death Review Process is located is unclear:

> '…there is a bit of a mismatch now between whether we are reviewing child deaths from a sort of social and safeguarding implications of them, or whether it is safeguarding thing. Or, because most obviously 35-40% of them are going to be neonatal, premature babies, all of them, that are expected deaths and should we be reviewing them. I don't know whether you can build it into this? Whether that is a good use of time or whether that should be done somewhere else?' (Kurinczuk and Knight, 2013:38-39).

The Child Death Review Process is a unique form of public family assessment ensuring that every bereaved family is categorised as 'known to' local authority Children's Services Departments either through direct child protection or safeguarding referral as part of the Child Death Review Process or simply by virtue of data recording with the Local Safeguarding Children Board (LSCG) and the Child Death Overview Panel (CDOP) (Kurinczuk and Knight, 2013). The enabling legislation for the Child Death Review Process is contained in section 14(2) of the Children Act 2004 and was introduced by statutory instrument in 2006. Six years after the enabling legislation was enacted the Child Death Review Process was included in the statutory guidance *Working Together to Safeguard Children* (Department of Health, 2010a:215).

The statutory guidance is intended to provide a framework for assessment where professionals 'work together' with families at the same time as investigating them. Unsurprisingly this process is reported as being a cause of conflict and trauma for families as well as creating a difficult position for professionals (Devine, 2015). Families' experiences of 'working with' professionals during and after assessment, even in situations intended to be consensual almost unanimously report a negative experience. Parents and their children report long term trauma caused by the strain of allegations, ongoing suspicions, and the need

to comply with social work and other professional requirements in respect of aspects of private family life (Butler-Sloss, 1988; Schultz, 1989:37; Richardson, 1990; Luza & Ortiz, 1991:108; Wakefield & Underwager, 1994; Prosser, 1995:10; Dale *et al*, 2005; Jones, 2001:1395; Prosser & Lewis, 1992:20). This trauma is not recognised in the statutory guidance, raising a question over the suitability of the inclusion of the Child Death Review Process in it given that bereaved parents are in a particularly vulnerable position.

It is not suggested that a thorough investigation of any sudden and unexpected death, whether in infancy, childhood or adulthood, is contra-indicated. However the justification and rationale for the need for the Child Death Review Process is not as clearly indicated: the existing criminal justice, clinical governance and Coroner's Inquest framework all provide mechanisms for establishing the circumstances surrounding a death. Recent research by the Department for Education raises a number of issues about how the process is operating, particularly in relation to the accuracy and consistency of information, and its recording:

> '…I wonder how accurate this data is because nobody is entering it in the same way.' (Kurinczuk and Knight, 2013:26).

> 'Yes. I think at the moment it is done so badly and so inconsistently that it is a waste of time and money..... I think if you wanted to do this properly, which I think if you want any sensible learning from it, you should be trying to do it properly and given the amount of money that is thrown at it….I think that the way that it is done at the moment is so haphazard, it is so idiosyncratic.' (Kurinczuk and Knight, 2013:26).

The depth of the investigation carried out during the Child Death Review Process was questioned:

> '**…**I know, because of the work I do that many authorities are actually filling those returns in after a very minimal review.' (Kurinczuk and Knight, 2013:26).

The Child Death Review Process seems to be a return to the pre-refocusing approach of suspecting parents of wrongdoing until they are 'screened out' of suspicion. In Gibbons *et al.*'s research (Gibbons *et al.* 1995) it was identified that families were 'filtered out' of a child protection response to referral as opposed to being 'filtered in'. This prompted a shift in assessment practice away from this policy, recognising it was causing unnecessary trauma to families. Those who simply needed support services based on need as opposed to parental insufficiency or child abuse were unnecessarily drawn into an investigatory process. The process of being 'filtered out' was precisely what was seen as being so traumatic to families who were largely found to simply need access to restricted welfare services. A return to this position seems contra-indicated as it is already known to yield a high false positive rate and a high traumatic cost to families. Even allowing for the different operational framework to other forms of family assessment used in the Child Death Review Process, bereaved parents may form a category of parents least able to cope with it. Their lack of direct involvement as participants does not acknowledge the ethos of 'working together' and may be a trigger to increase their trauma. Practitioners responding on behalf of CDOP have reported concerns about the emotional implications of the investigation, stating *inter alia* that:

> 'It is disrespectful to be honest for the children who have died, if you want to put it in bleak and emotional terms.' (Kurinczuk and Knight, 2013:26).

The key difference in assessment under the Child Death Review Process when compared with other assessments under *Working Together to Safeguard Children* is it is never consensual and does not aim to include parents as partners in the process. In non-bereaved families the trigger for family assessment is a referral to Children's Services Departments. The Child Death Review Process is triggered by the death of a child. This may reflect a more honest description of assessments generally as the line between all consensual and coercive assessment is blurred, particularly under the new Continuous Assessment structure (Department for Education, 2013). The successive versions of *Working Together to Safeguard Children* (Department for Education, 2013; Department of Health and Social Security, 1986; Department of Health, 1989, 1990, 1999, 2010a, 2010b; Department of Health, Home Office, Department for Education and Employment, 1999; HM Government, 2008, 2010) have drifted towards a position where it is hard to separate out the exact point where consensual assessment ends and non-consensual assessment begins (Devine, 2015).

The Anglo-American model of state assessment of families

The legal framework of child protection and safeguarding in England and other jurisdictions included in the Anglo-American model operate a selective provision of services for children only if eligibility thresholds are met. Decisions about whether thresholds are met are taken following family assessment. This process should enable local authorities discharge their duties to 'protect' using preventative strategies under s.47, and 'safeguard' using promotional strategies under s.17. Since the refocusing debate in the mid-1990s the method used to decide which children the local authority must either intervene to protect, or for whom the authority must provide services has changed. Emphasis has been placed on the use of s.17 assessment, which is consensual, escalating to s.47 assessment only when indicated. However, under the latest edition of *Working Together to Safeguard Children* the distinction is removed (Department for Education, 2013). Consequently the status of the new Continuous Assessment as a consensual process is unclear.

The Children Acts 1989 and 2004 create the key statutory provisions placing a duty upon local authorities to intervene to promote the welfare of children under certain circumstances: Where 'significant harm' is suspected under s.47 Children Act 1989, where a child requires 'services' under s.17 Children Act 1989 and to 'safeguard and promote welfare' under s.11 Children Act 2004. The provisions of s.11(1) place a duty on a wider category of agencies than local authorities. Undoubtedly under s.47 Children Act 1989 non-consensual family assessment is possible by operation of law. However, unless this statutory power to compel assessment can be invoked, parents and children should be able to withhold their consent to intrusion. However, assessment intended to be consensual can escalate to become coercive if consent is withheld. This can occur either by application by a local authority for a s.43 Children Act 1989 Order to compel parents to produce a child for assessment, or by simply escalating an assessment into a formal s.47 child protection investigation process.

The process of assessment is fundamentally conflicted under this framework: the requirement is to enquire into every aspect of a family's life as opposed to simply investigating the reason for referral (Department for Education, 2013:20). This creates a contentious situation. As there is no legal aid available for parents during assessment they may not understand the potential litigation consequences of assessment until after the event, or may consent to assessment believing it is the only way they can receive support services. It raises a question

over whether parents are fundamentally suspects, service users or both. In relation to all assessments, and particularly the Child Death Review Process, resolving this question is critical.

Modern assessment is carried out via comprehensive and extensive examination of family life with additional experts' reports where the local authority considers they are indicated (Department for Education, 2013). Although the modern approach to assessment was developed partly in an attempt to encourage collaborative working between parents and social workers during the assessment process itself, there is a fundamental dichotomy in mixing legislative provisions intended to be coercive with those intended to be consensual. The enabling Children Act 1989 kept these sections separate, including them under different Parts of the Act. Coercive measures are listed in Part V whereas consensual and supportive measures are listed in Part III. This separation is not reflected in the Statutory Guidance (Department for Education, 2013). Consequently attempts to operate a model of surveillance and policing within a collaborative assessment framework is flawed,

A multi-agency approach is adopted in all types of family assessment. However, the modern multi-agency approach to assessment as a 'fishing expedition' for evidence of parental wrongdoing is dichotomous with the notion of 'working together'. The concept of multi-agency working is of concern if one of the purposes of assessment is to decide whether there are grounds for civil or criminal proceedings which may include a decision on whether there is culpability on the part of the investigating agencies. The use in litigation of evidence gathered at a time when parents are not legally represented presents challenges and difficulties in relation to evidential reliability, fairness and inequality of arms. Problems at the assessment stage are likely to underpin problems during the later thresholds of intervention, including during litigation. The Child Death Review Process removes from parents the protections a more controlled process would afford, for example the protections afforded by PACE in a criminal investigation (Police and Criminal Evidence Act 1984) or the Coroner's Inquest Rules 2013 (SI 2013 No. 1616).

England's selective threshold model

In countries with a developed state duty of child protection there are, broadly defined, two theoretical models:

- Selective provision: this model operates on an investigative/policing model. It is bureaucratic, investigative and adversarial. The UK, Canada, the USA, New Zealand and Australia all operate broadly within this model although there are differences in relation to the level of mandatory reporting required in the different jurisdictions (Waldegrave, 2006).

- Universal provision: this model operates on principles of voluntary and collaborative services which are targeted at the whole family as opposed to just the child (Hill *et al* (eds.), 2002; Munro & Parton, 2007:5). Earlier non-selective provision for family services and support is available.

England adopts the former, selective provision model and does not have a mandatory reporting system. However, it has been argued that

> '…the new system being introduced in England is far more inclusive and wide ranging than any mandatory system' (Munro & Parton, 2007:5)

In England there is emerging evidence that even universal service provision is subjecting families to screening in order to access them:

> 'All women booked to deliver in the local NHS trust now have a Pre-CAF [Ref: common assessment framework] assessment record identifying risk of domestic violence, thinking about what needs to be done if they have other children and need admitting etc.' (Kurinczuk and Knight, 2013:38).

This expansion of the circumstances under which families are drawn into the assessment net, including pre-assessment checks which risk assess, is concerning. Research findings from jurisdictions which operate a selective provision report severe distress and shock as a response to assessment. There are many studies which support this finding from academic and government sources. (Butler-Sloss, 1988; Schultz, 1989:37; Richardson, 1990; Luza & Ortiz, 1991:108; Wakefield & Underwager, 1994; Prosser, 1995:10; Dale *et al*, 2005). Research identified false positive cases where families were investigated following an allegation that they had harmed their children as causing 'great suffering' (Jones, 2001:1395). The effects of an investigation were described as 'system abuse syndrome' following an ethnographic case study involving families who had sought help from Parents Against Injustice (PAIN). (Prosser & Lewis, 1992:20).

The statutory guidance surrounding public law family assessment, in *Working Together to Safeguard Children* (Department for Education, 2013) presents a model whereby all professionals working with children are expected to report 'concerns' about a child in order to fulfil their statutory duties under s.11 Children Act 2004. This is a contributing factor to a dramatic increase in referrals to local authority Children's Social Care departments, flagged up as a point of concern by Munro in her review of the system (Munro, 2011). As a result of these concerns the Government has made significant changes to the assessment process in the latest version of its guidance. These changes scale back the already insufficient protections and controls for families, for example the relaxation of timescales for assessment and the mixing of Initial Assessments and Core Assessments into a new, Continuous Assessment with a timescale of 45 days from the date of the referral (Department for Education, 2013:23).

Cases that reach the public family courts or the criminal courts in relation to child welfare have undergone family assessment, so ensuring assessment is a useful exercise is critical. These processes exist in order to select which families pass a number of thresholds, including the ultimate threshold of whether criminal proceedings will be brought or a s.31 application for a care order is made by the local authority. One purpose of assessment is therefore an evidence gathering exercise from which a legal case can be built. There is a danger assessment has become too wide ranging in relation to its enquiry into private family life and the private lives of family members. Consequently its usefulness is diluted and it is little more than a trawl of private family life for any evidence of parental insufficiency. Once the assessment process has started families cannot, or do not know how to, extricate themselves at a time when they have no legal representation. As it is not a consensual assessment, families cannot prevent themselves from becoming part of the Child Death Review Process and cannot either remove themselves from the process or be described as partners within it.

State powers & family rights

There is tension between families' desire for privacy and autonomy and professional concern for child protection and safeguarding. Despite Parliament's legislative attempt in the

Children Act 1989 to separate out categories of coercive and non-coercive interventions, successive editions of the government's policy guidance, the latest of which is in *Working Together to Safeguard Children* (Department for Education, 2013). Its categories have become progressively entwined, primarily through the process of assessment. The implementation of the Child Death Review Process extends the categories of family who become involved in public family assessment to include all bereaved parents. Although the precise mechanisms and primary focus of assessment can be distinguished, the framework of the Child Death Review Process is also embedded within *Working Together to Safeguard Children* (Department for Education, 2013:73) and is thus categorised by government as a form of public family law assessment.

The legislative framework surrounding the Child Death Review Process, including the Local Safeguarding Children Board's (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006. The enabling legislation is contained in section 14(2) of the Children Act 2004 which states that:

> 'A Local Safeguarding Children Board established under section 13 is to have such functions in relation to its objective as the Secretary of State may by regulations prescribe (which may in particular include functions of review or investigation)'

The responsibilities of the LSCB under Regulation 6 are:

> '(a) collecting and analysing information about each death with a view to identifying –
>
> (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
>
> (ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
>
> (iii) (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
>
> (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.'

The Department for Education found concerns were expressed by professionals working within CDOPs about whether this was achieved:

> **'**I have grave concerns about the integrity of the data. That's my big concern really. It doesn't appear to be systematically collected and I have always felt there should have been an actual database…. I also felt that the co-ordinators are taking responsibility for inputting this data and these co-ordinators really aren't supported. They are not given any training. There is no standardisation of how this data is collected and I am sure, as you know, the CDOPs across the country vary in size.' (Kurinczuk and Knight, 2013:25)

Concerns were also expressed about the lack of national consistency and lack of quality control:

> **'**Yeah and you know there is no standardisation. There is an inability really to answer any of the questions that we have. And there is no assurance or quality control about the data.' (Kurinczuk and Knight, 2013:26)

It seems that instead of providing a meaningful process, the Child Death Review Process is a framework of non-consensual review which places a family under surveillance, including consideration of whether a child protection investigation should take place under s.47 (Department for Education, 2013: Flowchart 7:84). It is clear that if a crime is suspected in relation to a child death there must be at least the possibility of risk to other children but the Child Death Review Process goes further in placing parents into a process of investigation without legal protections. However, research findings indicate that over 97% of deaths categorised as a 'sudden and unexplained death in infancy' (SUDI) are unrelated to child maltreatment so all parents are subjected to a process of suspicion that is statistically likely to be relevant to an overwhelmingly small proportion of them, as only the remaining <3% includes child maltreatment by a parent or carer, and includes medical error:

> 'In a study of the various causes of sudden unexpected death in infancy (SUDI), the most common non-SIDS diagnosis was infection (7.1% of 623 cases), followed by cardiovascular anomaly (2.7%), child abuse (2.6%), and metabolic/genetic disorders (2.1%).' (Cote *et al*, 1999:437–43)

Regardless of the infrequency of parental fault under this assessment framework all parents are placed in a very difficult position for two key reasons:

- The Child Death Review Process contains many elements which mirror the flawed family assessment model used to assess families under ss. 17 and 47 Children 1989; and
- Parents have few rights to see data collected and written about them and their child. They do not attend meetings and are not active participants in the process. They have little or no opportunity to challenge what is written or advance an alternative view. They are not medical or social work experts and may not know what is relevant, or what needs to be corrected or countered if they do not have all the available information.

Parents therefore have very little control over the process and conduct of family assessment, even in relation to the categorisation of the death of their child as 'sudden' and 'unexpected'. The use of the term 'unexpected' is potentially a contentious and controversial issue if there is disagreement between parents and professionals over whether a death should be categorised as unexpected. Parents, the medical profession, the police, the legal profession, social workers and health visitors may all have a perspective. Guidance on how to resolve this issue is not included in the process. The Department for Education research shows inconsistencies in data between areas:

> **'**....but for me as a Public Health person, the main thing is that if you are doing this sort of thing on a national basis, I think you should be doing it consistently.' (Kurinczuk and Knight, 2013:26)

This highlights how the lack of a national standard even for the categorisation of deaths renders the process problematic. If the term is intended to mean the death is 'sudden' and 'unexpected' *to authorities* it needs clarification as to which authority, and how (and by whom) such a death is categorised. There should be clear guidelines as to what happens if parents believe a death is 'sudden' and 'unexpected' but agencies do not agree, or vice versa.

A bereaved parent, particularly one who is in dispute with health, social care or justice agencies over the circumstances of their child's death is in a particular position of vulnerability and faces a quasi-criminal process in addition to the equivalent of a child protection or safeguarding referral. The multi-agency approach focuses attention on the parent; there is no independent investigation of any professionals involved as the investigation is multi-agency, relying on self-reporting. There are two fundamental flaws in this approach:

- How are professionals objectively assessed if they had contact with the child before the death? and
- As above, parents are not active participants in the process. They have limited rights to see what is being written about them and their child. They do not participate in meetings about their child's death and are left for several months not knowing whether they will be blamed, or what the outcome will be. There is no facility for parents to check the accuracy of what has been said about them, or whether their evidence conflicts with that of any involved professionals.

The rationale of the Child Death Review Process therefore seems to be in order to establish: whether criminal proceedings are indicated in relation to parents or non-professional carers of the child immediately before the death, whether the local authority has failed in its duty towards a child (if the child was known to them, or should have been known to them prior to their death), where there are public health implications, and whether the death triggers a threshold for family intervention if there are other, surviving children. As such it fulfils a function that is already covered by other investigatory bodies and processes, and it is not evident it objectively investigates all parties and all possible scenarios.

The abuse eradication narrative

The abuse eradication narrative, evident since the mid-1980s, has contributed to the difficulties evident in assessment. This narrative originated from research into the use of paediatric risk assessment in cases of suspected child abuse, and was expanded following research by the NSPCC. This research suggested social workers and other professionals could risk assess for future child abuse by assessing parental characteristics (Creighton, 1992). The uptake of risk assessment as a means of predicting and preventing child abuse has been very influential in relation to early intervention strategies. Since then the focus of family assessment has consequently emphasised the targeting of assessment and services towards families falling into categories considered to be 'risky'. This policy, however, is based on research with a high false positive and false negative rate (Browne *et al.,* (eds.), 1988) and has led to a rapid expansion over the last thirty years of assessment policies designed around an unrealistic expectation of what can accurately be either predicted or prevented.

The Child Death Review Process forms part of this narrative. Part of its remit is to risk assess families to decide whether a social work assessment should also take place under ss.17 and 47. It also attempts to establish the events leading to and surrounding the child's death. This includes considering whether there were opportunities for professionals to intervene to prevent the death, but it is unclear where in the process there is an opportunity to objectively consider professionals' roles in the death as well as that of parents and anyone else caring for the child. Historically an adverse role of professionals in a child's death has been difficult to identify and resolve without parental involvement in highlighting failures. This is evident particularly in cases involving health or social care failings.

Influence of Public Inquiries and Serious Case Reviews

The Child Death Review Process was introduced soon after high profile social care and public health failings involving children in Bristol. These failings included a number of child fatalities as a result of adverse medical events and interventions, creating a great deal of conflict between families and the medical profession. This resulted in a Public Inquiry and related litigation. *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol* investigated systemic failures at the same hospital Trust which produced the Child Death Review Process. This Trust also collaborated in the Bristol-based SIDS death research (Fleming *et al,* 2000). The forward was written by Sir Professor Roy Meadow who was at the time presenting flawed statistical expert evidence to support the theory advanced in this literature that some SIDS cases are really cases of infanticide. The literature, however, did not suggest a reliable method of sifting cases in order to establish infanticide, but looked at characteristics of parents stressing that little was known about whether these amounted to more than speculation. The evidence of Sir Professor Roy Meadow contributed to wrongful convictions of mothers, as well as a large number of s.31 public family law proceedings. The criminal convictions were those reviewed by the Law Commission in their Review and Report of expert evidence in the criminal justice system (Law Commission, 2009; Law Commission, 2011).

The Law Commission Review (Law Commission, 2009) and Report (Law Commission, 2011), however, focussed solely on expert evidence in criminal trials; its remit was restricted to consideration of issues surrounding the use of uncertain medical evidence (theory) presented as fact, experts giving evidence beyond their field of expertise and jury deference to experts, triggered largely by the high profile miscarriages of justice resulting from mothers convicted of murdering their children on flawed medical theory (R v Clark 2000 WL 1421196; R v Clark [2003] EWCA Crim 1020; R v Cannings [2004] EWCA Crim 1). Despite the Law Commission's findings, the government is reluctant to act on the vast majority of the Report's findings or their recommendations for statutory change, leaving the problems unaddressed and likely to reoccur. The government's rationale for the decision is fiscal (Ministry of Justice, 2013:4).

In its attempts to eradicate child abuse, the medical profession created and expanded theories attempting to categorise and detect 'signs of abuse'. It is these theories that have proved particularly contentious. These theories have varying levels of accuracy and have significantly contributed to the conflict between families and professionals. Families are placed under surveillance in relation to suspected child abuse on every contact families have with the medical profession. These difficulties intensified with the rise in paediatric attempts to explain uncertain phenomena in relation to child medical problems and fatalities. For example, in cases of Sudden Infant Death Syndrome (SIDS), theories such as Fabricated or

Induced Illness (FII), Munchausen's Syndrome by Proxy (MSBP) and Shaken Baby Syndrome (SBS) led to controversial and high profile criminal appeals (R v Clark 2000 WL 1421196; R v Clark [2003] EWCA Crim 1020; R v Patel (2003) (unreported); R v Cannings [2004] EWCA Crim 1; Harris, Rock, Cherry & Faulder [2005] EWCA Crim 1980).

The timing of these appeals occurred just after the conclusion of *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol* (Department of Health, 2001). The Inquiry highlighted the links between the disproportionately high number of fatal failings of child welfare and the 'club culture' identified amongst the agencies involved. It also highlighted the issue of agency insensitivity towards bereaved parents. *Inter alia,* the Inquiry identified system failings in relation to patient safety as a result of management style and processes of non-audited self-reporting. The necessity for investigation of medical and social care professionals as well as parents was firmly established by this inquiry, and has been consistently reinforced by subsequent Inquiries such as *The Shipman Inquiry* (Smith, 2002-2005)) and *The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary* (Francis, 2013). The need for scrutiny has thus been firmly established to operate in both directions between families and state agencies. This fits with a literal interpretation of the concept of 'working together' but is absent from the Child Death Review Process framework.

Much of the medical evidence gathered during the Child Death Review Process may by necessity involve theoretical or uncertain areas of medical expertise. This contributes to the difficulty of the parent's position unless they are viewed as equal partners, at least until some evidence of wrongdoing is reasonably suspected. If wrongdoing is reasonably suspected the investigation should operate within the criminal justice framework. The consequences for parents are serious if following a review a decision is taken to prosecute or to instigate s.31 Children Act 1989 proceedings based on inferences drawn from areas of medical uncertainty and controversy. For example, papers such as 'Was the message of sudden infant death study misleading?' (Gornall, 2006: 1165–1168) suggest that Child Death Review Process findings must be viewed with caution if there is any suggestion a death should be categorised as falling into an uncertain area.

Undoubtedly family assessment policy and practice is influenced by the findings of the Public Inquiries and Serious Case Reviews undertaken following a serious incident or a child fatality. Inquiries concerning cases of fatal caregiver abuse have created a series of recommendations for 'strengthening' the system and increasing the involvement with families of a wide range of professionals and agencies (see for example Lord Laming, 2003; Lord Laming, 2009; Haringey LSCB, 2009; Radford, 2010; Birmingham Safeguarding Children Board and Coventry LSCB, 2013). These reports have a common theme of criticism against professionals involved with children for failing to risk assess at every point of contact between child, their family and state agencies. The findings unanimously suggest an increasingly risk averse referral and assessment policy, of which the Child Death Review Process forms part. The process attempts to identify risk factors in relation to any surviving children in the family and whether public family proceedings should be bought, and also to decide whether criminal action should be brought in relation to the death.

On analysis, it is evident that relevant statistical issues of accuracy in relation to the use of risk assessment, including the consequences for children and families of false positives and negatives are not addressed in policy or practice. There is a consequence of false negatives for agencies who are frequently deemed in the Public Inquiry and Serious Case Review

Reports to have failed to identify risk factors and act upon them (Lord Laming, 2003; Lord Laming, 2009; Haringey LSCB, 2009; Radford, 2010; Birmingham Safeguarding Children Board and Coventry LSCB, 2013). However, in contrast, the consequence of false positives vests with parents and children for which remedies are extremely limited. The assumption that there is a welfare benefit to increasing numbers of coercive family assessment underpins policies and legislation, thus increasing the intrusion into private family life. However, the drift towards the high level of surveillance and investigation within this model arguably renders the ideology of collaborative working with families meaningless. The use of assessment findings as evidence in subsequent litigation is incompatible with the collaborative role required of parents during assessment.

Re-designing assessments

The current investigative framework focuses on the state as the investigator and the family as the investigated. However, as many instances of child abuse and child fatality occur following a child's contact with statutory services including Children's Services Departments, foster carers and the NHS it is important that decision making during assessment can equally investigate parental and state acts and omissions.

The following are suggested as starting points for re-thinking the design of all public family assessments. These points apply particularly to the Child Death Review Process as its remit must *de facto* include investigation of whether criminal proceedings should be brought given that a death has occurred.

- The *decision* to categorise a death as 'sudden and unexpected' or otherwise by medics must be able to be challenged and reviewed. A robust Coroner's response is indicated which takes into account the views of the parents about whether a death falls into this category;
- The *accuracy* of the information recorded during assessment must be able to be objectively verified and must adhere to a code of practice;
- The *completeness* of the information recorded during assessment (including the information from parents and family members, and the accuracy of secondary information including that taken from third party records) must be able to be verified and adhere to a framework and code of practice;
- The *separation* of fact from opinion must be clearly articulated in order that its probative value can be assessed in subsequent decision making and litigation;
- *Informed consent* be obtained for assessment, or if consent is bypassed it must be clear that it has been lawfully bypassed and that parents are aware to what extent they have the right to refuse;
- The *consequence* for a parent who questions the lawfulness of a non-consensual assessment or refuses to participate must be clear;
- It must ensure all parties involved are assessed on *an equal footing*, including professionals, as opposed to a multi-agency investigation where the focus of concern is solely on parents;
- The investigating body must have *clear accountabilities and remit*, and must be separate to other agencies involved with the child. This would entail setting up a new body specifically charged with this type of investigation which would include allowing the police to investigate potential criminality without a multi-agency partnership.

The outcome of assessment

Quantitative analysis of the available data about assessment practice and outcome raises further questions. These questions occur in relation to the rationale for all types of family assessments carried out under the current procedures in *Working Together to Safeguard Children*. Some reasons for assessment are obvious, for example the desire to identify and reduce child maltreatment, and to collect evidence to be used in subsequent litigation. Other reasons are less obvious, for example a desire to further medical knowledge in areas of uncertain and controversial expertise, for example in cases involving suspected sudden infant death syndrome, shaken baby syndrome and fabricated or inducted illness, and to enable systemic medical or legal failures to be quietly addressed avoiding the cost and adverse publicity of a Public Inquiry. For example *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*, cost in excess of £15 million (Department of Health, 2001); *The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*, cost in excess of £13.7 million (Francis, 2013); *The Shipman Inquiry* cost in excess of £21 million (Smith, 2002-2005). The cost of the Law Commission Review and Report (Law Commission, 2009, 2011) are unknown.

The widening remit of families referred for assessment since the Children Act 1989 has resulted in an increasing number of assessments in wider circumstances than was envisaged when the Act was passed. The quantitative data shows that the number of referrals of children to local authority social work departments has dramatically increased since the implementation of the Children Act 1989: 160,000 in 1991/1992 to 657,800 in 2013/14 a rise of over 311% (Department of Health, 1995:25; Department for Education, 2014). This, however, cannot be assumed to correlate with increasing levels of child abuse or better detection rates as analysis shows the ratio of substantiated cases of child abuse dramatically drops when increasing numbers of referrals for assessment are made (24.1% in 1991/1992 to 7.3% in 2013/2014). This raises questions about the basis for the rationale that increased numbers of assessments in widened circumstances is unquestionably a positive step.

It is easy to assume that increased reporting of concerns and the expansion of the use of family assessment via the Child Death Review Process to capture data from all bereaved parents is a positive step forward in understanding the circumstances in which children suddenly and unexpectedly die. Arguably this makes it easier for abuse of surviving children to be identified and addressed, support services to be supplied and decisions made about criminal and public family litigation. However, analysis of the number of families passing the thresholds for non-fatality related family assessment demonstrates a trend towards reduced efficiency when matched against child abuse prevalence studies (Cawson *et al.*, 2000 and Radford *et al.*, 2011). It could be argued that this is a consequence of improved early intervention provision via family support, but there is no quantitative data to support this. The trend increases the load on social work departments and individual social workers, creating an environment where an overload of referrals leaves resources scarce and the potential for serious cases of child maltreatment to be missed.

Despite the serious consequences of an adverse finding about parents during or following assessment there is a lack of a robust and enforceable Code of Conduct surrounding assessment. Important issues such as consent to assessment are not addressed. Criminal investigations are regulated by PACE (Police and Criminal Evidence Act 1984) but there is no corresponding code protecting families during assessment. Questions of lack of

consistency and accuracy in the conduct and written outcomes of assessment are therefore not easily addressed. The Child Death Review Process is of particular concern as parents are virtually excluded from the process as participants. The discussion earlier established that the process does not have a single clear objective: is its primary objective a criminal investigation, a medical inquiry, a social welfare intervention or an investigation of a family? If it is a criminal investigation the multi-agency approach is flawed as it starts from a presumption other agencies are working in partnership with the police. This excludes them as potential subjects of the investigation when a child has died following contact with them. This category particularly applies to death occurring in hospital or where a child is in the care of a local authority.

As the body responsible for criminal investigation it is difficult to see how the police can investigate potential criminality using this process unless there is a preconception that parents are the suspects as opposed to the other agencies 'working with' the police. The police need to be open minded in relation to all the circumstances when investigating potential criminality. It is difficult to see how that can be achieved with multi-agency working where the parameters of the investigated and those who could reasonably form part of an investigation are the investigators. The one excluded group, parents, are also the most vulnerable and least informed.

If it is a public family investigation primarily for welfare purposes it is unclear why the process would take place at all, other than to establish whether there are grounds for reasonable suspicion of significant harm to surviving children in which case the family assessment framework for this already exists. If, however, the process amounts to a multi-agency fishing expedition with the focus on parents there is a need for research into the process to understand more about how it functions, its impact and outcomes.

The aim of the government is for professionals to 'work together' with parents and their children. This is reflected in the title of the statutory guidance in relation to child protection procedure, *Working Together to Safeguard Children* (Department for Education, 2013). The meaning of 'working together', however, is not defined and is difficult to envisage in a relationship which is complex and adversarial from the outset. The conflicting narratives make the concept of 'working together' contentious. The following summarise the problems inherent within the concept:

- The inherent power imbalance within assessment makes it difficult for true collaborate working to take place;
- Consent may better be described as coercive consent: withheld consent could lead to escalation of coercive interventions;
- The nature of assessment amounts to a 'fishing expedition' investigating a family's private life. This goes further than a criminal investigation into an alleged crime but parents have fewer rights than if they were accused of a crime;
- The use of family assessment as a gateway to services as well as a threshold to further interventions, including litigation is problematic. *Inter* alia if families disclose information that they feel indicates they need support it may be used as evidence against them in subsequent litigation;
- There is a lack of clarity over what 'working together' means: does it mean partnership with parents, parental compliance, or only agencies 'working together' investigating parents?

Conclusions

The discussion in this article has identified the common themes in family assessments and the Child Death Review Process, contained in the statutory guidance document *Working Together to Safeguard Children.* It has also identified some key differences in their purpose and structure. The use of assessments for critical decision making in relation to all levels of child welfare needs and post-mortem investigation is generally inadequately considered in policy. This is acutely evident in the Child Death Review Process which attempts to serve too many functions and operates a 'black box' process of investigation from a parent's perspective. There are fundamental differences in perception, understanding and motivation amongst the actors involved in family assessment which have contributed to a confused and conflicted process. This can be explained as the welfare/policing dichotomy. This is particularly evident in the Child Death Review Process.

The concept of government welfare and support provision is mixed with the use of assessments to identify early intervention needs, interventions designed to protect children from parents and interventions to investigate child fatalities. The service rationing policy in England means that access to services is via a social work 'assessment gateway'. This gives families a difficult choice in accessing services. Families must undergo intrusive assessment which has potentially adverse consequences. In cases where children are suspected to have been abused, or where there has been a sudden and unexpected death the position of parents is very vulnerable.

The position for Children's Services Departments is also vulnerable; as selective service decisions and provision may later prove to be the wrong decisions with fatal consequences, triggering the Child Death Review Process. All other agencies with whom parents and children come into contact have the dilemma of whether or not to 'refer' a child for assessment. The consequences for failing to refer a child who is later shown to have been harmed are well documented, however the consequences for over referral rest solely with the parents and child who may be harmed by unnecessary interventions. This harm can range from psychological trauma, to wrongful prosecution, to wrongful imprisonment (R v Clark 2000 WL 1421196; R v Clark [2003] EWCA Crim 1020; R v Patel (2003) (unreported); R v Cannings [2004] EWCA Crim 1).

The lack of policy acknowledgement in relation to family assessment as a key evidence gathering mechanism for future litigation as well as a gateway to services has contributed to a low prioritisation of family rights and remedies during assessment. Conflicts between the position of families wanting help and support, or simply their privacy (particularly following bereavement) are evident. Further research into the consequences of family assessments in criminal and public family litigation is indicated, particularly in relation to the manner of investigation used in Child Death Review Process and its use in decision making, including as a basis for evidence in litigation.

The legality of non-consensual assessment following the death of a child has not been challenged in the courts. The absence of an accessible and readily available process for parents to use to challenge the process at a particularly difficult time in their lives, coupled with the paucity of legal aid, renders this unsurprising. However, despite the lack of relevant case law, the issue is nevertheless controversial. An investigation into the outcomes and consequences of the Child Death Review Process, including the views of families, is an important area for future empirical research.

References

Birmingham Safeguarding Children Board and Coventry LSCB (2013) *Final Overview Report of Serious Case Review re Daniel Pelka*, September.

Browne, K. (eds.) (1988) *Early Prediction & Prevention of Child Abuse*, Wiley, Chichester.

Butler-Sloss, E. (1988) *Report of the inquiry into child abuse in Cleveland 1987*, Presented to Parliament by the Secretary of State for Social Services by Command of Her Majesty, July, 1988, HMSO, London.

Cawson, P. *et al* (2000) *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect*, NSPCC, London.

Cote, A., Russo P, Michaud J. (1999) Sudden unexpected deaths in infancy: what are the causes? *J Pediatr*, 1999:135: pp.437–43.
http://www.ncbi.nlm.nih.gov/pubmed/10518077

Creighton, S. (1992) Child *Abuse Trends in England & Wales 1988-1990 & an overview from 1973-1990*, NSPCC, London.

Dale, P, Green, R and Fellows, R (2005) *Child protection assessment following serious injuries to infants: fine judgments*, NSPCC/Wiley series, Chichester.

Department for Education (2013) *Working Together to Safeguard Children*, HMSO, London.

Department for Education (2014) SFR43/2014, *Characteristics of children in need in England, 2013-14*, issued 29 October 2014, HMSO, London.

Department of Health (1989) *Working Together Under the Children Act 1989: A Guide to Arrangements for Inter-Agency Co-Operation for the Protection of Children from Abuse*, HMSO, London.

Department of Health (1990) *Working Together to Safeguard Children*, HMSO, London.

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

Department of Health (1999) *Working Together under the Children Act 1989: A Guide to Arrangements for Inter-Agency Co-Operation for the Protection of Children from Abuse*, HMSO, London

Department of Health (2001) *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*, HMSO, London.

Department of Health (2010a) *Working Together to Safeguard Children*, March 2010, HMSO, London.

Department of Health (2010b) *Working Together to Safeguard Children*, April 2010, HMSO, London.

Department of Health and Social Security (1986) *Child Abuse: Working Together – Draft Guidelines*, HMSO, London.

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

Devine, L. (2014) *The Child Death Review Process: Intervention & the Welfare/Surveillance Dichotomy,* paper presented to the Sudden & Unexpected Deaths in Infancy (SUDI) Conference, Bristol Civil & Family Justice Centre, 4th December, 2014.

Devine, L. (2015) Considering Social Work Assessment of Families, *Journal of Social Welfare & Family Law*, 47 (1) pp. 77-83.
DOI http://dx.doi.org/10.1080/09649069.2015.998005

Fleming, P. Blair, P. Bacon, C. & Berry, P. (2000) *Sudden Unexplained Deaths in Infancy: The CESDI SUDI studies 1993-1996*, TSO, London.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*, HC947, TSO, London.

Gibbons, J. *et al* (1995) *Operating the Child Protection System: Studies in Child Protection*, HMSO, London.

Gornall, J. (2006) Was message of sudden infant death study misleading, *BMJ*, Dec 2, 2006; 333(7579): pp.1165–1168.

Haringey LSCB (2009) *Serious Case Review: Baby Peter, Executive Summary*, February 2009.

Hill, M. Stafford, A. and Lister, P.G. (Eds.), (2002) *International Perspectives on Child Protection, Report of a seminar held on 20 March 2002*, Part of the *Scottish Executive Child Protection Review: Protecting Children Today and Tomorrow* Centre for the Child & Society, University of Glasgow.

HM Government (2008) *Safeguarding children in whom illness is fabricated or induced - Supplementary guidance to Working Together to Safeguard Children*, Department for Children, Schools and Families, HMSO, London.

HM Government (2010) *Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children*, March 2010, HMSO, London.

Jones, D. P. H. (2001) Spotlight on practice: editorial—false positives in the field of child maltreatment, *Child Abuse & Neglect* 25 pp.1395–1396.

Kurinczuk, J. & Knight, M. (2013) *Child Death Reviews: Improving the use of Evidence. Research Report,* Department for Education, National Perinatal Epidemiology Unit, University of Oxford.

Law Commission (2009) *The Admissibility of Expert Evidence: Consultation Paper 190*, (CP190), 7 April, HMSO, London.

Law Commission (2011) *Expert Evidence in Criminal Proceedings in England & Wales, (Law Com No. 325)*, (LC325), 21 March, HMSO, London.

Lord Laming (2003) *The Victoria Climbié Inquiry Report*, HC 570, 24 June 2003, HMSO, London.

Lord Laming (2009) *The Protection of Children in England: A Progress Report*, HC 330, March 2009, TSO, London.

Luza, S. & Ortiz, E. (1991) 'The Dynamic of Shame in Interactions Between Child Protective Services and Families Falsely Accused of Child Abuse' *Issues in Child Abuse Accusations*, Volume 3, pp. 108-123..
http://www.ipt-forensics.com/journal/volume3/j3_2_5.htm

Ministry of Justice (2013) *The Government's response to the Law Commission report: "Expert evidence in criminal proceedings in England and Wales" (Law Com No. 325)*, 21 November 2013, HMSO, London.

Munro, E. (2011) *The Munro Review of Child Protection: Final Report, A Child Centred System*, Department for Education, HMSO, London.

Munro, E., Parton, N. (2007) How far is England in the Process of Introducing a Mandatory Reporting System? *Child Abuse Review*, Vol. 16 pp.5-16.

Prosser, J. 1992 *Child Abuse Investigations: The Families' Perspective,* Parents Against Injustice (PAIN), 3 Riverside Business Park, Stansted, Essex CM23 8P.

Prosser, J. (1995) A Case Study of a UK Family Wrongly Accused of Child Abuse, *Issues in Child Abuse Accusations* Volume 7, pp. 1-12.
http://www.ipt-forensics.com/journal/volume7/j7_3_2.htm

Prosser, J. & Lewis, I. (1992) *Child abuse investigations: The families' perspective*, Parents Against INjustice, 3 Riverside Business Park, Stansted, Essex CM24 8PL, United Kingdom.

Radford, J. (2010) *Serious Case Review: Under Chapter VIII 'Working Together to Safeguard Children' In respect of the Death of a Child Case Number 14*, 26 April 2010, Birmingham Safeguarding Children Board.

Radford, L. *et al* (2011) *Child Abuse and Neglect in the UK today*, NSPCC, London.

Richardson, D. (1990) The Effects of a False Allegation of Child Sexual Abuse on an Intact Middle Class Family, *Issues in Child Abuse Accusations* Volume 2, 1990.
http://www.ipt-forensics.com/journal/volume2/j2_4_7.htm

Schultz, L. G. (1989) One hundred cases of unfounded child sexual abuse: A survey and recommendations, *Issues in Child Abuse Accusations* 1(1) pp. 29-38.

Smith, J. (2002-2005) *The Shipman Inquiry*, Reports 1-6, HMSO, London.

Wakefield, H. & Underwager, R. (1994) The alleged child victim and real victims of sexual misuse, in Krivacska, J. & Money, J. (eds.) (1994) *The Handbook of Forensic Sexology,* Amherst, Prometheus Books NY.
http://www.ipt-forensics.com/library/alleged.htm

Waldegrave, C. (2006) Contrasting National Jurisdictional and Welfare Responses to Violence to Children, *Social Policy Journal of New Zealand*, 27, (March).

Legislation

Children Act 1989 c.41

Children Act 2004 c.31

Coroner's Inquest Rules 2013, (SI 2013/1616)

Local Safeguarding Children Boards Regulations 2006 (SI 2006/90)

Police and Criminal Evidence Act 1984 c.60

Cases

R v Clark 2000 WL 1421196

R v Clark [2003] EWCA Crim 1020

R v Patel (2003) (unreported)

R v Cannings [2004] EWCA Crim 1

R v Harris, Rock, Cherry & Faulder [2005] EWCA Crim 1980