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The Child Death Review Process:

Intervention & the welfare/surveillance dichotomy

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Abstract

This paper discusses whether evidential and procedural issues identified in relation to public family law assessment can be used to further understanding of the Child Death Review Process, an under-researched but important process of statutory family assessment. Pre-litigation stages of family investigation, particularly in relation to child protection and safeguarding assessments undertaken within the framework for the assessment of children in need are 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 sudden unexpected deaths in infancy (SUDI cases). 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. If it falls into this category issues common to both types of assessment have ramifications for decision making, including decisions made by courts in subsequent public family law or criminal proceedings.

Key words

Child Death Review Process, family assessment, child protection, courts, expert evidence

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2 Organised by HHJ Stephen Wildblood; Chaired by Miss Claire Wills-Goldingham QC.
3 The full text of this paper, including Appendix A: Conference presentation slides, is available at: http://people.uwe.ac.uk/Pages/person.aspx?accountname=campus/l-devine
This paper discusses a number of issues in relation to family assessment and their impact including on the justice system during subsequent criminal and civil litigation. The purpose of this paper is to highlight the links between aspects of public law family assessment which, considered together, explain why family assessment has become progressively more invasive but arguably less useful. This paper aims to further understanding of assessments carried out under the guidance in Working Together to Safeguard Children.  

Information gathered during assessment informs decision making about a family, including decisions about criminal and public family proceedings. Research findings about this process may be useful in informing aspects of the Child Death Review Process and the underpinning policies despite differences in the trigger for the assessment. Family assessment is usually triggered by a referral to children’s social care however the Child Death Review Process is triggered by the sudden unexpected death of a child.

The research underpinning this paper forms part of an ESRC funded transformative research project Rethinking child protection strategy: evaluating research findings and numeric data to challenge whether current intervention is justified. This includes findings from qualitative and quantitative government data, a literature review and a meta-analysis of previous studies reporting on the effects of assessment in jurisdictions operating a selective provision model of welfare provision.

The paper discusses areas of concern in relation to family assessment. This includes the post-refocussing amalgamation of welfare and policing assessments into a general assessment framework, the impact of the abuse eradication narrative

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5 The Child Death Review Process is triggered by a sudden, unexpected death in infancy (SUDI). These deaths are reviewed pursuant to the provisions of Regulation 6 of the Local Safeguarding Children Boards Regulations 2006. The enabling legislation is contained in section 14(2) of the Children Act 2004.
6 ESRC grant number ES/M000990/1 for £202,487. Principal Investigator: Dr Lauren Devine, Co-Investigator Mr Stephen Parker.
8 The refocussing debate took place in the mid-1990s as a response to Gibbons, J. et al.’s government funded research ((1995) Operating the Child Protection System: Studies in Child Protection HMSO, London) identifying that families were filtered out of a child protection response to
and the role of Public Inquiries and Serious Case Reviews in influencing policy. Assessment forms the foundation of future decision making about the level of state involvement with a family and whether the state should start legal proceedings, either in the criminal courts or by making a public family law application pursuant to s.31 Children Act 1989. Problems at the assessment stage are likely to underpin problems during the later thresholds of intervention, including during litigation. There are limited rights and remedies afforded to parents and children facing assessment. Legal aid is not available. The rationale is *inter alia* so as not to interfere with the state’s duties in relation to protecting children. However, our data indicates that there is a year on year reduced efficiency in relation to the cost and outcome of assessment despite the lack of legal help for families. This, we argue, is a consequence of the lack of linkage between assessment policy, practice and quantifiable outcomes. Finally this paper acknowledges and highlights the child protection ‘myth narratives’ which contribute to the conflicted relationship between assessors and the assessed. The conclusions of this paper refer to the future stages of the research project, and at a more general level observe the need for more detailed research into the issues and their impact across all public law family assessments.

**The English model of family assessment: issues identified in research**

The legal framework of child protection and safeguarding in England operates a selective provision of services for children if eligibility thresholds are met. Decisions about whether thresholds are met are undertaken using a variety of family assessments designed to ensure local authorities discharge their duties under the provisions of the Children Acts 1989 and 2004 to ‘protect’ using preventative strategies, and ‘safeguard’ using promotional strategies. 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

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9 S.31 Children Act 1989 enables a local authority to apply for a ‘care order’.
changed. 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. 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, there is a fundamental dichotomy in mixing legislative provisions intended to be coercive\textsuperscript{12} with those intended to be consensual\textsuperscript{13} which is not reconciled with a blended assessment process. This paper draws attention to the issues that have arisen as a consequence of an attempt to operate a model of surveillance and policing within a collaborative assessment framework and considers to what extent they are replicated in the \textit{Child Death Review Process}.

Non-consensual family assessment is possible by operation of law. If there is no statutory power to compel assessment, parents and children should be able to withhold their consent to intrusion. 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.\textsuperscript{14} Assessment can become coercive if consent is withheld.\textsuperscript{15} The process of assessment itself is potentially conflicted: the requirement to enquire into every aspect of a family’s life\textsuperscript{16} (as opposed to simply investigating the reason for referral) 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.

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

\textsuperscript{12} S.47 Children Act 1989
\textsuperscript{13} S.17 Children Act 1989
\textsuperscript{14} 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) make the latter applicable to a wider category of agencies than local authorities.
\textsuperscript{15} 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.
expanded following research by the NSPCC suggesting social workers and other professionals could risk assess for future child abuse by assessing parental characteristics. 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 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 as part of its remit is to risk assess families to decide whether a social work assessment should 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.

The rise in paediatric attempts to explain uncertain phenomena in relation to child fatalities, for example SIDS, FII and SBS have led to controversial and high profile criminal appeals which resulted in a Law Commission Review and

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19 Historically the role of professionals in a child’s death, particularly where there is problematic medical intervention has been difficult to identify and resolve without parental involvement in highlighting the need for review. See for example the ‘Bristol Heart Inquiry’ 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.
20 Sudden infant death syndrome or ‘cot death’.
21 Fabricated or induced illness, or ‘Munchausen’s syndrome by proxy’.
22 Shaken baby syndrome: Referred to as ‘the triad’ this syndrome is characterized by bilateral retinal haemorrhages, diffuse cerebral haemorrhage and hypoxic ischaemic encephalopathy
Report\textsuperscript{25} recommending change to controls over expert evidence in criminal trials. However, the Review focussed solely on expert evidence in criminal trials and therefore did not consider any type of public law family assessment including the \textit{Child Death Review Process}.\textsuperscript{26} Given the context in which the \textit{Child Death Review Process} was introduced\textsuperscript{27} there is need for review of it to examine the implications of its use to inform decision making to ensure it does not contribute to the same evidential problems the Law Commission highlighted in relation to expert evidence.\textsuperscript{28} This is particularly important as 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.\textsuperscript{29}

Family assessment policy and practice is influenced by the findings of Public Inquiries and Serious Case Reviews undertaken following a serious incident or a child fatality. These inquiries have created a series of recommendations for ‘strengthening’ the system and increasing the involvement of a wide range of professionals in contact with families.\textsuperscript{30} These reports have a common theme of

\textsuperscript{25} Law Commission (21\textsuperscript{st} March 2011) \textit{Expert Evidence in Criminal Proceedings in England & Wales} (Law Com No. 325) HMSO, London

\textsuperscript{26} The \textit{Child Death Review Process} was introduced by statutory instrument in 2006. 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. The \textit{Child Death Review Process} was set out in the 2010 version of \textit{Working Together to Safeguard Children} (Department of Health (2010) HMSO, London: Ch. 7, at p.215)

\textsuperscript{27} There were a number of medical events and interventions that adversely impacted on parents and their families. For example the ‘Bristol Heart Inquiry’ \textit{ibid.} n.19 investigated systemic failures at the same hospital trust from where the \textit{Child Death Review Process} was developed and the Bristol-based SIDS death research (for example Fleming, P., Blair, P., Bacon, C. & Berry, P. (2000) \textit{Sudden Unexplained Deaths in Infancy: The CESDI SUDI studies 1993-1996} TSO, London). The forward was written by Sir. Prof Roy Meadow who was at the time presenting flawed expert evidence in relation to SIDS deaths during criminal trials leading to wrongful convictions of mothers, as well as in s.31 public family law proceedings. The criminal convictions were those reviewed by the Law Commission (\textit{ibid.} n. 24-25).

\textsuperscript{28} \textit{Inter alia} uncertain medical evidence (theory) presented as fact, experts giving evidence beyond their field of expertise and jury deference.

\textsuperscript{29} Ministry of Justice (21\textsuperscript{st} November 2013) \textit{The Government’s response to the Law Commission report: “Expert evidence in criminal proceedings in England and Wales”} (Law Com No. 325) HMSO, London.

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.

However, 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, frequently deemed in the reports to have failed to identify risk factors and act upon them.\(^{31}\) The consequence of false positives vests with parents and children. The assumption that there is a statistical benefit to coercive family assessment underpins policies and legislation increasing the intrusion into private family life. However, this paper questions whether the drift towards the high level of surveillance and investigation within this model 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.

As the extension of the circumstances where families are assessed by operation of law now includes the Child Death Review Process it is important that as much information as possible is gained about pre-existing and similar assessment processes. Much of the medical evidence gathered during the Child Death Review Process may by necessity involve theoretical or uncertain areas of medical expertise which contributes to the difficulty of the parent’s position. 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

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\(^{31}\) Ibid.

of medical uncertainty and controversy.\textsuperscript{32} Assessment findings must, in such circumstances be viewed with caution.

**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\textsuperscript{33} although there are differences in relation to the level of mandatory reporting required in the different jurisdictions.

- **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.\textsuperscript{34} Earlier non-selective provision for family services and support is available.

England adopts the 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’\textsuperscript{35}

It is certainly the case that the statutory guidance surrounding public law family assessment, in *Working Together to Safeguard Children*\textsuperscript{36} 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.

\textsuperscript{32} For example SIDS, SBS, FII. There is a wealth of medical literature on these issues, see for example the discussion by Gornall, J. (2006) ‘Was the message of sudden infant death study misleading?’ *BMJ* Dec 2, 2006; 333(7579): pp.1165–1168.


\textsuperscript{36} Department for Education (2013) HMSO, London.
This is a contributing factor to a dramatic increase in referrals to local authority Children’s Social Care departments\textsuperscript{37} flagged up as a point of concern by Munro in her 2011 Government review of the system.\textsuperscript{38} 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.\textsuperscript{39}

Cases that reach the public family courts or the criminal courts in relation to child welfare should have undergone a process of family assessment 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 so wide ranging in relation to its enquiry into private family life and the private lives of family members that it amounts to a fishing expedition from which families cannot extricate themselves at a time when they have no legal representation.

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 \textit{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 review. A robust Coroner’s response is indicated which takes into account the views of the parents about whether a death falls into this category;

\textsuperscript{37} 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) \textit{Child Protection: Messages from Research}, HMSO, London at p.25 and Department for Education Statistical Release numbers).


\textsuperscript{39} \textit{Ibid} n.36, p.23.
• 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.

**State powers & family rights**

There is tension between families’ desire for privacy and autonomy and professional concern for child protection and safeguarding. Despite the 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*[^40] the 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. 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*\(^4\)

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:

\(\text{‘(a) collecting and analysing information about each death with a view to identifying -}\)

\(\text{(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);}\)

\(\text{(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;}\)

\(\text{(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and}\)

\(\text{(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.’}\)

The legislation enables a process of non-consensual review which places a family under surveillance, including consideration of whether a child protection investigation should take place under s.47.\(^4\)\(^2\) 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

\(^4\)\(^1\) *Ibid*, Ch.5 at p.73.

Death Review Process goes further in placing parents into a process of investigation without legal representation. Research indicates that over 97% of deaths categorised as SUDI are unrelated to child maltreatment. The remaining <3% includes child maltreatment by a parent or carer and 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%).’

Regardless of the infrequency of parental fault under this assessment framework 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 little 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. Research findings from jurisdictions which operate a selective provision report severe distress and shock as a response to assessment. A

bereaved parent 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 focusses attention on the parent; there is no thorough investigation of any professionals involved as the investigation is multi-agency. 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, or 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) and whether the death triggers a threshold for family intervention if there are other, surviving children. As such it fulfils a function but it is not evident it objectively investigates all parties and all possible scenarios.

The legality of non-consensual assessment following the death of a child has not been challenged in the courts. The lack 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 lack of legal aid renders this unsurprising. The lack of case law however does not render the issue uncontroversial: an important area for future empirical research is an investigation into the outcome and consequence of the Child Death Review Process, including the views of families. The veil of secrecy that descends when public family proceedings are instigated contributes a lack of evaluation of the Child Death Review Process. Research into analogous family assessment and related criminal processes indicates it is an important area for research.

Exploring the data

Quantitative analysis of the data raises further questions about the level of clarity 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 are obvious, for example the desire to identify and reduce child maltreatment, and to collect evidence to be used in subsequent litigation. Others are less obvious, for example a desire to further medical knowledge in areas of uncertain and controversial expertise\(^46\) and to enable systemic medical or legal failures to be quietly addressed.\(^47\)

\(^46\) For example SIDS, SBS & FII.
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 to local authorities has increased from 160,000 in 1991/1992 to 657,800 in 2013/14.48 This, however, cannot be assumed to correlate with increasing levels of child abuse or better detection rates: neither is indicated in our research findings.49 In any event the point made above about the multi-factorial rationale for family assessment makes it difficult to make a definitive correlation. The increasing pressure on all professionals involved with children to refer on a very low threshold of concern is just as likely to be a relevant factor.

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.50 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.51 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. Our *Rethinking Child Protection Strategy* research will comment on this further on in the project. 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. In terms of families’ experiences of

49 *Ibid*, n.7.
50 The use of the term ‘unexpected’ is controversial: unexpected to whom? The parents/medical profession/police/legal profession/social workers/health visitors may all have a perspective. If a death is later found to be murder (by a parent/carer or a professional (for example nursing professionals such as Beverley Allitt) it may be that the death is not unexpected to that person as it may have been planned. If the term refers to ‘unexpected to authorities’ it needs clarification as to which authority, and how (and by whom) a death is categorised as unexpected. The same consideration should be afforded to the ‘sudden’ categorisation.
'working with' social workers qualitative data reports almost unanimously a negative experience, and in some instances families have been badly harmed by the process. Parents and their children report long term trauma apparently caused by the strain of allegations and the need to comply with social work requirements.\textsuperscript{52}

A further area of contention exacerbated by the increasing number of family assessments is the lack of a robust and enforceable Code of Conduct surrounding the conduct and extent of assessment and important issues such as consent.\textsuperscript{53} Issues of a lack of consistency and accuracy in the conduct and written outcomes of assessment are therefore not easily addressed. The \textit{Child Death Review Process} is of particular concern as parents are virtually excluded from the process as participants. The process itself 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. 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. 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 party is 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.

\textsuperscript{52} \textit{Ibid}, n.45.

\textsuperscript{53} Criminal investigations are regulated by PACE (Police and Criminal Evidence Act 1984) but there is no corresponding code protecting families during assessment.
The child protection agenda: myths and conflicting realities

Contention between professionals and families is particularly evident when hostile claims are made about the motivation and agendas involved in state interference into private family life to investigate child welfare issues.

The narratives can be broadly separated into two camps:

- Parents may see a conspiracy amongst professionals as they are within a system where they have fewer safeguards than within the criminal justice system; whereas
- Professionals may perceive a high prevalence of child abuse as a result of survey findings\(^54\) which reinforces their perception of their welfare role in detecting and preventing child abuse. Safeguards for parents are seen as an obstacle to risk assessment.

There is extensive debate in the public domain where opinion is strongly divided and argument is frequently *ad hominem* and polemic. The approach I’ve adopted in relation to these issues is to consider them in the context of their effect on family/professional communication at the threshold stage of intervention, and to investigate the extent to which the legal and procedural framework contributes to both positions.\(^55\) Regardless of their foundation, or lack of foundation, it is important to understand why the narrative exists.

The aim of government is for professionals to ‘work together’ with parents and their children. Indeed the title of the statutory guidance in relation to child protection procedure is *Working Together to Safeguard Children.*\(^56\) The meaning of ‘working together’ 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 observations are drawn from our qualitative findings:

- The inherent power imbalance within assessment makes it difficult for true collaborate working to take place;

\(^{54}\) *Ibid*, n.51.
\(^{55}\) *Ibid*, n.6.
• 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 or compliance?

The polemic positions may be to some extent irreconcilable, and there may be individual instances which support both positions. These narratives should not be dismissed, however, as they reveal a great deal about the fundamental conflicts and give insights into what needs to be done to resolve them.

**Conclusions: next steps**

The use of assessments for critical decision making in relation to child welfare is mixed with the use of assessments to identify early intervention needs. The service rationing policy in England gives families a difficult choice if they simply need support. They must undergo non-consensual intrusive assessment which has potentially adverse consequences. Selective service decisions and provision may later prove to be the wrong decisions with fatal consequences, triggering the *Child Death Review Process*. The lack of acknowledgement that family assessment is 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. Conflicts between the position of families wanting help and support, or simply their privacy (particularly following bereavement) are evident. The use of assessment in future decision making about a family has led to polarised positions and the creation of ‘myths’. Further research into the consequence of family assessments in litigation is indicated taking account of the efficiency measures identified in *Rethinking Child Protection Strategy*, together with qualitative research into families’ experiences of
the Child Death Review Process and its use in decision making, including as a basis for evidence in litigation.

This paper has discussed the common themes in family assessments and the Child Death Review Process contained in the guidance document Working Together to Safeguard Children. Research findings and observations in relation to local authority family assessment can be used to understand implications of the Child Death Review Process. There are fundamental differences in perception, understanding and motivation amongst the actors involved in family assessment which has contributed to this conflict. These can be explained as the welfare/policing dichotomy. The multi-agency approach to assessment is dichotomous with the notion of ‘working together’ if parents are not active partners. Multi-agency working is also of concern if one of the purposes of assessment is to decide whether there are grounds for civil or criminal proceedings. The use in litigation of evidence gathered at a time when parents are not legally represented presents challenges and difficulties that extend beyond consistent note-taking by professionals. More nuanced procedural and legal issues are present which merit debate and further research.

References


Parents Against INjustice (PAIN) Child Abuse Investigations: The Families’ Perspective 3 Riverside Business Park, Stansted, Essex CM23 8P


Department for Education Statistical Releases


**Legislation**

Children Act 1989 c.41

Children Act 2004 c.31

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
Appendix A: Conference presentation slides

The Child Death Review Process: Intervention & the welfare/surveillance dichotomy

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\footnote{The full text of this conference paper is available at: http://people.uwe.ac.uk/Pages/person.aspx?accountname=campus\l-devine}

Advancing the debate: Our research & initiatives

- **Rethinking Child Protection Strategy** (ESRC:ES/K000990/1)
  http://www1.uwe.ac.uk/bl/research/childprotectionstrategy.aspx
  - Large evaluative project to challenge whether current intervention strategy is justified.

- **Policing Parents**
  http://www.routledge.com/books/details/9781138782266/

- **IEEN** ([www.IEEN.org.uk](http://www.IEEN.org.uk))
  - Interdisciplinary & Expert Evidence Network

- **The SAFER Initiative** (webpages tbc)
  - Pro-bono help and support via our social enterprise project for families involved in state welfare assessments.

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Identifying issues

Our research is concerned with identifying a need for policy and legislative change. Why is this indicated? Our research findings indicate that the welfare/surveillance dual model of selective provision in England underpins many of seemingly irreconcilable issues. Our research investigates why this is the case and what change is indicated. Key areas of investigation include:

- **Post-refocusing amalgamation** of policing and welfare focussed family assessments: can families work together in a coercive, adversarial environment or is ‘working together’ a reinterpretation of ‘coercive compliance’?
- **The ‘abuse eradication narrative’** informs policy, in turn informed by the dominance of risk assessment & early intervention strategies. (NSPCC research & medical discourse underpins this).
- **Public Inquiries & SCR findings** retrospectively analyse opportunities for intervention. Findings inform policy.

A combination of these factors has led to a hostile and adversarial assessment system which has fewer controls than a criminal investigation. Courts cannot resolve the issue as they can only apply the law not resolve the conflicts created before the litigation process.

England’s selective threshold model

- **Threshold 1:** Referral
- **Threshold 2:** Assessment
- **Threshold 3:** Provision of services
- **Threshold 4:** Child protection plan (CPP)
- **Threshold 5:** Start of public involvement (SIP)
- **Threshold 6:** S.31 Application

- Family assessment pursuant to the provisions of s. 17 & 47 Children Act 1989
- Families concluded as falling into a s.17 category receive services
- Families concluded as falling into a s.47 category are expected to comply with a plan
- Statement of the intention to apply for a s.31 Order if parents do not comply with the CPP
- Referral to children’s social care
Family rights and remedies

- The tension between private need for privacy & autonomy and the professional duty to safeguard and protect create a potentially irreconcilable conflict.
- Professionals have statutory powers which are interpreted into policy which leaves the boundary between consent and coercion unclearly defined.
- Parents have very limited remedies, children slightly less so.
- With uncertain benefits this indicates challenge of the paradigms, initially through informed debate and transformative research.

What does the data show?

ESRC transformative research project findings: ‘Rethinking Child Protection Strategy: Challenging whether current intervention strategy is justified’

- Initial findings indicate that there are a number of complex assumptions causing year on year reduced efficiency. Key findings and reasons:
  - child abuse definition;
  - child abuse prevalence;
  - the reliability of risk assessment;
  - suitability of PI and SCR findings to influence policy;
  - the use of the post-refocusing family assessment policy.
- These translations, taken together, indicate careful rethinking of welfare/policing family assessment and underpinning selective provision model.
The child protection myth narrative

• A consequence of the mixed investigatory/policing/welfare provision model of assessment is a culture of confusion and conflict.
• Consequently there are a number of myths surrounding the relationship between parents, children and professionals. For example:
  – Parents may perceive a conspiracy amongst professionals as they are within a system where they have fewer safeguards than within the criminal justice system; whereas
  – Professionals may perceive a high prevalence of child abuse as a result of survey findings (NSPCC studies) which reinforces the need for their role in detecting and preventing child abuse. Consequently fewer safeguards for parents are argued to be indicated in order to detect and prevent the high levels of abuse.
• Both narratives contribute to a lack of balance and irreconcilable differences. The way forward? Debate and reform.

Next steps

• Three interdisciplinary symposia to take place during 2015 to coincide with key themes arising from our interim research findings;
• A conference to bring together the interdisciplinary thinking in relation to what works/does not work (and what we mean by ‘work’);
• Presentation to policy makers of a final project report;
• Proposals for review & change.