Child and family practitioners' understanding of child development: Lessons learnt from a small sample of serious case reviews

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Acknowledgements

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Introduction

The aim of the study is to provide an in depth exploration of a small number of serious case reviews to consider how the knowledge that practitioners, and especially social workers, have on child development might have had an impact on the case and on outcomes for the children. Six serious case reviews were selected from thirty three of the available serious case reviews which had been completed in 2009 or 2010.

The six case studies were purposively selected to include a wide age range with proportionately more younger children to reflect the expected age balance in the full cohort of serious case reviews. Three children died, and three were seriously injured. The issues raised by these six cases included, bruising to babies, problems with feeding and growth, disability, complex health needs, self harm, disguised parental compliance, and disputed and differing judgements made by health and social care professionals. The six children were all from white British families.   These children's cases were also specifically selected, for the purposes of learning, to have a greater degree of social care involvement than is known to be found in serious case reviews as a whole. (In serious case reviews as a whole, we know that almost half of the children tend not to be getting services from children's social care at the time of the incident which triggers the serious case review [Brandon et al 2008,2009,2010]). Two of the cases included children with a current child protection plan and two children were living in supervised settings as a looked after child one of whom was the subject of a care order. Two families were most recently getting help as 'children in need' cases.

Limitations of the study

There are limitations to any study and there are particular issues with regard to lessons drawn from these six cases which were purposively selected to illustrate learning about child development and social work. These cases, like all serious case reviews, are also not necessarily representative of everyday practice: children in similar situations very rarely die or are seriously harmed and even when there is good practice, the child can still die. Nevertheless, findings from individual case studies provide powerful illustrations and learning from the way that events can play out. Although there are similarities, patterns and themes within these six cases, it is important to note that there are more individual differences and nuances than similarities, not only in these six very complex cases but in all serious case reviews. However, certain core principles regarding child development can be established.

The transactional ecological perspective

Since development takes place in the context of a series of complex interactions between the child and the changing and evolving environment he or she is in, it is fitting that a transactional ecological perspective is used to analyse the six cases, as in our previous analyses of serious case reviews (Brandon et al 2008, 2009, 2010).   Attachment is the principal theoretical foundation for the analysis of the child's development in the context of their environment. A transactional model using

an attachment perspective in this way recognises the complex interaction of both parental and child vulnerability factors (Howe 2006).

Child development knowledge

Knowledge of child development is essential for all workers who come into contact with children and for their managers. The Children Act 2004 provides a mandate for all these practitioners to be concerned about children's safety and wellbeing. Understanding development is an important step towards being clear about what constitutes children's safety and wellbeing and promoting and preserving wellbeing. For social workers a good working knowledge of child development is a crucial component in family support and child protection and in assessment and planning interventions. The Children Act 1989 defines "development" as physical, intellectual, emotional, social or behavioural development and "health" as physical or mental health. In determining and defining which children are in need of services the Children Act 1989 has at its heart (in section 17) the child's right to achieve and maintain a reasonable standard of health or development.   A child's development must also be taken into account when a family court considers making a care or supervision order where the child's development is "compared with that which could reasonably be expected of a similar child." This comparison with a 'similar child' requires familiarity with the range of development any child might demonstrate. It also requires balancing the norms of development with the needs of the individual child (Daniel et al 2010).

Findings

Introduction to the children, their experiences and their development

The learning about the way these children's development interacts with maltreatment is presented in themes linked to age related stages, starting with the babies and toddlers and moving to the older children. The early parts of this section concentrate on professional responses to physical and emotional development in infants and young children in the context of bruising and faltering weight. Later parts of this section widen out to consider older children and professional responses to social and behavioural and other aspects of development, focusing on behavioural distress among young people, including among children with disabilities.   After discussing children in age related stages, the findings are analysed further by addressing crucial questions which help social workers and other professionals to think about and understand children's evolving development, namely, what does the child mean to the parent , and what does the parent mean to the child? The final part of the findings section summarises what has been learnt from these six cases about acting on maltreatment and development.

Each of the six children's lives and experiences were unique and different. However, there are some recurring themes in agencies' faltering responses to potential warning signs of abuse and neglect that could be seen to link to the child's development, or to an understanding of the child's likely developmental capacity. A central aim in presenting these findings is to highlight the messages from

these individual cases for both practitioners and for Local Safeguarding Children Boards. Where possible the findings are illustrated with examples from the six serious case reviews. However, to respect confidentiality, only limited aspects of each child's story can be used.

Themes arising from the cases which link development and abuse and neglect

Younger children - Bruising and minor injuries

Understanding the meaning and origin of bruising and minor injuries emerged from the analysis of two of the cases as a theme for pre-mobile babies and toddlers. Bruising and minor injury tended not to be considered in the context of the child's own development and capabilities nor in the context of a good understanding of the care they were receiving.

The reasons that explanations for bruising were accepted by practitioners without sufficient scrutiny appeared to be because:

- children had complex health needs or disabilities and the bruising was somehow (but implausibly) connected with this; or
- the child's development was otherwise good; or
- the person who posed a perceived risk of harm to the child (eg a dangerous male figure) was believed to be out of the picture; or
- the parents were hostile or difficult and somehow stopped the practitioner from seeing clearly.

The Welsh systematic review group provide a clear research evidence base for having child protection concerns when there is any bruising on any pre-mobile baby. In their review of patterns of bruising in childhood, they conclude that the prevalence, number and location of bruises in children are directly linked to motor developmental ability (Maguire, Mann et al. 2005). They highlight that bruising in babies who are not independently mobile is very uncommon, whereas around 17% of infants who are crawling or cruising have bruises, and the majority of preschool and school children have accidental bruises. They also point out that a child with impaired motor development would not be expected to have the same bruising patterns as other children of the same age, but different developmental abilities. Thus an understanding of normal motor development in childhood is essential for evaluating the significance of bruising and for distinguishing potentially abusive from non-abusive injuries. Further information for practitioners about children's developmental capabilities and accidents is available through guidelines for practitioners on accidents and child development (CAPT 2009).

What should professionals know and do?

The need for heightened concern about any bruising in any pre-mobile baby (up to the age of around six months) is explained through an understanding of the child's physical development.

Because physical self control and independent movement is very limited in young babies,   it is extremely difficult for them to bruise themselves. Any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused. The explanation, for example, as in the case of Sally , that a pre-mobile baby hurt herself while in her cot needs to be scrutinised very carefully and treated with suspicion.

Vignette - Sally

Sally was five months old when both the social worker and health visitor noticed a bruise on her face but they did not consider this to be a child protection concern. The fact that Sally was meeting developmental milestones (well enough) and her mother was thought to be cooperating with the contact arrangements for Sally with her father (who had limited and supervised contact because of domestic violence) should not have stopped these workers extending their curiosity about what might be happening in Sally's life. They needed to see things not just from Sally's perspective but also from the perspective of her young mother – who was a child herself. The serious case review revealed that Sally's mother had been feigning cooperation and was continuing her relationship with Sally's father. Since there were already concerns about Sally suffering harm (she was the subject of a child protection plan) this bruise should have put practitioners on high alert. The cause of this bruise should have been considered to be suspicious and urgent and robust enquiries should have been made. Sally's mother's supportive family and relatively problem free background are protective factors but they do not mean that the possibility of abuse can be disregarded.

Bruising in pre-school aged children

It is not surprising that bruising is more common in toddlers and especially in older pre-school age children. At this age children regularly have tumbles and accidents as they develop their gross motor skills and are exploring the world around them. However, any bruising will usually have a pattern and be on particular parts of the body, like the bony surfaces of the legs, arms and face which take the knocks in everyday falls (Maguire, Mann et al 2005). Frequent, repeated bruising in children of pre-school age might also signal that the child is not being kept safe and is not being appropriately supervised. There needs to be a sense of curiosity about how and why the bruising is occurring and how well the child is being kept safe and supervised.

Bruising in the context of complex health needs and disability

Vignette - Ben

Another young child, Ben, had numerous episodes of bruising prior to the incident of physical assault which ultimately triggered the serious case review. He also had complex health needs, but these did not restrict his mobility. The prevailing view of the multi-agency team was that the bruising was linked to his being a lively toddler and also to the demands made by his health care and health problems. The unusual pattern and site of Ben's bruising (which was not compatible with what

would be expected in a lively toddler) did not provoke curiosity or questioning. Again, the fact that Ben was the subject of a child protection plan should have put practitioners on high alert. The pattern of Ben's bruising should have been considered in the context of his development with specific care taken not to explain away the bruises because of his health needs or disability without careful checking. In this case repeated bruising did not cause the social worker or others in the multi-agency team to think more broadly about whether these might be non-accidental injuries, "S*ome (professionals) had difficulty in believing such a sick child could be harmed deliberately*".

These cases also show that the category and primary reason for the child protection plan is not always an indicator of where the risk of further harm or recurrence of harm is coming from. In Ben's case, although the child protection plan was linked to domestic violence, it was his mother not his violent step father who was inflicting the bruising.

In these two cases involving pre-school aged children, the following questions were not sufficiently attended to:

- Does the explanation for the bruise match the child's developmental capability and likely behaviour?   Was the child developmentally capable of causing these injuries to him or herself?
- Does this pattern of bruising match the particular developmental capabilities of a child of this age with these particular developmental needs?
- For a child who is otherwise meeting developmental milestones, might a parental explanation for injuries be too readily accepted?
- Is there a full understanding of the caregiving the child receives?

Who provides developmental advice?
When making judgements about babies and children, social workers need access to both formal and informal advice and developmental expertise. Good relationships with health visitors and paediatricians will enable social workers to check out concerns, or to have a sounding board for discussing babies' and young children's development. A good paediatrician should be happy to talk through concerns about bruising or minor injuries in a baby or child. We have argued elsewhere that skilled use of expertise and consultation in a coordinated manner could result in more rigorous assessments and promote greater professional trust and confidence (Brandon et al 2005). These routes through to advice and developmental expertise are important for social workers working with children of all ages. As children grow older the range of possible developmental experts with whom to consult expands. Sidebotham and Weeks (2010) have summarised the likely child development contributions made by different professionals in the multi-agency context.

Emotional development and faltering weight in young children

Poor or faltering weight gain for babies and toddlers was an issue in three of these reviews. In all of these six cases, not just the three concerning faltering weight, there was little evidence of knowledge about or sufficient interest in the child's emotional development. This rarely featured in

the individual management reviews or the chronologies and, in line with the findings from Ward's study of infants suffering harm (Ward et al 2010), was perhaps also often absent in practice. There were complex and differing reasons why parents appeared not to be nurturing their child. There was, however, a pattern in professionals' failure to recognise problems in the children's relationship with their caregivers and their emotional development as a key part of their faltering growth. The different issues presented in the cases and the professional responses are summarised as follows:

- Early difficulties in feeding could be linked, initially, with the baby's prematurity and subsequent complex health needs;

- in another case the baby was healthy at birth and the weight gain problems were not prompted by any easily recognised innate problems in the child;   and

- in all three cases barriers to understanding development in cases of faltering growth included treating the issue primarily as a mechanical feeding problem rather than raising questions about emotional development, attachment and the parent-child relationship.

What should professionals know and do?

Practitioners need to be aware of the parents' reactions to their child, and to specifically observe and reflect on the child's responses to his or her caregivers. These are the foundations of emotional development and of attachment behaviour. What happens during feeding provides powerful clues to emotional development.

 In each of these examples there was an emphasis in the professional response on the single issue of feeding and the mechanics of feeding rather than any concerted attempt to try to understand the child in the context of their caregiving environment and the different possible explanations for why the child was not gaining weight.

Usually, concerns about feeding and poor weight gain did prompt the social worker to request an additional or an enhanced developmental assessment for the child if this was not already taking place. This is good practice. However, in one instance the developmental assessment used by health staff, the NFER assessment, did not take account of faltering weight which was the particular problem highlighted. The serious case review noted that developmental assessments need to be global if they are to pick up the full range of developmental issues.

Vignette – Joe

Joe was born at term, healthy and within the normal weight range.   Within a month of his birth, Joe had not regained his birthweight. Instead he had slipped rapidly down the weight percentile chart. Although his mother was perturbed by Joe's lack of weight gain, her rough handling of her newborn baby was not congruent with this and he was often prop-fed.   When Joe was two months old he died of unexplained causes, however, a post mortem report concluded that his growth problem made him more vulnerable to stress thus contributing to his death. The rough handling and prop-

feeding are clues that point, not least, to the possibility of a lack of emotional warmth. There was also a pattern of faltering weight in his siblings.

Vignette - Melissa

Melissa was born prematurely with associated complex health needs, which meant that she was more difficult to feed and care for than a healthy baby born at term. There were concerns about her care from birth and these persisted. Melissa's mother continued to need to be prompted to feed her and it was noted that her mother was using her mobile phone almost constantly and not interacting or engaging with her. Melissa's lack of weight gain and her poor emotional development was assessed as non organic failure to thrive when she was a toddler, at which point she was made the subject of a child protection plan. This baby's failure to gain weight should have been assessed holistically in the context of her emotional need to be and feel connected with her mother as well as her physical need to be properly fed and well cared for. Poor care in this case was tolerated for a long period when evidence of impaired development had been apparent for many months.

Older Children

For the older children it was clear that to obtain a good picture of their current developmental state, professionals needed to get a sense of their developmental pathway over time. It was apparent in these cases that children who felt that their needs were repeatedly unrecognised, ignored or misunderstood were likely to become distressed, angry and desperate. Issues that prevented practitioners paying sufficient attention to the impact of maltreatment on young people's development were as follows:

- Not making a relationship or getting to know the young person.
- Not taking account of what the young person has to say to make sense of them as a person, nor to make sense of the impact that their experiences (especially of care and nurture) had on their sense of themselves and on how they behaved.
- Not speaking to the child. In one case the only consistent efforts to gain the child's view were at school (he had disabilities and global developmental delay) and the child was not spoken to during an assessment: "*This assessment fulfils the function of confirming the developmental delay … it fails to analyse what that means to (the child) in terms of care, safety and welfare needs*"(IMR Health).
- Allowing the parents' voice to dominate (especially if they are volatile and difficult to confront).
- Seeing the disability not the child and viewing a case essentially as supporting disability rather than supporting or protecting the child (including identifying and responding to signs and symptoms of harm).
- Accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child. A secondary health service acknowledged that they had different expectations of care for disabled than non-disabled children when they confirmed that in high risk disability cases locking children in their bedrooms was an acceptable strategy.

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- Pockets of good development in maltreated young people do not necessarily signal resilience.

What should professionals know and do?

One young person's good intellectual development, and his capacity to make relationships and confide in professionals, showed that not all aspects of his development were negative. Yet it would be a substantial leap from here to say that he was resilient. Rees and colleagues (2010) have found that professionals can be prone to misinterpreting positive aspects of a young person's demeanour or development as resilience (good development in adverse circumstances) and that this can blunt their capacity to appreciate the impact that maltreatment has on the young person's overall development and sense of self.

The overview report author in one case suggested that things might have been better for the young person if he had been assigned inquisitive social workers who wanted to know why his behaviour was so difficult at this point in his life, and who were curious about the research behind neglect, attachment and child development.

Social workers in particular, should work hard to develop a relationship with children and young people, getting to know and understand them as individuals. This includes taking notice of what they have to say, considering what it means - and where it meets with their best interests - acting on what they have to say. The social worker should act as an advocate for young people who are being looked after or have child protection plans, or find them an independent advocate. They should make sure that specialist assessments are completed (in one case a full mental health assessment requested from CAMHS was never followed through). Clear plans for the future should be set out based on an understanding of the young person's developmental needs and young people should be involved in these plans and understand them.

All of these activities are legitimately within the social worker's role and sphere of expertise. If the social worker is not able to carry out all aspects of this role they should make sure that someone else does.

Signs of distress in older children

Vignette-Shelley
Shelley took her own life, as a young adolescent, while in a therapeutic unit. Shelley's care order and placement protected her, to an extent, from harm at home (where she no longer wanted to be) providing her, in many respects, with safety and security. However, the meaning for her, of living for years with significant harm was not wholly taken into account when a standard strategy for managing challenging behaviour was imposed and when she perceived that contact with her family was dependent on her behaving well.

Shelley's behavioural and emotional development marked her out as different to other children from a young age. She had began to behave like a distressed, much older teenager when she was many years away from puberty engaging in defiant and risky behaviour, and also expressing suicidal thoughts and beginning to self harm. Shelley's exposure to years of neglect, physical and emotional harm at home had affected almost all aspects of her development, although her intellectual development was good. At all of her schools she was perceived as 'bright and able.' When tested, her reading age was well ahead of her chronological age.

Shelley's parents admitted that they had given up trying to control their children. Shelley's parents had never been able to see their daughter's distressed mental state. When she was very young and needed to have her distress and dysregulation recognised and contained, this parental sensitivity was missing. Instead, Shelley's parents either ignored her or lashed out at her. Because Shelley's parents were unable to take control of her safety and her needs, Shelley began to take these on for herself, a pattern commonly noted for children who develop a disorganised attachment (Howe 2005). Part of the controlling strategy that Shelley adopted included compulsive caregiving of her siblings and to a lesser extent of her parents.

The strategy children evolve to survive life at home is deeply ingrained and will be transported with them to any new environment. When she was away from home, in care, Shelley was consumed with anxiety about what was happening at home.

Vignette: Adam
Adam's disabilities were connected with a congenital neurological condition. Adam told teachers about being locked in his bedroom each night and how he tried to get out. Trapped in his room, isolated, and unable to get to the bathroom, Adam soiled and smeared faeces in his room which was described as being "in a terrible state." The condition of his bare and filthy room contrasted with the rest of the house. Adam's parents spoke to the social worker and others in the multi-agency team about locking him in his room as a way of managing his sleep disturbance, sleep walking problems and to stop him hurting himself. Despite many years of involvement, social workers had only seen Adam's bedroom four times. There is no evidence that any professional had considered the impact that spending a considerable amount of time isolated and locked away in this bare room was having on this young person.

Adam's distressed behaviour (smearing) escalated frustration in his parents who, largely because of their own childhood experiences of rejection and abuse, had a heightened sensitivity to their child's behaviour and disability which they interpreted as dependent, difficult and demanding. This triggered more coercive, rigid and insensitive care. In this example it was easy to see that the interaction of the vulnerabilities possessed by both child and parent played out to increase the risk of insensitive dangerous care and harm to the child (Howe 2006:754).

What does the child mean to the parent and the parent mean to the child?

The learning about bruising, and faltering growth in the younger children and about behavioural distress in the older children suggest that there are linked questions that practitioners need to be curious about:

- What does each parent or parent figure bring, psychologically, to the relationship with their child,

- What does the child mean to the parent, and

- What does the parent mean to the child?

Questioning the meaning of the child for the parent seems a good way for social workers, and for other professionals, to make sense of children's development and of their care and nurture. Grappling with these questions will help the social worker to understand the child in the context of their caregiving environment so that they can build a clear plan for help, support and protection together with the child, the parent(s) and other professionals.

The child's caregiving environment

The child's development is best understood in the context of the care they receive at home, or received at home pre-placement. In these cases there are examples or reports of specific parental behaviour that is incongruent with the child's developmental needs. This potentially developmentally harmful parental behaviour included:

- Not being emotionally available or attuned to the child's needs (for example being constantly on the phone);
- Handling young babies roughly;
- Not giving babies or children adequate food or 'forgetting' to feed them;
- Making the new born baby's regular night-time sleeping place a long way from the parents' bedroom (with no baby alarm);
- Reports of hitting a very young baby;
- Locking children in their rooms for long periods or keeping them out of sight;
- Opting out of responsibility or giving up trying to control a pre-pubescent child;
- Expecting children to be carers for siblings and to protect siblings from harmful parental behaviour like violence (including domestic violence).

Studying these cases in depth has emphasised the importance of puzzling over the meaning that each child has for his or her parents (or parent and step parent) and the way each child makes their parent(s) feel. In some of these families one child is singled out for particularly harsh or rejecting treatment, in others all the children in the family seem to be treated in a similar way. But even in families where the parenting seems to follow the same pattern for all children, each child's experiences will in reality be different (as studies of birth order have shown). In one family where weight loss was the key professional concern, one particular child provoked more anger in his

mother than did his siblings. The mother called him a 'devil child,' but it was a younger sibling and not this child who died.

Four of the six children who were the focus of this study began their childhood in an environment where they experienced both unpredictable danger (being hit as infants, living with violence or in other frightening environments) and/ or emotional abandonment experiences (not being tended to when distressed or ill, not being fed when hungry or not being held close when fed). These early patterns of experience repeated over time, would be likely to set the scene for a developmentally damaging, disorganised attachment. There is evidence from the serious case review that their carer or carers were during their early months and years likely to cause them distress and/ or fear for much or part of the time. Their parents' behaviour seemed to fit into the typologies of parents who were hostile, helpless or intermittently hostile and helpless (Howe 2006). These carers *frighten* their infants or behave in *frightened* way when they are faced with their child's basic needs for care and nurture. Howe describes how this plays out in the developing relationship between the parents and child, "Parent and child find themselves in a loop of catastrophic feedback, leading in each case to a state of emotional hyper-arousal and behaviour that becomes hopelessly out of control (hostile, helpless, or rapid switches between the two)" (Howe 2005:40).

The relationship histories of almost all of these carers revealed abuse, neglect, loss, rejection and trauma which increased the likelihood that they would be emotionally and psychologically unavailable when their babies needed them most. These parents were also living in a high stress environment, where most had debt problems or faced eviction, and struggled with mental ill health and substance misuse. Four sets of parents were caught up in volatile relationships where there was domestic violence. (Two children were the subject of a child protection plan because of domestic violence). These parents were highly likely to have felt overwhelmed by their own unresolved feelings of fear, abandonment and powerlessness.

In retrospect it is easier to recognise that some of these parents were finding ways to switch off from their children. There were examples of parents who did not feed babies or restricted their young child's intake of food, or made feeding a distressing experience. Other parents appeared to be too emotionally preoccupied and overwhelmed, or perhaps not intellectually able to keep in mind their child's need for regular food. Young children and especially babies are wholly dependent on their carers for nurture and for survival – by denying these children's most basic needs for survival, parents are in effect denying their child's existence. The child's demands appear to make these parents feel so distressed or angry that it feels better or safer not to connect with the child. Locking a child away each night behind a door is a similar demonstration that the parent cannot bear to see or hear that child.

In one case the meaning of the child to his mother was especially confusing. The pattern of this mother's complex behaviour (making regular emergency calls for medical help and not following through with advice or appointments) suggested that she was using the child as a way of meeting her own needs for life to contain high drama.   This case showed that what appeared to be compulsive help seeking behaviour was instead a means to meet the mother's own complex narcissistic needs. When the mother's behaviour was eventually recognised as a serious mental

health problem, it was not immediately acknowledged as affecting the safety and welfare of her children. In addition to a high level of health care use this mother also insisted to the social worker that her young baby had a bruise on her face even though when checked there was no bruise visible on the child and no other sign of injury. There were features of this mother's history and her current difficult and hostile behaviour which had similarities with cases of fabricated or induced illness (HM Government 2008). This type and pattern of behaviour needs to be recognised as it can result in children being harmed and in some cases dying as a consequence of the harm.

Further issues which connected the child's development to their meaning to their parent or carer were the meaning of the pregnancy to the mother (for example ambivalence) and differences in the meaning of the child to the mother and to the father (or unrelated male).

Being curious about the meaning of the pregnancy to the mother and noting any ambivalence gives a helpful context to the developing relationship between the mother and her baby. Cases where there is late ante-natal booking and poor ante-natal care provide an ambivalent backdrop to the mother–child relationship. In one of the cases the pregnancy was concealed and the mother gave birth alone and unattended. Little attention was paid to the mother's history, her own experiences of sexual abuse and the impact these had on her sense of self and her identity as a mother.   In another the mother had suffered multiple miscarriages. In two cases where the pregnancy was unplanned the mothers were children themselves when they gave birth.

There were interesting examples about the different meaning of the child to mothers and fathers, or unrelated males in the household. Our other studies of serious case reviews have emphasised how important it is to have a full understanding of the role that men – whether or not they are related to the child - play in the child's life (Brandon et al 2008,2009) and the risk and protective factors that they represent for each separate child in the family. These findings are borne out in the examination of these six cases which show that assumptions cannot be made for example about the child having a more negative meaning to the male than the female in the household.

 In three of the cases, damaging developmental influences came from both the child's mother and father (or in one case the stepfather). In another case the father was apparently the more sensitive carer than the mother and professionals' concerns about the mother's care were lessened while he was a significant caregiver. However in both this case and in another example where the mother was the better carer, professionals over-estimated the ability of the apparently more attuned carer to protect the child and promote their healthy development.

In one case where the mother was believed to be the better carer, professionals were most concerned by the child's father who had a history of offences against children. When he lost contact with his child, they were falsely reassured about the child's safety and attention was deflected away from the mother's care, which was not only neglectful, but posed a physical risk to the young child's life.

Acting on the understanding of the relationship between maltreatment and child development

A number of themes emerged in relation to practitioner and agency involvement and decision making in these cases.

Continuity and flux

In many serious case reviews we know that there is a high level of family mobility and a high level of staff turnover creating a system of almost constant flux.   In these six cases there was less mobility among families and when they did move, professionals were usually aware of these moves and usually kept in touch with the families. This does not mean, however, that there was continuity of staff seeing families, or continuity of staff support. Most cases had a strikingly large number of practitioners involved with the family, both over time and in the build up to the incident which prompted the serious case review. This was particularly true in the cases of children with disabilities and complex needs. However, even in one case concerning a physically healthy child, over 200 professionals had been involved with the family over a ten year period. Lack of supervision, lack of oversight or long gaps without oversight were a feature of many of these cases. Gaps in support and supervision are very worrying at a time when the need for good staff support in child protection is well recognised (Munro 2010, 2011).

Downgrading concern

A theme running through most of the reviews was the downgrading of concern about the child. Some cases, particularly where the key concern was faltering growth, tended to be dealt with as a child in need case with little or no recognition that the child may have been or was suffering significant harm.   In one instance this was in spite of the health visitor's recorded concerns about the child's development (faltering growth) and her opinion that this was a child protection issue. Because children's social care did not consider that the children should have been the subject of section 47 enquiries and perhaps further statutory intervention to protect them from harm, it was deemed appropriate in two cases to allocate the work to less experienced and unqualified staff.

 In one case an unqualified social care worker who made the assessment visited the family without adequate preparation including not reading the files. Therefore the worker did not discover that there had been a pattern of faltering growth for three successive babies in this family. The health service also used unqualified staff in one of these complex cases where an unqualified heath visitor carried out a developmental assessment which had been requested specifically because of developmental concerns about the child.

In another worrying example, an unqualified social care worker had been allocated the case even though a section 47 enquiry was being pursued. The enquiry was not handled with the appropriate urgency "there may have been less drift in this case once a decision to commence a s47 enquiry had been taken … if the case had actually been allocated to a social worker rather than a (unqualified)

duty social worker who may not have had the same capacity as an allocated worker" (Overview report).

Sometimes the downgrading stemmed from an inadequate social work assessment, for example where a 'wait and see' approach was adopted for a neglect case and the available evidence from other professionals about poor development was not properly marshalled. Another review suggested that had the common assessment framework (CAF) been used during pregnancy for the young parents it would have acted as a mechanism for getting people together and synthesising developmental information about these parents as children as well as about the needs of the unborn child. In this way the parents' vulnerabilities (especially the father's) could have been recognised and support could have been offered earlier.

Downgrading also occurred when one area decided to use a 'single agency protocol,' for responding to allegations of sexual abuse. In this case the GP examined a very young child, where sexual abuse had been alleged, and decided that there were no signs of sexual abuse. The telephone discussion between children's social care and the police decided that since there was 'little to go on' only a single agency enquiry would be pursued. This precluded both an expert paediatric examination and a wider discussion and sharing of information about the child and family as a whole.

It was difficult in these cases as in other serious case reviews (Brandon et al 2008) for social workers and other multi-agency colleagues to recognise and perhaps accept that children with complex health needs and disabilities could be being maltreated. Not only were these children's needs for protection being overlooked, their needs were also often assessed as not meeting the criteria for a social work service at all. Whether the ill or disabled child (and therefore their family), were judged to meet the threshold for social work services varied over time in the same cases. Sometimes the child would have a social work service, sometimes they would not in spite of the fact that their needs had not diminished and indeed the risks of them suffering harm had increased.

The role of specialists in child development

It was clear that the social worker should have been part of the group of experts in child development bringing their own knowledge about the child's overall development to the multi-agency grouping when making decisions about children's safety and welfare. However in these cases this expertise was not often apparent. In most of these six cases however, there was at least one professional who had a good understanding of the child's development (usually the health visitor, paediatrician, teacher or, to a lesser extent, the GP). If their information about developmental concerns had been known and understood by the social worker, it could have helped prompt the social worker into taking action to protect the child sooner or better.

Yet even when this information was forthcoming from other professionals, the social worker did not always agree with their opinion. In one instance where concerns were clearly communicated the social worker chose not to accept the health professional's view. However in other examples, child health specialists did not make their concerns about development and the implications of these concerns for the child explicit. For young children this often concerned emotional development linked to attachment, for example, bonding problems, feeding, nurturing, and emotional warmth.

Any professional involved with the child (including the social worker) should make developmental concerns explicit and relate them to the age of the child. Ideally, they should provide a benchmark of what the norm might be for a 'similar child.' This would provide a clear statement about what the child should or could be doing or achieving.

Children and their families as experts in child development

Other specialists in child development are the child and family themselves: they are experts in their own experiences. Failure to understand the impact of what's happening from the child's perspective means that the child's development cannot be wholly understood. Gaining this understanding involves talking to the child and observing the child and thinking about what is happening to them in the context of their particular family and environment.

Parents' perspectives are crucial to understanding the child's development. Parents' contributions to the serious case review itself provided important learning about the child and their development in ways that were not revealed in any other reports in the serious case review.

In reviews concerning disabled children a finding was that the onus appeared to be on the child's capacity to communicate well enough rather than the professionals' responsibility to find ways of communicating with the child. Even when disabled children did communicate well they were not listened to and key learning about their development and their experiences was missed.

 Missing developmental clues and professional challenge

Clues in the child's development which gave a good indication that things were not right were being missed, even at times, by developmental specialists who misread developmental information. Health visitor records in one case noted that the baby was weighed and was 'fine' since her weight was up. What had not been checked was the position of the baby's weight on the centile scale which was continuing to drop to a dangerously low point. The health visitor said she had felt 'overwhelmed' by this case and by the difficult and hostile behaviour of the mother. The impact of difficult and hostile families on the worker and the way that dealing with this hostility can overwhelm and paralyse the worker has been considered in our other studies of serious case reviews (Brandon et al 2008, 2009). As in this case, family hostility can impinge on the worker's capacity to think clearly and systematically and use their professional knowledge and expertise.

In two instances sustained weight loss for the child should, arguably, have triggered court proceedings. In one example this could have occurred as much as a year ahead of the incident which prompted the serious case review. Instead, a lack of professional urgency prevailed and the developmental information was not properly gathered or used. Gaps in support and supervision that have been noted in these cases thwart robust decision making to support families in protecting their children and militate against intervening with urgency when danger is evident.

In these cases professionals were rarely analysing the situation fully or challenging each others' or the parents' views robustly. There were some examples of good practice where professionals picked up on developmental information and challenged each other, for example a health visitor challenged a decision not to act on neglect and a youth offending worker insisted that what a child said about parental abuse must be acted upon. In another case a social worker who was new to the case started questioning and probing the family and challenging the mother. "This level of challenge had not taken place prior to this and had allowed the mother to manipulate the situation. (This social worker's) action eventually led to the removal of the surviving children" (Overview Report).

However, more often developmental clues were missed. Parents' apparent compliance or hostility or their implausible and insistent explanations for developmental harm suppressed the professional curiosity that was needed. In one example a child's mother insisted to her GP that her young baby was lactose intolerant. The GP took the mother's word instead of checking and hypothesising that this might be part of an elaborate pattern of difficulties that the mother was having in feeding the child rather than the child having an underlying medical condition.

Recording

Difficulties in recording are a perennial problem in serious case reviews and these six cases were no exception. Clarification about how developmental information is recorded and shared between health and social care professionals might be useful here. One potentially helpful approach from health is the type of recording used by midwives who complete concise, succinct notes giving a picture of the mother and baby and the father (where they are present). Midwives are individually professionally liable, so take care over their recording. They are also pressed for time so are not verbose.

Discussion

To widen the learning, the findings from the six cases are set against a wider literature review about maltreatment in the context of the developing child, and the expertise and training and of key child protection professionals as well as the contribution of families. The section concludes with a consideration of how outcomes for children might have been improved with a better understanding of child development, and what type of practice conditions would foster the ability to exercise professional judgment in relation to this knowledge.

Understanding maltreatment in the context of the developing child: concepts of childhood vulnerability – learning from the literature

The very nature of childhood involves the child as an active, changing (growing and developing) individual who interacts with his or her world and in turn both influences and is influenced by his or her environment (Aldgate et al 2006, Margolin and Gordis 2000). Within this context, children may be vulnerable to maltreatment and its effects, but this vulnerability varies between children and

over time and needs to be understood in the light of (a) characteristics of the children themselves, both their vulnerability as targets and their ability to protect themselves, (b) characteristics of the environments they inhabit and c) the interaction between the child and his or her environment (Finkelhor 1995, English, Upadhyaya et al. 2005).

Certain key developmental stages can be identified which have implications for understanding child maltreatment. In infancy, the child is particularly vulnerable to both physical abuse and neglect, because of rapidly developing skills in all areas, the formation of multiple neural connections in the brain, the importance of perceptual input, and the development of attachment relationships (Finkelhor 1995; Harden 2004). A lack of, or inappropriate, stimulation during this phase lays patterns that may affect the acquisition of future developmental milestones (Cicchetti and Howes 1991; Hildyard and Wolfe 2002). Failure to develop appropriate language skills due to neglect in this stage may lead on to wider cognitive and social impairments, whilst disorders of attachment can give rise to future emotional and social difficulties. During the pre-school years, there is a strong emphasis on social development. Early maltreatment may lead to difficulties in emotion regulation, initiating social interactions, and learning to respond appropriately to others (Cicchetti and Howes 1991). During the school years, the effects of early adversity may be seen in poorer academic achievement and further social difficulties, whilst early attachment disorders can result in persistent negative concepts of self and others (Cicchetti and Howes 1991; Harden 2004). In adolescence, these negative self-concepts can lead to personality disorders, anxiety, depression, and problem behaviours. Recognition of these different stages and of what constitutes normal development is crucial to understanding what is going on in the maltreated child's life, the likely impact of any maltreatment, and how it might manifest through disordered development or behaviour.

It is important to recognise that many maltreated children will also be exposed to a range of other adversities, including the effects of poverty, poor housing, parental mental health issues or low educational achievement and poor nutrition. All of these are potentially related to poor development per se, and it may be the interaction of multiple adversities, including maltreatment that has the biggest impact on development (Margolin and Gordis 2000). Extrapolating from this, the context within which children are growing will impact on their development. Issues such as good nutrition, maintaining good health, hygiene, physical and economic security, the physical environment, opportunities for social interaction and play, and aspects of parenting such as stability, availability, affection, and setting boundaries are all important for healthy development.

It is recognised that some disabled children may be at higher risk of being maltreated (Goldson 1998; Sullivan and Knutson 2000). The prolonged and heightened dependence of disabled children on their parents and carers may make them more susceptible to neglect, and may also increase the stress on parents as triggers for physical and emotional abuse (Murray and Osborne 2009, Goldson 1998). Because of their greater dependency, disabled children may be less able to protect themselves. Disabled children, particularly those with language disability, may be less able to express any maltreatment they are experiencing. It is important, however, to recognise that disabled children do not form a heterogeneous group, either in severity or type of disability, so an understanding of the particular nature of any underlying disability and how the child's development is affected is essential to appreciating the nature and impact of any maltreatment a child may be experiencing.

The practice context: what child development expertise can social workers and other professionals offer?

What should social workers know?

Social workers should have a good working knowledge of the key developmental processes for the child from infancy through to adolescence and maturity (Aldgate et al 2006). They do not need to be experts in child development, and indeed will work closely with colleagues in other agencies to consider the child's developmental progress. Nevertheless they should be able to recognise patterns of overall development, to promote optimal child development and to detect when such development may be going off track. However in a recent study, Ward and colleagues found that many social workers did not feel that child development had been a major part of their professional training and also that some professionals showed "little understanding of infant attachments; the impact of maltreatment on long term well being; of how delayed decisions can undermine life chances" (Ward et al 2010:6).

Different professional groups have particular expertise to offer in different aspects of child development, although there is obviously considerable variation in individuals' knowledge and experience. Sidebotham and Weeks (2010) have summarised the likely child development contributions made by different professionals in the multi-agency grouping:

Community Nursing staff (midwives, health visitors, school nurses): Chronology of child's history-infancy, pre-school, school years; child's physical development, behaviour and temperament; health needs, hygiene, feeding, growth parameters; observations of parent-child interaction (positive and negative); evaluation of parents' understanding of and capacity to respond to the child's needs at different developmental stages; growth and development of other children; child health surveillance.

General Practitioners: Chronology of child's medical history; identified health problems, past and current treatment and referrals; parents' background history.

Secondary Health Care Providers (paediatricians, specialist consultants, hospital staff, therapists) Specific assessments of child's physical and mental health, growth or development; identified health needs; specific assessments of parent's health; evaluation of parents' understanding of and capacity to respond to the child's needs at different developmental stages.

Adult Mental Health Care (psychiatrists, psychologists, community psychiatric nurses, drug and alcohol support teams); identified mental health issues in parents, including learning disabilities, mental illness, alcohol and substance misuse; specific assessments of parents' learning abilities and parenting capacity.

Education staff (Sure Start children's centres, and early years providers, teachers, head teachers, SENCOs, Connexions, Educational Psychologists): educational history of child; past and current educational attainment; assessment of any learning disabilities; presentation and behaviour in school or pre-school; interaction with others, aspirations and plans of young person (adapted from Sidebotham and Weeks, in Horwath (Ed) 2010).

What training in child development do professionals working with children receive?

The Munro Interim Report notes that child development is not covered thoroughly in all social work qualifying courses (Munro 2011:75). Most social work programmes fit child development within the broader curriculum of lifespan development (sometimes called human growth and behaviour). Since the remit of basic social work training is to provide a generic qualification covering all social work service user specialisms, including work with children and families, it is likely that constraints of time will limit child development coverage. It is only at the post qualifying level that social workers are expected to develop specialist knowledge. Beginning specialist learning for social workers and all those working with children young people and their families was set out in 2005 in a 'common core' of knowledge and skills (HM Government 2005, CWDC 2010). Child development was pivotal to this 'common core' in its original, and in its revised form. For safeguarding and child protection it currently includes:

> *Being able to recognise when a child or young person is not achieving their developmental potential, or when a child is displaying risky or harmful behaviour, or when their physical or mental health is impaired* (CWDC 2010:13).

However, there has been no consistency in the reach of common core training, nor in the level or standard of its delivery. This training gap was recognised some years ago by the then Department for Education and Skills who commissioned the *Developing World of the Child* book (Aldgate et al 2006) and training pack to assist with multi-disciplinary and multi-agency training (DCSF 2008). There has also been considerable investment since 2008, in early career development support for child care social workers. However, neither the Newly Qualified Social Worker Programme nor the follow on Early Professional Development Programme lay any emphasis on child development (CWDC 2008-2011). Given the limitations of child development input in basic social work training, this absence in follow up specialist development is a missed opportunity.

 Patchy child development training is also apparent among other professional sectors. In education training primary school teachers will receive very limited child development input but secondary school teachers will typically get none. In health, training in paediatrics for General Practitioners, is desirable but not a mandatory part of GP training, which is a cause for concern for the Royal College of General Practitioners (Harnden 2010). Lack of reach and consistency seems to prevail with regard to child development training for all professionals working with children including health visitors and paediatricians.

Overall, it would appear that there is scope for improvement in child development training for all professionals working with children. A good in-depth knowledge of normal development is essential if practitioners are to grasp the nuanced understanding that meeting developmental milestones is not a sufficient guide to good development or to safety. One of the key findings from Davies and Ward's analysis of a number of safeguarding studies was that there was abundant evidence that improved training in child development would benefit social work practice and enhance outcomes for the children they are working with (Davies and Ward 2011).

How might a better knowledge of child development have affected the outcomes for these children?

It is, of course, impossible to be clear whether better knowledge of child development among social workers and other practitioners would have made a difference to the outcomes for the children at the centre of the six reviews. A number of examples in the six case studies suggest that acting on child development knowledge with more confidence and a greater degree of urgency might have protected children sooner or better.

There were different developmental concerns but also some facets of the child's development that were positive for children of different ages in the six case studies. Overall these tally with MacMillan's summary of the adverse effects of maltreatment on children's development and wellbeing in three age bands (MacMillan 2009). In infancy she found injury, affect regulation, attachment, growth and developmental delay; in childhood there were anxiety disorders, mood disorders, disruptive behaviour, academic failure and poor peer relations; in adolescence likely effects included conduct disorder, alcohol abuse, drug abuse, other risk taking behaviours and recurrent victimisation.

Evidence from the six cases has underlined the importance of relationships. These include relationships between parents and children, between children and professionals, such as social workers or teachers, and relationships between professionals. Good relationships are important not only in terms of understanding but also for the success of therapeutic work with parents who abuse their children (Barlow and Scott 2010) and with children who have suffered trauma through maltreatment (Perry and Szalovitz 2009). Learning from emotional development in babies can help practitioners to be more attuned not only to the children and families they are working with but also to each other. This also includes a relational approach to organisational functioning:

> "(Concepts)that have been developed to make sense of the inner world of infants, and the ways in which such early development can be seriously derailed by non-optimal parenting, can also be applied in terms of the wider professional system and organisations"
>
> (Mandin 2007 in Barlow and Scott 2010:24).

Understanding the child's development and making good use of that understanding in exercising judgements and making decisions, clearly requires good relationship skills.

Developing good relationships and exercising judgements about child development require the kind of 'containing' practice conditions that encourage practitioners to be both thoughtful and confident (Ruch 2006). Practitioners need regular and challenging supervision, opportunities to enhance and extend their knowledge of child development and the time and opportunity to reflect on what they see and what they know. They also need the time and confidence to check out what they see and know with colleagues from other agencies. Fortunately, these practice conditions chime well with what is being recommended by the Social Work Reform Board and the tenor of the two early reports from the Munro Review (Munro 2010, 2011), but they are not cost neutral.

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