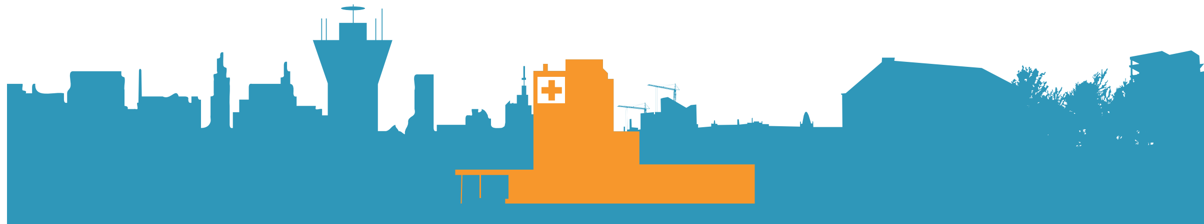
THE DUTCH SAFETY BOARD



About the physical safety of the young child

Thematic study: cases of child abuse with a fatal or near fatal end

ABOUT THE PHYSICAL SAFETY OF THE YOUNG CHILD

Thematic study: cases of child abuse with a fatal or near fatal end

The Hague, January 2011 (T2006GZ0628-04)

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DUTCH SAFETY BOARD

The Dutch Safety Board was established to investigate and determine the causes or probable causes of individual incidents or categories of incidents in all sectors. The sole purpose of a Dutch Safety Board investigation is to prevent future accidents or incidents and, if outcomes give cause to do so, issue associated recommendations. The organisation consists of a board with five permanent members, a professional Bureau manned by investigators and support staff and a number of permanent committees. Guidance committees are set up to oversee specific investigations.

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General secretary:	M. Visser		
Project manager:	Th.M.H. van der Velden		

Visiting address:	Anna van Saksenlaan 50 2593 HT Den Haag	Postal address:	Postbus 95404 2509 CK Den Haag
Telephone:	+31 (0)70 333 7000	Telefax:	+31 (0)70 333 7077
Internet:	www.safetyboard.nl		

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CONSIDERATION

In the Netherlands a few dozen children die every year as a result of abuse by (one of) their parents. The number of children of which it is known that they have died because of abuse is probably only the tip of the iceberg, because not all deaths were investigated until recently. Moreover, when the deaths were investigated it could not always be established whether abuse was involved.

The Dutch Safety Board considers the death of children through actions or neglect by their parents as a serious social issue. Young children belong to the most vulnerable groups of our society and cannot protect themselves. When parents do not protect their children and therefore do not assume their responsibility, children become dependent on others.

Traditionally, educating and therefore also guaranteeing the physical safety of children was regarded as the exclusive domain of parents. However, the view that the government has a responsibility when parents do not guarantee the safety of their child has become more widespread since the beginning of the twentieth century.

In the course of the 20th century the right of children to a safe living environment and the responsibility of the government were therefore embedded in legislation and international conventions and apply as generally accepted social standard. In 1989 it was explicitly laid down in the Convention on the Rights of the Child that *the task of the government is to offer safety to children when parents do not do this (sufficiently)*. The Netherlands ratified this convention in 1995. According to experts, this lapse of time was also caused by the restraint that exists in the Netherlands with regard to the government interfering with children in families.

When a child finds itself in a physically unsafe situation and the government receives a report, the safety of the child is no longer the sole responsibility of parents, but also that of the government. In such cases the responsibility of the government will be fulfilled by various institutions and professionals. They therefore act on behalf of the government.

Children sometimes also die when professionals are already involved in offering assistance to their family. Different professionals have been involved in various fatal cases. It is the job of these professionals to carry out the government task to protect children. The Dutch Safety Board thinks that it is extremely worrying that children die in these situations, in particular when there was a report and the government bears responsibility.
It is for this reason the Dutch Safety Board started a study following a number of fatal cases. The Dutch Safety Board wanted to investigate whether insights gained in other sectors could also be useful for this serious social issue.

Child safety system
This study highlights how the government fulfils its responsibility for child safety. Hereby various government layers, institutions and individual professionals are involved. This functional collaboration may be considered as a ‘child safety system’, but is not a legal or administrative entity. Two types of professionals are distinguished: 1. Professionals involved in the health and education of the family, such as doctors, employees in the child care and teachers, who have information about the family and who can give signals and reports about possible physical danger; 2. Professionals who are in charge of assessing and evaluating risks regarding the physical safety of children and who carry out possible measures, and in particular work at the Youth Care Office and the Child Care and Protection Board. They are responsible on behalf of the government to handle reports. For this they require information from professionals in the first category.

Viewpoints Dutch Safety Board regarding safety
In this study the Dutch Safety Board has applied its ideas about safety in organisations to the government task regarding child safety. According to the Dutch Safety Board, guaranteeing safety must be based on an adequate risk inventory and evaluation. On the basis of this it can be established which risks must be controlled and which measures are necessary in this respect. After this it is necessary to decide about and draw up a realistic safety approach, which can be applied

in practice. This safety approach can be implemented and maintained by realising a transparent, unambiguous description of responsibilities, which can be understood by all parties involved. This description includes the required staff deployment and expertise for the various tasks, the organisation of the internal supervision and the central coordination of safety activities. The safety approach must be highlighted continuously. This should be done by carrying out periodical (risk) analyses, observations, inspections and audits and a system of monitoring and investigating incidents, near accidents and accidents. By operating in this way, the risk of human failure and its consequences are limited as much as possible. If mistakes are made, this approach offers starting points to improve the way safety is tackled. It should, however, be stated explicitly that it is not always possible to prevent incidents with a fatal end, and that a death does not by definition imply avoidable human failure.

Viewpoints Dutch Safety Board regarding safety, applied to the child safety system
The viewpoints of the Dutch Safety Board regarding safety have been used as a starting point in this study. The Dutch Safety Board in particular investigated the way in which the government carries out the risk inventory and evaluation, handles responsibilities, expertise and coordination and learns from incidents. This risk inventory and evaluation is carried out by a professional who assesses the situation of a child, forms an opinion about this situation and, if necessary, draws conclusions from this situation. If the professional wants to take responsibility for the physical safety of children on behalf of the government, two conditions must be complied with in any case: a. the professional must have all relevant information at his/her disposal in order to carry out a full risk inventory and evaluation with regard to the physical safety of young children; b. the professional must have sufficient expertise in order to decide about applying all government instruments and corresponding powers and c. the professional must have the opportunity to learn from cases and incidents.

Professionals in the child safety system have a difficult job for various reasons. When the government has to take its responsibility for the child, it is confronted with the responsibility of the parents. In principle the government cannot set this aspect aside, temporarily or otherwise. However, it also has the task to exercise restraint as much as possible in this respect on account of the European Treaty for Human Rights and because of national legislation. Moreover, the work is also difficult because there is a transitional stage immediately after a report, in which it is still not clear how serious the physical danger is, although the government is already responsible. Various publications also show that professionals are very afraid that families are incorrectly qualified as families that are unsafe for children. After all, the measures to protect the safety of children may be radical (being placed in care, for example) and harmful for the physical and mental development of the child and the relationship with his/her parents. When the safety approach has been applied incorrectly in hindsight, the situation of safety will not have changed, but persons may have been affected negatively. The possibility that measures may have been incorrect in hindsight causes restraint in practice. This plays a smaller role in other sectors. The safety approach may also be inadequate for a different reason, that is to say, when the safety measures do not appear to be adequate.

Research question
The question that is answered in this study is:
How does the government fulfil its responsibility regarding the physical safety of young children when parents do not do this; what improvements are possible?

In practice the responsibility for physical safety is fulfilled by the parties in the child safety system: the institutions, professionals and their professional groups. A professional is a person who intervenes in families in practice, with the aim to care for the physical safety of the child.

In this thematic study 'realising one's responsibility' refers to the way in which professionals assess and evaluate risks regarding the physical safety of young children and the way in which the government and the parties in the child safety system enable professionals to carry out their complex job.

For the study 27 (near) fatal cases were investigated and rules and directives were examined.

Developments since the incidents
The investigated 27 incidents took place in the period between 2004 and 2007. Since then efforts have been made to improve the child safety system with regard to various bottlenecks mentioned in this study, first under the responsibility of the State Secretary for Public Health and then of the Minister for Youth and Family (until October 2010). For example, there has been a much greater focus on the safety of children and various instruments have become available to 'measure' physical danger. Furthermore, the focus on exchange of information between the various professionals has also increased, as well as the focus on the willingness of professional reporters to report, for example by providing more information about the duty of confidentiality and the right to report. There have also been efforts to increase the level of knowledge of the professionals involved. Moreover, the principle of 'when taking decisions, never do it by yourself' has also been introduced. Nevertheless, the Dutch Safety Board notes that the bottlenecks stated in this study have not been addressed yet or that they have been addressed insufficiently. This will be explained below.

Conclusions
On the basis of this study the Dutch Safety Board draws conclusions about: (1) the responsibility of the government for the physical safety of young children, (2) the required professionalism of individuals and institutions and (3) the initial stage in which signals should result in reports, which activate the responsibility of the government.

On the basis of its study the Dutch Safety Board first of all concludes the following:
1. *The government that is called to account in a report with regard to its responsibility for the physical safety of children cannot fulfil this responsibility under the current circumstances.*

The following two conclusions are the basis of this main conclusion:
1A. The conduct of professionals who are responsible for the physical safety of children on behalf of the government shows that the responsibility of parents prevails. As a result these professionals cannot carry out an adequate risk inventory and evaluation regarding the physical safety of young children.
1B. Professionals cannot carry out the risk inventory and evaluation adequately, because other professionals involved with the family are not obliged to cooperate with this. This means that the professional does not have the chance to actually take control on behalf of the government.

These two conclusions can be explained as follows.
Ad 1A. Professionals who have to carry out a risk inventory and evaluation on behalf of the government and act on the basis exercise restraint with regard to taking over the responsibility of parents. The government has instruments to take over the responsibility of the parents on a temporary basis (provisional supervision order, temporary removal of parental responsibility). These instruments were not applied (sufficiently) in the cases investigated by the Dutch Safety Board, except only after (near) fatal injuries were sustained. Since professionals exercise restraint regarding the use of instruments that temporarily restrict the authority of parents, they have insufficient access to information that is required in order to carry out a full risk inventory and evaluation regarding the young child.

Ad 1B. Professionals who have to carry out a risk inventory and evaluation regarding the physical safety of children on behalf of the government, depend on the cooperation of other professionals for information about these children and their parents, such as doctors and employees of the mental health care organisations (GGZ). It should be taken into account that it usually concerns multiproblem families, involving many professionals on behalf of both the parent and the child. These professionals are not obliged to share the information about children and members of the family; they have only been exempted from their duty of confidentiality. This means that they are allowed to make their own assessment about ending their duty of confidentiality. It happens regularly that they do not share information that is relevant for the physical safety of children. In such cases the professionals of Youth Care Office and the Child Care and Protection Board cannot carry out a full risk inventory and evaluation. This conclusion does not only apply before a child protection order is taken, but also when a measure already has become effective.

A second conclusion concerns the professionalism within the child safety system:

2. *The professionalism in the child safety system is insufficient for carrying out the government responsibility for the risk inventory and evaluation regarding children whose parents care insufficiently for their physical safety.*

This conclusion about professionalism is based on the following five partial conclusions.

2A. Professionals who are responsible for the risk inventory and evaluation on behalf of the government lack a clear framework to decide whether and to what extent they have to use the full government instruments when there are reports of physical danger for the young child. Dutch legislation and branch directives do not contain sufficient guidelines in this respect. The criterion of (physical) physical danger is not a basis for child protection orders and therefore not a part of the formal framework for the risk inventory that is required for taking protective measures. For child protection orders legislation applies the broad concept of 'mental and physical development'. In the policy development there has been a great focus on the subject of safety in recent years. In practice professionals have to work with open standards in which it is unclear when physical danger is involved, while they also have to guarantee the 'development of the child', preferably within the family.

2B. The availability of information regarding previous cases of (physical) physical danger in the same family is not guaranteed and professionals do not have a policy to tackle the safety for children from recidivist families in a structural way.

2C. Professionals do not make sufficient use of forensic-medical knowledge and this specialised knowledge is also not sufficiently available in practice. This means that professionals sometimes do not have the opportunity to recognise injuries on time as an indication of possible physical danger.

2D. The internal supervision of professionals who have to carry out the risk inventory and evaluation is mainly done through consultations with colleagues. Other forms of internal supervision of the various professionals involved in the risk inventory have not been worked out sufficiently yet.

2E. The government does not commission a standard systematic investigation in the event of death. With five of the 27 investigated incidents a public study was carried out, while this was not done in the other cases. The government has chosen disciplinary rules as a means to increase the professionalism of the employees in youth care. The sector also wants to (further) shape the professionalisation in youth care through disciplinary rules. The Dutch Safety Board notes that disciplinary rules are not a suitable instrument in the current circumstances, because professionalism is still 'in its infancy' in the sector. Disciplinary rules are aimed at individual dysfunctioning; the focus is not on professionals and institutions who are involved with children. Furthermore, disciplinary rules have a certain degree of arbitrariness: their application depends on whether a complaint is submitted, while the nature of the complaint does not have to be related to the content of the profession. A weighty argument is that the government itself offers insufficient frameworks to the professional.

Besides the two above-mentioned conclusions (about the responsibility of the government from the moment of receiving a report about a suspicion of physical danger) and the corresponding conclusion about professionalism, the Dutch Safety Board has drawn a conclusion about the stage before receiving a report of physical danger.

3. *The stage prior to a report, when signals of physical danger have to be understood in order to report, is also characterised, lust like other stages, by a reserved attitude of professionals, in particular in health care.*

This conclusion can be explained as follows.
Professionals, in particular in health care, who are confronted with children with injuries in the initial stage, often exercise restraint with regard to reporting suspicions of physical danger. When they are confronted with injuries and a suspicion of physical danger, they prefer to seek solutions themselves, without reporting these suspicions. However, if no reports are available, professionals who have to carry out the risk inventory and evaluation cannot combine relevant information.

Recommendations
The government is responsible for the physical safety of children on account of the Treaty on the Rights of the Child, that is to say, when their parents threaten them. The government must take care that it can fulfil this responsibility.
In the opinion of the Dutch Safety Board, the government itself must now improve the functioning of the child safety system, obviously in close cooperation with institutions and professionals that act on behalf of the government. However, the Dutch Safety Board notes that the government adopts a wait-and-see attitude with regard to intrinsic problems and focuses on a system change in youth care. It is expected that a system change may be a long-term process, while the problems continue to exist and the government does not act vigorously with regard to children living in a situation of physical danger.

Although organisational changes may also be necessary, the Dutch Safety Board thinks that the government must fulfil its responsibility regarding child safety and institutions and should equip professionals as well as possible, irrespective of how the system is organised. This is literally a matter of life and death for threatened children.

The Dutch Safety Board has the following recommendations.

Recommendation 1
To the minister of Public Health, Welfare and Sports and the minister of Security and Justice,
in coordination with the Interprovincial Consultations (IPO), Association of Netherlands Municipalities (VNG), Netherlands Youth Care, Royal Netherlands Medical Society (KNMG), the Dutch Municipal Health Services (GGD) and the Dutch Mental Health Care (GGZ):

Ensure that the institution (s) and professionals, who must act on behalf of the government after a report of a suspicion of physical danger, are able to carry out a full risk inventory and evaluation of the situation and take control when taking measures. For this it is necessary that professionals:
(1A) do not adopt a dependent attitude regarding the cooperation of parents when carrying out this task;
(1B) have all relevant information about other professionals involved with the family.

Explanation:
The instruments that professionals have to take over the responsibility of the parents, whether or not on a temporary basis (provisional supervision order, temporary removal of parental responsibility) must be applied, if this is required to carry out an adequate risk inventory and evaluation. Government institutions that have to investigate reports and carry out protective measures will benefit from an increase in effective opportunities to take control. The aim is to improve the exchange of information between institutions and professionals. The Dutch Safety Board deems it advisable that ministers who are responsible for this should enter into debate with the administrative authorities, institutions and most professional groups who are involved in (mental) health care.

Recommendation 2A
To the minister of Public Health, Welfare and Sports and the Minister of Security and Justice, Interprovincial Consultations (IPO) and Netherlands Youth Care:

Promote a further professionalisation of the child safety system, so that it is equipped to carry out an adequate risk inventory and evaluation and, if necessary, act in order to guarantee the physical safety of children.

Explanation:
If the government really wants to take control of the risk inventory and evaluation as described in the first recommendation, the professional in the child safety system must be equipped more adequately. In this study a number of elements are mentioned in this respect: physical safety must be made more operational; a policy with regard to (information about) recidivism is necessary; forensic-medical knowledge should be applied and be available more frequently and the internal supervision with the risk inventory must be improved.

Recommendation 2B
To the Interprovincial Consultations (IPO), Netherlands Youth Care, the minister of Security and Justice and the minister of Public Health, Welfare and Sports:

Learn from cases and incidents. Use this learning process to explain more clearly in which cases there is a threat of physical danger for a child and which research activities and safety measures are suitable in this respect.

Explanation:
The Dutch Safety Board thinks that the child safety system will benefit by learning more and by learning systematically from cases and incidents. Professionals must be able to share good practices and in this way they can also jointly decide whether safe or unsafe situations and adequate or inadequate measures are involved. This will help to create a common reference framework/framework of standards for physical safety.

The Dutch Safety Board does not regard disciplinary rules, which will be introduced in youth care, as a suitable means to increase professionalism in the current circumstances. The Dutch Safety Board thinks that professionals in youth care are vulnerable because there are no clear rules and guidelines. Supervision and internal inspection must play a more important role when increasing professionalism within youth care.

Recommendation 3
The following recommendation is addressed to the Interprovincial Consultations (IPO), Netherlands Youth Care, the Minister of Security and Justice, the Minister of Public Health, Welfare and Sports, in coordination with the Association of Netherlands Municipalities (VNG), Netherlands Youth Care, Royal Netherlands Medical Society (KNMG), the Dutch Municipal Health Services (GGD) and the Dutch Mental Health Care (GGZ):

Stimulate an increase in reports of (suspicions of) physical danger for young children and offer a reference framework for these reports.

Explanation:
Government institutions that receive reports of suspicions of physical danger, in particular the Youth Care Office / Advice and Reporting Centre Child Abuse and Neglect (ARCAN hereafter) the Child Care and Protection Board, must offer a clearer reference framework/framework of standards to professional reporters for reporting physical danger. In this respect there should be a discussion with professional groups in the (mental) health care, with the aim to formulate a policy about cases of physical danger, whereby postponing a report is unwanted.

The consequence may be that the number of reports of physical danger may increase as a result. If the government takes its responsibility seriously with regard to threatened children, it will accept this consequence.

Prof. Pieter van Vollenhoven
Chairman of the Dutch Safety Board

M. Visser
General Secretary

LIST OF ABBREVIATIONS AND DEFINITIONS

Abbreviations

ARCAN	Advice and Reporting Centre Child Abuse and Neglect
AMW	General Social Work
BJZ	Youth Care Office
BW	Netherlands Civil Code
EVRM	European Convention for the Protection of Human Rights and Fundamental Freedoms
GGD	Municipal Health Services
GGZ	Mental Health Care
IGZ	Health Care Inspectorate
IJZ	Youth Care Inspectorate
ISt	Inspectorate for Applying Sanctions
JGZ	Youth Health Care
JSO	Expertise Centre for Youth, Society and Education
KNMG	Royal Netherlands Medical Society
MOgroep	Social Entrepreneurs Group, as from 01-01-2011: Netherlands Youth Care
NFI	Netherlands Forensics Institute
NJI	Netherlands Youth Institute
NODO	Further investigation into the cause of death
Ots	Supervision Order
RvdK	Child Care and Protection Board
RIVM	National Institute for Public Health and the Environment
Sr	Criminal Law
Vots	Provisional Supervision Order = Child Protection Order
VRK	Convention on the Rights of the Child
Wjz	Youth Care Act
Wpg	Public Health Act

Definitions

Protective study: The study by the Child Care and Protection Board is aimed at the question whether child protection orders are necessary.

Case manager: The natural person who carries out the following tasks on behalf of a foundation that maintains a Youth Care Office:

- Assisting a client in exercising his right to youth care;
- Helping to realise a coherent assistance plan that is derived from the indication decision;
- Monitoring the provided youth care, assisting the client with questions regarding the content of this care, as well as evaluating this care;
- Advising the client with regard to the care that is necessary after terminating the youth care and assisting the client to obtain this care.[1]

Health centre: Previous name of youth health care for children between the age of 0 and 4. In this report this name is used because it is a common name.

Fatal child abuse: The death of a minor, whereby the injuries or anomalies that were caused by child abuse either are the immediate cause of death or have contributed to this death, although they are not the immediate cause.[2]

(Family) supervisor: Professional who carries out the statutory task of youth protection that is allocated to the Youth Care Office (the family supervision institution). Sometimes he/she is referred

1 WJz, art. 10.1f-i.
2 Verheugt, 2007.

to as ‘family guardianship worker’. For the sake of legibility the term of ‘family supervisor’ will be used in this report.

Domestic violence: Violence that is committed by a person living in the house of the victim or a person from the family circle. This includes physical and sexual violence, stalking and threats (whether or not through or accompanied by damage of goods in and around the house).

Intervention in the family: All forms of professional involvement with the family. In social work the term intervention is usually applied for specific therapeutic treatments.

Youth health care: Preventive health care, which is offered by the government to all children between the age of zero and nineteen in the Netherlands. The aim of youth health care is to follow the physical, social, psychological and cognitive development of children and monitor any disorders in this development, so that interventions can be offered on time.[3] The health centre is part of the youth health care for children between the age of 0 and 4.

Youth care: Supporting and assisting young people, their parents, stepparents or others who look after and educate a young person living with their family, when problems in growing up and parenting occur or when such problems may be imminent.[4]

Core decision : The most important decision moments for professionals of Youth Care Offices with regard to children, which are decisive for the subsequent course of the primary process.

Child: A person below the age of eighteen.[5]

Child abuse: Every form of interaction of a physical, psychological or sexual nature that is threatening or violent for a minor, which is imposed upon a child actively or passively by parents or other persons in relation to whom the minor has a relation of dependence or lack of freedom, which causes or may cause serious damage to the minor in the form of physical or psychological injury.[6]

Child safety: In the context of this study this refers to a level of protection agreed between involved parties against violence committed by parents. When ‘parents’ are mentioned in the report it also includes carers. The ‘narrow definition’ of safety is: a child is safe when it is not in peril of death and its physical integrity is guaranteed (physical safety).

Child safety system: In the context of this study this refers to the system of parties who jointly implement the government policy that is aimed at 1. observing, 2. investigating and 3. managing or removing threats to child safety. Monitoring (1) is a task of many different parties in society. The Youth Protection Department and the ARCANs and Neglect (ARCAN) of the Youth Care Office and the Child Care and Protection Board are specifically organised for the tasks referred to under (2) and (3) and are called primary parties or core institutions in the child safety system. In addition, one of the tasks of the police is the safety of children and prosecuting offences. In this report the police are referred to as a partner of the child safety system. It is not the task of the other institutions mentioned in this report to supervise the safety of children, however they have to monitor physical danger and cooperate with parties in the child safety system. The government bears responsibility for the safety of the child when parents do not assume their responsibility on account of the Convention on the Rights of the Child. It is also responsible for the functioning of the child safety system on account of this convention.

Multiproblem family*:* A family (at least 1 parent and 1 child) that has to contend with a chronic complex of social-economic and psychosocial problems.

3 See http://www.rivm.nl/vtv/object_document/o2391n20930.html.
4 WJz, art. 1c.
5 VRK, art. 1 (ratified by the Netherlands on 06/02/95).
6 WJz, art. 1p.

Foster home that offers a perspective: A family in which a child that has been placed in care is taken care of for an indefinite period.

Professional: In the context of this study this refers to individual professionals who are employed within the child safety system. This concerns: care workers, doctors at an advice centre, behaviour experts, family supervisors, team managers at key organisations such as Youth Care Office/ ARCANs (ARCAN), the Child Care and Protection Board (not exhaustive). It also concerns all professionals who monitor and report (see *professional reporters)*.

Professional reporters: In the context of this study this refers to persons who have a relation with the child because of their job and who therefore can observe signals of physical danger in the child. It concerns professionals from the social and (para)medical environment of the child, such as family doctors, youth doctors and youth nurses, teachers, police officers, employees in the child care, care workers from the mental health care, probation officers (this list is not exhaustive).

Risk inventory and evaluation: first part of safety management, in which risks are assessed and it is decided which risks must be controlled.

Risk factors: Family factors that carry a safety risk for the child, such as: developmental history of the parents, personality of the parent or characteristics of the parent, pedagogical awareness, family characteristics, characteristics of the child and living conditions.

Secondary prevention: The aim is to solve the deviation or the problem or prevent a deterioration. Primary prevention is aimed at preventing a deviation or problem by, for example, providing information or support before a problem starts.

Shaken Baby Syndrome: The Shaken Baby Syndrome' (SBS) is a term that is used to describe the effects of shaking a baby/young child. SBS usually occurs with children below the age of 1. Shaking babies may cause serious damage to the brains of a baby/young child. The damage that is caused by shaking is permanent and may vary from mild complaints to death in the most serious case. This kind of trauma usually does not only involve shaking. The term 'Shaken Baby Syndrome' is therefore an inapt term for this reason. The internationally accepted term is 'Abusive Head Trauma'.[7]

Safety management: The systematic and structural identification and analysis of risks and evaluating and managing them.

Early detection: Timely monitoring and recognising (psychosocial) problems, that may threaten the development of the child, so that it is possible to intervene at as early a stage as possible.

Care provider: The natural person or the legal person that offers youth care, which can be claimed on account of the Youth Care Act.[8]

7 Christian, Block and the Committee for Child Abuse and Neglect, 2009.
8 WJz, art. 1g.

1. INTRODUCTION

In the Netherlands a few dozen children die every year as a result of abuse by (one of) their parents.[9] The Dutch Safety Board considers the death of children through actions or negligence by their parents as a serious social issue. Young children belong to the most vulnerable groups of our society and cannot protect themselves. When parents do not protect their children and therefore do not assume their responsibility, children become dependent on others.

Traditionally, parenting and therefore also guaranteeing the physical safety of children was regarded as the exclusive domain of parents. However, the view that the government has a responsibility when parents do not guarantee the safety of their child has become more widespread since the beginning of the twentieth century.

In the course of the 20th century the right of children to a safe living environment and the responsibility of the government were therefore embedded in legislation and international conventions and apply as generally accepted social standard. In 1989 it was explicitly laid down in the Convention on the Rights of the Child that the task of the government is to offer safety to children when parents do not do this (sufficiently). The Netherlands ratified this convention in 1995. According to experts, this lapse of time was also caused by the restraint that exists in the Netherlands with regard to the government interfering with children in families.

When a child finds itself in a physically unsafe situation and the government receives a report, the safety of the child is not the sole responsibility anymore of parents, but also that of the government. In that case the responsibility of the government will be fulfilled by various institutions and professionals. They therefore act on behalf of the government.

Sometimes children also die when professionals are already involved in offering assistance to their family. Different professionals have been involved in various fatal cases. It is the job of these professionals to carry out the government task to protect children. The Dutch Safety Board thinks that it is extremely worrying that children die in these situations, in particular when there was a report and the government bears responsibility.

1.1 Reason study

The reason for this study were various incidents whereby children had died, while professionals were already involved with the families in question. The Dutch Safety Board initiated a study because of a few fatal cases[10] to see whether insights gained in other sectors could also be useful for this serious social problem. In this study the Dutch Safety Board applied its ideas about safety in organisations to the government task with regard to child safety.

Furthermore, the Dutch Safety Board thinks that the child safety issue is a serious social concern, in particular because children have died who had already been reported to ‘the government’, in this case to a professional, which meant that the latter had not been able to protect these children. As the government has a responsibility for the safety of children when parents do not fulfil their responsibility, the Dutch Safety Board is of the opinion that it is necessary to investigate how the government interprets this responsibility.

9 Chapter 2 offers more information about the extent of the problems. When a reference is made to ‘parents’ in the report, this also includes carers.

10 Shortly after the start of the study questions were asked in Parliament about whether this study was in line with the view on how the task should be carried out. The State Secretary of Public Health, Welfare and Sports, as well as the Minister of the Interior and Relations of State, stated that this study was in line with the commission of the Dutch Safety Board (see response to questions by Parliament 01/02/2007, KVR27212).

The subject of child abuse has received a considerable attention from the political-administrative field for some time. The State Secretary of Public Health (in the period 2002-2007) and the minister for Youth and Family (between 2007 and October 2010) had put child abuse on the agenda as an important subject.[11] Since then this subject has been highlighted again within the public administration. The safety of children being threatened by their own parents has frequently been the subject of study, for example by the Youth Care Inspectorate. The coalition agreement of October 2010 briefly referred to the subject of child abuse and formulated the intention to change the system of youth care.

The study of the Dutch Safety Board is based on 27 cases with a fatal or near fatal end. It concerns incidents from the period 2004 up to and including 2007. A study on children from the safety perspective who are threatened physically in their home situation and on the effect of the approach towards physical child safety, which is aimed at various professional groups and goes beyond the boundaries of the sectors concerned, has not been carried out before. Moreover, this is the first time that a series of fatal cases are investigated in the Netherlands.

1.2 Problem defintion

In this thematic study the Dutch Safety Board considers the responsibilities of various parties who are involved in the child safety: the parents and carers, the government, executive institutions, professional groups and professionals. The aim of this study is to contribute to the improvement of the effect of the child safety system12, so that (near) fatal cases can be prevented. Below it will be explained how the problem definition was established.

1.2.1 Professionals in the child safety system who fulfil government responsibility in practice

Professionals are those persons who fulfil the responsibility of the government regarding the safety of children in practice. In the Netherlands the care for the safety and development of children is first of all a private matter. It is in the hands of the parents in the context of the family. The government intervenes actively when parents do not guarantee the safety of the children who are in their care. In line with this, the government also has a responsibility for obtaining information about possible physical danger. This public task is carried out within the child safety system, through which the responsibility of the government is fulfilled. The central government formulates the frameworks regarding legislation and policy for the system, and makes funds available for the implementation of policy. The implementation of tasks within the child safety system is carried out by a network of institutions and professionals involved in these institutions. In chapter four a description is given of the organisation and effect of the child safety system. Parties involved also refer to the task in question as 'secondary prevention of child abuse'. 'Primary prevention' refers to the policy that prevents child abuse.

Whether and when the system is effectuated is determined by signals in the immediate environment of the child and the family. These signals may come from family and neighbours, but also from professional reporters such as youth nurses of health centres or family doctors. In response to these signals the parties in the child safety system decide whether they will play a role in caring for the safety of the child. With regard to responsibilities of parents and the government it is possible to distinguish three stages:

1. The autonomous family with fully responsible parents, without any suspicion that parents cannot fulfil this responsibility adequately. The responsibility of the government only consists of taking care that it receives information, which may be a reason to change to a different stage.
2. The autonomous family with fully responsible parents, with suspicions of physical danger. This therefore means that an appeal is made to the government to fulfil its responsibility

11 Programme Ministry Youth and Family, Action Plan Children Safe at Home (Actieplan Kinderen Veilig Thuis), 2007.

12 Child safety system: In the context of this study this refers to the system of parties who jointly implement the government policy aimed at threats against child safety. As a legislator the central government is responsible for the system with regard to the functioning of the child safety system.

for the safety of the child. Then action will be taken, first through an investigation and then, if necessary, in the form of an intervention. The government will have to investigate whether assistance or measures are necessary and, if this is the case, it should fulfil its responsibility for the child through a child protection order (supervision order, custodial placement).
3. The situation in which the government entirely takes over the responsibility for the child: removal of parental responsibility or withdrawal of parental rights.

1.2.2 View regarding safety
The Dutch Safety Board gained experience in various fields in its study on organisations and how these organisations dealt with safety. According to the Dutch Safety Board, guaranteeing safety starts with an adequate risk inventory and evaluation. On the basis of this inventory it can be established which risks should be controlled and which measures are necessary for this. After this it is necessary to choose and lay down a realistic safety approach that can be applied in practice. The implementation and enforcement of the safety approach will take place through a transparent, unambiguous description of responsibilities that should be accessible for all parties involved. This description includes the required staff deployment and expertise for the various tasks, the organisation of the internal supervision and the central coordination of safety activities. The safety approach must be continuously highlighted on the basis of the periodical implementation of (risk) analyses, observations, inspections and audits and a system of monitoring and studying cases, near accidents and accidents. By operating in this way, the risk of human failure is limited as much as possible. If mistakes are nonetheless made, they offer starting points to make further improvements. It should be stated explicitly that fatal cases can never be avoided entirely and that a death does not by definition imply avoidable human failure. However, there is an increasing intolerance with regard to mistakes[13], also because the knowledge about accident mechanisms has increased. With this knowledge there should be a continuous ambition to reduce the risk of human failure.

The starting points for the safety approach as described above have been applied to the task of the government in relation to child safety. In practice the safety approach is carried out by a professional, who must be supported by the child safety system. In order to be able to fulfil the responsibility of the government with regard to the physical safety of the child, the system must guarantee that three conditions are met: a. the professional must have all relevant information at his/her disposal in order to carry out a full risk inventory and evaluation with regard to the physical safety of young children; b. the professional must have sufficient expertise to be able to decide about applying all government instruments and corresponding powers and c. the professional must have the opportunity to learn from cases and incidents. This study assesses to what extent the child safety system functions in accordance with these starting points. The starting points for safety management that are applied by the Dutch Safety Board in all its investigations are explained in detail in chapter 3.

Professionals in the child safety system have a complex job for several reasons. An approach may also be inadequate for a different reason, that is to say, when the safety measures do not suffice. The Dutch Safety Board notes that the assessment of actual physical danger may easily become ‘contaminated’ because of the quality of the available measures and solutions. If there are no opportunities to create a safe situation for the child, this will affect the assessment of the professional.

1.2.3 Complexity of working in the child safety system
The professionals in the child safety system have to work in a complex environment. On the basis of a literature study the Dutch Safety Board distinguishes the following eight factors that make the work of professionals in the child safety system complex.[14]

13 WRR, 2007.
14 Munro, 1996; Munro, 2007; Baartman, 2006; Council for public health and care, Centre for ethics and health, 2008

1. *Uncertainty about the approach and case*
   Every decision by a professional in the child safety system is based on weighing the pros and cons of the risks related to intervening or not. Immediately after a report there is a transitional area in which the physical danger is not clear yet, although the government is already responsible. Various publications also show that professionals are very afraid that families are incorrectly qualified as families that are unsafe for children. After all, the measures to protect the safety of children may be radical (being placed in care, for example) and harmful for the physical and mental development of the child and the relationship with his/her parents. When the safety approach has been applied incorrectly in hindsight, the situation of safety will not have changed, but persons may have been affected negatively. The possibility that measures may have been incorrect in hindsight causes restraint in practice. This plays a smaller role in other sectors. In addition, professionals have few options to act when the child is in danger. In that case professionals can only try to take a decision that appears to be the best decision according to the available general knowledge and information with regard to a specific case at that moment. This will not always turn out to be the right decision.

2. *Almost incompatible social values*
   When the government has to take its responsibility for the child, it is confronted with the responsibility of the parents. The government can take over this responsibility from the parents, whether or not on a temporary basis. However, it also has the task to exercise restraint as much as possible on account of the European Treaty for Human Rights and because of national legislation. Moreover, the notion of 'outreaching care' is becoming more popular, however self-determination and protection of one's private life are also valued. After all, the tolerance in society with regard to mistakes of care workers has decreased as a result of a few tragic and much discussed cases. Because of the 'Savanna effect'[15] professionals would be less inclined to take any chances with children, because they are afraid of being prosecuted when things go wrong.[16] This will increase the pressure on the professionals.

3. *Complex professional environment*
   Professionals in the child safety system work in a system with a large and varied group of care workers and a complex organisational structure. Both factors may restrict the effectiveness of the actions of individual professionals.

4. *Multiple and complex problems*
   Physical danger in families is usually part of a much broader range of related problems experienced by a child or family. This sometimes makes it difficult to establish physical danger and assess the seriousness of the physical danger or possibility of reoffending. It is also often difficult to decide about the most effective intervention. This means that much flexibility is required when forming a judgement. Multiple problems also mean that various types of care workers are involved, so that additional requirements apply with regard to the mutual communication and coordination.

5. *Ambiguous signals*
   Physical danger can rarely be established or rejected on the basis of a single signal. Serious physical injuries that give cause to strong suspicions of abuse may have their origin in an accident or sickness. Professionals have to form a picture of the physical safety situation of the child on the basis of information about many kinds of variables. In each case it may be different which aspects are decisive in this respect, because sometimes there are no hard facts, but only risk factors. However, professionals also have to take decisions on the basis of limited information.

6. *Possible unreliability of statements*
   Physical danger in families is a sensitive subject. Sometimes submitted statements may be unreliable. Neighbours or former spouses may make incorrect claims because they are angry

15 Volkskrant, 4 September 2007.
16 Council for public health and care, Centre for ethics and health, 2008.

following a conflict with neighbours or a domestic quarrel. Parents who abuse their children are also inclined to deny accusations. Children find it difficult to discuss abuse by (one of) their parents in public with outsiders. They tend to support the explanation of their parents. The possible unreliability of some statements makes it difficult to establish physical danger.

7. *Time pressure*
   Particularly with young vulnerable children the speed of taking decisions and acting is crucial in some situations for the physical safety of the child. In these cases a decision will often be based on limited information about the family.

8. *Emotional burden*
   The work of professionals in the child safety system is emotionally demanding. Parents who are suspected of harming the physical safety of their children are sometimes difficult to approach, as is the case with their children. It is the task of the professional to build a relationship with them that is based on mutual trust. Moreover, the emotional impact may also affect the functioning of professionals in their job. It may mean that they function inadequately in their work and that their health is affected negatively. This may result in a withdrawal and turnover of staff.

1.2.4 Research questions

The central question of this study is:

How does the government fulfil its responsibility regarding the physical safety of young children, when the parents do not do his; what improvements are possible?

The responsibility for physical safety of young children is fulfilled in practice by the parties in the child safety system: the institutions, professionals and their professional groups. The professional is the person who intervenes in families in practice, with the aim to protect the physical safety of children.

In this thematic study 'fulfilling the responsibility' refers to the way in which professionals assess and evaluate risks regarding the physical safety of young children and the way in which the government and parties in the child safety system make it possible for professionals to carry out their complex job.

This question can be divided into four subquestions:
1. What are the laws, frameworks and directives in the child safety system? (see chapter 3)
2. How is the child safety system organised? (see chapter 4)
   - Which parties are involved?
   - What is their role in the system?
3. Which problems occurred in the cases when (alleged) threats of (physical) child safety were tackled? (see chapter 2 and 5)
   - Which institutions and professional groups were involved?
   - What information did the involved professionals have about the physical safety situation of the child?
   - How did they judge and act on the basis of this information?
   - To what extent are the problems in the cases addressed in the current framework of legislation and regulations and directives within which professionals in the child safety system have to operate?
4. What are the possibilities for improvement? (see chapter 5 and 6)
   - Which problems are addressed in recent policy plans?
   - In the opinion of the Dutch Safety Board, which additional possibilities exist to improve (the functioning of) the child safety system?

1.3 Study approach

For this study a total of 27 cases of child abuse with a (near) fatal end were investigated in the period between 2004 up to and including 2007. They were primarily selected on the basis of the degree in which they caused social alarm. In addition, the aim was to create a certain degree of

spreading in the type of incident that was investigated. The selection of cases will be explained more specifically in appendix B (extent and characterisation of child abuse and cases).
Files of the Netherlands Forensic Institute were used for the study, supplemented with files from Forum Educatief,[17] with data from the Youth Care Inspectorate and a few other inspections and court rulings. The Dutch Safety Board did not talk to professionals who are involved in individual cases. In some cases more specific file information was obtained from the authorities concerned. The file study was supplemented with a literature study and interviews with experts and the parties involved. In appendix A an account is given for this study.

1.4 Study demarcation

Cases and physical safety of young children
The study is based on 27 (near) fatal cases. The study is therefore limited to situations in which the physical safety of children cannot be guaranteed. Other cases and forms of physical danger have not been considered. This means that safety is interpreted in a limited way. After all, the safety of a child does not only refer to physical safety, but also to emotional safety. This is expressed, for example, in the definition of child abuse as applied in the Youth Care Act. The responsibility of the government and parties in the system for child safety is more in line with this 'broader' definition. The Dutch Safety Board therefore applies the 'narrow' definition in this study, and also restricts itself to children between the age of 0 up to and including 12. The children in the 27 (near) fatal cases belonged to this age group.

Cases and relation with legislation and regulations and directives
This study relates the cases to the current rules and directives of the branch. The reason that this relationship is discussed is that the Dutch Safety Board assumes that the open nature of the legislation and regulations play a role in problems experienced by professionals in practice with regard to the investigated cases. As a result of this open nature professionals have to find their own and unique solution to every situation. In addition, collective knowledge and experiences are normally combined in rules and directives.[18] It is for these reasons that the focus of this thematic study is specifically aimed at the rules and directives of this branch. According to some parties that were interviewed, the open character of the rules is inevitable in view of the complexity of the work. The Dutch Safety Board questions this inevitability.

Secondary prevention; shared responsibility
This study focuses on the functioning of the child safety system in the field of secondary prevention, which refers to preventing (further) threats to the physical safety of the child when there is a suspicion of abuse. The government is responsible for this system of care and protection, which comes into operation when parents do not sufficiently guarantee the physical safety of the child. The way in which parents and carers endanger the physical safety of children that have been entrusted to their care, as well as the causes and related options to act preventively have not been investigated. The study also did not focus on the role of the social environment of the child (relatives, neighbours etc.), but solely on the professional parties in the child safety system.

Moreover, we only investigated that part of the child safety system, in which the responsibility of the parents still applies. Situations in which the government has fully taken over the responsibility for the physical safety of the child (removal of parental responsibility or withdrawal of parental rights) were found in the files a few times, but only after the child had sustained (near) fatal injuries.

Relation with offences
Child abuse may result in being prosecuted for an offence. In most of the investigated fatal cases this was the case, usually after the child had died. The Dutch Safety Board does not deal with the question of guilt, but with the question how a lesson can be learned from what happened.

17 Forum Educatief is a centre for forensic medicine and behavioural sciences. This centre of expertise is part of the Van der Hoevenstichting and offers forensic-medical expertise when there are suspicions of (child) abuse, for example to judicial authorities.
18 For example, see Degas, 2010.

It is therefore important to emphasise that this thematic study does not deal with the question of guilt, but with the threat to the physical safety of the child and the question how the safety can be guaranteed better.

1.5 Bookmark

This report consists of seven chapters, including this introduction.

Chapter 2 includes an introduction of the child safety system and a few actual backgrounds, so that the other chapters are easier to read. Next, this chapter identifies a few bottlenecks that occur in the current functioning of the child safety system on the basis of the investigated fatal cases. For this reason the chapter presents aggregated findings from the investigated fatal cases.

The question on the exact organisation and functioning of the child safety system is discussed in chapters 3 and 4. Chapter 3 describes the relevant legislation and regulations, professional directives of the institutions and professional groups who are involved, as well as the starting points of the Dutch Safety Board for an adequate safety management. Chapter 4 offers an overview of the parties involved and their responsibilities.

Chapter 5 answers the question how the parties in the child safety system guarantee the physical safety of the child. It includes an analysis of how the government, institutions, professionals and professional groups control the physical safety situation of the child when parents do not fulfil their primary responsibility. For this purpose problems are derived from cases and related to the framework of legislation and regulations and directives.

The report is concluded by formulating conclusions in chapter 6. The recommendations are mentioned in chapter 7.

2. CASES AND BACKGROUNDS

An overview of the structure and effect of the child safety system is presented in this chapter with a view to readability of the other chapters. The nature and extent of the child safety issue in the Netherlands is described as well. Additionally, some bottlenecks in the effect of the child safety system are also identified in this chapter, which are based on the studied fatal incidents. Based on the compiled information from 27 cases of fatal and near-fatal child abuse, we have recorded which care workers were involved, which information was available to them and how they used that information.

2.1 A brief summary of the child safety system[19]

The child safety system consists of all parties, which jointly implement government policy aimed at opposing threats to child safety. The ultimate goal of the system - safeguarding a child's physical safety - is attained through various activities: identification and reporting, investigation of a report and provision of care to the family and protection of the child. For the purpose of this report, these activities have been divided into three process stages. Figure 1 shows the process stages.

1. Preliminary stage: Identification and reporting.
2. Process stage 1: Investigation and decision.
3. Process stage 2: Care and protection.

The division into process stages is linked to the stages of government responsibility (see also paragraph 1.2.1).

- Preliminary stage: Government responsibility consists of ensuring that it receives information about physical danger.
- Process stages 1 and 2: Government responsibility for the physical safety of the child is called upon and takes a more active and intervening shape - if necessary. The government must investigate if care or measures are necessary and - if so - must exercise its responsibility for the child with child protective measures (supervision order, custodial placement).

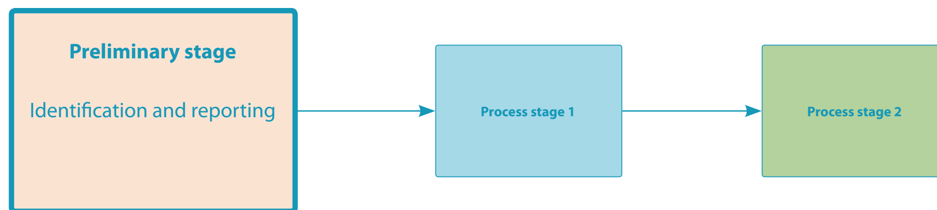
The child safety system is not an existing system, but a diagram which represents the duties. The duties of the child safety system, as described here, are a subset of duties placed with, inter alia, youth care and youth protection.

Figure 1. Functional division into process stages

The duties associated with each process stage are explained in more detail in the following subparagraphs.

19 Detailed descriptions of the legislation and regulations, responsibilities, duties and powers of the different parties are listed in chapters 3 and 4.

2.1.1 Preliminary stage: Identification and reporting



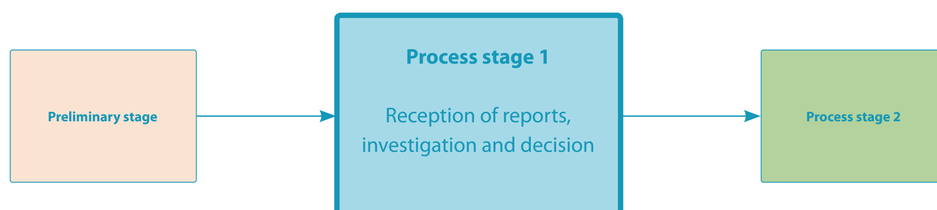
The system is activated when signals are picked up and reported. This takes place after the environment has received signals of the threat to the physical safety of a child and when the environment has reported these signals to the ARCAN of the Youth Care Office or to the Child Care and Protection Board. At this stage, it usually is a matter of suspicion, which may be based on issues such as medical conditions or injury, psychological problems of the parents or knowledge of the living conditions of the family.

Many persons and authorities in the child's environment may pick up and report such signals. About 70% of the reports received by the ARCAN come from professional reporters from the child's social or (para)medical environment. The other 30% of the reports comes from members of the public. The most important professionals from this group are shown in figure 2 in paragraph 2.1.4, with the police taking a special position. Police officers report many instances of child abuse. The police account for 30% of the total number of reports received by the ARCAN. The police assess if criminal law must be used. However, this does not happen very often in practice.

When someone calls the ARCAN of the Youth Care Office, a social worker or ARCAN doctor will assess the concerns with the caller and discuss if an investigation is needed. The procedure of the ARCAN is to start an investigation into the nature and seriousness of the abuse if the concerns are too great or when the caller cannot help the child and the family himself/herself.

This choice may be preceded by consultations by phone.
The Child Care and Protection Board can take receipt of a report directly, assess it and conduct an investigation in case of an immediate and life-threatening situation involving a minor.

2.1.2 Process stage 1: Investigation and decision



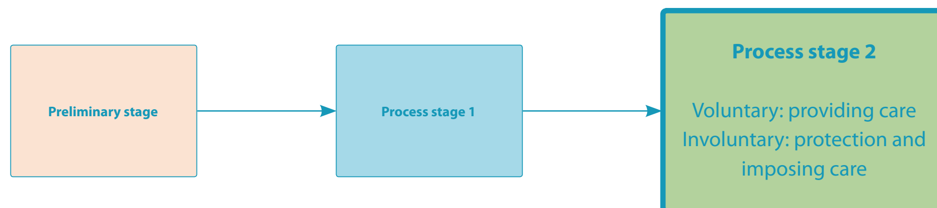
When the ARCAN[20] receive a report, they assess if the reported information gives cause for conducting an investigation into the physical safety situation of the child. In terms of the safety approach of the Dutch Safety Board, this study may be compared to a 'hazard identification and risk assessment' of threats to children.[21] Based on the results of this study, it will be decided what the best intervention is to safeguard the child's safety.

An investigation into the child's safety is in the first instance conducted by the ARCAN. If the development of the child is (presumed to be) at risk and voluntary care is not possible or sufficient, the Child Care and Protection Board will conduct a so-called child protection investigation. Based on this investigation, the Child Care and Protection Board can request the juvenile court judge to

20 For the sake of completeness, it is stated here that department 'Admittance' of the Youth Care Office also receives so-called 'intervention referrals' besides the ARCAN. These are mostly 'minor' reports from professionals to the Youth Care Office.
21 See paragraph 3.3.

take measures. The investigation can also show that there are still options for the child and the family within the voluntary framework. In critical situations, the Child Care and Protection Board may also request the juvenile court judge to issue a provisional child protection order without any investigation.

2.1.3 Process stage 2: Care and protection



There are various ways to safeguard a child's safety, which vary in the extent to which responsibility is taken away from the parents. Any involvement which takes place without the parents' consent requires a juvenile court judge to issue a child protection order. These are, in order of severity from low to high:

- Voluntary care, without a supervision order.
- Supervision order in combination with care (involuntary), with or without custodial placement, parents retain custody.
- Removal of parental responsibility (in the event of parental inability).
- Withdrawal of parental rights (in the event of culpable behaviour).

The last two measures involve[22] parents losing their parental authority. A child protection order usually is temporary. It is assessed if any follow-up measures are needed before expiry of the term specified in the measure. In general, a child protection order is combined with care for the child and its family.

In cases of an immediate threat to the child's safety, the law makes a provision for[23] an urgency procedure. In that case, a further investigation and associated final decision-making takes place after the intervention.

2.1.4 Core authorities in the child safety system

Responsibility for the process stages in the child safety system is vested in five core authorities, which carry out diverse tasks in the various process stages.

1. The police[24]
    - Preliminary stage: The police identify situations of child abuse and neglect and call in the Youth Care Office (ARCAN or 'Admittance').
    - Process stage 1: The police may start a criminal investigation based on a report and will send the file drawn up to the Public Prosecution Service, which will start criminal proceedings and a trial.

2. ARCAN of the Youth Care Office
    - Preliminary stage: The ARCAN of the Youth Care Office is the point of contact for reports of (a suspicion of) child abuse and has the task of giving advice. The Child Care and Protection Board can take receipt of a report directly, assess it and conduct an investigation in case of an immediate and life-threatening situation involving a minor.

22 These two forms of removal from parental authority will probably be merged in view of the anticipated changes in child protection legislation.
23 Dutch Civil Code.
24 The police is an important supplier of youth care in practice (see §2.1.1). The police identify and refer. However, the police do not have a core task in investigating if and which care measures are needed. Assessing if a criminal intervention is necessary, is an independent power of the police.

- Process stage 1: The ARCAN conduct investigations. The ARCAN are part of the Youth Care Office.

3. Department 'Admittance' and department Youth Protection of the Youth Care Office
   - Process stage 1: The department 'Admittance' of the Youth Care Office receives intervention referrals from professionals and conducts investigations into needs assessments.
   - Process stage 2 involuntary: The department Youth Protection of the Youth Care Office executes (family) supervision tasks in case of a supervision order. The Youth Care Office coordinates the care to the child and its family offered by care providers. The police and public administration may play a part in this process (prosecution of offences but also court injunctions for offenders).
   - Process stage 2 voluntary: The Youth Care Office also coordinates the care to the child and its family offered by care providers.

4. Child Care and Protection Board
   - Process stage 1: The Child Care and Protection Board takes care of the child's interests as a party to the proceedings in civil proceedings. The Board requests the juvenile court judge to take a child protection order and conducts an investigation into the child's situation to substantiate this request.
   - Process stage 2 involuntary: The Child Care and Protection Board examines per case if a child protection order can be terminated and/or authorisation for a custodial placement can be revoked (the assessing duty of the Child Care and Protection Board).

5. Judiciary (juvenile court judge)
   - Process stage 1 involuntary: The juvenile court judge takes child protection orders.

The process stages and authorities involved are displayed below.

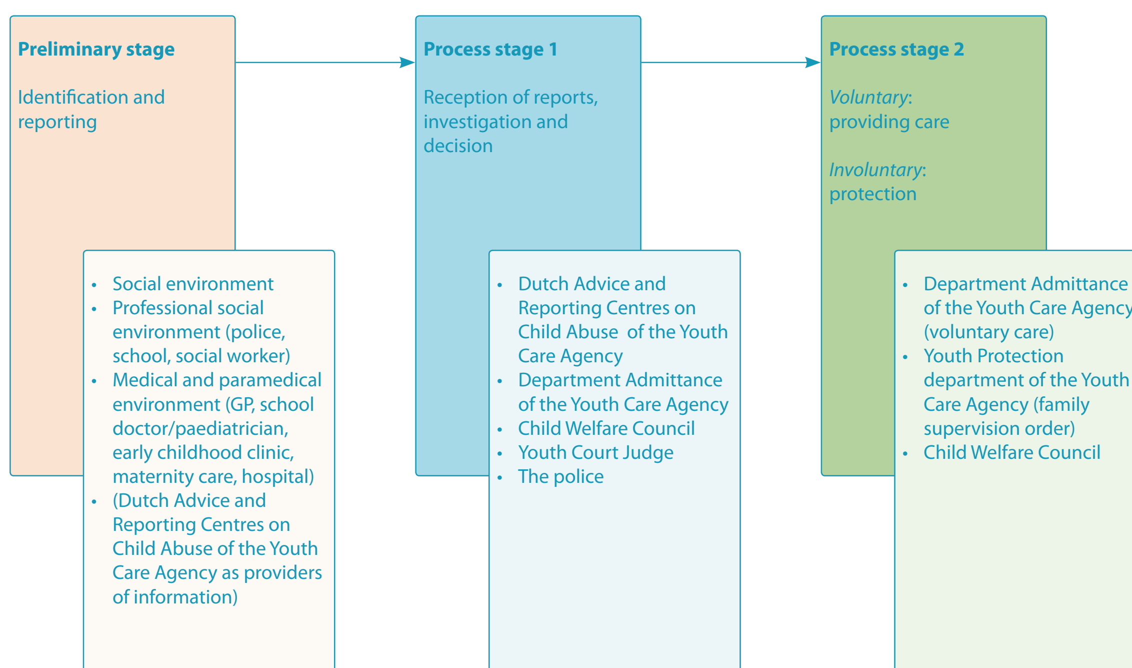


Figure 2. Process stages and core authorities involved

2.2 Extent of the child safety issue

Approximately 2.5 million children aged 0 to 12 were living in the Netherlands in the year 2009. In 2007, a prevalence study into child abuse focused on the Netherlands was conducted for the first

time.[25] An estimated 78,685 children aged 0 to 12 are victims of some form child abuse each year. The number of children aged 0 to 12 who are demonstrably harmed as a result of physical abuse is about 10,417.[26] The actual number of children per year who sustain injuries as a result of physical abuse is unknown.

The number of reports received by the ARCAN is only a fraction of the estimated total number of children who sustain demonstrable injuries as a result of child abuse. Physical abuse is 9.5% of the total number of reports of suspected cases of child abuse reported to the ARCAN. For 2009, this comes down to approximately 1,245 children aged 0 to 12, whose case is reported to the ARCAN in connection with physical child abuse.[27]

The number of children who die as a result of abuse by (one of) their parents is not easy to determine. The first Dutch investigation into deaths due to suspected child abuse was conducted in 1996 and published in 1998. This investigation revealed approximately 35 deaths due to suspected abuse of children aged 0 to 12. Presumably most children (24 of 35) were aged 0 to 2.[28]
Another way of estimating the number of fatal cases for children aged 0 to 12 is by studying the number of forensic autopsies performed by the Netherlands Forensics Institute. This institute has reported an annual average of 15 'certain' and 2 'highly likely' cases of fatal child abuse over a period of 14 years. Most children (64%) die from child abuse before the age of 2.[29]

Experts[30] have pointed out that a declaration of death by natural causes is wrongly issued in a number of deaths. This is mainly due to the fact that it is not always investigated if child abuse is involved and this cannot always be proven. Appendix B of this report further explains the extent of the issue and the relationship between the number of children who have died from abuse and the total number of abused children.[31]

2.3 Data regarding the investigated (near) fatal cases

The Dutch Safety Board has investigated 27 (near) fatal cases from 2004 to 2007. The 27 investigated cases involved a total of 29 children.[32] These children were aged 0 to 12. Twenty of the 29 children died and nine children became severely disabled: they nearly died from the abuse. Fifteen of the 29 children (nearly) died before reaching the age of one.[33] The most common injury was brain damage; this was established in 14 of the 29 children. Eleven children had been subject to (severe) physical violence and four children died by asphyxiation.

An extensive explanation and characterisation of the selected cases is enclosed in appendix B; the circumstances of the cases are described in appendix C. The Dutch Safety Board has collected available information about these cases from investigations by the Youth Care Inspectorate and the Health Care Inspectorate, from files of the Netherlands Forensics Institute and the Forum) and court sentences. Based on this information, we have recorded which professionals were involved in the cases, which procedures they followed and which decisions they took. Bottlenecks were discovered, which were examined by means of interviews with experts and literature study.

25 IJzendoorn et al, 2007. It concerns 107,200 children aged 0-17. This is translated into 78,685 children aged 0 to 12 who are the victims of any type of child abuse. The report 'Students on Abuse'('Scholieren Over Mishandeling') of January 2007 about abuse among 12- to 18-year-olds has not been incorporated in this report, because it concerns older children. See appendix B.
26 IJzendoorn et al, 2007. See appendix B.
27 Netherlands Youth Care, ARCAN, overview of 2009. See appendix B.
28 Kuyvenhoven, Hekkink & Voorn, 1998. See appendix B.
29 Soerdjbalie-Maikoe, V., R.A.C. Bilo, E. van den Akker, A. Maes. 2010. It concerns a total of 233 children from 24 weeks pregnancy up to and including 11 years of age over a period of 14 years, in which the cause of death is 'non-accidental child abuse'. This is a (rounded off) average of almost 17 children per year.
30 Kuyvenhoven, Hekkink & Voorn, 1998.
31 The Burial and Cremation Act has recently been amended (motion-Arib, TK30696/33), which makes doctors punishable when they establish the death of a minor without calling in a municipal forensic pathologist. It is expected that this measure will shed more light on the number of cases of fatal child abuse in the future.
32 Two of the 27 cases involved two children.
33 See paragraph B.4 in the appendix.

The Dutch Safety Board wants to emphasize that the investigated cases may not be representative of the state and the effect of the child safety system. The investigation of the cases was of a qualitative nature and was aimed at determining, based on a number of cases, if there are bottlenecks in the child safety system, which may indicate structural safety deficits. This research might not have identified existing structural safety deficits, because they did not play a part in the investigated cases. However, the bottlenecks that were identified indicate real system risks, regardless of their scale and the extent to which they occur in the entire system.

It was determined in which process stage - Identification and reporting, Investigation and decision, Care and protection - each case of (near) fatal abuse occurred. Depending on the process stage in which the (near) fatal abuse took place, the following aspects have been recorded:

1. For cases in which the (near) fatal abuse took place during the preliminary stage: Identification and reporting
    a. Which professionals were involved?
    b. Which information did they have?
    c. Which information was available regarding risk factors in the family?
    d. Was injury detected and if yes, was the injury related to a suspicion of child abuse?
2. For cases in which the (near) fatal abuse took place during process stage 1: Investigation and decision
    a. What was the source of the reports?
    b. Did the core authorities have sufficient information?
    c. How did the core authorities value the available information?
3. For cases in which the (near) fatal abuse took place during process stage 2: Care and protection
    a. Which professionals were involved?
    b. Which information did they have?
    c. Was any care or protection involved?
    d. How did the professionals involved handle new information which was made available?

The rest of this chapter will follow the above-mentioned questions. Paragraph 2.3.1 explains in which process stage the abuse took place. Paragraph 2.3.2 discusses the questions related to the process stage Identification and reporting. The questions related to the process stage Investigation and decision are discussed in paragraph 2.3.3. Finally, paragraph 2.3.4 deals with questions related to the process stage Care and protection. The C numbers, which refer to specific cases, correspond with the numerical order used in appendix C.

2.3.1 Distribution of (near) fatal cases into process stages

In eleven of the 27 investigated (near) fatal cases, the threat to the physical safety of the child was not noticed, clarified or reported in time. The children died or sustained serious injuries before a suspicion of danger was reported to the parties in the child safety system. In other words, they had died before a signal was reported.

In seven[34] of the 27 (near) fatal cases, a report had been made and the (near) fatal abuse took place during the investigation arising from the report. These children died before the investigation had been actually started or before the investigation and the decision were finalized.

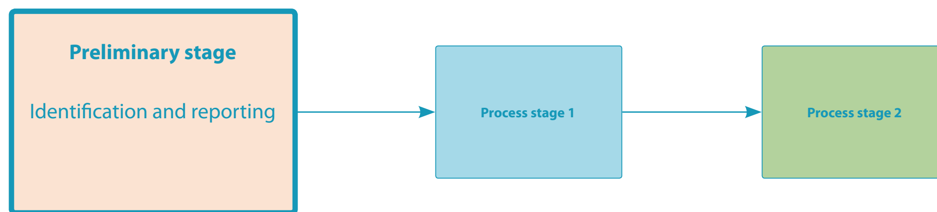
In nine of the 27 (near) fatal cases the investigation had been finalized. In four cases, a child protection order was taken before the child's death; in four other cases, voluntary care had been arranged and in one case, nothing (yet) had been arranged following the investigation.

It is remarkable that the (near) fatal abuse took place in all process stages: when only signals had been picked up and no report had been made, but also after a report of suspected child abuse and even when care was already given and/or child protection orders had been issued. The Dutch Safety Board decides not to attach any significance to this distribution.

34 It concerned nine children and in two cases, two children were involved.

After all, it is possible that these distribution numbers are different in a representative quantitative study. The fact that they are distributed over three process stages does mean that improvement is conceivable in all stages. More detailed information about the distribution according to age and process stage is included in appendix B.

2.3.2 Preliminary stage: Identification and reporting



The preliminary stage Identification and reporting starts when professionals reports or the social environment of the child pick up signals about a possible threat to the child's physical safety. One of the grounds could be the observation of actual injury or knowledge about the presence of risk factors in the family.

Regarding injury, it has been shown which professionals reports observed injury, if they connected the injury with potentially dangerous living conditions of the child and what the nature of the injury was. Youth healthcare uses guidelines which describe which injuries might indicate physical abuse. The interpretation of the injuries has been taken from the files, but has been checked by doctors with forensic expertise. Regarding risk factors, it is important to know if the authorities involved had knowledge of the presence of such factors in the family at the time of the report and which factors they were.[35] The investigated cases showed a risk factor which was directly related to physical safety, namely prior violence.

The eleven cases that took place during the preliminary stage Identification and reporting can be subdivided into three groups. Exclusion according to the following three steps was applied to divide the cases in the groups:
a. No injury determined, prior violence known.
b. Injuries had been observed, but they were not connected with the child's physical danger.
c. Injuries had been observed and one of the professionals had suspected child abuse.
For the sake of completeness, it should be noted that the professionals did not report these cases. The reader should take into account that more than one professional may be involved in a case. For instance, the police might have an insight into the risk factors regarding domestic violence or drug use and a doctor sees 'suspicious' injuries. The cases are briefly discussed below.

Re a. No injury determined, prior violence known
In six cases, no injury had been observed in the child who (nearly) died, but there was knowledge of risk factors. The following circumstances had been identified by professionals in the cases.
- Case C1 was a situation of domestic violence and the father was known to the police, because he had been suspected of sexual abuse of minors.
- Case C2 concerned a father whose prior children had been put in custodial placement after an investigation by the Child Care and Protection Board. The father received therapy imposed by the court about how to deal with children.
- Case C3 was a teenage mother and her eight-month-old child. The mother's past as a victim of abuse was a risk factor known to the police. There were no indications of prior injury or other visible signs of danger to the child.
- In case C4, a child had died under suspicious circumstances in a previous relationship of the father. Additionally, the father had previously been reported to the police for placing a

35 Factors corresponding with a higher risk of danger are known in the literature. See for instance: Baartman, 1996; Ruiter, C. de & de Jong, E.M. 2005. CARE-NL. Guideline for a Structured Assessment of the Risk of Child Abuse (Richtlijn voor gestructureerde beoordeling van het risico van kindermishandeling); Dobowitz & Depanfilis, 2000; Munro, 2008.

baby in a freezer. The father used alcohol excessively, had previously abused other children and had a history of drug abuse.

- In case C7, the ARCAN and Neglect conducted an investigation into an older child in the family who had sustained injury (burns) under suspicious circumstances.
- In case C11, a maternity carer had noticed that an older child in the family was hit hard with the flat of the hand.

Re b. Injuries observed, but not connected with danger
In two cases, doctors or a teacher observed injuries, but did not connect them with child abuse. In these cases, different doctors observed injury at different times.

- In case C6, several parties involved observed the following injuries in succession over a period of nine months:
  - Severe bleeding and swollen sexual organ (GP and urologist)
  - Fractured tibia (GP, paediatrician)
  - Several accidents (school)
  - Stitches and scars on and around the head area (GP and school)
  - Bruises in the face (school)
  - Damaged and swollen tongue (school)
  - Red spots on abdomen (school)
  - Injury (Municipal Health Services)
- In case C5, the father took a three-month-old baby to the GP. He discovered a broken arm and referred them to the hospital. One month later, there was another injury. The parents declared that 'someone had accidentally sat on the baby'. Another month later, the day nursery noticed the baby's eyes turning.

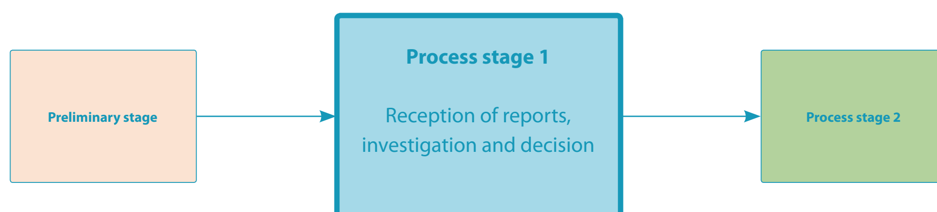
In these two cases, the professionals of the child safety system had prior knowledge of risk factors in the families.

Re c. Injury observed and connected with danger
Finally, in three cases doctors observed injuries and suggested that they may have been caused by child abuse. This was prior to the (near) fatal injury eventually inflicted by the parent. These three fatal cases, however, were not reported by the professional reporters to the ARCAN.

- In case C8, the doctor of the early childhood clinic noticed bruises on a three-month-old baby. This led to the suspected child abuse. The paediatrician of the early childhood clinic consulted the GP about his suspicion. This did not, however, lead to the confirmation of the suspicion of the paediatrician of the early childhood clinic.
- In case C9, the early childhood clinic observed a bulging fontanel. The early childhood clinic referred them to the GP, who called in the hospital.
- In case C10, the early childhood clinicobserved wounds and was informed about the special risk factors. The early childhood clinic referred the mother to the GP, but the mother did not visit her GP.

In two of these three cases, the inflicted injury eventually - later - led to the child's death. One child became severely disabled.

2.3.3 Process stage 1: Investigation and decision



In the seven investigated cases, eight[36] children sustained fatal or near fatal injuries during the investigation of the presumed danger to the child. In six of the seven cases, this investigation was carried out after a report of suspected child abuse had been submitted to the ARCAN. The seventh

36 In two cases, two children were involved.

case concerned fatal abuse during a child protection investigation conducted by the Child Care and Protection Board.

Source of and reason for the reports
These seven cases involved three groups of reporters:
a. the social environment (two cases);
b. the police (four cases);
c. the GP (one case).
Only in the last case was observed injury the reason for the report; in the other six cases, reported by the police and the social environment, knowledge about prior violence in the family was the cause for the report.

Re a. Report by the social environment
In two cases, the social environment applied to the ARCAN.
- In case C12, the biological father contacted the ARCAN. He was worried about the drug abuse of this ex-wife's new partner.
- In case C13, someone from the social environment reported to the ARCAN before the baby was born. The reporter stated that the parents would not be able to bring up their, at that time unborn, child because of their alcoholism.

The ARCAN started an investigation in both cases. In the first case, two children were killed by the mother's new partner several days after the decision of the ARCAN to start an investigation. In the second case, the ARCAN drew up an intensive action plan to establish a (care) network for this family. There were increasing signs of danger: the baby lay in its own vomit and the neighbours were concerned about the baby's loud crying. In a meeting with all parties involved, it was decided that the parents would receive extra notices to come to the children's outpatients department. Two weeks later, during a consultation at the children's outpatients department, the baby was diagnosed with having an increased head circumference due to Shaken Baby Syndrome.[37]

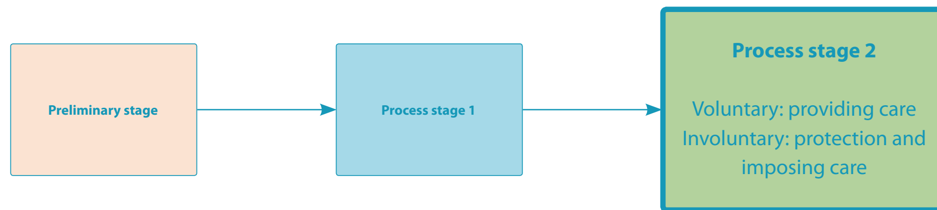
Re b. Report by the police
In four cases, the police turned to the ARCAN.
- Case C18 concerned a report before the baby was born, in a family in which the father had previously been a suspect in the death of another child.
- In case C14, the police reported to the ARCAN at the instigation of the father as a result of the disappearance of mother and child. There were escalating relational problems in the family.
- In case C17, the arrest of the father for domestic violence was the reason why the police reported to the ARCAN.[38]
- In case C16, a woman turned to the police because of domestic violence, but initially refused to report it. The police reported it to the ARCAN.

Re c. Report by the GP
In case C15, the GP observed bruises in a young baby's face. Both parents stayed in a social care farm for the mentally impaired. The GP, together with the midwife, reported the suspected child abuse to the ARCAN.

Failure to report
In each of these seven cases, professionals were involved who failed to report the signals they picked up. A closer analysis of the files indicates that a total of 22 professional reporters were involved in the seven cases discussed here. 13 of the 22 professionals, who had been involved in 6 different cases, failed to report risk factors known to them. Two professionals established injuries in two different cases and failed to report them. In one case (C6), five professionals had picked up signals and did not report them.

37 Shaken Baby Syndrome: Shaken Baby Syndrome is a term used to describe the effects of shaking a baby/young child. Shaking babies can cause severe brain damage in babies/young children. The internationally recognised term is Abusive Head Trauma.
38 In the context of 'Kindspoor', a police project focusing on children who have witnessed domestic violence.

2.3.4 *Process stage 2: Care and protection*



In nine of the 27 cases, the investigation by the ARCAN or the Child Care and Protection Board into the suspected danger had been completed. In four of these cases, care without a child protection order had been provided; in four other cases a child protection order had been taken and in one case nothing (yet) had been arranged after the completed investigation.

No care
In one case - C19 - the ARCAN concluded that no intervention was necessary. The case concerned a two-month-old baby. The baby had a torn lingual fraenum in combination with bruises. The ARCAN investigated this case, but the investigation did not prove that the parents had intentionally inflicted the injury. The ARCAsN therefore terminated the investigation. The parents were advised to attend parenting classes. Two weeks later, the baby died from severe brain damage.

In the other eight cases, steps were taken, because there were concerns about the upbringing of these children. Agreements were made with other institutions about the care for the children and their families. In four cases, the care was voluntary and in four other cases, supervision orders were issued.

Voluntary care
In four of the nine cases, voluntary care was provided. In two cases, the families were assisted by the Youth Care Office; in the other two cases, the parents made arrangements with the ARCAN or with the Child Care and Protection Board.

- In the first case (C20), there was a long history of aid to the father (by a mental healthcare institution) and his daughter (Regional Institute for Outpatient Mental Healthcare, Municipal Health Services, Youth Care Office and several other healthcare providers). In addition, the police had reported suspected child abuse several times to the ARCAN. In this case, the Youth Care Office carried out a risk assessment at different times. It was decided not to apply for a child protection order.
- In the second case (C21), a mental healthcare institution reported to the ARCAN, because the mother was suicidal and had to be committed. The Youth Care Office and the mental healthcare institution made agreements with each other and with the social environment of the mother about the care for her baby. The mother went back home within one week and killed her daughter several days later.
- In the third case (C23), a family supervisor had been appointed for an older child in the family. The family supervisor made agreements with the care workers who assisted the parents in connection with their problems. No formal authority framework (a supervision order) had been arranged for the new-born child, so more drastic child protection orders could not be issued in this case.[39]
- In the fourth case (C22), a baby became permanently disabled as a result of Shaken Baby Syndrome. Two months after that incident, a paediatrician observed bruises and he informed the ARCAN. The ARCAN reported it to the police. The Child Care and Protection Board carried out an investigation, in which it was advised to provide care to the father.[40] The juvenile court judge was not requested to take a formal measure. Both father and child received voluntary care. During this stage, the child sustained injuries at different times, including leg fractures.

39 Youth Care Inspectorate, 2008, Report Baby T.
40 Agreements for voluntary care are usually not made by the Child Care and Protection Board.

Involuntary care
In the other four cases, involuntary care was provided in the sense of a supervision order issued by the juvenile court judge.

- In the first case (C24), two older children had already been placed in custodial placement The third child, a three-year-old girl, lived with her mother again after custodial placement, but was still supervised. The mother received care from different authorities such as a mental healthcare institution and home care. This child was seriously neglected by her mother and stepfather and died from neglect and asphyxiation.
- In a second case (C25), the family received intensive assistance from the Youth Care Office, the juvenile court judge and a mental healthcare institution (for the mother). The mother was regularly committed to a mental healthcare institution. At a certain point, the judge decided to issue an authorisation for out of home placement. The child, a five-year-old boy, was temporarily placed in a foster home. The family supervisor wanted this child to be placed in a foster home for a longer period of time, which could offer prospects for the future and where he could stay until he turned eighteen. The juvenile court judge did decide to issue a custodial placement, but not with a foster home which would offer prospects. The judge thought it was of paramount importance that the parents and the child would maintain good contact. Plans were made for a more comprehensive visiting arrangement and replacement with the boy's mother. In the end, this child was killed by his mother during a visiting weekend.
- In a third case (C26), a six-month-old girl sustained multiple disabilities. The paediatrician established brain damage and suspected child abuse. He informed the ARCAN. At the request of the Child Care and Protection Board, the juvenile court judge issued a provisional supervision order. The girl was put in custodial placement for three months. The Youth Care Office applied for an extension of the custodial placement with the juvenile court judge. During the legal proceedings, the parents argued that the brain damage was caused by a vaccination. The juvenile court judge rejected the application for an extension and ruled that it was important for the girl's recovery to return home. She did, however, remain under supervision for a year. One year after the first incident, a second incident took place and the girl sustained bruises and the mother reported the father to the police for child abuse.
- In a fourth case (C27), a supervision order was issued for an eight-month-old boy who sustained multiple disabilities probably due to Shaken Baby Syndrome. The parents were the suspects. The boy stayed in a nursing home pending the criminal investigation into the abuse. He died in the nursing home more than two years later.

3. LEGISLATION AND REGULATIONS, DIRECTIVES AND REFERENCE FRAMEWORK SAFETY MANAGEMENT

This chapter describes the framework of legislation and regulations in which the child safety system functions. The texts of relevant conventions and legislation will be discussed in paragraph 3.1. In paragraph 3.2 we address sectoral directives and standards. In paragraph 3.3, finally, the basic premises will be introduced that the Dutch Safety Board applies on behalf of effective safety management.

It is important to mention that the formal framework of legislation and regulations in which the child safety system functions has changed only minimally since the commencement in effect of the Youth Care Act of 2005.[41] Most of the changes in the sector concern the directives developed by the relevant organisations within the sector. Developments in those directives took place with and after the fatal incidents that occurred, so that at the time of the fatal incidents they were not yet in effect or not yet fully implemented. In this chapter we will present the situation as at the end of 2010. The analysis of the cases in the period 2004-2007 takes these developments into consideration and shall also take a look at the significance of changes that have occurred.

3.1 Conventions and legislation on the physical safety of the child

Here is a brief summary of relevant convention texts and legislation in which the safety of the child is regulated.

3.1.1 International conventions

The functioning of the child safety system in the Netherlands is to a great extent determined by obligations that are delineated in two conventions: The Convention on the Rights of the Child (VRK[42]; accession Netherlands in 1995), and the European Convention on Human Rights and Fundamental Freedom (EVRM; commencement in effect 1950). The VRK imposes upon the state the following obligations:

1. The state must ensure that threats to child safety can be reported and that reports are effectively followed up;
2. The state must ensure that interventions can be established and imposed, and that the authorisation to intervene is assigned so that the safety of the child is indeed guaranteed;
3. The state must promote the actual reporting of danger;
4. The state must comprise the above mentioned obligations in a system of legislation and regulations, institutions and procedures.

In the Netherlands the government has responded to these obligations by establishing a normative and operational system. The normative system consists of national legislation and regulations. The methodical implementation of the national policy is realised by the public and private organisations in the child safety system. This operational system functions on behalf of provincial and municipal authorities to whom the implementation of national policy is delegated.

The EVRM, article 8, forms the foundation for the right to a family life, translated in practice to the right of parents to have a life together with their children. The right to a family life can be at odds with another right in the EVRM, article 3: no one may be subjected to humiliating treatment. From this article stems the obligation to above all be alert to danger to the child and to actively protect him.[43] It has been established that as long as not all forms of contact between the child and the parents are withdrawn but their interrelationship continues to be allowed, active professional

41 With the exception of art. 1:247 Civil Code to which it has been added that parents may assert no mental or physical violence (see par. 4.1.2).

42 The Convention is often referred to as the International Convention for the Rights of the Child (IVRK).

43 Bruning, 2003.

involvement with the child including forced hospital admittance for investigation does not represent a violation of the right to family life.[44]

3.1.2 National legislation

Six laws apply to the organisation of the child safety system:

a. Civil Code
b. Youth Care Act
c. Criminal Code
d. Temporary Restraining Order
e. Public Health Act
f. Psychiatric Hospitals Compulsory Admittances Act

These laws are briefly described below.

Ad a. Civil Code

Title XIV:1 CC, *Authority over minor children*, regulates the rights and obligations of parents. It obliges the parent to take care of his child and to raise him, and it also gives him the right to do this. Taking care of and raising is understood to mean the care and responsibility for mental and physical welfare and the safety of the child, as well as furthering the development of his personality. In caring for and raising the child the parents inflict no mental or physical violence or any other humiliating treatment.[45]

There are *three* different orders that the juvenile court can impose:

1. Supervision Order, with or without custodial placement: the authority remains with the parents.
2. Removal of parental responsibility: parental authority terminates.
3. Withdrawal of parental rights: parental authority terminates.

The first order, the Supervision Order, can be imposed if a minor child grows up in such a way that his moral or emotional interests or his health are at serious risk and the parents do not voluntarily cooperate with help.[46] The Child Care and Protection Board asks the court to place the child under supervision. The placement under supervision is effected by the Youth Care Office. The authority is limited in the sense that a supervisor is appointed for the child. The parents must accept support from the supervisor and follow written orders -if any- from a Youth Care Office. Should the parents fail to fulfil the written orders of the Youth Care Office during a placement under supervision, the supervisor has the option of requesting authorisation from the Juvenile Court for the child to be put in custodial placement. In itself the refusal to follow written orders is not a ground for custodial placement; this can only be done if it is necessary in the interest of caring for and raising a child or for an investigation into the child's mental or physical condition.[47] The court then takes a decision as to whether, and if so for how long, the child can be taken out of the home without the agreement of the parents.

The second and third order are the most far-reaching and are enforced only rarely: removal of parental responsibility or withdrawal of parental rights. In such cases the parents lose their authority over the child and the juvenile judge appoints a guardian, usually a Youth Care Office.[48] The release is intended for parents that are unsuitable or unable to care for the child. Withdrawal of parental rights is the most serious order. This takes place only if the parents behave in a culpable manner. Both a Supervision Order and the appointment of a guardian can be done on a 'provisional' basis in urgent cases; the Child Care and Protection Board then carries out its investigation after the fact.

44 Bruning, 2010.
45 Art. 1:247 was supplemented in 2007 with the care and responsibility for the safety of the child and the ban on the exercise of violence. This rejects all forms of violence by parents - other than to prevent acute danger to the child - and means that parents can no longer appeal to the 'right to parental discipline' if they are accused of child abuse.
46 Art. 1:254 CC.
47 Art. 1:261 CC.
48 Janssen & Bosschaart, 2009.

When a Supervision Order is issued, a Youth Care Office maintains supervision over the minor and ensures that the minor and the parent that holds authority over him are offered help and support in order to remedy the threat to the moral or psychological interests of the minor. This help and support is focused on as far as possible allowing the responsible parent to retain the authority to care for and raise the child.[49] When a guardian is appointed the parents no longer have this authority and the Youth Care Office represents all the interests of the minor child.

Ad b. Youth Care Act

The right to youth care and the responsibility of ensuring that this right can be exercised are delineated in the Youth Care Act ('Wet op de jeugdzorg', Wjz). The Youth Care Act (Wjz) delegates the responsibility to ensure that the child can exercise his right to youth care to the provincial authorities.[50]

One Youth Care Office is active in this context in each county. The Youth Care Office is responsible for determining the care needs of clients and taking decisions concerning the provision of care, with the agreement of the client or his parents or otherwise. The foundation that maintains a Youth Care Office also has the task of providing an ARCAN. Point of departure on the exercise of these tasks is that care serves the interest of an unthreatened development of the child and responds to the needs of the client. This care is therefore not further reaching than necessary and is offered as close as possible to the place where the client resides permanently and during the shortest possible period.[51] Youth care is in principle only provided on the request of the client; if he is a minor, his legal representative must grant his permission. When a child is placed under supervision youth care can also be provided without a request thereto.[52]

In the Youth Care Act (Wjz) it is regulated[53] that the person that is obliged to maintain confidentiality on the grounds of a legal regulation or on the basis of his official role or profession can provide information to the Youth Care Office without the permission of the person concerned if this can be considered necessary in order to terminate a situation of child abuse or to investigate a reasonable suspicion of child abuse. Finally, the Youth Care Act forms the foundation for the possibility that care providers have of anonymously reporting suspicions of child abuse.[54]

Ad c. Criminal Code

The Criminal Code makes abuse punishable.[55] The abuse of a child is hereby considered an aggravating circumstance.[56]

Ad d. Temporary Restraining Order

In 2009 the Act on the Temporary Restraining Order went into effect whereby a mayor may issue a temporary restraining order against the perpetrator of domestic violence.[57] If children have been the victim or witness of violence between partners, a report is always made to the Youth Care Office/ARCAN.

Ad e. Public Health Act (Wpg)

The Wpg charges municipalities with the implementation of youth health care. According to this Act municipalities have the task of identifying developments in the health condition of youths and to follow up on these, as well as the factors that further or threaten health.[58] The institutions and professionals in youth health care form an important group of professional reporters of (suspicion of) child abuse.

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49 Art. 1:257 CC.
50 Youth Care Act, art. 3.
51 Youth Care Act (Wjz), art. 5.4.
52 Youth Care Act (Wjz). art. 7 par. 6a (refers to art 10 par. 1b where the implementation of a Supervision order is regulated).
53 Youth Care Act (Wjz), art. 48 par. 3.
54 Youth Care Act (Wjz), art. 13.7; implementation decree WJz, art. 55.
55 Dutch Penal Code ('Wetboek van Strafrecht, WvS'), Title 20. Mishandeling, articles 300 through 306.
56 Article 304, par. 1 Dutch Penal Code: 'with regard to the perpetrator that commits the offence against his mother, his father to whom he is related, his spouse, his life partner, his child, a child over whom he has authority or a child in his care or whom he is raising as belonging to his family'.
57 Government Gazette, 2008, 421.
58 Dutch Public Health Act ('Wet publieke gezondheid, Wpg'), art. 5.2.

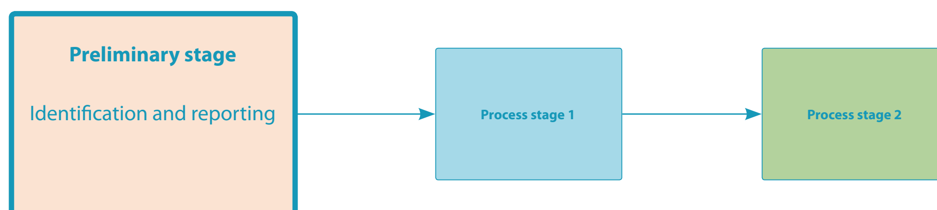
Ad f. Psychiatric Hospitals Compulsory Admittances Act (Bopz)
Based in the Bopz, on the request of the public prosecutor the court can issue provisional authorisation to have a person that is disturbed in his mental capacity admitted and retained in a psychiatric hospital.[59]

3.2 Policy and directives for dealing with (physical) danger

The implementation of the legislation discussed above is the domain of the parties in the child safety system. Above all in recent years they have developed various guidelines and methods that support the professionals in the sector in their actions during the process stage of Identifying and Reporting, Investigating and taking decisions, and Caring for and protecting.

This study focuses on cases in the period 2004 - 2007. Since that time various policy developments have been initiated that are focused on improving the identification of possible child abuse, shortening the investigation time and better assessing the danger of children. In the following subparagraphs the relevant policy developments per process stage are discussed briefly. A more detailed overview of the existing sector-specific guidelines, protocols and codes is included in appendix D.

3.2.1 Preliminary stage: Identifying and reporting



The former Youth and Family minister sent an action plan for dealing with child abuse to the Lower House in June of 2007 entitled 'Children Safe at Home'. This action plan contained a number of key points for dealing with child abuse during the Cabinet period Balkenende IV. Six of these are discussed below.

1. *Introduction of the RAK-approach[60] to child abuse.*
   In 2008, 35 central municipal authorities, provincial authorities and municipal districts made a commitment to the realisation of a cohesive and effective, conclusive regional approach to child abuse. The municipalities establish agreements between local and regional partners concerning dealing with child abuse and offering a programme for training and education for professionals. At the end of 2010 the basis of the network of cooperative chains focusing on dealing with child abuse will be ready. In this context each region will have introduced a conclusive manner of dealing with child abuse. The national introduction of the regional approach to child abuse is based on the RAK-approach that was developed between 2003 and 2006 in four test regions. The results of this were the springboard from which this work method was introduced throughout the Netherlands. This approach covers the entire care continuum: from population-oriented universal prevention and upbringing support through curative interventions after detected child abuse. The basic premise was and is that there be the closest possible link with developments and existing structures already present in the region. Within the regions agreements can be made in the work plans, regional action protocols and educational plans in such areas as education concerning the 'Shaken Baby Syndrome',[61] the (prenatal) screening of women in order to identify risk situations and the

59 Bopz Act, article 2, par. 1.
60 Formerly RAAK, Reflection and Action Group to Combat Child Abuse ('Reflectie- en Actiegroep Aanpak Kindermishandeling').
61 Shaken Baby Syndroom: The Shaken Baby Syndrome is a term that is used in order to describe the consequences of a baby/young child being shaken vigorously. Shaking him can cause serious injury to the brain of a baby/young child. The internatiionally accepted term is 'Abusive Head Trauma'.

education of professional groups with regard to child abuse.[62] The national RAAK support from the federal government will conclude at the end of 2010. Regional plans will continue to be carried out by the regions even after 1 Jan. 2011.

2. *The (re-) development of report codes.*
   A law[63] is being prepared at the federal government level that establishes the obligation of independent professionals and organisations to utilise a report code for domestic violence and child abuse. The obligation will apply to youth health care, education, childcare, youth care, the social support bodies and police and the justice system.[64] Many professional groups have already developed such a code. In this paragraph we list the report codes that focus on the professional groups that can come in contact with young children that have suffered injury:
   - *Youth Health Care (JGZ) directive*.
     The directive 'JGZ-directive secondary prevention of child abuse: How to act in response to the suspicion of child abuse' (RIVM, 2010)[65] gives instructions for recognising and dealing with child abuse. The directive was already in effect in 2003 and was entirely revised in 2009. The directive was written by professionals in youth health care such as paediatricians and youth nurses working at early childhood clinics and in school health care. The directive is focused at so-called early detection of risks for the development of young children. The goal is to prevent a threat to the development and safety of the child.
   - *KNMG-report code*.[66]
     For physicians the 'KNMG-report code Child abuse' (2008) is the current professional standard. This replaces the KNMG report code of 2002. The premise 'be silent, unless' was discarded and replaced by the premise 'speak, unless'. The health care professional has no obligation to report, but rather a right to do so. Additionally there is indeed an obligation to take action, all the more so if the professional decides not to report but to personally assume responsibility for action. Many professional groups in health care have developed their own specific protocols based on this KNMG-report code, including the Royal Dutch Association of Birth Attendants and the National Association of Family Practitioners. The KNMG-report code emphasises professional responsibility in response to child abuse and pays special attention to the relationship of trust that medical practitioners have with their clients. The codes deal with the circumstances under which they are expected to bypass their usual obligation to maintain confidentiality and report their suspicion of child abuse. An obligatory step is the consultation of a Dutch ARCAN and preferably also an experienced colleague. Since the introduction of the report code, physicians have been more willing to report.[67]

3. *Order for detection and role of the police.*
   A third topic is the 'Order for detection and prosecution concerning child abuse' that went into effect on 1 August 2009. This order gives police and the judicial system instructions

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62 Dutch Programme Ministry for Youth and Families ('Programmaministerie Jeugd en Gezin'), consultation response.

63 A second topic in the Action Plan of the minister is the Act on the Report Code on Domestic Violence and Child Abuse that is expected to go into effect in 2011. Institutions and independent professionals will be obliged to apply a report code for domestic violence and child abuse.

64 See letter dated 20 November 2008 from the state secretary of VWS and the ministers of Youth and Family and Justice to the Lower House, TK28345/72. See also http://www.rijksoverheid.nl/onderwerpen/huiselijk-geweld/meldcode-kindermishandeling-en-huiselijk-geweld. It is expected that the Act on The Report Code on Domestic Violence and Child Abuse will go into effect in the spring of 2011.

65 The definitive version was established in 2010. RIVM: National Institute for Public Health and Environmental Hygiene.

66 KNMG: Royal Dutch Medical Association ('Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst').

67 In 2006 1.3% of all reports (13,815) originated form the family practitioner, 4.1% from youth health care and 4.4% from a hospital. In 2009 1.8% of all reports (16,574) came from family practitioners, 4.0 % from youth health care and 7.5 from hospitals. The general observation of the presence of risk factors is not part of these codes. A reason to make a report only exists if suspicion of abuse exists. Source: Annual figures ARCAN of 2006 and 2009.

for the detection and prosecution of child abuse. The goal of the order is that there be more attention and alertness with regard to child abuse in the broadest sense of the word. A wide range of types of child abuse falls under this order. Criminal law will more rapidly become involved. In this context a protocol is being developed that contains cooperation agreements concerning reporting serious (suspicion of) child abuse from the agencies Youth Care / ARCAN to the police. From the approach to violence between partners it has been noted that the police can make a contribution to stopping violence by using their criminal penalisation authority, certainly if the public prosecutor then includes the provision of help to offenders in this sentence demanded. The intention is not the penalisation of offenders but rather to ensure by persuasion or force that they accept help which would often not have been accepted voluntarily.

4. *Referral index youth at risk.*
   The goal of the referral index[68] is to realise early mutual coordination between 'persons authorised to report'. This coordination envisages providing young people with timely, suitable help, care or support in order to prevent, limit or erase actual threats to the necessary conditions for health and safe development into adulthood. A professional that is authorised to do so can report a young person to the referral index if he has a reasonable suspicion that this young person is threatened in his development to adulthood by one of the risks specified by law. If another professional reports the same young person to the referral index, the referral index informs the professionals concerned of each other's involvement with the young person in question. In the referral index no other data are processed than the civil service number of the reported young person and the identification and contact data of the professional that makes the report and, in relevant cases, of the coordinator meant in article 21 of the law.[69]

5. *Digital dossier youth health care /EKD.*
   The digital dossier on youth health care (DD JGZ) contains information about the child, the family situation and the environment of the child. This dossier was also referred to in the past as the Electronic Child Dossier or EKD. The DD-JGZ is the medical dossier that employees of Youth Health Care maintain on children under their care. The dossier follows the development of the child. The dossier is not accessible to persons other than the paediatrician or youth health care nurse that has direct contact with the child. On 3 October 2007 the Lower House requested that the Electronic Child Dossier of Youth Health Care (JGZ) be expanded in order to facilitate the exchange of information between Youth Health Care and other parties in the youth assistance sector. At the end of 2008 the minister for Youth and Family, on the grounds of a feasibility study, considered this going too far for such reasons as, amongst other things, the need of care workers to be able to provide verbal elucidation on information about families, a deficiency of unity in language between the various disciplines, privacy problems and ICT problems. He focused policy further on the Referral Index.

6. *Helpdesk for professionals for privacy topics.*
   The Helpdesk Privacy Youth and Family was established to answer questions from the field with regard to privacy in the realm of young people in the ages from 0 to 23 years. The helpdesk works for the sectors justice and police, education, (youth) health care and help.

68 The bill was elevated to law and was published (Government Gazette 2010, 89). With the publication of the amvb under this law, the law went into effect simultaneously with the amvb as of 1 August 2010 (Government Gazette 2010, 302).
69 Programme ministry Youth and Family, perusal reaction.

3.2.2 *Process stage 1: Investigations and decisions*

The Youth Care Offices, the ARCANs and the Child Care and Protection Board utilise difference protocols and policy in order to support the professionals working in their organisations during the process stage Investigation and directives. Over the last years the actors in the sector have worked on various tracks. These are discussed briefly below.

1. *Preparing umbrella policy with regard to safety by Youth Care Offices*
   In 2008 the MO group Youth Care[70] established the document 'Safety Policy and Risk Management in the Youth Care Office'. This document derives from the National Action Programme Dealing with Child Abuse (LAAK) of the MOG group Youth Care. LAAK stipulated that all institutions for youth care must include safety for children as a core value and develop and implement this on all levels within youth care.
   In the policy document the MO group Youth Care says that dealing with child abuse is of the highest priority for the Youth Care Offices. The document comprises a comprehensive vision of safety policy and risk management that includes attention to a methodical approach to work, the employees and the organisation. Another chapter concerns making decisions on safety in practice. These (core) decisions must proceed in a structured manner. For every core decision[71] the employee of the Youth Care Office must collect information and carry out an assessment. All decisions are first discussed internally by the professional with the behavioural scientist or supervisor. In the document the concept of physical safety was also elaborated.[72] The instruments or methods used by the Youth Care Office were adapted (see below), whereby the core decisions on safety were used as the basic starting point. This concerns ORBA, the (new) Manual Indication for Treatment and the Manual Delta Method Family Supervision / guardianship.

2. *Developing (new) methods and protocols*
   The agencies of Youth Care, ARCANs and Child Care and Protection Board have all invested in the development of new protocols and methods.[73]
   - ARCAN revised the 'Protocol of action of the ARCANs on suspicion of child abuse in relationships of dependency and lack of autonomy'. (MO group Youth Care, 2009; original version 2004). The action protocol gives guidelines for the employees of ARCANs. Additionally, Advice and Reporting Centres use the ORBA systematology for the more methodical elaboration of nine so-called core decisions[74] to be taken. In order to support professionals in these core decisions, six tools - checklists and decision making diagrams - were developed. The CARE-NL is used for risk assessment at most ARCANs.
   - Youth Care Offices have described their primary processes in detail in relation to the legal context of the Youth Care Act (Wjz) in the 'Reference work model Youth Care Office'(Ordina, 2005). This reference model also forms the basis for the 'Handbook Indication for Treatment Youth Care' (MO group Youth Care, 2007).[75] This Handbook indication contains the 'Light Instrument Risk Assessment Child Abuse' (LIRIK, a tool for determining in a structured manner whether a situation of

70 MO group: Social Entrepreneurs Group, as of 1 Jan. 2011 Netherlands Youth Care.
71 See appendix D.
72 See appendix D.
73 See appendix D.
74 See appendix D.
75 A revised version of this handbook will come out in 2010.

child abuse might exist and estimating the safety risks for the young person in the future) and the instrument 'Structured Checklist Admittance' (GCT).

- The Child Care and Protection Board applies protocols with a detailed description of the prescribed method for protective investigations (Protocol Protective Tasks).[76] This protocol explores, amongst other things, the method of the council investigation, specifically: intake, with quality requirements with regard to the intake work; investigation; the report; the assessing task. This protocol was revised in 2009. The Child Care and Protection Board also developed a new method in 2009 for carrying out protective investigations: New Advisory Method (NRM).

3. *Improving the quality of youth protection*
   The policy programme 'Better Protection' commenced in 2005 and was recently (in 2010) completed.[77] The goal of this programme is to increase the quality of youth protection by:
   1. Shorter turnaround time in the youth protection chain.
   2. Improved provision of information in the youth protection chain.
   3. Improved implementation of child protection orders.

4. *Revision of child protection legislation.*
   Above all the first two goals strive to arrive at a single national method for cooperation between the core organisations (ARCANs / Youth Care Office, Child Care and Protection Board and juvenile court). The goal of the new method is that turnaround times be shortened and decisions taken more rapidly in concrete situations with regard to the implementation of youth protection measures.[78] To this end, since 2009 there has been a so-called case discussion on protection in each region between these parties. For the improved implementation of the child protection orders, the Dutch Safety Board refers to the following paragraph. The revision of child protection legislation has been submitted to the Lower House as a bill.

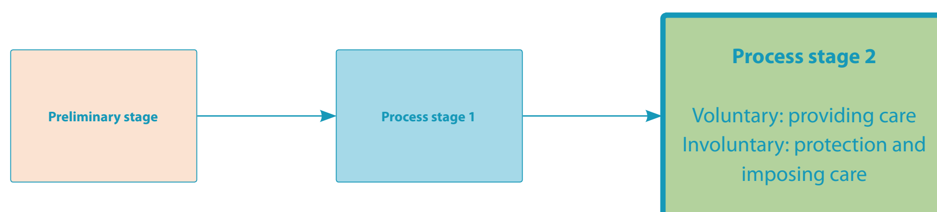
5. *Professionalisation of youth care*
   In the context of the professionalisation of youth care, the minister for Youth and Family and the sector have commenced a number of quality programmes including the 'Improved Indication Setting for Youth Care Offices' (VIB). In 2007 the 'Action plan Professionalisation in Youth Care' commenced. This action plan wishes to provide professionals in youth care with a professional context within which to carry out their tasks. This action plan comprises attention to professional profiles, a professional register, a professional code and, finally, the introduction of a code of discipline.

76 The Child Care and Protection Board carries out more tasks than only protective investigations. The Quality Framework 2009: Policy terms with regard to the work method of the Child Care and Protection Board' contains the general context that applies to the methods of the Child Care and Protection Board.

77 Letter from the minister of Youth and Family, 15 February 2010. TK 2009/10. 31001, no. 85 and letter from the minister of Youth and Family, 17 August 2010. TK 2009/10. 31001, no. 93

78 In concrete terms, the objective is that the chain turnaround time of a protection case must be decreased from (formerly) more than one year to approximately two months. The established standards are: (1) Within one day after the report of concern, an estimate is made of the seriousness of the risk; (2) Within 2 months, where necessary an investigation is carried out by the Child Care and Protection Board and a measure for child protection is implemented; (3) Within 5 days thereafter there is actual contact between the family guardian and the child and/or family.

3.2.3 Process stage 2: Care and protection



The directives, protocols and policy programmes to improve this process stage focus to a great extent upon further professionalisation of executive professionals and reinforcement of their judgment capacity. The most important initiatives are delineated below.

1. *Developing Delta Method Family supervision*
   The 'Delta method family supervision'[79] is a method for the implementation of such actions as the issue of supervision orders. The method focuses on family supervisors and came about as part of the programme 'Better Protection' of the Ministry of Justice. The Delta method is based on an analysis of the legal principle of the imposition of supervision orders (art. 1:254 CC), and offers the professionals of Youth Care Offices practical guidelines to give form to broadly formulated legal stipulations. Basic premise in the Delta method is the 'interest of the child'. The Delta method concretises this interest from a developmental perspective.[80] This means that professionals must constantly check to see how the child is developing and whether this is a matter for concern compared to the 'normal development' of a child. The risk to the child is therefore formulated in terms of the risk to his development. Here, safety is named as a condition for normal development.
   On request of the minister for Youth and Family, a risk assessment instrument must be utilised annually in youth protection cases.[81]

2. *Resumption of assessing task by the Child Care and Protection Board*
   Since 1995 the Child Care and Protection Board has had to assess in all concluding supervision orders whether the termination of the relevant measure is indeed a responsible move. However, this task has not been carried out. Subsequent to the death of the toddler Savanna, the minister announced that the assessing task would indeed be carried out in the future. By 2008 the assessing task, in the opinion of the Youth Care Inspectorate, had been insufficiently carried out.[82] Between the agencies Youth Care and the Child Care and Protection Board cooperative agreements have now been established about the implementation of the assessing task. By the end of 2010 the assessing task must once again be completely carried out.[83]

3. *Regulation of the coordination of care*
   In order to clarify who is responsible for managing and providing help if two or more organisations are involved with a young person or a family, in 2009 the minister for Youth and Family submitted a proposal for a revision of the Youth Care Act to the Lower House.[84] In the proposed bill the municipality is given the management role in the youth care chain.

79 PI Research/Van Montfoort, 2009.
80 Handbook Delta Method Family Guardianship, version 3, December 2009.
81 The instruments to be used are listed in appendix D.
82 The Youth Care Inspectorate carried out a study in early 2008 into the assessment by the Board of the proposed decisions of the Youth Care Office to place the child back in the home, and came to the conclusion that this assessing task was carried out at an insufficient quality level (report 'The assessing task of the Child Care and Protection Board' of September 2008).
83 The Youth Care Inspectorate issued a report in 2010 concerning improvements that have been made, and came to the conclusion that the quality of implementation of the assessing task in decisions to place a child back in a home - despite the efforts of the Board and the MO group Youth Care - as a whole is still insufficient (report 'The assessing task of the Child Care and Protection Board in decisions concerning returning (the child) to the home' of February 2010).
84 Lower House 2009-2010, 31977, no. 2.

This means that the municipality must see to it that the various organisations involved in providing care to young people must make conclusive cooperative agreements. One of the topics concerning which obligatory agreements must be made is the coordination of care. If two or more organisations are involved with one child or family and the family itself cannot handle the coordination, it must be clear which organisation is responsible to see that the necessary help or care is indeed provided.
In principle the care worker that is most involved with the child or family should be responsible for the coordination of care. Should an impasse arise, the bill entails giving the mayor the authority to allocate an organisation that is charged with the coordination of care. This allocation can be given to an institution for (school) social work, an institution that carries out youth health care, or a Youth Care Office.[85] The minister for Youth and Family did not state how this municipal role is embodied vis-a-vis the management by the Youth Care Office if youth protection is involved as well as the involvement of professionals that are not part of the municipality.[86]
Additionally, a parliamentary study group has taken a look at the future of youth care.[87] The outline thus obtained also shifts voluntary youth care to municipalities. In the context of the establishment of centres for youth and the family a document[88] has been prepared that gives starting points for dealing with child abuse and the contributions that youth health care makes to this effort. This document, as well, mentions management by this municipal service with respect to voluntary care.

3.3 Reference framework for safety management

In this study, the Dutch Safety Board applies its insights into safety to the task of the government with regard to child safety. In its studies, the Dutch Safety Board applies its own reference framework with five general starting points for assessment of the quality of safety management with regard to the parties concerned. These five basic premises apply, in the studies of the Dutch Safety Board, to organisations and how they contribute to safety. Through such an approach the likelihood of human error and its consequences is limited as far as possible. Errors that occur nonetheless offer leads for identifying new risks and further improving safety. For this study of child safety the five points from the reference framework are 'translated' into the approach of government organisations and professionals that they apply in concrete cases when the physical safety of a child is at stake. It must be emphasised here that events with a fatal outcome cannot all be prevented, and that a death need not specifically signify that avoidable human error has occurred.

The reference framework of the council comprises the following five points.

1. *Insight into risks as basis for the approach to safety*
   Effective safety management uses the risks to be controlled as the starting point for its approach to safety. The risks are inventoried and on the basis of these it is established what risks must be managed and what measures this will require.

   For this study this means that professionals inventory, in a concrete case, the risks that threaten the physical safety of the child in his family situation, and evaluate these. Based on this inventory and evaluation of risks it can be determined what risks must be controlled and what safety measures this requires.

The Dutch Safety Board assumes that parties take into consideration the relevant laws, regulations and directives during the risk inventory and evaluation and that they involve best practices from their sector when doing this. It is also expected that the parties concerned include earlier experiences in

85 Source: Programme ministry for Youth and Family, consultation response.
86 Letter minister for Youth and Family to the Lower House dated 2 November 2009.
87 Study group Future Perspective Youth Care, 2010.
88 GGD-Netherlands, Zorgcoördinatie in de Jeugdgezondheidszorg, 2006. Elaboration of Operation Young Action Point Early Identification. Vision document Care and GGD Netherlands; Fact sheet Care coordination, V&VN Fraction JGZ, version 1.0, May 2008.

their risk management. The Dutch Safety Board also expects that in the risk inventory all threats and aspects that influence the risk are included.

2. *Demonstrable and realistic approach to safety*
Subsequently, a realistic and practically applicable approach to safety must be chosen and documented that focuses on preventing unwanted events and managing risks. In any case this approach includes the following:
   - A description of the manner in which the safety approach that was taken is actually implemented, with attention to concrete objectives, plans and resultant measures.

For this study this means that the professionals concerned determine an approach on behalf of the government in a concrete case that guarantees the physical safety of the child.

3. *Implementation and maintenance*
Thirdly, the quality of safety management is determined by the degree to which the envisaged safety approach is indeed implemented and the manner in which the organisation supervises this process. Implementation and maintenance of the approach takes place through:
   - Transparent and unequivocal division of responsibilities on the work floor for the implementation and maintenance of safety plans and measures;
   - Clear-cut delineation of the required personnel use and expertise for the various tasks;
   - Clear and active central coordination of safety activities.

   For this study this means that professionals actually implement the approach to the physical safety of the child and supervise the effects thereof.

   The Dutch Safety Board expects that the parties concerned in the approach to safety include framework conditions for the good implementation and maintenance of the approach in order to guarantee the physical safety of the child.

4. *Fine-tuning*
The approach to safety must be fine-tuned continually based on new information about risks. Risks are not static data, but change with the context in which processes are implemented. An effective system of safety management creates a so-called learning loop,[89] in which experience from the process is systematically used to improve the process and update risk management.

   For this study this means that each concrete case is constantly monitored to confirm that the approach to safety actually results in the envisaged physical safety of the child.

   Secondly, this specific premise is applied on an organisational level with respect to how the institutions concerned learn from incidents and events.

   The Dutch Safety Board expects that the approach to safety be continually fine-tuned on the basis of:
   - The periodic implementation, at least upon each change in basic premise, of (risk) analyses, observations, inspections and audits (pro-active approach);
   - Systemic monitoring and investigation of incidents, near accidents and accidents, as well as an expert analysis of these (reactive approach). Based on this, evaluations are carried out and possibly the management adjusts the approach to safety. Additionally, points for improvement are brought to light that can be actively steered.

89 Learning loop (single): Comparing the result with the envisaged goal and, if indicated, adjusting the programme implemented for reaching that goal. In this study: determining whether interventions and protective measures have functioned as intended and adjusting these as may be necessary.
Learning loop (double): Determining whether the envisaged goal was adequate. In this study: determining whether the correct protective measures were chosen.

5. *Management steering and communication*
   Finally, for the viability of safety management it is important that the management demonstrate involvement and effect active steering with respect to implementation. Also essential is on-going communication concerning the establishment, implementation and adaptation of safety management. This point will not be part of this study.

4. PARTIES CONCERNED AND THEIR RESPONSIBILITIES

In the cases that were studied, various other parties were involved in addition to the parents. Below we name these parties and describe their tasks and responsibilities insofar as these are involved with guaranteeing the physical safety of the child when safety is under threat in his home situation.

Only parties that have played a role in the cases studied are involved in the summary. In this context it is important to mention that the Youth Care Offices are organised provincially,[90] whereby there are considerable differences in the manner in which the implementation of work takes place. The Child Care and Protection Board, although it is indeed a single organisation, has also organised its tasks in a decentralised manner. Not all fifteen Youth Care Offices are represented in this investigation, due to the fact that national coverage was not aimed for in the selection of the events to be studied.[91]

Paragraph 4.1 gives a brief summary of the parties involved in the child safety system and their respective roles in guaranteeing the physical safety of the child. In paragraphs 4.2 - 4.4 the tasks, authorities and responsibilities of the parties are discussed for each process stage to be differentiated.

4.1 Overview of child safety system

Guaranteeing the physical safety of the child when parents do not do this is a task of the government. The protection of the child has its origin in charitable institutions in the private sector. Slowly but surely the protection of the child has become more a part of the political-administrative system. In 1995 the Netherlands ratified the Convention on the Rights of the Child, in which the responsibility of the government is explicitly formulated. The government established a special programme ministry for Youth and Family in 2007. The cabinet at that time felt that youth and family policy required more attention. The programme ministry for Youth and Family became responsible for a cohesive child- and family-friendly policy that was the domain of the parents, professional care workers, municipalities and provinces.[92]
Since the governmental agreement of 2010, the programme ministry has been wound up and two different ministers are responsible, the minister of Health, Welfare and Sport and the Minister of Security and Justice.[93]

For implementation, a process chain has been established that can be subdivided into the process stages Identification and Reporting, Investigations and directives and Care and protection. These stages are introduced in chapter two.

An important party in the process chain are Youth Care Offices, for which the provincial executive or the administration of the metropolitan regions Amsterdam, Rotterdam and The Hague are still responsible at present. Advice and Reporting Centres, which play a significant role at the vanguard of the process chain, are an independent part of the Youth Care Office.
The government intends to shift (voluntary) youth care to the municipalities. What will happen to youth protection (non-voluntary youth care, see chapter two), is not yet known.[94]
The Advice and Reporting Centres of the Youth Care Office are dependent for their functioning upon reports of suspicion of child abuse originating from the environment of the child. These reports

90 Art. 4 Dutch Youth Care Act stipulates that Youth Care Offices function on a provincial level. For the metropolitan regions Amsterdam, Rotterdam and The Hague a different regime has been established; for their territories, the tasks and authorities allocated to the Provincial Executive are exercised by the administration of the metropolitan regions. This brings the total number of Youth Care Offices to fifteen.
91 See NJI, Secondary Analysis ARCAN studies, Research report at the request of the Youth Care Inspectorate, Jan. 2010 for a thorough comparison of the method of the 15 ARCANs in the period 2000 - 2009. For other institutions in the child safety system no comparison is available.
92 TK 31001, no. 5, Programme for Youth and Family, 28 June 2007.
93 In the period 2007-2010 there was a coordinating minister for Youth and Family.
94 Status as of the end of 2010.

can be made by the social environment - family, neighbours, friends and acquaintances - or by professional persons from the social or (para) medical environment of the family.

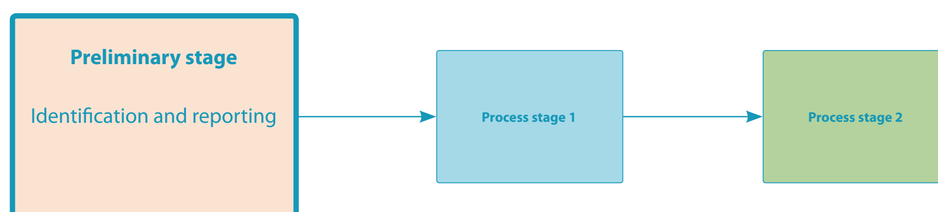
The officials at the Youth Care Offices and ARCANs are responsible for taking so-called core decisions with regard to the provision of care to the child and the family. The interests of the child and the most limited intervention possible are the basic principles here. If the parents do not wish to cooperate with assistance in a voluntary context, or if this help is insufficiently utilised, the Child Care and Protection Board is involved in the process chain. The Child Care and Protection Board represents the interests of the child; it can ask the juvenile court to issue an order for child protection. In this case parental authority is bypassed.

In the coordination of care and protection for the child the Youth Care Office - the departments of Admittance and Protection - plays a key role once again. The Youth Care Office exercises family supervision with regard to supervision orders, determines who coordinates the care of the child and coordinates the provision of care. Care is not provided by the Youth Care Office itself, but through care providers such as the GGZ (Youth Mental Health Care) and other institutions for youth care.

The organisation of the child safety system and the manner in which this is steered by the municipal and provincial authorities will be left out of consideration in this study. However, the Mayor and Aldermen are, pursuant to the Public Health Act, indeed responsible for the implementation of youth health care, in which a large group of professional persons is employed. The municipality therefore plays a significant facilitative role in the process stage Identification and Reporting. As stated, the role of the municipality will change in the near future and the municipality will also receive tasks from the Youth Care Office.

For this study the parties concerned are identified on the basis of legislation and regulations and on the basis of the events that led to the death or near death of the children in the dossiers studied. The following chapters illustrate that.

4.2 Preliminary stage; Identification and reporting



In the process stage Identifying and reporting, the institutions are concerned where professional parties effecting reports are employed. They are the ones that can report a suspicion of child abuse to the ARCAN.[95] Considering the nature of their work - they are frequently involved with the growing child for a long period of time, and they see many children during the exercise of their profession - professionals making reports possess the knowledge which in principle enables them to recognise and assess threats to the physical safety of a child more rapidly than can persons making reports from the social environment. This study differentiates two groups of professionals that make reports:

- Professionals that may be involved, in the context of their profession, to injuries in children. This group includes, first of all, professionals from the medical and paramedical environment of the child such as family practitioners, birth assistance personnel and paediatricians and youth nurses employed at welfare centres and in school health care. Secondly, this group includes professionals from the social environment of the child, such as personnel in child care, primary school teachers and employees of youth care.

95 The social environment of the child can also report suspicions of abuse to the ARCAN. However, the social environment is not part of this study.

- Professionals that can see risk factors in parents. This group includes the police, Dutch probation services and Mental Health Care for adults.

Professionals are primarily responsible for the implementation of the task for which they come in contact with the child and the parents: providing instruction, providing assistance with the problems with which the client presents, maintaining public order, tracking down punishable acts, etc. Identifying risks to the physical safety of the child takes place as an extension of the exercise of their professions.

The basic premise of the child safety system is that everyone must report if there is reason to do so.[96] In order to increase the alertness of professionals to signals of possible child abuse and to offer them action perspective for those cases, report codes attuned specifically to the exercise of their profession have been developed. The identification and reporting of danger thus gains a clearer position in the responsibilities and tasks of the professional.[97] In daily practice, the police are one of the most important parties making reports; they are responsible for nearly 30% of the influx at the ARCANs.

Health care professionals - including paediatricians and juvenile nurses employed at care organisations and Municipal Health Services- hold a special position in the group of professionals making reports because youth health care is charged with the statutory task of monitoring the development of the child from his birth to adulthood.[98] In particular, youth health care must follow developments in the health condition of young people and identify factors that favour or threaten his health. Additionally these professionals, as is the case with other professionals that are normally obligated to maintain (professional) confidentiality, must report suspicions of child abuse to the ARCANs without the authorisation but indeed with the knowledge, of the client.[99]

The document Private Violence - Public Matter[100] appeared in 2002. This goal of this paper was to describe an infrastructure for the approach to domestic violence in the context of which locally cooperating partners could go about their work. This infrastructure consists, amongst other things, of Advice and Support Points on Domestic Violence (ASHG).[101] At these support points a number of organisations work together in dealing with domestic violence, including the police and the Youth Care Office.

4.3 Process stage 1: Investigations and decisions

Various parties are involved in the process stage investigation and conclusions. The investigation can be carried out by the ARCAN and the department of Admittance of the Youth Care Office and the Child Care and Protection Board. The Child Care and Protection Board can request a child

96 See Children Safe at Home, action plan minister for Youth and Family, 2007, pg. 6.
97 An overview of report codes is included in appendix D.
98 Every municipality is obliged by the end of 2011 to have a Centre for Youth and Family of which youth health care is a part.
99 Reporting without authorisation is permitted if this is necessary in order to terminate a situation of child abuse or to investigate a reasonable suspicion of child abuse. WJz, art. 53.3. For professionals here it applies, in contrast to non-professionals: 'not anonymous, unless'.
100 Interdepartmental study group Ministry of Justice, Ministry of VWS. 2002. Private Violence - Public Matter. A document on the dual approach to domestic violence.
101 Ministry of Justice. Letter to the Lower House, 6 November 2007.

protection order ('requestration'); the juvenile court then takes a decision. Each of the partners in this (youth protection) chain has his own responsibility and function. The police can also carry out an investigation, but this, then, concerns an investigative study in the context of criminal law.

4.3.1 Police

Child abuse is a crime according to the Dutch Civil Code, so that the police have an investigative task. Investigation can lead to prosecution by the public prosecutor. This concerns a serious crime: abuse of the child with (nearly) fatal outcome. Investigation (whether or not pursuant to a report) rarely leads, in practice, to the preparation of an official report and involvement of the public prosecutor. This is a result of the fact that abuse is not intentional on the part of (one of) the parents, but stems from feelings of impotence and ignorance. These days the Public Prosecutor does act more frequently. Nonetheless the police usually opt for a report to the Youth Care Office, ARCAN or the department of Admittance, or to the Child Care and Protection Board. The intention is that the police play a greater role in dealing with child abuse and this be passed on more frequently to the Public Prosecutor, who can prosecute if indicated. The Dutch Safety Board feels that persons involved in situations of physical danger must take an explicit decision concerning the most suitable context(s) within which the matter can best be handled. At that moment parties do not yet consider criminal law in a structural context.

4.3.2 ARCAN

The ARCAN of the Youth Care Office investigates reported suspicion of child abuse and gives citizens and professionals advice concerning dealing with (suspicions of) child abuse. The ARCAN is part of the Youth Care Office and has the following statutory tasks:[102]

- Investigating whether a situation of child abuse exists subsequent to a report of child abuse or suspicion thereof.
- Assessing the matter of whether, and if so what, steps should be taken in response to the report of child abuse or suspicion thereof.
- Transferring a case within the Youth Care Office on behalf of the implementation of the provision of assistance to or protection of the child.
- The immediate transfer of a case to the Child Care and Protection Board, if a measure with regard to the authority over the minor should be considered.
- Informing the Public Prosecutor of child abuse or suspicion thereof, if the interest of the minor or the seriousness of the situation to which the report applies calls for this.
- Informing the person that made a report of the steps that were taken in response to the report.
- Providing advice to a person that has a suspicion of child abuse about the steps that he can take in regard to this and if necessary providing him with support in doing this.

The ARCAN of the Youth Care Office differentiates between preliminary investigation and investigation. If necessary the ARCAN can commence in the first four weeks with the collection of data from professionally involved third parties, without the knowledge and authorisation of the parent. This takes place sporadically with the goal of determining whether the suspicion of abuse is shared and in order to assess the risk.[103]

Incidentally, in acute emergency situations, the ARCAN can use a rush procedure in order to directly contact the Child Care and Protection Board and thus commence the issue of provisional supervision orders. In such cases the assessment of the contents of the intervention takes place afterward.[104] The tasks of the ARCAN are carried out by child abuse counsellors and social workers.

4.3.3 Youth Care Office, department Admittance

The fifteen Youth Care Offices are organised in a provincial or metropolitan system. Amongst other things they fulfil the following statutory tasks in the child safety system:[105]

102 Youth Care Act art. 10, 11.
103 MO group Youth Care. 2009. Protocol of action Advice and Report Points on Child Abuse on suspicion of child abuse in relationships of dependency and lack of autonomy.
104 Art. 1:255 CC. The involvement of the ARCAN with the case stops after transfer to the Child Care and Protection Board.
105 Youth Care Act, art. 5-8, 10. See also Implementing Order Youth Care Act.

- Determining whether a client requires assistance in relation to growing up, parenting or psychiatric problems or for problems that stand in the way of unthreatened development.
- Determining what assistance is needed, to what purpose, for what period of time and who can best coordinate this assistance. The indication decision of the Youth Care Office then gives the client access to the necessary assistance to be provided by a care institution.
- Assisting the client in realising the right assistance, proceeding through the assistance process, evaluating the assistance and taking decisions concerning follow-up (case management).

The Youth Care Act explicitly states that the Youth Care Office constantly assesses, during the exercise of its task, whether a measure with regard to authority (supervision orders, removal of parental responsibility or withdrawal of parental rights) should be considered. As soon as the Youth Care Office concludes that this is the case, for example where there are concerns for safety, it so informs the Child Care and Protection Board.[106]

4.3.4 Child Care and Protection Board

The core task of the Child Care and Protection Board is to create the necessary framework conditions for the protection of the child. To this end the Child Care and Protection Board has the authority to infringe upon parental authority over the child. The Child Care and Protection Board provides the juvenile court with information and advice. The Child Care and Protection Board can ask the juvenile court on the basis of an investigation into the situation of the child to issue a child protection order. The three possible measures are, as has been mentioned earlier, supervision orders, removal of parental responsibility and withdrawal of parental rights.

The Child Care and Protection Board is consulted by the Youth Care Office if it is not possible to solve the family problems and the suspicion exists that the family situation is threatening to the development of the child. The ARCAN and the Youth Care Office then transfer the available information to the Child Care and Protection Board.[107]

Since the date of commencement of the Youth Care Act on 1 January 2005, the Child Care and Protection Board has been a secondary care organisation in protective matters. Since that time, reports of threatening situations concerning children have first gone - with the exception of crisis situations - to the Youth Care Office or the ARCAN. In acute, life-threatening situations involving minors, the Child Care and Protection Board can receive a report directly, assess it and commence an investigation.

The Child Care and Protection Board and the Youth Care Offices have made mutual national agreements that have been established in a national assessment context. These national agreements are the basis for cooperative agreements at a regional level.

The Child Care and Protection Board substantiates its requests by means of protective investigation: an investigation into the child and his family in order to determine whether a threatening family situation indeed exists. To determine this, investigators from the Child Care and Protection Board speak with the child and his parents, social workers and others from the environment of the family. The Child Care and Protection Board does not provide assistance. The Board investigation can come to the conclusion that there is insufficient reason for a measure. In that case the Child Care and Protection Board refers the case to social care providers in a voluntary context. Based on the results of the Board investigation a decision can also be made to file a request with juvenile court for the imposition of a child protection order.

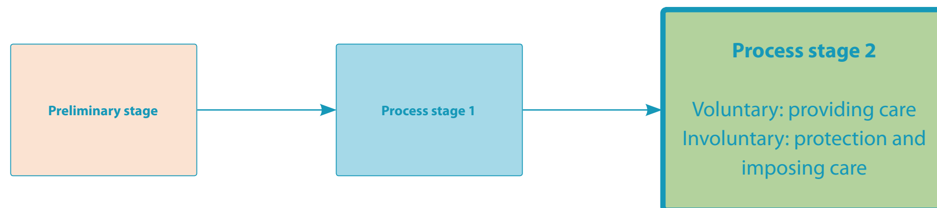
4.3.5 The Court

At the request of the Child Care and Protection Board the Court handles a case and takes a decision concerning the need or lack thereof of a measure of child protection based on the Board investigation

106 Youth Care Act, art. 9.
107 Since 2009 the Youth Care Office (Admittance and ARCAN) presents the cast to the Child Care and Protection Board by means of Better Protection case study

and assessment in terms of legal context (including the VRK and the EVRM). The juvenile judge allocates the Youth Care Office as the implementer of the measure.

4.4 Process stage 2: Care and protection



The provision of assistance to the child and the family can take place in a voluntary context or under a measure of child protection. Additionally, offering protection to the child by removing it from the parent (placement out of the home) can take place voluntarily but also through an involuntary measure of child protection.

4.4.1 Youth Care Office

The Youth Care Office includes 'voluntary' Youth Care and 'involuntary' youth care. Voluntary Youth Care is coordinated by the Youth Care Office, Admittance department. Involuntary Youth Care and the request for authorisation to remove a child from his home is the domain of the department of Youth Protection of the Youth Care Office. The law (art. 1:254 BW) appoints the institution that maintains a Youth Care Office as the one under whose supervision the child will be placed.[108] This institution employs officials for the implementation of the supervisory task that are allocated as family supervisors. The responsible implementation of tasks includes, in any case, that they are based on a plan that is coordinated to the needs of the client.[109] The family supervisors of the department of Youth Protection organise the assistance of their clients and report at least once a year, at the renewal of the supervision orders, to the juvenile court concerning the policy they have practiced. If the Youth Care Office requests such renewal from a supervisory body or wishes to terminate a removal from the home, the Youth Care Office places the matter for assessment before the Child Care and Protection Board. On the basis of this the juvenile judge can decide to revoke or renew an order that has been issued. In all other cases the order terminates after the period that the court has established.

Care providers and Youth Care providers

Care for the child and the family is provided by (youth) care providers from outside the child safety system, such as institutions for mental health care, social work, institutions for mental health care (GGZ) for youth and for adults, addict care, disabled care, Dutch probation services and other service organisations.

108 Art. 1:257 BW (Civil Code) formulates the task of the Youth Care Office to supervise the child and to ensure that the child and the parent responsible for him are offered assistance and support in order to deflect a threat to the moral or emotional interests or the health of the child.

109 Youth Care Act, art. 13.

5. ANALYSIS

The analysis focuses on the efforts of the government, institutions and professionals in situations in which parents cannot fulfil their primary responsibility for the physical safety of their child. In these cases, the child may be in a life-threatening situation. Pursuant to the aforementioned treaties and laws, the government has a responsibility towards the child when the parents do not take their responsibility. As discussed in the previous chapter the child safety system has been set up in order to take this responsibility.

This chapter focuses on answering the main question of this investigation:
How does the government take responsibility for the physical safety of a young child when the parents do not; what improvements can be made?

In practice, parties in the child safety system - the institutions, professionals and their professional organisations - provide a framework for the responsibility for physical safety. The professional is the person who intervenes in families in practice with the objective of ensuring the child's physical safety.

In this thematic study, 'providing a framework for responsibility' means the way in which professionals identify risks to the young child's physical safety, evaluate them and then take action and the manner in which the government and the parties in the child safety system enable professionals to carry out their complex task.

In any case three conditions must be met: a. the professional must have all relevant information to carry out a risk assessment and evaluation of the young child's physical safety; b. the professional must have adequate expertise to be able to decide whether to use his powers; c. the professional must have the opportunity to learn from events and incidents.

Very diverse professionals may be involved in the preliminary stage of identification and reporting. There is less diversity of professionals in the process stages investigation and decisions and providing care and protection, and youth care and youth protection are the main concerns.

To answer the investigation question the data from the dossier study is combined with insights from laws, frameworks and guidelines and the ensuing organisation of the child safety system and the parties involved as specified in chapters 3 and 4.

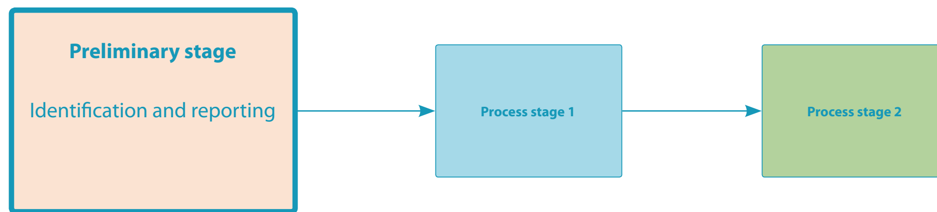
This chapter is structured as follows. The following two questions are posed for each of the three process stages - (section 5.1) Preliminary stage: Identification and Reporting, (section 5.2) Process stage 1: Investigation and Decision, (section 5.3) and Process stage 2: Care and Protection:

1. Which problems occurred in practice in the incidents?
2. To what extent are these problems addressed in the current framework of law and legislation and formal duties, powers and responsibilities that professionals have to work with in the child safety system?

A conclusion is drawn for each process stage and improvement options are discussed.

This investigation relates the incidents to the current legislation and the guidelines of the sector. The reason why this relationship is being discussed is that the Safety Board assumes that the open nature of law and legislation plays a role in problems encountered by professionals in practice in the incidents investigated. Because of this open nature, professionals have to find a solution for each situation. In addition, collective knowledge and experience is usually combined in rules and guidelines. For this reason this thematic study is specifically focused on the legislation and guidelines for this sector. According to some of those interviewed, the open nature of the rules is unavoidable in view of the complexity of the work. The Safety Board discusses this unavoidability.

5.1 Preliminary stage: Identification and reporting



The government expects the social environment, institutions and professionals to identify and if necessary report child abuse and unsafe home situations of children. The policy plan[110] of the former Minister for Youth and Families that focuses on tackling child abuse states: 'identifying and undertaking action where necessary to stop child abuse and to bring about suitable care is the responsibility of all institutions, professionals and volunteers working with children and in addition anyone in the child's environment such as neighbours and family'.

This section deals with the problems accompanying identifying and reporting a child at risk. The problems that were observed in the incidents are discussed first (section 5.1.1). Then these problems are placed in the context of the current law and legislation (section 5.1.2). Possible improvements are also explored in relation to recent developments (section 5.1.3).

In many cases, assessing injury was a problem. Potential reporters often found it difficult to assess the physical danger to a child in the family situation because physical danger or violence is seldom directly visible. Injury is an important basis for physical danger, certainly in combination with risk factors. However, injury does not mean that there is danger and it must be further investigated. A specific example is bruises on very young children who are not yet able to hurt themselves. For experts this applies as a direct indication of physical danger. In any case, experts believe this should lead to further investigation in order to exclude a different explanation for these bruises, such as rare blood diseases. In general, this appears to happen too infrequently.[111]

5.1.1 Which problems occurred in the incidents?

In almost all incidents investigated where there was a case of injury, professional reporters encountered difficulty interpreting this injury and relating it to a report to the ARCAN. Injuries consisted of bruises but also fractures and bleeding. Two problems were observed in how professional reporters deal with injury:

1. professional reporters spend too long looking for confirmation or negation of their suspicions of abuse;
2. professionals interpret the injury wrongly.

These two points are further explained here below.

Explanation of the two practical problems based on the incidents

Firstly, the Safety Board established that professional reporters confronted with injury focus their attention on looking for confirmation or negation of their suspicions of abuse. They do this by asking another professional for a second opinion or by attempting to establish whether the parents are the offenders.

- In one case[112] for example, a report was not made to the ARCAN after Shaken Baby Syndrome had been established. The father denied shaking the baby. The police started an investigation to verify whether it was possible that an intruder had got into the home and had shaken the baby until it had suffered serious injury. When this could not be established no further action was taken to investigate and arrange for the child's safety.

110 Actieplan Kinderen Veilig Thuis, 2007.
111 See inter alia Nijs, 2009. Indications for physical child abuse are also described in: Council on Scientific Affairs, 1985; Verhulst and Verheij, 1992, page 576-679.
112 Incident C22.

- In another case,[113] a physician at the early childhood clinic found bruises on a baby on two occasions. He suspected child abuse and discussed his suspicions with colleagues and referred the parents to the general practitioner but did not report it to the ARCAN.

By looking for confirmation or negation of the abuse, professionals are delaying making a report. Failure to make a report means that information on the injury cannot be combined with information known to other care workers on risk factors. Risk factors form an important aid in clarifying injury and determining possible danger. In many families in this survey, there was a case of risk factors, for example, the parents had addiction problems.[114] If children are injured and form part of families with risk factors the chance of physical danger is greater. Additionally, certainly for vulnerable children in families with complex problems, it is important that a quick 'scaling up' towards professional help in a protected context is effected.
In addition, this working method means that the problems of the parents are the key element rather than the risk to the child. This distinction is further discussed in section 5.2.

Secondly, it was observed that in many cases the injury provided such points of reference that doctors with state-of-the-art forensic medical knowledge should have recognised it as an indication of a possible threat to the child's physical safety.[115] This applied for various babies with bruises for example. In addition, injuries were also not noticed. In some cases after the child had died old fractures were established which had not been discovered previously.

- In two cases,[116] for example the hospital established a number of old fractures in a child as well as Shaken Baby Syndrome.
- In another case,[117] a baby with wounds around its mouth from a family with known risk factors was referred to the general practitioner by the early childhood clinic. The parents did not go to the doctor. When the baby died the hospital initially thought that cot death was the cause but a forensically trained doctor who happened to be present insisted on further examination. As well as recent bone fractures old bone fractures were established in the four-month-old baby.
- In another case,[118] the doctor assumed that it was cot death. A forensic doctor who happened to be present insisted on further examination, which showed that the child who was approximately three months old had died as the result of broken ribs and a broken collarbone as well as older fractures also being established.

If doctors with forensic medical knowledge had examined these children or had been assisted by experts in the field, they would have obtained more indications about the danger.

5.1.2 To what extent are these problems addressed by the current framework of law and legislation and guidelines?

This section describes to what extent the existing guidelines (reporting codes) used by the relevant sectors support the professional reporter in identifying and reporting concerns about the child's physical safety. Indications on injury are given special attention. To what extent guidelines devote attention to bringing in forensic medical experts is also looked at. The guidelines and reporting codes studied were: 'Youth healthcare guideline secondary prevention child abuse' and 'Reporting code KNMG' as well as the appendix 'SPUTOVAMO form'. In this respect therefore the term professional mainly refers to professionals working in the paramedical and medical sector.

Findings

The guidelines studied leave it up to the professional's judgement as to whether and when there is a reason to make a report. Looking for confirmation of suspicion of abuse is not limited by a time period or scope. The health care professional can choose not to make a report and to arrange for

113 Incident C8.
114 The following categories of risk factors are distinguished in literature: development history of the parents, the parents' personality characteristics, pedagogic realisation, family characteristics, the child's characteristics, and living circumstances. Source: Klein Velderman and Pannebakker, 2008.
115 Source: interviews OVV.
116 Incident C5, C22.
117 Incident C10.
118 Incident C11.

care himself: no reporting obligation but a duty of care. In addition, in this case the duration and scope is left up to the professional. The guidelines do not link the required actions to observed facts and circumstances such as the nature of the injury, the child's age or further risk within the family.

The current guidelines see acting as a result of a suspicion of abuse as part of professional responsibility, emphasising the complexity of the problem and the importance of due care. The guidelines encourage the professional to look for confirmation or negation of his suspicions and ask the professional to follow a phased plan in the event of suspected child abuse. The guidelines outline the room that those making the report have to put their professional privilege aside, which must be done in order to make a report. The guidelines do not encourage reporting, rather expressing apprehension about disciplinary proceedings which could take place if doctors violate their professional privilege without good reason. Consulting colleagues is encouraged in the guidelines while bringing in forensic medical experts is not dealt with.

Explanation of findings based on the guidelines studied
The following overview illustrates these findings based on the guidelines from the sectors that come into most contact with young children with injuries, notably
a. youth healthcare and
b. healthcare in general (KNMG).
The most recent version of these guidelines has been used.

Re a. Youth healthcare guideline
The guideline 'Youth healthcare guideline secondary prevention child abuse: Acting on suspected child abuse'[119] is used in youth healthcare (JGZ). This guideline distinguishes four situations that a professional reporter in youth healthcare may encounter and describes what action should be taken in each of these four situations. The different situations and options for intervention are:

1. There is a serious suspicion of child abuse and the child is in a life-threatening situation. In that case the family is reported directly to the ARCAN, the Child Care and Protection Board or the police.
2. There is a serious suspicion of child abuse but the child does not seem to be in a life-threatening situation. Depending on the willingness to cooperate and the seriousness of the situation the family is reported to the ARCAN and/or referred for help to the Youth Care Office, an institution for mental health care or general social work.
3. Child abuse is possible or probable but more advice or information is needed from other people.
4. There is another problem besides child abuse. The relevant help is discussed with the parents and if necessary they are referred.

What is striking is that the user of the guideline can choose *which organisation* he reports to. With regard to the matter of *which facts and circumstances* he should report, the guideline acknowledges that a specific case of child abuse does not always easily fit into one of these categories. To make a decision in these cases the professional can use the definition of child abuse and an overview of the known signs of child abuse for children of various ages which is also included in the guideline.

Besides the general definition of child abuse as referred to in the Youth Care Act, the guideline uses the following definition of *physical* child abuse: 'There is a case of physical child abuse if the offender uses physical violence on the child such as hitting, shaking, kicking, biting, pinching, scratching, inflicting burn wounds, dropping, etc'.[120] However, the guideline also states that there is not always a case of child abuse in the event of violence towards children: 'The intention and intensity of the physical violence, the duration and frequency determine whether there is a case of child abuse'.[121] This qualification implies a threshold value which has not been further worked out. A comparably balanced position is adopted with regard to the list of signs, which the guideline emphasises is an aid '... *to substantiate a suspicion of child abuse, not to prove child abuse. Practically all signs referred to could be caused by something else. The more signals given off by the child the greater the chance*

119 Version October 2009.
120 JGZ Guideline, page 16.
121 Guideline, page 20

that there is a case of child abuse. There are also children in whom it is barely noticeable that they are being abused.'[122]
With this more balanced position the guideline on secondary prevention makes a serious appeal to the professional reporter's ability to judge.

Re b. KNMG reporting code[123]
The 'KNMG Reporting Code Child Abuse' is used as a point of departure in healthcare. It states that the healthcare professional does not have a reporting obligation but a reporting right. In addition there is an obligation to act, certainly if the professional decides not to make a report and to organise care himself. The code devotes attention to making a suspicion of child abuse a subject of discussion and the shift in thinking about the duty of confidentiality in the case of child abuse. Section 53.3 Youth Care Act states that a duty of confidentiality can be disregarded and a report can be made if deemed necessary to end a child abuse situation or to investigate a reasonable suspicion of child abuse.

With regard to *making a report* the KNMG reporting code (p.18) states the following: *'If the suspicion is confirmed or in any case not removed and there is an actual chance of harm due to child abuse or continuation of child abuse then the doctor will report this as soon as possible to the ARCAN and the Youth Care Office. The doctor will make his report even if the parents, when informed, object to it.'* The code gives extra responsibility to the doctor in his capacity as reporter by imposing two additional conditions. He must first estimate that the abuse will cause actual harm: *'For a report there must be an actual risk of harm and that risk must be assessed to a certain extent. The word "actual" makes it clear that the theoretical possibility of harm is not an adequate basis for a report'* (p. 18). Secondly before proceeding to reporting he must follow a phased plan. A mandatory step is requesting advice from the ARCAN and preferably also from an expert colleague.

In addition the KNMG reporting code (p.18) requires the doctor to inform the parents about the report *'unless this is not possible in relation to the child's safety or that of other children in the family, if there is a reasonable fear that the doctor would lose sight of the child or the doctor fears for his own safety.'*

As well as making a report the doctor also has the option of not reporting and arranging care himself: *'....if the doctor is convinced that rendering assistance on a voluntary basis will remove the risk to the child then he will endeavour to provide the necessary assistance or organise it elsewhere. The doctor monitors the progress and effectiveness of this assistance or ensures that someone else monitors it.'* The doctor must then if necessary still make a report: 'If the abuse does not stop or completely stop or there are indications thereof then the doctor will report to the ARCAN anyway' (p. 19).

The KNMG states in its inspection response: *'The leading perspective of the reporting code is starting up assistance and not the actual reporting. The main objective is uncovering and making safety risks to children manageable. Achieving this without reporting, would of course be preferable at times.'*

The reporting code explicitly demands attention for the requirements made of due care. *'If the disciplinary court is asked in hindsight to give an opinion on the actions of the doctor then the due care is mainly assessed for the conclusion of the decision. Matters to be considered are collegial consultation, careful collection of relevant facts and a cautious and specific weighing up of interests. Also for this reason it is important that all steps and reasons that led to these steps have been carefully recorded in the file'* (p. 28). The KNMG indicates that disciplinary procedures can pressurise the willingness to report.

The reporting code does not specify *which facts and circumstances* should be considered for reporting. One of the appendices to the reporting code is the so-called SPUTOVAMO form for the

122 Guideline, page 93.
123 KNMG: Royal Netherlands Medical Society. The previous 2002 code has been replaced by a completely new reporting code (2008).

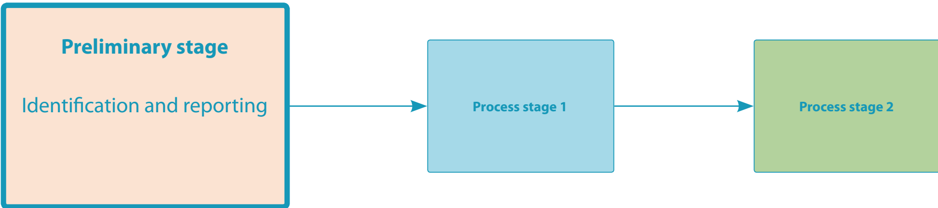
Accident and Emergency room at hospitals. This is an identification protocol for child abuse which connects physical injury to a suspicion of child abuse. It is not linked to any further intervention options.

All in all the reporting code set serious requirements to the professional's ability to judge. The additional conditions in the reporting code about actual harm occurring, informing parents, the possibility of organising care and the emphasis on due care in actions can contribute to more reluctance to report than is actually desirable for the child's physical safety. Moreover, in the event of acting with undue care the professional runs the risk of disciplinary action being taken against him.

With regard to the issue of which body should be reported to, the reporting code gives the following option: *'The ARCAN is the primary care facility for making reports. However, if there is a case of a very acute situation that requires immediate action by a child protection order then the doctor will report to the Child Care and Protection Board.'* (p.24). *'If the child's safety or life is in acute danger then the doctor, besides reporting to the ARCAN or Child Care and Protection Board, will contact the police immediately'* (p. 26). It is left up to the professional's ability to judge what constitutes an acute situation that demands *'immediate action by a child protection order'* and the situation which is *'acute danger to the child's safety or life'.* In fact the professional must decide what is necessary: care in a voluntary framework, care in an involuntary framework or the police. The formulation indicates that only acute situations involving risk to life require protection measures.

The Safety Board comments that the reporting code implies that a report should preferably be made in the event of continuing risk if care in a voluntary framework is not or no longer sufficient. If care in a voluntary framework no longer suffices then an imposed framework is required. However the Child Care and Protection Board is the designated route and not the ARCANs for Child Abuse.

5.1.3 Conclusions and discussion about improvement options



In this section, two conclusions are drawn with regard to the analysis of the process stage Identification and Reporting. The policy that has been pursued since 2007 to better control the child's safety during this process stage and the remaining improvement options are also discussed.

Two conclusions
Firstly, it appears that professionals did not report their suspicions of physical danger in the incidents or reported too late. There was often a long wait after injury had been established before a report was made or investigation carried out. Injury is 'fleeting' information and must be investigated by an expert as soon as possible. The haste was not always adjusted to the age of the child. Certainly in the case of young children haste is a requisite because of their vulnerability. The guidelines however do not provide anything to go on and seriously impose on the potential professional reporter's ability to judge. The professional making the report is asked to assess whether there is a case of physical danger without any specific indications for it. Because of the lack of specific indications experiences from case-based reasoning are not structurally made available to the professional for his considerations.

The healthcare professional may also decide to take up the investigation into the child's situation and the organisation for care himself. The KNMG indicates that it is preferable if the necessary help can be organised without making a report. This professional's efforts and the delay in a report are not limited by time and it is not made dependent on the kind of injury. The Safety Board wonders whether and how this approach corresponds to the available competences. The healthcare professional establishing injury and arranging assistance does not have the specific knowledge

about danger and abuse which the 'recipients' of reports do have. The available time and powers in healthcare are also not adjusted towards family problems. This is even more pressing when children in families with multiple problems are concerned. The Safety Board wonders whether and to what extent such a point of view is effective in the event of injury or threats to the child's physical safety.

Secondly, it is apparent that the injury is not always correctly indicated and that existing forensic medical knowledge to assess the injury properly is not always used. This partly has to do with the limited forensic medical knowledge amongst general practitioners and paediatricians and the limited availability of forensic medical experts.[124] The available expertise is not systematically used to indicate injury.

In the process stage of identification and reporting the government is responsible for discovering and reporting children in physical danger. It does so by encouraging professionals to make reports. The central government is preparing a bill on this matter which imposes an obligation on organisations and independent professionals to use a reporting code for domestic violence and child abuse. If and how the professional groups will do this is seen to a large extent as their own responsibility.

The Safety Board believes that at this stage - a situation in which professionals have to take an important decision for a child on its physical safety whereas that is not their primary task - it may be expected that professionals be given intrinsic support. The appeal made to them should be in proportion to the knowledge which they have. The potential professional reporter does not have the specific knowledge about safety and abuse which the 'recipients' of reports have.

Discussion of improvement possibilities
The developments, policy and improvement possibilities in the area of Identification and Reporting are explained point by point for the two conclusions.

Firstly, the following measures have been taken since 2007 with regard to the established problem of failure to make reports:

- More attention paid to child abuse in doctor training;[125]
- Collaboration programme to promote reporting conduct of institutions (in the scope of the regional approach to child abuse - RAK);
- Setting up a help desk for professionals for privacy issues;
- Instruction on investigation and prosecution with regard to child abuse from the Board of Attorneys General on the role of the police;
- Reference Index children at risk where care workers can register their contact with children;
- Implementation of Registration Code for Domestic Violence and Child Abuse Act;
- Implementation of reporting right for confidentiality obligations (as part of the general reporting code for child abuse and domestic violence);
- Youth Healthcare Digital Dossier.

The Safety Board establishes that there are many initiatives to support the professional in issues relating to boundary conditions but none of them addresses the issue of the situation when a report should be made and how long to wait until the report is made.

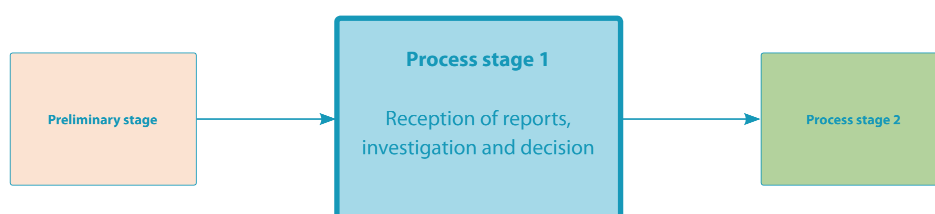
Secondly, with regard to the lack of use of current forensic medical knowledge the Safety Board establishes that there are still too few doctors specialised in forensic medical investigation into child abuse and that this knowledge is not used structurally.[126] The NFI pleads for improvement in doctor training in the field of child abuse.[127] This plea concerns forensic examination of deceased children. The Forensic Outpatients Clinic for Child Abuse asked attention in the media for forensic examination

124 Source: interviews, Bruning, 2010.
125 Working Group Education on Child Abuse for Paediatricians.
126 Source: Bruning, 2010.
127 News report NFI, 8 April 2010. Many non-natural deaths are still missed. Based on a recently performed retrospective analysis of cause of death in minors on whom forensic autopsy was carried out in the last 14 years there was a case of non-natural death in around 60%. Source: V. Soerdjbalie-Maikoe and A. Maes, Forensic post-mortem autopsy on minors, theoretical and practical recommendations for doctors and pathologists, Netherlands Forensic Institute, April 2010.

of *living children*.[128] Based on these considerations the Safety Board considers improvement possible with regard to wider availability of forensic medical knowledge and a structural use thereof so that physical danger to children is better recognised. This does not necessarily imply that every doctor should have this knowledge.

Reviewing this process stage the Safety Board remarks that an image of two different worlds arose in various incidents and interviews: that of the potential reporters from youth healthcare and that of the 'recipients' of youth care. This picture is confirmed by the Evaluation Study on the Youth Care Act which mentions that various groups of professionals sometimes have little confidence in the youth care chain with the risk that they muddle through for too long.[129] In this respect the Youth Care Inspectorate concluded that the Youth Care Office/ARCANs do not give enough feedback to professional reporters.[130]

5.2 Process stage 1: Investigation and decisions



If the ARCAN or the Child Care and Protection Board has received a report of a suspicion of physical danger to a child, the government's responsibility has been addressed. The institutions must investigate the child's situation on behalf of the government.[131] In this report this is referred to as the process stage Investigation and Decisions. The investigation is in fact a risk assessment and evaluation as described in section 3.3 and must provide a definitive answer about the risks to the child's physical safety. On this basis a decision must be made about the desired approach to safeguard safety whether or not by way of a civil child protection order.[132]

In the cases investigated it appears that it is not always easy for the professionals involved in this process stage to get the full picture of the child's home situation. The accompanying problems are dealt with here below as seen in the dossier study (5.2.1) and put into the context of the current law and legislation (5.2.2). Possible improvements are also discussed (5.2.3).

5.2.1 Which problems occurred in the incidents?

The incidents showed that the investigations and/or risk assessments carried out by the Youth Care Office/the ARCAN and the Child Care and Protection Board do not always lead to a full picture of the physical safety situation. There are three problems that occur:

1. the investigation is not primarily focused on establishing the child's physical safety;
2. the investigation is too dependent on the parents' cooperation;
3. the collection of information for the investigation is hindered by the lack of cooperation from other professionals, in particular those involved in the medical care of or the care for the parent.

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128 Volkskrant 13-04-2010. The Board of Chief Commissioners indicates that the lead times for their forensic investigations into child abuse are unnecessarily long because of the lack of forensic experts. The youth healthcare doctors in the Netherlands indicate that forensic medical knowledge is inadequately available in youth healthcare and an investment in this knowledge for paediatricians and paediatric nurses is required.
129 BMC, 2009. See also Rus, 2009.
130 Youth Care Inspectorate, 2010. Nationwide supervision ARCAN 2009, Does the ARCAN see the child and get back to the reporter?
131 In this chapter the lighter 'care reports' to the Admittance Department of the Youth Care Office are disregarded. The police are also disregarded because in these cases a criminal or other investigation was not started up; this only took place if near fatal or fatal injury occurred.
132 If in the event of serious danger it is structurally considered against what kind of background the approach can best take place, the police could also be seen as part of the child safety system.

These three problems are analysed here below in more detail.

Explanation of the three practical problems based on the incidents
Firstly, it appears that the investigation is frequently not focused on primarily establishing danger to the child. The investigation is performed with a view to the desired approach and mainly encompasses an estimate of the possibilities of providing assistance and the parents' cooperation. Preserving the family situation insofar as possible is a key point in which the parents can be given the benefit of the doubt even if there are risk factors present. In various cases[133] no investigation was made into the child's physical safety and sometimes the Youth Care Office/ARCAN acted from different points of view.

- In one case[134], investigation by the ARCAN could not demonstrate that the injury had been caused by the parents (a torn frenulum linguae). The family was not investigated and no care was provided.
- In another case[135], the ARCAN did not start an investigation into the possible threat of physical safety of an unborn child but did agree on assistance.
- In another case[136], after their investigation the Youth Care Office and the Child Care and Protection Board concluded at a multidisciplinary consultation that the children needed help because they had witnessed domestic violence their entire lives. The children's physical safety was not investigated.
- In another case[137] it was stated that the father had committed domestic violence and that the mother of the child was drunk and used drugs. The ARCAN did not bother with urine tests because it doubted the drug use and wanted to give the mother the benefit of the doubt.
- In again another case[138] the investigation by the ARCAN into a family where a child had previously died because of abuse was incomplete. The ARCAN partly coordinated the assistance for the parents who were open to it. That is not one of the formal duties of the ARCAN.

If there was a risk and the parents did not cooperate it first had to be demonstrated that there was a reason to intervene. Consequently the child's physical safety cannot be guaranteed during this process stage. An approach focused on the child's physical safety was not found in any of the seven cases investigated in this process stage. The Safety Board remarks that this is an effect of the current design of the system in which taking a protective measure is provided with safeguards of due care. The cases studied show that carrying out an investigation carefully takes time and this time could be a dangerous period for the child. In this interim stage protective measures are not always taken whereas the child may well be in an unsafe situation. Provisional measures are possible but usually only applied in practice to prevent acute danger to life.
As a corollary it is striking that the route followed after identifying risk can vary greatly. The route chosen (choice of institution that performed investigation) is usually determined by the parents' cooperation and not by the safety situation.

Secondly, it is apparent that in various cases the collection of information for the investigation came to a halt because the parents did not want to cooperate. Sometimes this meant that the investigation did not cover physical or psychological examination of the child and no personality assessment or medical examination of the parent was carried out.

- In one case[139] the ARCAN visited a family where a child had previously died. The mother had said that the father was prone to fits of temper but during the home visit both parents denied these fits. The child was not examined by a doctor.
- In another case[140] a ARCAN doctor from the ARCAN visited a mother to be after a report (alcohol problems and domestic violence) who did not want to speak. After the birth the

133 C13, C16, C17, C18 and C19.
134 Incident C19.
135 Incident C13.
136 Incident C16.
137 Incident C17.
138 Incident C18.
139 Incident C18.
140 Incident C13.

hospital was concerned about the situation and the paediatrician made a house call. No one answered the door.

The child can only be physically examined with the parents' consent. In practice, attempts are made to examine the child physically in a roundabout way. For example the child can be kept in hospital for a bit longer. This proactive conduct is in fact 'for account of' the doctor in question. The Safety Board considers this 'by hook or by crook' situation a breach of child safety for children facing serious violence.

Thirdly, the investigation performed with regard to a report does not always result in all relevant information on the child's physical safety situation because professionals providing assistance to the parent in particular do not always cooperate. The need for wide collection of information follows from the fact that often multi-problem families are involved in suspicions of child abuse. In these families there is often a case of various risk factors and often from a wide range of care workers involved. Examples of the diverse parties involved were:

- Observations in the family by a midwife;
- Experience of supervisors in a care farm where mentally disabled parents reside;
- Information from the parents' company doctor or general practitioner;
- Information from the parents' psychiatrists or psychotherapists;
- Information from the parents' probation officers;
- Information from doctors, nurses or social workers at a hospital.

In the investigated cases it is apparent that the professionals who were asked for information did not always comply. In particular these were professionals assisting the parent. Insofar as can be derived from the dossiers they often have formal objections.

- In one case[141] the ARCAN of the Youth Care Office asked the company doctor at the institution where the mother worked for information. The company physician refused to provide the information. This meant that the Advice and Reporting Centre was not given any information about the mother's psychological or other condition. In the same case the ARCAN asked the mother's lawyer for information about her place of residence. The lawyer refused to provide this information.
- In another case[142] the ARCAN collected information about the family from the public prosecutor, the general practitioner and the gynaecologist. The ARCAN also contacted the probation and after-care service. It promised to make a risk analysis of the father but failed to do so because a formal document was missing and it did not report back to the ARCAN.

5.2.2 To what extent are these problems addressed by the current framework of law and legislation and guidelines?

This section describes to what extent the existing law and legislation supports professionals at the ARCAN of the Youth Care Office and the Child Care and Protection Board in carrying out an investigation as a result of reported suspicion of child abuse and the decision to intervene that they have to take based on this investigation.

Three findings

In summary it appears that the framework of law and legislation does not provide a starting point for the abovementioned problems. The legislation does not require the investigation into the child's situation to give a picture of the physical danger; the guidelines meanwhile do. Neither the parents nor third parties were or are required to cooperate with the investigation. These three points are further explained here below.[143] This situation makes too much of an imposition on the professional.

Explanation of the three findings based on law and legislation and guidelines.

Firstly, the Safety Board establishes that the investigation into the child's situation does not have to provide a picture of the physical safety. The statutory framework of the child safety system may be formed around the notion 'the child's interest' but does not explicitly mention the child's physical

141 Incident C14.
142 Incident C18.
143 For more information on law and legislation, see section 3.2.2 and appendix D.

safety in its elaboration of that term. This detail is particularly visible in the statutory grounds for a supervision order (Section 1:254 Netherlands Civil Code) which refers to a 'serious threat to the moral or emotional interests of the health' of a child. The reason usually given in the decision for a supervision order is that there is a case of a threat to the child's emotional or moral interests. Physical mistreatment or risk do not explicitly form the grounds in the Netherlands Civil Code for a child protection order. Obviously these criteria may well form an implicit part of 'the interests or health of the child',[144] but the statutory framework does not yet require it.[145] Since 2007 Section 1:247 Netherlands Civil Code does refer to safety as part of care and upbringing and prohibits parents from using violence; however this is not interpreted in the grounds for measures.

At the time of the incidents the Youth Care Office guidelines had no specifications, classifications or criteria for danger. These classifications have been present in literature for some time but they did not yet serve as a basis for decisions in guidelines.[146] [147] The Needs Assessment Manual of the Youth Care Office reports five degrees of seriousness and refers to the literature previously mentioned. These degrees are not further worked out in this Manual. The Manual refers to thirteen indicators for the child's safety which mainly refer to development risks.[148]

The guidelines for the investigation by the Child Care and Protection Board likewise give no criteria based on which a family situation can be classified as (physically) unsafe.[149] The assessment of a case seems to be mainly based on the issue of whether the parents cooperate or not with assistance or pursuant to an estimate of the extent to which there is a case of a threat to the child's development. The guidelines outline which factors have to be investigated but do not make clear which findings are needed to arrive at the conclusion that a child is living in an unsafe situation.

Room for considerations per case by professionals seems to be the point of departure for both the Youth Care Office and the Child Care and Protection Board. The parties involved endorse this approach to cases.[150] The point of departure is that per case the professionals and bodies involved review whether a child is safe in a specific situation and whether the child's development is adequately safeguarded.[151] The professionals must define what is not safe and verify their findings by colleague consultation per case. There is no differentiation in safety levels based on practical cases and a linked set of intervention options.[152]

Lately the instruments of Youth Care Office/ARCANs have been providing more support to the professional. CARE-NL enables the professional to compile a risk score and this instrument generally indicates what the consequences of a final score are on subsequent actions of the professional at the Youth Care Office.[153] CFRA, a method that is still in development, gives a relatively large amount of instructions for scoring and seems to have relatively high validity.[154] However, this instrument does not contain any instructions on action for the professional. For these instruments applies that they are only used at the Youth Care Office/ARCANs and not at other institutions in the child safety system.

The development of a safety term is not yet 'fed' by knowledge of considerations which the court takes into consideration in the issue of whether a child protection order is justified. A bottleneck here is the limited reasoning by the juvenile court in family supervision cases. In most cases the juvenile court confines itself to standard reasoning which only refers to the section of a law in question on 'a

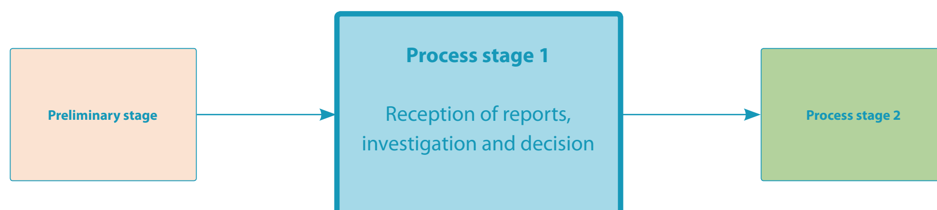
144 Section 1:254 Netherlands Civil Code.
145 When the Netherlands Civil Code was amended in 2007 the Council of State remarked that the legislature had added the terms safety and violence to Section 1:247 but Section 1:254 remained the same.
146 Willems, 1999, page 522.
147 Netherlands Family Council, 2001, page 75. The Safety Board is not aware why this recommendation has not been followed up.
148 Brink, ten & Veerman, 1998.
149 Protocol Protection Duties 2009. New Method of Council Investigation in Protection Cases
150 In this case the Social Entrepreneurs Group Youth Care: Social Entrepreneurs Group Youth Care, the employer's organisation in youth care, which comprises all Youth Care Offices.
151 Social Entrepreneurs Group, 2008, Safety and risk management, page 9.
152 A comparison with 'case law' presents itself here. In addition, based on individual cases, generalisations are made.
153 See appendix D.
154 California Family Risk Assessment. Source: J. Hermanns, 2010. Validity is based on several years of research into the predictive value of the instrument (actuarial method).

threat to the child's development'.[155] Usually this reference is not further substantiated with facts: how is this ground met? The standards and facts which a juvenile court bases its decision on are often not specified. In appeal the Court of Appeal reasons more extensively but this only concerns a very limited number of cases.

Secondly, according to the current rules the parents must agree to forensic medical and/or psychological examination of the child (which may be necessary to establish abuse) and of the parents (which may be necessary to estimate the child's situation). This not only applies for an investigation; the parents' consent is also required to request medical information about the child or the parents.

Thirdly, the Safety Board establishes that current law and legislation does not adequately guarantee cooperation by third parties with the investigation by the ARCANs or the Child Care and Protection Board. Care workers bound by confidentiality can be exempted from their confidentiality obligation by their own guidelines and the Youth Care Act if they cooperate with requests for information from the ARCANs or the Child Care and Protection Board.[156] Further, in various areas there is a case of cooperation agreements between the ARCANs and other parties such as the police. However, umbrella legislation in this field is lacking. A change in legislation concerning child protection orders is being prepared. This intends to provide clarity about the transfer of information to the family supervisor with regard to information about the child.

5.2.3 Conclusion and discussion of improvement options



This section discusses three conclusions with regard to the analysis of the process stage Investigation and Decisions. The policy pursued since 2007 to better manage the child's safety during this process stage and the remaining improvement options are also discussed.

Three conclusions
Pursuant to the incidents and the guidelines the Safety Board concludes firstly that the investigation by the ARCANs and the Child Care and Protection Board does not provide the full picture of the child's physical safety and does not have to. Secondly, the Board concludes that to a large extent the investigation depends on cooperation by the parents and thirdly that collecting information for the investigation is impeded by limited cooperation by professionals caring for the parents and that this cooperation is also not regulated. The investigation appears to be dominated on the one hand by the orientation towards assistance in a voluntary scope within the family and on the other hand by considerations of due care.

In this process stage the government's responsibility for the child's physical safety is addressed; the government must be active and must investigate whether parents take their responsibility for the child's physical safety or whether assistance or measures are necessary.
The Safety Board is of the opinion that in this stage - a situation in which suspicions of risk have arisen - it may be expected that the child's physical safety is the guiding principle for all professionals

155 Section 1:254 Netherlands Civil Code.
156 Youth Care Act, Section 48 paragraph 3. Anyone required to observe confidentiality due to his position, profession or office can be exempted from giving information or allowing for inspection insofar as his or her confidentiality obligation extends to that.

involved with the family.[157] The lack of clarity about cooperation which may be expected from other professionals involved is a serious imposition on the professional.

Discussion of improvement possibilities
The developments, policy and improvement possibilities in the field of investigation and decision forming are explained point by point for the three conclusions.

Firstly, the Safety Board sees some developments with regard to the notion of 'the child's safety'. In the Netherlands Civil Code the child's safety has also been part of the parents' duty of care since 2007. However this is not implemented in Section 1:254 Netherlands Civil Code in the grounds for measures. In recent proposals for amendment to the Netherlands Civil Code, safety is referred to as a preliminary condition for any upbringing but not included as a ground for a supervision order.[158]

The legislator is of the opinion that the sector itself must improve the scope in which the decision to intervene or not is made in order to limit the decision space of the individual professional. This is also apparent from the response from the Youth and Families Minister to the report 'Dilemmas on the threshold' in which the Council for Public Health and Health Care suggests that reflection is needed by the government on the moral substantiation of the current, more invasive youth policy and that the government must ensure that acceptable limits are not exceeded.[159] In response to that report the Minister for Youth and Families placed responsibility explicitly with the professional and asserted that he would only steer towards further professionalisation of the sector.[160] In addition, some literature about youth care provides in an explicit role for the professional in this substantive debate in which the professional is invited to make his dilemmas known so that society and politics can empathise.[161]

The Safety Board considers better support of the professional essential in order to fulfil the government's responsibility for the investigation. Professionals in the process stage Investigation and Decisions should in any case have clear criteria for the urgent procedure that exists to protect the child against acute threat, in particular if a suspicion of danger is reported by a doctor or another professional reporter. Here the Safety Board has very young children in mind in risk families where there is no time to lose. Finding bruises on a baby unable to hurt itself should always be a reason for prompt follow-up including forensic medical examination. One development in this direction is the protocols which have been made in most hospitals by the Child Abuse working groups; these protocols describe which steps should be taken if a young child comes to the hospital with an injury and a suspicion of child abuse. The child is given a full physical examination and reported to the ARCAN. The child may be admitted in consultation with the ARCANs without there being a medical need.

With regard to the reasoning by courts there is an intention to amend Book 1 of the Netherlands Civil Code.[162] In order to explain to the parents and the minor which problems will be worked on during the supervision order it will be determined that the juvenile court includes the specific threats to the minor's development in the decision. This enhances the transparency of the supervision order.
Secondly, there are developments in the role of the police with regard to the cooperation by parents in the investigation. Police and Youth Care Offices are working on a protocol in which reports to

157 In practice the intervention alternatives are considered in the decisions. This means that the child's safety is not assessed independently. This assessment should be separate from the possibilities with regard to solutions.
158 'If a child is abused or neglected, obviously the child can not develop in a healthy and balanced manner and if the parents do not or cannot take their responsibility then the government must protect the child. Absence of child abuse, including neglect, is therefore a preliminary condition for any upbringing situation.' (TK32015/3, amendment to Book 1 Netherlands Civil Code, Explanatory Memorandum, page 8).
159 Council for Public Health and Care, Centre for Ethics and Health, 2008.
160 Speech by Minister for Youth and Families on 25 September 2008 in response to publication by Council for Public Health and Care. The Minister announced that his Family Memorandum would deal with the moral dilemmas of care workers. However the Family Memorandum only reports that these exist and focuses mainly on the support for families (meant preventatively).
161 Van Doorn, 2009.
162 Amendment to Section 1 Netherlands Civil Code: 255 paragraph 5, parliamentary document 32015, no. 3 (Explanatory Memorandum).

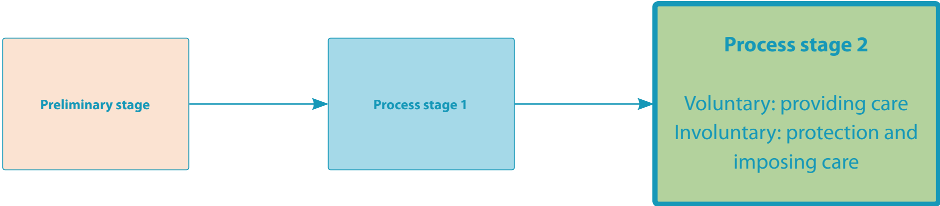
the Youth Care Offices are passed onto the police. In addition in 2007 the Youth Care Inspectorate made a recommendation to the Minister of Justice: 'Ensure that the Public Prosecutor always orders a personality assessment of the parent if it has been established that the parent has abused the child such that this led to serious injury or death'.[163] This recommendation has not yet been followed up.[164] In addition, the Safety Board believes that in an investigation into the physical safety situation of the child a personality assessment of the parent must also be considered. This is already possible now in the scope of an application for a protective measure but is not used much in practice.

The Safety Board remarks in this respect that to a large extent the child safety system respects parental autonomy, even in cases where the child's physical safety is seriously endangered. Yet it is precisely the incapacity of the parents to implement this autonomy that constitutes a reason for intervention of the child safety system. The point of departure of the system is that parents ensure and are responsible for the child's physical safety and that support is given with respect for parental autonomy. This goes 'wrong' if parents' opinions of what is right for their child deviate from what care workers consider acceptable and no correction appears possible. This is the case with serious psychiatric problems, intellectual disability and addiction and yet still the system leans strongly on parental autonomy. The police and the Public Prosecutor do intend to exercise more 'force' on parents from a criminal law point of view for their cooperation with investigations and measures.

Thirdly, the Safety Board establishes that the alleged impediments to obtaining information from third parties with confidentiality obligations, which existed at the time of the investigated incidents, have been addressed with improved information on privacy legislation.[165] However, it remains problematic that the 'suppliers of information' from the other sectors were permitted to provide information but were under no obligation to do so. They still see impediments to cooperating. Considerations must be made by the professional from the other sectors (in particular doctor, Municipal Health Service worker). For these types of professionals there is no supervision that checks whether their considerations are adequate.

If there is a report about a child and there are suspicions of danger, doctors and Municipal Health Service care workers see impediments to providing information. It was established in the previous section that doctors in particular are reluctant to make reports. As a corollary of both these findings, the Safety Board expects that Municipal Health Service care workers will also be reluctant to make reports.

5.3 Process stage 2: Care and protection



If the investigation confirms an unsafe family situation, intervention must take place in the family in the way of care and assistance, voluntarily or possibly combined with a protective measure. During this process stage, the child's physical safety is taken care of. The accompanying problems are dealt with here below as seen in the dossier study (5.3.1) and put into the context of the current law and legislation (5.3.2). Conclusions are drawn and possible improvements discussed (section 5.3.3).

163 Youth Care Inspectorate, Implementation of Sanctions Inspectorate, Healthcare Inspectorate, 2007, Investigation into child abuse cases.
164 Source: interviews
165 Brouwer-Korf Committee, 2009.

5.3.1 Which problems occurred in the incidents?

In the incidents investigated there were four cases of abuse with a fatal outcome in which the family was given assistance on a voluntary basis and four times where the family was given imposed assistance during a supervision order.[166]

The incidents show that professionals also have trouble estimating and dealing with information about danger to the child in this process stage. The Safety Board establishes that there is a case of six problems:

1. the professionals involved do not use the child's physical safety as an independent criterion;
2. the professionals involved did not adjust the care and protection regime even though new information gave rise to do so;
3. the cooperation of the parent is more decisive for the approach than the child's physical safety;
4. the family supervisor is given limited cooperation and information by professionals in the medical profession and professionals focused on the care for the parents. This means that the family supervisor cannot fulfil his coordinating task;
5. even after physical danger to previous children in the family professionals do not appear to follow any special approach;
6. internal monitoring of professionals is carried out in part.

These six points are explained in greater detail below.

Explanation of the six practical problems based on the incidents

Firstly, it seems that physical safety is not seen as an independent criterion. Frequently, wider more indefinite criterion of the child's 'development' was concerned. Various dossiers discussed the issue of whether the child's *development* was endangered and whether parents cooperated or not.

- In the case of a five-year old boy[167] the key element was his development and in that respect care workers worried about changing the place of residence of the child.
- In another case[168] a girl suffered brain damage on two occasions. When the child was six months old the paediatrician discovered brain damage for the first time and suspected child abuse. He informed the ARCANs. The child was taken away for three months. After these three months the Youth Care Office asked the juvenile court to extend the custodial placement. During the court case the parents put forward that the brain damage was caused by vaccination. The juvenile court dismissed the request for extension and ruled that in the interest of the daughter's recovery she should go home. She was put under supervision for a year. One year after the first incident a second incident followed in which this child suffered serious brain injury again.

Furthermore, it was noticed in various incidents that the physical safety in the home situation was not reassessed when the juvenile court decided not to extend the custodial placement.

Secondly, the Safety Board established that in some cases investigated that new information became available during the process stage Care and Protection but that family supervisors or other parties involved did not revise their actions based on this information. The Safety Board assumes that there are various reasons for this. A possible reason which the Safety Board would like to name is the limited number of intervention options that professionals have when parents do not cooperate.[169] Besides giving instructions usually only a custodial placement remains.

- In one instance[170] there was a case of a parent with a newborn child and a daughter who was nearly four who had been assigned a family supervisor. The Advice and Reporting Centre for Child Abuse received various signals with regard to the baby but also the report

166 In total there were nine cases, in one case nothing had been arranged after finalisation of the investigation.
167 Incident C25.
168 Incident C26.
169 The Safety Board did not investigate why new circumstances in these cases did not lead to adjusting the care provision plan. Further study of these cases can provide valuable insights into the weaknesses of the current family supervision system. It is known from the literature (Munro, 1999) for example that the human ability to process new information and make new plans based on it is slow. In addition, in general people tend to underestimate child abuse or even to deny it (Cooper, 2006).
170 Incident C24.

that the parent 'dealt strangely' with the older daughter. In addition, the body supervising the parent reported to the family supervisor that the parent had not followed instructions. Despite this new information none of the bodies involved decided to have the three-year old daughter placed outside of the home or to apply for an custodial placement for the baby.

- In another case[171] an investigation by the Child Care and Protection Board did not lead to child protection orders but to advice for the parent. In the subsequent period various care workers involved with the family, employees from an orthopedagogic centre, the general practitioner and an employee from a home care organisation noticed that the child regularly had bruises. However, this information remained restricted to the individuals involved and was not shared. The information was also not reported back to the Child Care and Protection Board which had previously carried out child protection investigation in the family.

Thirdly, family supervisors are to a great extent dependent on the parents' cooperation and the lack thereof in some cases remains without consequences. Here, too, it is the case that the family supervisor has few intervention options if the parent does not cooperate.

- One example concerned the case[172] in which a supervision order had been given for the daughter. Assistance had also been arranged. The early childhood clinic insisted on placing the child in a medical day care facility and in a playgroup. The mother did not want either. In addition at some point the mother stopped supervision she was getting from mental health care. This lack of cooperation had no further consequences for the policy pursued.

Fourthly, the Safety Board established that in the network of professionals involved in this process stage with the child and its parents no one formally has supervision or overriding authority. Even if a child is under supervision and a family supervisor has been appointed he has no authority with regard to the other care workers involved. Assistance for the parent on the one hand and help and protection for the child on the other hand are carried out by different institutions as two separate processes.[173]

Families where there is a case of danger are often so-called multi-problem families where the balance between the burden of the parent (the complexity of the parental task) and his capacity (the ability to perform the parental task) is disturbed.[174] Because this disturbance can be caused by a range of problems often many specialised helpers are involved to remedy the balance and remove the threat of physical danger to the child. They work from various institutions, sectors and angles and their objectives can vary strongly.

If a supervision order is given during this process stage and the help is not voluntary, it should be obvious that the family supervisor has supervision because he can better perform his responsibility. In practice this is not the case. The family supervisor only has control over giving care to the child. He does not have control over assistance for the parent as part of adult care services and he also cannot get any information about it. The parents are the point of contact for the family supervisor. The family supervisor did draw up a plan, which the parents had to keep to, but did not directly contact the adult care service on the manner in which this plan was implemented. This means a lack of cohesion in the assistance for the child and the parents arises.

- In one case[175] a family supervisor was appointed and a child was placed in custodial care while the mother became pregnant again. A social worker from the Salvation Army gave assistance to the family on a daily basis. This social worker knew of an aggressive incident involving the father but did not pass this information on to the family supervisor. This family supervisor was approached by the ARCAN to give advice on the matter of how the newly born baby should be dealt with in the family. In hindsight it cannot be said whether this new information about the incident would have led to different decisions but it does illustrate that not all relevant information is known to those dealing with the child's physical safety, in this case the ARCAN and as a corollary the family supervisor for the older child.

171 Incident C22.
172 Incident C24.
173 Chapter 4 shows a schematic diagram of the various care and social workers involved with the family in the process stage Care and protection.
174 Bakker, Bakker, Van Dijke and Terpstra, 1997.
175 Incident C23.

In various incidents there was no case of an integrated approach of the problems within the family or for sharing information. In the incidents investigated for example one or more of the following parties from the adult care was involved:

- Debt assistance
- Pedagogic assistance if parenting skills were lacking
- Psychiatric supervision for psychiatric problems of the parents
- Aggression management therapy for parents with aggressive disorders
- Addiction treatment for alcohol and drug addictions
- Probation and after-care if parents had served a prison sentence

A joint approach was not formulated with any of these parties. This applies in both the voluntary and involuntary situation. An example of a 'voluntary situation': one incident[176] involved a family where various forms of voluntary help had been given to various members of the family for several years. The father was given help by an institution for mental health care and his daughter was involved with the Regional Institute for Outpatient Mental Health Care, youth healthcare, the Youth Care Office, various schools, doctors[177]and care providers. Over the years, the family composition changed, too. The police had reported a suspicion of child abuse several times to the ARCANs. In this case the Youth Care Office made risk assessments for the daughter at various times. This led to forms of voluntary help, also because the father was prepared to cooperate. Neither the Youth Care Office nor the other institutions involved had a full overview of the child's situation in the family. The information exchange between the Youth Care Office and assisting institutions was limited to one-off contact.

Fifthly, it was noticed that there was no special approach for reoffending. In various cases the fact that there had previously been a case of an unsafe situation for a child in the families in question was unknown. This concerned families for example in which a previous child had been abused or had died as a result of violence, families about whom reports had been made to the police of domestic violence or families for whom a child protection order had previously been implemented.

- In one case[178] two children in a family had been abused with a fatal outcome when a third child was born to the father (different mother, ten years later) and had died within a few weeks because of inflicted injuries.
- In another case[179] the first child died because of a parent's actions. The ARCAN was informed of the pregnancy before the birth of the second child. The ARCANs brought in help. A few months later the second child suffered serious brain injury also caused by one of the parents.
- In one case[180] a six-year old boy was systematically abused by his stepfather who had been reported to the police a year earlier by his ex-partner for domestic violence.
- In another case[181] two children in a family were put in custodial care. One had come back under conditions when a third child was born, stayed in the family and died of his injuries four months later.
- In another case[182] two older children were placed outside of the home. A third child was put under supervision and reports on the newborn baby were made to the ARCAN by professionals who were concerned.
- In again another case[183] the father was known to the police because he had abused his ex-girlfriend as well as her three-year old daughter in a previous relationship.

In these cases actions were sometimes taken based on this 'prior knowledge' when a new child came along and sometimes they were not. There did not seem to be any systematic approach towards reports about families with serious risk factors.

176 Incident C20.
177 The father changed doctor
178 Incident C4.
179 Incident C18.
180 Incident C6.
181 Incident C2.
182 Incident C24.
183 Incident C10.

- In one case[184] a second child was born in a family. The ARCAN had ceased an investigation on the first child because the parents did not have a fixed place of residence. Both parents of the family were addicted to drugs and alcohol. No action followed after the birth of the second child.
- In another case[185] a daughter was born in a family where the ARCAN had previously carried out an investigation in relation to burn wounds of the older son. The daughter died later of Shaken Baby Syndrome. Here again no action followed.

Sixthly, insofar as information was available, it appeared that the internal supervision was only carried out 'horizontally'.[186] By internal supervision the Safety Board understands organising vertical supervision (supervision) and horizontal supervision (intervision) focused on actions in a specific case.

The Safety Board has information about the internal supervision in two incidents:
- In the first case the content assessment of individual cases is lacking.[187] One finding is that in this regional branch a system for timely internal control and management is lacking. This concerns the defective substantiation of the steering and controlling role of the manager; at this level he is responsible for the decisions of the family supervisor.
- In the second case[188] the physical safety was considered at various times in consultation with the case manager (usually a social worker) and the behavioural scientist. The parties involved see this as multidisciplinary consultation. The Safety Board remarks that here for example no doctors or other paramedic disciplines were involved.

5.3.2 To what extent are these problems addressed by the current framework of law and legislation and guidelines?

This section describes to what extent the existing law and legislation supports the acts of professionals (in this case family supervisors and case managers of the Youth Care Office) in the process stage Care and Protection.

Six findings

In summary it can be asserted that legislation and guidelines are limited in their support of professionals. Firstly, the legislation does not specify what should be seen as physically unsafe. The Youth Care Office's Delta Method for Family Supervision Manual that should support professionals, does specify safety. However, the Manual does not differentiate between safety levels. The assessment of physical unsafety depends strongly on the professional opinion of the family supervisor. Secondly, the Manual provides no indications of what information about the family should lead to changes in the protection regime. The professional has to make these judgements himself and the Delta Method for Family Supervision Manual endeavours to provide support in dealing with uncertainty. Thirdly, the family supervisor has little authority compared to the parents. Fourthly, the Delta Method for Family Supervision Manual provides no handles for collaboration between the family supervisor and the care workers involved with the family who may have relevant information. Fifthly, there is no specific policy with regard to 'reoffending'. Sixthly, the Manual recently puts more emphasis on collegial consultation: 'never do it alone'. All together this means far too much of an imposition on the professional's ability to judge.

Explanation of the six findings based on the legislation and the Delta Method for Family Supervision Manual

There has been increasing attention for the safety of children in families since 2005 at the Youth Care Office and the Social Entrepreneurs Group Youth Care. This can be traced back to the policy memo 'Safety policy and risk management' of 2008 and the Delta Method for Family Supervision Manual for family supervisors. The terms safety and physical safety are explicitly explained in the policy memo. The memo applies to all Youth Care Offices and the safety policy implemented at the Youth Care Offices. Version 3 of the Delta Method Manual (December 2009) and the revised version

184 Incident C9.
185 Incident C7.
186 Based on a number of reports from the Youth Care Inspectorate
187 Youth Care Inspectorate. 2005. Investigation into the quality of the assistance process for S.
188 Youth Care Inspectorate. 2007. Investigation 'Maasmeisje' girl. Report Youth Care Office Rotterdam.

of the Improvement to the Special Needs Manual of the Youth Care Offices have been brought into line with the safety policy. The Delta Method Manual explicitly devotes attention to risk management and the safety of the child during the planning and implementation of child protection orders as seen in the following passage:[189]

'Point of departure for risk management is that there are risks to the child in any supervision order. The supervision has been ordered because the child is in serious danger. This threat was demonstrated by the Child Care and Protection Board and ascertained by the court. Hence the family supervisor must assume these facts. Therefore it is not the question of whether there are risks but of how many risks there are, what they are, how threatening they are and how they can be reduced. It is not enough for the family supervisor to establish that there are no signs indicating risks and lack of safety. It is a case of 'onus of proof resting with the other party': the family supervisor actively looks for actions and experiences which indicate that the situation is safe enough and asks parents to explicitly provide convincing arguments that the child is safe.'

The policy memo and the Delta Method explicitly explain the term physical child safety. A description is given of unsafe situations. The Manual refers to possible signals which could indicate that the child's physical safety is compromised, and factors which may be an indication of the seriousness of the threat. For one of the key decisions in the Manual - 'applying for a custodial placement' - there are some concrete possibilities to remedy the safety of the child in the home situation.

Further, the Delta Method for Family Supervision Manual states that when returning the child to the family after serious abuse, the point of departure must be that the home is not safe unless the home situation has demonstrably changed.[190]

The Safety Board has its doubts about the legislation and both Manuals. The Manuals and pertaining instruments do not report any built up differentiation in safety levels and a linked set of handling options based on practical cases[191]. There is no support for the link between the seriousness of the threat and the manner of response. The family supervisor does not have an 'escalation model' - gradual build up in the extent of takeover of the responsibility of the parents.

The Delta Method for Family Supervision Manual appears to assume the assumption that help in itself already offers safety which does not have to be the case. Further, the Manual exclusively applies to family supervisors and not to other professionals involved with the family. As already discussed in the previous section, instruments such as CARE-NL which can be used to assess safe or unsafe are not validated or only to a limited extent. They do not provide concrete indications of which situations should be deemed to be unsafe or safe. It is the professional who, in collegial consultation, makes a consideration, gives a final opinion and determines the need for intervention.

In addition, in the recent Delta Method for Family Supervision Manual as a corollary of the legislation the threat to the child's development appears to play an important role in the considerations. The child's *development* is a broader term than safety. The Safety Board expects that making safety paramount as was done recently will not necessarily lead to changes in practice. The accent on the so-called development perspective of the child is most widespread as apparent from the literature. There also seems to be term ambiguity; the instruments sometimes use development aspects under the denominator of 'safety'.

Secondly, the indications given by the Delta Method for Family Supervision Manual about how the professional should deal with new information and under which circumstances such information gives reason for changes in the protection regime are barely concrete and differentiated. The Delta Method for Family Supervision Manual does pay attention to this problem in adjusting the approach. Insofar as known to the Safety Board no special attention is devoted to the problem of adjusting the approach in the voluntary framework.

189 Delta Method Family Supervisor Manual 2009, page 69
190 Delta Method for Family Supervision Manual 2009, section 8.2.3.
191 A comparison with 'case law' presents itself here. In addition, based on individual cases, generalisations are made.

Thirdly, the powers of the family supervisor with regard to the parent are limited in the legislation. The family supervisor must draw up a plan which the parents agree to. He can use his power to give instructions.[192] If parents do not cooperate he can request the court for authorisation for custodial placement but the court does not have to agree to it. In itself the refusal to follow instructions does not constitute grounds for a custodial placement; this is only possible if it is necessary in the interests of the care and upbringing or investigation of his emotional or physical condition. Moreover custodial placement violates the other statutory assignment of the family supervisor, namely keeping the family together. The incidents also gave an impression of a limited range of intervention options.

The options for the family supervisor are also limited with regard to the child. For example he cannot obtain any information or indications about the child's medical treatment; this is restricted to the child and/or parent.[193] Because the family supervisor does not decide on medical treatment he also has no right to this information. The information can be provided by doctors but doing so is their right and not an obligation.[194]

Fourthly, it appears that the monitoring and organising role of the family supervisor, in which the law provides, cannot be carried out properly. Pursuant to Section 1:257 Netherlands Civil Code it is his duty to monitor the child and to ensure that the child and the parent charged with the responsibility are given help and support in order to avert the threat to moral or emotional interests or the health of the child.[195] No authorities with regard to other bodies are linked to this provision. The family supervisor does not have the following options:

- Setting preliminary conditions for the care for the parents with the objective of removing the threat to the child's interest and health.
- Monitoring the effect of care on the parents and obtaining information on them from the care providers in question. Using the results of care given to the parents in his opinion of whether further child protection orders are necessary.

The Delta Method for Family Supervision Manual does not give any indications about the interaction between the family supervisor and the care workers involved with the family who may have relevant information and/or could provide a contribution towards forming an opinion.

Fifthly, there are no guidelines in youth care with regard to reoffending. Outside of Youth Care, to an increasing extent youth healthcare uses risk profiles for families. This means that families with risk factors are given more attention by the early childhood clinic and are summoned more often. The Youth Healthcare Digital dossier also contributes towards this. However, the Safety Board establishes that in principle youth healthcare does not have information about previous risk and violence and is still inadequately equipped to timely identify any possible danger specifically in multi-problem families.[196] Further, there is the 'reference index risk youth' instrument. Doctors can file reports here about children in unsafe situations, but KNMG and general practitioners association LHV advise doctors not to report a youth to the Reference Index unless they have obtained consent to do so from the youth or his parents.[197]

Sixthly, it appears that internal supervision has not yet been clearly worked out in guidelines. Organising internal supervision in the Youth Care Office is described in a memo 'Safety policy and risk management at the Youth Care Office'.[198] The design of this consultation may differ per Youth Care Office. Consultation on a case is what is meant here.

In the more elaborated guidelines (Needs Assessment Manual and Delta Method for Family Supervision Manual) the rule is that key decisions on the child's safety can never be taken alone by

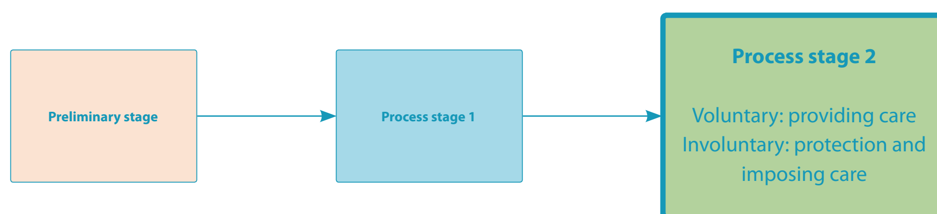
192 This authority is described in chapter three.
193 Medical Treatment Contracts Act, WGBO, Section 457. This legislation is going to change; see 5.3.3.
194 Youth Care Act Section 48 paragraph 3.
195 If care is given to the child and parents on a voluntary basis, case managers from the Youth Care Office have a comparable function; this is laid down in the Youth Care Act.
196 De Waal, 2010.
197 Source: KNMG website October 2010.
198 Social Entrepreneurs Group. 2008.

the employee of the Youth Care Office.[199] In other words: these decisions are taken in consultation with the manager (vertical) or the behavioural scientist (horizontal). The exact procedure for this consultation can differ per Youth Care Office.[200] In one of the core decisions, the commencement of a measure, the Delta Method for Family Supervision Manual prescribes a multidisciplinary consultation between the family supervisor, the behavioural expert and the team manager.[201]

The guidelines do not prescribe how internal supervision should be organised. Organising internal supervision is left to the Youth Care Offices.

In 2008 in a study of children under supervision the Youth Care Inspectorate concluded that the authorities and responsibilities with regard to risk management of the various employees within youth care were not laid down. Most organisations have no established working methods for assessing the performance of risk management. The mode of operation at the Youth Care Offices is far too dependent on the coincidental knowledge and working method of the staff officer or executive involved.[202]

5.3.3 Conclusions and discussion about improvement options



Six conclusions with regard to the analysis of the process stage Care and Protection are discussed in this section. In addition, the policy pursued since 2007 to better control the child's safety in this process stage and the remaining improvement options are also discussed.

Six conclusions
There were six problems in the incidents: (1) the child's physical safety was not the leading principle, (2) the care and protection regime followed was not adjusted even though new information constituted a reason to do so, (3) the parents' cooperation and not physical safety is particularly decisive for the approach; (4) the family supervisor lacks instruments needed to substantiate his coordinating task and is not automatically given information by other professionals, (5) there is no approach for reoffending and (6) internal supervision is only carried out horizontally.

The Safety Board establishes that the legislation and the Delta Method for Family Supervision Manual do not provide enough control. Firstly, the demarcation between safe and unsafe situations is inadequately specified and secondly it is not sufficiently clear under which circumstances new information gives rise to changes in the protection regime. Thirdly, the Delta Method for Family Supervision Manual provides no indications for dealing with the family supervisor and the care workers involved with the family who may have relevant information. In addition a fourth point is that the family supervisor has too few powers with regard to the parents. Fifthly, it is apparent that a systematic approach to prevent reoffending has not been provided for. Information on previous risk (reoffending) which in particular is known from investigation by the Child Care and Protection Board, the ARCANs or criminal investigation of the parents was not always found in the youth care chain. These parents 'have a clean slate' with the next child whereas increased monitoring and supervision is advisable.

199 Social Entrepreneurs Group. 2009. Delta Method for Family Supervision Manual 2009, p. 73; Social Entrepreneurs Group. 2007. Needs Assessment Manual. p. 76
200 Social Entrepreneurs Group. 2009. Delta Method for Family Supervision Manual 2009, p. 73.
201 Social Entrepreneurs Group. 2009. Delta Method for Family Supervision Manual 2009, p. 105.
202 Youth Care Inspectorate. 2008. Inadequate monitoring of children put under supervision.

In this process stage the government's responsibility for the child's physical safety is addressed and if necessary given an active and significant form. The government now knows that help or measures are necessary. The Safety Board believes that in this stage - a situation in which investigation has shown that concerns for the child's physical safety are justified - it may be expected that the child's physical safety is the guiding principle for all professionals involved with the family, that coordination is possible on the help and that everyone is clear what changes in the situation must lead to a different regime, in particular what the consequences are of a parent not cooperating. High requirements are set to professionals at this stage. The open standards must be further operationalised. If there are limits to this these open standards require very experienced professionals, who keep each other sharp and who are given sound internal feedback and internal supervision.

Discussion of improvement options
The developments, policy and improvement options in the field of Care and Protection are explained point by point for the six conclusions.

Firstly, with regard to maintaining child safety as a leading perspective there have been and still are various developments. The edition of the Delta Method for Family Supervision Manual which was in use at the time of the investigated incidents did not sufficiently support professionals in safeguarding the child's physical safety during the process stage Care and Protection but as stated a lot has changed.

The Safety Board sees a potential for improvement by explicitly defining physical safety and making a connection between the extent of danger and the extent of intervention. It does seem worth having an escalation model so that family supervisors have other options in between the 'designation' and custodial placement with which they can guarantee the child's physical safety. There are local initiatives attempting to do that. One example is *'Signs of Safety'* in Zeeland and Drenthe.[203] The key *Signs of Safety's* approach is establishing concerns about the child's safety, the existing dangers and things that are going well. This is summarised into a grade for safety, which is given by a wide group involved with the whole family. In addition an attempt is made to realise safety within the family by organising informal supervision within the family. Incidentally the way that the *Signs of Safety approach* is currently implemented can be criticised.

Secondly, there are also developments with regard to the topic 'changes in the regime to be implemented'. The effects of these changes in the Needs Assessment Manual with regard to adjusting the approach are not yet known. An evaluation of the implementation of the Delta Method shows that the lead time for supervision is reduced by a clear approach. This concerns the 'light' cases in which a short period suffices. It remains to be seen whether this means that a clearer approach also leads to timely adjustment in the more serious cases.

Thirdly, there are also some developments concerning the problem of the supervisor's powers with regard to the parents. A change in legislation is being prepared with regard to child protection orders, which is intended to provide clarity about the transfer of information to the family supervisor with regard to information *about the child*. This means that professionals with a duty of confidentiality may breach it to provide relevant and necessary information to the family supervisor who has to decide on the child's physical safety and must have all relevant information to do so. However, it remains a right of professionals and not an obligation.[204] The Safety Board however believes that information *about the parents* is also relevant to the child's physical safety. There have also been developments in the role of the police. It is the intention that the police provide a contribution towards the approach to child abuse by using their criminal law powers, for example causing the public prosecutor to include assistance for offenders in his sentence demanded. As well as punishing offenders criminal law can contribute by ordering offenders to accept help where often no use is made of this voluntarily. Use of criminal law does not give the family supervisor more authority but

203 Sulkers and Dijkstra, 2009. Meanwhile there are more bodies experimenting in various locations in the Netherlands with Signs of Safety.
204 Explanatory Memorandum Amendment to Book 1 Netherlands Civil Code, parliamentary document 32 015, no. 3, page 18.

may be an alternative or addition to civil law measures and that way arrange for more influence over the parents.

Fourthly, with regard to instruments to substantiate the coordinating duty, there are various local initiatives and nationwide policy programs that intend to improve the management of and cooperation of third parties in the child safety system. One example is the 'De Aanpakkers' initiative, which incidentally not only focuses on child safety.[205] The most important development in this respect is the proposed management role for municipalities. However, for the time being this does not refer to the Care and Protection process stage. In particular, when child protection orders are implemented the situation remains the same. There may be effects due to new forms of cooperation between the agencies involved, which remains to be seen.

The Safety Board believes that the family supervisor should in any case also have the option of exchanging information with the adult care service, which parents are given and that the family supervisor can set preliminary conditions to adult care, can monitor them, and attach consequences to results or lack thereof of this care.

Fifthly, more attention is being paid to preventing reoffending, inter alia by the Inspectorates. In addition in 2007 the Youth Care Inspectorate made a recommendation to the Minister of Justice: 'Ensure that the Public Prosecutor always orders a personality assessment of the parent if it has been established that the parent has abused the child to such an extent that this led to serious injury or death'.[206] In 2008 the Youth Care Inspectorate made the recommendation 'Develop a vision of how to deal with families where a new child is born and other children are already under supervision'.[207] These recommendations have not yet been given nationwide follow-up.

A recent report[208] from the Youth Care Inspectorate also addresses this problem due to the deaths of three newborn babies in families for whom a child protection order had already been issued for one or more children. In the Rotterdam area after previous calamities as of 1 January 2009 an agreement has applied about reporting babies and unborn babies whose brothers or sisters were under supervision to the Child Care and Protection Board. The Safety Board is not aware of other formal agreements in the Netherlands focused on preventing repeated offences. There is the intention of the so-called entire supervision order; i.e. that supervision is not per child but for the whole family but it has not yet been implemented.

The Safety Board believes that improvement is possible by developing a nationwide policy with regard to reoffending. Physical danger by reoffending parents played a role in various cases which this investigation referred to. In particular, the Safety Board sees possibilities for improvement concerning families where previously one child died or almost died due to abuse by the parent.[209] The Safety Board deems it advisable that here in any case improved provision of information comes from the criminal law chain and from previous contacts with civil youth protection. In addition, more policy or an approach is desirable, aimed at the parents who previously did not guarantee physical safety.

Sixthly, the Safety Board deems improvement possible with regard to internal supervision. After the death of the infant Savanna and the Youth Care Inspectorate's report on that matter more attention has been given in youth care to organising internal supervision. This can be seen in the

205 Care model for continual support for people (and families) with limited educational self-reliance. De Aanpakkers is based on experiences from the United States, Enschede, Rotterdam and Hulp aan Huis Overijssel using 'community based care'. De Aanpakkers aids in a return to normal life, provides continual care, low threshold with clear management and responsibility. The principle of a local problem owner is paramount. (Source: www.deaanpakkers.nl).

206 Youth Care Inspectorate, Implementation of Sanctions Inspectorate, Healthcare Inspectorate, 2007 Investigation into child abuse cases.

207 Youth Care Inspectorate, 2008 Report Baby T.

208 Youth Care Inspectorate. 2010. Report Investigation in the council area Rotterdam Rijnmond and BJZ Rotterdam after the death of three babies.

209 The programme ministry for Youth and Families has indicated that in serious criminal cases the Public Prosecutor can use an instrument (BOOG) to assess the need for personality assessment. This means that after previous physical danger a personality assessment is not necessarily standard.

memo 'Safety policy and risk management in Youth Care Office' and the Delta Method for Family Supervision Manual from Youth Care the Netherlands in which it is stated that the key decisions for the child's safety should not be made alone.

Points for improvement for the Youth Care Offices are establishing tasks, authorities and responsibilities of the family supervisor, the behavioural expert and the manager. The current Youth Care the Netherlands' memos and manuals do not work this out with sufficient clarity for all Youth Care Offices. In view of the problem of *physical* danger the considerations that professionals make in youth care require internal supervision that corresponds to them. It is important to use various points of view and knowledge from various disciplines. The composition of this internal consultation which takes the role of internal supervision would have to be more multidisciplinary, in the sense that professionals with knowledge in the field of *physical safety* participate.

General: learning from incidents
Finally, the Safety Board asks attention for the subject learning from incidents and also the subject of disciplinary law. Part of the further professionalisation is the desire to set up disciplinary rules for employees in youth care. The parties involved see disciplinary rules as the final stage of professionalisation. The Safety Board remarks that it is an approach focused on individual dysfunctioning in which surrounding professionals remain out of the picture. Further, the use of disciplinary rules has a certain measure of arbitrariness: their use depends on whether a report is made and the nature of the report does not have to be (professional) content-linked by nature. Experiences in other sectors have further shown that a safe working environment for the professional is not necessarily served by it. A safe working environment requires that professionals can talk about their mistakes in all openness and mutual trust and learn from them. Disciplinary law could be opposed to this. For these reasons the Safety Board believes that it is preferable to use other aspects of professionalisation such as supervision and forms of internal supervision and to exercise caution with regard to implementing disciplinary law. The Safety Board notices that reflection, systematisation of experience and intervision are referred to as elements of professional action in the action plan but that these elements are not further elaborated on in the action plan.[210]

The Safety Board concludes as 'by-catch' of its investigation that drawing a lesson from incidents with a fatal outcome in practice is practically exclusively the task of the Inspectorates and in particular the Youth Care Inspectorate. Youth Care Offices evaluate internally but do not share these lessons with other Youth Care Offices. Learning is incidental and local.

In comparison: in England an investigation is required if a child dies or suffers serious harm and there is a suspicion of abuse or negligence. In these cases the Local Safeguarding Children's Boards must carry out a serious case review to determine what went wrong, to learn from it and to work towards better cooperation between various parties. The outcome of this investigation is public.[211] One example is the report about *Baby Peter* from the *Local Safeguarding Board Haringey.*

In order to evaluate and learn, it is first of all necessary to know whether the death of a young child was caused by child abuse. In some of the cases in this study the fact that the child died as a result of child abuse was discovered more or less by coincidence after an initial certification of 'natural death'. Other studies show that doctors certify a natural death whereas there are suspicions of possible abuse.[212] Structural investigation into the cause of death of children is regulated by law since 1 January 2010 after a compromise reached with the profession of doctors.[213]

The Youth Care Inspectorate in particular plays a role in evaluating and learning from incidents with a fatal outcome. In recent years the Youth Care Inspectorate has maintained the point of view that institutions learn most from incidents and events if they immediately (and prior to any

210 HBO council, Social Entrepreneurs Group, MOVISIE, NIP, NJi, NVMW/Phorza and NVO. 2007. Action plan for Professionalisation in youth care.
211 NJI, 2009. See also Hochstadt, 2006
212 Kuyvenhoven, Hekkink & Voorn, 1998; Soerdjabalie, Bilo, Akker & Maes, 2010.
213 Section 10a, paragraph 1 of the amended Burial and Cremation Act; letter from the Minister for Youth and Family, 8 June 2010 giving municipal forensic pathologists until 1 January 2013 to ensure that they meet the quality requirements for forensic doctors.

investigation by the Youth Care Inspectorate) perform an investigation into the internal mode of operation used and actions taken in an incident. As a condition the Youth Care Inspectorate says that the investigation should be independent (i.e. the parties involved in the incident or event do not participate in the investigation). Moreover the Youth Care Inspectorate provides the institution in question with preliminary conditions to carry out an investigation and to ask questions it wants answered. Based on the report of the investigation carried out by the youth care institution, the Youth Care Inspectorate decides whether there are additional questions it would like to ask or decides to perform its own investigation.

From 2011 onwards the Youth Care Inspectorate will prioritise emergencies at institutions (i.e. serious and fatal incidents). From the time when the report is made the Youth Care Inspectorate will have clear control over who will investigate what and for what reason. This might mean that the Youth Care Inspectorate decides to start its own investigation, taking into account its point of view that the learning effect is great if institutions carry out independent investigation.

Between 2005 and 2009 five of the incidents dealt with in this report were reported to the Youth Care Inspectorate and investigated by it. In some cases this was done together with other inspectorates including the Healthcare Inspectorate and public reports were published. The total of fatal incidents where it is known that there was a case of child abuse is approximately sixteen per year.

The Healthcare Inspectorate carries out an investigation into children who die because of child abuse according to the Guideline reports.[214] This takes place if care institutions and/or individual medical professionals such as general practitioners were involved in the incident. The investigation concerns whether those involved were alert enough towards signs or identification of risk of abuse and acted adequately to prevent the risk. The Healthcare Inspectorate did not draw up an investigation report of any of the 18 cases in this study which were in the preliminary stage or process stage one. For process stage two, the Inspectorate, after several contributions to joint investigation by several inspectorates (see here below), drew up its own report about the 'Maasmeisje' case. This report was intended to formulate clearly what the Inspectorate expects from the youth healthcare (JGZ) in identifying and acting on 'suspicions of child abuse. In particular this concerned Youth Healthcare for ages 0-4 due to the large range. This report was followed up on by thematic study into the working method of the Youth Health Care also in accordance with the standards formulated by the inspectorate in the report on the 'Maasmeisje' case.

The Inspectorate also carried out a thematic study into the identification of child abuse at A&E departments of hospitals and GP surgeries.[215]

214 Inspectorates can decide to start an investigation into the provision of care if they were informed about an incident in which a child dies due to abuse whereas professionals/institutions under their supervision were involved with the child or the family.

215 Inspectorate for Healthcare, 2008 and 2010.

6. CONCLUSIONS

The research question of this study was as follows:

How does the government fulfil its responsibility regarding the physical safety of young children when parents do not do this; what improvements are possible?

In practice the responsibility for physical safety is fulfilled by the parties in the child safety system: the institutions, professionals and their professional groups. A professional is a person who intervenes in families in practice, with the aim to care for the physical safety of the child.
In this thematic study 'realising one's responsibility' refers to the way in which professionals assess and evaluate risks regarding the physical safety of young children and the way in which the government and the parties in the child safety system enable professionals to carry out their complex job.

The Dutch Safety Board analysed 27 (near) fatal cases, and rules and directives were examined that apply to the physical danger for children. The findings are presented in chapter 5 for each of the three process stages (monitoring and reporting, investigating and deciding, providing care and protecting) according to which the functioning of the child safety system can be defined. The findings for each process stage have a number of similarities as regards content. They are combined below.

The Dutch Safety Board arrives at three conclusions on account of the analysis and findings per process stage: a general conclusion about the responsibility of the government for the physical safety of young children (6.1), a conclusion about the professionalism of individuals and institutions required in this respect (6.2) and a conclusion about the initial stage in which signals should result in reports that activate the responsibility of the government (6.3).

6.1 About the responsibility of the government

The Dutch Safety Board first of all concludes the following on the basis of its study:

1. *The government that is called to account in a report with regard to its responsibility for the physical safety of children cannot fulfil this responsibility under the current circumstances.*

The following two conclusions are the basis of this main conclusion:

1A. The conduct of professionals who are responsible for the physical safety of children on behalf of the government shows that the responsibility of parents prevails. As a result these professionals cannot carry out an adequate risk inventory and evaluation regarding the physical safety of young children.

1B. Professionals cannot carry out the risk inventory and evaluation adequately, because other professionals involved with the family are not obliged to cooperate. This means that the professional does not have the chance to actually take control on behalf of the government.

These two conclusions can be explained as follows.

Ad 1A. Professionals who have to carry out a risk inventory and evaluation on behalf of the government and act on the basis exercise restraint with regard to taking over the responsibility of parents. The government has instruments to take over the responsibility of the parents on a temporary basis (provisional supervision order, temporary removal of parental responsibility). These instruments were not applied (sufficiently) in the cases investigated by the Dutch Safety Board, except only after (near) fatal injuries were sustained. Since professionals exercise restraint regarding the use of instruments that temporarily restrict the authority of parents, they have insufficient access to information that is required in order to carry out a full risk inventory and evaluation regarding the young child.

Ad 1B. Professionals who have to carry out a risk inventory and evaluation regarding the physical safety of children on behalf of the government, depend on the cooperation of other professionals for information about these children and their parents, such as doctors and

employees of the mental health care organisations (GGZ). It should be taken into account that this usually concerns multiproblem families, involving many professionals for both the parent and for the child. These professionals are not obliged to share the information about children and members of the family; they have only been exempted from their duty of confidentiality. This means that they are allowed to make their own assessment about ending their duty of confidentiality. It happens regularly that they do not share information that is relevant for the physical safety of children. In those cases the professionals of Youth Care Office and the Child Care and Protection Board cannot carry out a full risk inventory and evaluation. This conclusion does not only apply before a child protection order is taken, but also when a measure already has become effective.

With regard to the (lack of) cooperation with the care workers concerned there are various policy programmes and local initiatives that intend to improve the cooperation of third parties to the child safety system. It involves a whole range of initiatives that still have to prove themselves, but which do not affect the statutory powers.

6.2 About professionalism in the child safety system

A second conclusion concerns the professionalism within the child safety system:

2. *The professionalism in the child safety system is insufficient for carrying out the government responsibility for the risk inventory and evaluation regarding children whose parents care insufficiently for their physical safety.*

This conclusion about professionalism is based on the following five partial conclusions.

2A. Professionals who are responsible for the risk inventory and evaluation on behalf of the government lack a clear framework to decide whether and to what extent they have to use the full government instruments when there are reports of physical danger for the young child. The Dutch legislation and branch directives do not contain sufficient guidelines in this respect. The criterion of (physical) physical danger is not a basis for protective measures for children and therefore not a part of the formal framework for the risk inventory that is required for taking protective measures. For protective measures the legislation applies the broad concept of 'mental and physical development'. In policy development there has been a strong focus on the subject of safety in recent years. In practice professionals have to work with open standards in which it is unclear when physical danger is involved, while they also have to guarantee the 'development of the child', preferably within the family.

2B. The availability of information regarding previous cases of (physical) physical danger in the same family is not guaranteed and professionals do not have a policy to tackle the safety for children from recidivist families in a structural way.

2C. Professionals do not make sufficient use of forensic-medical knowledge and this specialised knowledge is also not sufficiently available in practice. This means that professionals sometimes do not have the opportunity to recognise injuries on time as an indication of possible physical danger.

2D. The internal supervision of professionals who have to carry out the risk inventory and evaluation is mainly done through consultations with colleagues. Other forms of internal supervision of the various professionals involved in the risk inventory have not been worked out sufficiently yet.

2E. The government does not commission a standard systematic study in the event of death. With five of the 27 investigated cases a public study was carried out, while this was not done in the other cases. The government has chosen disciplinary rules as a means to increase the professionalism of the employees in youth care. The sector also wants to (further) shape the professionalisation in youth care through disciplinary rules. The Dutch Safety Board notes that disciplinary rules are not a suitable instrument in the current circumstances, because professionalism is still 'in its infancy' in the sector. Disciplinary rules are aimed at individual dysfunctioning; the focus is not on professionals and institutions who are involved with children. Furthermore, disciplinary rules have a certain degree of arbitrariness: their application depends on whether a complaint is submitted, while the nature of the complaint does not have to be related to the content of the profession. A weighty argument is that the government itself offers insufficient frameworks to the professional.

6.3 About the initial stage of monitoring and reporting

Besides the two above-mentioned conclusions (about the responsibility of the government from the moment of receiving a report about a suspicion of physical danger) and the corresponding conclusion about professionalism, the Dutch Safety Board has arrived at a conclusion about the stage before receiving a report of physical danger.

3. *The stage prior to a report, when signals of physical danger have to be understood in order to report, is also characterised, just like other stages, by a reserved attitude of professionals, in particular in health care.*

This conclusion can be explained as follows.
Professionals, in particular in health care, who are confronted with children with injuries in the initial stage, often exercise restraint with regard to reporting suspicions of physical danger. When they are confronted with injuries and a suspicion of physical danger, they prefer to seek solutions themselves, without reporting these suspicions. However, if no reports are available, professionals who have to carry out the risk inventory and evaluation cannot combine relevant information.

7. RECOMMENDATIONS

The government is responsible for the physical safety of children on account of the Convention on the Rights of the Child, that is to say, when their parents threaten them. The government must take care that it can fulfil this responsibility.

In the opinion of the Dutch Safety Board, the government itself must now improve the functioning of the child safety system, obviously in close cooperation with institutions and professionals that act on behalf of the government. However, the Dutch Safety Board notes that the government adopts a wait-and-see attitude with regard to intrinsic problems and focuses on a system change in youth care. It is expected that a system change may be a long-term process, while the problems continue to exist and the government does not act vigorously with regard to children living in a situation of physical danger.

Although organisational changes may also be necessary, the Dutch Safety Board thinks that the government must fulfil its responsibility regarding child safety and institutions and should equip professionals as well as possible, irrespective of how the system is organised. This is literally a matter of life and death for children at risk.

The Dutch Safety Board has the following recommendations.

Recommendation 1
To the minister of Public Health, Welfare and Sports and the minister of Security and Justice, in coordination with the Interprovincial Consultations (IPO), Association of Netherlands Municipalities (VNG), Netherlands Youth Care, Royal Netherlands Medical Society (KNMG), the Dutch Municipal Health Services (GGD) and the Dutch Mental Health Care (GGZ):

Ensure that the institution(s) and professionals, who must act on behalf of the government after a report of a suspicion of physical danger, are able to carry out a full risk inventory and evaluation of the situation and take control when taking measures. For this it is necessary that professionals:
(1A) do not adopt a dependent attitude towards the cooperation of parents when carrying out this task;
(1B) have all relevant information about other professionals involved with the family.

Explanation:
The instruments that professionals have to take over the responsibility of the parents, whether or not on a temporary basis (provisional supervision order, temporary removal of parental responsibility) must be applied, if this is required to carry out an adequate risk inventory and evaluation. Government institutions that have to investigate reports and carry out protective measures will benefit from an increase in effective opportunities to take control. The aim is to improve the exchange of information between institutions and professionals. The Dutch Safety Board thinks that it is advisable that ministers who are responsible for this should debate this with the administrative authorities, institutions and most professional groups who are involved in (mental) health care.

Recommendation 2A
To the minister of Public Health, Welfare and Sports and the Minister of Security and Justice, Interprovincial Consultations (IPO) and Netherlands Youth Care:

Promote a further professionalisation of the child safety system, so that it is equipped to carry out an adequate risk inventory and evaluation and, if necessary, act in order to guarantee the physical safety of children.

Explanation:
If the government really wants to take control of the risk inventory and evaluation as described in the first recommendation, the professional in the child safety system must be equipped more adequately. In this report a number of elements are mentioned in this respect: physical safety must

be made more operational; a policy with regard to (information about) recidivism is necessary; forensic-medical knowledge should be applied and be available more frequently and the internal supervision with the risk inventory must be improved.

Recommendation 2B
To the Interprovincial Consultations (IPO), Netherlands Youth Care, the minister of Security and Justice and the minister of Public Health, Welfare and Sports:

Learn from cases and incidents. Use this learning process to explain more clearly in which cases there is a threat of physical danger for a child and which research activities and safety measures are suitable in this respect.

Explanation:
The Dutch Safety Board thinks that the child safety system will benefit by learning more and by learning systematically from cases and incidents. Professionals must be able to share *good practices* and in this way they can also jointly decide whether safe or unsafe situations and adequate or inadequate measures are involved. This will help to create a common reference frame of reference of standards for physical safety.

The Dutch Safety Board does not regard disciplinary rules, which will be introduced in youth care, as a suitable means to increase professionalism in the current circumstances. The Dutch Safety Board thinks that professionals in youth care are vulnerable because there are no clear rules and directives. Supervision and internal inspection must play a more important role when increasing professionalism within youth care.

Recommendation 3
The following recommendation is addressed to the Interprovincial Consultations (IPO), Netherlands Youth Care, the Minister of Security and Justice, the Minister of Public Health, Welfare and Sports, in coordination with the Association of Netherlands Municipalities (VNG), Netherlands Youth Care, Royal Netherlands Medical Society (KNMG), the Dutch Municipal Health Services (GGD) and the Dutch Mental Health Care (GGZ):

Stimulate an increase in reports of (suspicions of) physical danger for young children and offer a reference framework for these reports.

Explanation:
Government institutions that receive reports of suspicions of physical danger, in particular the Youth Care Office / Advice and Reporting Centres on Child Abuse and Neglect (ARCANs) and the Child Care and Protection Board, must offer a clearer reference framework/framework of standards to professional reporters for reporting physical danger. In this respect there should be a discussion with professional groups in the (mental) health care, with the aim to formulate a policy about cases of physical danger, in which postponing a report is unwanted.

The consequence may be that the number of reports of physical danger may increase as a result. If the government takes its responsibility seriously with regard to children at risk, it will accept this consequence

Administrative authorities to whom recommendations are made must make their viewpoint known to the minister concerned with regard to following up this recommendation within half a year after the publication of this report. Non-administrative authorities or persons to whom a recommendation is made must make their viewpoint known to the minister concerned with regard to following up this recommendation within one year after the publication of this report. A copy of this response must be sent simultaneously to the chairman of the Dutch Safety Board as well as to the Minister of the Interior and Kingdom Relations.

APPENDIX A. JUSTIFICATION FOR INVESTIGATION

A.1 Immediate cause

The immediate cause for this investigation is described in chapter 1.

A.2 Problem definition

The problem definition of this investigation is described in chapter 1.

A.3 Investigation approach and stages

Approach to the investigation

For this investigation 27 instances of child abuse with fatal or near-fatal outcomes were studied. These were primarily selected on the basis of the degree to which they gave rise to social concern. Additionally the objective was to achieve a certain degree of distribution in terms of the types of events that were studied. The selection of events is discussed further in appendix B (Scope and characterisation of child abuse and events with (near) fatal outcome).

For the investigation we used dossiers from the Netherlands Forensic Institute (NFI), supplemented with the dossiers of Forum Educatief. Forum Educatief is a centre for forensic medicine and behavioural science. This knowledge centre is part of the Van der Hoeven foundation and offers forensic medicine expertise on suspicion of (child) abuse, including on behalf of the courts. Additionally data are used from the Youth Care Inspectorate, a few other inspectorates and legal decisions. The dossiers served as a basis for the investigation and were not verified per case. This detailed information is included in a fully anonymised manner in the case description in Appendix C. The dossier investigation was supplemented with literature study and interviews with experts and parties concerned. With the exception of a few exceptions, the Dutch Safety Board did not speak with professionals that were involved in the individual cases.

Project stages and implementation

The complete investigation consisted of 3 project stages:

1. An orientation of the system of child protection from the moment that a suspicion of abuse or neglect could be known. In this sub-investigation the system for the protection of the child is delineated based on legislation and regulations and policy and scientific documentation concerning the Dutch system of the protection of a child and the development of that child. The sub-investigation paid attention to the identification chain: when and how it becomes known that the safety of the child is threatened and that protection may be required. Both the informal and the professional observers of child abuse were involved, such as neighbours, family members, obstetricians, family practitioners and educational institutions, and the places they can apply to. The system for the protection of the child was also studied for when a suspicion of abuse has been reported. The four partners in the protection system, specifically ARCANs, the Youth Care Office, the Child Care and Protection Board, police and the legal system are discussed. In the investigation attention was paid to earlier investigations into the protective system of the child.
2. A dossier study into the course of events in instances of child abuse with a fatal or near-fatal outcome, based on available dossier information. Per case the following are noted: the institutions involved, the information c.q. signs that they saw concerning the family, the action that was undertaken and the effects of these actions and, as far as known, the considerations that were applied. For each event a time line was prepared in which the various events per person concerned were specified. The time line gave an overview of the consecutive events commencing at the abuse with (near) fatal outcome and the ways in which these were followed up on. Striking incidents were noted per case and discussed and combined with other cases. Tentatively the structural safety deficits in the system for the protection of the child were noted.

3. A further investigation into the structural safety deficits.[216] For this legislation and regulations, guidelines and policy developments were analysed and supplemented with literature studies and interviews with persons concerned from the sector.[217] Additionally, for comparison the English method was presented briefly. Because there are many initiatives for improving the system, we also studied what structural deficits and their underlying causes receive attention in the policy developments. The findings of the analysis of structural deficits and underlying causes were presented at a meeting to experts from the various sectors concerned. The provisional results were discussed with representatives of the organisations most involved.

Sub-investigation 1 was carried out largely by Bureau Beke on behalf of the Dutch Safety Board. Sub-investigation 2 was carried out by employees of the Dutch Safety Board together with the Youth Care Inspectorate, Bureau Beke and a few other external experts. Sub-investigation 3 was carried out by employees of the Dutch Safety Board together with external experts.

Manner of dealing with Information
By way of source specifications in the report, the collected relevant documentation was evaluated insofar as it concerns public information. Where confidential information was concerned only a general reference to the organisation whose information was studied is made.

A.4 Investigation demarcation

The demarcation of the investigation is stated in chapter 1.

A.5 Cooperation

In the Netherlands there are two organisations that carry out investigations into cases of child abuse with fatal or near-fatal outcome: Forum Educatief[218] and the Netherlands Forensic Institute (NFI).[219] Additionally, inspectorates independent of institutions carry out investigation in response to events. It is not the task of the Dutch Safety Board to assess studies from the institution itself and other institutions or carry these out again. The investigations of NFI and Forum Educatief contain much useful information. Additionally inspections (Health Care Inspectorate, Youth Care Inspectorate) had carried out research into a number of serious incidents. In a limited number of fatal cases there was collaboration between several inspectorates (Health Care Inspectorate, Youth Care Inspectorate, Inspectorate for Sanction Application and Public Order and Safety Inspectorate).

For this reason the Dutch Safety Board made contact in an early stage of the investigation with these investigative institutions on behalf of the investigation of the events in the cases studied by the Dutch Safety Board.
When the dossiers studied by Forum Educatief, NFI or the Youth Care Inspectorate indicated this, contact was sought with other involved institutions such as the Youth Care Offices, the Child Care and Protection Board, the Health Care Inspectorate, and the Inspectorate for Public Order and Safety.

216 A structural safety deficit is a deficit that: a) occurs in many cases; b) can be viewed as a deficit that may have a negative effect on safety in the future; c) is more typical of an organisation or system than for an individual or the methods in a certain place or time.

217 A point of the protection of children is that all areas of life with which children are involved are important and that, therefore, many sectors, from the police to health care and from education to welfare, have their own responsibility.

218 Forum Educatief wsa asked in the context of penal processes against suspected perpetrators of child abuse to prepare expert reports in which not only the direct cause of the injury (violence from outside or another medical - somatic study) was considered, but also the background (the circumstances in which and the manner in which the injury occurred). Forum Educatief is part of the Van der Hoeven Foundation in Utrecht.

219 The NFI carries out forensic studies when there is an investigation concerning children in criminal cases and when an unnatural death has occurred or there are indications of an unnatural death. The NFI is part of the Ministry of Justice.

A.6 Project organisation

An investigation of the Dutch Safety Board was carried out in a team context by a core team of investigators of the Dutch Safety Board supplemented by external experts. The external investigation orders were carried out in a context of confidentiality. The Dutch Safety Board remained the owner at all times of the collected knowledge and reported findings.

Project team from April 2008

From April 2008 the below investigation team carried out a study of the structural deficits. Additionally they involved a few new dossiers in the study.

Name	Function
Th.M.H. van der Velden	Project leader
S.H. Akbar	Investigator
R. Gaasterland	Investigator (external)
A.J. van der Kolk	Investigator
A.J. van Montfoort	Investigator (external)
A.P. Nelis	Investigative manager
S. van Rossenberg	Investigator
N. Smit	Adviser Investigation and Development
T. Veldman	Project support
R.T. van Vianen	Investigator (external)
W. Walta	Investigator
E.J. Willeboordse	Adviser Investigation and Development
J. Zwaan, A. Drooger-Kuiper	Project support

Project team to April 2008

In the orientation stage and during the dossier investigation until April 2008, the following employees of the Dutch Safety Board for Safety and external investigators made a contribution.

Name	Function
L.J. van Wagtendonk-Vink	Project Leader
M. Baart	Investigator
T. van den Berg	Investigator
E.M. de Croon	Investigative Manager Investigation and Development
T. van Hoorn	Investigator
B de Jong	Project support
S. Pijnse van der Aa-van Gelder	Investigator
S. van Rossenberg	Investigator
Th.M.H. van der Velden	Investigative Manager
W. Walta	Investigator
L. de Wilde	Investigator

External Investigators Bureau Beke

Name	Function
I.M.G.G. van Leiden	External Project Leader
N. Arts	Investigator
A. Cornelissens	Investigator
J.P. Jakobs	Investigator

The following experts were consulted:

Name	Function
S. van Arum	Orthopedagogue/psychotherapist, head of treatment affairs youth De Waag Nederland, Centre for Forensic Psychiatry - adult and youth
H.E.M. Baartman	Emeritus professor Prevention and Care concerning child abuse
R. Bilo	Forensic physician, Netherlands Forensic Institute
M.H.V.C. Christophe	National Programme Agency Domestic Violence, the role of the police
J. Hermanns	Professor emeritus, University of Maastricht
M.J.J.M. Malmberg	Manager Ordina consulting
E. Munro	Professor at the Department of Social Policy, London School of Economics and Political Science
E. Sulkers	Child Abuse Counsellor ARCAN, Youth Care Office Zeeland and paediatrician Hospital in Walcheren
J.C.M. Willems	Professor emeritus Rights of the Child, Maastricht University

The investigation was monitored by a guidance committee. The members of this committee were:

Name	Function
J.A. Hulsenbek	Chairman from 1 Dec 2008; board member.
F.J.H. Mertens	Chairman to 1 Dec 2008; board member and former portfolio holder health care.
J.P. Visser	Board member and portfolio holder health care.
M.R. Bruning	Professor emeritus Youth Rights Law Faculty of the Rijksuniversiteit Leiden, judge and deputy.
O.M.H. Knoet-Vrehen	Chief of DOEN agency, Police Haaglanden.
F. Lamers-Winkelman	Professor emeritus Child Abuse.
A.J. van Montfoort	Speaker youth care and youth policy Hogeschool Leiden, judge-deputy Member until 1 Apr. 2008, thereafter Investigator/Investigative Manager.
H.G.T. Nijs	Forensic physician, Netherlands Forensic Institute.

A.7 Interviews

In the course of the investigation interviews were held with representatives of involved organisations in the realm of youth care and juvenile law:

Physicians youth health care Netherlands
Forum Educatief
GGD Netherlands
Youth Care Inspectorate
Health Care Inspectorate
Interprovincial Council
National Client Forum Youth Care
Youth Care Netherlands
Netherlands Forensic Institute
Netherlands Youth Institute
Programme ministry Youth and Family
Child Care and Protection Board
Legal Council
Council for Criminal Enforcement and Child Protection
Association of Dutch Municipalities

APPENDIX B. EXTENT AND CHARACTERISATION OF THE CHILD SAFETY ISSUE AND THE INVESTIGATED (NEAR) FATAL CASES

It is difficult to indicate an accurate estimate of the extent of the issue. Child abuse does not always lead to death or, in less serious cases, a visit to the GP. Often, people from the child's environment suspect abuse. Child abuse as a theme has a broader nature. It concerns:[220]

- Physical abuse;
- Sexual abuse;
- Psychological abuse;
- Neglect.

A suspicion of (physical) child abuse is viewed as a delicate problem. It takes courage to report a suspicion. At the same time, voiced suspicions are often hard to investigate and prove; the delicacy of the matter also plays a part in this. When a child has died from suspected child abuse, it does not always appear to be possible to prove the abuse in retrospect.

The number of children who die from child abuse each year can be seen as the tip of the iceberg, meaning that the visible part (the fatal accidents) is very small in relation to the underside (the non-visible abuse).

This appendix further explains the extent of the issue and the relationship between the number of children who have died from abuse and the total number of abused children. Different categories of abuse are described. Finally, the number of investigated (near) fatal cases and the selection made in this investigation are clarified. The appendix is concluded with a characterisation of the investigated cases.

B.1 Fatal child abuse and the total extent

The total number of children aged 0 to 18 in the Netherlands is approximately 3.8 million. Approximately 2.5 million children of this number are aged 0 to 12. About 185,000 children were born in the Netherlands in 2008.[221]

Determining the total extent of the issue is largely based on estimates. Research, but also investigated casuistry, indicates that there a number of problems in determining the number of children who have died from abuse:[222]

- The child's body is discovered accidentally, for instance in a refuse container, in water or in a park. These incidents usually involve young children who were only a few hours or a few days old. In those cases, it usually is impossible to determine if it was a case of a stillborn child, a death by natural causes in the first hours of life or abuse.
- Violence or neglect is not the first cause of death, but the child primarily dies from pneumonia sustained in the weakened state.[223]
- Wrong medical diagnosis, for instance wrongly diagnosed cot death. Cot death is a diagnosis which is not determined based on a number of clearly present symptoms, but rather on the lack of symptoms. Therefore, actual cases of child murder are sometimes mistaken for cot deaths. Research of the Netherlands Forensics Institute into children's deaths by unnatural causes shows that it is not always certain if a child has died from cot death or Shaken Baby Syndrome. In addition, the individual cases show that determining injuries resulting from child abuse is not easy, medically speaking, especially when there are no other signals or suspicions.[224]

220 The division into categories differs per study.
221 CBS, Statline.
222 See also Verheugt, 2007.
223 See Soerdjbalie-Maikoe et al 2010 in which the authors name the problem of 'delayed death' as a result of prior child abuse.
224 See Soerdjbalie-Maikoe et al 2010, in which the authors establish after forensic autopsies of 2 children on average per year that they are 'highly likely' cases of child abuse.

- Legal evidence is hard to produce. The researchers of the Netherlands Forensics Institute and/or Educational Forum cannot completely rule out other causes: parents put forward alternative explanations for the deaths (such as a recent vaccination), parents deny involvement and/or their part in it remains unclear. Sometimes, they are acquitted of the principal charges against them - the death of the child - but they are convicted for abuse.
- Resistance in care workers to use the term child murder: despite suspicions of death by unnatural causes, a declaration of death by natural causes is issued. In the investigation by the Dutch Safety Board, two cases were found in which a declaration of death by natural causes had been issued, while there were suspicions of child abuse and a forensic pathologist in the second instance found that the children had died as a result of abuse.[225]

Despite these bottlenecks, a clear picture can be painted of the total extent of the issue based on several studies. The study by the Dutch Safety Board is aimed at children aged 0 to 12. Most studies are related to the age category 0 to 18. The studies mentioned below state the key indicators for the age category 0 to 18 and these have been translated into the age category 0 to 12, where possible. The following four studies are relevant:

1. The Leiden Attachment Research Program (LARP)[226] conducted a study into the prevention of child abuse among professionals who can pick up signals about child safety. LARP found that an estimated 107,200 children aged 0 to 18 are abused. In this study, 73.4% of the children are aged 0 to 12. This means that an estimated 78,685 children aged 0 to 12 are victims of some form of child abuse. Nearly 13% (about 14,192) of all abuse cases concerning children aged 0 to 18 involves physical abuse with demonstrable injury.[227] This indicates an estimated 10,417 children aged 0 to 12 with demonstrable injuries (with a percentage of 73.4 of children aged 0 to 12).[228]

2. The number of children who sustain severe - but not fatal - injuries as a result of child abuse is unknown. What is known is the number of children reported to the ARCAN where physical child abuse plays a part. In 2009, a total of 16,574 suspicions of child abuse were reported to the ARCAN for children aged 0 to 18. 9.51 per cent of the reports were registered as suspicions of physical child abuse.[229] In other words, 1,576 children were reported as possible victims of physical child abuse aged 0 to 18. The Netherlands Youth Care does not have differentiated numbers per category of abuse and per age. This means that the key indicators which are available have to be used for an estimation of the number of children who have been physically abused from the age category of 0 to 12. It can be deduced from the data of the Netherlands Youth Care that 79 per cent of all reports concern children aged 0 to 12.[230] With the aid of this percentage, which applies to all reports and not to the category of reports of physical injuries, it can be calculated that approximately 1,245 children aged 0 to 12 were reported due to physical abuse. Van IJzendoorn (2007) points out that especially young children are relatively often victims of physical abuse with demonstrable injuries. This indicated that the group of children under 12 who were reported due to physical child abuse is, in fact, larger than the abovementioned estimated 1,245 children based on the calculation.

225 See also study of Kuyvenhoven et al, 1996 in which doctors state to have issued a declaration of death by natural causes six times, while there were suspicions of child abuse.
226 Van IJzendoorn et al, 2007.
227 The LARP study also has a category of children with presumed injuries (physical injuries). This has been included in the calculation of the total number of abused children. The percentage of children who sustain both demonstrable and presumable injuries is 19 per cent. In calculating the key indicators for children aged 0 to 12, only the category of demonstrable injuries has been taken into account. Table B1 in the appendix (IJzendoorn et al, 2007) shows an estimated 14,192 children with demonstrable injuries for physical abuse of children aged 0 to 17.
228 The research population somewhat deviates from the division of the total population of young people under 18 in terms of age categories. Van IJzendoorn et al (2007) mentions that ´especially young children are overrepresented in the group of abused children and they are relatively often victims of physical neglect with demonstrable and presumed injuries (see Table 7.9, p. 111).'
229 Netherlands Youth Care, ARCAN, overview of 2009.
230 Meeting with Netherlands Youth Care about the annual figures for 2009.

It is unknown in which cases the suspicion was confirmed and/or if the Child Care and Protection Board was called in. In 2007, 11,533 applications were submitted to the juvenile court judge or, for 1 out of 330 children a child protection order was issued. However, this applies to all categories of child abuse or severely threatened development.

3. What is known about the number of children who die as a result of child abuse in the Netherlands? Three studies shed light on the extent:
   a. In 1996, the first Dutch investigation into the deaths from suspected child abuse was conducted.[231] This investigation arrived at an estimated 40 deaths of children aged 0 to 18 due to suspected abuse. This estimation was based on 32 reported deaths and an increase due to non-response. The reported data showed that 28 of the 32 deaths were children under 12 (78.5 per cent). For the age group of 0 to 12, this translated into (78.5 per cent of 40) 35 deaths of children aged 0 to 12. Besides an insight into the extent, this study also provided information about:
      - More than half (24 of 35 cases) involved children aged 0 to 2.
      - In one-fifth (7) of the cases, a declaration of death by natural causes had been issued.
   b. In 2010, a study was published into the extent and characteristics of domestic murder and manslaughter.[232] This study identified and listed the number of deaths due to domestic violence in 2006. This study demonstrates that 12 children aged 0 to 12 were victims of domestic violence.[233] Nearly all victims were younger than six years old and half of them were under the age of one.
   c. Doctors of the Netherlands Forensics Institute have recently published a study into unnatural deaths due to child abuse. This study was based on forensic autopsies over a period of 14 years (1996-2009). They reported an annual average of 15 'certain' and 2 'highly likely' cases of fatal child abuse.[234] This concerns a total of 239 children aged from 24 weeks pregnancy to 18 years, in whose cases it was decided, after forensic autopsies, that they had died as a result of fatal child abuse.[235] 6 children aged 12 to 18 died as a result of fatal child abuse.[236] Most children (64%) die from child abuse before the age of 2.[237]

The studies by Kuyvenhoven et al (1996) and Soerdjbalie-Maikoe (2010) indicate that in the estimations of the number of children who die as a result of child abuse, there is a possibly high *'dark figure'*. There is reason to assume that GPs and the police have stated natural deaths in case of doubts, while the actual cause was, in fact, child abuse.[238]

- In the study by Kuyvenhoven et al (1996), it is estimated that doctors issued 7 declarations of death by natural causes, while they suspected possible child abuse.
- On average, 1600 children aged 0 to 18 die annually; in 200 cases, there were inconclusive explanations for the deaths, which means that there is a risk of erroneous assumption of death by natural causes.[239]
- In 49 cases on average, the Netherlands Forensics Institute performs a forensic autopsy into the deaths by unnatural causes of children aged 0 to 18.[240] 35 per cent of the investigated deaths per year on average were unnatural and non-accidental due to child

231 Kuyvenhoven, Hekkink & Voorn, 1998.
232 Nieuwenhuis, A. & Ferwerda, H. 2010.
233 Nieuwenhuis, A. & Ferwerda, H. 2010; See Figure 4 on page 24. This concerns a total of 24% of the 49 victims.
234 Soerdjbalie-Maikoe, V., R.A.C. Bilo, E. van den Akker, A. Maes. 2010. It concerns a total of 233 children from 24 weeks pregnancy up to and including 11 years of age over a period of 14 years, in which the cause of death is 'non-accidental child abuse'. This is a (rounded off) average of almost 17 children per year.
235 Soerdjbalie-Maikoe et al 2010, Table 3, p. 3.
236 This leaves 233 children (239 - 6) between 24 weeks pregnancy and the age of 12 who died as a result of child abuse. When translated into an annual average, this does not influence the rounded off number of a total of 17 deaths per year as a result of fatal child abuse, as presented in the study.
237 Soerdjbalie-Maikoe et al 2010. Table 3, p. 3. A total of 150 of 233 children are under the age of two.
238 'A Forensic Pathologist for Each Deceased Child' ('Schouwarts voor elk overleden kind') of 20 March 2006 (ANP); Kruyer, 2006, p. 28-30. See also Soerdjbalie-Maikoe et al 2010.
239 Novum, 2006.
240 Soerdjbalie-Maikoe et al 2010

abuse.[241] Soerdjbalie-Maikoe (2010) point out the lack of knowledge and experience among GPs and paediatricians, as a result of which aspects of child abuse are not recognised and erroneously attributed to death by natural causes.

4. Based on English and American studies, it appears that child murder occurs nearly three to seven times more often than becomes apparent from official statistics. For the Netherlands, the official statistics of 10 to 15 cases per year can be adjusted to 30 to 70 children aged 0 to 18 who die as a result of domestic abuse per year.[242] Taking 70 children per year as a starting point, this translates into 1 in 55,000 children aged 0 to 18. These studies do not distinguish into the research group of the present study: children aged 0 to 12.

Taking these data as a starting point, the extent of the issue and the relationship between the children who die as a result of child abuse and the children who are abused to a greater or lesser extent can be displayed with the aid of an accident pyramid.

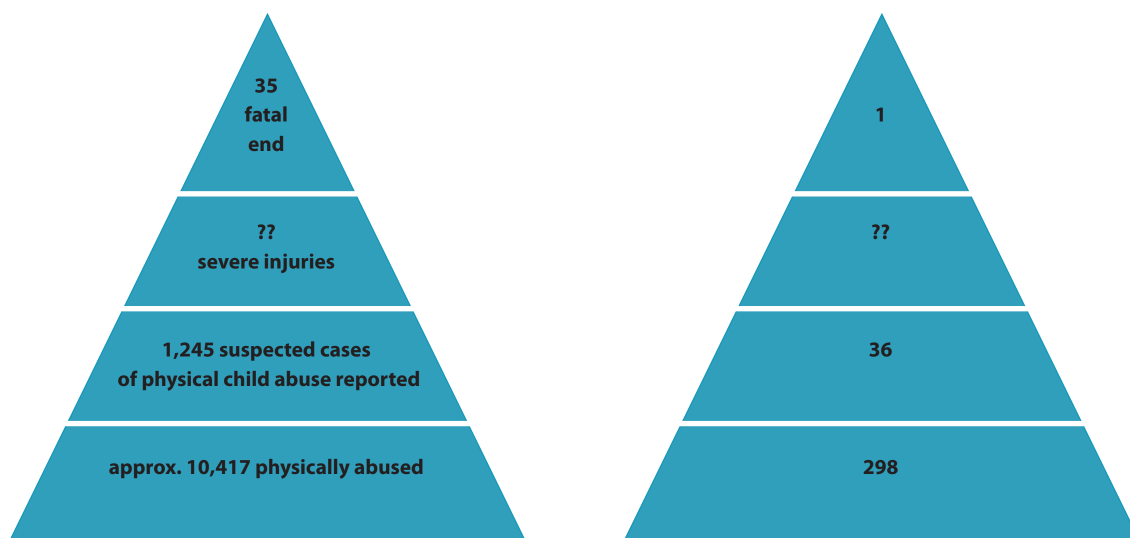


Figure B1: The number of cases of fatal child abuse related to abuse resulting in serious injury, and the total number of cases of physical child abuse for children aged 0 to 12.

B.2 Further characterisation of the issue

Fatal child abuse can be roughly divided into three categories based on the age of the victims:

1. *Neonaticide*: The child is killed within 24 hours after it is born. New-borns are killed by asphyxiation or violence. These babies are generally born without the knowledge of care workers, so nobody formally knows about their existence. This category has been included in the determination of the extent, but not in the study.
2. *Infanticide*: The child is more than one day old but under the age of 1. These children mostly die as a result of shaking and ensuing brain damage (Shaken Baby Syndrome).
3. *Filicide*: The child is more than 1 year old. In this category, children mostly die as a result of asphyxiation or external violence (including stab injuries) or burns. This study has only included children aged 1 to 12.

Taking the family situation as a starting point, the Dutch Safety Board has discerned another two categories for the purpose of the study:

4. *Recidivism*: Families about which abuse of other children has been reported and child protection orders have been taken before the fatal abuse took place. This group occupies a special place, because in these cases, the risk of possible abuse has been identified before

241 Soerdjbalie-Maikoe et al 2010. In the research period of 14 years, this applies to 239 cases of the 688 forensic autopsies on minors.

242 Van Erpecum, 2002.

and sometimes has been recognised before. The question is how the system, aimed at child protection, deals with this information.

5. The so-called *family killings*: The children who die in family tragedies usually fall within the category of filicide, even though, sometimes, family tragedies (also) involve younger children. One feature of family killings is that one of the partners not only kills or tries to kill the children but also himself/herself (and the partner). The killings also notably involve the act of one parent against several family members at the same time. The protection of each individual child, however, does not differ from the protection of one child. No special attention has been paid to this group in this study.

B.3 Inventory of 81 (nearly) deceased children

In order to have a clear view of the Dutch situation, an inventory was made of the number of children who (nearly) died in the period 2004 - 2007 as a result of abuse by (one of) the parents and/or direct carers. These cases were:

- recent enough to make enquiries about facts from the files;
- the factual investigation had been completed by third parties (medical, legal), so all necessary file information was available.

The inventory involved children aged 0 to 12. A total of 81 files were investigated of children who had not died by natural causes or who had sustained life-threatening injuries, presumably due to domestic violence.

The results of the inventory are displayed in table B2. Regarding the near fatal cases of child abuse, it has to be noted that there is no institution in the Netherlands, which conducts an investigation into (near) fatal cases of child abuse - such as the Netherlands Forensics Institute for deaths of children by unnatural causes. The public prosecutor applied for an investigation by the Educational Forum in the cases displayed in the table below. The table gives an overview of the number of children in the Netherlands who have survived but are severely disabled. However, a number of cases from this category has been included in the study.

	2004	2005	2006	2007	Total
Fatal child abuse	13	17	16	19	65
(Near) fatal child abuse	3	4	2	7	16
Total	16	21	18	26	81

Table B2: Overall view of the extent of (near) fatal child abuse.

65 files of deceased children

A total of 65 files have been found, which record fatal child abuse. 19 children of 65 children died within one day after birth; the so-called neonaticides. Fifteen children died within one year after birth (infanticides). 31 children died between their first and twelfth years of life (filicides).

Twenty children of 65 children died in so-called family tragedies. In these cases, children were killed at the same time at one specific point of time by a parent. The files do not show that there were prior concerns about the children's safety. This does not mean that they were not there. Research has shown[243] that signals of potential danger are not picked up in many cases.

	2004	2005	2006	2007	Total
Neonaticide (< 1 day)	5	4	3	7	19
Infanticide (> 1 day < 1 year)	2	4	5	4	15
Filicide (> 1 year)	6	9	8	8	31
Total	13	17	16	19	65

Table B3: Overview of child abuse.

243 Verheugt, 2007.

The number of children aged 0 to 12 who die by unnatural causes and demonstrably die as a result as physical child abuse traceable at the Netherlands Forensics Institute comes down to 65 in four years, i.e. 16 children per year on average. The estimated number of child deaths in the Netherlands is 35 children aged 0 to 12 per year.[244] The factors which cause this have been mentioned earlier in this appendix.

16 files of nearly deceased children
One category within this study involves children who were victims of near fatal abuse. This definition refers to inflicting injuries resulting in hospitalisation (for instance, severe burns, internal injuries) and to permanent physical injury or mutilation or deformity. The sources[245] consulted by the Dutch Safety Board reveal the following numbers from the research period:

	2004	2005	2006	2007	Total
(Near) fatal child abuse	3	4	2	7	16

Table B4: Overview of child abuse.

In the research period, the files of 16 children were found, which recorded severe brain damage or physical injuries and the survival of the child.

B.4 Selection of the 27 cases of (near) fatal abuse

For the purpose of this study, the files of 81 children were studied. Not all 81 files have been described as cases, namely:

- The group of neonaticides, 19 children, is not described. The reason for this is that not enough information was available for this group about possible signals. Furthermore, in many of these files the parent was not known.
- Of the 20 children who died in a family tragedy,[246] only two fatal cases (4 children) have been included in our fatal cases. This is because youth care institutions were involved in these fatal cases at any point for investigational or care purposes. Signals of possible danger to the children from these families were known. In all other cases, it was unclear based on the file if signals about danger to the children had previously been picked up. Therefore, 16 children of the family tragedies have not been described in the study.

Of the 81 cases, 46 children remain[247] from a period of four years (2004-2007), about who signals of physical danger were known. Of these 46 children, the Dutch Safety Board chose to include 29 children in the study. This concerns 27 cases. As has been mentioned before, two children from one family died at the same time in two cases. This selection cannot be viewed as being representative. Cases have been selected when:

- The available information could offer insights into the effect of the system, i.e. cases in which a lot of information was available about the involvement of institutions;
- A criminal or civil court ruling was available, so that the judgment of the forensic expert about the cause of the injury (child abuse) had been confirmed.

In other words, 17 children were excluded from this study. A further explanation of this exclusion is as follows:

- In 2004, two children were not included because it remained unclear if healthcare or youth care professionals had picked up signals about these children. Criminal proceedings, however, were instituted as a result of the deaths of these two children.

244 Kuyvenhoven, Hekkink & Voorn, 1998.
245 Netherlands Forensics Institute, Educational Forum.
246 In 2004: 3 children (1 family); 2005: 8 children (4 families); 2006: 4 children (2 families); 2007: 5 children (3 families).
247 81 children minus 19 neonaticides and minus 16 children of family tragedies = 46 children.

- In 2005, one child was not included in this study. Both the Youth Care Office and a Mental Health Care institution were involved in these cases. At the time of the data collection, it was still unclear if criminal proceedings due to the child abuse had been instituted.
- In 2006, two children were excluded. They were both near fatal child abuse cases. In one case, it was unknown if healthcare or youth care professionals had picked up signals. In a second case, parents denied involvement and no criminal proceedings were instituted at that point.[248]
- For the year 2007, a few fatal cases have been described to see if studying those files would yield additional insights. There is no description for a total of 12 children in 2007. The reason is that, here too, at the time of data collection, it was unclear if criminal proceedings had been instituted.

B.5 Characterisation of the 29 children in the 27 fatal cases

Of all 29 children in the 27 fatal cases,[249] information is available about their age at the time of the incidents, the injury which caused their deaths and in which process stage they died.

These are the features of the selected cases in our study. The characteristics of the children only serve a descriptive value: representativeness was not intended.

248 The Netherlands Forensics Institute determined in this case that the child had suffered near fatal abuse and that it was a case of child abuse.
249 Two children from one family died at the same time in two cases.

Age

Most children in the study are under the age of 1. It concerns more than half of all children (15 of 29).

The distribution of the children's age in the two groups

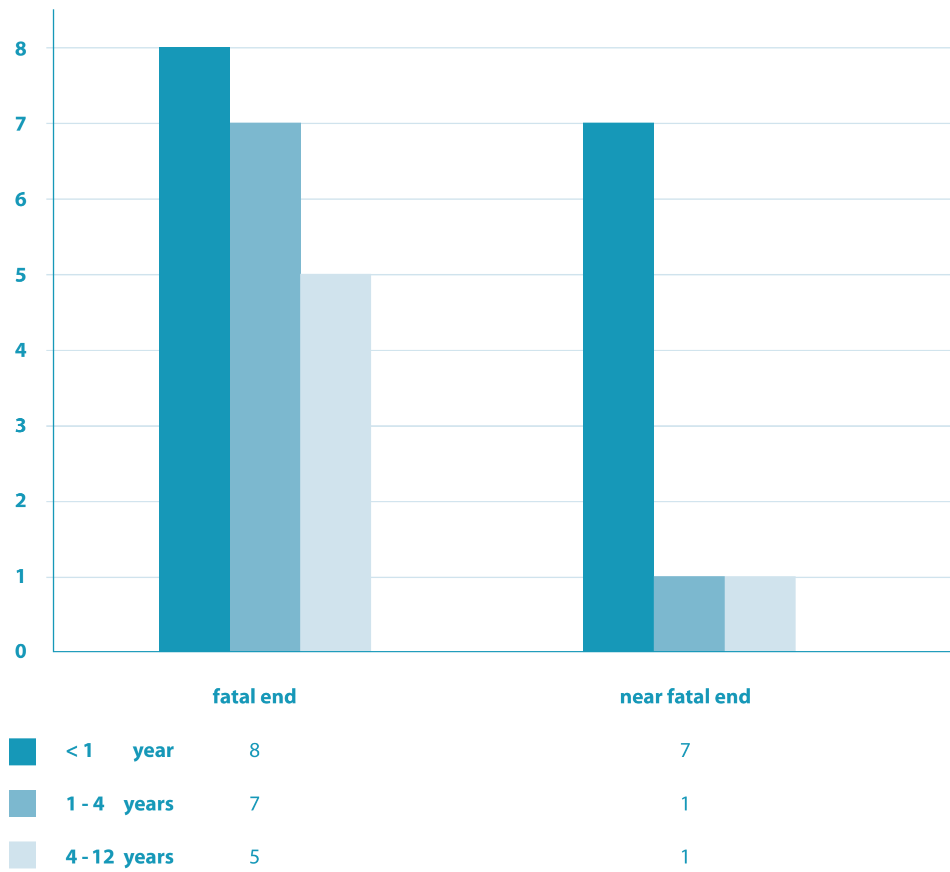


Figure B5: Age of the children

Sex
Of the 29 children who suffered (near) fatal abuse, 16 were boys and 13 were girls.

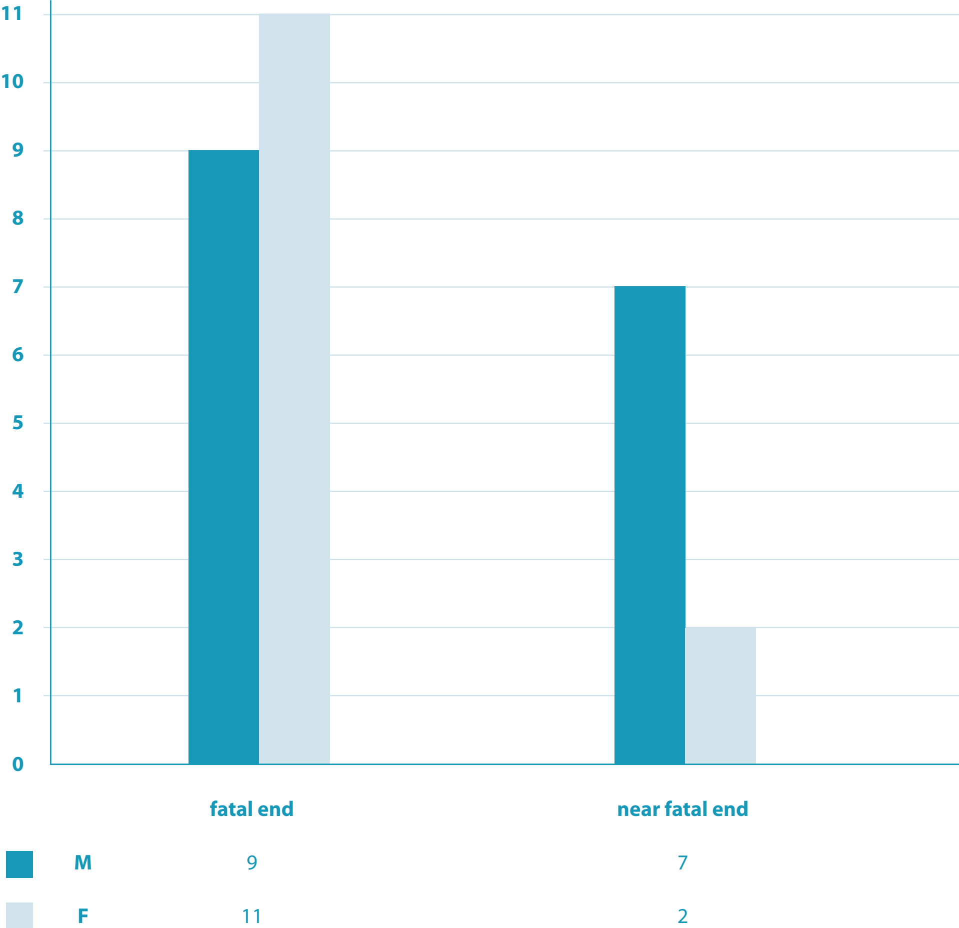
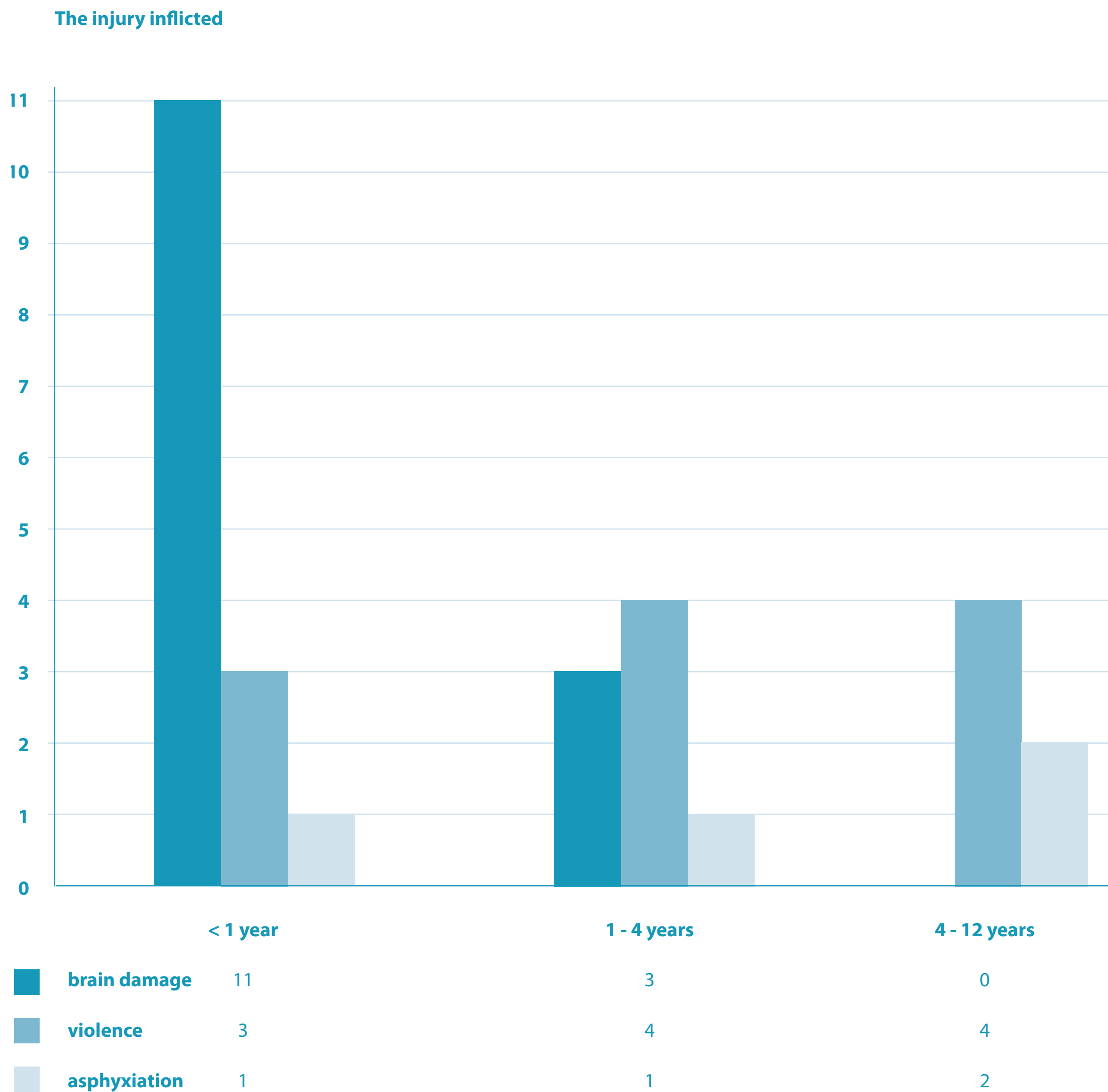


Figure B6: The children's sex

Injury
It is known which injury caused the deaths of these children and what the nature of the near fatal abuse was.



	< 1 year	1 - 4 years	4 - 12 years
brain damage	11	3	0
violence	3	4	4
asphyxiation	1	1	2

Figure B7: The injury inflicted.

A total of 14 of the 29 children sustained severe brain damage, almost always caused by shaking of the infant (Abusive Head Trauma). This also becomes apparent from figure B8, which combines the injuries with the age of the children.

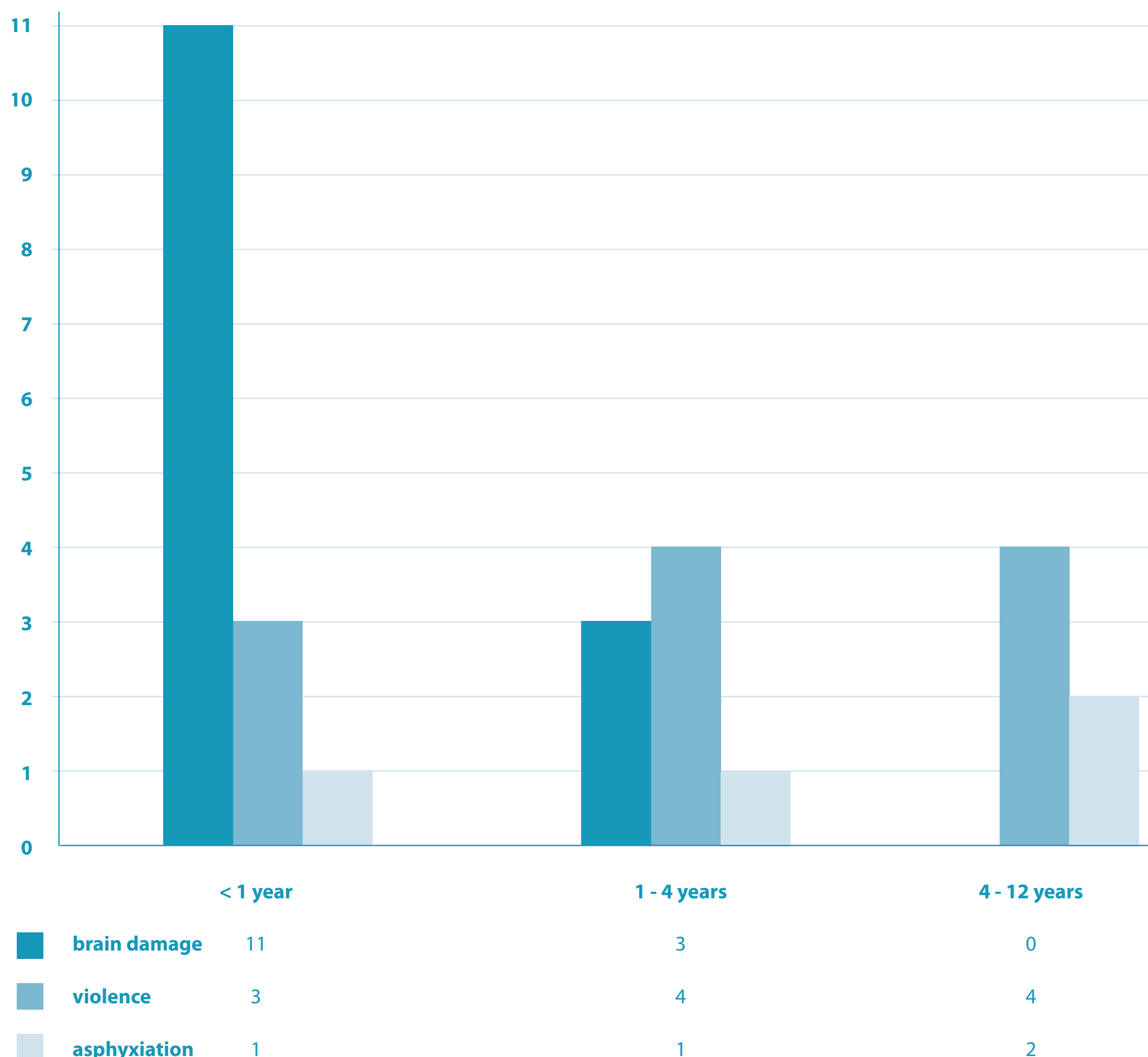


Figure B8: Inflicted injury combined with age

The (near) deaths of children due to violence (knife wounds, repetitive mechanical violence) is especially prevalent in the group of children aged 4 to 12.

The table displayed below lists the way in which the children involved in the studied cases were distributed over the three process stages as well as the age groups.
The Dutch Safety Board has distributed the cases according to the three process stages, in which the children sustained (near) fatal abuse:

- Preliminary stage: Identification and reporting
- Process stage 1: Investigation of a report and making a decision
- Process stage 2: Care and protection

Process stage	Age group	< 1	1 - 4	4 - 12	Total
	Preliminary stage: Identification and reporting	10	0	1	11
	Process stage 1: Investigation of a report and making a decision	3	4	2	9
	Process stage 2: Care and protection	2	4	3	9
	Total	**15**	**8**	**6**	**29**

Table B9: Number of abused children per age group and process stage.

APPENDIX C. DESCRIPTION OF (NEAR) FATAL CASES

The Dutch Safety Board has investigated 27 cases of (near) fatal abuse, which involved 29 children. Two children from one family died at the same time in two cases. As stated above, this selection cannot be considered representative.

The nature of the injury and the living conditions of the child have been recorded per investigated case. Additionally, a timeline of the events, which preceded the injury that (nearly) killed the child has been drawn up: identifying and investigating the physical danger to the child and child protection orders. The focus was on the actions of professionals.

The sequence of the (near) fatal cases is not chronological. The Dutch Safety Board has divided the fatal cases into the process stages of the child safety system, in which the children were when the danger manifested itself:

- Preliminary stage: Identification and reporting.
- Process stage 1: Investigation and decision.
- Process stage 2: Care and protection.

Figure B10 shows the process stages.

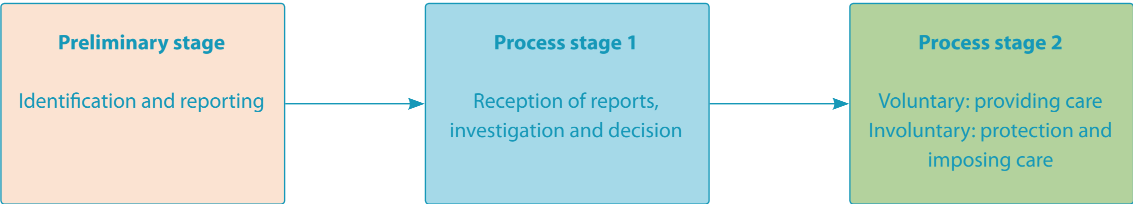


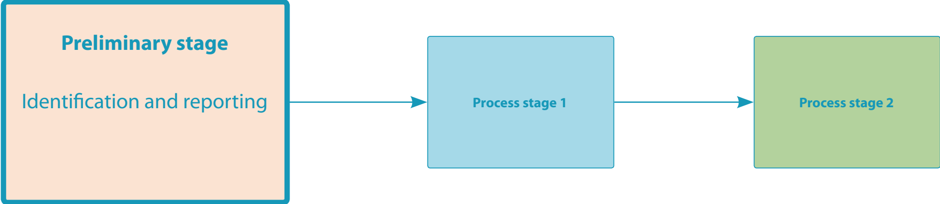
Figure B10: Process stages.

Stage	Number of cases	Number of children
Preliminary stage: Identification and reporting	11	11
Process stage 1: Investigation of a report and making a decision	7	9
Process stage 2: Care and protection	9	9

Table B11: Process stages and the number of cases and the number of children who died in that particular process stage.

The process stages have been indicated by colours. The timeline has been indicated in the process stages. The most important events in the fatal cases have been chronologically described in the right column. These are facts, which became evident from the compiled files. Special attention has been paid to the professionals involved and their actions.

C.1 Preliminary stage: Identification and reporting



Eleven children became victims of (near) fatal abuse during the preliminary stage. Seven of them had suffered (near) fatal abuse before a suspicion of a dangerous situation for the child arose (cases C1 - C7). There was a suspicion of danger in the other four cases, but it was not reported to formal authorities (cases C8 - C11). In a number of cases, the parties involved were aware of risk factors or there were indications of a physically dangerous situation.
In a number of cases, a report was submitted to the ARCAN of the Youth Care Office or to the Child Care and Protection Board after the (near) fatal injury had occurred. These authorities issued child protection orders after the fact. A number of cases show that this took place within a few days. This is the so-called urgency procedure (provisional supervision order), where children are directly put under supervision and can be put in custodial placement, if necessary.

C1 A 28-days-old baby, near fatal end

0	The baby was born.
2 weeks	The police visited the family because of 'relational' problems. The father was known to the police on account of, among other things, sexual abuse of minors.
4 weeks	The baby was admitted to the accident and emergency department of a hospital with breathing problems. The attending paediatrician diagnosed haemorrhaging behind the cerebral membrane and the eyes. The child went into a coma. The injury of the child did not correspond with the father's explanations. The paediatrician suspected Shaken Baby Syndrome. The ARCAN were informed.
4 weeks	They reported the incident to the Child Care and Protection Board, which eventually reported it to the police.
4 weeks	Several days later, the juvenile court judge issued a provisional supervision order. After more than a month, the baby was discharged from the hospital and placed with foster parents.

C2 A four-month-old baby, fatal end

5 years earlier	The mother gives birth to a second child. A report was submitted to the ARCAN. This eventually led to a supervision order for both children - after an investigation by the Child Care and Protection Board. The mother reported the father to the police during the investigation. The father received therapy in a forensic Mental Health Care facility imposed by the court about how to deal with children. Both children were put in custodial placement. The second child went back to live at home. The return of the second child to his parents was not unconditionally allowed, but linked with intensive family guidance. Four months after the second child had returned home, the intensive family guidance was started.
0 months	The third child was born.

4 months	On a certain night, while the mother was away, the baby started crying. The father had fallen asleep on the couch - it was nine o'clock at night - and woke up because of the baby's crying. The father picked up the baby and tried to quiet the baby by violently shaking it. The baby became limp and pale. The father then called the GP and because he noticed that the baby did not respond anymore, he took the baby to the GP out-of-hours surgery. The GP immediately had the baby admitted to a nearby hospital. At the hospital, serious injury as a result of external violence was established.
4 months	The ARCAN were informed and after that, the Child Care and Protection Board. The Child Care and Protection Board applied for a child protection order.
4 months	At the moment the baby was discharged from the hospital, the Child Care and Protection Board informed the hospital that the baby would be picked up to be placed in a foster home. The Board informed the mother that they would report the abuse to the police if she refused to do it herself. Since the mother refused, the Board reported the abuse to the police. One week after the baby had been placed in a foster home, the second child was also put in custodial placement.

C3 An eight-month-old baby, fatal end

	The expectant mother reported several family members to the police for abusing her.
0	A baby (boy) was born; his mother was still a minor. Her new boyfriend was not the baby's father.
0-8 months	There were regular visits to the early childhood clinic and a number of doctor's visits for 'regular infant health problems'. During these visits, the baby was examined naked and nothing suggested abuse. The mother's boyfriend shook the baby at night when putting the baby to bed. The baby lost consciousness. They called the emergency number and the baby was rushed to hospital. Two days later, the baby died in hospital.
8 months	When the baby arrived at the hospital, the Intensive Care doctor reported the abuse to the police. The police informed the ARCAN. The conclusion of the forensic experts was that the baby had been violently shaken a few days prior to his death and/or there had been repetitive brain trauma. This death by unnatural causes led to a report and legal proceedings.

C4 An eight-day-old baby, fatal end

-15 years	The father had a baby. The baby's mother reported the father to the ARCAN for abuse. The mother also reported him to the police when she had come home unexpectedly and saw that the father had put the baby in the freezer. There were no consequences.
-14 years	The father married a woman and a child (boy) was born in the new family. The child was admitted to hospital, because there was food in his airway. Two weeks later, the child was admitted to hospital again; this time because it was blue and blood came out of his nose. The child died eight days later. The cause of death was inconclusive: neglect or abuse. A declaration of death by natural causes was issued and nobody was reported to the police.[250]
0	The father had a relationship with another woman and a new baby was born in this new family.

250 Afterwards, it became clear that the child had injuries, which had resulted from abuse.

0-1 week	The baby sustained several minor injuries in the first week after it was born. These were: marks in the face, blood from the ear, red spots on the left cheek. Nobody notices anything out of the ordinary; not even the midwife and the maternity carer.
1 week	One week after the baby was born, the parents got into a fight at night. The father was drunk and sat on the couch with the baby on his knee. The father grabbed the baby roughly (the father violently shook the baby's head and he hit her in the face), which enraged the mother, who threw a French boule ball at the father. The baby instead of the father was hit by the boule. The baby was immediately rushed to hospital.
1-5 weeks	The paediatrician informed the ARCAN of his suspicion of child abuse. The baby was on artificial respiration for a month before she died. The prior minor injuries were interpreted by doctors as subcutaneous contusions. Two days after the baby was admitted to hospital, both the baby and the 7-year-old daughter, from a previous relationship of the mother, who was living at home were put under supervision and put in custodial placement. The results of the investigation into the family situation and the history of both parents.

C5 A 3-month-old baby, near-fatal end

0	A baby was born in a family (father, mother, two-year-old son).
1 week	The baby and family received regular maternity care. Nothing out of the ordinary was observed.
1 week to 1 month	The baby was brought to the early childhood clinic on the agreed on dates and times for check-ups. The early childhood clinic also made a house call. Nothing out of the ordinary was observed during these visits.
1 month	When the baby was one month old, the father noticed after he had come home that one arm of the baby looked strange and that the baby had a swollen wrist. The mother thought nothing of it. The parents decided to wait another day. The next day, the decided to see a GP after all. He referred them to the hospital. The baby was diagnosed with having a fractured forearm.
2 months	The baby ended up with the GP. The nature of the injury was inconclusive. A probable cause was that someone had accidentally sat on the baby. The GP warned the mother that she had to protect the baby better. A regular visit to the early childhood clinic one day later revealed nothing unusual.
3 months	When the baby was three months old, she stayed at the day nursery for the second time. The employees of the day nursery noticed that the baby was groggy and abstracted, that her eyes were turning, that she had convulsions (reflexes with her mouth) and that her foot was twitching. The employees were not worried enough that they called the mother. When the mother eventually picked up the baby, the mother was informed that she had to keep an eye on the baby, because she had drunk less that afternoon and had made no eye contact. When the mother came home with the baby, she called the father and told him that there was something wrong with the baby. When he had arrived home, he too noticed that the baby made no eye contact, that one of the corners of her mouth was twitching and that she was drooling. After she had consulted a friend of the mother, the parents took the baby to the GP out-of-hours surgery.
3 months	The GP's diagnosis was that the baby possibly had brain haemorrhage or meningitis. Since the symptoms were life-threatening, the child was rushed to hospital. After an examination, the baby was transferred to a university hospital where it was directly admitted to the Intensive Care unit. Shaken Baby Syndrome was diagnosed after a few examinations and some old fractures. The ARCANs were informed and the paediatrician reported the abuse to the police.

4 months	The ARCAN called in the Child Care and Protection Board. A provisional supervision order was issued. The baby was discharged from the hospital and placed in a foster home.

C6 A 6-year-old boy, near-fatal end

0	A boy was born.
5 years	The single mother of the boy developed a relationship with a man. An ex-partner of this man had reported him to the police for domestic violence one year earlier. This did not have any consequences.
5 years and 6 months	The boy was taken to the GP with severe bleeding and a swollen sexual organ and he was referred to an urologist for further examination. The parents stated that the cause was a fall on the edge of the shower stall. The boy was taken to the GP again 3 weeks later; now with a fractured tibia. The stepfather said that the boy had fallen against the slide at school. The school denied that. The internal counsellor at the school contacted the Municipal Health Services, because the boy had so many accidents. This resulted in a meeting with the Municipal Health Services, the mother and the boy for three months later. In the meantime, the paediatrician in the school healthcare system would assess and check the boy's motor skills. The boy was temporarily confined to a wheelchair because of the fractured tibia. The school established that the boy had stitches in the mouth and scars on his head. The school also noticed that the boy only wanted to be picked up from school by his mother. He started to cry when he would be picked up by his stepfather. The school noticed bruises in the face. The boy said that he had run into the room door. At one point, the boy could not speak well; his tongue was damaged and swollen. His mother said that he had fallen in the shower. (Examinations by the hospital and the Child Care and Protection Board revealed that the injuries had been sustained, because the stepfather had hit the boy hard against the bottom of his chin and had forced him to stick out his tongue.)
5 years and 9 months	The agreed on meeting took place with the Municipal Health Services, the mother and the boy. The mother stated that the boy had fallen off a climbing frame. All injuries were discussed at this meeting and a new meeting was planned for four months later after the holidays. In the meantime, he received special training (Remedial Training) to improve his motor skills from a play therapist. The sessions, which were supposed to take place on a weekly basis, started shortly after this meeting. During the training, the therapist concluded unsafe bonding and that the boy suffered from a moral conflict between the biological parents and the stepfather. During the following holidays, the family, expanded with the stepfather's daughter, visited an amusement park. During lunch, the stepfather dragged the boy to the toilets due to unwanted table manners. The boy received a beating in the toilet.
6 years	At the beginning of the new school year, a second meeting with the mother, the boy and the Municipal Health Services took place. This was a check-up. It became clear during this meeting that the boy might be depressed. The doctor in attendance of the Municipal Health Services had to discuss certain things with the play therapist when the training sessions were over two months later. Two weeks later, the play therapist indicated that the boy was weary and did not want to have contact with other children.

	Several days later, the boy did not want to play sports and said he was nauseous and had a bellyache. The teacher noticed red spots on his stomach and also ascertained that the boy was downcast and hardly ever was rumbustious.
6 years and 2 months	The stepfather picked up his wife's son with his motor scooter. When they came home, the stepfather lay down on the couch. The boy played outside with the puppy. The stepfather woke up and found that the boy was practically unconscious. The stepfather hosed the boy down with a garden hose in order to create a shock reaction. Eventually, the alarm number was called and the boy was transferred to the hospital with an emergency helicopter, where he underwent a physical examination.
6 years and 2 months	The ARCAN were informed and the incident was reported to the police. From meetings with the ARCAN and professionals, it became apparent that the boy had been regularly abused for two years. The ARCAN informed the Child Care and Protection Board.

C7 A 5-month-old baby, fatal end

-2.5 years	The mother was abused several times during her pregnancy by the father-to-be.
-2 years	The mother had her first baby. After her son had been born, the relationship between the mother and father ended. The mother was confused after the birth of her son and the boy was looked after by the mother's parents. The mother received treatment from the Regional Institute for Outpatient Mental Healthcare at the time.
-1 years	The mother started a new relationship.
-6 months	The (meanwhile two-year-old) sustained second-degree burns on both his hands. At the time of the incident, the mother's boyfriend - hereinafter referred to as the stepfather - was alone at the house with the boy. After she had found out, the mother took her son to the accident and emergency department, where her son was referred to the burns unit in Groningen. The paediatrician was consulted in connection with the suspicious circumstances of the trauma. It was reported to the ARCAN. Among other things, it was reported that there were doubts about the parents' statement. It was not consistent with the nature and extent of the burns.
-5 months	An employee and a ARCAN doctor of the ARCAN made a house call as a result of the report. The ARCAN advised the parents at the end of the house call to contact the district nurse of the early childhood clinic for support with the upbringing. The district nurse held meetings with the mother and the stepfather.
-3 months	The ARCAN decided to close the file, now that a care worker had had contact with the family.
0	A daughter was born in the family.
5 months	About five months after the daughter was born, the father was home alone with the baby. The baby felt ill that day (throwing up, fever, weak, pale). One day later, the baby was home alone with the father. She was normal that day. The day after, the father found his daughter in her bed in a very poor condition. The baby was unconscious and had stopped breathing. The father called an ambulance and she was rushed to hospital.
5 months	The hospital called in and informed the ARCAN of the suspected Shaken Baby Syndrome. Two days later, the report was discussed at the ARCAN and it was decided to investigate the case. The administration system revealed that the family was already known. The ARCAN knew about the existence of the (older) brother, but did not know how he was doing at that time.

	After internal deliberations at the ARCAN, they decided to report the incident to the police, to report the family to the Child Care and Protection Board and to have a meeting with the parents. At the hospital, a meeting was held with the ARCAN and the parents. The mother indicated that she was not present in both cases (of the son and of the daughter) and she agreed to the report to the Child Care and Protection Board and to the report to the police.
5 months	A day later, the baby died at the hospital. Three days after the baby died, the ARCAN, with a view to the brother's safety, transferred the further investigation to the Child Care and Protection Board. One day later, the ARCAN reported the incident to the police.

C8 A nearly three-month-old baby, fatal end

0	At the end of September 2005, the girl was born. One week after the birth, she went to the early childhood clinic for the first time. Nothing out of the ordinary was reported. Furthermore, the parents had an introductory talk with their new GP. They wanted a new GP in connection with better accessibility now that they had a baby. A month after the baby was born, they visited the early childhood clinic for the second time. The standard check-ups were performed.
6 weeks	Approximately six weeks after she was born, the early childhood clinic noticed bruises on the girl. The doctor and nurse thought it was strange and decided to stay alert. Several days later, the nurse of the early childhood clinic discussed her observations with her colleagues. The clinic made a house call on the same day in connection with the bruises. The child seemed calm. The parents would contact the clinic if it happened again. The nurse of the early childhood clinic thought the situation was still 'fishy'.
2.5 months	There was a new meeting at the early childhood clinic. The physician at the early childhood clinic again found two bruises around the eye. He asked the parents to call in the GP. The mother promised to make an appointment. A few days later, the early childhood clinic contacted the GP. The mother had seen the GP, but he saw no cause for concern. He had seen the girl and had not found bruises, but he did see eczema on her cheeks. The GP had discussed the concern of the early childhood clinic with the parents. They were not happy to hear about their suspicions.
3 months	A week later, the parents cancelled the meeting at the early childhood clinic because the mother was ill. A week after that, they did visit the walk-in surgery hour at the early childhood clinic. They were seen by another nurse. The child seemed fine. A day after the child's visit to the early childhood clinic, she died aged three months. It was established that the child had died from abuse.

C9 A 4-month-old baby, near-fatal end

-2 years	Birth of the first daughter. The parents did not have a fixed abode. Both parents were addicted to alcohol and drugs.
-1 years	The ARCAN received a report about this child from the night shelter where the parents were staying. The ARCAN referred the report to the Child Care and Protection Board. The Board started an investigation. The investigation was terminated because the parents were missing.
	The parents moved in with the father's parents.

0	A son was born at the hospital. While the mother and the baby were still in the hospital, the grandmother informed the district nurse that the family situation was alarming. The district nurse informed the hospital. The hospital informed the GP and the GP informed the social worker. The social worker was advised to inform the ARCAN. In the end, it did not happen, because the grandmother wished to remain anonymous. The parents did not show up at the agreed on check-up one month after they were discharged from the hospital.
14 days	The parents did not show up at the check-up 14 days after that. The hospital therefore contacted the district nurse. The nurse informed the GP. The GP made a house call and stated that the parents had to go to the early childhood clinic with the baby.
4 months	The parents went to the early childhood clinic with the baby. The early childhood clinic observed a bulging fontanel and the baby was referred to the GP. The parents went to the GP, who directly referred them to a paediatrician. The GP arranged an appointment himself for the next day. When the GP found out one day later that the parents had not shown up, he went to the parents and took them and the baby to the paediatrician at the hospital. The GP made sure that the four-month-old baby was immediately admitted to hospital. The baby needed neurosurgery. The baby's serious injuries indicated Shaken Baby Syndrome. The baby appeared to be severely abused.
4 months	The hospital informed the ARCAN. The ARCAN referred the report to the Child Care and Protection Board. An investigation was started.
4 months	The baby and the older sister were put under supervision and put in custodial placement before the baby was discharged from hospital.

C10 A four-month-old baby, fatal end

earlier	The father (to be) had come into contact with the criminal justice system in the past and had been evicted by a housing association. He had abused his ex-girlfriend and her three-year-old child.
0	The father and his new wife had a baby. The family caused their neighbours a lot inconvenience. The entire neighbourhood was scared of the father and his family and especially his twin brother. A neighbour had reported to the housing association in connection with the nuisance and out of concern about the baby. The housing association advised the neighbour to report to the ARCAN. This did not happen. In the first months of his life, the baby was taken to the early childhood clinic. The baby was taken to the early childhood clinic for vaccinations. Other visits were regularly cancelled. The early childhood clinic had become aware of the risk factors in this family due to, among other things, house calls. At an early stage, wounds next to the baby's mouth were discovered during a visit. The early childhood clinic advised the mother to visit the GP for the wounds. The mother had never visited the GP, because the father strictly forbade it, according to the mother.

4 months	One night, the baby was about four months old, the couple fell asleep with the baby in the bed. The mother woke up in the middle of the night. The baby lay in an unnatural position and was blue/grey. An ambulance was called and took the bay to the hospital. It was established that the baby had died. At first, cot death was assumed to be the cause of death. A forensic doctor, who happened to be present, insisted on an in-depth examination. This examination revealed that the baby had both recent and old fractures. The couple was questioned by the police. When questioned, the mother decided to report the father to the police for abusing the baby.

C11 A two-and-a-half-month-old baby, fatal end

0	A girl was born in a family consisting of a father, a mother and another daughter.
4 days	The maternity carer thought that there was a loveless atmosphere in the house and that the three-year-old daughter was regularly slapped with the flat of the hand. She reported this by telephone to Youth Health Care.
5 days	A day later, she reported it again to Youth Health Care.
13 days	Eight days later, Youth Health Care informed her that she had to report it to the ARCAN doctor of the ARCAN. The protocol for the maternity carer indicated that it had to be reported to the executive maternity carer. When the occasion arises, the executive maternity carer informs the ARCAN doctor of the ARCAN, according to the protocol. In this case, it was not reported to the ARCAN.
+/- 4 weeks	A district nurse of Youth Health Care made a house call to the family 2 weeks later. Both children were not there at the time. The mother and her baby did visit the early childhood clinic that week.
1 month- 2.5 months	The mother regularly took her baby to the early childhood clinic for regular check-ups. The first time one month after it was born, then once every 14 days. Nothing out of the ordinary was observed during these visits.
2.5 months	When the baby was two-and-a-half months old, the father sat behind the computer in a room on the first floor. When the baby started to cry, the father called down the stairs, where the mother was talking to a guest, that he would see to the baby. The father picked up the baby and held it tightly to his chest to make it quiet. The baby became quiet and was put back in the bed with a dummy in its mouth. Two-and-a-half hours later, the mother went to look at the baby and found that it was grey-faced. The mother rushed the baby to hospital with the guest, a friend of the mother, where the baby was found to have died. The GP at first thought that it was a case of cot death. A post mortem examination of the baby’s body, insisted on by a forensic doctor who happened to be present, revealed that the baby had highly probably died from fractured ribs and a fractured collar bone. This examination also revealed many old fractures.

7 fatal cases were reported involving 9 children[251] who died in the process stage Investigation and decision. These children had been reported to the ARCAN, the Youth Care Office ('Admittance') or the Child Care and Protection Board. In three cases, the children died before the investigation had been started (C12-15). In four cases, the children died during the investigation into the danger to the child (C15-C18).

C12 Two children aged two and four, fatal end

0	The first child was born.
2 years	The second child was born.
4 years	The mother and her two children went to live with her new boyfriend.
4 years	In the same period, the biological father contacted the Youth Care Office (ARCAN and 'Admittance'). The first time, he said he was worried about the living conditions of the children. The mother's new boyfriend possibly used drugs. He based his report on information from other people. The biological father called the ARCAN for the second time three weeks later. He provided additional information, which he had obtained by own observation, according to him. The ARCAN employee announced to the reporter, based on the additional information, that it would be internally discussed if the information was sufficient to start a (preliminary) investigation. The employee wanted to make the report official at that point and discussed the cases for a (preliminary) investigation at the multidisciplinary meeting. Five days later, the case was discussed in a multidisciplinary intake and it was decided to start a preliminary investigation. Another three days later, the ARCAN employee called the biological father. He told the biological father that the ARCAN wanted to make an official report and he discussed the situation (waiting list) and the conditions of the preliminary investigation. The reporter agreed.
4 years + 3 months	The report was discussed again in a multidisciplinary meeting. The preliminary investigation was planned in order to check with authorities if they recognised the concerns and also to determine the urgency of the investigation. The mother and her boyfriend got into an argument five days later, he abused her and she fled the house. He then killed the two children.

251 In two families, two children died.

C13 A 1.5-month-old baby, near-fatal end

-9 months to 0	The ARCAN received a report from the social environment during the pregnancy. The reporter stated that the future mother and father would not be able to raise the child due to problems with alcohol. Both parents were alcoholics. The expectant mother had been admitted to hospital due to alcohol poisoning 6 months earlier. They were both known to the police due to domestic violence and relational problems.
-6 months	A ARCAN doctor of the ARCAN made a house call. The expectant mother, however, did not want to say anything.
0	The child was born in the hospital in autumn. At the hospital, there were doubts if the mother (and the father) would be capable of taking care of the baby. As a precaution, the baby was admitted to the neonatal intensive care unit so they could check if the situation at home would be acceptable for the baby. A hospital nurse made a house call. All facilities necessary for taking care of a baby seemed to be present. The paediatrician of the hospital then informed the GP by letter and proposed a multidisciplinary meeting to discuss the home situation of the child. The parents could take the baby home after 8 days. One day after the baby had been discharged from hospital, a paediatrician accompanied by an internship doctor made an unannounced house call. The door was not answered.
12 days	Three days later, the previously agreed on multidisciplinary meeting with the paediatrician, the hospital nurse, the GP, the housing association and the ARCAN doctor took place. During the meeting, a number of conditions were formulated for the care of the baby: • The baby had to be taken to the outpatients department for weekly check-ups; • Once every two weeks, the GP would make a house call; • A specialised family carer would be at the family's house for one and a half hours each day for five weeks; • Social work would also be offered to the family. Everything would be evaluated at the following multidisciplinary meeting. The same day, the paediatrician and the internship doctor made another house call. The door was not answered again. When the paediatrician called the mother on her mobile phone, they were welcomed into the house. Furthermore, the specialised family carer was present at the house on the same day. The assistance took place according to the agreement. When the baby was almost one month old, the family carer got the feeling that she was starting to lose contact with the mother. The family carer contacted the paediatrician at the hospital. A couple of days later, the mother with the baby (and the dog) no longer lived in the house. They were staying at the house of a close friend. The mother told the family carer that she did not know yet when she would return to the house. The mother did go to the outpatients department for her check-ups. The mother and the baby were not at home at the next house call from the GP. They did not go to the following check-up at the outpatients department.
1 month	More than a month after the birth, the second multidisciplinary meeting took place. It appeared that the child had cried a lot and had lain in its own vomit. The neighbours, worried by the loud cries of the baby, had knocked on the parents' door and had ascertained this. It was decided to extend the weekly visits to the outpatients department with six weeks. Furthermore, it was determined at the multidisciplinary meeting that there were not enough signs for an intervention in this family. The house calls and the visits to the outpatients department took place as agreed on, according to the parties involved.

1.5 months	The child was taken to the outpatients department for its check-up on the agreed on times. During this check-up, it was determined that the baby's head circumference had suddenly increased and that the baby was groggy. An in-depth investigation was started. It revealed that this was probably due to Shaken Baby Syndrome. That same day, the ARCAN was informed. The parents were told about the suspected child abuse. One day later, the child was referred to a university hospital. Examinations showed that the baby had sustained brain damage at different stages. This was reported to the ARCAN. The ARCAN referred the report to the Child Care and Protection Board. A provisional measure was immediately applied for. When the baby was discharged from hospital a few weeks later, it was not given to the mother, but placed in a foster home.

C14 A 2-year-old girl, fatal end

0	A girl was born. The girl had no siblings and lived with her parents just across the border abroad. Both parents worked for the same organisation in the Netherlands.
1 year and 10 months	The company social worker of the organisation visited the family, because of an escalation of prior relational problems between the parents. They made agreements with the company social worker about creating some peace and distance. Despite the agreements, the situation heated up again the next day. The mother reported to a few colleagues with her child that day and she seemed incoherent and fearful. A forensic doctor of the Municipal Health Services called in by the organisation saw the mother and concluded that she had psychiatric problems. The mother took her child to another place of residence. After the mother and child had disappeared, the father contacted the ARCAN. Based on the chaotic impression the father made, and based on the not voiced concerns about the child, the employee of the ARCAN advised the father to have the company social worker contact the ARCAN. That same day, the company social worker contacted the ARCAN. After internal deliberations, the ARCAN informed the company social worker would not be handled as a crisis case. The company social worker agreed. The company social worker would keep an eye on things and contact them if necessary.
1 year 11 months	One week later the company social worker submitted an official report to the ARCAN, because he had no insight into the situation of mother and child. It was decided that the ARCAN had to be contacted if the company social worker knew about the mother's place of residence. One week later, the ARCAN decided to immediately act on the report based on the nature of the concern, namely the psychiatric problems of the mother with potential danger to the child. The social worker of the ARCAN visited the mother's mother. She said that the concerns about the mother were unfounded. She explained that the mother's behaviour was due to marital problems; the father apparently had been threatening to the mother. She did not give the address of the mother and her child. The ARCAN also contacted the mother's lawyer, who confirmed that concerns about the mother and her child were unnecessary. He, too, refused to give their address. The ARCAN requested information from the company doctor and the mother's GP. However, the company doctor refused to give information and the GP had not ascertained psychological problems of the mother, or relational problems between the parents. An interdisciplinary assessment of the report took place involving the social worker and the ARCAN doctor. It was decided to close the file.
2 years	The child was found dead abroad just across the border. The mother had also tried to kill herself.

C15 A ten-day-old baby, fatal end

-9 to 0 months	Both parents were mentally impaired and lived on a social care farm.[252] The father received medication for aggressive behaviour. The carers at the farm, the GPs and the midwives spent a lot of time and attention to prepare both the father and the mother for the upcoming birth.[253]
0	The baby was born.
2 days	The father called the midwife at 4 AM because of the baby's constant crying. In the morning, the midwife contacted the family. Nothing special was going on.
3 days	Nothing out of the ordinary was observed during a house call.
6 days	The GP, the maternity carer and the midwife saw bruises on the baby's face. At first, it was assumed that this could have been caused by an unintentional elbow punch when sleeping. The baby slept in bed with the parents. The following day, the midwife contacted the GP and together they informed the Youth Care Office. That same day, the GP visited the social care farm and did a full examination of the baby. The baby had bruises in several places. The GP informed the ARCAN.
8 days	The ARCAN deliberated with the MEE[254] and the GP. MEE promised to advance the date of the appointment (which was scheduled to take place one week later).
9 days	The midwife observed the family for an hour the next day. Nothing out of the ordinary was observed.
10 days	The next night, the father called the midwife at 4 AM, because the baby did not want to drink, was cold and exhibited indistinct reactions. The next morning, the midwife contacted the parents. The baby's temperature had increased, but that the baby did not want to drink well. Shortly after, the midwife contacted the parents again and said that the early childhood clinic wanted to examine the baby. The father was just on his way to the GP, because he said the baby seemed dead. The midwife went to the social care farm where the parents lived. When she arrived, the baby was in a very poor state. The parents and the midwife took the baby to the hospital. At the hospital, Shaken Baby Syndrome was diagnosed. The baby died in hospital at night. The hospital informed the ARCAN that the baby had died from abuse.

C16 Two children aged nine and eleven, fatal end

0	The first child was born.
2 years	The second child was born. The marriage of the parents can be characterised by a pattern of violent behaviour and threats of violence, in a series of periods which started immediately after they got married.
8 years	The mother went to the police because she had been abused by her husband. Since she did not want to report it, no criminal proceedings were instituted. They were, however, referred to Mental Health Care. The care was terminated, because the parents did not want to cooperate anymore.

252 A social care farm is farm where people live in sheltered accommodation based on the Exceptional Medical Expenses Act. The social care farm concerned is a private institution where several mentally impaired people live under the guidance of two adults.
253 In these cases, two GPs, two maternity carers and three midwives offered assistance to the family at different points in time.
254 An organisation which supports people with a physical, sensory or mental handicap.

10 years	The mother reported her husband to the police for abuse and threats. The mother took her children to live somewhere else temporarily. That same year, they were divorced and the mother moved to a new address with the children.
10 years and 4 months	The police reported the case to Kindspoor, a project of the Youth Care Office and the Child Care and Protection Board focusing on children who have witnessed domestic violence. The Child Care and Protection Board was informed of the case and the different steps during the entire process. The Youth Care Office and the Child Care and Protection Board were responsible for the decision to start the voluntary care process. The executive party, the Youth Care Office, was responsible for the care in this case.
10 years and 6 months	It was not possible to contact the parents and to start the care and, therefore, the case was referred to the ARCAN. Based on the data, the case was assessed as being 'middle' and was put on the waiting list.
10 years and 8 months	The case was handled, once again, by the ARCAN and both parents were contacted. It was decided in a multidisciplinary meeting that the children needed help, because they had witnessed domestic violence their entire lives. It was also deemed necessary that both parents would receive care from Mental Health Care. Once again, it was decided that the father needed care, combined with assistance from the Youth Care Office. The parents did not respond to the invitations.
11 years	Two weeks before the father killed both children, he was sentenced for abuse by the magistrate. The father of the family killed his ex-wife, his children and himself. There were no indications that the father had ever used violence against his children, except for the violence he used to kill them. There were indications that he had repeatedly threatened with violence, and the children had been named as potential victims.

C17 A one-and-a-half year old boy dies from abuse

0	A boy was born.
4 months	The ARCAN received a (first) report from the police. The police reported that the father had been arrested for domestic violence against the mother. The mother was drunk and possibly under the influence of drugs. The ARCAN started an investigation as a result of the report. The ARCAN contacted the early childhood clinic, among other things, for information. The early childhood clinic saw the family several times after the report.
5 months	The early childhood clinic received information that the mother had started to raise the child by herself and they referred her to social work.
8-9 months	After that, the mother visited the early childhood clinic. The ARCAN decided not to make the mother do a urine test. The ARCAN had doubts if the mother had actually taken drugs. The ARCAN decided to transfer the case to General Social Work. After a reminder of the ARCAN (the boy was eight months old then), which involved the ARCAN talking to General Social Work and the early childhood clinic, the ARCAN decided to take no further steps.
12 months	The police reported to the ARCAN for a second incident of violence between the parents.
13 months	After this report, the ARCAN contacted the early childhood clinic. The early childhood clinic stated that the boy had looked well during the last visit in June. They had agreed with the mother that she would contact a social worker, but she had not done that. The ARCAN made a house call.

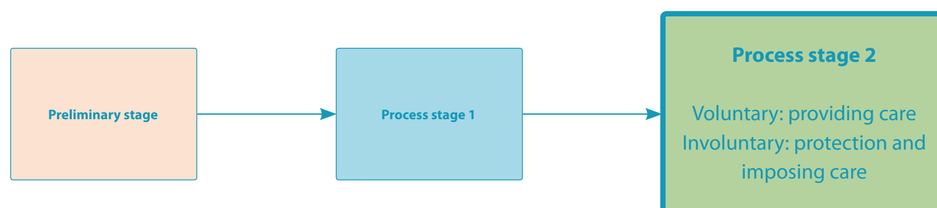
13-14 months	The ARCAN requested the Child Care and Protection Board to conduct an investigation. They stated that the relationship between the mother and the father and the circumstances of the mother were the reasons for doing this. The ARCAN indicated that there was no crisis situation. The intake by the Board decided that the case should not have the highest priority.
14 months	The early childhood clinic had contact with the mother and her child. The mother had a new boyfriend.
16 months	The Child Care and Protection Board started the investigation. The Council deliberated with the ARCAN and a first house call took place. The mother stated that things were going well and the boy looked fine and did not display special behaviour. The Council requested information from the police about the escalation between the parents and both their parts in it. The police indicated that they would look into the matter.
17 months	After the telephone number of the father had been retrieved, the father of the boy was informed about the investigation by the Council. On the same day, the boy died as a result of repetitive, severe, mechanical violence. Both the mother's new boyfriend and the mother had to appear in court. The court concluded that the boy had been the victim of structural child abuse and that the abuse had not been limited to one time. This not only resulted from the medical information. In the last few months, several acquaintances of the family had noticed remarkably many bruises on the boy.

C18 A four-month-old baby, near fatal end

Prior	A boy was born in a family, who died in the hospital after one month. Based on an examination, it was determined that the child had died from abuse. The Public Prosecution Service called the death of the boy a tragic accident and the case was dismissed under the condition that the father would receive treatment from the probation and after-care service for two years. The treatment, as would become clear later on, consisted of a total of two meetings.
-3 months	Approximately 6 months after the first baby's death, the mother was pregnant again. The ARCAN were informed about the pregnancy by the Juvenile and Vice Police. The report was followed up and the ARCAN started an examination that day. The ARCAN's investigation consisted of collecting information about the family from various sources. The ARCAN contacted the Public Prosecutor, the GP and the gynaecologist. The ARCAN decided that the baby could be taken home after it was born and organised supporting measures without the risk analysis of the father. The ARCAN did not inform the early childhood clinic and maternity care about the death of the first baby.
0	The second child, a boy, was born. The ARCAN contacted family care. The care was satisfactory; the parents were open to receiving help. The father stated not being able to contact the probation and after-care service. The ARCAN then tried to contact the probation and after-care service seven times, but to no avail. The Public Prosecutor was then informed. The prosecutor would contact the probation and after-care service. The probation and after-care service had created the idea with the ARCAN, the Public Prosecution Service and the father that they would set up assistance and possibly a treatment programme for the father. The probation and after-care service did not start the supervision, because a source document with the written assignment of the Public Prosecutor was lacking. The probation and after-care service had not kept the ARCAN informed. After receiving notification that the probation and after-care service had no contact with the father, the ARCAN did not adjust their own assessment and intervention. In the two months after the boy was born (March, April), the parents took the baby to the GP several times for health problems, including a bump above his scrotum, inflammation of the right middle ear and a groin rupture. One month later, the mother went to the GP because the baby had blue buttocks. She stated that he had fallen off the chest of drawers.

3 months	The private therapist[255] called the ARCAN that the mother would be calling for help. Then the mother called the ARCAN that the parents liked to receive help for the father's outbursts of anger in the past. After this notification, the ARCAN started an investigation to assess if the child would still be safe with the parents. The ARCAN made an appointment with the parents for a house call one week later. During the call, both the mother and the father denied that the father had had any outbursts of anger since the baby's birth. During the house call there was no doctor of the ARCAN present who could assess the child. After the house call, the ARCAN had doubts about the reliability of the parents. The ARCAN contacted the early childhood clinic. The early childhood clinic, which had not been informed about the cause of death of the first child and the risks of child abuse in this family, stated not to have noticed anything out of the ordinary since the birth. The medical social worker of the hospital and the specialised family carer[256] stated that the family was doing fine. The specialised family carer had been informed by the medical social worker, but the medical social worker thought, despite the meeting with the ARCAN, that the second child would not be in danger. This is the reason that the specialised family carer did not view the family as high-risk. The ARCAN assessed that there was no immediate emergency situation.
4 months	One week later, the baby was admitted to hospital with severe brain damage. That same night, the father turned himself in. Afterwards, the mother explained that there had been multiple incidents in the last months. She had not informed care workers, because she was afraid that the baby would be taken away. After the baby had been admitted to hospital, it was reported to the ARCAN and he was placed under supervision and put in custodial placement at the request of the Child Care and Protection Board. It was determined that the child was being abused.

C.3 Process stage 2: Care and protection



In this process stage, 9 children died after the investigation was terminated. For one child, no care or protection had been arranged (C19). Four children died while some form of care for the child had been arranged for the family (C20-C23) and the other four children died while a child protection order had been taken (C24-C27). When a child protection order had been taken, care had usually also been arranged.

C19 A 3-month-old baby, near-fatal end

0	A boy was born. It was the first child of both parents. Everything went normal around the time of the birth and in the first two months. Maternity care, the early childhood clinic and the GP did not see the need for special care.
2 months	The baby was admitted to hospital. The lingual fraenum seemed to have been torn or cut and the baby had bruises. The attending paediatrician informed the ARCAN.

255 Assisted the bereaved parents.
256 Called in by home care.

2 months	The ARCAN immediately stated that the baby could not be taken home by the parents before it had been ascertained that the baby´s safety was guaranteed. A day later, the paediatrician of the hospital discussed his suspicion with the parents. The ARCAN contacted the family´s GP. The GP was surprised, but he stated that there were some risk factors in the family. The day after, the social worker of the ARCAN held a meeting with the parents. The parents stated that they wanted a second opinion. This was permitted. The baby was transferred to the university hospital. At this hospital, the diagnosis of the attending paediatrician was confirmed. The ARCAN started a complete investigation. During this investigation by the ARCAN, the baby was discharged from the hospital and entrusted to the parents. The results of the investigation by the ARCAN were made available within two weeks. The investigation indicated that it could not be demonstrated that the parents had inflicted the injury intentionally. The report suggested that the injury was inflicted by a sharp finger nail of the mother.
3 months	The parents were eventually advised to take a training, ´Opvoeden zo´(Parenting advice). The file was subsequently closed. Two weeks later, the baby was admitted to hospital with severe brain damage and some other external injuries, such as pointy bleeding and contusions. The baby was rushed to the academic neurosurgical centre. The baby lapsed into a coma, from which it would not wake up. The father stated that the baby had fallen out of his hands. It was determined that this was not likely, because the baby showed the classic symptoms of Shaken Baby Syndrome. It was reported to the ARCAN, the Child Care and Protection Board and finally the police. Eventually, the father admitted to abusing the baby.

C20 Twelve-year-old girl, fatal end

4-6 years	The early childhood clinic (youth healthcare 0-4) transferred this child´s file to youth healthcare for 4-12 year olds (Municipal Health Services) when she turned 4. The file contained some notes, which mistakenly did not alert youth healthcare. The police knew about the family situation, in which there was regular domestic violence. The father and the stepmother divorced. The father was assisted by Mental Health Care and received medication. At the age of 6, the Youth Health Care picked up signals from the school that there were problems and that the Regional Institute for Outpatient Mental Healthcare and daytime assistance had possibly been appointed; this did not instigate action. The father went to the GP one month later because of the girl´s behavioural problems and the GP referred the girl to the Regional Institute for Outpatient Mental Healthcare.
6-8 years	In the next two years, the Regional Institute for Outpatient Mental Healthcare assisted the girl and temporarily placed her in an institution for crisis relief. The crisis relief drew up a risk assessment if the girl would be safe at home and advised the Regional Institute for Outpatient Mental Healthcare. At the end of the temporary placing, the Regional Institute for Outpatient Mental Healthcare thought that residential placement would be the best care after the crisis relief, an alternative was intensive family guidance. The father refused both. Eventually, they reached a compromise and the girl went to live with her stepmother. All family members saw care workers. For the girl, they were the Regional Institute for Outpatient Mental Healthcare, the Youth Care Office and the subsequent schools and the School Attendance Office. Nobody had a complete picture of the problems and risk factors.

Age	Events
	The girl had four subsequent GPs. Two out of four GPs did not have enough information about the family situation and the associated risks, because they had not performed an extensive intake procedure or a risk assessment. The schools and the School Attendance Office did not have a complete overview of the circumstances in which the girl lived and they had not performed explicit risk assessments either. The information of all care workers involved with the family members was not combined into a broad risk assessment by any of the parties involved. Youth Health Care had not requested or exchanged information with other care workers. The institutions within youth healthcare communicated well, but the exchange of information between youth healthcare and care workers outside youth healthcare was limited. At the start of the care by youth healthcare, there had been a one-off contact between the Youth Care Office and the father´s care worker, the girl´s school and the Regional Institute for Outpatient Mental Healthcare. After that, no more exchange of information took place between these parties.
9 years	The police noticed that there was domestic violence between the father and the stepmother and the girl was left alone at night. The police then called the Child Care and Protection Board, which referred it to the ARCAN. The report was assessed the next day and it was decided that further investigation by the ARCAN was needed. A risk assessment was made and the case was assessed as having priority 'middle'. After this, the police received a notification about the girl. She refused to go home and indicated that she was regularly abused. Based on this information, the police contacted the Child Care and Protection Board. The Board referred the police to the ARCAN and they referred the police to the crisis intervention team of the Youth Care Office. The police contacted the crisis intervention team. The crisis intervention team received information from the ARCAN after the report by the police. The ARCAN and the crisis intervention team attuned the information. The crisis intervention team immediately acted on the report and talked to the girl and the stepmother´s family member, where she was staying. The girl said that her father abused her. The father stated that he sometimes hit her from powerlessness. No more signals of abuse were picked up after this. The crisis intervention team did a risk assessment and decided which care was needed.
10-12 years	The Youth Care Office placed the girl in crisis relief. Shortly after this, the crisis intervention team received written information from the Regional Institute for Outpatient Mental Healthcare. After the crisis relief, it was decided to let the girl return to her father. This happened after the father had refused to cooperate with a transfer of his daughter to a (temporary) follow-up group until daytime assistance was arranged for her. The father was open to assistance with the raising. He received this assistance from educational community family counselling. In the months preceding the girl´s death, the father had been slowly switching to other medication on orders of his new psychiatrist. About one month prior to the fatal incident, he told his care worker that he missed his old medication and that he felt more easily irritated, especially with his daughter. Mental Health Care did not see a reason to report this to the ARCAN. At the beginning of summer, the father reported his daughter sick at school. The school then contacted the father and reported this to the Youth Care Office (the case manager) and the school attendance officer. The Youth Care Office sent the educational community family counsellor to check on the family. The counsellor went to the house a couple of times and left voicemail messages, but did not receive a reply. At the end of the summer, it was clear that the father had returned from his stay abroad without his daughter. The mutilated body of the deceased girl was identified in autumn. She had died at the age of 12. It was established that she had died from abuse.

C21 A 7-year-old girl, fatal end

0	Birth of the child.
6 years and 11 months	The mother of the girl reported to Mental Health Care, accompanied by her ex-husband, her brother and her mother - hereinafter referred to as the grandmother - after a referral by her GP. The grandmother stated during this visit that there was a chance of suicide and potential killing of the girl. It was decided that the mother had to be admitted to the Psychiatric Unit of the General Hospital. This was a secure unit where people stayed involuntarily or voluntarily. The risk of the mother committing suicide was assessed as being slightly to moderately increased. For the mother, they chose the 'voluntary' stay. In case the mother wanted to leave the unit early, a 24-hour guarantee of a remand in custody by the Emergency Service was agreed on. Furthermore, it was agreed on that the daughter would have to be looked after by the father (the mother´s ex-partner), the grandmother and the mother´s brother during the mother´s stay at the unit. The child had to be reported to the Youth Care Office by Mental Health Care. The next day, Mental Health Care called the Youth Care Office to report the child. Information about the family situation was passed on. It was stated that the father now stayed at the mother´s house to take care of the child. Mental Health Care did not assess the child´s situation as critical. On the same day, the second day of the mother´s stay at the unit, she stated that she wanted to go home as soon as possible. The mother had slept without medication and made a coherent and capable impression. At first, a new appointment with Mental Health Care was made for three days later to assess if the mother was fit to go home. It was later decided to discharge the mother the next day. The next day, the mother called the Youth Care Office and asked if the appointment, which her ex-husband had made for her child, could be moved to an earlier date. The mother said that things were not at all well with her child. The mother did not think it was necessary for the child to be put in custodial placement. Another two days later the appointment with Mental Health Care, which had already been made, planned two days after the mother was discharged and initially aimed at assessing if the mother could be discharged, was held. The mother, the ex-partner and the grandmother showed up at the appointment. The mother made a better impression during this visit. The immediate problems seemed to be over. It was agreed on that the family would keep an eye on things and that they could call, if necessary. It was also decided to make a new appointment in the short term. On the same day of the appointment with Mental Health Care, the mother cancelled the appointment with the Youth Care Office. She had already stated during the visit with Mental Health Care that she wanted this. Mental Health Care did not think it was a good idea. The appointment had been made by her ex-husband. The ex-husband had to end his short stay at his previously marital home for work that weekend. The father lived and worked somewhere else. The Youth Care Office employee tried to contact the mother by phone to discuss the cancelled appointment. The employee asked the mother the reason for the cancellation. The mother indicated that she no longer needed the Youth Care Office. She was asked if the ex-husband, the father of the child, agreed with the cancellation. The mother confirmed. Immediately after that telephone conversation, the employee informed with Mental Health Care about the mother´s condition. To the opinion of the employee, the mother´s consent was needed for this. The consent was obtained. The information from Mental Health Care about the mother´s condition was fairly positive and was not disturbing. Mental Health Care and the Youth Care Office decided to inform each other regarding the developments in this case. Late in the afternoon, the mother was informed by telephone by the Youth Care Office employee about this agreement. The mother seemed normal during that conversation.

6 years and 11 months	One day, the mother killed her child, probably in the presence of her (ex) partner (not the father of her child). The next day, the mother and the (ex) partner were arrested. They both had attempted twice to commit suicide.

C22 A 13-month-old baby, fatal end

0	A boy was born.
5 weeks	The early childhood clinic observed a (too) increased head circumference in the boy. The mother died. The early childhood clinic observed that the head circumference had increased more and requested the father to bring his baby to the early childhood clinic the next day. The early childhood clinic asked the father to visit the GP. The GP referred him to the paediatrician. The next day, the father called the alarm number. The baby had trouble breathing and was vomiting. After the baby had been resuscitated, he was admitted to the regional hospital. That day, the crime scene investigators of the police department searched the father´s house for evidence of an intruder who had supposedly entered the house. No evidence was found to support this claim. The radiologist at the hospital determined the next day that the baby had fractured ribs. The baby was transferred to the university hospital soon after. It was determined there that the baby had probably sustained permanent brain damage as a result of Shaken Baby Syndrome. The child was permanently disabled. At the university hospital, fractured ribs were not determined. The baby was transferred back to the regional hospital. The baby went home with his father.
+/- 4 months	A paediatrician diagnosed the baby with having a hip injury two months later. Recovery took months and required plaster and splints. When these were applied, bruises were found. The legs did not seem to be fractured. The paediatrician informed the father after a week that would inform the ARCAN about the child abuse. The official report took place several days later. The ARCAN reported it to the police. The police collected information at the hospital within a few days. The ARCAN informed the Child Care and Protection Board a few days later and the latter started an investigation. The boy was allowed to go home with his father before the Child Care and Protection Board´s investigation had been completed.
7 months	The Council´s investigation resulted in a care/assistance advice one month later. A supervision order was not applied for with the juvenile court judge. Care in a remedial educational day-care centre was arranged and the father was assisted by MEE. The day-care centre´s manager regularly called the father about the child´s bruises. The father always had explanations.
13 months	The father took the baby to the accident and emergency department, because he was vomiting and he was groggy. The child was admitted. A CT scan revealed that both tibias and one fibula of the child were fractured. Furthermore, old fractures were also visible. The ARCAN were informed. The ARCAN informed the Child Care and Protection Board.

C23 Four-week-old baby, fatal end

Prior	The Youth Care Office was in charge of the supervision order for the parents´ first child. This child had been put in custodial placement. At that point, the parents were homeless, used drugs and had financial problems. The mother became pregnant again. The family supervisor stated conditions, which the parents had to meet if they wanted to take care of the child themselves. The parents were assisted by a Salvation Army employee.
Before the birth	The hospital where the mother went for her pregnancy check-ups reported it to the ARCAN on account of the mother´s history. The ARCAN deliberated with the family supervisor who supervised the other child. The family supervisor reported that care had been arranged: the Salvation Army employee made two house calls per week, the father took an aggression regulation course and the mother a social skills course. The ARCAN transferred the report to the family supervisor.
0	When the baby was born, the ARCAN checked with the family supervisor if the baby could go home with the parents. The family supervisor agreed and the ARCAN reported this to the hospital. The baby was not under supervision, the family supervisor had formally only been appointed to the parents´ previous child.
4 weeks	On the same day that the baby was given to the parents, the father felt menaced and he went into the streets with knives. As a result of this incident the Salvation Army employee - who knew about this incident, but did not report it - accompanied the father to his therapy appointment. In the previous week, the appointment with the called in prevention worker had been cancelled. When the mother visited her older child, she turned up alone despite the agreement. The baby supposedly had a cold. The parents later stated that they had noticed injuries in the baby. On the day of the appointment with the Youth Care Office, the baby had a spot near her eye and the mother did not want the Youth Care Office employee to see it. Afterwards, he admitted to having hit the baby several times on the morning of the appointment. In the afternoon, the mother noticed that the baby´s body temperature had dropped to 34 degrees. The parents tried to revive the baby but paid no more attention to the dying baby. The next morning, the mother called the ambulance. The police and the ambulance found the dead baby. The autopsy revealed that the child had died earlier. In the week preceding the death and shortly before the death, at least two trauma incidents had occurred.

C24 A child of almost 4, fatal end

-10 and -1	Two previous children of the mother had been put in custodial placement.
0	A girl was born.
9-11 months	Care was arranged for the girl´s family, because the burden of raising the child was great for the mother. This institution reported it to the ARCAN. The report included malnourishment and neglect, suspected abuse, lacking parenting skills and refusing to take advice regarding the caring for and raising of the girl.
11 months	The girl was put in custodial placement at a crisis relief by the juvenile court judge at the request of the Child Care and Protection Board. She was also placed under provisional supervision order at a Youth Care Office. The Youth Care Office drew up a care plan. Conditions were stipulated in the plan, which had to be met before the girl was allowed to go home. The care during the custodial placement consisted of assistance to the mother when visiting the girl; Mental Health Care aid to the mother and domestic care. During the custodial placement, the mother moved to another region. The move did not result in a transfer of the file to the Youth Care Office in that region.

1 year, 3 months	In connection with the supervision order, the juvenile court judge received a report. The end date of the custodial placement was determined. In the decision of the Youth Care Office, it was generally stated that the mother had met the conditions and that the child could go home. The decision to return the girl was not reported to the Child Care and Protection Board by the Youth Care Office.
1 year, 5 months	The custodial placement ended, the girl remained under supervision. The family supervisor made a few house calls. The Mental Health Care aid and domestic help were upheld. These two institutions did not agree about the situation. When the girl was 1 year and eight months old, the family supervisor became ill.
1 year, 10 months	A new family supervisor started working in connection with the supervision order of the girl. The new family supervisor was immediately faced with the concerns of the care agencies about the girl. These were concerns about the girl´s nourishment, the mother´s attitude towards the girl, punishment by the mother and the fact that the mother could not take advice from others. The care workers insisted that the Youth Care Office would place the girl in a Medical Day-Care Centre. This did not happen.
1 year, 11 months	The ARCAN called the Youth Care Office with a report about the girl; the family supervisor was not available at the time. Two weeks later, the family supervisor called the ARCAN. It had been reported that a lot of screaming was heard, but that the girl was never seen. The report was discussed in a joint meeting that day, and a house call was made. The family supervisor found that the contact between the mother and child was good. An annual evaluation evaluated the conditions of the placement at home. These conditions were not completely met. No (visible) consequences were attached to this.
2 years	The mother refused help from the Mental Health Care institution. The early childhood clinic contacted the Youth Care Office for the first time. They had had concerns for a long period of time, but did not know about the supervision order. Over a period of six months, three house calls were made by the family supervisor and a joint meeting was held at the mother´s house. In June, there was a troubled home situation.
2 years, 6 months	When the girl was 2.5 years old, the family situation changed. The mother started a new relationship and became pregnant. Domestic help was reduced. The concerns were still present: the early childhood clinic had ascertained that the girl had not grown enough, the mother trivialised the problems and saw no reason for help. The conclusion in a semi-annual report of the Youth Care Office was that supervision remained necessary. The early childhood clinic found out in this period that the child had a language developmental delay and advised a placement in a day-care centre. The mother refused. The early childhood clinic and the family supervisor noticed bruises on the girl. The mother said that the bruises came from slipping and falling. The early childhood clinic thought that the bruises came from child abuse. The GP referred the girl to examine her on account of the language developmental delay and the falling.
3 years, 2 months	The girl´s sister was born, immediately after that multiple reports were received by the ARCAN. According to these reports, the mother acted strangely towards the new baby, but most reports were about the maltreatment of the older child. The reports about the new-born baby were too scanty to refer them to the Child Care and Protection Board.[257] During the time that the reporters were in contact with the mother; they did not know that a family supervisor had been appointed for the eldest child. The early childhood clinic received serious signals of different professionals who were involved with the mother at the time of the report and also from someone who knew the mother privately. In connection with this, the early childhood clinic called the Youth Care Office and told them to remove the children. They agreed on making an unannounced house call together.

	The ARCAN investigated the report regarding the new baby and made a house call. The Youth Care Office asked the ARCAN several times to refer the case to the Child Care and Protection Board, because the Youth Care Office thought that a supervision order was needed for the baby. The ARCAN came to the conclusion that a report to the Child Care and Protection Board with the aim of a supervision order was not possible, because the baby´s situation was not serious enough. The ARCAN did not investigate the report about the older girl, because she had been placed under supervision. The family supervisor together with the early childhood clinic made an unannounced house call for the older girl. The family supervisor decided that the situation was not severe enough to put the girl in custodial placement. She made agreements with the mother. The mother had to immediately take care of treatment for her problems and allow care workers back in the house. The early childhood clinic announced that they did not have faith in this and were very concerned about the girl´s safety. The family supervisor made house calls once every two weeks until the extra care started. A total of five care services were involved in helping this family. • Mental Health Care held an introductory talk. After this, two more house calls were made at monthly intervals. • Service 1 went to the mother´s house for the baby. This service (from 3 months before the girl´s death) made a total of four house calls. Contact between the mother and her baby was fine, giving advice was a problem. The mother let this service know that she did not want them to see the baby, because so many people would come to the house. • Service 2 was for the mother and made three-hour house calls. • The early childhood clinic. The mother informed the Youth Care Office that she no longer wanted to take the girl to the early childhood clinic and she never went anymore. • The Youth Care Office´s family supervisor.
3 years, 7 months	The girl died. It was determined that she had died from abuse.

C25 A 5-year-old boy, fatal end

1 year	A son of divorced parents was raised by the mother, who suffered from a psychological illness. The mother received aid from a Mental Health Care institution for her illness.
3 years	The persons treating the mother requested the Youth Care Office to arrange relief for the boy while his mother was being treated. The mother did not agree with this choice at first and took her son to his father and asked for help somewhere else. The person who treated the mother then reported this to the ARCAN. The ARCAN referred the case to the Child Care and Protection Board. Eventually, the person treating the mother agreed to the boy being looked after by his father and the extra aid to the mother. The ARCAN checked twice if the aid was sufficient and closed the file.
4 years	A year later, the mother contacted the Youth Care Office twice with the request to arrange care for her son in connection with a voluntary for herself. The person who treated the mother had a foster family where the boy could stay. The Youth Care Office´s help was not needed. The mother received short treatment and the boy came to live at home again.

257 The first reporters stated that they had submitted extensive reports and had visited the family in their professional capacity a lot. When they were allowed to read their reports to the ARCAN, they found that only some sentences had been jotted down.

4 - 5 years	The mother contacted the Youth Care Office again with the same request. The Youth Care Office contacted the person who treated the mother and heard that the aid to mother and son was sufficient. Not much later, the mother contacted the Youth Care Office in a confused state. She had suicidal tendencies and threatened to kill her son. She also feared custodial placement. Together with the mother, the Youth Care Office came up with a solution for the problems that had arisen, and the boy was placed in a foster home while the mother received (intramural) treatment.
5 years	The next day, it became clear that the mother had not reported for treatment. The Youth Care Office deliberated with a youth care provider and the Child Care and Protection Board about a provisional supervision order. It was decided not to apply for a provisional supervision order, but to conduct an urgent investigation regarding supervision. The mother could take her son home under certain conditions, but she did not meet those conditions. The Youth Care Office and the youth care provider requested the Board to apply for a supervision order with an authorisation for a custodial placement with the juvenile court judge. The juvenile court judge issued one for three months. The mother ended up in a crisis situation and the boy went to a secret foster family of another youth care provider. About a week later, the boy was transferred to the host family of the person who treated the mother after the mother had raised objections. This family became the official foster family. Based on a ruling of the juvenile court judge, the mother was allowed to take her son home for the day one month later. Soon after, the boy was not returned to the foster home. The mother had put her son (assisted by a family member) on a plane to another country. The mother then regretted this and took the son back to the foster home a few days later. After the mother had called the police for help, she was re-admitted for treatment. The mother was not allowed to take her son anymore, but she was allowed to visit him in the foster home. Meanwhile, a supervision order was issued for nine months with a custodial placement of one and a half months. The juvenile court judge stated that people had to work towards returning the boy home. Since the foster home stopped the fostering after one month (because it was too hard), that date became the deadline. The foster family did remain available as a host family for one weekend every 14 days and during any admittances of the mother. The mother went back home with aid from Mental Health Care. Shortly afterwards, the boy was allowed to live at home. He went to the host family one weekend every two weeks and one weekend per month he stayed with his father. The mother arrived at the foster family where the boy was staying while she was being treated in a severely confused state. The foster mother called the Youth Care Office. After deliberation with the person who treated the mother, the Youth Care Office decided to admit the boy to crisis relief. An urgent authorisation for custodial placement (one month) was applied for with the juvenile court judge. One month later, the Youth Care Office applied for a new authorisation for custodial placement with a foster home which offered prospects, because both the family supervisor and the person who treated the mother thought that the boy´s development could be threatened due to the changing places of residence. The person who treated the mother did state that the mother would respond with increasing suicidal behaviour if she was no longer allowed to care for her child. The juvenile court judge did decide to issue a custodial placement, but not with a foster home which would offer prospects. The judge thought it was of paramount importance that the parents and the child would maintain a good contact. Plans were made for a more comprehensive visiting arrangement and return to the boy’s mother.

	The mother started more intensive treatment for her problems. Deliberations took place between the persons who treated the mother, the foster home and the Youth Care Office regarding the visiting arrangement. The mother was allowed to take her son home in the weekends and the father also saw his son once in a while. After an evaluation with the foster home, the visiting arrangement was adjusted by the Youth Care Office (the boy no longer visits his mother each week for the entire weekend, because that is too tiring for him). The people who treated the mother and the family supervisor agreed to intervene when a visit from the boy would no longer be safe.
5 years and 6 months	The mother called the family supervisor to announce that an evaluation about her treatment would soon be held. She stated that she wanted to take care of her son again. The people who treated the mother indicated that the treatment had not been completed. The family supervisor talked to the mother about the fact that she was not allowed to take of her son just yet. After the boy had visited his mother for the weekend, the foster mother contacted the family supervisor and the person who treated the mother. According to the foster mother, the mother had suicidal tendencies and refused treatment. The visiting arrangement was not adjusted. A week later, the foster mother stated that it was hard that the mother called her very often. The family supervisor talked to the mother about this. The mother said she would change her behaviour and asked if this would have consequences for the visiting arrangement. The family supervisor told her that the current visiting arrangement would be upheld. The mother said that she had no faith in it. A few days later, the mother picked up her son for a visit over the weekend. The next day, the mother went to the police in a confused state and said that she had killed her son. At the time of his death, the boy was five-and-a-half years old.

C26 A 1.5-year-old girl abused, (near) fatal end

0	A girl was born.
2-6 months	During the first visit to the early childhood clinic, the daughter physically examined and nothing out of the ordinary was observed. During the monthly check-ups that followed, nothing out of the ordinary was found. The daughter did have red dot in her eye about three times in a row in the stated period.
6 months	The mother and her daughter were in a bar when the girl suddenly went limp and collapsed. Since the daughter was still breathing, the mother took no steps. The mother thought that her daughter had fallen into a deep sleep.
6 months and 1 week	The father was home alone with his daughter and he was bottle-feeding her. During or after feeding, the daughter became unwell. The father took her to the hospital where he stated that when he got into the care he had bumped his daughter´s head against the car door. An ambulance driver saw the bruise on her head and thought it strange that the bruise was visible so soon, seeing that the child supposedly had just bumped her head. The paediatrician determined apnoea: the result of brain damage. The paediatrician thought that the father´s story was unclear. The daughter sustained multiple disabilities. She needed Intensive Care and was transferred to a university children´s hospital the next day.
6 months and 1 week	The paediatrician reported it to the ARCAN this day. The ARCAN immediately called in the Child Care and Protection Board.
6 months and 1 week	At the request of the Child Care and Protection Board, a provisional supervision order with a custodial placement for three months was issued on this day for the daughter.

9 months	The Youth Care Office applied for an extension of the custodial placement with the juvenile court judge after these three months. During the legal proceedings, the parents argued that the brain damage was caused by a vaccination. The juvenile court judge rejected the application for an extension and ruled that it was important for the girl's recovery to return home. She did, however, remain under supervision for a year.
1 year and 2 months	The William Schrikker Foundation took over the family supervision from the Youth Care Office. The family supervisor made two house calls. The family supervisor announced that she would visit again and these visits could also be unannounced.
1.5 years	The mother discovered bruises on her 1.5 year-old daughter after she had been alone with her father. The mother took her to the accident and emergency department. The father stated that an accident had happened when blow-drying his daughter´s hair. A shelf with things on it had fallen on top of her causing the injury. The girl was referred to the hospital. The family supervisor, the mother and the hospital´s social worker held a meeting. During the meeting, it was decided that the mother would report the father to the police. The father was arrested and brought before the public prosecutor. One month later, the daughter was discharged in a relatively good shape. The hospital did follow up check-ups in the outpatients department.

C27 A 3-year-old boy, fatal end

0	A boy was born. It was the first child of the parents. There were four visits to the early childhood clinic. The first three times, nothing out of the ordinary was observed. The last time, an extraordinary increase in weight was determined. The parents seemingly overfed their son. The parents stated that the child was quiet as soon as it was fed. No authorities other than the early childhood clinic and the GP were involved in the family.
5 months	The mother left for work early. The father was home alone with the son. The father was bottle-feeding the baby. Suddenly, food started to come out of the baby´s nose. The father removed the baby from the chair and patted it gently on the back. The baby became limp and his lips turned blue. The father went to the nearest GP out-of-hours surgery. The GP immediately recognised the seriousness of the situation and called an ambulance. The baby was resuscitated and taken to a university hospital. The baby lapsed into a coma. The baby was extensively examined at the university hospital. An older internal bleeding was found, which is a possible indication of prior violence. Suspicion of Shaken Baby Syndrome arose. The ARCAN doctor of the ARCAN and Neglect reported the (serious) abuse to the police. The Child Care and Protection Board started an investigation.
About 8 -12 months	The baby stayed at the university hospital and was then admitted to a rehabilitation centre. During this period, he caught pneumonia. The boy was admitted to a neuro-rehabilitation programme.
12-13 months	A supervision order was issued after three months. An authorisation for custodial placement was rejected by the juvenile court judge: the child was in a rehabilitation centre. Three months later, the authorisation for custodial placement was issued in connection with a newly started criminal investigation into the possible abuse: the boy was admitted to a children's hospice.
13 months	The boy was suspected of having pneumonia and he was admitted to another university hospital for ten days. On account of a second opinion, he was admitted to a third university hospital.
1.5 - 3 years	The boy stayed in a nursing home.

3 years	The boy stayed in a nursing home. About two weeks prior to his death, there was a suspicion of a fractured right thigh bone, after which a further examination at a hospital would have taken place. About one week prior to his death, the fractured right thigh bone was diagnosed and the boy was supposedly taken to the hospital. A short time after, he died at the hospital from a fever and a possible pneumonia. The criminal proceedings led to the father´s conviction.

APPENDIX D. REFERENCE FRAMEWORK FURTHER EXPLAINED: HAS NOT BEEN TRANSLATED

APPENDIX E. REFERENCE LIST

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APPENDIX F. RESPONSES TO INSPECTION AND PROCESSING: HAS NOT BEEN TRANSLATED

The Dutch Safety Board
telephone +31(0)70 333 70 00 • **e-mail** info@safetyboard.nl • **website** www.safetyboard.nl
visiting address Anna van Saksenlaan 50 • 2593 HT The Hague
postal address PO Box 95404 • 2509 CK The Hague • The Netherlands