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# Research review:

## Child care proceedings under the Children Act 1989

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# Research Review:
# Child care proceedings under the Children Act 1989

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The Research Unit, Department for Constitutional Affairs, was formed in April 1996. Its aim is to develop and focus the use of research so that it informs the various stages of policy-making and the implementation and evaluation of policy.

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## Disclaimer

The views expressed are those of the author and are not necessarily shared by the Department for Constitutional Affairs.

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# Executive Summary

## Background to the research review

This research review was commissioned by the Child Care Proceedings Review Team, Department for Constitutional Affairs. It was commissioned initially as a briefing paper for the team to provide an evidence-based background to the work of the team in reviewing care proceedings, and to provide some information on the process and the nature of applications for care orders.

It focuses on care proceedings under s.31 of the Children Act 1989 concerning allegations of ill-treatment of children by parents/carers. The research review covers larger scale empirical research on care proceedings, primarily but not entirely commissioned by government in the fourteen years following implementation of the Children Act.

The subject areas and the questions posed under each of five headings were discussed and refined with the review team. They were based on the information likely to be available from existing studies in so far as these address the issues and questions which would have to be addressed by the review team in building a case for change.

The subject headings were: the profile of children and parents likely to be involved in proceedings, the use of expert evidence in cases, the views and experiences of children and parents involved in proceedings, final orders, care plans and the placement of children, and adherence by local authorities to final care plans once proceedings were concluded.

## Research on care proceedings

This is a highly complex and under-researched area. What is striking about academic research on care proceedings in the fourteen years following the Children Act 1989 is first, the small number of studies on proceedings and second, the fact that most major work in this field was not in fact funded by the Department for Constitutional Affairs, but rather by the Department of Health.[1]

The strength of academic research is that with notable exceptions, it has been based on random samples of cases, it has used a variety of research methods drawing on evidence in court records, court hearings and in-depth interviews with judges, lawyers, children's guardians, and clinicians - but to a much lesser extent, parents and children. Moreover, most research has been published and subject to peer review.

Nevertheless research on care proceedings has been limited by a lack of funding (and thus opportunities to develop longitudinal data), and severely hampered by a failure of courts to collect basic management information. The former limitation precluded very large-scale, multilevel, multilocation studies to support policy development; the latter amongst other things has forced researchers to seek assistance outside of courts to identify relevant samples.

In effect, each study has to 're-invent the wheel'. Certain areas of the country and certain courts remain under-researched, certain issues and certain large scale survey studies require updating, and independent research is required to assess the impact of the Protocol for Judicial Case Management introduced in 2003.[2]

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[1] Prior to the transfer of the policy agenda for Part III of the Children Act to the DfES. Other studies were funded by charities (the Nuffield Foundation and the NSPCC).

[2] This Protocol was introduced in 2003 in an effort to address aspects of delay in care proceedings; it set a guideline of 40 weeks for the completion of cases, and set out six steps (key stages) to the management of cases. While it is seen as a change in approach to case management for all professionals, it is argued that it is

## Key features in the profiles of children and parents subject to proceedings

Research indicates that most cases contain multiple categories of child ill-treatment and multiple allegations of failures of parenting. All applications contained serious allegations of maltreatment; borderline cases are not brought before courts.

Research also identifies that most children and parents are well known to local authorities. Data on the socio-economic circumstances of parents requires updating but data in the mid-1990s demonstrated most parents are struggling on the bottom rung of the ladder - over 80% were on income support at that point (Hunt et al.1999).

With regard to specific concerns/allegations resulting in failures of parenting, research demonstrates most parents are highly vulnerable on several indices. For example, over 40% are likely to have mental health problems, many (20-30%) are likely to have drug/alcohol problems, many lead chaotic lifestyles (about 36%). Many mothers also endure domestic violence (45-50%), many parents (some 61% in the latest study) are unable to control children. Half of all parents are also likely to experience housing problems (Brophy, Jhutti-Johal and Owen 2003; Hunt, Macleod and Thomas 1999; Bates and Brophy 1996).

In addition to the above features, most applications (over 70%) also include allegations regarding the failure of parents to co-operate with welfare and child health professionals (Brophy, Jhutti-Johal and Owen 2003).

## Building a case for change: key messages from the profile of children and parents

In building a case for any change in this field and in looking at (a) features in the profile of parents and children which would need to be addressed and (b) whether/which features in the profile of children and parents may be significant variables, two issues are relevant from research to date:

- First, there are multiple vulnerability factors in the profile of almost all parents and children.
- Second, the need to explore current and prospective harm, and in many cases a need for a dual diagnosis indicates case complexity and also the need for clinical input. Clinical skills and opinion evidence are likely to be required, for example, to address the aetiology of a child's problems/difficulties/injuries and to arrive at a prognosis about future harm, children's needs and parental capacity for change.

Those factors are likely to make attempts at 'case profiling' a difficult exercise – at least in so far as this is concerned to identify different types of cases/predictive model. To produce meaningful information[3] will require a large highly detailed sample to enable some multilevel modelling techniques to be tried.

Even then, given existing data it seems likely the outcome in terms of providing variables associated with/predictive of a case 'type' is likely to be problematic. This is in part because of the difficulties of predicting non-legal social and emotional responses of parents and

not in practice a fresh start as such but rather a collation and distillation of best practice. The Protocol contains standard forms (e.g. standard directions form, case management questionnaire and checklist, and pre-hearing review checklist), standard documents, a code of guidance for experts and social services assessment and care planning aide-memoire (DCA 2003 Protocol for Judicial Case Management in Public Law Children Act Cases).

[3] Beyond some obvious statements which might be drawn from existing cases/data.

indeed children/young people but also because of variability in the quality and timing of assessments aimed at achieving change in parenting practices.

It *may* be possible to look at discrete parts of the process in terms of a cost per stage basis using a retrospective study of court records – albeit that is likely to be costly and labour intensive and much would depend on the quality and detail available about costs from a range of records.

### Use of experts

Research indicates the vast majority of cases will include some expert evidence.

While there may well be some regional variations regarding *certain* types of evidence, distinct features within the categories of child ill-treatment and in the psychological, developmental and emotional profiles of children and parents indicate many cases are likely to require knowledge, skills and diagnostic and prognostic expertise beyond those of social workers.

Available research evidence does not indicate a huge rise in the use of experts over a ten year period,[4] for example Bates and Brophy (1996) indicated 80% of cases involved some expert evidence, Hunt et al. (1999) indicated 87% of cases involved experts and Brophy et al. (2003) indicate 89% of cases. In other words, despite substantial concerns and 'received wisdom' in this field, available research indicates comparatively little variation over time. Some follow-up studies in the early study regions are required.

Research identifies that as the applicant for the order, the local authority has been responsible for most expert evidence filed. For example, in the national survey of cases involving expert evidence (Brophy, Wale and Bates 1999) local authorities filed expert evidence in 76% of cases (compared with 52% of cases by guardians and 27% of case by parents). The vast majority of this evidence was commissioned during court proceedings. The degree to which that national pattern has been influenced by any increases in joint instructions and changes to the funding of experts who are jointly instructed requires further work.[5]

The key clinical reports commissioned remain: paediatric (filed in about 35% of cases); child and adolescent/family psychiatric (combining all types, filed in over 60% of cases); psychological (based on parents 24% of cases; based on children only, 14%); and psychiatric reports based on adults only (about 35% of cases). Cases also contain family centre assessments commissioned during proceedings (about 34% of cases).

Despite 'received wisdom', research indicated more than one opinion on the same issue is not the 'norm' – even when concerns about this issue were arguably at their highest (in the mid-1990s) less than 30% of cases contained a *potential* for such evidence. Moreover, parents do not routinely obtain a second opinion of expert evidence commissioned by the local authority; and second opinion evidence can play a vital role in certain complex cases.

### Patterns in the use of experts and types of cases: key messages from research on the use of experts

While recent studies have not detailed the use of joint letters of instructions to experts, there is case law and guidance to courts and parties about the need to use joint instructions

[4] And bearing in mind for example, samples contain cases that, prior to the Children Act, would have been Wardship proceedings where considerable use was made of expert evidence.

[5] In the national survey some 6% of cases contained an element of joint instructions to an expert. Since that study, practice directions and case law have emphasised the need to use joint instructions wherever possible.

wherever possible. It is likely therefore that there are now more jointly instructed experts than was the case in the earlier studies where use was marginal (i.e. less than 10% cases).

However research evidence (Brophy, Wale and Bates 1999) and recent case law also demonstrate that, on occasion, developments in a case and certain types of child ill-treatment/injury require a highly specialist clinical assessment where a second opinion is necessary and indeed helpful to the court.

Some broad trends are indicated for different categories of child maltreatment and profiles of parents.[6] Equally there is a broad logic in the sequence in which evidence is usually acquired. Evidence indicates the key clinicians instructed have remained broadly the same since the mid-1990s.

With regard to contribution of experts, the work of paediatricians is varied and detailed in the research review; it includes, but is not limited to, physical injury and neglect of children.

The important point about the work of child and family psychiatrists and some psychologists, is that it is not generally limited to assessing current harm. Rather the approach is holistic and contributions form a 'package'. This includes current and future risk but also potential for change and likely timescales and whether a parent might benefit from parenting skills work. Clinicians also address children's placement, contact and treatment needs.

Choice in the selection of experts is linked to issues of availability and quality. The availability of sufficiently trained and experienced psychologists and child psychiatrists for child protection proceedings remains a problem (Brophy Wale and Bates 1999), as does the question of whether this work should be provided within/outside of mainstream NHS work. Equally, work to date indicates that single and multidisciplinary training is necessary for clinicians wishing to act as expert witnesses in the child protection arena (Brophy et al. 2001).

### The views of parents and children on attending care courts

Research on parents' views about care proceedings are very few in number; those 'contextualised' with a legal framework and against control data (i.e. evidence in court files), are even fewer.

Studies indicate there are lessons to be drawn from parents' experiences of proceedings but care is necessary regarding the weight to be attached to certain views. This is not an argument about the validity of views per se, rather a need to place certain findings[7] within a robust framework.

This is complex work; even in the more robust studies where attempts were made to obtain a random sample, researchers nevertheless identify problems of representation and caution against generalisation from findings.

Bearing in mind those caveats, most parents indicated most judges are good with parents. Satisfaction levels are likely to be highest where judges engage directly with parents (speaking and listening to them, displaying understanding and an interest in children and taking time to explain issues and decisions) and lowest where they are ignored in court

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[6] For example, paediatric evidence is unlikely to be the only expert evidence in cases; cases involving a parent with mental health, emotional, or behavioural problems will normally contain psychiatric/ psychological evidence. Cases involving a child/parent with a learning disability and parents with drug/alcohol problems are likely to require a clinical input.

[7] For example, some of those relating to denial of any maltreatment.

(Freeman and Hunt 1998; Brophy et al. 2005). While parents tended not to differentiate between courts, parents' solicitors argued that on the whole judges tended to be better with parents than magistrates but that could depend on the particular judge/magistrate (Brophy, Jhutti-Johal and McDonald 2005).

Some parents felt their solicitors tried hard to prepare them for court but it remained a frightening experience. Parents also wanted a reduction in outdated jargon and lengthy statements and needed written information about proceedings in terms they could understand.

Some parents also wanted an increase in judges and improved listings to reduce waiting times; some wanted to be able to speak to the judge, and to sit next to their lawyer in court. Parents associate family courts with crime; a view not helped where family and criminal courts share the same premises.

In the absence of ethnic monitoring by courts research evidence from minority ethnic parents is limited to very small samples but indications are parents wanted judges to demonstrate that they do understand different backgrounds. Some parents also wanted more judges and magistrates from minority ethnic backgrounds (Brophy et al. 2005).

Research based on children's views about care proceedings is in its infancy, and with notable exceptions, is also limited to relatively small samples.

Available research indicates several dimensions to children's views about care proceedings. These influence the degree to which children wished to see and speak with judges, or to be present in hearings and read documents. There are also different types of hearings to consider, different time frames in which to consider a young person's attendance and different safeguards depending on the child and the type of case.

### Parents and children in proceedings: some key messages

Indications are that courts need to be flexible where children and young people are concerned, but willing to speak with them. Indications are that views are inextricably linked to the participatory rights of children. This means rights to be consulted, and to party status and thus rights to welfare and legal representation. Young people require transparency in the decision-making process in which adults engage on their behalf; they also require respect for their privacy at time of high stress and vulnerability.

For parents, while many courts appear to be doing reasonably well, there are some causes for concern. An extension of contemporary approaches to 'judgecraft' would help parents feel an equal partner in court as would some attention to language, length of documents and room layout.

### Approaches to problem solving: specialist alternative dispute resolution and contemporary care proceedings

One pilot study attempted to assess specialist ADR in child protection cases. Based on a critique of care proceedings as adversarial, researchers aimed to demonstrate that a *specialist* mediation team could reduce the need for proceedings and contested hearings, was quicker, could alleviate conflicts for social workers and improve co-operation between parties (King et al. 1998).

In practice, despite immense work the study was unable to meet any objectives. It received 36 referrals over a three-year period, 12 reached a specialist mediation session. Amongst other things, the poor response rate illustrated some of the intractable issues in the child

protection arena, for example lack of co-operation of many parents in the absence of legal proceedings, the need to provide and *maintain* a place of safety for children while assessments are undertaken, establishing parents understand and engage in the process.

Research on care proceedings under the Children Act highlighted several improvements for children and parents. These included the movement from oral to written evidence, the requirement that all expert evidence is filed, that letters of instruction if not jointly written, should be circulated to all parties for comment, and filed with the court. In other words, substantial improvements in openness and transparency so that parents are able to engage in proceedings on equal terms with other parties and the applicant in particular (Brophy and Bates 1998).

In addition, the introduction of directions hearings[8] provided a mechanism through which courts could control the evidential process, the use of experts, the examination of children and ensure that cases are timetabled. Research also demonstrates most cases do not result in a fully contested final hearing; most reach agreement on the threshold criteria by the pre-trial review.

Thus it is inaccurate to describe care proceedings as simply 'adversarial'; they are a 'hybrid' increasingly incorporating many inquisitorial features. Subsequent Practice Directions, Guidance and Protocols attempt to take proceedings yet further away from that model while retaining the option for rigorous testing of evidence if that becomes necessary.

Research demonstrates proceedings are dynamic: they provide a protected, managed space in which assessments can be undertaken and where parties can attempt to work towards a solution. In that process all parties, including the local authority, are made accountable to courts for actions and decisions.

Within that protected framework change is achieved for some children: research indicates about 30% of applications for care orders may change during the course of proceedings (Bates and Brophy 1996; Hunt et al. 1999; Brophy et al. 1999; Brophy et al. 2003; Masson et al. 2004).

## Specialist ADR and contemporary care proceedings – some key messages

Research does not suggest that court proceedings are without fault, on the contrary. Equally, despite the failures of the project, important lessons can be drawn from attempts at specialist ADR. Together studies indicate the importance of addressing what the court process offers parties, what it secures for children, and what features – clinical, legal and welfare - need to be addressed in an endeavour to divert some cases away from the legal arena.

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[8] Directions appointments and hearings (referred to as 'directions hearings') were introduced by the Children Act 1989 and have two main purposes: (a) to maintain the court's control and direction of a particular case and (b) to deal with evidential and procedural issues to ensure the case is ready to be heard at the final hearing. Directions hearings are held at all tiers of the court structure in specified proceedings; they are thus used to prepare cases and decide any assessments required and are a means by which courts aim to avoid delay in cases, thus the court draws up a timetable for the case with a view to disposing of the application without delay; and gives directions as it considers appropriate for the purposes of ensuring so far as is reasonably practical that the timetable is adhered to s.32 (1) CA 1989. Rules of court may specify periods within which specified steps must be taken in relation to such proceedings, they also require the child's guardian to advise the court on a range of issues including the most appropriate forum for the case and the timing of proceedings. Directions hearings take place before a district judge in the county court and High Court and before a legal adviser (previously called a justices' clerk) in the magistrates' family proceedings court. In certain circumstances, for example, if a decision of the court is required on a contested issue, directions hearings are heard by magistrates or (with the exception of the PRFD) a county or High Court judge.

The system relies on a set of interrelated duties and obligations in Parts III and IV of the Children Act, and on child and adult mental health services external to the family justice system. The legal framework allowing the State to remove children from parents incorporates a high threshold of harm and an evidence-based procedure. This is located within rights-based domestic and international legislation.

Given that framework, nevertheless, a series of linked options might be tried. Under Part III of the Children Act, an early opportunity for social workers to consult with clinical experts in Child and Family Mental Health Services (CAMHS) to assist directly in analysis and planning of work. Also, a meeting with parents to explain and document in *simple, brief and straightforward terms* what the issues are, what parents need to achieve and the timescale, along with support services to be provided, with the clear objective of diverting cases from legal proceedings.

Where statutory intervention remains necessary as part of a 'next steps' it may be worth revisiting the idea of piloting an early and discrete hearing before a judge[9] to determine immediate safety issues, assessments and services necessary.

To be effective however, the judge would need time to read *summary* materials and if appropriate (and if parents wish) to consider hearing directly from parents. In both instances (at the meeting with parents and an early hearing before a judge) to be *effective* and Human Rights compliant, children require welfare and legal representation and parents require legal representation.

The range of orders available to courts could remain unchanged, assessments could be directed, and the welfare of the child would remain paramount. The Protocol for Judicial Case Management in Public Law Cases offers a framework for developing these options.

### Implementation of final care plans for children

Results from two follow-up studies indicated that most *final* placement plans were pursued by local authorities. In one study 70% of 'first plan' placements were still ongoing at the end of a research period (Hunt & Macleod 1999), in the other study 60% of children were living in the placement specified in the final plan (Harwin, Owen, Locke and Forrester 1999).

With regard to *changes* to plans the picture is complex and caution is necessary because of small numbers in placement categories.[10] 'Breakdown' rates varied by type of placement. For example, in one study for cases where plans were *not* pursued, 60% of long-term placement plans were terminated, as were 35% of plans for placement with a parent and 35% of plans for placement with a family member (Hunt and Macleod 1999).

Where plans required a *move,* for example, 57% of new placements were made by six months but 22% took 12 months. Where the plan was adoption, 50% of placements were made by six months but 35% took over eight months (Hunt and Macleod 1999).

The studies detailed the problems encountered by local authorities demonstrating how child profiles (their age, large sibling groups, high rates of emotional disturbance and educational needs) and a lack of suitable adopters impacted on success rates for placement plans.

[9] This option was first posited as a possibility during the latter part of the 1990s following completion of the large-scale studies funded by the Department of Health (Brophy et al. 1999; Hunt et al. 1999).
[10] The options are: kinship care, long-term foster care, placement with parent(s) and adoption.

### Implementation of final care plans – some key messages

Overall findings were more positive than anticipated. A minority of children were not in permanent placements, some changes occurred, but only in about 15% of cases was placement uncertain/unachieved, and most children were in a settled placement within 12 months of the final hearing.

The planning process for 'looked-after' children will, however, change following implementation of the Adoption and Children Act 2002. The introduction of an Independent Reviewing Officer is intended to address drift or failure to implement plans by local authorities.

# Introduction – Framework for the research review

## Policy background

This review of major research on care proceedings was undertaken to inform a review of public law Children Act cases being carried out by the Department for Constitutional Affairs. The overall aim of the review of public law Children Act cases was to 'improve cross-government delivery of the core principles of the Children Act 1989,[11] and in line with the vision for children set out in the Green Paper – Every Child Matters'.[12] This research review began life as a briefing paper to provide an evidence-based background to the work of the review team in the Consumer Strategy Directorate at the Department for Constitutional Affairs.

In view of the limited time frame and resources available for the research review and to enable the research review to provide an ongoing input into the work of the public law review team, it was decided for the most part to concentrate on the major larger scale studies of care proceedings mostly (but not entirely) commissioned by central government.

The specific areas reviewed (subsequently Chapters one to five herein)[13] and the questions addressed in each section were discussed and refined with the review team in the context of what was broadly known about the issues addressed in publicly funded studies and the type and range of information provided, and the information required to inform the wider work of the public law review team. Each section of the research review was therefore written and submitted as a free-standing document although as demonstrated in this final report, the themes and questions are inextricably linked.

In terms of relevant research, the review has a specific focus; it is for the most part limited to major *empirical studies* which have concentrated on collecting primary data on care proceedings and the work of courts, for example, through the direct examination of care applications and evidence in court files, observations of hearings, and interviews with judges, magistrates, children's guardians, expert witnesses, and children and parents about the operation of care proceedings under the Children Act 1989.

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[11] These are: the interests of the child are paramount; delay in determining the questions of a child's upbringing is likely to prejudice the welfare of the child; and non intervention in cases except where it can be demonstrated that a court order would be better for a child than no order (s.1 (1), (2) and (5) of the Children Act 1989.

[12] *Every Child Matters (2003:6)* states every child should benefit from being healthy, staying safe, enjoying and achieving, making a positive contribution and experience well-being.

[13] In practice, there were six sections to the research review, one of which focused on case duration and was limited to a series of meetings with the review team to discuss available research on case duration and the factors associated with increased duration.

It is *not* a systematic literature review of everything that has been written about care proceedings; it does not include tracking/comment on the development of case law nor does it include commentary or secondary analysis of judicial statistics,[14] or the reports based on HM Inspections of CAFCASS or review visits to courts,[15] or more recent statistics from the DfES on 'looked-after' children.[16]

Equally it does not address research on the work of local authorities prior to proceedings under Part III of the Act[17] or indeed studies which take a sample at some point post-proceedings and explore issues such as short and long term foster care,[18] adoption,[19] or placement issues for specific categories of children (e.g. sexually abused children,[20]children with learning difficulties, or kinship care etc.).

Rather, it reflects that part of the agenda of the public law review team concerned with court proceedings and the need for an overview of independent empirical studies of proceedings along with an explanation of the type and nature of cases of child maltreatment which come before courts under s.31 of the Children Act 1989.

Other sections of the review concerned with specialist alternative dispute resolution (S-ADR) and the views of parents and children have taken a wider brief in terms of a literature review (i.e. they are not largely limited to larger scale government funded studies). But again the remit was limited to identifying work that focuses on child protection cases resulting in care proceedings. Thus, the research review does not include work on (non specialist) ADR in the context of private law proceedings, or its use in other jurisdictions (and does not for example look at the system of Children's Hearings in Scotland).

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[14] For example, the work and commentary of Beckett (2001a) *Children who wait for the courts: Legal delay in care proceedings*, British Journal of Social Work, 31, pp 317-323; Beckett C (2001b) *The Great Care Proceedings Explosion*, British Journal of Social Work, 31, pp 493-501.

[15] HM Inspectorate of Court Administration (2005) *Safeguarding children in family proceedings*. London HMICA.

[16] Pertaining to Social services Performance Assessments Framework Indicators, the Children in Need survey results, or Children 'Look-After' by Local Authorities – year ending data (and see for example Statham, Candappa, Simon and Owen (2002) Trends in Care. London: Institute of Education).

[17] The extensive research studies relating to Part III of the Children Act funded by the Department of Health are reviewed by Aldgate and Statham (2001) *The Children Act Now: Messages from Research.* London: The Stationery Office.

[18] Such as those on foster care reviewed by Sinclair (2005) *Fostering Now: Messages from Research*. London: Jessica Kingsley.

[19] For example, the work of Selwyn and Quinton (2005**)** Stability, Permanence and Outcomes: *Foster Care and Adoption compared*, in Adoption and Fostering Vol 28 no 4 pp 6-15.

[20] For example, in the work of Elgar and Head (1997) *From court process to care plan*: *An Empirical study of the placement of sexually abused children*. Oxford: Wolfson College; Farmer and Pollock (1998) *Sexually Abused and Sexually Abusing Children in Substitute Care*. Chichester: Wiley.

With regard to the focus on parents and children (see below), a wider literature search[21] revealed a number of articles which included the search terms 'courts', 'care proceedings' and 'child protection' in titles or article abstracts. In practice, however, very few articles were based on empirical studies; even those which mentioned child protection and the courts in their title (e.g. Booth 2001; 2004; Corby, Miller and Young 1996) in fact contained little or no empirical data on the work of courts as such.

Most articles referring to parents and children and child protection, legal or court proceedings are in fact about private law proceedings, or investigations under Part III of the Act, or are focused on issues relating to 'looked-after' children (e.g. children and/or parent's involvement in decision-making and the review process). As Chapter three below illustrates there is little research that specifically focuses on obtaining the views of parents, or indeed children who have been involved in care proceedings following allegations of child ill-treatment.

## Structure of the research review and the questions addressed

### *Chapter 1 – profiles of children and parents*

Chapter 1 outlines research evidence with regard to the profiles of children and parents subject to care proceedings. With regard to children it sets out the familial and maltreatment profile of children (including information of the history of child protection concerns for the subject children, the allegations, the age and number of children in cases). It also includes research on the location of children at the start of proceedings and the use of emergency powers.

With regard to parents/carers routinely involved in proceedings, Chapter one sets out the nature and range of allegations contributing to failures of parenting and child ill-treatment, the marital status and living arrangements of parents, legal representation, family size (including the likelihood of the involvement of extended family members in proceedings), along with available evidence on socio-economic and ethnic group status and levels of parental participation in proceedings.

It highlights key findings on the profile of children and parents subject to care proceedings and identifies those features, which would need to be addressed in making a case for change in this field.

[21] Databases: Web of Science, (formally BIDDS) and Google Scholar; Law and Social Science e-journals: the years set for the search for this section of the review were January 1995 to August 2005.

***Chapter 2 – the use of experts in care proceedings***

Chapter 2 focuses on research evidence on the use of experts in proceedings. It addresses the number of cases likely to involve experts, whether it is possible to distinguish the types of cases typically involving experts, the types and sequence of expert evidence filed, the contributions and 'added value' of clinical expertise. In addition, Chapter 2 also reviews available evidence on single and joint letters of instruction and second opinion evidence, and information on the choice and availability of experts for care proceedings.

Chapter 2 presents key findings from research in the use of experts in proceedings; it demonstrates the four key clinical disciplines involved in court proceedings outlining some of the main areas of information required by courts and on which social work evidence alone is unlikely to be sufficient.

***Chapter 3 – the views and experiences of children and parents in care proceedings***

Chapter 3 looks at research on the views and experiences of children and parents in proceedings. It explores research evidence on whether children and parents have different views and experiences depending on which court they attended, whether they experienced different styles or approaches to them in court from judges and magistrates, and if so what approaches were perceived as most helpful/productive.

Chapter 3 highlights those features of court proceedings which parents and children found helpful and those areas where they would like to see some improvements.

***Chapter 4 – specialist alternative dispute resolution and care proceedings as a dynamic process***

Chapter 4 explores research that attempted to assess a specialist alternative form of dispute resolution (S-ADR) in cases where there are serious child protection concerns. It explores stated outcome measures that aimed to evaluate the model looking at a range of stated outcome measures, including user satisfaction. It also explores the types of problems/families seen as appropriate for S-ADR, optimal time frames posed for the process, and the safeguards for children during the process.

Chapter 4 also explores research on care proceedings. It examines whether proceedings are accurately described as 'adversarial' and demonstrates that in fact they are not. While research highlights some of the weaknesses in the system, it also demonstrates some of its strengths. In particular it demonstrates litigation and negotiation are not necessarily different processes, that the current system is a 'hybrid', and one of its strengths is that it provides a

protected space in which the safety of children is paramount and guaranteed while the court controls the evidence gathering process, makes parties accountable for their actions and focuses the process on developmental problem-solving.

Chapter 4 demonstrates the difficulties encountered by S-ADR, the strengths and weakness of care proceedings and the features which would need to be addressed and retained in any attempt at changes to procedure and practice in this field – bearing in mind the rights of parents and the protection and rights of children within both domestic and ECHR legislation.

***Chapter 5 - care planning and outcomes for children***

Chapter 5 explores research on care planning for children during proceedings. It looks at research evidence on interim and final care plans and placement of children. In addition it explores follow-up research on a court sample where the aim is to assess whether local authorities generally stick to the care plan filed with the court, and where this does not happen, the reasons underlying any changes. This Chapter also highlights some of the changes to this field of practice resulting from the implementation of the Adoption and Children Act 2002.

Chapter 5 also highlights that while most children are likely to be placed away from birth parents following care proceedings, care proceedings are able to achieve some change for a significant number of children.

# Chapter 1 – The profiles of children and parents subject to care proceedings

## 1.1 The children - types and patterns of child ill-treatment

Available research demonstrates that cases containing allegations based on a single category of child ill-treatment remain relatively rare; a majority of cases are likely to contain at least two types of maltreatment, many contain three from the categories: physical ill-treatment, sexual abuse, emotional ill-treatment, neglect and ‘child beyond parental control’ (e.g. Hunt et al. 1999; Bates and Brophy 1996; Brophy et al. 2003).

Neglect coupled with emotional maltreatment is the commonest form of harm to children in contemporary samples.

Most cases that contained allegations of physical ill-treatment and sexual abuse also contain allegations of emotional ill-treatment.

Some studies indicate continuing relatively high levels of physical maltreatment of children. In the early years following implementation of the Children Act 1989 physical maltreatment (coupled with neglect) was the most prominent combination of maltreatments (e.g. Hunt et al. 1999).

Thus, so far as allegations of child maltreatment are concerned almost all applications for care orders are likely to be complex containing two or more categories of maltreatment.

Indications are that cases that demonstrate an exception to this trend are likely to include those where there is evidence of a serious physical injury to a very young child with no previous involvement/concerns about parenting by social services. Further research on ‘new/never known’ families who become subject to care proceedings would be helpful in verifying whether there are other types of ‘single event’ cases and the profile of such cases. However it indicates these are likely to be relatively rare – albeit equally challenging in terms of professional practices.

Available research over a thirteen year period following the introduction of the Children Act 1989 indicates only the most serious cases are brought to court. Researchers did not identify low or borderline cases so far as the threshold of significant harm is concerned.

Research identifies that most families who became the subject of care proceedings had been struggling along the bottom rung of acceptable parenting for some time (see below – history of child protection concerns), with a particular event, decline in parenting or ending of agreements between parents and social workers resulting in proceedings to protect and safeguard children.

There is some indication that *certain* minority ethnic children may be over-represented in cases subject to statutory intervention. This is an ongoing concern that researchers have attempted to address. However without appropriate ethnic monitoring of public law cases and compatible datasets across government departments and in relation to 2001 census categories, categorical answers about which groups appear most vulnerable to statutory intervention and what categories of maltreatment might predominate, cannot be answered.

Indications are that the *number* of likely allegations in cases concerning minority ethnic children remain similar to those for White British children – most cases are likely to contain multiple categories of child maltreatment (Brophy et al. 2005).

However, more further research is necessary on the combinations of different types of maltreatment by ethnic groups and the movement of children along a continuum from those in need, 'at risk' and on child protection registers to those 'looked after' voluntarily and those subject to statutory intervention by disaggregated ethnic groups.

Where researchers have aggregate numbers for minority ethnic groups (because of the difficulties of small numbers) and compared results with those for White British children some differences have been suggested. However the value of this method is questionable. Numbers are relatively small and researchers have demonstrated the shortcomings of this approach in understanding the interplay of diversity and issue of child maltreatment, and the response of the family justice system.

Ethnic monitoring of applications for public law cases will alleviate problems of sample identification; it would enable some of the findings of recent studies (e.g. Hunt et al. 1999; Brophy et al. 2003, 2005) to be tested and developed and to further understand how the child protection system in general and the family justice system in particular can develop to address issues of diversity and child protection.

A limited amount of research (Masson et al. 2004) has focused on the use of emergency measures (emergency protection orders and the use of police powers) - albeit some

applications for care orders are made to coincide with the expiry of emergency protection orders (Brophy et al. 2003).

The circumstances under which these orders are sought are a mixture of events in which an imminent crisis is not necessarily the only factor. Events include the removal of a child at birth; child found home alone/no carer; withdrawal of co-operation by parents of a child already living away from home under a voluntary agreement, a crisis, and non-co-operation by parents with social welfare and health professionals.

### *Numbers of children likely to be involved in cases*

Research indicates that most applications are unlikely to contain more than two children – some 80% of cases concerned no more than two children. This figure has remained constant in available quantitative studies from the first years of implementation to 2003 (Hunt et al.1999; Brophy et al.2003). Cases involving four or more children account for between 3 and 7% of sample cases).

### *Age*

In terms of age bands, children subject to statutory interventions tend to be very young: indications are that between 60 and 63% of children are less than six years of age at the point of application. There is some indication that in certain minority ethnic groups there are few children in the younger age bands (e.g. 46% of children in a stratified sample were under 5 years of age – Brophy et al. 2003) suggesting a slightly different age structure for children likely to be the subject of statutory intervention but this needs further research.

There is some suggestion that certain minority ethnic children may appear more frequently in the higher age bands (over 11 years) but disaggregated the numbers are very small and therefore this issue also requires further work with larger samples.

Qualitative work indicates some similarities in the problems some parents experience with parenting young people regardless of ethnic group but there can be additional factors for some minority parents and teenagers related to issues of ethnicity, race and religion which impact on the picture.

The figures for very young babies likely to become the subject of proceedings indicate between 10 and 14% of children under twelve months were subject to a court application; for those subject to an emergency intervention the figure is higher - some 18% of applications concerned babies under twelve months.

### *Gender*

Most studies with predominantly or overwhelmingly White British samples have found broadly similar numbers of males and females in overall samples.

Where a sample is stratified by ethnic group the *aggregated* figures for Black and South Asian children indicate very similar numbers of males and females for the South Asian group, but more males than females in the Black group (overall a 12% increase in the number of males). Disaggregated, the figures are relatively small and the age of children at application by ethnicity requires much more research (Brophy et al. 2003).

In the mixed group there were many more females than males (63% compared with 38%) while in the white group that situation is reversed: females accounted for 38% of the sample and males 62%.

### *Minority ethnic families*

Work on the issue of diversity in the field of child protection has increased but as indicated above it continues to struggle with sampling problems.

Research on the first two years following implementation of the Children Act (Hunt et al.1999) suggested that when *aggregated,* minority ethnic families presented a less deviant profile on all indicators of social morbidity, presented less frequently with multiple causes for concern or repeated child maltreatment, were less chronically entangled with the child protection system before court action was taken, were more likely to be subject to compulsory intervention and more likely to lose their children to long-term substitute care.

However, even at the time researchers stipulated these ‘findings’ were only indicative, given the size of the sample and the small scale of some of the differences. Equally, it was acknowledged that the research was not designed to address the issue of ethnicity and differences between groups in a direct way. Like many researchers they struggled to say something about issues of diversity within the limitations of a small sample.

Later available large-scale survey data on complex care cases (Brophy et al. 1999) indicated some worrying features about the numbers of some minority ethnic children likely to be subject to statutory intervention.

For example, the national random survey of cases involving experts[22] indicated that, compared to their representation in the general population, Black children were over-represented in the sample (6% compared with 2% in the 1991 census); mixed groups were substantially over-represented (8% compared with 1% in census data); while South Asian children were under-represented (2% compared with 5% in census data). As indicated at the time, much work remained to be done to explain these figures.

Two subsequent studies focused specifically on minority ethnic families in care proceedings in 2003 and 2005. Findings are outlined across the headings for the review but as indicated above (profiles of allegations regarding ill-treatment) such families are in fact likely to present multiple categories of child maltreatment and as indicated below (failures of parenting) they are also likely to exhibit multiple and complex problems in parenting.

However, as indicated above, more sophisticated national data and analyses (for local populations and for stages in care 'careers') are necessary in order to address questions about over- and under-representation of children by ethnic group.

### *History of child protection concerns*

Research in the early years of implementation suggested that about one-third of parents were likely to have been through care proceedings with a previous child, but most parents (two-thirds) had no previous experience of care proceedings (Hunt et al. 1999).

### *Children on the child protection register*

Most cases in care proceedings concerned parents with at least one child on the child protection register; there is some indication that this figure is rising (early work indicated 64% of families had at least one child currently registered, more recent work indicated 73% of children were/had been on the child protection register (Brophy et al. 2003)).[23]

### *Children subject to emergency protection orders (EPOs)*

Research on the use of emergency powers is limited, one study has specifically focused on EPOs (Masson et al. 2004) but available research on care applications suggested a varying picture over time. In the early days of the Act, Hunt et al. (1999) identified about 17% of care

[22] Subsequently seen as likely to demonstrate the vast majority of cases in specified proceedings since a later study based on a random sample of all cases (with and without experts) indicates most will include some expert evidence – see Chapter 2 below (use of experts in public law proceedings).

[23] In the study of emergency protection orders, Masson et al. (2004) indicated that in just under half of all cases the child was registered, and several further families had a child previously registered, making half the families in the study subject to registration at some point.

cases that were subject to an EPO in the period immediately prior to the care application, while later studies identify a little over one-third of care applications coincided with the expiry date of an emergency order (Bates and Brophy 1996; Brophy et al. 2003).

In Brophy et al. (2003) the study was based on a random sample of cases stratified by ethnic groups and there was some indication that the overall figure for EPOs *may* hide variation in the use of emergency powers between ethnic groups and this issue requires further investigation.[24] Disaggregated figures from some minority ethnic groups are small and therefore much caution is necessary but, for example:

- 19% of children in the White British group (9/47 children) were subject to an EPO immediately prior to proceedings;[25]
- 60% of children in the aggregated South Asian group (25/42) were subject to an EPO;
- 68% of Black African children (5/26) were subject to an EPO. [26]

In a further qualitative study of care proceedings limited to a minority ethnic sample, overall most children (77% - 17/22 children) were subject to an emergency protection order prior to care proceedings (Brophy et al. 2005).

In the study of EPOs by Masson et al. (2004), where sampling was limited to EPO applications, most families (90% - 77/86 cases) were subsequently also subject to care proceedings.

Contemporary studies based on random samples in care proceedings which also detail the use of emergency measures are limited in number but available evidence indicates EPOs can and often do act as a precursor to care proceedings.

Moreover, coupled with work that specifically addresses the use of emergency measures, research demonstrates most families (over 70%) are known – some well known[27] – to social

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[24] This is in part because the sample for Bates and Brophy (1996) (which produced similarly high rates) nevertheless was based on a largely White British population.

[25] And this figure is more in line with that found in the early work of Hunt and Macleod (at 17%) - the sample of minority ethnic families in this latter study was small (total number 33) and, except for the mixed group, there were no more than 3 children in each of the disaggregated groups.

[26] The disaggregated numbers become small but 3/15 children of African Caribbean origin experienced an EPO – this, of course, needs further checking with a larger sample but it suggests a 'trend' in the region of some 20%.

[27] For example, the EPO study noted that 36% of families had more than five years involvement; 24% had between 2-5 years and 11% between 1-2 years (9% had less than three months involvement and 7% had between 3-12 months) (Masson et al. 2004).

services prior to the instigation of proceedings and most children are on/will have been on the child protection register.

### *Location of children at start of care proceedings*

Indications are that some children – perhaps as many as 50% - are already living away from their birth parents at the commencement of proceedings (either accommodated by the local authority under a voluntary agreement or subject to an order).

Based on samples in the early and mid-1990s research suggested this figure to be between 44 and 55%.[28] More recent research in 2003 (Brophy et al. 2003) identifies that 50% of children subject to a care application were already living away from their birth parents at the point of application (most were placed with foster carers under voluntary agreements).[29]

In the study of emergency powers, most children were living with a birth parent(s), however 27% were either accommodated, in hospital or living with relatives at the point of the application (Masson et al. 2004).

For most families subject to emergency intervention and for most social workers, the EPO was an incident (albeit a major one) in a continuing relationship that was already likely to be poor. In some cases (46%) social services had intervened through the courts or with the assistance of the police, without prior notice to parents, and in some cases (a further 11%), the police had taken action independently to safeguard children deemed at risk of harm.

### *Courts and transfer*

Many of the cases in the studies were transferred to the higher courts: the range was from 31% to 54%, in most studies at least 40% of cases were transferred – in some studies this figure was well over 50%.[30]

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[28] The former study based on all courts in one large local authority area (Bates and Brophy 1996), the latter covering three local authorities (Hunt et al. 1999).

[29] This study covered some 26 local authorities; it indicates there may be some variation in this issue according to ethnic groups. For example, in the aggregated South Asian group almost all children were already in foster care, most under a voluntary agreement, as were almost all the children of mixed heritage, this compared with under half (45%) of the children in the White British group.

[30] In Bates and Brophy (1996) 31% of cases were transferred; in Brophy et al. (1999) - 53%; in Hunt et al. (1999) - 57%; in Brophy et al. (2003) - 41%, and in Masson et al. (2004) - 54%. The lower rate in the 2003 study in an otherwise sequential rise may in part be explained by the fact that district judges sit in one of the major FPCs included in this study. That court was thus able to hear longer cases than most FPCs. In addition, it is a dedicated family court hearing only family proceedings. Thus, at the time of the study it was arguably one of the most experienced family courts with attendant legal expertise in both district judges and legal advisers.

The major reason for transfer on was 'exceptional gravity, urgency or complexity' – this was the reason cited in over 80% of all transferred cases. Where research included a considerable minority ethnic population this figure rises to 98% of all cases (Brophy et al. 2003),[31] but interestingly falls to 66% in one recent study.[32]

***Final orders***

The picture on final orders in so far as *initial* applications for care orders resulted in care orders, is slightly complicated because of different sampling procedures and different methods of presenting results in studies.

Some studies have taken most/all 'specified proceedings'[33], others have simply been selected on the basis of a care application (albeit such cases may also include other types of applications which fall within 'specified proceedings' and which may become care applications during proceedings).

Focusing on c*hildren* in cases where applications started or very quickly became care applications indicates are most resulted in a care *order* but substantial changes to applications (from a request for a care order to something else) were achieved in 25 - 39% of cases:

- In Bates & Brophy (1999) applications for 80 children began or became care applications,[34] care orders were made in relation to 60 children, indicating some change occurred in 25% of applications. Nevertheless, in this study 75% of applications for care orders resulted in a care order being made.
- Comparable data from Hunt et al. (1999) is slightly more difficult because of the presentation of applications and outcomes but findings indicate 51/83 index children were subject to a care order. This indicates some 61% of applications resulted in a care order. Thus, there was much more change during proceedings in this study than later studies.[35]
- The national survey data (Brophy et al. 1999) was much larger in terms of sample size (557 cases, 963 children) but a more complex data set in terms of the types of cases/applications included. However most applications in this sample were for single orders (92%) and most of these (79%) were for care orders. In 48% of cases

[31] And this study includes cases initiated in the specialist family proceedings court detailed in note 30 above.
[32] This study (Masson et al. 2004) was based on EPOs but it contains some data on cases that continued to care proceedings.
[33] For example, including applications in relation to care and supervision orders, discharge/variation of a care/supervision order, extension of a supervision order, contact with a child or permission to refuse contact, a residence order for a child in care but excluding applications dealing with an ICO after a s.31 direction, child assessment orders, secure accommodation orders, change of name of application for a child to be taken out of the country.
[34] That is, combining cases which started with EPO (22 children) and where the timing of a care application was instigated to coincide with the expiry of the EPO, and those cases which started life as applications for an EPO (58 children).
[35] Some 17 cases were ultimately withdrawn, 14 were subject to a supervision order and 18 were not subject to a public law order.

care orders were ultimately made. This accounted for 225/557 cases (41% of total sample cases) and 60% of the children (578/963 children).

- In other words, in the survey sample, excluding cases involving other types of applications (21%), approximately 771 children were subject to a care application, care orders were made in 578 cases, indicating about 75% of cases which started life as care applications, resulted in a care order.
- In the subsequent 2003 study (Brophy et al. 2003), 92% of cases (172/182 children) contained an application for a care order at the start of proceedings: care orders were made regarding 115 children indicating 67% of cases resulted in a care order. This indicates some changes were achieved in about 30% of cases.[36]
- In the 2004 study (Masson et al. 2004) for those EPO orders that were followed by care proceedings (77/87 cases), 62% resulted in care orders; 37% of cases resulted in other orders or no order.
- In the qualitative study of 2005 (Brophy et al. 2005), which was limited to minority ethnic families, although small in terms of numbers, in half the target cases (5/10 cases, six children) some change to the original application was achieved during proceedings.

In summary, where no changes are achieved during proceedings, most applications for a care order resulted in a care order. However, for a significant proportion of children (about 30%) some change was achieved during proceedings allowing them to return to/remain with a parent (albeit usually under a supervision order) or to be placed with an extended family member (also under a supervision or a section 8 order). Equally, children may be placed with a parent under a care place.

Placement plans for children in these studies will be outlined in Chapter 5 below – see implementation of care plans for children subject to care orders.

## 1.2 Parents - a profile

Research evidence confirms that the majority of cases concerning child maltreatment are likely to contain several concerns/allegations about parenting attitudes/behaviours contributing to failures of parents; three studies have provided highly detailed information on the nature of local authority allegations in proceedings and several themes are recurrent.

***Relations and concerns leading to failures of parenting***

Refusal to co-operate with agencies - perhaps not surprisingly at the point of statutory intervention, most cases included concerns/allegations about a parent's refusal to co-operate with public agencies - mostly the local authority but also health professionals

[36] Applications for seven children did not start as care applications but for two children these became care applications during proceedings; most changes to applications however were from a care to supervision order (some 30 children); applications in relation to 28 children were ultimately withdrawn.

wishing to gain access to children at home or to retain children in hospital. Refusal to co-operate was cited in:

- 62% of cases in Bates and Brophy (1996)
- 73% of cases in Brophy et al. (2003).

Mental health - concerns about parents subject to allegations of maltreatment of their children cover a wide range of conditions from depressive and personality disorders to severe psychiatric disorders including schizophrenia and related disorders characterised by psychotic symptoms such as delusions and hallucinations, within these conditions there is a spectrum of severity. Concerns/allegations about the impact of mental illness on a parent occurred in many cases (frequently coupled with a parent's refusal to accept professional help/support for this):[37]

- 62% of cases in Bates and Brophy (1999)
- 48% of cases in Hunt et al. (1999)
- 43% of cases in Brophy et al. (2003).[38]

Substance abuse - allegations regarding the impact on parenting capacity resulting from substance abuse also featured in a number of cases:

- 31% of cases included alcohol abuse in Bates and Brophy (1999)
- 10% also included drugs in Bates and Brophy (1999)
- 20% of cases included drugs and alcohol in Hunt et al. (1999)
- 23% of cases included allegations of drugs in Brophy et al. (2003)
- 20% of cases also included alcohol abuse in Brophy et al. (2003).

Domestic violence - allegations by the local authority concerning 'domestic violence' also featured in many cases:

- 21% of cases in Bates and Brophy (1996)
- 51% of cases in Hunt et al. (1999)
- 45% of cases in Brophy et al. 2003 (and highest in the White British group at 65% of all cases).[39]

Chaotic lifestyles - occurred in 36% of cases in Brophy et al. 2003 (such lifestyles were frequently associated with involvement in drugs).

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[37] Masson et al. (2004) also point to this issue as a contributory factor in cases which progressed from EPOs to care proceedings.
[38] And in over half of these cases (26%) a parent had refused professional help; for many parents at the severe end of the mental illness continuum this frequently meant failing to take anti-psychotic drugs.
[39] In Brophy et al. (2003) the data differentiated between male violence in households, and violence from other family members, the figure above relates to male violence.

Crime - a parent's involvement in serious crime featured in:

- 61% of cases in Hunt et al. (1999)[40]
- 20% of cases in Brophy et al. (2003).

***Parent unable to cope with/control a child***

61% of cases in the study by Brophy et al. 2003 *included* concern/allegations that a parent was unable or unwilling to cope with or control a child.

Findings concur across those studies which have analysed in detail the primary evidence underscoring applications for orders: what united the vast majority of cases within and across studies is the number and complexity of allegations; most cases contained multiple concerns and allegations contributing to a failure of parenting, and multiple categories of child maltreatment.

*Parents who are subject to proceedings*

Studies demonstrate that parents who are subject to proceedings based on allegations of child maltreatment are likely to be poor; many live deprived and troubled lives in complex and dislocated circumstances.

As the preceding section on the profile of children demonstrates, parents are mostly well known to social services, many children are already on the child protection registers, some parents will already have a child in care; many children subject to care proceedings were already living away from birth parents.

Hunt et al. (1999) also demonstrated:

- 84% of parents were dependent on income support
- 61% of cases contained a parent who was abused as a child
- 58% of children were not full siblings of an 'index' child'[41]
- 25% of cases parents cared for a child with special educational needs
- 22% of parents had a learning disability
- 27% of parents had a physical disability.

[40] The number of parents with a criminal record was high in this study (and the authors argued allegations tended to be more serious compared with a pre-Children Act sample), offences covered malicious wounding, grievous bodily harm, burglary, robbery, drug dealing, and single examples of arson, rape, blackmail and kidnapping (Hunt et al. 1999).

[41] That is, the child/case tracked for the purposes of the study.

Comparisons with other populations of parents are difficult and further work is necessary to update that of Hunt et al. (1999) - not least to evaluate whether subsequent initiatives to alleviate child poverty, improve interagency work in the field of child protection, and additional resources to child and adolescent mental health services has had any effect on the socio-economic profile of parents who come to court.

When Hunt and colleagues compared their sample with families of children on the child protection register (CPR) - a previous stage on the continuum of children 'at risk' of maltreatment:

- 48% of the court sample included concerns/allegations regarding mental illness compared with 13% of those on the CPR[42]
- 51% involved domestic violence compared with 27% on the CPR
- 84% were dependent on income support compared with 53% on the CPR
- 52% were headed by a single parent compared with 36% on the CPR
- One in three parents in the court study had been abused as children compared with one in seven of parents of children on the CPR.

Highly detailed analyses of completed care cases indicate such families are likely to exhibit a greater concentration of problems (and a multiple problem profile) compared to the general population of families entering the child protection system but not reaching the courts.

As the profile of children and most parents indicate, combinations of ill health and socio-economic difficulties coupled with personal vulnerability factors indicate that the vast majority of families subject to statutory interventions are struggling on the lowest rung of the ladder - until an incident or a combination of factors – coupled with a breakdown of co-operation and trust between parents and professionals results in statutory intervention.

### *Parental responsibility*

At the time of the studies all mothers held parental responsibility for their children; the position of fathers depended on marital status or the existence of an agreement or a court order regarding parental responsibility.

In the 1996 study (Bates and Brophy 1996), 25 fathers (covering 43/114 children - 37% of the sample) held automatic parental responsibility by virtue of marriage to the child's mother and thus held automatic party status. Fathers of 71 children (63% of the sample) were not

[42] The researchers made useful comparisons with data from the work of Gibbons J, Conway S and Bell C (1995) *The Operation of the Child Protection Registers*. London: HMSO.

married to the child's mother and did not acquire parental responsibility by a court order or by agreement.[43]

In the 2003 study (Brophy et al. 2003), fathers who held parental responsibility by virtue of marriage to the mother accounted for 26% of children. However, there was some variation by ethnic group, for example, in the Bangladeshi group fathers held parental responsibility by virtue of marriage to the child's mother in almost all cases (94% - 14/15 cases) compared with 15% (7/47 cases) in the White British group.

***Parents living together at the start of proceedings***

Detailed information on the living arrangement for parents is fairly limited, one study (Brophy et al. 2003) addressed this issue and findings indicate whether married or not, most parents (85%) were not living together at the point of the application (and this figure remained high across most ethnic groups).[44]

In Masson et al. (2004), although no comparable data is reported for cases that reached care proceedings, at the point at which an EPO was made the authors note that most parents (57% - 49/86 families) were not living together.[45]

***Legal representation***

Two studies tracked aspects of legal representation in cases (Bates and Brophy 1996 and Brophy et al. 2003) but other studies (Hunt et al. 1999 and Masson et al. 2004) provide some important information.

***Joint/separate legal representation - parents***

In Bates and Brophy 1996 (in 65 cases, 114 children) nine parents were jointly represented and 45 mothers and 24 fathers were separately represented. However, this study did not collect information on statements filed by parents.

In Brophy et al. (2003), (100 cases, 182 children), for just under half of children (48% - 87/182 children) both parents were represented (24% were jointly represented,[46] 24% were separately represented).

[43] S.4 of the Children Act 1989. Four fathers acquired parental responsibility during the course of proceedings and a mother's partner acquired this for two children as a result of a joint residence order with the children's mother – s.12 (2) Children Act (giving him parental responsibility for the duration of the order).
[44] This does not *necessarily* indicate parents are estranged.
[45] In 14% of cases (12/86 families), the father was either deceased or his identity unknown.
[46] In a limited number of cases children in families had different fathers, thus some cases had more than one respondent father.

In Hunt et al. (1999) (83 cases, 133 children) the researchers do not present a comparable breakdown of data but they make the following points:

- Not all 166 parties were separately represented
- 10 parents were jointly represented
- In total 149 adult interests were legally represented, with only 14 cases having more than two interests represented, and two cases with more than three interests (see below – other parties)
- There was also some 'joining' of representation (i.e. parent and a new partner, grandparents and a parent).[47]

In the study by Masson et al. (2004) data was not presented on subsequent care proceedings but with regard to legal representation and indeed the attendance of parents at an EPO application:

- Overall, (that is, in cases heard without notice, on short notice or on notice) in almost half the cases (42/85) only the local authority attended the EPO application
- A parent and lawyer attended 40/85 hearings
- A parent's lawyer alone attended a further 8/85 hearings
- A parent attended without a lawyer in 5/85 cases
- A children's guardian or lawyer attended fewer than half of all EPO applications (46%)
- Half of mothers attended the EPO hearing or were legally represented; two fathers attended.

***Extended family members/other parties in proceedings***

- In Bates and Brophy (1996) grandparents were parties to proceedings in 14% of cases (9/65 cases); other people were involved in 6/65 cases.[48]
- In Brophy et al. (2003), in almost all cases (91% - 165/182 children) parents were the only respondents; few cases contained other respondents such as step-parents, grandparents, aunts, uncles etc.[49]

As indicated above, while the work of Hunt et al. (1999) does not allow for direct comparisons with the two later studies, the authors noted that extended family members

[47] And, for example, cases can contain several adults but they may be linked in terms of interests; Hunt and Macleod (1999:176) give an example of a case with seven adult parties but only three interests represented: the mother and her parents, the father and his parents and the mother's cohabitee – three groups, three lawyers.

[48] These were an aunt and uncle; a half sister; a stepmother; and the other ex-foster parent who had been caring for the children. Another case involved the potential adopters of the child's sibling. A remaining case involved the mother's cohabitant who was thought to be the father of one of the children (genetic testing proved otherwise and his party status was revoked).

[49] And like some of the cases in the Hunt et al. study (see note 50 below) some of these relatives will have been jointly represented with a parent; in total they cover nine cases and 17 children.

were jointly represented - but only 14/83 cases had more than two interests, and 2/83 cases more than three interests.[50]

***Parents' participation in legal proceedings***

Evidence indicates, perhaps not surprisingly, that legal proceedings do galvanise parents and engender co-operation from most mothers and some fathers – not least because most children are removed on the basis of an earlier EPO or an interim care order.

Research demonstrates that a substantial number of mothers (68%) and some 47% of fathers participated in proceedings, filing at least one statement (Brophy, Wale and Bates 1999; Brophy et al. 2003).

## 1.3 Key features in the profile of parents and children that indicate a need for clinical expertise, and would need to be addressed in reviewing existing law and practice and building a case for change

The children subject to care proceedings are usually drawn from the most vulnerable families in the poorest sections of society. Parents experience multiple and multilayered problems with combinations of mental ill health, addiction and socio-economic difficulties, personal misfortunes and some poor personal choices. They are likely to be struggling on the lowest rung of the ladder in general, and with regard to parenting capacities in particular.

Many parents who are accused of ill-treating their children are themselves highly vulnerable adults – albeit often quite dangerous to their children whether by intent, neglect or misfortune or combinations of all three.

Most children are subjected to two or more categories of ill-treatment (physical injury, sexual abuse, neglect, and emotional abuse) resulting from parent actions/inactions.

For example, allegations of physical injuries to children arose in about 38% of cases in Brophy et al. 2003. Injuries to children can range from burns, bruises and soft tissue injuries (hand, fist and finger marks, kicks etc.), to injuries caused by implements and bites, head and abdominal injuries, to bone fractures, contact burn injuries, scald injuries and friction and chemical burns and to subdural haemorrhages in very young babies.

[50] If, for example, all these additional interests were extended to family members that would suggest 19% of cases contained extended family members. However that is likely to be an overestimation since in some families children have different fathers, thus some of the additional respondents will in fact be additional *parents*. It is not possible to estimate the figure from the data presented in the study.

These injuries require assessment and diagnostic skills from a range of paediatric, radiological and other child health specialists. Equally, children and young people who have been sexually abused, neglected and emotionally maltreated may need specialist clinical input.[51]

Some children have special educational needs requiring assessment by an educational psychologist; some children will have additional behavioural problems (e.g. obsessive compulsive disorders) requiring separate assessment from a clinical psychologist. Some children may self-harm as a result of poor/abusive parenting, some parents may self-harm and some may also threaten to harm their children.

Some children may exhibit extreme forms of violent behaviour at home and at school; some children may exhibit over-sexualised behaviour with adults and other children.

Overall, many parents experience problems across several dimensions. A high proportion of mothers will also experience male violence; children will observe/be aware of this and that experience adds to the emotional maltreatment many already experience.

Moreover, over 40% of cases contain concerns/allegations regarding a parent's mental health. These cases may require the input of an adult psychiatrist. Adult psychiatrists will also assess parents with drug and alcohol problems monitoring compliance or commenting on likely compliance with rehabilitation programmes.

[51] For example, in documenting physical injuries experts may address patterns of bruises and marks likely to be made by different instruments (straps, sticks, buckles, hard objects, bite marks etc.), likely injuries from hand marks (e.g. grab marks, hand print and slap marks, pinch and fist marks). Also, experts may estimate the age of bruises, and the implications of the site of bruising on various parts of a child's body is likely to require specialist clinical expertise. Fractures can be serious injuries resulting from extreme forms of violence to children, they may occur in any bone, they may be observable or detectable only on radiography. Particular clinical skills are required in deciding when to do a skeletal survey, in ageing fractures, and taking and interpreting family histories and explanations for such injuries. Specialists are also required for investigating cases of subdural haemorrhage ('shaken baby syndrome') in infants. In addition, in cases of alleged sexual abuse, and where a medical examination is thought possible/appropriate, physical examination requires specialist skills and expertise in the examination and determination of a range of possible injuries (to boys and girls) along with experience in differential diagnosis. In cases of neglect a multidisciplinary approach which includes but is not limited to the expertise of social workers can include a community paediatric working with 'normal' and 'failure to thrive' children. This clinician might work through a range of assessments and diagnostic tools to determine neglect and maltreatment, checking children who are failing to reach developmental milestone against age appropriate criteria. Specialist consultant paediatricians will usually also be involved in cases where a child has multiple problems, for example, a child born with disabilities who also appears to suffer neglect/physical ill treatment and where parents are failing to handle/address a child's ill-health and ensure appropriate medial provision/consistent levels of care.

Over 40% of parents also experience serious problems with discipline and school attendance of children/young people and a higher proportion – some 60% - are unable to cope with and control children.

Many of these children and parents are likely to be assessed by child and adolescent psychiatrists - in part because parents and/or children exhibit emotional and behavioural problems, but also to assess the dynamics of the parent-child relationship in the light of the problems exhibited by parents.

Research demonstrates that levels of harm to children are serious, sometimes life threatening, certainly damaging to children's health, development and welfare. Additionally, some children also have a range of physical, developmental and psychological problems, which are exacerbated by poor/inadequate parenting.

A substantial number of children subject to proceedings are likely to be young - less than six years of age. They are likely to have been 'at risk' in their families and registered for some time. They are likely to have siblings or half-siblings who are/have been registered.

These families represent a small proportion of those families for which local authorities have a responsibility and duty to provide support and services under Part III of the Children Act 1998. They are, however, a group where the partnership model between social services and parents has failed/broken down and where any services provided by social services have failed to result in sustained improvements in parenting.

During proceedings almost all children were subject to an interim order whilst assessments were undertaken (see Chapter two below). Where no changes are achieved in the course of proceedings, most children are likely to be permanently removed from their parents (about 70%). However, some change in parenting or other factors in cases is achieved during the course of proceedings, and in about 30% of cases applications for care orders are changed or to a lesser extent, withdrawn.

Detailed research on local authority concerns and allegations contributing to failures of parenting indicate not simply a need for specialist clinical assessments of parents and children (see Chapter two below) but also for dual diagnoses in certain types of cases (e.g. when addressing adult mental health problems in combination with substance abuse).

Some parents cannot or do not accept responsibility or at least some culpability for ill-treatment of their children, some parents cannot understand/refuse to accept the impact of their actions/inactions on the health, development and well-being of their children. Some parents are resistant in varying degrees to professional intervention; some exhibit limited empathy for children where they are suffering pain, humiliation or distress. Some parents find it hard to sustain improvements in parenting once any family support service is withdrawn.

Once proceedings are initiated some parents nevertheless try very hard and against sometimes overwhelming odds that include serious ill health, poor housing, addiction problems; they often have little personal support and very limited 'internal' resources in the face of multiple and overwhelming problems.

Research demonstrates that the ultimate sanction of removing maltreated children galvanised even the most vulnerable mothers and some fathers into taking seriously the concerns of welfare and health agencies. This includes those parents who score highest with regard to the number of allegations leading to failures of parents and who were responsible or culpable for multiple categories of child maltreatment.

Overall most mothers but fewer fathers participate in proceedings; they seek advice from a solicitor and then do participate in welfare and clinical assessments and also attend court hearings. Research evidence indicates that for highly vulnerable parents with multiple problems the court provides:

- Immediate and effective protection for maltreated children, placing their safety and welfare needs first, while bringing home to parents the serious nature of concerns in a forum that, nevertheless, is independent of the party making the allegations.
- A protected space in which assessments can be undertaken and where serious and time limited considerations can be given to whether parents can change to meet the needs of their children. Courts also control and monitor that process safeguarding children against multiple assessments/examinations.
- A forum in which local authority applicants are accountable for their actions and their plans for children.

In summary therefore, research on the profile of children and parents subject to care proceedings indicates there are some key features in cases which are enduring, and which realistically are unlikely to change – at least without massive increases in resources to child and family health and welfare services.

Many, if not most, cases will continue to require some specialist skills beyond those of social workers because they demand different training, expertise and knowledge (see Chapter two below).

To be successful and find support with key stakeholders it is likely any case for change would need to be able to demonstrate:

- An understanding of the complex multiple problem profile of parents subject to care proceedings and the range of ill-treatments experienced by children/young people
- Knowledge of the profound needs and demands of such families
- An understanding of the benefits currently provided by statutory intervention in cases.

A case for change would need to demonstrate how any proposed changes would provide the same level of protection for maltreated children while at the same time addressing the needs of parents for a fair and just hearing and thus providing opportunities for achieving changes to parenting in a system that is transparent and compliant with Articles 6 and 8 of the European Convention of Human Rights (ECHR).

# Chapter 2 – The use of experts in proceedings: cases involving expert evidence

## 2.1 The number of cases involving expert evidence

Available evidence indicates that the majority of cases containing an application for a care order contain some expert evidence; those studies based on a random sample (e.g. Bates and Brophy 1996: Hunt et al. 1999; Brophy et al. 2003) indicate between 80% and 89% of cases contained some expert evidence.

However some caution is necessary. While the issues underscoring these figures are complex,[52] it is interesting to note that despite substantial concerns about this field, available figures from research at least suggest comparatively little variation over time, for example:

- Bates and Brophy 1996 indicated 80% involved some expert evidence
- Hunt et al. 1999 indicated 87%
- Brophy et al. 2003 indicate 89%.

It is likely there will be *some* regional variations[53] but without some national monitoring it is difficult to address actual, from perceived, trends.

Equally, it is important to understand the nature of much of this evidence. It has to be set in the context and profile of the children and parents/carers outlined in Chapter one above.

All studies to date demonstrate that cases transferred to the county court/High court almost always contain some expert evidence;[54]and most cases completed in the Magistrates' Family Proceedings Courts were also likely to contain some expert evidence (Brophy et al. 2003).[55]

[52] And for example, samples contain cases that, prior to the Children Act, would have been Wardship proceedings where considerable use was made of expert evidence.

[53] More helpful data in terms of regional trends might usefully be sought from the Legal Services Commission.

[54] And of course the use of experts has implications for length of a final hearing and potential case complexity and it is one issue underscoring Justices' Reasons for Transfer.

[55] Some 56% of cases were started and completed in the FPC; 10% of these cases contained no expert evidence (Brophy et al. 2003).

## 2.2 Types of evidence filed in cases

***Key disciplines instructed in proceedings***[56]

The major clinical disciplines providing expert evidence have remained broadly the same over a fourteen-year period. These categories are paediatrics, child and adolescent/family psychiatry, adult psychiatry, and psychology. Family centre assessments also constitute a substantial proportion of the assessments sought during proceedings.

***Types of expert reports filed:***

Paediatric reports - Available research indicates paediatric reports are filed in about 35% of cases.

If reports from paediatric radiologists are added, national survey data indicates this would add about 10% to the (national) figure, and other medical reports perhaps a further 12%.[57]

Child and adolescent/family psychiatric reports - Indications are many cases are likely to include reports from child and adolescent/family psychiatrists based on assessments of children and parents or (to a much lesser extent) limited to assessments of children.

Some 41% of cases in the national survey (Brophy et al. 1999) and 33% of cases in one area (Brophy Jhutti-Johal and Owen 2003) contained reports based on assessment of children and parents. However these figures underestimate the total use of child psychiatrists in proceedings:

- If reports based on assessment of a child only are added, the figures are 52% nationally and 45% 'locally'.
- Additionally, if multidisciplinary assessments are included (which will invariably include a child psychiatrist) this adds a further 15%, and 2% respectively.

In other words, nationally at the end of the 1990s, about two-thirds of all cases (67%) contained some evidence from child and family psychiatrists.[58] The most recent data from one court circuit (Brophy et al. 2003) indicates some 47% of cases contained such evidence.

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[56] Reports from these disciplines appear consistently in data over a fourteen-year period. Other types of expertise are on occasion sought but the numbers are very small compared to the key disciplines described above. Recording of additional types of reports varied but for example, Bates and Brophy (1996) indicated reports from psychotherapists were filed in 11% (7/65) of cases; reports from general practitioners in about 12% (8/65) of cases, and DNA reports appear in about 5% (3/65).

[57] For example, a report from a pathologist, obstetrician, physiotherapist etc.

[58] In Bates and Brophy (1996) this figure was 70%.

Adult Psychiatric reports - Evidence indicates about a third of cases contain reports based on the assessment(s) of a parent by an adult psychiatrist (29%) in the mid-1990s (Bates and Brophy 1996), 32% nationally (Brophy et al. 1999), rising to 35% in the latest study (Brophy Jhutti-Johal and Owen 2005). The latter study identified that almost all adult psychiatric evidence in that study was based on assessments of mothers.

Psychological reports - Psychological reports may be based on an assessment of a child or an adult, or (less frequently) of both:

- Research indicates that reports limited to an assessment of a parent were filed in 16% to 24% of cases (national data indicates 24%, more recent work from one large circuit puts this figure at 16% (Brophy et al. 1999 and Brophy et al. 2003 respectively)).[59]
- Information on reports, which included a parent and a child(ren), is limited to that available from the national survey data in which such reports were filed in 12% of cases (Brophy et al. 1999).
- Reports based on assessment of a child only may be educational or clinical; educational psychological reports were filed in 10% to 13% of cases (Brophy et al. 2003; Brophy et al. 1999 respectively) and clinical reports were filed in 7% to 14% of cases (Brophy et al. 2003 and Brophy et al.1999 respectively).

Family Centre Assessments - Assessments of parenting skills commissioned during proceedings (residential and non-residential) vary from 46% in one study (Bates and Brophy 1996) to 23% in national survey data (Brophy et al. 1999); and 34% in the most recent study (Brophy et al. 2003).

### *Changes over time*

It is difficult to look at trends over time from these data (because of the different samples and locations of studies). However it is interesting to note:

- Paediatric assessments appear to be fairly constant over time and between data sets filed in just over one-third of all cases.
- When all types of child and adolescent/family psychiatrist assessments are combined, the most recent data indicates nearly half (47%) of cases are likely to contain this category of evidence (however, nationally the figure appears to be much higher - at 67%).[60]
- Adult psychiatric reports also appear to be fairly constant at between 30-35% of cases.

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[59] Bates and Brophy (1996) put this figure at 15% but that figure is based on *all* psychological reports filed in cases (i.e. those based on assessments of children, those on children and parents and those limited to parents).

[60] Brophy and Bates (1996) indicate a similarly high figure at 70% of all cases.

- Family centre assessments commissioned during proceedings may be increasing; findings from the latest study compared with those from the national survey data suggest an increase of just over 10% (from 23% to 34%).[61]

## 2.3 Expert reports based on examinations obtained prior to the start of care proceedings

With regard to the major categories of expert evidence filed in proceedings (see above) reports based on assessments/examinations obtained *prior* to a care application (and filed within proceedings):

- In Bates and Brophy (1996) 22% of *cases*[62] contained a report obtained prior to care proceedings.
- Hunt et al. 1999 put this figure at 38% of cases.
- Brophy et al. 2003 indicated 45% of *children* were involved in an expert assessment/ examination prior to proceedings.[63]

However cases seldom proceeded through to a final hearing without any additional assessments/examinations being undertaken and filed.

## 2.4 Reports based on assessments/examination commissioned within care proceedings

***Parties filing expert evidence***

All studies identify that the local authority as the applicant for an order is the party responsible for the majority of expert evidence in cases – almost all the 'prior' reports, and a majority of reports commissioned within proceedings were sought and filed by the local authority (Hunt et al 1999: Brophy et al 1999; 2003). While practices in joint instructions may 'distort' this picture slightly for some purposes, the fact remains that the local authority will remain responsible - jointly or alone - for the majority of expert evidence in cases.

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[61] There is also evidence from research based in three court circuits drawing on the experiences of 45 solicitors that this figure will continue to rise: many solicitors expressed concern about increasing numbers of cases in which proceedings were initiated without a core assessment (Brophy et al. 2005).

[62] In some studies data is presented by case, in others by child and by case.

[63] It should be noted some 'prior' reports are written a matter of days before the initial application, and the results of an expert's assessment may well lead to the initial application. One common example of this concerns certain non-accidental injury cases in which a child is admitted to hospital following a visit to the Accident and Emergency Department. A number of medical examinations are undertaken suggesting a child's injuries are non-accidental; this may result in an application by the local authority for an interim care order (to secure the short term safety of the child, co-operation of parents, and to allow further examinations/assessments to be undertaken). In these circumstances the local authority will file the medical reports following admittance to hospital in support of its application for an interim care order. Equally, a local authority may file 'prior' reports obtained in relation to other children in a family, or obtained in previous proceedings.

## 2.5 Multiple experts in cases

***Received wisdom and evidence-based data***

The studies were undertaken over a period in which practices in the instruction of experts underwent considerable change. In the early days of the Children Act 1989 (prior to directions regarding joint instructions/use of the guardian to obtain expert evidence wherever possible/appropriate), very few reports (under 10%) were jointly commissioned:

- In Bates and Brophy 1996 no reports were based on joint instructions.
- In Hunt et al. 1999, 8% were based on joint instructions.
- In Brophy et al. 1999 (national survey) 6% of cases contained a report(s) based on joint instructions.

However it would be a mistake to conclude that even in the early days of the Act, the volume of expert evidence was a direct reflection of single instructions and where all the major parties routinely sought expert evidence.

Even when concern about the use of experts was arguably highest (predating practice directions and protocols on joint instructions), research evidence did not support the view that 'multiple experts are now commonplace'.[64] Two of the most robust studies in this regard demonstrate this was not the case - in so far as this was taken to mean that all parties were commissioning experts and that parents and/or children's guardians were routinely commissioning second opinions on evidence filed by a local authority.

For example, following a detailed analysis of 'psycho-medical' evidence filed in 76% of cases, Hunt et al. (1999) concluded that reports based on examination/assessment of the same issues as a previous report were far from the 'norm':

- Most expert evidence was commissioned and filed by local authority applicants.
- Few guardians filed expert evidence – about 11% (9/83) of cases - one case contained a report based on a second opinion.
- Most parents did not file any expert evidence - about 27% (23/83) cases contained expert reports filed by parents (10 cases (12%) involved second opinion evidence).

As Hunt et al. (1999) concluded these findings hardly support the view that parents routinely instruct experts to countermand evidence filed by professionals as a universal practice. Slightly later findings from the national survey of cases containing expert evidence (Brophy et al. 1999) concurred with some findings from Hunt et al. (1999), but also revealed a slightly different picture. Survey findings concurred with Hunt et al. regarding the small number of

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[64] Expert Witness Group (1999).

cases in which all three major parties were likely to file evidence. Survey findings also confirmed that the local authority remained the party responsible for most of the expert evidence filed in cases, moreover:

- Few cases in the survey (18%) contained evidence filed by all three major parties in proceedings.
- The local authority was the major party filing expert evidence in cases (whether as the only party filing evidence in cases (27%), or as one of a number of parties filing evidence - 69% of cases).
- Guardians however filed more expert evidence nationally than was indicted in the regions explored by Hunt et al. sample - 52% of all cases in the national survey contained evidence commissioned by the guardian.
- Reports filed by parents however remained broadly similar to the regional data provided by Hunt et al. (1999): nationally parents filed expert evidence in 22% of all cases.

***Potentially competing expert evidence***

In the national survey, for those cases which contained evidence filed by more than one party (46% - 256/557), some 65% (166/256) were identified as having some potential for competing evidence.[65] Under a third of these (31%) involved children in more than one assessment – but most of these were in fact based on 'paper exercises' or an assessment of a contact session.

Where the local authority and the parents filed *potentially* competing evidence, four issues underscored parents' decisions to seek further evidence:

(a) they disagreed with medical evidence regarding whether physical injury was non-accidental;

(b) they disagreed with existing mental health evidence;

(c) they felt an existing report was inadequate (it was biased, limited or too narrow); and

(d) cases in which parents had multiple complaints about existing expert evidence.

***Comparisons between reports***

Comparison of reports in these cases indicated a substantial number of experts (41%) were in fact in agreement, but 18% disagreed about recommendations to be made - and a further 30% indicated only partial agreement with previous recommendations. However:

- Most expert evidence commissioned by parents did not include direct access to children;[66] rather it focused on assessments of parents only.

[65] That is, about 30% of the total number of cases in the survey.

[66] Most parents (72%) did not seek leave of the court for a direct assessment of children, of those who did (28%), a third were refused and 18% obtained restricted leave (limited to an observation of a child (ren)). Most parents however (76%) sought leave of the court to disclose papers to an expert (in 25% of cases leave was refused (Brophy et al. 1999:41)).

- Where experts commissioned by parents did address issues of the most appropriate court order for children (and this was a minority) they did not always oppose the order requested by the local authority, nor did they unanimously support the position of parents.

Where guardians commissioned further expert evidence on substantially the same issues/concerns addressed in a previous report, two issues were clear:

- The main reason for seeking a second opinion was serious concerns about the quality of an existing report, (i.e. the decision to seek further evidence was not based on changed circumstances in cases or because a parent wanted a second opinion).
- Comparisons between these reports indicated some divergence of view between experts: in 34% of such cases disagreement focused on the assessment, in 32% of cases it focused on appropriate recommendations (a further 26% and 19% respectively indicated partial disagreement on both counts).

In other words, the overall number of cases where there was potential for conflicting expert evidence was relatively low - about 29% of cases and thus far from universal.[67] Within that sub-sample of cases however, the number where some actual disagreement arose was substantial. Combining cases where there was only partial or no agreement between experts, it was in over 40% of cases where parents filed a second opinion, and over 50% in those cases where the guardian had filed a second opinion.[68]

These findings support findings from both earlier and later research and theoretical writing on clinical and legal discourse (Brophy et al. 1998; Brophy et al. 2001): much of this work is not an exact science. As the Court of Appeal has recently also demonstrated[69] expert opinion in cases of child maltreatment may differ. For example, different views may be taken as to the cause of, say, a head injury in a baby and whether certain types of injuries in babies are invariably non-accidental in causation or whether they can be caused by accident – for example by a fall or being dropped. Different theoretical/clinical perspectives in the psychological and psychodynamic traditions[70] may pose aspects of personal/emotional/ psychological problems differently and may have different perspectives on the potential/

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[67] That is, numbers did not support the assertion that most cases involved experts all examining the same issues/concerns.

[68] With regard to the group of cases in which guardians sought second opinions, comparisons of the assessment between expert reports indicated in 34% of cases the expert appointed by the guardian did *not* support the assessment made in a previous expert report, in a further 26% of cases it was supported in part. In other words, there were more cases in which there was a level of disagreement between experts than there were cases in which experts agreed (Brophy et al. 1999:40).

[69] Lord Justice Gage, Mr Justice Cross and Mr Justice McFarlane, in Harris, Rock, Cherry and Faulder [2005] EWCA, Crime, 1980 html. (Review of medical evidence, alleged non-accidental injuries to children, four cases reviewed following the judgment in R v Cannings [2004] 2Cr.App.R7).

[70] For example, perspectives on a parent's potential for change in parenting beliefs/practices may in certain circumstances differ depending on whether a clinician takes a psychoanalytic or a cognitive behavioural perspective.

capacity for change in adults. Thus clinicians are not infallible, expert knowledge is not static, nor is it a unitary category (Brophy et al. 2001).

In addition to the need to address questions/limitations in existing expert evidence, the additional benefits of second opinion evidence in *certain* complex cases has been posed (by judges, lawyers, legal advisers and children's guardians) in several studies in terms of social justice to parents as litigants who often face permanent removal of their children. Under domestic and European law parents have a right to consider, and if appropriate, to challenge evidence alleging current harm and future risk - and this includes in appropriate cases, instructing an expert.

Moreover, the additional value of a second report that confirms the work of a previous expert is that it can help parents come to terms with difficult decisions. It can also assist in future working relationships with parents and between parents and children. However in certain cases, seeking a second opinion could sometimes prolong 'parental denial' (Hunt et al. (1999); Brophy et al. (1999)).

In summary, even at a time when concern about the use of experts was arguably at its highest level:

- Most cases did not contain evidence filed by all three parties.
- Most expert evidence was filed by local authorities (as the applicant for the order and thus with the responsibility of establishing the threshold criteria for a court order).
- Expert evidence filed by parents was limited; it did not usually involve direct assessment of any children and was more likely to focus on adults in general and parental mental health in particular.
- When guardians or parents filed potentially competing reports to those filed by the local authority, some level of disagreement was identified in a significant number of cases (over one-third).
- Some cases may contain a mixture of reports – some based on assessments/ examination sought prior to proceedings and those commissioned after proceedings had begun. If cases start with some expert evidence this was almost always added to during proceedings.
- Most research evidence – even that obtained from studies in the very early days of the Children Act - indicates that commissioning expert assessments usually begins at the first directions appointment/interim hearing and it begins with the local authority.
- Local authority 'motivation' in seeking expert assessments was usually 'developmental' related to ongoing decision-making, case management and planning in cases.

## 2.6 Core Assessments under Part III of the Act

It might be argued that perhaps local authorities should have cases more tightly sown-up prior to instigating legal proceedings. Research indicates several reasons why that may not happen/may not be possible:

- As indicated in Multidisciplinary above, lack of co-operation from parents was a majority issue in most applications across studies spanning the fourteen years since implementation of the Children Act. That finding indicates that it may not be possible to conduct the necessary medical/psychiatric assessments outside of the framework provided by court proceedings.
- As Multidisciplinary above also indicates, many children are already living away from their birth parents at the time of application, it may only become apparent that there are major problems once assessments are intended/started and at that point parents may withdraw consent and demand the return of a child accommodated under a voluntary agreement.
- Local authority plans/intentions may necessarily be unclear until expert assessments are complete.
- Local authority plans may also depend on a range of subsequent developments both with regard to assessments and issues concerning wider family members in longer term planning.[71]
- However, concern is also increasingly expressed about a lack of resources, skills and expertise in many local authorities to undertake core assessments, indeed as indicated above many cases start care proceedings without a core assessment (34% - Brophy et al. 2003)

## 2.7 Joint letters of instruction and the sequence of evidence gathering

As suggested above, the use of joint instructions, the control of the court over this practice and Guidance for judges, lawyers and others has undoubtedly resulted in incremental increases in the use of joint instructions over the period of Children Act proceedings – although this is not quantifiable (Brophy et al. 2003).[72]

The most recent detailed work on court files (Brophy et al. 2005), while not presenting data on joint instructions, noted that in some courts, at least when compared with previous studies, this issue appeared to be easier to track - in part because of the use of standard directions forms[73] and the fact that more letters of instruction may be filed.

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[71] Research also identifies that extended family members can be unwilling to consider or put themselves forward as potential carers for children until it is clear that a parent cannot care for his/her child – and that will not necessarily be apparent until assessments have been undertaken (Hunt et al 1999: Brophy et al 2003).

[72] Case law and Guidance in this field is outlined and discussed in Brophy et al 1999; 2003. This includes guidance to judges (e.g. from Practice Directions, case law in the 1990s and most recently the Protocol for Judicial Case Management in Public Law Children Act Cases (2003) DCA). The role of lawyers and indeed guardians has been addressed, for example, in Good Practice in Child Care Cases, (2004), The Law Society, along with the Code of Guidance for Experts in Family Proceedings (Appendix C of the Protocol; and in the forthcoming (second edition) of the Expert Witness Handbook (Wall and Hamilton 1st ed 2000)).

[73] Which details directions regarding joint instructions along with the parties involved, plus a standard direction to 'circulate for comment and file' the letter of instruction *whether or not* the expert is jointly instructed.

Equally, standard instructions and the introduction of meetings of professionals (as a case management tool) as directed by the Protocol may have resulted in further increases in the number of reports jointly commissioned. However, it remains the case that a careful and transparent balance has to be made in this field. There will be circumstances where joint instructions will be inappropriate – and where second opinion evidence has proved vital to the safety and well-being of children (see below – contributions of experts).

In terms of the sequence of evidence filed, paediatric evidence will generally predate any psychiatric and psychological evidence.

Prior to the Protocol where expert evidence was filed by parents, this tended to come in the latter part of cases (Brophy et al. 2003). By that stage most, if not all the local authority evidence has been collected and filed. Parents and children will have undergone assessments and parents will know the nature of the allegations in so far as these are likely to satisfy the threshold criteria for a court order (as indicated above, that is usually resolved by the pre-trial review, for which a threshold statement is normally filed (Brophy et al. 2003)). Care plans may thus also be clearer for a substantial number of children (see below - interim and final care plans).

## 2.8 Types of cases typically involving experts

Available research evidence indicates expert assessments are likely to be the norm rather than the exception in most care cases (Brophy et al. 2003). The profile of allegations regarding maltreatment to children and concerns/allegations leading to failures of parents (see Multidisciplinary above) demonstrate cases are complex, parents are usually highly vulnerable on a range of psycho-social indicators and the allegations of maltreatment of children are serious.

Cases including some form of serious physical ill-treatment of children usually also contain concerns/allegations of emotional maltreatment.[74] A paediatrician will usually be necessary

[74] There is substantial clinical research and writing about the antecedents, operational definitions and consequences for children's future health and development resulting from parental ill-treatment (physical, sexual and emotional) and with single and multiple harmful attributes resulting from a range of parental problems (e.g. mental illness, alcohol and drug abuse and domestic violence). *Working Together to Safeguard Children* (DoH, 1999) states that children should be registered under one or more of the categories of physical, emotional or sexual maltreatment or neglect (para 5.101). This facilitated the use of emotional abuse as a joint category of registration. Concurrent registration of emotional maltreatment concurred with evidence from clinical research and writing (e.g. Glaser, Prior and Lynch 2001) regarding the high rate of emotional abuse found in a study of children registered under the category 'emotional abuse'.

to carry out an assessment of a child's development; causation and date of injuries and long term prognosis for a child:

- A paediatric haematologist may be necessary to advise on the causes of bleeding
- A paediatric neuro-radiologist will be required for skull fractures and subdurals
- A paediatric neurosurgeon to address subdural haematomas
- If injuries have caused retinal haemorrhages an ophthalmologist will be necessary
- A paediatric radiologist will be required if injuries include suspected broken bones/fractures, (evidence will be sought to read the skeletal survey, MRI scan and/or CT scan)
- A paediatric metabolic consultant may be necessary where there is concern about a metabolic disorder
- Where there has been a child's death, a forensic paediatric pathologist may be involved[75]
- A geneticist may be commissioned to help with questions regarding gene deficiency, chromosomal abnormality or a rare syndrome.

For example the work of Cobley et al. (2002) explored a diagnosis of subdural haemorrhage (SDH) in young babies in a sample of 69 cases admitted to hospital. Sixteen cases resulted in an application for a care/supervision order; in 13 cases a care order was made. This study collected substantial data on the work of clinicians with regard to diagnosis, referral to child protection agencies and commencement of criminal proceedings and addressed clinical debates about causal mechanisms of 'shaken baby syndrome' (SBS).[76]

Cobley et al. (2002) confirmed the use of experts in such cases with regard to evidence on causation of injuries; these are predominantly paediatricians, plus radiologists and paediatric neurologists.

[75] So for example where an application concerns a child in a family where there has been a suspicious child death and which involved a forensic pathologist, a judge in care proceedings may direct that the pathologist's report be filed in the current care proceedings.

[76] The starting point for this study was medical records but it included data from the police, social services and courts along with some socio-economic information of the parents. Much of this latter information confirms the profile of parents outlined in Multidisciplinary drawn from random studies of all parents involved in proceedings – parents are vulnerable on a number of indices. In this study cases referred to social services were tracked (for registration and risk assessments). However, of the 16/69 cases with a diagnosis of SDH that resulted in care proceedings, court records could only be traced for nine cases. Most of these cases were transferred to a higher court (7/9, 3 were transferred to the High Court), most (7/9) contained an interim care order, and the plan for most (7/9) was rehabilitation with parents. The researchers urge much caution given small numbers but note a suggested higher 'trend' towards rehabilitation following this type of child injury compared with that drawn from random samples for all types of injuries. This requires further research.

A child and adolescent/family psychiatrist [77] may be sought in relation to the issue of emotional ill-treatment of children; this work will address the quality and dynamics of parent-child relationships and questions of future risk.[78] A child psychiatrist may thus be instructed to explore a range of symptoms in children and whether and how these relate to parenting behaviours/attitudes, and likely impact on a child's current and long term health and development, for example examining:

- Developmentally inappropriate interactions with or expectations of a child, inappropriate stresses and demands on a child[79]
- Severe denigration, hostility and criticism[80]
- Rejection and withdrawal of affection[81]
- Lack of empathy with a child's suffering
- Being emotionally unavailable or unresponsive to a child in the face of neglect[82]
- Deprivation of attention[83]
- Inconsistency of expectations of a child[84]
- Threats of abandonment.[85]

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[77] There are *some* regional variations in the way in which child psychiatrists and psychologists may be used; some of these differences are historical, for example, certain areas of the country have lacked front line CAMHS (child and adolescent mental health services) and in such areas work for courts (which has also been extra contractual) has shifted to the next available expert in the field of psychological and emotional functioning. There are however crucial differences in the two fields of expertise but there is also some overlap and some evidence that the child and adolescent psychiatrists who have been involved in child protection litigation have extensive training and experience in both fields (see Brophy et al. 2001).

[78] Clinicians delineate this form of child ill-treatment as distinct from other forms of ill-treatment because it refers to a *relationship* rather than an event or series of events, and because evidence of harm to a child is usually non-physical.

[79] For example, a child may see his/her depressed mother repeatedly being beaten by her partner or taking an overdose; a parent may look to a child for inappropriate support, in effect reversing parent-child relationships and responsibilities so that the child feels responsible for the happiness and well-being of a parent.

[80] For example, a parent may only focus on/seek out the 'bad' qualities in the child, subjecting him/her to a 'withering fire of critical and demeaning comments' for which a child is not emotionally or developmentally equipped to handle.

[81] For example, a child may receive no warmth or cuddles from a parent and is continually spurned if/when he/she makes overtures. This can lead to desperate emotional frustration in children and if prolonged, can lead to a desperate need for intimacy at any costs placing a child at risk within and outside of families. In some cases one child is also treated very differently to others, becoming a scapegoat for other problems in families and this can exacerbate a child's feelings of rejection.

[82] For example, being unable or refusing to empathise with the pain and suffering of a child who is continually beaten, blaming the child, telling a child they provoked the physical attack, telling the child he/she is evil, is being punished for their badness, or needs the badness beating out of them. Equally, a parent may fail or refuse to understand the psychological impact on a child and the sense of humiliation resulting from severe physical neglect (e.g. continually missing school or arriving late, being dirty and smelly, without clean cloths/underwear and thus being ostracised, becoming isolated and possibly bullied at school).

[83] For example, a child is ignored especially when he/she is quiet or 'behaving', when he/she seeks to play or seek approval, it is withheld. In some cases very young children have become completely withdrawn and unresponsive to adults and their surroundings; in older children this has been linked with less socially acceptable behaviours and to antisocial behaviour and aggression.

[84] For example, behaviour from a child that is acceptable one moment, but results in crushing criticism and heavy punishment the next; a parent may be warm and welcoming in the morning as a child leaves for school/nursery, totally rejecting on its return. This leads to confusion in a child and an inability to predict or trust adults and a constantly fearful perspective.

[85] For no reason related to the child, or for what may be very minor acts of perceived misbehaviour, the child is threatened with expulsion from the home, the child may have his/her suitcase packed or clothes dumped in a

Common indicators of impairment of a child's emotional and psychological development which are routinely explored are:

- Unhappiness
- Low self esteem
- Depression
- Educational[86] or developmental underachievement.

Children may also exhibit a range of symptoms such as deliberate self-harm, suicide attempts, eating disorders, anxiety disorders, obsessive-compulsive disorders, attachment disorders, enuresis, faecal soiling, language impairments and psychosomatic symptoms. Adolescent disorders also include substance abuse.

Child sexual abuse is also likely to be accompanied by concerns/allegations of emotional maltreatment. Physical evidence in relation to sexual abuse[87] may be sought from a paediatrician[88] who will usually be a specialist in this field. However as identified above, it may not be possible or appropriate for a child/young person to undergo an intimate physical examination. An assessment by a child psychiatrist/psychologist – usually a specialist in sexual abuse - will usually also be sought.

Assessments will focus on both the alleged abuse, but also the likelihood of re-abuse if the child/young person is to remain with or be returned to the household in which the abuse happened. Thus, a central factor in the risk assessment may well be the ability of a mother

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plastic bag, he/she may be taken to social services or a police station. The constant fear of abandonment in this situation precludes the development of a secure base for the development of relationships and often results in anxious attachments identified in children.

[86] And it may be necessary for a child to be examined by an educational psychologist.

[87] In cases of suspected sexual abuse there are extensive guidelines on the investigation and interviewing process protocols to be carried out in conjunction with the police. Physical examination of the anus and external genitalia is only undertaken by a paediatrician, gynaecologist or a police surgeon trained for the purpose. Allegations may result in both care proceedings and criminal proceedings. Certain issues (e.g. tearing and bruising – see note 88 below) have been seen as strongly suggestive of abuse, weaker signs may be of uncertain significance but a negative physical examination does not rule out the occurrence of sexual abuse; it can make a criminal prosecution less likely or more difficult, it does not, however, prevent care proceedings.

[88] Sexual abuse of children can take a number of forms including but not limited to rape: the definition utilised by the NSPCC for example covers 'the involvement of children in sexual activities they do not truly comprehend, to which they are unable to give informed consent or which violate the social taboos of family life or are against the law'. Some texts classify sexual abuse into three major groups – non-touching, touching and violent. Non-touching offences include verbal abuse, obscene telephone calls, exhibitionism voyeurism and witnessing adult intercourse. The touching activities include fondling, genital stimulation, oral stimulation and intercourse; violent acts include vaginal and anal rape and physical injury. Physical indicators (in genital and anal areas include bruises, scratches and other physical injuries not consistent with accidental injury (masturbation by a child does not cause bleeding); itching, soreness, discharge or unexplained bleeding. Foreign bodies in urethra, bladder, vagina and anal canal; abnormal dilation of the urethra, anus or vaginal opening, pain on micturition, signs of sexually transmitted infections, semen in the vagina or anus or in the external genitalia.

to address and accept what has happened, and her willingness and ability to protect the child/young person if he/she is returned home.

Research identifies neglect as the most common form of ill-treatment in cases which result in care proceedings (usually associated with emotional maltreatment) (Hunt et al. 1999; Brophy et al. 2003). Cases may require the involvement of paediatricians and child psychiatrists.[89] Some of this work will be child focused,[90] some will focus on parents, and most will address children and a parent(s).

A paediatrician may address a child's age, growth, development and physical health, checking size and weight charts (centile distributions) to indicate how the child compares with children of the same age in the general population (checking the percentage of the population with values greater or smaller than that of the child measured).

A detailed history and physical examination will be undertaken along with a developmental assessment (e.g. learning stages might be checked along with motor skills for age appropriate development); dietary assessments may also be made. This work is put in the context of a family assessment in collaboration with other professionals; research indicates this is likely to be a child psychiatrist.

For example, in addition to appearing underweight for its age, a baby may have substantial and seeping sores as a result of being left for long periods in wet/soiled nappies. As indicated above, a child may regularly appear at nursery or school dirty, smelling of urine; he/she may have persistent diarrhoea, may have unclean/no underwear, sores which will not heal and skin complaints that are not treated. He/she may have a serious medical condition that is left untreated, ignored or denied by a parent.

Equally, a child may always appear hungry, or underweight, or may have a voracious appetite, may hide/hoard food, or may refuse to eat. A child may also be totally unresponsive to adults or the world around him/her and may appear physically 'frozen' holding one position for long periods.

[89] Physical neglect can broadly be defined as a failure to provide the necessities of life for a child; lack of medical care, adequate nourishment, appropriate clothing, supervision and adequate housing are all factors that contribute to a picture of neglect.

[90] For example, exploring symptoms and levels of impairment and whether these are organic or non-organic (stemming from parental behaviours/attitudes or genetic factors, or a combination of both).

Where children are neglected, some parents may also have a ‘transient lifestyle’ thus children may not be registered with a GP or a health visitor. Some homes may be chaotic despite substantial input by social services and thus with no food, heating or bed linen, and little or no furniture; floors may be filthy, infested, covered with animal urine and faeces, empty and broken bottles and cans may be left lying around on the floor where babies crawl and young children play. A home may be used to deal in drugs/prostitution with used needles and condoms in evidence and thus be unsafe for children.

Equally, children may not know where they are supposed to be on a daily basis, may be confused about where they live, who is to pick them up from school/nursery; they may be moved to various houses and flats, left with people some of whom they know, some they do not. They may be ‘abandoned’ at a nursery or child minder (i.e. simply not collected), left at a police station, left unattended for several hours; very young children may be left alone without food, light or heating for long periods.

Depending on the age of a neglected child, a child psychiatrist may also interview the child and indeed the parents (see below); it may, for example, also be necessary for a child to see an educational psychologist (e.g. to assess learning difficulties and special educational needs).

In addition to seeing children, child and family psychiatrists will interview parents and take a full clinical family history. In cases of physical injury paediatricians will not only explore injuries to children and general health and development, they will also explore a parent’s view or account of how injuries might have occurred, what a parent thinks is wrong with a child, and how a parent accounts for a child’s condition/problems.

Research evidence demonstrates child psychiatrists will not only explore current harm to a child and whether parental actions, inaction and interactions have fallen below what is considered ‘good enough’ parenting for the *particular* child. They will also address future risks to a child if he/she is returned to a parent, the potential of a parent to change, and whether a parent has the capacity and willingness to do so within a timeframe that is acceptable for the specific child.

Some cognitive/psychological testing of parents may also be sought (e.g. where it is felt parents may have a learning difficulty).

Moreover child psychiatrists and some psychologists will be looking at issues of treatment/therapeutic input and whether parents might benefit from further welfare input/support, and if so what type.

As indicated above, many parents subject to care proceedings are likely to have mental health problems (over 40%). Research demonstrates that adult psychiatrists will address a range of mental health problems exploring signs, symptoms and syndromes in parents.

- Some parents will have more than one condition and while clinicians may use slightly different classifications, mental health problems in parents subject to care proceedings run from schizophrenia and manic disorders including drug induced disorders, to anxiety and obsessive disorders, alcohol disorders, personality disorders, depression, dissociative disorders, developmental disorders and conduct disorders, adjustment disorders and reactions to stress.
- Some adult psychiatrists who submit reports will have a clinical responsibility for a parent that pre-dates court proceedings; some parents (around 26% of those for whom there is a mental health concern) will have refused professional help/support to address their mental health problems (Brophy et al. 2003). When asked to report on parents for care proceedings, adult psychiatrists will address the aetiology of problems, diagnostic and clinical features of parents, prognosis and treatment offered/accepted and drugs prescribed, and if appropriate, whether a parent has co-operated with treatments offered.
- In the case of parents who are being treated for a drug problem, adult psychiatrists will report on whether a parent is complying with a detoxification programme and the likely duration of treatment.

In other words, research evidence indicates that where cases concern highly vulnerable children and parents with complex multidimensional problems – and this is likely to be the majority of cases - they usually demand a range of knowledge, clinical skills and expertise beyond those of social workers.

## 2.9 What are experts asked to do? Instructions to child psychiatrists

Research on the views and experiences of experts in care proceedings is not wide;[91] detailed qualitative work about proceedings is largely limited to child psychiatrists and comes from one study (Brophy et al. 2001).[92] With regard to what child psychiatrists reported they

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[91] There is, however, a range of literature on how to be an expert witness, for example, how to write court reports, prepare for attending court and give evidence in chief etc. - this material is reviewed in Brophy (2000) Child Maltreatment and Cultural Diversity.

[92] The Royal College of Paediatrics and Child Health has undertaken a short questionnaire survey of members following recent complaints about the work of a limited number of paediatricians. The survey aimed to ascertain the number of paediatricians who have been the subject of a complaint about their work, how far the complaint had been taken and whether paediatricians are deterred from working in the child protection arena (RCPCH, 2003). A further report arising from a two day study event for Specialist Registrars in Community Paediatrics also addressed training needs and gives some (very limited) information on child abuse issues and training needs; it does not, however, look at training specifically for care proceedings (Thornes 2001).

were generally asked to do by parties, views broadly concurred with research based on court reports:

- Most were asked to comment on whether a child has suffered, or was likely to suffer significant harm.
- Most were asked to assess future risks to children – and prospective risk could be quite a complex exercise.[93]
- Most were asked to address the capacity of parents to 'parent', and if necessary, whether a parent was capable of change to meet a child's needs, and the likely timetable for that, given the needs of the child.
- Many child psychiatrists also identified particular fields of clinical work, research and writing for which they were known, for example, issues of emotional abuse, childhood trauma, rehabilitation of maltreated children, work with very young parents, depression in mothers etc.
- Some experts were asked to comment on prospects for longer-term rehabilitation and what would be needed to make that a possibility.
- Most child psychiatrists were not routinely asked to comment on the type of order the court should make[94] – although some (about half this sample) said they would nevertheless comment on this issue.
- Some were also asked to comment on whether future contact was appropriate; most would make recommendations about contact in reports.[95]
- Most experts would always comment on a child's therapeutic needs – whether or not they were requested to do so.
- Recommendations about future treatment however raised substantial dilemmas for child psychiatrists, not least because of a national shortage of CAMHS and thus the likelihood of locally based services being able to take recommendations forward.

In summary, a major question in the overall 'package' of work requested in most referrals was 'where do we go from here?'. This meant assessments of current and future risk, and the *capacity* of a parent to change - and whether change could be achieved in a time frame appropriate for the child. Thus, care planning and placement was a major part of their package for courts.

However child psychiatrists were not the only discipline with responsibility for risk assessment – adult psychiatrists, forensic psychiatrists and social workers were also seen as having a role in the assessment of risk and this was not necessarily duplication (see below).[96]

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[93] And 'prospective risk/likely harm' can be more difficult where clinicians are dealing with maltreatment of very young babies, where social services have no prior knowledge of a family and parents have no previous children.
[94] That was usually seen as an issue for the judge – and guidance confirms that view.
[95] Although it was pointed out that sorting out the detail of contact – once the principle had been established and agreed by the court – was the job of the social worker.
[96] Some child psychiatrists complained about a failure to understand the differences between the work of the adult, and the child psychiatrist. Adult psychiatrists are not trained to assist or assess children and their needs. Thus, many argued that instructions to adult psychiatrists should be focused on diagnosis, treatment required and prognosis and likely effects of illness, but the actual task of assessing current parent-child interaction and future likely parenting capacity against the assessed needs of the specific child, is the task of the child psychiatrist.

Social workers have to know what the likely risks are and need to be able to identify risks and concerns, for example, about poor attachment. However child psychiatrists argued it was their job to turn the social worker's concerns into reliable evidence for courts based on an assessment of the quality and dynamics of current attachments between children and parents and implications for a child's current and future health and development.

Risk assessment is not however a certain/exact 'science':[97] child psychiatrists identified it as a difficult balancing exercise and often a source of conflict in proceedings. Responsibility for putting together the full picture for courts, based on their own clinical work, information and assessments from social workers, adult psychiatrists and others was said to be the task of the child and family psychiatrist.

## 2.10 Clinical perspectives on social worker assessments

Most child psychiatrists were familiar with the framework for comprehensive social work assessments.[98]

Concerns were expressed about non-completion of assessments prior to court proceedings - child psychiatrists said about half of cases referred to them during proceedings had not had a core assessment.

The quality of work was also said to be highly variable, much depended on the skills and experience of the particular social worker. Some assessments were said to be very sophisticated pieces of work but in some areas work was said to be very, very poor, often very process oriented with little or no analysis.

However clinicians argued that shrinking budgets, lack of resources in social services departments and increased pressure and stress on social workers has had a disabling effect on social work practice.

Social workers were expected to examine practical issues, for example:

- Current parenting skills
- Housing and home care

[97] That position forms part of the general principles for practice of the Royal College of Psychiatrists: 'risk cannot be eliminated; it can be rigorously assessed and managed, but outcomes cannot be guaranteed' (RCP (1996) *Special Working Group on Clinical Assessment and Management of Risk).*

[98] At this point the applicable guidance was DoH (1988) *Protecting Children*, HMSO (often referred to by professionals as the 'Orange' book assessment (subsequently replaced by the 'lilac' book assessment).

- Social networks and support for parents and children
- Children's attendance at school and with GPs and health visitors.

These are issues that demand skills and expertise that clinicians readily acknowledged they do not have. Moreover social workers were said to have strength and an additional value in that they had the benefit of knowing parents over a period of time.

## 2.11 The clinical framework underscoring views of 'added value'

Extensive medical training, clinical experience with child and families, skills and knowledge across a range of complex multidimensional issues, options and treatments underscored clinicians' perspectives about what might be termed their 'added value' in this field. So, for example, child psychiatrists stated they had:

- Medical training and an understanding of how ill health impinges upon functioning and behaviour
- Training in adult mental illness
- Training in child mental health
- Knowledge of the availability and effectiveness of various treatment approaches
- Training and experience to make a prognosis regarding risks to a child
- Training in abnormal behaviour of children
- Research knowledge and experience
- Substantial experience working with disturbed children and families
- Additional training in psychology, psychotherapy and family therapy
- An ability to take a clinical family history.

## 2.12 Choice and availability of experts

***Introduction***

The shortage of experts who are both willing and sufficiently experienced to provide opinion evidence in child care proceedings has been an ongoing concern since the early-1990s. For the most part, concern centred upon child and adolescent/family psychiatrists and psychologists. However, attention has recently included paediatricians following criminal cases involving child deaths in 2003/2004 and subsequent criticism of certain aspects of paediatric evidence (see below). Nevertheless the framework in terms of research evidence regarding questions of choice, availability, training and accountability of experts was developed in the mid-1990s in research funded by the Department of Health (see below).

***Choice and satisfaction with the work of experts***

Research confirmed that, with regard to psychology and child psychiatry, choice of expert is intrinsically linked with availability and satisfaction with the likely quality of work. A national random survey of children's guardians (Brophy et al. 1999) identified considerable variability regarding satisfaction with local child and family mental health services (CAMHS): 19% of guardians were mostly satisfied with services but 31% were not satisfied and a further 50% reported services were variable, much depended on the local area.

With regard to the problems encountered:

- 72% of guardians reported local services had no resources or commitment to undertake further therapeutic work with children.
- 63% said local CAMHS lacked staff with experience in undertaking assessments and preparing reports for courts.
- 59% experienced delays in getting reports.
- 49% said assessments had not been sufficiently thorough (Brophy et al. 1999).

Guardians reported a need for more locally based services but also for CAMHS able to offer ongoing therapeutic services to children and parents. Children's guardians also identified a need for improvements in the training and resources of CAMHS to enable services to develop multidisciplinary teams and respond to the needs of the family justice system.

Research also identified a high degree of agreement on the criteria for appointing experts in child and family mental health: most (74%) wanted the experienced and trusted experts,[99] most (83%) also wanted a consultant sensitive to the complex needs of families subject to proceedings; most (73%) also wanted a consultant with an understanding of law and legal procedure, able to distinguish fact and opinion evidence, confident if necessary in giving oral evidence. An ability to report to specified time scales was important (63%) but getting the right expert so far as particular skills and expertise were concerned was central to good case management (Brophy et al. 1999).

Research indicates this is not an area where guardians are prepared to take risks on behalf of children by instructing inexperienced clinicians: consultant status with the years and breadth of experience with vulnerable children and parents, plus experience of care

[99] This did not mean experts who supported their views, rather clinicians who retained a critical perspective on research and practice issues and were thus open to new ideas and ways of working with highly vulnerable children and parents – (Brophy et al 1999; Brophy and Bates 1999).

proceedings were essential criteria (Brophy et al. 1999). Research with existing clinician experts also indicates that in so far as their evidence may be central in the permanent removal of children from their parents, they argue the work demands skills, knowledge and experience from clinicians who are at, or near the top, of their profession.

***Shortages of child psychiatrists***

While many complained about shortages of sufficiently experienced experts, relatively few guardians reported actually failing to appoint a psychiatrist or psychologist[100] but shortages could mean delay in getting a first choice. Very few guardians (12%) reported any difficulties in obtaining expertise in areas other than psychology and psychiatry (Brophy et al. 1999). However we lack robust data on the time it takes to obtain reports, by region, and by type of assessment required.

Nevertheless there are indications that shortages are becoming more acute in some disciplines - in part because many of the consultants who have traditionally undertaken this type of work are near to/retiring and they are not being replaced (Brophy et al. 2001).

In addition, funding issues in this field remain complex: in the field of child and family psychiatry and some aspect of psychological assessments, some of this work has been undertaken ‘extra contractually’ (that is privately, or under (what was) ‘category II’ work under NHS contracts – see Brophy et al 2001). Moreover, research also identifies that some consultants are opposed to this work being undertaken extra contractually, privately or by clinicians who have retired from mainstream NHS clinical practice, arguing that it should be part of the NHS remit and thus subject to clinical support in the same way that other categories of vulnerable children are (Brophy et al. 2001).

This situation remains problematic and resulted in the commissioning of a report from the Chief Medical Officer.[101]

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[100] In a sub-sample of some 321 guardians, 8% reported failing to find an adult psychiatrist in a case, 15% had failed to appoint a child psychiatrist, 9% had experienced failing to appoint a psychologist for an assessment of a child and 7% had tried and failed to find a psychologist (Brophy et al. 1999).

[101] The issue was raised in 2001 when new employment contracts were negotiated between the NHS and the BMA (see Brophy et al. 2001); it was again raised with the Chief Medical Officer (CMO) for consideration in the context of a report commissioned by the (then) Minister for Children. The CMO was charged with an initiative to determine how best to ensure the availability of medical expert resources to the family courts. The terms of reference for the CMO’s Working Party were widely drawn and included a remit to examine the participation, competences and best practice for expert witnesses along with a remit to advise on how to ensure a *sustainable supply of competent quality-assured expert medical witnesses* - and to make recommendations to Government ministers in early 2005. The report remains outstanding.

However, research with child psychiatrists also indicated that many CAMHS were already overstretched and unable to meet general clinical demands. There were indications that in some areas waiting lists for general appointments exceeded waiting times reported for reports for courts, and in some areas the NHS was unable to provide a CAMHS.

It has also been argued that some clinicians dislike the adversarial 'feel' of aspects of the court process and feel personally criticised and sometimes humiliated but this is a complex issue, which requires further work. First, robust data, for example, comparing this view with those of clinicians who perhaps understand and are more comfortable with the process of evidence testing along with some control data regarding the quality of reports is not available.[102]

Second, some highly experienced consultant child psychiatrists have argued that while the process may be difficult and challenging, as a principle, it is essential that expert evidence remains open to testing. Indeed these clinicians argued that if that option were no longer possible, 'it would be time for the child psychiatrist to get out of the legal arena' (Brophy et al. 2001).

***Shortages of paediatricians***

In the wake of concerns about the work of some paediatricians, the Royal College of Paediatrics and Child Health undertook a short survey to assess the extent of complaints about the work of paediatricians and the impact of complaints on willingness of members of the college to undertake child protection work.

14% reported they had been the subject of a formal complaint.[103] Most of these complaints (79%) were dealt with at a local level, a very small number (8%) went to independent review, while 11% were serious enough to be referred to the General Medical Council (GMC).

Of the complaints that were dealt with locally, 76% were dropped, 21% were found unproven and 3% were upheld.

Of those complaints which went to the GMC, (some 11%), 41% were dropped and 59% were found not proven.

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[102] A major problem in this field has been the lack of training for the court process within clinical education and training. This issue has been addressed by the Family Justice Council, for example through the work of the expert sub-group, and through the introduction of a judicial mini-pupilage scheme.

[103] And the number of complaints is reported as increasing from fewer than 20 in 1995 to over 100 in 2003 – RCPCH (2004).

Of those 14% of paediatricians who had received complaints, 29% said they were less willing to become involved in child protection work.[104]

In other words, a very small number of paediatricians have been subject to a formal complaint, most of which been resolved at a local level; 3% of complaints were upheld at that level. A tiny proportion had gone on to a further tribunal (independent or the GMC), none of the complaints were upheld at this level. Thus, research to date indicates it is important to keep this issue in proportion; it does not support the view that there are now many complaints in this area of practice[105] and large numbers of clinicians are refusing to do public law work.

## 2.13 Key features in patterns in the use of experts, possible links between use and contribution of experts and types of cases based on profile of children and parents

In summary, the use of clinical evidence in cases is the norm rather than the exception; this is linked to the complexity of cases in terms both with regard to socio-economic and what might be termed 'psychopathological' features and multidimensional problems of most families.

The major types of expert evidence commissioned in proceedings – equally unsurprising - are those clinical disciplines which address issues of health and illness and adversity in adults and children in general and in alleged ill-treatment of children in particular: paediatrics, child and adult psychiatric and psychological, and family assessment centres focusing on parenting skills.

The most recent data indicate cases are likely to contain multiple allegations concerning physical, sexual, emotional maltreatment and neglect of children. A majority of cases therefore are likely to require a range of clinical expertise.

In most cases it will be necessary to look at prospective harm to determine whether a child might be returned to parents at some point. This work is invariably undertaken by a child psychiatrist but with the input of other professionals including, in many cases, adult mental health evidence.

104 And further qualitative work (telephone interview) is being undertaken with this sample.
105 Although there are more now than ten years ago – see note 103 above.

In summary therefore, the complexity of cases indicate that any future attempt at 'case modelling' in this area – if done properly - is likely to be costly and highly complex. It will demand a much larger data set than has been possible to date in order to try some fairly sophisticated multilevel modelling.

Current research indicates models based on a 'single event equals a single type of expertise equals a case type' is too simplistic and indeed inaccurate. We know from all existing research that 'single event' cases are rare, and cases are almost never 'single issue' cases.

Current data indicate categories of child maltreatment and parent profiles are likely to result in certain combinations of evidence. Multilevel modelling is questionable - at least to predict an 'evidential landscape' which in a well prepared case will be fairly obvious to skilled practitioners, child care judges and others in this field. That is not to say that some breakdown by cost and time would not be helpful but rather a caution against simplistic typologies aimed at predicting types of cases.

The sequence of evidence is dictated by local authority concerns/allegations and its responsibility, as the applicant for the order, to provide evidence to establish the facts to meet the threshold criteria. However, there is some suggestion that the logical sequence is not always followed.[106]

Evidence filed by child and adolescent/family psychiatrists will also address the question of, 'where do we go from here?' looking prospectively at risk, longer term needs of children, placement and plans (including contact and possible rehabilitation of children). Thus, certain parts of the package cannot easily be 'detached' – either clinically or 'forensically'.

Equally, in terms of understanding patterns in the filing of evidence and the response of parents, under current legislation parents have a right to see the full evidence against them. Research indicates that the *precise* picture of that evidence and its implications will take time – it is a *process,* highly dependent on assessments. Parents need time to respond accordingly, having seen the documentation and to come before the court on equal terms with other parties (now a Convention Right, Art. 6, ECHR, but importantly a right in Children

[106] For example, where there are concerns about mental health issues or learning difficulties, there is little point in sending a parent for a family assessment until professionals have some information regarding a parent's ability to acquire and retain information and thus the most appropriate setting for any further work.

Act proceedings pre-dating incorporation of Convention Rights into domestic legislation under the HRA 1998).[107]

The availability of sufficiently trained and experienced psychologists and child psychiatrists for child protection proceedings remains a problem; further training and multidisciplinary training for all experts wishing to work in the legal arena remains necessary.  Equally, the framework for this work and whether it should be provided within or outside the mainstream NHS work remains unresolved.

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[107] The position regarding parents as litigants in proceedings prior to the Children Act is outlined in Brophy and Bates 1998.

# Chapter 3 – The views and experiences of children and parents: seeking and assessing parents' views

## 3.1 Robust research

Empirical studies based on parents' views about care proceedings are few in number. Robust studies, that is, studies with multilevel data which are contextualised within the appropriate legal framework,[108] and which include control data from court files and observations of courts hearings are even fewer (see Freeman and Hunt 1998; Brophy, Jhutti-Johal and McDonald 2005).[109]

The above researchers point out there are important issues about the validity of parents' views and the weight to be attached to views about different aspects of the legal process, and to findings of fact by courts. This is *not* an argument against research on the views of parents who are accused of serious child maltreatment, rather so far as policy development is concerned, a need for contextualised research within a multilevel data framework.

With regard to sample selection, even in the more robust studies where attempts were made to obtain a random sample, researchers repeatedly identify problems with the representativeness of samples and argue views and experiences cannot be taken as typical of all parents who pass through the court process. Indeed it is pointed out that parents themselves vary along a continuum with regard to contact with and experiences of the child protection process prior to involvement in legal proceedings.[110]

Studies that focus on parents' views about private law proceedings are not included in this review. There are some dimensions to parents' experiences of the legal process in private and public law which may be similar; there are, however, several crucial differences. As indicated above, in the context of care proceedings relatively few empirical studies use control data to *demonstrate* the need to achieve a balance between family autonomy and the duty of the state to intervene in family life to protect children from serious ill-treatment by parents.

[108] With regard to the Children Act 1989 and ECHR.
[109] Or cross checking with solicitors, some of the information given by parents, see Lindley 1994.
[110] With regard to whether they were known families and how long local authorities might have been working with them and the actions that resulted in legal proceedings, engagement with the process and outcomes in terms of child placements.

## 3.2 Unreasonable parenting?

In the more robust studies of parents which use multilevel control data (e.g. Freeman and Hunt 1998; Brophy et al. 2005) researchers reiterate the point made in Multidisciplinary above: there had been local authority concerns over the quality of parental care for a substantial period, most children were already on the child protection register (and thus deemed at risk of harm) and many were already living apart from their parents. Freeman and Hunt 1998 note that while a proportion of cases did not result in a public law order none failed because the threshold were not met.[111] Moreover, they highlight: '…after due process of law in which the matter was thoroughly examined before an independent tribunal with full rights of representation, the children of parents interviewed were deemed [by courts] to have suffered or were at risk of suffering significant harm attributable to the quality of their parenting, yet 83% of parents continued to deny, in full or in part, the nature of the severity of the concerns which resulted in court action'.

Brophy et al. 2005 present a similar finding from smaller qualitative study based on interviews with minority ethnic parents following the conclusion of care proceedings: where children had been removed following physical maltreatment, some parents nevertheless remained committed to a perceived right to use severe 'physical punishment'. Parents did not accept that children had suffered physical or emotional harm[112] or that the state had a right to intervene on children's behalf.[113]

## 3.3 Exploring the background to care proceedings with parents

### *Receiving services*

Freeman and Hunt 1998 is the only study that presents any detailed control data on pre-court practices. With regard to perspectives on the local authority services, researchers argued that there was 'little meeting of minds' about the grounds for concern, and parents were extremely negative about the 'help' that had been provided.

For example in 12 cases parents denied receiving any services at all, a claim that was easily disproved by reference to control data. Even parents who acknowledged receiving some assistance generally did so begrudgingly and tended to under-report the extent of assistance. Where a particular service was appreciated there were criticisms that it was

[111] As with the data from Brophy et al. (2003).
[112] Despite medical evidence to the contrary.
[113] Care should be taken here, this is not a finding about ethnicity and parenting per se; there were also minority ethnic parents in this study who did not use or approve of physical punishment of children. Rather it is a finding about the nature of child maltreatment, beliefs about a right to hit children, and thus the need for statutory intervention.

inconsistent or withdrawn too soon. Many parents were ambivalent about accepting services with some 20% saying they would have preferred to 'paddle their own canoe'.

The authors point out that it is easy to pillory social services as uncaring, untrustworthy and predatory and that this offers a useful device by which parents with fragile and battered egos can protect themselves from unpalatable truths. Parents' accounts may often have been fractured, inaccurate or misleading but they also conveyed a powerful sense of desperate unmet need.

While parents did not accept the totality of official concerns, many did acknowledge that they had some family problems; some made suggestions as to the forms of help they needed to address their difficulties. A majority of these suggestions focused on their own emotional needs arising from past or present life experiences. It should be noted that a high proportion of these parents had themselves been abused as children and/or spent part of their childhood in public care. Several parents spoke of needing help to resolve their feelings about that background.

Freeman and Hunt (1989) reported that some mothers with violent/abusive partners felt that social workers had little grasp of the effect of male violence and rarely focused upon it as a problem. Mothers would have welcomed more support both emotionally and legally in securing their own protection; they resented the fact that social services focused on deficits in the care of children to the detriment of mothers who were trying to provide that care.

Freeman and Hunt (1989) made two further important points which demonstrate the importance of robust multilevel data in this field in order to address the difficult balance which has to be struck between the principles of parental autonomy and protecting vulnerable children.

First, with regard to the provision of help for parents the researchers reflect back on days of preventative family-oriented casework and forward to assistance to parents in their own right as troubled adults, alongside or independent from the provision of child welfare services for children under s.17 of the Children Act 1989. They note that it is a desperately difficult task to attempt with parents where low self-esteem and a sense of failure may be expressed in alcohol or drug abuse and masked by hostility and aggression.

The researchers argue this is skilled, time-consuming and demanding work, which 'sits' badly with the pressurised and increasingly managerial climate in which public services now

find themselves functioning. Much depends on the quality of the relationship between a parent(s) and the particular skills and experience of the social worker, and it is difficult to combine work on child protection without either endangering the child or neglecting the parent (Freeman and Hunt 1998:22).

Along with others (e.g. Brophy et al. 1999; 2003; 2005) Freeman and Hunt highlight that in such cases it may well be impossible for social services to work with such parents without (a) the involvement of another specialist agency and (b) outside of the timed and secured legal framework offered by courts.[114]

Second, Freeman and Hunt reported that parents wanted more attention to be given to the practicalities of their lives: unsafe or squalid accommodation in particular was identified as a major stress factor adversely affecting the parents' ability to cope.

That point is also made in Brophy et al. 2005. However, as identified by reference to control data which includes information on the circumstances of the subject children, it is unlikely that repeated and severe physical injuries to children could be directly attributed to, for example, poor housing. While conditions contribute to a child-hostile environment and to increased and substantial stress for already vulnerable and isolated parents, the link is unlikely to be one of direct causality and there is much data pointing to multiple psychosocial and socio-economic factors indicating the need for multiple support systems.

***Use of accommodation as an alternative to care***

Data from related studies on care proceedings (e.g. Hunt et al. 1998; Brophy et al. 2003) demonstrate that the use of s.20 of the Children Act 1989 (voluntary accommodation) is a point of entry to the court process.[115] While early work (Packman and Hall 1998) indicated voluntary accommodation of children was generally working reasonably well, some concern has been expressed that at least some local authorities may utilise 'accommodation' as an alternative to court proceedings.

Freeman and Hunt 1998 identify that this strategy by a local authority initially applied in just over half of their sample.[116] From parents' perspectives at least, few parents (3 in total)

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[114] Researchers point out, however, that this does not resolve the responsibility of the local authority to try and work in partnership with parents during proceedings (Lindley 1994; Brophy and Bates 1998; Hunt et al. 1998).

[115] Accommodation under the Children Act was conceived as part of the range of services available to help families in difficulties, the voluntary nature of the contract between parents and the local authority is stressed by the removal of the requirement to give 28 days notice of intention to remove a child once he/she has been in care for six months.

[116] In practice that was an under-estimate – interviews with practitioners increased this to about 70% of cases.

reported they readily agreed to the accommodation of their children in the first instance; the remainder reported feeling pressured to comply, with court action posed as an alternative if they refused. Equally researchers reported many parents maintained their own agenda on how far they were prepared to conform to the arrangements, and most hoped the voluntary arrangement would be a short-term measure.

However, the researchers highlight that in all the 'enforced' (*voluntary)* accommodation of children, such children were accommodated after they had suffered significant harm. The researchers therefore argue 'it would seem that choosing the voluntary option does not require parents to face up to the real concerns about their care of children'.[117]

In the longer term some parents in this study felt ill informed about local authority plans and their rights within the system, some felt disillusioned and deceived when court proceedings were finally instigated. Most parents had not sought legal advice at the point at which children were accommodated and regretted this.

The researchers point out that some parents felt confused about uncertain and changing goals and felt powerless within the social services system. While accepting multiple agendas between parents and local authorities, the researchers note that this was not how s.20 of the Children Act 1989 and the facility of accommodation of children was intended to make parents feel, and is some distance from the ideal notion of partnership between officials and parents.

## 3.4 Parents' views and experiences of care proceedings

### *Recognising the need for intervention*

In studies to date (e.g. Hunt et al. 1998; Bates and Brophy 1996; Brophy et al. 1999; Brophy et al. 2001; Brophy et al. 2003) parents experienced a range of serious problems contributing to failures of parenting and children were usually subject to allegations amounting to significant harm/likely risk of harm across more than one field of maltreatment (see above Chapter one).

[117] It should also be noted there are concerns by practitioners about what is referred to as '*gun to the head section 20s'* where local authorities (albeit often under enormous resource/skills shortages) may resort to this strategy as a cheap way of keeping children in care without the demands of proper paperwork, court demands for proper assessments, contact arrangements and planning. And there is some worrying evidence with regard to the completion of assessment in the statutory period: for the year to 31 March 2004, of the 63,600 core assessments undertaken in the year only 62% were completed within the required 35-day timescale (see Core Assessments and Child Protection Registers - http://www.dfes.gov.uk/rsgateway/DB/VOLv000553/Vol01-2005CPR3v1.pdf)

Freeman and Hunt 1998 highlight that in practice most parents accepted that social services were justified in having ‘concerns’ – albeit some felt these were exaggerated. Where care proceedings were precipitated by emergency measures (emergency protection orders/police protection orders) there was a greater degree of congruence with the agency perspective and some recognition of the need for intervention (in 75% of the parent sample – Freeman and Hunt 1998). However, recognition did not extend to accepting the need for court action - not surprisingly, only a quarter expressing satisfaction with the way things then developed.

Where cases did not begin with emergency measures, parents tended to be much less convinced that there were major reasons for concern. Nevertheless, over 60% of parents admitted that they had indeed received prior warnings from social services that court action was being considered. The authors note that given that the majority of parents failed to accept responsibility for their part in the maltreatment, the honest admission of a substantial number of warnings is fairly high.

The researchers reported their impression of the ‘early warning system’ in this scenario was one of ‘brinkmanship’ with practitioners not always giving sufficiently clear and authoritative messages while parents disregarded or tested out the seriousness of the intent to take firmer action.

***Preparing for court***

In the early days of the Children Act 1989, Freeman and Hunt (1998) noted most parents had unrealistic expectations of care proceedings; for those without any previous experience of proceedings there was some confusion between criminal and family proceedings. That expectation remains and is not easily dispelled where family courts continue to share a building with criminal/youth courts (Brophy et al. 2005).

Both Freeman and Hunt 1998 and Brophy et al. 2005 note that whilst parents are given information about proceedings and what to expect by their lawyers and others, parents and indeed lawyers acknowledge it can be very hard to prepare for this process – especially at the beginning of proceedings where there may be very little time prior to a first directions hearing. Part of the problem is that the process itself is not known/understood outside the child protection field. Moreover, the range of personal issues that must be explored result in some shame, and high levels of anger, anxiety and stress in most parents.

As Freeman and Hunt 1998 note, where people are distressed they are often unable to take in everything they were told and may have difficulties retaining information. Parents in the

Brophy et al. 2005 study confirmed that view; parents said their solicitor had tried very hard to prepare them;[118] nevertheless they experienced high levels of stress and anxiety making it difficult to retain information and ask meaningful questions – especially in the early days of cases.

In both studies (Freeman and Hunt 1989 and Brophy et al. 2005) parents and indeed solicitors made a number of recommendations about how to improve parents' knowledge and experiences in this regard (see below) – as indeed did the Woolf Report with regard to the need of litigants in general in civil proceedings to have access to good information.[119]

***Waiting in court***

In both studies parents reported high levels of anxiety as they waited to go into court for the first time. These natural and perhaps inevitable feelings of apprehension were exacerbated by having to wait in a public area. The most common complaint from parents was a lack of privacy, that it was noisy with lots of people around.

Whilst some parents in Freeman and Hunt 1989 reported being able to go into side-rooms most felt there was nowhere to go to escape an exposure they felt was 'degrading', 'embarrassing' or made them 'feel like a criminal'. If they wanted to talk, some said, they had to whisper 'in case they were overheard'.

In spite of high levels of anxiety nevertheless some parents (about 43% in Freeman and Hunt 1989) noted the poor facilities in court waiting areas ('cold and dreary ', 'not that clean', 'squalid'). Few courts may meet the physical environment provided by the Principal Registry of the Family Division and even then resources could be stretched with shortages of judges and courts (Brophy et al. 2003).

Most parents reported some delay before getting into court on the days their cases were listed for a hearing. Freeman and Hunt noted that delays in getting before a judge/magistrate were broadly confirmed by observations data. More up to date information on this issue would be helpful particularly in view of recent efforts to improve listing arrangements in some courts. But there is evidence that judges remain well aware and

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[118] Lindley (1994:90) makes the same point noting there was considerable praise from the majority of family members for the work of their solicitors. They appreciated their solicitor's advice, extensive efforts to explain and prepare their case, and a willingness to advise parents almost on demand.

[119] Woolf LJ (1995) Access to Justice: Interim Report to the Lord Chancellor on the Civil Justice System in England and Wales.

concerned about the problems created for court users by ongoing listing problems (Brophy et al. 2003; 2005).

Researchers note that lawyers and children's guardians are accustomed to hearings not starting on time; some are instructed to attend court early in order to ensure issues and applications are ready for the listed slot; some practitioners have used this extra waiting time productively in discussions and negotiations with advocates for other parties. However, research identifies that for parents this process and the 'clubby' atmosphere it can engender amongst professionals can be disconcerting and can increase levels of anxiety for some parents (Lindley 1994; Freeman and Hunt 1989; Brophy et al. 2005).

This is especially the case for some families from minority ethnic parents who are newly arrived in the UK and/or where English is not a first language or where they originate from countries where officials – including lawyers and judges – are seen as corrupt. In these circumstances negotiations between advocates outside of the courtroom can increase a parent's anxiety about deals being struck in private.

***Privacy and secrecy***

Any support from friends or extended family members did not usually transport into the courtroom itself and indeed research identifies this is a complex issue. Some relatives may be there because they have a direct interest in proceedings and a view that may be at odds with that of a parent.

Some parents try hard to prevent knowledge of care proceedings leaking into local communities. Regardless of levels of anger, studies also identify feelings of shame and humiliation among parents who make considerable efforts to ensure proceedings are not common knowledge in their extended family/neighbourhood. Some parents saw family/friends as distinctly unhelpful – or as Freeman and Hunt (1998) identify – saddest of all – identified to researchers that they had no family or friends.

Most parents in all ethnic groups report feelings of anger, shame and humiliation at attending court following allegations of child maltreatment. However research indicates this situation can be especially complex for certain minority ethnic parents (Brophy et al. 2003; 2005). For example, one result of care proceedings becoming known in wider communities in some sections of Asian British society can be the complete ostracisation of a parent. In the absence of any supportive network in the UK or elsewhere, and perhaps with little or no

English, it is not surprising that advocates for some mothers reported real concerns for the their position and survival (Brophy et al. 2005).

***Understanding the court structure and changing courts***

With regard to court venues, Freeman and Hunt 1(998) and Brophy et al. (2005) identify that some parents were not clear about which courts they had attended and why their case had been moved from one court building to another.[120]

Comparing courts that combine crime and family work with those few which are limited to hearing family proceedings, solicitors for parents tended to feel that the specialist family court was likely to provide a better overall experience for most parents. Moreover, it was felt that care centres were also likely to provide a better experience for parents than some family proceedings courts (Brophy et al. 2005).

Nevertheless, research teams engaged with multilevel data note that despite changing court buildings and feeling angry and ashamed, most parents/mothers do attend most hearings (e.g. Hunt et al. 1998; Brophy et al. 2003). Both research teams highlight that high attendance rates reflect the hopes and trust that parents invest in the court process; parents see the court as the final arbiter and court proceedings as a way in which they could get an independent hearing on an equal footing with the local authority, and an opportunity to clear their names.

Good attendance by parents was part and parcel of that process; compliance - albeit carefully facilitated by child care lawyers - was seen by parents as part of the process. *Expectations* of the process, for all its resource and timing problems, were that it would be a fair and just process (Brophy et al. 2005).

***Seating layout in courts***

The seating arrangements in many courts in which parents were usually seated at the rear of the court and often behind their lawyers, made many parents feel excluded from the process (Lindey 1994; Freeman and Hunt 1989; Brophy et al. 2005); it is also reminiscent of criminal courts.

[120] That is why cases were transferred from the Magistrates' Family Proceedings Courts to a Care Centre/High Court.

Moreover, if professionals were softly spoken this could result in difficulties in hearing, if advocates wished to consult/seek instructions from parents during proceedings, that was also difficult in a traditional courtroom layout.

Equally, if a parent requires an interpreter in court, professionals cannot monitor the work ‘from behind’. Advocates and judges and indeed independent observations of proceedings confirmed this can be a problem (Freeman and Hunt 1998; Brophy et al. 2003; 2005).

There was some preference – from both parents and solicitors - for the arrangements adopted in some magistrates’ family proceedings courts in which a conference or U-shaped layout is used. Here parents sit next to their advocate, and have a direct line of vision to the judge/magistrates and legal adviser and to other parties in proceedings.

***Having one’s say***

While most parents anticipated they would at some point have an opportunity to ‘have their say’ in court, in practice relatively few cases result in a contested final hearing in which parents may be required to give oral evidence and be cross examined (Brophy et al. 2003; 2005; Freeman and Hunt 1998).

Both the above studies indicate parents can feel ignored, excluded and inconsequential to the court process where they do not get an opportunity to speak to the judge. However caution is needed with this issue. As Freeman and Hunt note in their study, few parents who did give verbal evidence felt they had acquitted themselves well; some felt rushed with insufficient time to say what they wanted, most suffered nerves and even the most articulate felt they had failed to do themselves justice.[121]

Undergoing cross-examination is a difficult and disliked aspect of the process; advocates and others were extremely cautious about exposing some highly vulnerable parents to cross-examination (Brophy et al. 2005). Nonetheless in the Freeman and Hunt study, none of those parents who did this ultimately regretted attempting to put their own point of view. Lindley (1994) made a similar point, noting that while some parents felt they had done well or quite well, giving oral evidence was a difficult task. Researchers suggest that with greater preparation and a degree of sensitivity, encouragement and forbearance on the part of

[121] In the earlier study of parents’ views and experiences by Lindsey (1994), of those parents who had given oral evidence (23/42 cases), more parents (14/23) were reasonably happy with their performance, nevertheless there were considerable pressures. The lack of a random sampling procedure in this study may account for the higher proportion of parents who reported giving oral evidence.

practitioners and the judiciary, parents might do a better job in this regard, with subsequent effects on their sense of justice.

***Cross-examination and 'adversarial' issues for parents and others***

In the early stages of Children Act proceedings, Freeman and Hunt argued that traditional adversarial approaches to cross-examination, drawn from criminal proceedings, were inappropriate to care proceedings but this issue has been taken forward on several levels by Brophy et al. 1999; 2001; 2003.

Those studies demonstrated that a robust questioning of evidence in child abuse cases is necessary, but it is inaccurate to depict Children Act proceedings as simply 'adversarial'; that is to misunderstand the process of evidence gathering and the specific nature of care proceedings.

As outlined in Chapter four below, evidence from the local authority and parents may need to be tested. As demonstrated in research (Brophy et al. 2001; Brophy et al. 1999; Brophy and Bates 1999) and re-iterated in recent case law:[122] experts are not infallible, expert knowledge is not a uniform category of knowledge, nor do many of the most experienced child psychiatrists claim it to be so (Brophy et al. 2001).

Thus where the ultimate sanction of society is the permanent removal of children from birth parents, mechanisms for cross-examination and the testing of evidence remain crucial to a fair and just legal system on two grounds:

- First, to enable care proceedings and case law to develop as welfare and clinical knowledge about children and parenting is developed and tested; and
- Second, to comply with ECHR agenda under Article 6 (rights to a fair trial, and issues of equality of arms between parties in proceedings).

As indicated above, parents have a right to question the evidence on which children are to be removed from their care and if appropriate to challenge that evidence.[123] In practice, as outlined above, research indicates most cases do not contain competing expert reports and most do not involve contested threshold hearings.

[122] Harris, Rock, Cherry and Faulder – HMTL version of judgment - [2005] EWCA Crim 1980.
[123] Although as demonstrated in Chapter 2 above (use of experts in proceedings) in practice it is inaccurate to argue that parents constantly challenge expert evidence.

Moreover as indicated by Brophy et al. (2001) and reiterated by senior judiciary in interdisciplinary forums, it is open to judges to ensure that where necessary cross-examination of witnesses – parents, experts and others – is rigorous but also fair and not unnecessarily harsh or intentionally humiliating.

Freeman and Hunt (1998) explored parents' views about the quality and accuracy of local authority evidence: there was criticism ranging from accusations of fabrication, exaggerations and distortions with inaccuracies in dates and names – blaming the wrong partner for the abuse or labelling the parent as a result of past errors.

While the researchers reported it was difficult to obtain sufficient information to explore all parental claims in details, responses highlight the need for professionals to take great care in the accuracy of their statements 'as it would seem that not all parental perceptions are without foundation' (Freeman and Hunt 1998:43).

### 3.5 Improvements on pre-Children Act proceedings

As researchers in this field have identified, in pre-Children Act proceedings most evidence was oral, written evidence usually consisted only of reports submitted for the final hearing from the social worker and the child's guardian. Parents were not informed of the context of statements/reports until the hearing was imminent – sometimes not until the day of the hearing (Murch, Hunt and Macleod 1991); a situation which was not Human Rights compliant – and difficult to imagine even in the relatively short history of some fourteen years following the Act.

Under the Children Act all parties are required to disclose in advance the substance of any evidence upon which they intend to rely.[124] Major researchers in this field working with multilevel data (e.g. Hunt et al. 1998; Brophy and Bates 1998; Brophy et al. 1999; Masson et al. 2004) note this as a significant improvement on pre-Act proceedings when parents and their lawyers were impeded in case preparation because they were unaware of the precise accusations.

The Children Act gave parents a right to challenge perceived inaccuracies and distortions by submitting their own evidence. This has been generally welcomed. However there is a perception among parents that compared with the statements of professionals, parents' statements count for very little (Freeman and Hunt 1989).

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[124] Family Proceedings Court Rules 1991 r17 (1) and Family proceedings Rules r4 (17)(1).

There is also some evidence that some parents are not always entirely satisfied with the content of their statements (Brophy et al. 2005); this is however a complex issue. Getting a parent's story in their own words and translating that story into the framework and language of law and courts often necessitates a degree of 'translation' into the dominant (legal) discourse.

For some parents at least – and perhaps especially certain parents from minority ethnic backgrounds - some things can be lost in 'translation', some issues which for a parent at least are culturally important, may for the purposes of proceedings be deemed legally irrelevant (Brophy et al. 2003; 2005). Parents and solicitors in Freeman and Hunt 1989 and Brophy et al. 2005 (and in Lindley 1994) argue for a further reduction of legal jargon in documents to assist the position and understanding of parents.

### 3.6 Feeling 'heard and understood' by judges and magistrates

With regard to notions of fairness and sensitivity on the part of the judiciary, Freeman and Hunt (1998) argued a majority of parents were impressed with judges/magistrates. This might be surprising given that judges were the final arbiters making decisions which often went against parents, and that some parents went to court expecting to have their version of events vindicated. A small number of parents were critical – either with regard to issues of impartiality but more commonly of judicial coldness and impersonal approaches. In the main, however, judges and magistrates came in for only mild criticism.

Highest levels of satisfaction were expressed when the judiciary directly addressed parents, listened patiently and sympathetically to what they had to say, showed an interest in the children and displayed respect, warmth – and explained to parents what was happening in court and why.

Bearing in mind small numbers in the study to date of minority ethnic parents' views of proceedings (Brophy et al. 2005), some minority ethnic parents have expressed concerned about whether they have been 'heard and understood' by courts. Some parents felt they were not understood, sometimes because the court had not had sufficient information about their diverse cultural/religious backgrounds, sometimes because parents felt the court did not understand the information it had received – and some minority ethnic parents simply did not know if they had been heard and understood by courts.

The difficulty was that parents in general did not often get an opportunity to address judges or magistrates; this adds to concerns about whether parents have been heard and understood by courts. Interestingly given debates about increased ‘throughput’ of cases, parents are well aware of the pressure on judges to get through cases quickly and some felt this had a negative effect on the time available to them in court hearings (Brophy et al. 2005).

In the Freeman and Hunt study, parents placed a high premium on judicial continuity and complained about lack of continuity among the judiciary hearing their case – changes occurred in 19 of the 25 sample cases. Parents in that study were anxious about a new judge getting only a superficial view of the case by reading the documents. Those views were held irrespective of the outcome of cases.

Brophy et al. (2003; 2005) highlight that the issue of judicial continuity has been addressed by the Judicial Protocol for case management with the aim to achieve judicial continuity in the allocation of care cases. Further work is necessary to assess how successful that has been.

Moreover interviews with advocates for parents found little fault with the threshold criteria as such but many felt the *process* for some parents left much to be desired. For example, some judges/magistrates did not welcome or acknowledge parents in court. When coupled with being seated at the rear of the court, and not having an opportunity to speak to the judge this contributed to some parents feeling they were not ‘heard and understood’ (Lindley 1994; Freeman and Hunt 1998; Brophy et al. 2003; 2005).

Where these experiences were combined with a statement that did not rehearse everything a parent wanted said, this could increase any doubt a minority ethnic parent had about whether they had indeed been ‘heard and understood’ by some courts.

Overall however most judges were described as good or excellent with all parents; parents and advocates alike praised those who actively engaged with parents in hearings/directions appointments where parents would otherwise not have an opportunity to speak to the judge.

Researchers commented on qualities within what might be termed judgecraft in the modern family justice system (e.g. Freeman and Hunt 1998; Brophy et al. 2005). Although historically such skills may not have been seen as critical to the performance of the judicial role in most other types of legal proceedings, they are increasingly shown to be important to the task of judge and magistrates hearing child care cases.

## 3.7 Parent's views about the pace of proceedings

Much has been said about delay in Children Act care proceedings at the level of policy debate; Freeman and Hunt 1998 approached perceptions of delay with parents (as did Lindley, 1994). In the study by Freeman and Hunt, those cases covered by the parental interview sample lasted anything from nine weeks to 18 months with a mean of 26 weeks and a median of 22 weeks. This chimed very closely with the duration of the sample in the wider study of case proceedings (Hunt et al. 1998).

The pace of proceedings was described as about right by parents/family members in just under 25% of cases (6/25 cases – and in most of these cases children were returned home or placed with an extended family member). For a further two children subject to a Care Order and placed for adoption, parents felt proceedings were too short. Both mothers had lost previous children to care: one felt more time was necessary to come to terms with what she saw as inevitable, the other mother felt that a slower pace might have affected the outcome by giving her more opportunity to break with her violent partner and demonstrate her determination to do so permanently (Freeman and Hunt 1998:57).

Most parents however indicated they felt proceedings had been too long and the reasons they gave for the length of the process matched those articulated by professionals. Interestingly, parents also identified what professionals call 'purposive' delay, that is, a 'delay' whilst something useful/purposeful such as a residential assessment was taking place.

While parents may have comprehended the reasons for the duration of cases they were nevertheless often critical of the reasons and its impact on their relationship with children (Freeman and Hunt 1998; Lindley 1994). Very few solicitors were reported as successful in their attempts to try and expedite matters but parents were not critical of them in this regard, they were perceived as trying hard and being very aware of the impact on children and parents of delays: 'he was trying to do his best' (Freeman and Hunt 1998).

## 3.8 Do parents have sufficient information, support and advocacy before and during proceedings?

As the above studies highlight overall, most parents had considerable praise for their solicitors, most appreciated the advice and extensive efforts solicitors made to explain and prepare their case, and their willingness to advise and support them - almost on demand.

With regard to pre-court circumstances, however, researchers have raised concerns about parents where notions of partnership with social workers have broken down and have suggested a need for an independent advocate for parents (e.g. Hunt et al. 1999; Freeman and Hunt 1995; Corby, Miller and Young 1996).

There appears to be relatively little research on the use, availability, training, cost and impact of advocacy services. The work of Lindsey, Richards and Freeman (2001a,b) address some issues in this field; it was based on interviews with parents, their advocates and social workers in some 36 cases following the instigation of a s.47 enquiry. This study sets out views about the role, expectations, concerns and funding of an advocacy service.

Researchers identify two main types of providers of formal specialist advocacy: those employed by specialist advocacy organisations (known as specialist advocates), and solicitors specialising in child care law, known as solicitor advocates.

These advocates were generally from a professional background in a related field and all had received some specialist training on child protection law/policy/procedure, although specialist advocates received more of this training than solicitor advocates.

Specialist advocacy organisations were rare and were generally founded as a result of the energy and commitment of one of several pioneering individuals.

Parents were generally referred to local specialist advocacy groups by social workers familiar with the group, or when the partnership was under strain and they needed help to engage parents with the issues. Some parents were resourceful in tracking down a specialist advocate but this was difficult.

There was a consensus that there should be a standardised referral service, preferably as part of the local child protection procedures, to ensure that parents have access to advocacy services early in the process.

The funding of specialist advocacy was dependent on charitable grants. This was generally inadequate and short term thereby creating financial insecurity.

The funding of solicitor advocates was either public funding where the parent fell within the eligibility limits or where there were proceedings pending, or private payment which most parents found onerous, if not prohibitive.

### *Function of an adviser/advocate*

Adviser/advocates aimed to develop a trust relationship with a parent to enable the advocate to give information and advice, and to work with parents to help them understand concerns and expectations of them as parents.

In the public sphere, advocates supported parents at meetings, translated jargon, managed parents' behaviour, raised cultural issues, acted as a witness, and assisted parents to express their views. Advocates also tried to build bridges and partnerships between parties, clarifying issues in dispute and inter-party expectations, challenging the local authority on issues/processes, and/or encouraging parents to co-operate.

### *Professional approaches*

Depending on how receptive parents were and the level of risk, advocates were generally 'directive' in approach. Ultimately, however, parents formulated their own views since they had to live with the consequences.

The independence of the advocate from the local authority was a fundamental feature forming the basis on which it is argued the parent could trust their opinion to be objective.

Advocates reported they generally maintained a parent's confidentiality unless they became aware of potential harm to a child that was not already known to social services. Here, researchers said advocates were under a self-imposed duty to report the information unless the parent did so.

Some social workers feared advocates might collude with parents placing a child at risk. This fear was greater with lay advocates, friends and family, compared with specialist advocates who were the focus of this study.

Some advocates had been invited to collude with parents; they resisted this. This fear was generally allayed if the advocate had a professional manner, and the social worker was aware that they adopted a reporting duty.

Despite being an advocate for the parent, advocates and social workers thought it important that the advocate considered the child's perspective, maintaining some detachment from the parent in order to give sound advice.

Solicitor advocates were more constrained in what they did than were specialist advocates; this was due to a range of factors including financial constraints and professional resistance to their involvement. Solicitors were frequently confined to observer status in meetings.

A majority of respondents thought it would be helpful to develop an advocacy protocol addressing professional and ethical issues and clarifying the role, so that there was less room for confusion/mistrust about the work of advocates.

A majority of respondents also thought that advocacy was helpful provided it is specialist, independent and non-confrontational, and it is instigated early in the child protection process.

***Important caveats***

The researchers identify inequalities in access to advocacy due to regional variations of service provision and financial constraints; there was also a lack of a uniform system of referral to sources of advice and advocacy.

Mistrust could arise where there was a lack of clarity about the advocate's role and where there were problems in communication if the advocate was too adversarial.

Some parents were dissatisfied because they felt their advocate was not challenging enough to social services. Conversely there was a fear amongst some social workers that advocates might collude with the parents unless the advocate demonstrated their professional integrity. Parents' views can become masked if the advocate is too directive in their advice or too vociferous in their advocacy.

## 3.9 The views and experiences of parents – summary

Robust data is in short supply and the problems of securing samples, let alone representative samples in this field, are enormous. Findings from more than one study suggest some possible 'trends' but much caution is necessary in any generalisations.

With the above caveat, studies to date indicate parents were not always clear about which courts they had attended; many could not/did not differentiate between dedicated family courts and combined courts but did not like attending family courts within buildings which also housed criminal courts. Lawyers working in dedicated and combined courts tended to think parents' overall experiences were likely to be better in dedicated family courts.

Overall, available evidence indicates both parents and solicitors thought that most judges were good or excellent with parents.

However parents – and indeed advocates - experience some variation in personal styles from judges/magistrates in what might be called judgecraft. Research indicates that routine engagement with parents in court was the key to a good experience for parents contributing to whether they felt 'heard and understood' by courts. Some sample sizes are necessarily small for this exercise but overall indications are that this may not be related to outcomes - some parents whose children were permanently removed nevertheless felt the judge had understood them.

Highest levels of satisfaction occurred when the judiciary addressed parents directly, listened patiently and sympathetically to what they had to say, showed an interest in the children, displayed respect, warmth and humanity and importantly took the time to explain directly to parents what was happening in court and why. This made parents feel part of the process where otherwise (e.g. in the absence of any contested hearings) they would have little/no opportunity for active participation in directions/hearings in courts.

Thus, in terms of the improvements, parents would like to see in the care proceedings:

- Opportunities for parents – if they so wished – to speak with the judge or magistrate.
- Welcoming parents in court, explaining issues and decisions to them and demonstrating an understanding of the parent's issues and background.
- Further efforts to reduce legal jargon, outdated terminology and lengthy statements in proceedings.
- Training for judges and magistrates to improve knowledge and understanding of diverse backgrounds. It would also help some parents if judges and magistrates improved their understanding of the work of interpreters in care proceedings.
- Increases in the numbers of care judges and improved listing for care centres to reduce the waiting time before going into court.
- Improvements in the layout of family courtrooms removing the vestiges of criminal courts, seating parents next to their advocate.
- Increases in the numbers of judges, magistrates and clerks from minority ethnic communities and recruitment of magistrates from a wider socio-economic background.
- Provision of information about care proceedings in a form, language and terms parents can understand and to which they can refer.

Research on pre-court advocacy services for parents demonstrate there is much to achieve in this field, both with regard to the provision and funding of specialist services and with

regard to further work exploring the impact of such services on parents, children and social workers and in reducing cases which might otherwise result in legal proceedings.

## 3.10 Children's views on care proceedings

***Available research***

In research terms at least, a focus on views and experiences of children and young people attending care courts is in its infancy; with the exception of Timms and Thoburn (2003) research is limited to extremely small samples and case studies supplemented by professional views. Some already small samples in 'specified proceedings' but which include some care cases nevertheless do not differentiate 'findings' between care and other types of proceedings. As with research on parents, therefore, much caution is necessary and it is not possible to generalise from available empirical studies to date.

Although in terms of principles of practice, most professionals adhere to some notion of children and young people 'knowing better than most' what it is like to be the subject of care proceedings, in the research arena for ethical and other reasons it has been extremely difficult to explore those experiences first-hand with children and young people.

In exploring the various dimensions to children's views and experiences it is necessary to identify and 'unpeel' a number of discourses – legal, social and cultural - about the nature of children and childhood, and their position and ascribed views and feelings about ill–treatment by those charged with their care: their birth parents.[125]

Historically professionals and courts have sometimes been seen to hold fairly negative views or protective attitudes towards the attendance of children and young people at care hearings. This, amongst other issues, has tended to inhibit discussions with children about issues of participation in care proceedings.

As other researchers and indeed some judges have pointed out however, the question of the attendance of children at care courts is a multidimensional issue. There are different

[125] Prior to the Children Act 1989 in the magistrates' court children over the age of five years had to be brought before the court for care proceedings unless they were indisposed or in the case of an interim order, legally represented (1969, ss 2 (9), 22(1). In the county court and the High Court children's attendance was generally considered inappropriate except in adoption where it remains compulsory. Section 95 of the Children Act 1989 gave the court complete discretion over the child's attendance at court. The rules provide that the proceedings may take place in the absence of a child who is represented by a solicitor or guardian if the court considers this to be in the interests of the child. The child's solicitor and guardian and the child if competent, have the opportunity to make representation to the court and the guardian has a specific duty to advise the court of the child's wishes about attending court (FPR r 4.16 and FPR r 4.11 (4)(b) respectively).

dimensions and levels of participation, different aspects to children's needs (to see and be seen, to read documents, to feel heard and understood by courts), different types of hearings to consider, different timeframes in which to consider attendance, and different safeguards may be necessary for different dimensions, different children and types of cases.

Protecting children from long and acrimonious hearings is one concern and response to the question of whether children might attend court. But as research demonstrates, such hearings do not represent the majority of cases. Cases that start off as highly contentious frequently come to an agreement – at least about the threshold – by the time a pre-trial review is reached (Brophy et al. 2003). Thus the attendance of children/young people – for those who want it – can be a question of timing (Masson and Winn Oakley 1999), albeit this may still appear somewhat 'stage-managed'.

There remains however a substantial gap in robust information about what children want and how courts might best develop to meet some/all of that agenda. In this exercise, limited though available studies are in terms of relevant samples, some important information provides a starting point.

For example, Masson and Winn Oakley (1999) interviewed 20 children aged 9-15 years in 'specified proceedings'; nine of those children were subject to care proceedings. Overall, children were divided between those who wanted to attend court and those who did not, 5/20 children attended the final hearing but there was a wide spectrum of views and feelings about this issue.

### 3.11 Speaking to the judge and observing the architecture

Some children did want to speak to the judge, thus the offer of a tour of the court building and an empty courtroom was not enough, as one young person reported to a researcher on being offered a tour of the court: '…*I told her, I'm not really interested in the architecture...'* Like parents, some young people associated courts with crime, and were fearful. Guardians in this study reported county court judges were opposed to children attending hearings (but not to visiting courtrooms); magistrates were more likely to be sympathetic to a request, guardians themselves were generally uneasy about children being in court.

### 3.12 Flexibility to meet a range of needs

Some children were ambivalent about attending court, some clearly rejected attending. Fear, associations with crime and wrongdoing, not wanting to know the decision, not wanting

to meet certain people including parents, fears about being recognised/loss of privacy/shame featured - and some children simply changing their mind about attending.

### 3.13 Timing decisions about children's attendance

The researchers note that directions for the child's non-attendance were frequently made when the nature and duration of the final hearing was not known, and ultimately there were no contested final hearings in this sample.

### 3.14 Exposure to long hearings and horrendous details

Solicitors were also concerned about the nature and content of proceedings and effects on children. Some were reluctant to discuss attending a hearing with a child because of the negative attitude of courts; some were concerned that judges might not demonstrate the necessary compassion.

Researchers point out there are timing and environmental issues to consider (as indicated above, the layout of some courts are not parent or child friendly). Different safeguards may be needed at different stages in the process but most cases do not result in highly distressed parents rehearsing horrendous verbal evidence in court. Some children wanted to meet the decision maker, others, however, did not.

This is a small qualitative sample so far as care proceedings are concerned but it does reflect the multiple dimensions to this issue: children, like parents, have a range of views; there are different aspects to the question of attending court, from wishing to know where and who will make the decision, to wanting to talk directly to the judge to ensure he/she understands the child's views.

### 3.15 A postal survey of children/young people in care

Timms and Thoburn (2003) provide information from a sub-sample of some 163 children (from a total sample of 706 children/young people). This study was based on a postal questionnaire (with mainly closed-questions) distributed through a magazine. Participation was therefore self-selective and unfortunately in 63 cases where responses came from children with experience of attending court, data did not allow for differentiation of care, youth offending and secure accommodation cases, thus caution is necessary when looking at results in so far as these can be generalised to care courts.

Most children who participated in the survey had not been to court; nevertheless some 23% had attending a court hearing. Girls were twice as likely to say they had not attended but would have liked to have done so.

Children did not perceive proceedings as an avenue of communication through which they could be involved in decision-making. Younger children were less likely to indicate they had attended court (9% of 6-11 year olds, compared with 21% of 12-14 year olds, and 39% of 15-16 year olds).

***Someone alongside me?***

In the court sub-sample (163 children), most (70%) described having enough help during proceedings, most (78%) had someone to talk to and most (84%) also had someone who explained what was happening.

***Someone to help and to hear me?***

However, fewer children felt they had enough practical help during proceedings (49%), or had a chance to speak to a judge (27%), or felt they were listened to (47%). Some 38% did not have a chance to speak to the judge; a further 19% had wanted an opportunity to speak to a judge.

In terms of the adults children felt were helpful to them during proceedings, their social worker was noted by 28%, their solicitor by 26%, a named person in 18% of cases, a family member in 12% and their guardian in 6% of cases.

When asked what would have made things easier for them during proceedings, 34% said more support, 34% said more information, 24% said 'nothing', and 12% said more practical help.

As with Masson and Winn Oakley (1999), Timms and Thoburn (2003) identified a range of views and experiences offered to children/young people. It is worth noting that the survey indicates many children who went to court – whichever court that was – either had a chance to speak to the judge, or would have *liked* to have done so (some 46% in total);[126] 47% said they were listened to, 25% said they were not – and 25% did not know.

[126] Some 16% of children/young people, however, said they did not want to speak to the judge.

## 3.16 The views of children in care proceedings - summary

Sample sizes to date mean much caution is necessary here; research with specific regard to care proceedings is in its infancy. More multilevel studies are necessary but information to date indicates the views and experiences of children and young people are inextricably linked to their participatory rights.

What children may want in this regard in terms of improvements to the system is likely to be multidimensional. A rights framework incorporating party status, representation, consultation, equality of arms with others, and transparency in decision-making is a starting point. Within that framework, approaches tailored to the participation, observation and information requirements of the particular child/young person may be needed.

Some of these issues have been identified in empirical work to date but much remains to be done before children and young people can be described in any meaningful way as 'court users' – and indeed a more critical approach to that concept is necessary. In research terms, there is enough information to date to argue that further research will require a degree of methodological sophistication in order to reflect the reality of the lives and options for children likely to be subject to care proceedings.

# Chapter 4 – Approaches to problem resolution: the need for compulsion, attempts at specialist ADR, and the contemporary role of care proceedings

## 4.1 Alternative approaches to dealing with parental ill-treatment of children - background

In the UK formal attempts at developing and appraising a model of alternative dispute resolution (ADR) in cases of child maltreatment are rare.

In some social work literature, care proceedings have been posed as highly adversarial and a limited number of commentators have suggested that other forms of dispute resolution might be preferable. Thus, for example, family group conferences and models of mediation utilised in private law proceedings have been posed as more conciliatory in approach and less traumatic/damaging to parents compared with court proceedings.

The background, hypotheses and findings from one attempt at mediation in child protection cases are discussed below. This is followed by research findings on care proceedings exploring how current philosophies, processes and practices compare with traditional depictions of proceedings as essentially adversarial.

## 4.2 Specialist alternative dispute resolution in child protection cases

The report of King, Trowell and Roberts (1998) is based on a pilot study, which attempted to develop and appraise a model of 'alternative dispute resolution' (ADR) to address disputes between parents/carers and the State regarding children subject to maltreatment.[127]

The project aimed to identify the necessary knowledge and skills applicable for Alternative Dispute Resolution in cases concerning child maltreatment; these skills were then to be applied in a pilot study, and, if appropriate, developed into a training module.

The background to this pilot project lay in a critique of both legal proceedings and social workers. Proceedings were described as too adversarial leading to further polarisation and conflict between parties while social workers were said to occupy conflicting roles: they were expected to intervene to protect maltreated children but also to preserve families by minimising the involvement of local authorities and courts.[128]

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[127] This study was funded by the Department of Health; particular thanks are expressed to the authors for discussions and access to the unpublished report for the purposes of this review.

[128] Albeit this is arguably based on a misunderstanding of the terms of state intervention in families to protect children, and also the limitations to a right to respect for family life. This latter right is a qualified right; the State

A form of mediation in such cases was therefore posed as a possible alternative to court proceedings. Drawing on literature relating to disputes between parents in private law proceedings, it was felt that a form of 'alternative dispute resolution' was likely to offer a more constructive and collaborative approach to resolving disputes between parents and the State through a consensual process based on joint decision-making. Against that background the researchers argued ADR 'should maximise the opportunities of satisfying the respective interests of all involved' (King et al. 1998).

## 4.3 Adding clinical and welfare expertise to mediation skills

The pilot project was innovative; unlike models used in private law disputes it involved mental health professionals (child psychiatrists and psychoanalysts) along with social workers and trained mediators. While the clinicians had substantial previous experience of public law cases, this was not so for mediators whose work in the UK has been limited to private law disputes.[129]

## 4.4 Hypotheses for the pilot study

The working hypotheses for the pilot project were (i) ADR would be less disruptive to children, it would be cheaper, less time consuming and less conflictual than litigation, and it would be less likely to result in parental resistance or alienation of children by their parents; (ii) ADR could diminish feelings of role conflict said to be experienced by social workers; (iii) ADR could more easily establish co-operation of parents with social workers, and this is the most important step in protecting children; (iv) ADR could provide an impartial third party intervener either to evaluate the situation or to mediate in a dispute or problem. The aim was to help social workers and parents find a solution that protected the child without destroying the social worker-parent relationship.

Importantly, the researchers argued that ADR would allow the needs and interests of parents to be addressed, and the more parents were involved in a collaborative process, the more in control and therefore co-operative they were likely to be. Moreover, ADR was said to have as its central plank a commitment to the best interests of the child as paramount and that 'disputing parties knowing this criterion might find it easier to accept

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may intervene where the law permits if this is necessary to protect a child's rights and freedoms including protecting the child from significant harm (Art. 8, Human Rights Act 1998). However only action that is proportionate is accepted as necessary.

[129] There is a body of writing on various forms of mediation in private law disputes; it is not the purpose of this review to rehearse those debates but it is important to reiterate that there are important and fundamental differences and consequences for children between private and public law proceedings.

difficult and painful outcomes' (King et al. 1998).

## 4.5 The principles of mediation and a model of ADR in child maltreatment cases[130]

In brief, mediation is a form of intervention in which a third party assists the parties in conflict to reach a negotiated settlement. In general terms the mediator does not have a stake in the dispute, is not identified with any interests, and has no power to impose a settlement on parties. Thus parties retain the power and authority for making their own decisions. At the heart of mediation theory therefore and central to its success in resolving disputes is the notion of voluntarism.

In attempting ADR in the child protection arena the researchers retained certain principles fundamental to the model (e.g. the voluntary nature of the process, the need for parties to devise their own agreement, and the lack of power of mediators to impose a settlement on parties).

However, the model is developed in two ways. First, the mediators voice an interest: the welfare and safety of children is paramount in the process. Second, the project extends the knowledge and expertise of the mediating team by including clinical practitioners.

The 'added value' of clinical skills and expertise in this exercise was:

[130] While it is not the focus of this section to review mediation more generally or research on family group conferences, various approaches, principles and practices come under the umbrella of 'mediation'. For example, according to King et al. (1998), ADR is differentiated from Family Group Conferences (FGC) and while there are several variants of FGC, the one said to be promoted by the Family Rights Group is delineated by the following principles: families are encouraged to resolve difficulties concerning a child by bringing family members together and clarifying the issues to be resolved by an FGC; social workers do not intervene directly in conference discussions and there is no social work involvement in the family's planning although the family will be made aware of social work concerns. The family is given responsibility for the plan. Final family plans are however subject to the agreement of social workers and to that extent social workers are able to maintain control over the outcome of conferences. Past disputes between a family and social services are not usually dealt with in the FGC, such issues are dealt with by a facilitator or co-ordinator before the FGC takes place in order to establish the scope and nature of the issues the conference is permitted to address. Disputes can occur after the conference if social workers find the FGC decisions unacceptable or the local authority cannot provide funding deemed necessary. A co-ordinator is not directly involved in the family's planning for the child but remains available to answer questions/help with problems. As the researchers note, there are important differences between the FRG model, the model of mediation adopted in the pilot study and the original model developed in New Zealand. Equally, it should be noted models of mediation in other jurisdictions have used both lay and trained people and have employed varying degrees of compulsion. King et al. (1998) noted that other projects in the UK have been very limited, tended to be informal, have not involved child mental health professionals and have been limited to work with older children on issues of contact and home visits.

- Experience of child protection assessment, treatment and management
- Experience of seeing families at the extremes of disturbance, interpersonal violence, emotional pain and suffering where there is very little rational or reasonable functioning.

Moreover, it is argued that a clinical input brings an understanding of:

- Human growth and development
- The influence of diversity
- The nature of unconscious processes, groups and organisations
- Knowledge of the Children Act
- Mental illness, personality disorder, learning difficulties
- Mental health legislation
- The operation of social services departments.

In addition a clinical input was able to offer

- Skills in observation
- Assessment of mental states and dangerousness
- Self awareness and the use of self
- Communication skills with the whole range of children and adults including those with mental illness and learning difficulties.

Thus, the model of mediation is differentiated from that used in private law; it is tailored to the issues pertinent in public law cases. To make this differentiation clear and to mark it as a defining feature of the pilot study, the researchers employ the term 'specialist child care mediation' to denote the multiple skills and expertise on which the project is predicated.

***The first three years: take–up of the service***

Despite extensive and laudable attempts to recruit cases, the pilot project received only 36 enquiries during the three years it was in operation; fifteen were accepted. The reasons for non–acceptance of the remaining twenty-one cases included change of circumstances, refusal of one or more parties to take part, or because the case did not in practice involve a public law issue.

Most cases (11/15) were referred by social services Departments; of the fifteen referrals that were accepted and to which mediators were allocated, three further cases were lost because of the unwillingness of parties to meet.

Most cases were referred at a late stage in the relationship between social services and parents/carers; most/all cases had already been through court,[131] all were complex due to the intransigent nature of conflicts and the number of parties involved.[132]

In the fifteen cases allocated to a mediator[133] most children were already living away from their birth parents (seven children were already in foster care, two were adopted, five were living with a parent, one child was in a psychiatric hospital, two children experienced a change in circumstances during the course of mediation).

In 9/15 cases the relationship between the social workers and the parents had almost completely broken down; in three cases the relationship between parents was a problem; and in three cases it was the relationship between adoptive or foster parents and natural parents.

In other words, and in so far as this is ascertainable, these cases were largely about post 'disposal' issues (many focused on disputes about contact either following a care order or with regard to children in foster care under voluntary agreement). They were not on the whole cases concerning a dispute about whether the parent's treatment of a child breached the threshold criteria and whether it was possible to divert the case away from legal proceedings.

***Evaluation***

The researchers stated that 'of the nine cases which proceeded to mediation, some degree of agreement was reach on the issues in dispute. Six of these were minor issues (not the main problem), in one case participants changed their minds, and in three cases sessions were cancelled and no agreement was reached, with cases going back to court' (King et al. 1998:24).

***Expectations of mediation by those involved in the pilot***

Most participants interviewed before the mediation session had little/no knowledge of mediation and were unsure what to expect. However most of the 47 participants (eighteen

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[131] The report is slightly unclear about this, at one point it states 'most cases', at another, 'all cases' as having been through the court process.

[132] It should be remembered that in mediation in private law proceedings there are usually only two participants in conflict; in public law proceedings the conflict may be between three/four parties (the local authority, the mother, the father, the child/guardian).

[133] Most of the families (10/15) were white; five were black; there were no referrals of families of South Asian origin. The researchers noted that there was at least five where it was felt issues of diversity were perceived as relevant to the issues in dispute (King et al. 1998; 24).

professionals and twenty-nine lay people) were fairly confident that they would be able to talk freely and explain how they felt.

When asked - post mediation - if in fact that had been the case, for those for whom data is available, 13/47 said 'completely', 12/47 said 'adequately', 7/47 said 'not really' or 'not at all'.

***Feeling heard in the mediation session***

As to whether participants felt their worries and problems had been listened to, eight said 'completely', nine said 'adequately' but fifteen said 'not really' or 'not at all'.

***Fairness and impartiality in the mediation***

Just over half of participants felt the sessions were fair (24/47), impartial (27/47), and even-handed (24/47), but some were not convinced, thus while 24 participants thought sessions were even-handed, 17 were not sure and six said they were not.

In summary, the reactions of the participants to the session(s) varied but the authors concluded that it [was] clear that for the majority their expectations had not been met; many felt frustrated, disappointed, angry, resigned and exhausted (King et al. 1998:25).

At a follow-up evaluation interview, the sample figures reported are unclear but for the 20 responses discussed most (13/20) reported being dissatisfied with mediation and its outcome (King et al. 1998:26).

***Mediators and health professions in the pilot exercise***

Several points are important in comparing this pilot study with a legal forum:

- The mental health professions found meeting families without first reading background papers quite strange; they were used to reading the history of cases prior to meeting families.
- While parents valued this lack of prior knowledge by health professionals, it resulted in frustrations on the part of social workers because they had to give a succinct explanation of issues.
- It was felt parents needed more time/sessions than the professionals. By working in pairs mediators aimed to avoid alliances with participants and to focus parties on the needs of children rather than their own concerns/needs.
- Participants tended to want more time but further appointments were extremely difficult to timetable resulting in high levels of frustration at the long gaps between sessions.
- The safety of children was paramount and thus a non-negotiable position. The team's expectations of parties were that preferred solutions would involve compromise; this meant that each participant went away only partially satisfied.

- While mediators hypothesised that the process of mediation would facilitate better communication to continue between sessions, the researchers note there was no evidence that this in fact happened.
- Mediators were very frustrated by the very high proportion of cancelled appointments. They note the importance attached in England to 'voluntary' as opposed to 'mandatory' mediation and that in some countries courts can order clients to see a mediator. However they also note that it is conceptually impossible for mediation itself not to be voluntary; if a client refuses to negotiate his/her own solution, mediation will simply not take place. The researchers highlight that the only mandatory element of court-ordered mediation elsewhere is the court telling parties to see a mediator to find out if mediation may offer a resolution of the dispute.
- Nevertheless, the researchers hypothesise that had the courts ordered parties to try mediation it would at least have saved endless time trying to co-ordinate appointments, many cancellations and much wasted time.
- With regard to the multidisciplinary nature of the team, the researchers noted disagreements between members, these mirrored the different professional cultures and backgrounds of team members.
- There were indications that it may be possible to involve older children (over eleven years) in this form of mediation but it requires careful planning and skills. However, it should also be noted that most children did not wish to attend the full mediation session, preferring to have their views represented. Children/young people were able to explain what they felt and wanted but had problems in accepting that what they wanted from mediation might not happen. This led to children questioning the point of mediation.

***A pilot project in specialist ADR – summary***

The pilot project was not able to demonstrate that specialist mediation in child protection cases reduced the need for legal proceedings, or that it reduced contested court hearings.

Equally it was not possible to establish that mediation was cheaper and less time-consuming than care proceedings; nor that mediation alleviated role conflict in social workers, or achieved better/more co-operation between parties outside of mediation sessions.

The poor response rate from both professionals and families demonstrated some of the intractable issues in child protection cases.

In later reflections on the study, King (1999) suggested that in so far as poor referrals were concerned, this was not only due to the perceptions of social workers and lawyers about mediation but also perhaps to deeper and more psychodynamic factors such as defence mechanisms said to underscore decision-making.

Poor response rates were no doubt also responsible for the fact that the pilot project did not gain further government funding to continue the work.

Notwithstanding the benefits of having highly experienced health professionals involved in cases and laudable attempts to empower some parents, the theoretical framework for some of this study was problematic.

*Some* of the arguments tabled about the nature of care proceedings were not substantiated by research evidence (see below).

Some of the discussion about contested court hearings was also problematic. So, for example, it was argued that a local authority, starting from the belief that a full care order is necessary, 'may well settle for something less than a care order'. In practice this is not the case: research indicates that where there are no changes or developments in the circumstances of cases (as outlined in Multidisciplinary above), most applications for care orders resulted in a care order (Hunt et al. 1999; Brophy et al. 1999; 2003).

This is *not* to say that changes do not occur in cases but rather that it is necessary to look at empirical evidence about where and how change is achieved. A central question is whether changes are due to changed circumstances in cases, or a failure to establish the threshold criteria; research evidence indicates it is the former.

## 4.12 The contemporary role of courts in care proceedings

***The Children Act 1989 – monitoring and evaluation***

Three studies on care proceedings included observations of hearings and directions appointments/hearings and tracked cases throughout the process (Hunt Macleod and Thomas 1999; Bates and Brophy 1996; Brophy, Jhutti-Johal and Owen 2003).

***The Children Act 1989 and changes to law***

Researchers have explored the conditions necessary for making a care order (the threshold criteria), issue of prospective harm and assessments of a parent's capacity/willingness to change. The latter part of this process has been identified as adding to the complexity of proceedings both with regard to determining future care and also some contact issues.

While a focus on 'diagnostic' and predictive considerations under Children Act proceedings was not entirely new[134] it was given a more explicit focus and one which – given the multiple

[134] As Hunt et al. (1999) noted, under previous legislation an assessment of proper development, health and ill-treatment was necessary to meet the requirements of s.1 (b) (i) of the CYPA 1969.

problems of parents - was often likely to require expertise beyond that of social workers (Brophy et al. 1999).

The (prospective) framework is driven by the philosophy underscoring both domestic and International legislation, which states that in principle children are usually best cared for by their birth parents. Where it is deemed necessary to remove children, a care order should, where possible, be seen as a temporary measure, the long-term objective being the rehabilitation of parents and children.

***The Children Act 1989 and changes to legal procedures***

Changes to proceedings following the Children Act included a movement from largely oral to written evidence, new rules of disclosure and a requirement that regardless of content, all expert evidence should be filed,[135] it should be filed prior to the final hearing, and letters of instruction to experts should also circulated and be filed with the court.

Researchers identified that the former two features have had a considerable impact on care proceedings, but perhaps foremost has been increased transparency in the issues and concerns in cases and at a much earlier stage in proceedings than was previously the case (Hunt et al. 1999; Brophy et al. 1999).[136]

In addition, as indicated in Multidisciplinary above, the introduction of directions hearings/appointments enabled the court to exert control over the evidential process, the examination/assessment of children, the timetabling of statements and reports, and the date of the final hearing.

Furthermore, as Multidisciplinary above identifies, research demonstrates that in many cases (over 70%) parents have, amongst other things, refused co-operation with public agencies (both health and welfare). Research demonstrated that care proceedings provided a protected space in which assessments could take place and where, in a managed way, parties could work towards a resolution of difficulties, or demonstrated that this was not going to be possible. Equally during this process all parties - including the local authority – are made accountable to courts for their actions/inactions.

[135] Whether or not it supports the interests of commissioning parties.
[136] It should be noted that, prior to the Children Act 1989, a local authority would typically try to keep much of its evidence under wrap - to the extent that lawyers for parents sometimes had to force a contested interim hearing to ascertain to nature of the case against parents (Hunt et al. 1999).

Researchers with both pre- and post-Children Act samples argued that while use of the court process in this manner was not entirely new, Children Act proceedings with a strong familial and voluntaristic philosophy accelerated this development. Once proceedings were initiated guardians and clinical experts assess carers and potential carers; changes in family composition, circumstances and attitudes along with new information and new family members impact on the process (Hunt et al. 1999; Brophy et al 2003).

As multidisciplinary above demonstrates new carers and assessments can result in changes in the original order sought. These shifts should not be read as indicating local authorities pursued but failed to achieve a care order. Rather that changes which were achieved were planned and negotiated within the framework provided by proceedings.

Moreover, for those cases that resulted in care orders and the permanent removal of children, research identifies that for most, a resolution of the conflict over the threshold criteria was achieved without a contested final hearing (Hunt et al. 1999; Brophy et al. 1999). In most cases an agreed threshold statement was likely to be filed for the pre-trial review (Brophy et al. 2003).

Research thus identified that while most final hearings are not the dramatic and adversarial testing of all evidence and cross examination of parties and positions which a lay audience might envisage, this is because the real work has taken place over the preceding months in detailed assessments and negotiations.

Thus, conceptions of care proceedings as an adversarial process between parents and social workers with courts simply acting as final adjudicators in a highly contested process is inaccurate. Research identifies that proceedings are a dynamic process and at several stages, 'inquisitorial' (Hunt et al. 1999; Bates and Brophy 1996; Brophy and Bates 1999; Brophy et al. 2003). Indeed the process is more accurately described as something of a hybrid between two systems (Brophy et al. 2001; Brophy and Bates 1999).

Subsequent Practice Directions, case law and case management guidance and protocols for courts, advocates and experts[137] seek to increase the inquisitorial nature of the process whilst retaining recognition that aspects of proceedings by their very nature involve a dispute

[137] See for example, Brophy et al. (1999) for case law and Practice Directions throughout the 1990s; also DCA (2003) Protocol for Judicial Case Management in Public Law Children Act Cases and Appendix C – Guidance for Experts; The Law Society et al. (2004) Good Practice in Child Care Cases, and Wall with Hamilton (2000) Expert Witnesses in Children Act Cases.

between parents and the state. Nevertheless, it is accepted that wherever possible proceedings should be non-adversarial.

Guidance states that advocates should not behave in an adversarial, aggressive and confrontational manner and that the process should be professional and co-operative. However, parents and children are not usually involved in proceedings by choice and the removal of children is one of the most severe steps a State can take; lawyers and courts are therefore under a duty to ensure that evidence indicating such a move is necessary, is rigorously tested.

### 4.13 Contemporary care proceedings - summary

Analysis of the process coupled with the nature and profile of children and parents in proceedings, identifies several features:

- Care proceedings are dynamic: while the concerns/allegations of the local authority may be clear, in many cases certain things will remain unclear until assessments are undertaken. Thus, courts and parties are dealing with a *process* not an event.
- In principle, the specific features and demands of the case determine the sequence of expert assessments.[138]
- Until the process of assessment is complete a local authority is unlikely to specify a final care plan[139] – thus in most cases involving expert evidence the final care plan will be unlikely to be filed until the latter part of the case – typically for the pre-trial review (Brophy et al. 2003).
- It is also the case however that the necessary logic in some of the evidence gathering can make it hard for parents to intervene at an early stage in cases: they need to wait to see how the local authority's evidence 'shapes up' and what the final plan will be for children (Bates and Brophy 1998).
- There is also evidence that where parents instruct solicitors who are not child care specialists (i.e. not on the Children Panel of the Law Society), this can be highly problematic (Hunt et al. 1999; Bates and Brophy 1996; Brophy et al. 2003).

[138] Thus for example, if the case concerns a parent with a mental health problem, a learning difficulty or an addiction problem, it may be necessary to have an expert assessment to ascertain whether the parent might be able to engage in and benefit from some form of treatment and some parenting skills work. It may also be necessary to explore the initial parent-child dynamic (for which a child/family psychiatrist might be necessary) in order to see how the relationship needs to change, whether a parent has the capacity for this, and the type of family centre which might be necessary to undertake this work. To some extent however, a lack of multidisciplinary centres and the fragmented nature of clinical services for care proceedings also dictates the sequence of evidence (Brophy et al. 2001).

[139] Research also demonstrates that the absence of firm and final objectives should not automatically be conflated with a lack of clarity in local authority thinking. More typically it reflected the multifunctional purposes of the court process (Hunt et al. 1999; Brophy et al. 1999; 2003). However, it is the case that Children Act 1989 and Guidance placed an emphasis on the need for planned rather than crisis driven interventions, and voluntary alternatives to care orders. It was envisaged that the proportion of cases in which the local authority engaged in proceedings before formulating its objective would drop; subsequent research on the number of care cases which were immediately preceded by an emergency protection order and during which, final plans awaited the outcome of assessments, indicated that for a considerable proportion of cases this has not in fact happened (Hunt 1998; Brophy et al. 2003).

- For example, non-specialist practitioners may not understand the specificity of care proceedings and the focus on problem identification and solving. Non-specialists can also be inappropriately adversarial, unfamiliar with case management expectations, and less skilled in working with vulnerable parents who may be less well-advised and prepared for certain unpalatable results.

This is not to suggest that research evidence on care proceedings indicates the system is without faults (see below) but rather that the dominant legal model posed in an argument for specialist mediation was largely inaccurate – even at the time of the study.

Equally, important lessons can be drawn from the piloting of specialist mediation in child protection cases. Taken together, studies demonstrate the need to consider what the court process offers parties and especially children, and what features and options – clinical and legal - would need to be considered in any future attempts at diverting cases away from the legal arena.

The specialist pilot project indicates that this model of ADR is unlikely to work in the child protection arena without amendments; these amendments and in particular a removal of the voluntary aspect of the model itself would render its principles, theory and practice, unworkable.

Mediators do not have training, skills and experience in serious child maltreatment or working with highly vulnerable adults. The availability of mental health clinicians with experience in child protection work is already extremely limited; Child and Family Mental Health Services (CAMHS) are currently unable to meet the existing needs of courts. In reality therefore and in the short to medium term, it is highly unlikely that child mental health specialists would be available to undertake training and assist in the development of specialist mediation schemes.

***The strengths of Children Act care proceedings:***

- Child care proceedings are built on a model of rights for parents and children.
- Children remain at the centre of the process; their needs for safety are met.
- Proceedings have achieved a level of internal transparency in the evidence necessary to substantiate the removal of maltreated children.
- Evidence is timetabled; the use of experts and the examination of children are controlled.
- All parties are made accountable for actions and decisions.

- Parents are given an opportunity to demonstrate a capacity and willingness to change.
- The process is Human Rights compliant.

***Weaknesses of current proceedings:***

- A lack of local and national management information which enables linkages to be made within and across the overall system (Parts III and IV of the Act) in terms of cost, timescales, availability and quality of welfare and clinical (CAMHS) services.
- Choice of experts is severely limited by availability and the system offers limited feedback to clinicians who do assessments for courts.
- Preparation work prior to proceedings can be highly variable, with about a third of cases arriving in court without a core assessment.
- Approaches to expert assessments are often fragmented; this is partly dictated by the evidential process but also by a lack of multidisciplinary centres offering a holistic approach to working with families.
- Parents can be alienated by social workers; some of this is inevitable where parents are dangerous and unco-operative and where the local authority retains a statutory duty to protect children.
- Nevertheless, there may be areas where the balance between support and investigation might be improved. Relationships - as these are apparent in court - plummet for several reasons including poor resources and social work skills, interventions in families which are not clearly planned and explained, and where families have several changes of social worker.
- While proceedings have without doubt increased internal transparency, this has not always been matched by efforts to enable highly vulnerable parents to understand the process and to feel *actively* engaged in it.
- Some proceedings remain extremely lengthy.

Thus while research evidence does not identify 'law' or legal procedures as such, as fundamentally flawed, it does however highlight that resources, skills and support to enable the system to work effectively are problematic.

## 4.14 Options for change

Research indicates that a single solution is unlikely to be tenable; the system relies on a complex set of duties and obligations, and on some external services over which it has little/no control. However a series of linked options that might be worth revisiting are:

***Under Part III of the Act***

An early opportunity for consultation and input by clinical experts in CAMHS to assist social workers in analysis and planning in cases along with a timescale for re-assessment (Brophy et al. 2001).

An early meeting with parents to explain and document in *simple, brief and straightforward terms* (a) what the issues/concerns are, what parents will need to achieve, and a timescale for that change, in order to divert the case from legal proceedings, and importantly (b) the support and services to assist parents in that endeavour.

***Under Part IV of the Act - statutory interventions***

As part of a next step,[140] it may also be worth revisiting suggestions made by researchers in this field (e.g. Hunt 1998; Brophy et al. 1999; 2001) and re-considering if there is scope for an early and discrete hearing before a judge.[141] This hearing to decide immediate safety issues, and further assessments and services necessary.

To be effective however, the judge would need time to read *summary* materials and if appropriate, and if parents so wished, to consider hearing directly from parents.[142] The range of orders available to the court could remain the same and assessments could be directed,[143] and the welfare and safety of the child would remain paramount.

For this to be effective and Human Rights compliant parents will require legal representation; for the approach to be appropriately focused and productive this should come from a child care specialist. This is because uninformed agreements entered into by parents who already feel disempowered, followed by further work with them based on inadequate or poorly targeted services with limited/no clinical input is unlikely to result in sustained changes that protect children, and engage and empower parents.

There is also now arguably a more receptive climate and a better opportunity for revisiting this option within the framework provided by the Protocol for Judicial Case Management in Public Law Cases (DCA 2003).

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[140] And bearing in mind the profile of children and parents outlined in multidisciplinary above.

[141] This option was raised and discussed in a closed one-day seminar between the principal researchers and the (then) President of the Family Division (Sir Stephen Brown), senior judiciary and policy advisers from the Department of Health.

[142] And this may have implications for judicial training.

[143] Albeit this would necessitate improvements in the funding and availability of services from CAMHS.

# Chapter 5 – Interim and final care plans and the implementation of final care plans for children

## 5.1 Introduction

This Chapter explores available larger-scale government funded research which addressed/included information on interim and final care orders, and the placement of children both during proceedings and once care orders and final plans were made.

*Contemporary contexts: the power to monitor final plans*

In practice, several points should be noted in the context of policy regarding care planning. First, research tracking the *implementation* of final care plans predated the controversy sparked by (a) the (somewhat short-lived) practice of using 'starred' care plans in an attempt to highlight the essential features of a plan,[144] (b) subsequent case law[145] and (c) the ultimate decision of the House of Lords[146] on whether courts in fact had the power to monitor the discharge of a local authority's function once care orders were made.[147]

Second, major research on the implementation of plans (i.e. Hunt and Macleod 1999; Harwin, Owen, Locke and Forrester 1999[148]) while predating the above controversy, nevertheless addressed the extent to which local authorities failed to implement care plans according to the agreed plan filed with the court (see below).

Third, however, as a response to those (post 2001) events dealing with the power of courts to monitor care plans, there is now a somewhat changing landscape in this field, and it is important to note that practice and procedures regarding planning and the placement of

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144 That is, marking those elements of the child's care plan to indicate the court considers them to be so fundamental that were they not attempted by dates fixed by the court, then a breach of human rights (Article 8) might be threatened. In short, the aim was to prevent drift in the main element in the plan.

145 Re W and B; Re W (Care Plan) [2001] EWCA Civ 757; [2001] 2FLR 582.

146 Re S (Minors) (Care Order; Implementation of Care Plan) (Care Order); Re W (Minors) (Care Order: Adequacy of Care Plan [2002] UKHL 10 [2002] 1FLR 815.

147 It is not the function of this paper to rehearse that history (see for example, Tolson 2002) but in brief, in March 2002 the House of Lords delivered a judgment in two conjoined appeals, Re S and Re W concerning the power of the court to monitor the discharge of the local authority's obligations - including the implementation of the care plan - once a final care order had been made. Concerns had been expressed about opportunities to revisit cases once final orders had been made and where there was a failure to implement a plan - and the apparent lack of legal redress given ECHR. The court concluded that the courts had no general power to monitor the discharge of the local authority's function, but a local authority that failed in its duties to a child could be challenged under the Human Rights Act 1998 – most probably under Article 8 of the ECHR relating to family life. However, the court also expressed concern that some children with no adult to act on their behalf may not have any effective means to initiate such a challenge. This was described as a "lacuna" which a subsequent provision within the Adoption and Children Act 2002 (s.118 amending s.26 of the CA 1989 - review of cases of looked after children) sought to remedy, in the creation of the role of the Independent Review Office (IRO) – see below.

148 The review is based on the report of the study prepared for the DoH. The work was subsequently published as Harwin J, Owen M, Lock R and Forrester A (2003) (2003) *Making care orders work?* London: The Stationery Office. (Thanks are expressed to Judith Harwin for access to the report and subsequent discussions).

*certain* children will change as a consequence of the implementation of the Adoption and Children Act 2002.[149]

Fourth, while a primary focus of the 2002 Act is on practices and procedures with regard to children for whom adoption is the long-term plan, there are some changes that will be relevant to the future planning for all 'looked-after' children. For example, for those 'looked-after' children for whom adoption is the long-term plan, a Placement Order will be required in order to move a child to a prospective adoption placement.[150]

Finally, with regard to the implementation of care plans, the 2002 Act also updates the duties of local authorities to review Children Cases by introducing Independent Reviewing Officers (IROs). As indicated above (note 147), local authorities are required to have IROs to chair review meetings for all 'looked- after' children. Among the duties and powers of the IRO, where they have concerns about failures to implement a care plan – and as a last resort - an IRO can refer cases back to CAFCASS Legal. The Act also introduces Special Guardianship Orders.[151]

## 5.2 Interim and final care orders and the placement of children

In the absence of a court order parents remain responsible for deciding where a child should live. As indicated in Chapter one above, studies of care proceedings indicate a number of children are likely to already be living apart from birth parents at the start of proceedings - either as a consequence of an emergency measure, or under a voluntary agreement with a local authority (under s.20 of the Children Act 1989).

[149] Broadly, the aim of the Act was to bring adoption law into line with the Children Act 1989, to be Human Rights Act compliant, to speed up the process of adoption, to bring in consequential amendments to the Children Act 1989, to introduce the new Special Guardianship Order and to replace 'freeing for adoption orders' under the 1976 Adoption Act, with Placement Orders, and - as indicated above - to introduce Independent Reviewing Officers with responsibility for overseeing the implementation of plans for children 'looked-after' by local authorities.

[150] As from 30 December 2005; this order will replace Freeing Orders to be used with care orders where the plan is adoption.

[151] Special Guardianship orders were drafted to meet the needs of a significant group of children for whom legal severance from birth family is deemed inappropriate but for whom a new route to permanence was thought necessary. The order will last until a child is eighteen years of age and the Special Guardian will have clear responsibilities and decision-making powers with regard to the child (who will no longer be a 'looked after' child). The child will be in a legally secure placement but links with the birth family can be preserved, and the placement is accompanied by access to the full range of support services (DoH, 2000). A range of children may benefit from this new order, for example, some children or carers in minority ethnic communities where there are religious or cultural difficulties with the concept of adoption; unaccompanied asylum seeking children with parents overseas, foster carers who are not prepared to adopt but have a strong attachment to a child, children with high support needs, and children for whom adopters could not be found and who are settled in a foster placement (Collier, 2005).

In principle, a wide menu of orders available to courts in public law proceedings provides for a range of circumstances through which a child might be protected from harm pending a final decision of the court.

As Chapter four above outlines, all applications are subject to a number of directions hearings and some may be subject to contested interim hearings. Directions hearings provide the mechanism through which the court exercises control over the direction, evidence, and the timing of cases. Interim contested hearings – whether these are about the applicability of an interim order to protect a child, or other issues such as contact during proceedings - are not meant to be an opportunity to rehearse the substantive issues underscoring the application for a care order.

Although an interim care order is of limited duration it may be renewed repeatedly during the preparation of cases to enable the local authority to ensure a child's safety while assessments are undertaken, statements/reports are filed, and on the basis of those developments, further planning for children is undertaken. Thus, children may remain in the interim care of a local authority for the duration of proceedings.[152]

It should also be noted however that retrospective data drawn from court files has not always been sufficiently detailed to ascertain whether a particular hearing might have been contested. Sources of data on interim hearings may need to be supplemented with a prospective study based on observational data. Nevertheless, timing, consent and logistical issues in locating contested hearings on court lists and the labour intensive nature of this exercise means that this type of data can be very difficult and costly to obtain.

As outlined in Chapter two, it is also important to note that in addition to commenting on maltreatment, certain experts (e.g. child and adolescent/family psychiatrists and some psychologists) are asked to comment on issues pertaining to planning and placement for maltreated children.

Thus, in the context of planning and placement, such experts are frequently asked to assess future risks to children, prospects for rehabilitation and future contact between parents and child. Such clinicians will also comment on any future therapeutic needs. This exercise is in

[152] And the local authority can of course place a child with parents or an extended family member under an interim order if it is satisfied that the child will be protected in the interim period.

line with clinical policy and thinking in this field in that it forms a holistic approach to the exercise and the child, and thus will inform a local authority's final care plan (Brophy et al. 2001).

## 5.3 Location and circumstances of children at the start of proceedings

In addressing patterns in the use of interim orders and interim placement of children during proceedings, it is necessary to bear in mind the profile of children in terms of ill-treatment, and that of the parents/carers with regard to the range of concerns/allegations as outlined in Chapter one above.

It is also necessary to bear in mind the location of many children at the start of proceedings and the use of emergency powers immediately prior to proceedings. As Chapter one above sets out, available studies indicate that many children – perhaps as many as 50% - are likely to already be living away from their birth parents at the start of care proceedings.

## 5.4 Interim orders and interim placements

Research indicates most children subject to care proceedings are also subject to an interim care order, and most are placed/remain in the care of the local authority under an interim order:

- One study in the mid-90s found 86% of children were subject to an interim care order during proceedings and most of these children (75%) were placed in care under an interim order (Bates and Brophy 1996).
- In a further study 75% of children also began the journey to a final hearing with an interim care order and most of these children (69%) were placed in care under the order (Hunt et al. 1999).[153]
- Findings from a more recent study indicated almost all children (96%) were subject to an interim care order at the start of proceedings and most (63%) were placed in the care of the local authority (Brophy et al. 2003).[154]

In other words, in most cases it has been considered necessary to obtain an interim care order at the start of proceedings to ensure the safety of children and most children were placed in the care of the local authority under such an order. Other types of orders were rarely thought appropriate/sufficient to ensure the safety of children in the interim period.

[153] Some 21% were placed in a mixed placement (public care and another placement), 8% were placed with parents, 2% with friends. Only three children in this study remained with a parent(s) during proceedings without any legal protection.
[154] Some 14% placed with parents, 8% with an extended family member, and 15% in other placements.

## 5.5 Contested interim hearings

As indicated above, a retrospective study of court files while providing information on the number of hearings, may not provide robust information on whether hearings were contested and the issues contested. Two studies however included a prospective sample based on observational data drawn from hearings. This type of data offers some limited information.

In the study of court records, Hunt et al. (1999) provided some information on 359 'attendable' hearings; they found 'one in five hearings' were reported as contested. While quantitative date is not available, the researchers stated that contested hearings ranged from 'fully contested hearings (i.e. a hearing involving witnesses and cross-examination of witnesses on both sides) to a majority of hearings in which some aspect of the interim handling of the case was contested'.

In the same study however and drawing on a prospective sample based on observations data, Hunt et al. (1999) reported 14/30 cases had at least one contested hearing. Interim care orders were contested in 8 cases, interim contact issues in 5 cases. Other issues contested were the transfer decision, attendance of a child at court and adjournment of the final hearing.

In a further observations exercise, 36 hearings were observed, and while the purpose of the observations was to explore other issues, it was reported that in the County Court sub-sample, 10/14 interim hearings included a contested issue (Brophy et al. 2003).

Disputed issues in this study tended to focus on interim contact and placement issues, for example, whether a child could stay overnight with a parent, whether unsupervised contact was appropriate, contact with a mother with serious mental health problems, and disputes about placing a child with an extended family member.

Courts also dealt with disagreements about whether extended family members might be joined as parties, whether further or residential assessments might be appropriate and disputes about access to and funding of detoxification programmes for parents with drug/alcohol problems.

## 5.6 Relationships between interim orders and likely outcomes

Hunt et al. (1999) indicated that contested hearings at the interim stages of cases were not a good predictor of what would happen at the final hearing; only half of cases with a contested interim hearing ended with a disputed final hearing.

Equally, the researchers noted that interim care orders were not infallible guides to final outcome - although cases subject to an interim care order throughout where there were no changes to circumstances were more likely to end in a care order (76%).

Moreover, the researchers suggested that an interim care order is unlikely to be a reliable indicator of the final order (10/41 cases with an interim care order up to the final hearing, did not end up with a care order).

The researchers did, however, note some suggested variations between local authorities in the use of interim orders, which might benefit from further exploration.

In summary, research data on contested interim hearings is in reality very limited; it currently comes from just two studies and as in many areas in this field, numbers are small. Research teams highlighted that court files alone were not necessarily a robust source of information on the number and focus of interim contested hearings.

Limited though these data are, they suggest that contested interim hearings are less likely to be about whether the grounds for an interim order are met and more likely to be about issues such as contact with children during proceedings and further assessments. This is not to suggest that these latter issues are less important, on the contrary, they may be crucial and thus require robust judicial management.

In addition, while further work is necessary in this field – at least in so far as interim hearings might have any relevance for notions of 'case profiling' - initial data, such as it is, suggests that such orders of themselves are likely to be poor predictors of final orders and outcomes. While larger samples would be helpful, given other factors in cases and specifically ongoing assessments and planning which often do not come to fruition until the latter part of the case, that suggestion is not perhaps especially surprising.

## 5.7 Long term planning for children: the position at application

In addition to indicating why a child is thought to be suffering or to be at risk of suffering significant harm, the standard form for a care or supervision application requires the local authority to indicate its plans for the child if the order is granted.

Research to date indicates that, for many, if not most cases, final plans for children are contingent on subsequent assessments and developments in cases:

- In Bates and Brophy (1996) in almost half the relevant cases (47%), at the time of the application, the local authority indicated firm long term plans for the child's placement would be filed after a planned assessment.[155]
- Hunt et al. (1999) confirmed that trend, and a more recent study suggested it might be increasing: at the start of proceedings the long-term plan for 67% of the sample children was 'to be decided after further assessments' (Brophy et al. 2003).

In summary therefore, most children are subject to interim care orders, most are likely to be placed outside their families during proceedings, most (but not all) long term planning for children will depend on and await the contribution of further clinical and welfare assessments commissioned during proceedings.

## 5.8 Final Orders

As indicated in Chapter one above indications are that most applications for care orders (about 70%) that proceed to a final hearing without any change in familial circumstances, or in the attitudes or behaviours of parents are highly likely to result in a care order. For most of these children, the care plan is for permanent removal from birth families (see below – final care plans).

However, as indicated in Chapter four above, care proceedings provide a framework and a protected space in which assessment can take place and in which some change is achieved for some 30% of children.

[155] In a further 20% of cases, the local authority indicated that the plan at the start of proceedings was to find a permanent substitute family, in 13% of cases the plan was for placement with parents under a care order, in 10% the plan was for placement with parents under a supervision order and in a further 10% information was other/not known.

## 5.9 Contested final hearings

Available research (Hunt et al. 1999; Brophy and Bates 1999; Brophy et al. 2005) points to the work done during proceedings by lawyers and children's guardians in order to try and resolve issues, arrive at an agreement and avoid a contested threshold hearing.

Comparisons between studies on the number of contested hearings is slightly difficult in part because of the way in which this information has been recorded in court files and in part because of the way in which some data is presented in research reports.

On available research in Hunt et al. (1999) of the 30 observed cases, three in five were reported as no longer in dispute at the final hearing.
In Brophy et al. (2003) for those cases which proceeded to a final hearing without any change, the threshold was contested in 5% of cases (4/86); other issues were contested in 15% of cases (13/84 cases).[156]

In Masson et al. (2004) most cases ('over 60%') were reported as uncontested by the time they reached a final hearing: where cases contained an element of contest researchers reported this was usually only in relation to the care plan (grounds for a care order were disputed in about 8% of cases; and care plans most likely to be contested where the plan was adoption (7/29 cases)).

## 5.10 Final care plans for children subject to care orders

Most research to date indicates that for most children subject to a care order the care plan is for permanency outside of birth families, overall relatively few children were to be placed with parents/extended families.

In Bates and Brophy (1996) the plan for most children (57% - 51/88 children) was for permanent removal (in 44% the plan was to find a permanent substitute family, and in 11% children were to remain in a substitute family).[157] The plan for a further 34% was placement within the family (placement with a parent/extended family member in 6%, planned rehabilitation with a parent in 9%, and immediate placement with parent in 19%).

In a national survey data set (Brophy, Bates and Wales, 1999) the final care plan for most children (63% - 578), was also permanent removal from parents (for 44% the plan was to

[156] In this sample, 4/14 cases transferred to the High Court were contested on some issue.
[157] A further 7% placed in other accommodation, subject to review.

find a permanent substitute family, 17% were to remain in a substitute family).[158] Some 25% were to be placed in their families (18% with a parent,[159] 7% with extended family).

In the study of Hunt et al. (1999), the plan for most children (76% - 39/51) was long-term substitute care. In just under one-quarter of cases it was planned that children would return to or remain with a parent, in 10 cases children were to be placed with a parent and in 12 cases with a relative.

In the study of Brophy et al. (2003) the final plan for most children (72% - 82/114 children) was permanent removal (for 59% the plan was to find a permanent substitute family, for 13% the plan was to remain with a permanent substitute family). The plan for a further 13% was for children to stay with or return to a parent(s) and for the remainder a range of other plans was filed.

In Masson et al. 2004, plans were much more evenly split between those for whom it was removal (53/109 children) to foster care, residential care, or adoption (with adoption being the largest single group at 36%) and those 56/109 children where the plan was to rehabilitate a child with parents or place them with a relative.[160]

## 5.11 Implementation of final care plans by local authorities

Against a background of concerns, frustrations and suspicions by members of the judiciary and other family justice practitioners regarding implementation of final care plans, two major studies have explored whether local authorities implemented the plans agreed at final hearings.

Hunt and Macleod (1999) looked at outcomes for almost all the children (131/133) in their original study (Hunt et al. 1999); Harwin, Owen and Locke (1999) explored outcomes for 100 children. Researchers tracked children where care proceedings ended with firm plans on the completion of care proceedings.

Harwin et al (1999) reported that by the end of the study 60/100 children were living in the placement type specified in the court plan:

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[158] Some 2% were to be placed in a children's home.
[159] Not necessarily the parent with whom the child had previously been living.
[160] Some care is necessary here since this study was based on a purposive sampling procedure in which cases were recruited to the original study on the basis of emergency protection application.

- Kinship placement had the highest fulfilment of care plan rate at 78%
- Foster care plans were met in 68% of relevant cases
- Adoption plans were fulfilled in 58% of cases
- Placement at home achieved only a 41% success rate
- Foster care was the main collecting ground when placement places were not fulfilled.

In 15/100 cases where the care plan presented to the court had not been fulfilled, children failed to enter the recommended placement within a specified time. The reasons why that happened were complex and interrelated:[161]

- For example, a lack of suitable adopters accounted for the majority of non-implemented adoption plans, especially for children in large sibling groups.
- Children aged three or over at the time of the final hearing and those with developmental delay featured; age was also important in explaining breakdowns in foster care or kinship care but this was usually coupled with higher rates of emotional disturbance and educational needs in the subject children.
- The presence of a sibling group always complicated placement, as did the presence of initial difficulties among children (Harwin et al. 1999).

Hunt and Macleod (1999) reported some attempt was made to follow the overall direction of the plan in every case, 98% were pursued and 88% of placements were in accordance with the plan.

Where the final plan required a *move:*

- Overall 78% of children were placed as envisaged in the move described in the care plan. For those for whom the move involved adoption, this was met in 77% of cases: where it involved long term foster care this was met in 50% of cases, where the move was to a parent, this was achieved in 86% of cases, and where the plan was to move a child to kinship care this was achieved in all cases. Plans for three children were deemed inappropriate and changed at a very early stage; three others remained in converted placement rather than moving to new ones, and eight children were not placed.

With regard to timing:

- 57% of all new placements were made within 6 months but 22% took more than 12 months and 18% more than 18 months.

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[161] For example a lack of suitable adopters accounted for the majority of non-implemented adoption plans, especially for children in large sibling groups, those aged three or over at the time of the final hearing and those with developmental delay. Age was important in explaining breakdowns in foster care or kinship care but this was usually coupled with higher rates of emotional disturbance and educational needs in the subject children. The presence of a sibling group always complicated placement, as did the presence of initial difficulties among children (Harwin et al. 1999).

- 50% of adoptive placements were made within 6 months but 35% took more than 18 months. Four children were still awaiting placement three or more years after care proceedings were concluded.

With regard to stability:

- 70% all ‘first plan’ placements (that is, plans agreed at the final hearing) were still ongoing at the end of the research period or had continued for as long as necessary.
    - However, 60% of long-term care placements had terminated
    - 35% of parental placement had also terminated
    - 33% of placements with kin had also ended.
- 73% of continuing ‘first plan’ placements were considered to be working for the benefit of the child; there was some concerns about the remainder.

Thus of the 120 plans, the researchers argued 50% could, with reasonable confidence, be said to have worked out, that is, placements were as planned, continued and were judged to be in the child’s interests.

By the end of the research only a minority of children were not in ‘permanent’ placements. However, for a quarter this was achieved through changing the original plans or through replacement after breakdown, once, twice or three times. For 16% of the whole sample, current places were either uncertain or unachieved.

Two in three of the final placements were in accordance with the final plan. Rates for such concordance were highest where the original plans had been adoption (at 81%) followed by kinship care (at 67%), and parental placement (at 64%), and long-term care (at 53%).

Most placed children were in ‘settled’ placements within a year of the final hearing. However 3 in 10 had to wait more than 18 months.

### 5.12 Implications for social services

Researchers argued that however these findings are viewed (‘disappointing, par for the course or better than expected’) bringing practices nearer to ideal outcome requires improvements in the performance of social services.

The researchers also argued that to a large extent the remedy is in achieving consistency and implementing what is already recognised to be good practice, rather than instituting structural or policy change.

This then was some of the background to the short-lived 'starred' care plans – before the House of Lords ruled that courts had no general power as such to monitor the discharge of the local authority's function.

Amongst other things, in 1999 Hunt and Macleod had recommended that a designated officer should have a specific duty to oversee the implementation of final care plans. This was a lacuna in the system to which the House of Lords also referred in giving judgement on the two co-joined appeals (Re S and Re W)[162] in March 2002 and to which the Adoption and Children Act 2002 presents a remedy in the role of the Independent Review Office (IRO).[163] It is the task of the IRO to monitor plans and reviews so that if a local authority fails in its duties to place a child as finally planned, it can be challenged.

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[162] See footnote 146 above.

[163] As indicated above (introduction), The Adoption and Children Act 2004 introduced the Independent Review Officer (Review of Children's Cases (Amendment) (England) Regulations 2004) with effect from 27 September 2004, and amended the 1991 Regulations). The Regulations require all Local Authorities to have IROs to chair statutory review meetings for all 'looked after' children including children who are in an adoptive placement prior to an adoption order. In brief, the purpose of the IRO system has to be read in light of care planning duties and practices; all children should have a care plan within 14 days of being 'looked-after', such plan to be presented to the court if a s.31 application is made. As also outlined above, the intention is that if a local authority is failing to fulfil a plan for a child, the IRO (who chairs the review meetings) can, as a last resort, refer the case back to CAFCASS for an application back to the court for a judgement. To date, no cases have been referred to CAFCASS on these grounds (personal communication – CAFCASS Legal).

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# Appendix

## Major studies reviewed – methods and samples

### Chapter 1 – profiles of children and parents

1 Bates P and Brophy J (1996) The Appliance of Science? The Use of Experts in Care Proceedings: A Court-Based Study

1 Year of data collection - 1993/4
2 Sample selection: 'snapshot' study - all live and new applications in care proceedings initially over a three-month period - extended
3 Sample size: 65 Cases - 114 children
4 Methodology - quantitative and qualitative
5 Area: One local authority area - all (5) FPCs and County Court Care Centre.

2 Brophy J, Wale C and Bates P (1999) Myths and Practices: A National Survey of the Use of Experts in Care Proceedings

1 Year of data collection - 1994/95
2 Sample selection: national random sample of cases
3 Sample size: 557 cases and 963 children
4 Methodology - qualitative and quantitative study based on detailed questionnaire send to 476 guardians from 34 participating panels. All panels were stratified according to size and then randomly selected from this frame. The procedure produced a sample of 36 panels with a total of 721 registrations; further work on currently active/relevant guardians resulted in 34 panels and produced 476 eligible guardians. Of the 467 questionnaires 338 were returned giving a response rate of 71%. It was estimated that this in fact covered some 44% of the workforce.=
5 Area: national survey of guardians in England and Wales.

3 Hunt J, Macleod A and Thomas C (1999) The Last Resort

1 Year of data collection - Oct 1991-93 (first two years of implementation)
2 Sample selection: pre-CA cases and post-CA cases - Detail on how cases were selected? - 'Cases selected by two methods - retrospective from a sampling pool derived from court records and LA information - cases started in first 15 months of Act/research period…' says 'multi methods' - check
3 Sample size: 105 pre-Act cases, 83 post-Act cases (133 children)
4 Methodology - quantitative and qualitative, file studies (LA and court) plus interviews with professionals and parents
5 Area: Three local authorities, three court circuits, one FPC and CC per area.

4 Brophy J, Jhutti-Johal J and Owen C (2003) Significant Harm: Child Protection in a Multi-Cultural setting

1 Year of data collection – 1998-2000
2 Sample selection: in date sequence, retrospective, random sample stratified by ethnic group (eight ethnic groups including White British)
3 Sample size: 100 cases, 183 children
4 Methodology – qualitative and quantitative data

5 Area: cases identified via panel database – panels covered 26 local authorities, FPC courts in which cases initiated dictated by local authority area, one county court care centre and High Court.

5 Brophy J, Jhutti-Johal J and McDonald E (2005) Minority Ethnic Parents and their Solicitors

1 Year of data collection – 2004
2 Sample selection: various (mainly via court records)
3 Sample size (for cases): 10 cases, 22 children
4 Methodology - qualitative study but included detailed case comparative data from court files for the parent cases plus interviews
5 Area: cases drawn from three court circuits.

6 Masson J, Winn Oakley M and Pick K (2004) Emergency Protection Orders: Court Orders for Child Protection Crises

1 Year of data collection – 2004
2 Sample selection: via court records and from information provided by DCA statisticians on number of EPOs in each area; sample consisted of all applications for EPOs in 12 months prior to initial visit to area courts – dates for 3 areas ranged from September 2000 to April 2003 and was based on all EPO applications made.
3 Sample size: for EPOs - 86 cases, 127 children (77 cases subsequently resulted in care proceedings)
4 Methodology - qualitative and quantitative
5 Area: three areas (selected from eight included in a previous study of PPOs) relate to three Magistrates' Courts Committee areas covering 6 local authorities.

## Chapter 2 – the use of experts in care proceedings[164]

7 Bates P and Brophy J (1996) The Appliance of Science? The Use of Experts in Care Proceedings: A Court-Based Study

See (1) above.

8 Brophy J, Wale C and Bates P (1999) Myths and Practices

See (2) above.

9 Hunt J, Macleod A and Thomas C (1999) The Last Resort

See (3) above.

[164] This section focuses on research on expert witnesses and research evidence on the use of experts in care proceedings following the Children Act 1989. There are further materials (including Practice Directions from the President, case law and guides) about what is expected of an expert witness in proceedings and the cardinal principles to this work, how to write reports for courts, approach professional meetings, address instructions, prepare for court, give evidence in chief, and which clearly delineate the respective roles of the judge and the expert. This has been further supplemented with updated Guidance for experts under the Judicial Protocol for the Management of Public Law cases (DCA 2003). There is, of course, also extensive literature in psychology, psychiatry and paediatrics - about children and families in general and vulnerable families in particular, along with frameworks and guidance for the assessment of child and parents subject to legal proceedings (much of this work is reviewed in Brophy J (1999)). Subsequent to that review, the murder of Victoria Climbie within her family, publication of the Green Paper (Every Child Matters, DfES) and reports in the Safeguarding agenda, the Royal Colleges have responded with a range of documents addressing the need for specialist expertise and services, views regarding Children's Trusts and the availability and training of clinicians for work in the child protection arena. This section of the review however focuses on research addressing the use of experts.

10 Brophy J and Bates P (1999) The Guardian ad Litem, Complex Cases and the Use of Experts following the Children Act 1999

1 Year of data collection - 1995
2 Sample selection: random from three panels (see below)
3 Sample size: 35 guardians
4 Methodology – qualitative, interviews were undertaking using a three-stage case vignette as a mechanism to explore case management and decision-making in complex cases involving experts and including the mediating role undertaken by guardians. The study was backed by a related court file study and a national survey of guardians about the use of experts. All interviews were taped fully transcribed using a relational database
5 Area: three large and diverse panels in England, guardians were randomly selected from one northern, one southern and one panel in the Midlands.

11 Brophy J, Brown L, Cohen S and Radcliffe P (2001) Child Psychiatry and Child Protection Litigation

1 Year of data collection - 1996
2 Sample selection: a mixed sampling method was adopted: eighteen panels in England and Wales were selected and stratified by size and geographical spread into three bands. From lists of consultant child psychiatrists provided by each panel experts were identified according to whether they worked locally or nationally, respondents were then randomly selected from the lists – six from each of three bands
3 Sample size: seventeen
4 Methodology - In-depth qualitative interviews using a semi-structured interview schedule; all interviews were taped and fully transcribed
5 Areas: consultants were drawn from the North East, the North West, the Midlands, East Anglia, the South East, the South West, Inner and Outer London, the West Country and Mid and South Wales.

12 Brophy J, Jhutti-Johal J and Owen C (2003) Significant Harm

See (4) above

13 Brophy J, Jhutti-Johal J and McDonald E (2005) Minority Ethnic Parents, their Solicitors and Child Protection Litigation

See (5) above

14 RCPCH (2004) Survey of complaints against paediatricians, London: Royal College of Paediatrics and Child Health[165]

1 Year of data collection – 2003
2 Sample selection: all paediatricians registered with the RCPCH
3 Sample size: N/A – response rate given as ‘over 78%’

[165] The Royal College has followed this questionnaire survey with qualitative work based on a sub-sample of paediatricians who had experienced complaints being made against them; publication of this latter study is planned for October/November 2005.

4 Methodology - short 2-page postal questionnaire about whether respondent had been the subject of a complaint, this to be followed with a (self selected) follow-up sample (telephone interview) with those who said they were less willing to do child protection work
5 Area: national.

## Chapter 3 – the views and experiences of children and parents in care proceedings

15 Freeman P and Hunt J (1998) Parental Perspectives on Care Proceedings

1 Year of data collection - 1993/4
2 Sample selection: sub-sample of cases from a larger study (Hunt et al 1998) of 83 cases in which information from court files had been obtained along with observations of hearings concerning some but not all parents
3 Sample size: 34 family members drawn from 25 cases, backed by control data from case files and court observations
4 Methodology – semi-structured interviews, all taped and fully transcribed
5 Area: three local authority areas.

16 Brophy J, Jhutti-Johal J and McDonald E (2005) Minority Ethnic Parents and their Solicitors

See (5) above

17 Lindley B (1994) Families in Court. London: Family Rights Group

1 Year of data collection - cases with final hearing date by 1 March 1993
2 Sample selection: multiple and in part self selected: (a) via several social service departments requesting families with a final hearing date within the deadline to participate by contacting FRG (b) recruitment of parents who contacted the FRG help line
3 Sample size: 41 cases, 48 family members interviewed
4 Methodology - qualitative and some quantitative (i) interviews with a family member mostly face-to-face but 8 interviews were conducted by telephone (ii) 48 questionnaires were also sent to family members' solicitor, 24 were returned (i.e. 50% response)
5 Area: London.

18 BMRM (2004) CAFCASS Client Satisfaction Survey

Study focuses on satisfaction with CAFCASS services; findings excluded because (i) data is not disaggregated for the small number of public law cases included in the survey and (ii) focus on court proceedings is in practice limited to views about the CAFCASS report.

1 Year of data collection - 2003
2 Sample selection: adults only, random retrospective from final hearing date, identified from CAFCASS records
3 Sample size: 330 telephone interviews, almost all (92%) with private law clients; no separate data for the 8% public law cases
4 Methodology - telephone interviews
5 Area: original aim was for selection from 10 CAFCASS regions.

19 Lindley B and Richards M (circa 2001) Summary of Findings: Qualitative study of advice and advocacy for parents in child protection cases

1 Year of data collection - 1997-2000
2 Sample selection: 36 cases (self-selected sample) referred within 6 months of s.47 enquiry; parents not necessarily representative of all those drawn into the child protection process, they tended to be more articulate, white, mature and employed
3 Sample size: 43 parents, 28 advocates and 45 local authority staff
4 Methodology - qualitative study using semi-structured interviews undertaken in two phases
5 Areas: N/A.

20 Masson J and Winn Oakley M (1999) Out of Hearing: Representing Children in Care Proceedings

1 Year of data collection - 1996-7
2 Sample selection: all 'live' cases in defined study period, 38 cases (46 children) identified, agreement to participate obtained in 17 cases (20 children)
3 Sample size: 9/17 cases were for care applications; 12 guardians and 12 solicitors were also interviewed
4 Methodology - interviews with children/young people, guardians and solicitors; observations at meetings between children/young people and their representatives
5 Area: Two local authority panel areas under the (pre-CAFCASS) administrative system for guardians ad litem and reporting officers.

21 Timms J E and Thoburn J (2003) Your Shout! - A survey of the views of 706 children and young people in care

1 Year of data collection - 2002
2 Sample selection: Self-selected from children and young people in residential care, foster care, in care living with parents, in secure accommodation and in young offenders' institutions
3 Sample size: sub-sample of 163 responses to seven questions from children/young people who reported they had 'ever been to court', sample is mixture of proceedings covering care, secure accommodation and youth offending therefore caution is necessary in generalising results to care proceedings per se
4 Methodology - questionnaire to children/young people in care distributed through magazine *Who Cares*? (distributed through the Who Cares? Trust); mostly closed-questions (with boxes to tick); self-completion
5 Area: national.

22 Brophy J and Bates P (1998) The position of parents using experts in care proceedings; a failure of partnership?

1 Year of data collection -1994-5
2 Sample selection: based on three studies (a) a national random survey of 557 cases concerning expert evidence (b) snapshot study of all cases in a specified period in one circuit in the South East (65 cases) and (c) a random sample of 35 guardians
3 Sample size: 557 cases; 65 and 35 respectively
4 Methodology - quantitative and qualitative
5 Area: national (for the survey data) one court circuit for the court file study, three diverse regions for the interview data.

## Chapter 4 – approaches to problem resolution: the need for compulsion, attempts at specialist ADR, and the contemporary role of care proceedings

23 King M, Trowell J and Roberts M (1998) A Pilot Project: Alternative Dispute Resolution

1 Year of data collection -1994-5
2 Sample selection: pilot project press released and details sent to 'various possible sources of referrals' including Inner and Outer London local authorities and Home Counties social services Departments, plus (what were) Inner and Outer London GALRO panels, court clerks and named judges in the PRFD, solicitors on the Children Panel in Greater London. The Foster Care Association and Fostering Officers were also approached. Several subsequent attempts were made with various professional groups (e.g. liaison meetings with local authorities, seminars and training sessions in courts and with solicitors) to try and improve very poor referral rates
3 Sample size: over a three-year period, 36 referrals made to the project, 15 met the pilot criteria, 12/15 cases reached a joint mediation session. It is not possible to calculate the referral rate based on either the number of children on CPRs or subject to statutory interventions over this period, but of the small number of cases referred to the project, about one-third (12/36) met the criteria and progressed to a mediation appointment
4 Methodology - qualitative, interviews undertaken pre- and post-mediation aiming to appraise the pilot model, respondents were professionals and a family member (a small number of children aged over eleven years were also interviewed)
5 Location: London.

24 Bates P and Brophy J (1996) The Appliance of Science? The Use of Experts in Care Proceedings: A Court-Based Study

See (1) above.

25 Hunt J, Macleod A and Thomas C (1999) The Last Resort[166]

See (3) above.

26 Brophy J and Bates P (1999) The Guardian ad Litem, Complex Cases and the Use of Experts following the Children Act 1999.

See (10) above

27 Brophy J, Brown L, Cohen J & Radcliffe P (2001) Child Psychiatry and Child Protection Litigation

1 Year of data collection - 1996
2 Sample selection: mixed sampling method: eighteen panels in England and Wales were selected and stratified by size and geographical spread into three bands From lists of consultant child psychiatrists provided by each panel experts were

[166] And Hunt J (1998) A moving target: care proceedings as a dynamic process. CFLQ, Vol 10 No 3.

identified according to whether they worked locally or nationally, respondents were then randomly selected from the lists – six from each of three bands
3 Sample size: seventeen
4 Methodology - in-depth qualitative interviews using a semi-structured interview schedule; all interviews were taped and fully transcribed
5 Areas: consultants were drawn from the North East, the North West, the Midlands, East Anglia, the South East, the South West, Inner and Outer London, the West Country and Mid and South Wales.

28 Brophy J, Jhutti-Johal J and Owen C (2003) Significant Harm

See (4) above.

## Chapter 5 – interim and final care plans and the implementation of final care plans for children

29 Bates P and Brophy J (1996) The Appliance of Science? The Use of Experts in Care Proceedings: A Court-Based Study

See (1) above.

30 Brophy J, Wale C and Bates P (1999) Myths and Practices

See (2) above.

31 Hunt J, Macleod A and Thomas C (1999) The Last Resort

See (3) above.

32 Brophy J, Brown L, Cohen S and Radcliffe P (2001) Child Psychiatry and Child Protection Litigation

See (11) above.

33 Brophy J, Jhutti-Johal J and Owen C (2003) Significant Harm

See (4) above.

34 Brophy J, Jhutti-Johal J and McDonald E (2005) Minority Ethnic Parents and their Solicitors

See (5) above.

35 Masson J, Winn Oakley M and Pick K (2204) Report - Emergency Protection Orders: Court orders for Child Protection Crises

See (6) above.

36 Hunt J and Macleod A (1999) The Best-Laid Plans: Outcomes of Judicial Decisions in Child Protection Proceedings

1 Sample selection: Follow-up study of the families selected in Hunt et al 1999
2 Sample size: 131 children from 81 families
3 Methodology - examination of social services files, a self-completion, postal questionnaire of practitioners (137, response rate 44%); face-to-face interviews

with guardians, plus a case-based questionnaire for some guardians and solicitors plus a further general questionnaire for another sample of solicitors and guardians. In terms of samples and response rate this resulted in 28/37 guardians (response rate 76%; 29/136 solicitors –21%; family interviews were undertaken with 19 adults in 17 families)
4 Areas: Three local authority areas.

37 Harwin J, Owen M, Locke R and Forrester A (1999) Research Report - making care orders work.

1. Year of data collection - 1997-1998
2. Sample selection: all cases in which care order was made in specified time frame (1 March – 30 September 1997) (see 5 below – areas)
3. Sample size: 100 children from 57 families who were the subject of care orders made between March and September 1997
4. Methodology - mixed, quantitative and qualitative: two phases of data collection: phase I interviews with judges and collection of information from court files, semi structured interviews with key social workers, guardians and local authority solicitors; phase II (at 21 months) further interviews with key social workers and analysis of social services files; plus some standardised tests (in-house 'welfare progress' and 'welfare status') with current carers, children over seven years and birth parents
5. Areas: five local authority areas (3 inner city, one large rural county and a suburban area on fringes of a large city) (Authorities also chosen because they were using the DoH action and assessment records).

DCA Research Series No. 5/06

**Research Review: Child care proceedings under the Children Act 1989**

This review was commissioned as a briefing paper by the Child Care Proceedings Review, focussing on Section 31 of the Children Act 1989. It covers larger scale empirical studies of care proceedings, mainly but not entirely commissioned by government.

Key findings include the seriousness of the cases which are brought before the courts. Most parents are highly vulnerable - for example many have mental health problems, drug or alcohol problems - and lead chaotic lifestyles, including violence in the home. In addition, most applications include allegations regarding the failure of parents to co-operate with welfare and child health professionals.

Clinical skills are needed to address the aetiology of the child's case and to arrive at a prognosis about future harm, children's needs and parental capacity for change, but research indicated that more than one expert opinion on the same issue is not the 'norm'.

There is little research evidence of the views of parents or children of care proceedings. Most of the parents interviewed thought that judges are good with parents, but that although solicitors were thought to have worked hard to prepare them for the court, it remained a frightening experience.

Research demonstrates that care proceedings are not simply adversarial, they are a hybrid including many inquisitorial features, through Practice Directions, Guidance and Protocols. Furthermore they are dynamic, providing a managed space in which assessments can be undertaken and parties can try to work towards a solution.

The evidence concerning the implementation of care plans was more positive than had been anticipated, in that for only 15% of cases was placement uncertain or unachieved, and most children were in a settled placement within 12 months of the hearing.

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