Learning lessons from serious case reviews: year 2

Ofsted's second year of evaluating serious case reviews: a progress report (April 2008 to March 2009)

This is Ofsted's second report on serious case reviews. It covers the evaluations of 173 reviews carried out and completed between 1 April 2008 and 31 March 2009. As in the first report, *Learning lessons, taking action*, this one brings together findings in relation to the practice issues arising from the reviews, the process of conducting them and the emerging lessons.

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Introduction by Her Majesty's Chief Inspector of Education, Children's Services and Skills

This report gives a full account of the outcomes of Ofsted's evaluations of 173 serious case reviews carried out and completed between 1 April 2008 and 31 March 2009. An important part of the context is the work now underway to implement Lord Laming's recommendation, in his report published in March 2009, *The protection of children in England – a progress report*, that Ofsted should in future 'focus its evaluation of serious case reviews on the depth of the learning a review has provided and the quality of the recommendations it has made to protect children'. The evaluations which provide the evidence for this report have been carried out using Ofsted's existing evaluation framework and methodology, and we hope to be consulting shortly on a revised framework which will give full effect to Lord Laming's recommendations. However, it seems to me appropriate that I should briefly introduce this report in the spirit of those recommendations, which both the Government and Ofsted have fully accepted, and focus on the two issues – what do we need to learn from these reports; and what improvement is needed in the way that learning is translated into recommendations and actions? – to deliver what Lord Laming rightly identifies as the ultimate purpose of the serious case review process: to learn from what has happened in the past to improve the way in which children are protected in the future.

In paragraph 6.11 of his report, Lord Laming goes into a little more detail about what he thinks Ofsted should concentrate on in its evaluations. He suggests that our evaluations should focus on:

- the quality of the process of the review
- the adequacy of learning and change
- professional practice
- the quality of the recommendations in protecting children to ensure that they are actively driving improved outcomes and better safeguarding systems.

Overall, this report suggests that there have been some significant improvements in the quality of the case review process, although there is a very long way still to go. There are some very good individual examples of learning and change. But the issues about professional practice are almost identical to those which were raised in our first report, *Learning lessons, taking action*. There is little change in this area. And although the report highlights that best practice in the reports evaluated is characterised by more robust quality assurance, recommendations and action plans, more evidence is still needed as to whether the actions recommended and taken are actually improving the quality of the protection of children.

The evidence that the quality of the process itself is improving is encouraging. It is also very encouraging that the pace of improvement appears to be accelerating.

However, it must also be noted that the percentage of reviews assessed as inadequate has only fallen from 40% in 2007/08 to 34% in 2008/09. It is a particularly concerning finding that the quality of attention paid to issues of race, language, culture, or religion was poor in all but a handful of reviews, although again encouraging that there were signs of improvement in this respect in the latter part of the year. This is a dimension of the review process in which we must expect to see continuous year on year improvement.

However, improvements in the quality of the process – which are extremely important – cannot mask the fact that the rate of improvement in practice and in service delivery is as yet much slower. It is really important to recognise that social workers and others working with the families whose lives can be discerned behind the pages of a serious case review are working with some of the most difficult, chaotic and unpredictable families in the community. Having said that, the failures and deficiencies which too often lay behind the sad events that triggered the reviews evaluated in 2008/09 were very little different than those that had emerged in the evaluations completed in 2007/08. It is very striking, when one studies the summary of emerging lessons in relation to practice, that very few of them are new lessons. That does not detract from the fact that some of them are stark – it is distressing to read, for example, how often nobody thought to ask a child who was clearly demonstrating how unhappy they were what was wrong. It is salutary to be reminded that the most common risk factor in the cases reviewed was neglect. This gives extra weight to Lord Laming's observations that:

> Where children are supported at home, the child protection plan must clearly identify the objectives to be achieved, with timescales, that signal either the withdrawal of support to the family or, if the objectives are not achieved, indicate the point when further action must be taken. This is particularly important in cases of child neglect where often there is no single event that 'triggers' matters escalating to an application for a court order. ….Realistic timescales need to be applied for these cases to ensure that a child is not subjected to long-term neglect.'
>
> Laming, para. 3.12

It is clear that professional and organisational boundaries, getting in the way of effective joint working and information sharing, can still be real barriers – and worrying that some of them are relatively new. There are examples in the cases reviewed, for example, of the division within local authorities between adults and children's services sometimes creating new barriers.

The focus of the individual serious case review must be on learning the lessons for the responsible Local Safeguarding Children Board and the individual agencies that come together in it – in order that in the future children can be better protected. Local Safeguarding Children Boards should not wait for the completion of the serious case review process before they start learning lessons and putting the results of that learning into practice. There are encouraging case studies in this report where the

learning and the action have started as soon as the information about what has happened begins to emerge. Ofsted wants its overall evaluation report to be a source of learning for the system as a whole – so that all children, everywhere, can be better protected in the future. The most important lessons that emerge are not about procedures or policies. Just as last year's report did, this report suggests that the absence or adequacy of procedures is seldom the issue – it is too often staff's ignorance of them or failure to follow them. There are a range of specialist training needs identified in the sample of serious case reviews relating to looked after children and young people considered in the report, and these specialist training needs are important. But this should not mask the more basic question about how we ensure basic skills and sensitivities across the workforce – so that, for example, staff will routinely think to ask a very unhappy child why they are unhappy.

The most important lesson to emerge from this report is that it continues to be essential to focus unremitting attention on the full range of issues identified by Laming and others across the whole system – issues of leadership, workforce, training, resourcing, policy and strategy – if the quality of child protection services is to be transformed in the way that everybody recognises is necessary.

Executive summary

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. They are carried out by Local Safeguarding Children Boards so that lessons can be learned. The responsibility for evaluating serious case reviews was transferred to Ofsted from the Commission for Social Care Inspection in April 2007.

In December 2008 Ofsted published its first report about serious case reviews, *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008* (referred to as *Learning lessons, taking action*).[1] The report analysed the first 50 serious case reviews which had been evaluated by Ofsted between 1 April 2007 and 31 March 2008.

This second report covers the evaluations of a further 173 reviews. These evaluations were carried out and completed between 1 April 2008 and 31 March 2009. As in *Learning lessons, taking action*, this report brings together findings in relation to the conduct of serious case reviews, the practice issues arising and the lessons learned. It considers how the process of conducting serious case reviews affects the quality of the outcomes and the depth of learning given. It identifies emerging lessons and issues which require further consideration.

[1] *Learning lessons taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008* (080112),Ofsted, 2008; www.ofsted.gov.uk/publications/080112.

This report focuses explicitly on the depth of learning. Each section of the report includes the emerging lessons from the serious case reviews which were evaluated in 2008–09. These are summarised below.

Key findings

- There is evidence to suggest that Local Safeguarding Children Boards are taking a more robust approach in relation to serious case reviews and that some of the previous barriers to learning are being removed.
- However, many of the weaknesses in practice identified in our previous report remain and there is still much to do to ensure that lessons are truly learned and that all agencies who support our most vulnerable children and young people work together to safeguard them more effectively.
- A greater number of Local Safeguarding Children Boards are carrying out more serious case reviews, with a consequent increase in volume.[2] This is despite the numbers of children killed or seriously injured where abuse or neglect is suspected remaining stable.
- The backlog of historic cases has largely been addressed. Local Safeguarding Children Boards are increasingly aware that lessons must be learned from these tragic incidents quickly and are more willing to explore the issues involved. However, Local Safeguarding Children Boards' exploration of the social, cultural and ethnic issues within serious case reviews remains a weakness.
- In instances where the history of a case spans more than one area, Local Safeguarding Children Boards are cooperating more readily across boundaries in undertaking a serious case review jointly to see if there are lessons to be learned.
- Serious case reviews are generally being carried out more speedily, although concerns remain about the length of time required for reviews of complex cases where the understandable requirements of judicial procedures can impede the speed of learning.
- Local Safeguarding Children Boards are becoming more rigorous in their scrutiny of individual management reviews and overview reports. When weak individual management reviews have been returned to the commissioning agencies for revision, there has been a subsequent improvement in quality and in the depth of learning evident.
- Fewer serious case reviews are being judged as inadequate, although the overall proportion remains too high.
- Local Safeguarding Children Boards have responded positively to the 2008 ministerial letter of 16 December 2008 clarifying the independence requirements

[2] Thirty-three Local Safeguarding Children Boards submitted serious case reviews for evaluation in 2007–08, 96 in 2008–09.

regarding chairs of panels and overview writers. As a consequence there has been a steady improvement in levels of independence within the serious case review process.

- The pace of improvement in serious case reviews has accelerated in recent months. Several factors have been identified as supporting this improvement by interviewees from the 'good practice' survey conducted as part of this report. These include:
  - direct feedback to Local Safeguarding Children Boards by Her Majesty's Inspectors (HMI) as part of the evaluation process has improved the depth of their learning, as evidenced by improvements in subsequent reviews
  - the increased requirements on Local Safeguarding Children Boards announced by the Secretary of State in the wake of the Baby Peter tragedy have ensured that the serious case review process and the subsequent depth of learning are more effective
  - processes for conducting serious case reviews have been strengthened with more robust quality assurance, recommendations and action plans.

Summary of emerging lessons in relation to practice

1. Reviews of looked after children

Seventeen of this year's 173 evaluations concerned children who were looked after. Examination of these cases identified some key lessons for future practice:

- the importance of listening and directly working with children to understand their perceptions of their experiences, particularly when they present as unhappy or unwell
- the need for the looked after service to be planned and managed as part of a continuum of local authority services rather than being considered entirely separately
- the need to assign sufficient staff resources, with appropriate expertise, to provide and support services for looked after children
- the importance of following the requirements of legislation and regulations in relation to the assessment, approval, matching and support for foster carers and adopters despite the challenges of finding placements for children
- the need for management oversight to be clear so disputes between professionals can be resolved and for a clear process by which any disputes can be escalated through the management line
- the importance of ensuring that all agencies consistently fulfil their responsibilities, including the completion of personal education plans and

holistic health assessments, and rigorous responses by the police and other agencies when children are missing from care.

2. Reviews where disability issues were a factor

In 19 of the serious case reviews, concerning either disabled children, one of their disabled siblings or a disabled parent, the following key lessons were identified:

- disabled children and young carers who may be caring for a disabled parent are not always receiving the assessments of needs to which they are entitled and as a consequence do not receive services which meet their needs
- the focus of support for parents of disabled children needs to be tailored to meet the individual needs of the child and provide the parenting skills to enable the adult to address her or his overall care, safety and well-being
- good practice in safeguarding children is seen where there are robust links between child protection workers and disability workers and where there is sufficient training to increase the understanding and ability of disability workers to take into account both disability and child protection issues
- cases involving disabled children benefit from the involvement of more experienced workers with extensive experience when there are dual issues of child protection and complex disabilities involved
- voluntary organisations often play a valuable part in supporting children and families. It is important that staff in these agencies have a good understanding of, and confidence in addressing, child protection responsibilities
- clear processes for communication and information-sharing across different remits within children's services, and across adult and children's services, are vital when there are child protection concerns in families in which the children have caring responsibilities for disabled parents.

3. Issues of race, language, culture and religion

From a review of all this year's evaluations and an in-depth scrutiny of a sample of 17 serious case reviews, the following key lessons emerged:

- recording of ethnicity is inconsistent in serious case reviews
- there is generally poor attention to whether agencies identified the ethnic, cultural, linguistic and religious needs of the child and the family, and took account of these when providing services.

4. Individual management reviews and the overall quality of serious case reviews

- This report presents examples of good practice, which have improved the quality of serious case reviews and of individual management reviews. Some of the strategies outlined in these case studies may be helpful to Local Safeguarding Children Boards when embarking on a new review or by those that are required to formulate a plan to address the inadequate features of a serious case review previously judged inadequate by Ofsted.
- In serious case reviews judged to be good, individual agencies give careful consideration to the choice of independent authors for individual management reviews. They ensure that there is robust planning from the start of the process and that the terms of reference encompass the range of information that the review should cover. They also put in place quality assurance processes to consider the review process before it is signed off.

5. Independence in the serious case review process

- Although the independence of the overview report writer is important and is an increasingly common feature, the quality of reports also depends upon a range of other factors. These include the appropriateness of the terms of reference, the quality of the individual management reviews, and the robustness of the recommendations and action plans.
- The involvement of representatives from agencies which are not contributing to the serious case review helps to ensure a greater element of independence in serious case review panels.

6. Involvement of families

From the sample of 17 cases the following key lessons emerged:

- in good examples the serious case review panels use different methods of involving families in the process, including family members other than the parents, and offer continuing opportunities for them to participate in the review process
- good overview reports include reference to whether family members were involved in the serious case review process and, where it was decided not to do so, a comment as to whether this was the appropriate decision.

Background

1. Responsibility for evaluating serious case reviews, conducted in accordance with the guidance set out in Chapter 8 of *Working together to safeguard children* (referred to as *Working together*), transferred to Ofsted on 1 April 2007.

2. The guidance states that where a child dies and abuse or neglect is known or suspected, the Local Safeguarding Children Board must conduct a serious case review. It must also consider conducting a serious case review where:

   - a child sustains a potentially life-threatening injury or serious and permanent impairment to health and development through abuse or neglect
   - a child has been subject to particularly serious sexual abuse
   - a child's parent has been murdered and a homicide review is being initiated
   - a child has been killed by a parent with a mental illness
   - the case gives rise to concerns about inter-agency working to protect children from harm.

3. Chapter 8 of *Working together* defines the purpose of a serious case review as being:

   - to establish whether there are any lessons to be learned from the case about inter-agency working
   - to identify clearly what these lessons are, how they will be acted upon, and what is expected to change as a result
   - to improve inter-agency working and better safeguard and promote the welfare of children.

4. Local Safeguarding Children Boards are required by *Working together to safeguard children* to send the completed review to Ofsted for evaluation. These are complex documents and include a large volume of separate documentation: terms of reference; individual management reviews from all statutory and voluntary agencies who may have been involved with the child concerned during the period covered by the review; an overview report which draws together the findings from the individual management reviews; action plans; and an executive summary, which is the published outcome of the enquiry. Ofsted evaluates the effectiveness of all parts of the process in ensuring that lessons have been learned.

5. The outcome of the evaluation is shared with Local Safeguarding Children Boards and forms part of the evidence used for Ofsted's wider evaluation of the effectiveness of children's services in a local area. Outcomes of evaluations are also shared with the Department of Children, Schools and Families.

6. Ofsted's first report on serious case reviews, *Learning lessons, taking action*, concluded that, despite an increased focus on partnership working within children's services, much remained to be done to ensure effective learning and action from every serious case review. All services needed to appreciate their role in making this happen. The report underlined the key role which universal services, such as education and health, play in ensuring that children are safe. It also highlighted weaknesses in record-keeping and communication which allow children to fall into gaps between services, and the need for more training for staff to enable them to identify and report the signs and symptoms of abuse and neglect.

7. A key finding of last year's report was that serious case reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why. This had a detrimental effect on the lessons learnt. *Learning lessons, taking action* stated that a fundamental shift of approach was required, with a greater emphasis on the practice of individual members of staff and managers.

8. From the 50 serious case reviews evaluated in *Learning lessons, taking action*, 20 were judged to be inadequate. The report made suggestions for remedying the weaknesses still apparent in the serious case review process. The most important issue was the need for all reviews to focus much more closely on the child concerned rather than on the agencies involved.

9. In last year's report the main reasons for the inadequate judgements were the timescales, with some reviews taking up to three years to complete, and the poor quality of the individual management reviews. These weaknesses had a direct impact on the quality of the findings, the impact on the lessons learnt and the potential to take action where failings were identified.

10. This second report has been produced against a background of heightened public awareness of serious case reviews.

11. As a result of the high number of reviews judged as inadequate in 2007–08, the Secretary of State for Children, Schools and Families wrote to the directors of children's services in all local authorities. This letter informed them that Local Safeguarding Children Boards whose serious case reviews had previously been evaluated as inadequate by Ofsted were required to review them and to send a report to the Secretary of State and to Ofsted by the end of February 2009. These reports needed to outline the actions which the Local Safeguarding Children Boards had taken to address the identified weaknesses and their impact on improving local practice. Any subsequent serious case reviews judged as inadequate should be reviewed in the same way, with a report to the Secretary of State and to Ofsted within three months.

12. In addition to the 173 reviews, by 31 March 2009 Ofsted had received and evaluated 63 statement of action reports from Local Safeguarding Children

Boards on the measures they had taken to address the weaknesses identified in those serious case reviews previously judged inadequate overall. These covered 43 Local Safeguarding Children Boards. Ofsted judged that the previously identified weaknesses had been satisfactorily addressed in all except one case. Processes for conducting serious case reviews had been strengthened with more robust quality assurance, new recommendations and revised action plans. Information from these has also been included in this report.

13. The Secretary of State also commissioned Lord Laming to conduct a review of the state of child protection in England. His findings, *The protection of children in England – a progress report*, were published in March 2009 and, if implemented in full, have the potential for significant impact on child protection in England.

14. The majority of the serious case reviews which were analysed for this report (150 out of 173) had been completed before these developments took place. However, the current context is important in considering both the issues arising from these evaluations and the messages for the future.

15. *Learning lessons, taking action* focused on three aspects:

- factual information about the children who were the subject of serious case reviews, their families and the nature of the incidents
- the lessons about the practice of agencies involved
- the quality of the process of carrying out the reviews in terms of how they met the guidance in *Working together*.

16. This second report covers the same three aspects. Since many of the issues are inevitably similar to those from the first 50 reviews, this report does not duplicate all the detail from *Learning lessons, taking action* but provides an in-depth analysis of progress in some of the priorities from last year's recommendations. In addition, visits were undertaken to 10 Local Safeguarding Children Boards which had undertaken serious case reviews judged good by Ofsted. Positive examples from these visits are included in this report.

The children, their families and the incidents

Age profile

17. During the period between 1 April 2008 and 31 March 2009, Ofsted received 174 notifications of deaths of children where abuse was or was suspected to have been a factor. These comprised 38 deaths arising from homicide, 44 from other external causes such as killings by other young people or drowning; 47 accidents or adverse incidents including factors of neglect and substance misuse; and 45 where the cause of death remains undetermined following criminal investigations and coroner's enquiries. These numbers are broadly

consistent with those for the previous year. Further information and the ages of the children concerned are set out below:

Table 1: Details of child deaths for which Ofsted was notified between 1 April 2008 and 31 March 2009

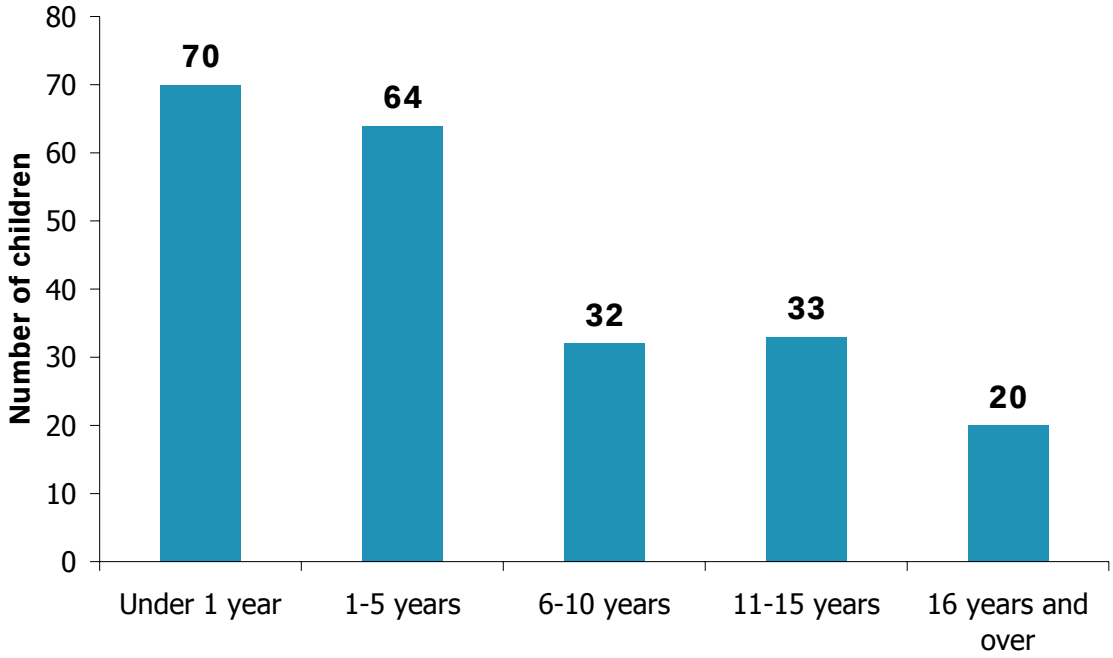
Homicide	
Murder by parent/carer*	24
Other**	14
Total	**38**
Other external cause	
Killing by another young person	9
Suicide	24
Other***	11
Total	**44**
Accidents and adverse events	
Concealed birth	6
Result of accident but neglect a factor	17
Overlay by parent/carer	5
Substance misuse	13
Road accident	6
Total	**47**
Undetermined	
Unexplained cause	13
Unknown cause	23
Other****	9
Total	**45**
Grand total	**174**

* Parent/carer was convicted of the murder of the child.
** Includes deaths arising from malnourishment, neglect, physical abuse, shaken baby or arson.
*** Includes deaths from fire and drowning.
**** Includes deaths where children were subject to child protection plans or known mental health and teenage parenting.

18. Also between 1 April 2008 and 31 March 2009, Ofsted evaluated 173 serious case reviews, a significant increase on the previous year. This included reviews which may have been initiated prior to 1 April 2008 as well as those which were notified, completed and evaluated within the period of this report. The reviews concerned 219 children since some of them dealt with more than one child in the family. The total number of serious case reviews evaluated is considerably larger than in the previous report because:

- some serious case reviews submitted had taken a significant length of time to complete
- the report covers a full year of evaluations, whereas in 2007–08, due to the recent transfer of responsibility to Ofsted, the first serious case review evaluation by Ofsted was completed in July 2007
- over the past year, a larger number of Local Safeguarding Children Boards have initiated more serious case reviews. Reviews from 33 Local Safeguarding Children Boards were submitted for evaluation in 2007–08. Ninety six Local Safeguarding Children Boards submitted reviews in 2008–09.

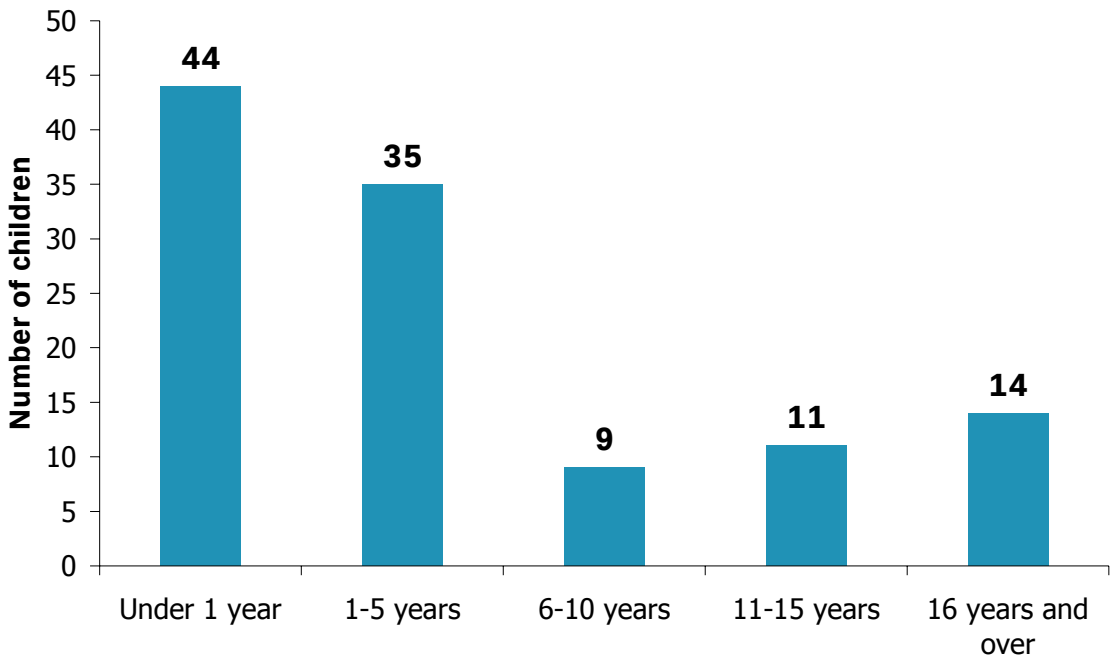
Figure 1: Ages of 219 children who were the subject of a serious case review evaluated by Ofsted between 1 April 2008 and 31 March 2009



19. In a few cases (six of 219 children) where serious sexual abuse had taken place over many years, it was not possible to give one age that applied to the children at the time of the incidents. The ages given for these children are those which applied when the abuse was disclosed.

20. In total, 113 of the 219 children died as a result of the incident: 44 of the babies aged under one; 35 of the children aged one to five; nine of the children aged six to 10; 11 of the children aged 11 to 15; and 14 of the young people aged 16 and over.

Figure 2: Ages of the 113 children who died as a result of the incident (number of children)



Gender and ethnicity

21. Of the 219 children who were the subject of a serious case review, 115 were boys and 103 were girls. The gender of one child who died at birth was not recorded.

22. Incomplete recording of basic information was a feature of nearly a third of the serious case reviews (54 out of 173). In five reviews there was no record of the ethnicity of the child and in a further 51, their ethnicity was not absolutely clear.

23. The largest recorded ethnic group was White British (135 out of the 219 children identified). Eight children were recorded as Black or Black British African and three as Asian or Asian British Pakistani. Where ethnicity was identified, there was a lack of consistency in the range of categories used.

Table 2: Ethnicity of 219 children in serious case reviews evaluated by Ofsted between 1 April 2008 and 31 March 2009

Ethnicity	Number of children
Asian or Asian British – Indian	1
Asian or Asian British – Pakistani	3
Black or Black British – African	8
Black or Black British – Caribbean	2
Chinese	1
Mixed – Asian and White	3
Mixed – Black African and White	4
Mixed – Black Caribbean and White	4
White – British	135
White – Irish	1
White – any other White	1
Unknown	5
Not recorded	5
Unclassifiable ethnicity	46

Involvement of children's social care

24. Of the 219 children, 149 (68%) were known to children's social care services at the time of the incident. There were others who had been known to the services previously but not at the time of the incident.

25. There were 19 children identified as being in the care of the local authority (looked after children) when the incident occurred. Two further children were adopted. Twenty three further children had been looked after when they were younger or had a sibling who had been, or was being, looked after.

26. At the time of the incident, 41 of the 219 children, almost 19%, were subject to a child protection plan. In addition, others had a child protection plan which had been discontinued prior to the incident. In terms of the age profile of those who were the subject of a child protection plan, nine children were aged under one, 15 were aged between one and five years old, eight were aged between six and 10 years old, seven were aged between 11 and 15 years old, and two were aged 16 or over.

The families

27. *Learning lessons, taking action* analysed the pattern of characteristics in the families of the children covered by that report. The most common issues were drug and alcohol misuse, domestic violence, mental health problems and/or a learning disability. It was not unusual for more than one of these characteristics to exist in any one family. The report found:

    - a failure of agencies to adequately assess the risks posed by drug and alcohol misuse, particularly to very young babies
    - a failure of agencies to understand, accept and assess the impact of domestic violence on children
    - variation in the cooperation of mental health NHS Trusts and other specialist services in relation to the families involved
    - insufficient assessment of the impact of the learning difficulties of adults on their capacity as parents and on their own mental health.

28. This year's analysis of the 173 serious case reviews has revealed a similar profile. Common risk factors were present in many of the families reviewed. Domestic violence was an issue in 47 cases, drug and alcohol in 40 and mental illness in 43. It was also notable that neglect had either been identified previously or during the serious case review process in 50 cases. More than one of these risk factors was present in a considerable number of the cases which were subject to serious case reviews.

29. The serious case review information showed that many of the families were living chaotic and complicated lives, making it difficult for professionals to obtain a good picture of the family circumstances and dynamics. Some agencies were often missing from the early information-gathering processes, notably housing and adult services in general, such as social care, adult mental health services, and drug and alcohol services. These agencies were later found to have held important information about family circumstances.

30. *Learning lessons, taking action* also concluded that issues of race, language, culture, religion and disability were not covered well in the serious case reviews or in the way professionals had worked with the families. This year's analysis also looked at these factors and paragraphs 54–81 of the report consider these issues in greater detail.

Nature of the incident

31. As in *Learning lessons, taking action*, many different causes contributed to the serious incidents or deaths of the children. They varied across the different age groups.

32. **Children aged under one:** Forty-nine of the 70 children were the victims of physical abuse by a parent or parent's partner. Ten babies died of sudden unexpected death in infancy, of whom seven were known to children's services. In these cases there were concerns about standards of care and neglect and several were associated with alcohol and drug abuse.[3] Two babies born to teenage mothers died at birth following a concealed pregnancy and two babies were overlain by their parents, where alcohol was a factor.

33. **Children aged one to five:** Twenty-three of the 64 children suffered physical injury by a parent or parent's partner. Sixteen suffered neglect, including seven who died from methodone ingestion, two who suffered dehydration and serious neglect after being unattended following the death of their mother, four who died in house fires, and three who died from drowning where neglect was a factor. In two serious case reviews children of this age group had witnessed the death of their mother at the hands of her partner. Four concerned murder or attempted murder by a parent, who also committed suicide.

34. **Children aged six to 10:** There is less of a pattern for the 32 children in this age group. Four children were either murdered, or were victims of an attempted murder, by their mothers. All these cases involved parents with mental illness. In three cases, children witnessed the murder of their mother by an ex-partner. Two children were murdered by their father, and in one case the children and their mother were both murdered by the father. There were four cases of sexual abuse, six of neglect (including one child who died in a road traffic accident), two of physical abuse and one case of poisoning. There was also one suicide and one attempted suicide.

35. **Children aged 11 and over:** The most common reason for a serious case review in this group was suicide, which affected 10 young people. Five young people were stabbed and five were shot. Eight were sexually assaulted, five were victims of sexual exploitation and one was a perpetrator. Other causes for the deaths of the young people included drowning following an attack by a gang, overdose of drugs and alcohol, death in house fires, neglect, road traffic accidents linked to neglect, physical abuse and anorexia.[4]

Lessons for practice

36. In last year's report, the main findings related to the failure of staff to identify and report signs of abuse, with poor recording and communication, and limited

[3] 'Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm', *Working together to safeguard children*, DCSF, 2006.

[4] 'Anorexia nervosa, commonly referred to as 'anorexia', is a life-threatening eating disorder. If not treated, anorexia can lead to permanent physical damage and in some cases, even death. Anorexic behaviour is complex… most people, especially adolescents, who suffer from anorexia usually have a distorted mental image of his/her body… caused by low self-esteem', *Anorexia Nervosa UK 2007.*

knowledge and application of basic policies and procedures. Professionals failed to consider the situation from the child's perspective. Too often they also took the word of parents at face value without considering the effects on the child.

37. The report also found that issues of race, language, culture, religion and disability were not covered well, either in the serious case reviews or in the way professionals had worked with the families. This means lessons were not learned and vital issues were missed.

38. The factors related to drug and alcohol misuse, domestic violence, mental illness and learning difficulties were often not properly taken into account in assessing risk and considering the impact on the child. Agencies were found to be particularly poor at addressing the impact of chronic neglect on children and intervening at an early stage to prevent problems from escalating. For a number of older children the problems in the family had been evident for some years.

39. The poor practice issues identified in last year's report were also a feature of the 173 serious case reviews evaluated for this report. The cases cover an overlapping timeframe and pre-date any changes arising from *Learning lessons, taking action*, Lord Laming's report *The protection of children in England – a progress report*, and the Government's responses. The cases also reflect the complex risk factors which professionals need to balance in reaching their decisions.

40. There are some encouraging signs from Local Safeguarding Children Boards which have used the lessons from serious case reviews to improve local practice, as these three examples illustrate:

> As a result of serious case reviews, a Local Safeguarding Children Board in the North West carried out a domestic violence audit, which revealed a lack of clarity about thresholds for referrals and resulted in the development of a domestic violence project. The Local Safeguarding Children Board sub-group, led by the police, produced a threshold document which was launched with multi-agency training. A specialist team now assesses domestic violence referrals which meet the criteria and puts together safety plans with children and carers. This has resulted in an increase in referrals and earlier intervention to prevent harm to children.
>
> To deal with this the Local Safeguarding Children Board set up a multi-agency domestic violence pilot service staffed by professionals who specialise in domestic abuse. It includes social workers, police officers, a health visitor, midwife and children's centre worker. It is also supported by other agencies, including the NSPCC, a children's centre and specialist domestic violence voluntary organisations and there are strong links with Connexions, registered social landlords and the Youth Offending Service.

The pilot programme started in January 2009 and is due to be evaluated in September 2009. In the interim there has been positive feedback from families and professionals. Service demand is high and a multi-agency service has been provided to around 100 families. The pilot has also enabled the children's centre to provide a more effective service for families who often find it hard to engage with local professionals.

A Local Safeguarding Children Board in the North East has used the learning from a serious case review to make changes in how cases are allocated to social workers. In a previous serious case review, there had been concern about the impact on siblings' needs as a result of practitioners dealing with a demanding adolescent. The siblings had received significantly less attention. The local authority has now changed its allocation arrangements and, in such cases, may now allocate more than one social worker to ensure that all siblings receive appropriate attention. This has also led to improvements in contact plans as sub-sets of children's care plans.

One of the London Local Safeguarding Children Boards ensures that learning from serious case reviews takes place as soon as possible, often commencing before the review has been published. In a recent case, school staff were involved in drawing up the action plan and a key development was the tightening up of procedures for the transfer of records between schools, including special educational needs and school health records. Copies of key documents are now kept in the outgoing school until an audit confirms that the records have been received.

41. Because the practice issues from this year's serious case reviews are similar to those set out in *Learning lessons, taking action*, a more detailed analysis of three aspects of practice was carried out to establish whether there are any new lessons to learn. The focus was on:

- children and young people looked after by local authorities
- disabled children or parents
- race, language, culture and religion.

Children and young people looked after by local authorities

42. At 31 March 2008 there were 59,500 children and young people in England who were in the care of local authorities (looked after).[5] Seventeen of this year's 173 serious case reviews concerned looked after children and these cases were

[5] 2008 annual data submission to DCSF, SSDA 903. Release of the figures for 2009 is expected in mid-October 2009.

analysed for this section of the report. They included the reviews of children and young people who were looked after at the time of the incident and two adopted children who had previously been looked after. Some reviews concerned more than one child in the family. In total the 17 cases involved 21 children, of whom one was under one year old, four were aged six to 10 and 16 were 11 and over.

43. Of the 21 children covered by these serious case reviews, three were victims of child sexual abuse and six were victims of sexual exploitation. Other causes leading to the review were suicide (2), attempted suicide (1), abuse by foster carers (3), abuse by adopters (2), being stabbed by a person unknown (1), drug and alcohol abuse (1), death in a motor vehicle accident linked to neglect (1) and being the perpetrator of a murder (1).

44. Six groups of factors contributed to the deaths of the children or to the serious incidents in these 17 cases. These were:

    1. insufficient focus by professionals on the needs of the children
    2. shortcomings within the process for assessing the children and decision-making
    3. lack of consistent rigour in the assessment and approval of foster carers and adopters
    4. failings in joint working between agencies
    5. lack of compliance with statutory requirements and guidance
    6. gaps in meeting staff training needs.

    Each of these factors is explained in more detail below.

45. **Insufficient focus on the needs of the children:** Many of the children, particularly those aged 11 and above, had a long and complex history of concerns, some of which dated back to birth, with periods of being looked after, previously being on the child protection register or, more recently, subject to a child protection plan. Nevertheless, the serious case reviews identify that the concerns which the children themselves raised were not addressed sufficiently. Where there were frequent visits to Accident and Emergency, these were not recognised as possible cries for help; concerns about bullying were not investigated satisfactorily; children who often went missing were seen as offenders or absconders rather than children in need. Overall, the serious case reviews found that these looked after children who presented as unhappy had not been asked the cause.

46. **Shortcomings within the process for assessing the children and decision-making:** A number of cases were affected by the inconsistent quality of individual agencies' assessments and the involvement of a complex, and at times confusing, group of professionals. In a few cases there were unresolved disagreements between professionals within or across different council areas. Examples include disagreements on whether a child be discharged from care or

in relation to the appropriateness of placements. This made it difficult to establish priorities and take decisions. The serious case reviews also identified examples of delay in the recognition and assessment of looked after children's learning difficulties.

47. **Lack of consistent rigour in the assessment and approval of foster carers and adopters:** The main issues of concern were a failure to take account of potential foster carers' and adopters' previous history or minimising its significance; gaps in the assessment of family members; omitting to take into account the views of other children within the family of the foster carers and adopters; and insufficient challenge by the respective approval panels when making the decisions.

48. Once families had been approved there were cases where a 'rule of optimism' prevailed, with an unwillingness to consider concerns which arose as possible signs of abuse. The significance of what children were saying was minimised or insufficiently explored. Problems were denied because of the scarcity of alternative placements. Assumptions were made that foster carers would cope but insufficient support was given to them. In addition, when decisions were made about additional placements with the foster carers there was a failure to consider previous recommendations about the numbers and type of children to be placed.

49. **Failings in joint working between agencies:** Of the 17 serious case reviews, 11 identified that joint working was ineffective. Agencies were working at cross-purposes, for example through poor information-sharing when children moved placement or by closure of cases without consultation with relevant partners. Most of the children concerned had incomplete or no personal educational plans. Some schools had limited understanding of their responsibilities for supporting looked after children.

50. Four of the reviews found that health assessments did not consider all the children's needs. In one serious case review, the Child and Adolescent Mental Health Service was not sufficiently available and had insufficient coordination of referrals, with service provision depending upon the children remaining in the same placement. Inconsistencies in the assessments from the Child and Family Court Advisory and Support Service (Cafcass) and from youth offending teams were identified. Different police forces had a varied response to children missing from care. Responses often lacked sufficient focus in exploring the reasons why the child repeatedly ran away or did not return to their placement.

51. **Lack of compliance with statutory requirements and guidance:** Examples of inadequate practice which contributed to the incidents in the sample of serious case reviews included poor quality or absence of care and placement plans, delays or failure by placing authorities to notify receiving authorities about the placements, and introduction of children into placements without prior consultation with them. The reviews identified that there was

confusion when applying both the child protection procedures and the allegations against carers procedures at the same time. These difficulties were made worse by changes in the allocation of social workers.

52. **Gaps in meeting staff training needs:** From these 17 serious case reviews, various training needs for staff were identified relating to looked after children. These included training on assessing the impact of substance misuse, management of challenging behaviour including the use of restraint, assessing the impact of sexual abuse on children and young people, working with children who exhibit sexually harmful behaviours, management of absence without permission, and risk management. Cases were allocated to inexperienced staff who had not yet developed the necessary knowledge and skills.

Emerging lessons

53. Seventeen of this year's 173 cases concerned children who were looked after children. Examination of these cases identified some key lessons for future practice:

- the importance of listening and directly working with children to understand their perceptions of their experiences, particularly when they present as unhappy or unwell
- the need for the looked after service to be planned and managed as part of a continuum of local authority services rather than being considered separately
- the need to assign sufficient staff resources, with appropriate expertise, to provide and support services for looked after children
- the importance of following the requirements of legislation and regulations in relation to the assessment, approval, matching and support for foster carers and adopters despite the challenges of finding placements for children
- the need for management oversight to be clear so disputes between professionals can be resolved and for a clear process by which any disputes can be escalated through the management line
- the importance of ensuring that all agencies consistently fulfil their responsibilities, including the completion of personal education plans and holistic health assessments, and rigorous responses by the police and other agencies when children are missing from care.

Disabled children or parents

54. Disability was a factor in 19 of this year's serious case reviews. These cases were analysed in greater depth. They included eight reviews involving disabled children, one of whom was also a looked after child. There were also three cases where there was a disabled sibling and eight involving disabled parents.

55. In a further five reviews, children who did not originally have a disability had been left permanently disabled as a result of the incident that led to the serious case review. These children are not included in the numbers referred to below.

56. The eight disabled children ranged in age from 10 months to 15 years. Their disabilities included cerebral palsy, attention deficit hyperactivity disorder, autism and sickle cell anaemia.

57. In the eight serious case reviews where the parent's disability was a factor, this included both learning and physical disabilities. In two of these cases both parents were disabled.

58. Analysis of these 19 serious case reviews has identified four main themes with regard to disability:

- inadequate recognition of the children as Children in Need under Section 17 of the Children Act 1989
- failure to address the impact on the family of either a disabled child or disabled parent
- issues of disability masking the child protection concerns
- poor communication between services.

59. **Inadequate recognition as Children in Need:** Six of the 19 serious case reviews included disabled children whose needs had not been assessed under the Children Act 1989. Where services were needed, these were not therefore provided for the children. The reviews found that inexperienced staff were allocated to these cases but, because they were not defined as 'children at risk', they were given a lower priority.

60. In the eight serious case reviews where there was a disabled parent, the children were not assessed as young carers and were therefore not provided with services. There were also related issues because of the different principles applying to adult and children's services. The reviews identified conflicts between the parent's right to lead as normal a life as possible and the child's right to protection and 'good enough' care. In addition, it was found that different thresholds for service provision apply for adult services, which were unable or unwilling to contribute to assessments because the parents did not meet these thresholds. The children's needs did not take sufficient priority.

61. **Failure to address the impact on the family of either a disabled child or a disabled parent:** There were issues in five of the eight serious case reviews that involved disabled children of failure to acknowledge and take account of the challenges of parenting a disabled child. Common stress signals, such as tiredness, depression and missed appointments, were overlooked and were not recognised as symptoms which might give rise to greater concerns. In

nine cases where a number of individuals in the family were receiving services there was no overall assessment of family circumstances.

62. In the three cases where there was a disabled sibling, their needs were not sufficiently considered, either as a contributory factor to family stresses, or in terms of the impact of changes of family circumstances on them. Parents' ability to cope with all the children was not adequately assessed. The reviews identified that stress signals were missed, such as the negative way that a depressed mother talked about other children.

63. Where the reviews identified a disabled parent, there were also issues concerning the impact on the whole family. In four of the eight cases there was a failure specifically to assess the parenting skills of parents with learning disabilities.

64. **Issues of disability masking the child protection concerns:** The concerns in the eight serious case reviews with a disabled child related to a focus on the child's disability and the provision of services to address this, without assessing the wider needs of the child and the family. Child protection concerns were missed. In four of the eight reports there was a failure to recognise the increased vulnerability of disabled children, for example to child sexual abuse.

65. In four of the reviews, the workers involved with disabled children were not sufficiently experienced and knowledgeable about child protection issues and tended to focus primarily upon the children's disabilities. Some voluntary organisations had a limited understanding of child protection and their statutory responsibilities.

66. Where there was a disabled parent, the serious case reviews identified examples of the focus on their disability tending to mask the child protection issues. For example, some concerns about general neglect were not defined as posing a risk of significant harm and therefore meeting the threshold for a child protection investigation. In one case, the difficulties that a disabled parent had in complying with the complicated feeding regime required by their disabled child was not adequately recognised by services and thus insufficient support was provided. This issue was explored thoroughly in the subsequent serious case review.

67. These cases identified the importance of staff working with disabled children having knowledge of and experience in child protection.

68. **Poor communication between services:** In the eight serious case reviews, four identified concerns about poor communication between services, each of which had its own priorities. Education was focused on special educational needs issues, health services on the health impact of the disability, and children's social care on general support and respite, often via voluntary

organisations or social worker assistants. The reviews identified that even within children's social care services there was sometimes poor communication between disability services and those responsible for child protection. An example of inadequate communication concerned a service which closed a case because the child did not attend an appointment, which should have been seen as an indicator of the stresses within the child's life.

69. There were also examples of cases of poor communication between adult and children's services. Key concerns about the adults, for example mental health issues, offending or domestic violence, were sometimes not known about.

Emerging lessons

70. In 19 of the serious case reviews either the children concerned, one of their siblings or their parents had a disability. The following key lessons were identified in these cases:

- Children with a disability and those who are caring for a parent with a disability are not always receiving the assessment of needs to which they are entitled and as a consequence do not receive the services they require to meet their needs.
- The focus of support for parents of children with disabilities needs to be tailored to meet the individual needs of the child and also to provide the adult with the parenting skills required to address her or his overall care, safety and well-being.
- Good practice in safeguarding children is seen where there are robust links between child protection workers and disability workers and where there is sufficient training to increase the understanding and ability of disability workers to take into account both disability and child protection issues.
- Cases involving children with a disability benefit from the allocation of more experienced workers with extensive expertise where there are dual issues of child protection and complex disabilities involved.
- Voluntary organisations have a very valuable role in supporting children and families. It is important that they have a good understanding of, and confidence in addressing, child protection responsibilities.
- Clear processes for communication and information sharing across different remits within children's services, and across adult and children's services, are vital when there are child protection concerns in families in which the children have caring responsibilities or parents have disabilities.

Race, language, culture and religion

71. Very few of the evaluations of serious case reviews found that race, language, culture or religion had been addressed by agencies in a meaningful way. As recorded earlier, it is of concern that ethnicity was not considered or recorded

consistently in all cases. There were positive comments about this area in only 18 evaluations of the 173 serious case reviews, nearly all of these in the latter part of the year. Where it was addressed, there were some good examples of sensitive and careful analysis.

72. There was a general assumption that where the family was of White British origin, there were no issues of culture to be considered. This overlooked, for example, considerations such as the particular norms and traditions of a community or family, the role of the extended family, the impact of class, and the role of language and its meaning in a family.

73. Where the issue was addressed, it was seldom followed through meaningfully into lessons learned and implications for practice. In agencies' individual management reviews there was little detailed evidence of how the issue had been addressed and incorporated into practice by those who had been working with the family prior to the incident. General statements were made such as 'the service is sensitive to the needs of...' without any supporting evidence.

74. There are, however, some signs that improvements are being made by Local Safeguarding Children Boards. Following the Secretary of State's requirement that serious case reviews previously judged inadequate by Ofsted needed to be reconsidered by the Boards, many have revised procedures to include attention to racial, cultural, linguistic and religious issues.

75. In order to look at issues of race, language, culture and religion in more detail, 17 serious case review evaluations were selected for more in-depth analysis. Of the 27 children involved in these 17 reviews, 16 were White British, two were Black or Black British African and eight of an unclassifiable ethnicity, usually described as mixed heritage. The ethnicity of one child was not recorded.

76. Of the 17 cases, there was no recorded reference to any issue of race, language, culture or religion in 12 cases and limited references in the remaining five. The following extracts from two of the evaluations illustrate this:

> The overview report was of good quality with comprehensive identification of the key issues. There is a robust multi-agency action plan which addresses shortfalls well. However, individual management reviews are of variable quality and only one makes reference to the family's racial, cultural, religious and linguistic identity.[6]

[6] Extract from the evaluation of a review where the specific religious and ethnic identities of the family were of particular significance to the events which occurred.

> The review fails to address a key feature of the terms of reference.[7] The ethnic, cultural, linguistic and religious needs were not taken into account. There is no reference to research or previous reviews, and it is unclear how the Local Safeguarding Children Board will monitor implementation of the action plan.

77. Race, language, culture and religion were partially addressed in five cases in the sample of 17. Of these, two were White British and three were mixed heritage. In one example, the family's religious affiliation and racial background were considered to be factors in their lifestyle and parenting methods. In this case, the church provided an individual management review and made relevant recommendations about their own practice and procedures in terms of safeguarding. Another individual management review took account of the different child-rearing practices in the country of origin of one of the adults. However, where factors of race, culture or religion were addressed in individual management reviews, they were not always picked up in the overview report, so it was unclear how or whether appropriate lessons would be integrated into practice.

78. In another example, the complex racial mix in a family was addressed through a comprehensive genogram (a pictorial display of the family's relationships). One of the individual management reviews had a 'race assessment' section, which ensured that details of the agency's practice in this respect were analysed, including the fact that the ethnicity had been wrongly recorded. However, the same individual management review stated that 'there was no evidence of discriminatory practice' and, again, it was not clear how any findings would be translated into improved practice.

79. Another evaluation considered that the review had been 'uncomfortable' in its consideration of the issue of race. The family history collated for the serious case review was limited. Individual management reviews had made statements that the particular ethnic needs of the children concerned were well understood by the service but this was not backed up by evidence. When there had been plans to accommodate the children, there had been difficulties in finding a same-race placement and the implications of this were not explored in the review.

80. The most comprehensive coverage was in a review where the mixed-heritage child of a White British mother had been abused by her partner. His racist attitudes were considered to be a significant factor in the abuse. Nearly all of the individual management reviews submitted for this review included concerns about his racist attitudes and about services to minority communities. The

[7] Extract from the evaluation of a review where the different ethnicities of the natural mother and father, and stepfather were all a feature of the case.

overview report included a discussion of the difficulties of tackling racist attitudes in assessing risks to children.

Emerging lessons

81. From a review of all this year's evaluations and an in-depth scrutiny of a sample of 17 serious case reviews, the following key lessons emerged:

- recording of ethnicity is inconsistent in serious case reviews.
- practitioners in all agencies would benefit from help with assessment of the implications for practice of race, language, culture and religion.
- there is insufficient reference in individual management reviews and overview reports to the issues of race, language, culture and religion. Increased learning in serious case reviews about these important aspects would help to improve practice further.

The quality of the serious case review process

Ofsted's evaluation of serious case reviews

82. In *Learning lessons, taking action*, 20 of the 50 serious case reviews were judged to be inadequate. The main reasons for the inadequate judgements were the timescales, with some taking up to three years to complete, and the poor quality of the individual management reviews. These weaknesses had a direct impact on the quality of the findings, the impact of lessons learned and the potential to take action where failings were identified.

83. As a result of Ofsted's last report, the Secretary of State asked each Local Safeguarding Children Board responsible for an 'inadequate' serious case review to reconsider their review. Forty-three Local Safeguarding Children Boards submitted reconsidered statement of action reports to Ofsted for evaluation. Sixty-two of the 63 reports submitted were judged to have satisfactorily addressed the previous weaknesses. A further report was requested in respect of the one inadequate report; the revised version was judged as satisfactory. These reconsiderations resulted in greatly strengthened reviews and valuable lessons learnt with regard to safeguarding practice. Although improved processes will not in themselves improve practice, the actions taken and the processes employed should provide a more robust framework for improvement.

84. All the 43 Local Safeguarding Children Boards had used the exercise as an opportunity to review their overall approach to serious case reviews, rather than simply focusing on the individual case. Forty-seven of the 63 reports indicated that the Local Safeguarding Children Board concerned had either produced guidance or conducted further training on various aspects of the overall process, particularly with regard to conducting effective individual management reviews. Greater independence had been introduced, action plans were improved and many Local Safeguarding Children Boards had commenced work on learning from the inadequate judgements before the Secretary of State had made his request.

85. Ofsted has refined and developed its procedures for evaluation over the year. This has included:

- increased clarity of grade descriptors, including clarification about the requirement to anonymise executive summaries and more information in our evaluation letters about the consideration of aspects of the review in determining our judgements
- separate judgements for each element of the serious case review, in order to demonstrate where strengths and weaknesses occur, plus an overall judgement on the quality of the review, which is informed by the depth of learning

- ongoing feedback meetings offered to Local Safeguarding Children Boards to explain the judgements in more detail. Local Safeguarding Children Boards report that they value these discussions and the impact they have in supporting improvement.

Overall judgements

86. Between 1 April 2008 and 31 March 2009 Ofsted evaluated 173 serious case reviews. Fifty-nine of these were judged to be inadequate, 74 were judged to be adequate and 40 were judged to be good. No review was judged as outstanding.

Figure 3: Percentages of judgements for 173 serious case reviews evaluated by Ofsted between 1 April 2008 and 31 March 2009

Percentages are rounded and may not add to exactly 100
Based on 173 serious case reviews

87. Care needs to be taken in making comparisons with last year's judgements because of the smaller number of cases evaluated in 2007–08. The balance of judgements is similar to the position in last year's report. Although there is a small decrease in 'inadequate' judgements (40% last year, although of only 50 cases) and a small increase in 'adequate' judgements (36% last year), it is of continuing concern that so many serious case reviews were judged inadequate.

88. In last year's report concern was expressed about the time taken to complete the reviews. A breakdown of this year's cases was carried out to explore whether there was a link between the time taken and the quality of the reviews.

89. Only four cases were completed within four months. One of these was judged to be good, two were adequate and one was inadequate. Twenty-four serious case reviews took between four and six months to complete. Five were judged good, 12 were adequate and seven were inadequate. The extra time taken to carry out these reviews and to ensure that, for example, individual management reviews were of a suitable quality impacted positively on the depth of learning evident in these cases. There was also a relatively high proportion of adequate and good judgements from the serious case reviews that were completed this year within a period of between six months and one year. Of the 79 cases, 22 (28%) were judged to be good and 31 (39%) were adequate. The combined proportion of those judged adequate or better was therefore slightly less than 70%.

90. By contrast, 56 reviews took between one year and two years. While 25 of these were judged to be inadequate, 22 were adequate and nine were found to be good. By itself the time taken did not automatically determine the quality of the review and taking longer did not necessarily improve it. However, there were evident improvements in those serious case reviews which had been delayed as a result of the effective scrutiny of overview panels returning inadequate individual management reviews to services whose first contribution lacked analysis or challenge. Nonetheless, longer timescales raised questions about the effectiveness of the reviews in identifying lessons to be learnt quickly enough and thus making a difference in practice.

91. The critical point was whether there has been purposeful and ongoing work to ensure that lessons were learnt as the review progressed, with good project management and a clear focus by the serious case review panel on moving the work forward. For some cases there are additional factors, such as criminal proceedings, which need to be taken into account when completing the review and in these cases the responsibility for agreement to an extension of timescales for completion if required rests with the Government Office. In the most effective reviews clear expectations about timescales are set out at the beginning and the reasons for any subsequent delay are explained and addressed.

92. Analysis of this year's reviews has concentrated on three aspects of the process:

- whether there has been any measurable improvement in the quality of individual management reviews and, if so, how this has affected the overall quality of the serious case reviews
- whether there is evidence of greater independence in the process and, if so, whether it has impacted on the quality of serious case reviews
- whether there is any evidence of improved involvement of family members in the process, and any examples of good practice in this area.

Individual management reviews and the overall quality of serious case reviews

93. As part of the serious case review process each agency involved with the case is expected to produce an individual management review. In *Learning lessons, taking action*, the poor quality of individual management reviews was found to be an area of serious concern. Since these individual management reviews are the core documents on which the quality of information, analysis and lessons learnt depend, the poor standard is a considerable shortcoming.

94. This year there is increasing evidence that many Local Safeguarding Children Boards are taking this matter very seriously and are supporting improvements. For example:

- from the most recently submitted serious case reviews, it is evident that Local Safeguarding Children Boards are now agreeing a format for the completion of individual management reviews
- senior managers in agencies are taking responsibility for the process
- authors of individual management reviews are being commissioned with the relevant level of seniority and expertise to undertake the task; there is also increasing use of independent authors to complete the task; training is being provided for the authors
- workshops are being held at the beginning of the serious case review process to clarify the terms of reference, the timescale, any key issues already known or needing to be covered and the project management arrangements
- quality assurance processes are being established within agencies to evaluate the quality of individual management reviews before they are signed off at senior levels of the agency. Individual management reviews are also being presented to the serious case review panel by authors.

95. There are also several individual management reviews which have been judged as good or outstanding. Six individual management reviews were judged outstanding in three serious case reviews that were judged as good overall. These individual management reviews had:

- a comprehensive history and chronology
- good depth of detail covered, with a clear family history
- interviews with staff and managers, as well as a case file audit
- appropriate identification of strengths and good practice
- a critical analysis of practice failings and missed opportunities
- well-focused recommendations.

All these elements suggested that good learning had taken place.

96. In two cases these outstanding individual management reviews had been completed by managers especially seconded to undertake the process and in a further two cases they were carried out by independent consultants.

97. However, this year's analysis also showed that a frequent reason for inadequate overall judgements was the quality of the individual management reviews. This quality was dependent first and foremost on how robust the terms of reference were, since these determined the scope of the individual management reviews.

The concerns were usually accompanied by other shortcomings, such as the lack of analysis throughout, poor recommendations and action plans, and the length of time taken to complete the review.

98. The following extracts from the evaluations of serious case reviews judged to be inadequate illustrate the concerns about the quality of individual management reviews:

> The terms of reference are inadequate, three of the four individual management reviews are inadequate, and reviews were not requested from all the agencies that were involved with the family.

> While the overview report is logical and sets out recommendations based on evidence, it is apparent that much more analysis of the case may have led to a different and fuller conclusion. The quality of four of the individual management reviews is inadequate. There was a serious delay in delivering this serious case review and this delay is compounded by the lengthy timescales in the action plan.
>
> Terms of reference set from the outset were not specific enough and fail to address all the significant issues in this case. All the individual management reviews are inadequate and follow a format that does not allow sufficient analysis of key issues leading to robust conclusions for each agency. Many individual management reviews appear incomplete. Individual agency accountability remains unclear.
>
> The time taken to complete the review was too long. There is insufficient emphasis in the terms of reference to the effectiveness of multi-agency working. All individual management reviews and the overview report are judged inadequate with insufficient analysis.

99. Although much of the emphasis has rightly been upon improvements required in inadequate serious case reviews, there have also been examples of good serious case reviews this year, with some outstanding features. In the good serious case reviews:

- the process was well managed, with purposeful work, regularly monitored by the serious case review panel, and clear reasons for any delays in timescales, where appropriate
- there was a thorough scoping process, covering clear terms of reference, family involvement, and decisions about relevant individual management reviews, membership of panel, timescales and contingency plans
- individual management reviews were adequate or better
- there was a strong focus on the child
- race, language, culture and religion were addressed sensitively

- family members were involved or, if not, satisfactory reasons were given
- there was a good overview report, with a robust analysis, clear and measurable recommendations and an action plan, and a succinct, accessible and anonymised executive summary
- good attention was given to lessons learned and robust monitoring arrangements for the implementation of the action plans
- robust and cooperative measures were taken to ensure a joint approach in monitoring the action plan in serious case reviews which span more than one Local Safeguarding Children Board.

100. These positive features are illustrated in the following extracts from the comments of HMI as part of the evaluation process of individual serious case reviews:

> The review process is managed well. There is good analysis of practice, details of lessons learned and their translation into recommendations. An identified failing in the individual management reviews is rigorously examined by the overview report and results in an appropriate recommendation and a good action plan. The family engaged well in the review process.
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> ◇
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> The scoping for this review is good leading to clear and focused terms of reference. Individual management reviews are mainly of good quality. The overview report is good and contains a robust analysis of all aspects of this case leading to clear and measurable recommendations for action. The executive summary, which is suitably anonymised, is a good document which clearly defines the processes for this review and the recommendations arising. The action plan is comprehensive and is constructed to facilitate appropriate monitoring by the Local Safeguarding Children Board.
>
> ◇
>
> The terms of reference are set out well. The quality of individual management reviews is at least adequate. The overview report is comprehensive, analytical and evidence-based. The multi-agency action plan is full and clear, and robust monitoring arrangements are in place.
>
> ◇
>
> The overall quality of the serious case review is good with some outstanding features. There is a clear focus… on race, religion, language

and culture. The overview report is good and lessons to be learned are identified well.

101. There were also four examples of overview reports which were judged to be outstanding or to have some outstanding aspects. The factors which contributed to these judgements are demonstrated in the following extracts:

> The quality of the analysis is outstanding and is addressed thematically under sub-headings. There is a thorough and critical analysis of actions taken and decision making. Key turning points are identified well. There is a well-focused and robust conclusion at the end of each sub-heading topic. Good practice is recognised and appropriate lessons to be learned identified for attention both nationally and locally.
>
> ◇
>
> The executive summary is excellent. It is very carefully anonymised. It provides a very well written, clear summary of the key issues from the case and appropriately stresses the national policy and guidance implications. It will provide a very useful tool for setting the national recommendations in context.
>
> ◇
>
> The analysis in this report is very good. The analysis is carried out under the following headings: drug misuse, alcohol misuse, mental health, domestic abuse, parenting capacity, missed appointments and holidays, assessment practice, inter-agency communication, case conferences, following through, supervision, recording, terms of licence, rule of optimism, lack of child focus and conclusions. This analysis of the themes of the case across agencies provides an excellent picture of where the case went wrong.

Emerging lessons

- This report presents examples of good practice, which have improved the quality of serious case reviews and of individual management reviews. These can be used by Local Safeguarding Children Boards when embarking on a new review or by those that are required to formulate a plan to address the inadequate features of a serious case review previously judged inadequate by Ofsted.
- In good serious case reviews, individual agencies give careful consideration to the choice of authors for individual management reviews, ensure that there is proper planning right from the start of the process, and put in place quality assurance processes before the review is signed off.

Level of independence in the serious case review process

102. Last year's report raised concerns about the lack of independence in many serious case reviews. It found that in too many instances the overview report author was not independent of the Local Safeguarding Children Board. The evidence in *Learning lessons, taking action* also showed that most serious case review panels consisted solely or mainly of representatives from agencies which were also responsible for preparing individual management reviews. This called into question their independence and ability to adequately challenge the quality of individual management reviews.

103. Over the past year, there has been continuing debate about what is meant by independence in this context and what would be best for producing effective serious case reviews that help Local Safeguarding Children Boards to learn the lessons from the review. Lord Laming has recommended that there should be increased independence in the process and it is anticipated that this will be defined more clearly in the revised version of Chapter 8 of *Working together* which is currently subject to a DCSF consultation and due to be published later in 2009.

104. In the meantime, there is evidence of increased independence being introduced into the process, based on the responses from Local Safeguarding Children Boards in their considerations of the inadequate aspects of serious case reviews previously judged inadequate overall:

> The Local Safeguarding Children Board has introduced the commissioning of independent overview report writers with robust commissioning standards.
>
> ◇
>
> A reconvened serious case review panel has been established with a new and entirely independent membership chaired by an independent consultant; the author of the report is an independent consultant.
>
> ◇
>
> The Local Safeguarding Children Board commissioned a revised overview report from the independent author without the involvement of the Local Safeguarding Children Board's member who co-authored the initial report. The review report confirms that the revised report is far more robust and provides a more rigorous analysis of agency involvement with some clearly defined conclusions.

105. This year's serious case reviews were analysed for evidence about independence in relation to:

- overview report writers
- individual management review authors
- membership and chairing of serious case review panels.

Overview report writers

106. Ofsted has previously raised concerns that overview report authors were often not independent of the Local Safeguarding Children Boards. On the other hand, when independent authors were used, some were not sufficiently knowledgeable about child protection, and were not able to analyse the evidence in an appropriately critical way to ensure that lessons were learned. The lack of clarity in the guidance *Working together* in this regard has been commented on previously by Ofsted and later by Lord Laming in *The protection of children in England: a progress report 2009*.

107. Of the 173 overview reports, 114 were written by independent authors. The reviews were analysed to see if there was a link between Ofsted's overall judgement and the independence of the overview report writer.

108. Thirty-five of the 59 inadequate serious case reviews had overview reports written by an independent author, 20 of the 74 adequate serious case reviews and 26 of the 40 good serious case reviews had overview reports written by an independent author. These figures suggest that the use of an independent author did not in itself ensure a good overall judgement. The quality of reports depended more upon other aspects which have been highlighted in previous sections of this report, such as the appropriateness of the terms of reference, the quality of the individual management reviews and the robustness of the recommendations and action plans.

109. Seventeen overview report writers were also the chairs of the serious case review panels. This has been the subject of much debate. Further guidance on these matters will be available shortly in the revisions to Chapter 8 of *Working together*, which is part of the DCSF's response to Lord Laming.

110. Two examples of good practice and one of inadequate practice are illustrated by the following comments in Ofsted evaluations:

> The overview report is written by an independent author who was instructed well through clear terms of reference by the serious case review panel. The overview report is appropriately critical of all agencies involved and this shows a good level of independence.
>
> ◇

The overview author is an experienced and suitably qualified independent social worker who has clearly been able to exercise objectivity and formulate good judgements on issues associated with the case. The author is not a member of the serious case review panel.

◇

There was no identified independent element to the review. The author of the overview report was from probation services, which was one of the agencies which completed an individual management review.

Individual management review authors

111. A related issue is the authorship of the individual management reviews. The level of independence was frequently increased by ensuring that individual management review authors were not also members of the serious case review panel. This may become normal practice in future, with senior managers becoming panel members and taking responsibility for commissioning and assuring the quality of individual management reviews, rather than writing them.

112. Such a move raises new questions. It ensures greater independence, and therefore potentially greater and more rigorous scrutiny of agency involvement. However, agencies will also need to be confident that the authors have the skills and authority to question not just front-line practice but also the role of management and supervision. These areas are often not well addressed and challenged in individual management reviews.

Membership and chairing of serious case review panels

113. *Working together* (2006) requires that 'the overview report be commissioned from a person who is independent of all the agencies/professionals involved'. Following different interpretations of this, the DCSF confirmed that 'independent' means independent of all agencies and of the Local Safeguarding Children Board, not just independent of the particular case.

114. To encourage ownership and relevance, most serious case review panels do include representatives from agencies that are also responsible for preparing individual management reviews. However, to enhance the independence of the serious case review process, the DCSF's consultation on a revised Chapter 8 of *Working together* states additionally that

> 'The chair of the serious case review panel should be an experienced person who is neither a member of the Local Safeguarding Children Board nor an employee of any of the agencies involved in the case nor the overview report author. The serious case review panel chair can be the independent Local Safeguarding Board chair or someone from another

Local Safeguarding Children Board which is not involved in the serious case review or from an agency not involved in the case.'

This clarification may remove the perception that most serious case review panels consist solely or mainly of representatives from agencies that are also responsible for preparing individual management reviews. Previously this may have called into question their independence and ability to challenge the quality of individual management reviews.

115. This year's serious case reviews were analysed in terms of the relationship between membership of serious case review panels and the submission of individual management reviews.

116. The main agencies of children's social care, education, police and health still make up the majority of panels and also prepare the greatest number of individual management reviews. For example, the police were represented on all except two of the serious case review panels and this service also produced 153 individual management reviews. Health representatives were members of all the panels, and the primary care trust and the local NHS hospital trust contributed individual management reviews to every review. Education services were represented in 112 panels and contributed to 108 individual management reviews.

117. There has been some increase since last year in representation from probation, independent agencies and voluntary organisations. Adult social care services were represented on one panel. Adult social care services also provided seven individual management reviews. Drug and alcohol services were represented on seven panels, preparing five individual management reviews. Some independence is evident through the involvement of fire services, Connexions and Cafcass when they have had no direct involvement in the case.

118. There is also evidence that panels are making more use of independent professional advisers for specific issues relevant to the review, and taking greater shared responsibility for quality assurance of the overall review process and its outcome, for example in challenging inadequate individual management reviews by returning them to the services concerned for further work to be undertaken. This is intended to improve the depth of understanding and analysis, the quality of the individual management reviews and the overall standard of the overview report. However, in order for this to be effective, it is important that roles and responsibilities are clearly defined and the status of any advice differentiated from the information contained in individual management reviews.

Emerging lessons

- Although the independence of the overview report writer was important, the quality of reports also depended upon a range of other factors. These included the appropriateness of the terms of reference, the quality of the

individual management reviews, and the robustness of the recommendations and action plans.

- The use of representatives from agencies which are not contributing to the serious case review helps to ensure a greater element of independence in serious case review panels.

Family involvement

119. *Working together* recommends that serious case review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'. Ofsted's previous report on serious case reviews found that this aspect was not covered well in the reviews evaluated. It was rare to see family members included and their views recorded.

120. There are indications that the importance of this matter is now being considered by Local Safeguarding Children Boards. The evidence from the visits to 10 of the boards whose serious case reviews were evaluated as good is that they are making a more concerted effort to involve families. In the better examples this takes place at an early stage in the review process and there are offers to meet on more than one occasion. Links between the serious case review process and family members through the police's family liaison officers have also proved helpful.

121. An example of good practice took place in a Local Safeguarding Children Board which carried out a review that involved another local authority. At the start of the review discussions were held with the other Local Safeguarding Children Board to decide which of them was best placed to make contact with the family. It was subsequently agreed that this should best be carried out by the child protection coordinator in the first authority.

122. A more detailed scrutiny of 17 of this year's reviews (approximately 10%) was conducted in order to analyse the extent of involvement by parents and other family members. Data was analysed from these cases and showed that:

    - in five cases, the serious case review panel sought the involvement of parents or other family members and included their views in the report
    - in six cases parents or family members were invited to participate but no contribution was received
    - in the other six cases the panel did not seek the involvement of parents or family members.

123. **Where the family did contribute:** In the five instances where parents did contribute, their views were given proper weight within the overview report. All of these cases involved one or both parents but not any other family members. In one instance the serious case review included the views of a man who had

previously lived with the family and who believed he was the father of a sibling of the child who had died.

124. One review illustrated the importance of offering more than one opportunity to contribute. The parents initially were invited to give their views but refused to participate. After the review had been completed the parents did agree to meet with safeguarding workers and the parents' views were recorded as an appendix to the overview report.

125. Another review shows the important role that parents can play in the process. In this case parents were able to give some relevant information about the time that they had to wait at Accident and Emergency, which was not available from other sources.

126. **Where the family were invited but did not contribute:** In six cases parents and other family members were invited to contribute but did not do so. One set of parents declined the opportunity but in the other five cases there was no response to letters. Two of the cases included approaches to family members other than parents.

127. Serious case review panels gave some evidence of the efforts they made to contact parents and family. One describes hand-delivering the letter, offering an interpreter and planning interview arrangements in consultation with the police. A second made more than one attempt to make contact, both during the review process and following the inquest into the case. Others made sure that they sent a second letter if they received no response to the first one. Overall, however, these cases are characterised by the use of formal approaches, for example sending letters and reports, which may not always be the most appropriate means of seeking a positive response, particularly in very difficult circumstances and where parents may have already been involved in long and formal processes or may not be able to read well.

128. Some cases raised particular difficulties, for example where the parent or other family members were involved in criminal proceedings, either as alleged perpetrators or witnesses or where the local authority had initiated care proceedings. In such instances the timeliness of completing the review had to be balanced with the potential contribution of the family.

129. **Where the family were not invited to contribute:** In six cases neither the parents nor any other family members were invited to contribute.

130. As with the previous section, in two of these cases the Local Safeguarding Children Board considered the matter but decided that it was inappropriate to do so because of criminal proceedings. The reasons explain the decisions but the overview reports did not comment on whether they were appropriate.

131. In four cases no information was given about whether there was any consideration by the serious case review panel about trying to involve family

members. It is not clear whether these families were even aware that a serious case review was being undertaken.

Emerging lessons

132. From the review of the sample of 17 serious case reviews, the following key lessons have been identified:

- In good examples the serious case review panels use different methods of making contact with families, including family members other than the parents, and offer more than one opportunity for them to participate in the review process.
- Good overview reports include reference to whether family members were involved and, where it was decided not to involve them, a comment as to whether this was the appropriate decision.

Conclusion

There is emerging evidence of developments by Local Safeguarding Children Boards to improve the process of carrying out serious case reviews and to learn the lessons from them. However, there are still many areas of concern identified in this report. There must be a continuing focus on improving the quality of reviews, on ensuring that the findings of the reviews are rigorously implemented, and on tackling the practice issues that both this year's report and last year's have highlighted.

Appendix 1

Good practice visits to Local Safeguarding Children Boards

Council
Enfield
Kent
Liverpool
Rotherham
Sheffield
Somerset
South Tyneside
Tower Hamlets

Appendix 2

All 173 serious case reviews considered in the *Learning lessons* report

Local authority	Serious case review evaluation	Date of evaluation letter
Barking & Dagenham	Good	17/10/2008
Barnet	Good	16/09/2008
Barnsley	Inadequate	22/07/2008
Bexley	Inadequate	19/01/2009
Birmingham	Inadequate	28/11/2008
Birmingham	Inadequate	25/06/2008
Birmingham	Inadequate	25/06/2008
Birmingham	Inadequate	26/06/2008
Birmingham	Adequate	14/08/2008
Blackburn with Darwen	Adequate	06/11/2008
Blackpool	Inadequate	16/02/2009
Bolton	Inadequate	06/05/2008
Bournemouth	Inadequate	01/10/2008
Bournemouth	Inadequate	01/10/2008
Bradford	Adequate	29/12/2008
Bradford	Inadequate	04/09/2008
Brighton & Hove	Good	23/01/2009
Bristol	Inadequate	07/11/2008
Bromley	Adequate	12/08/2008
Buckinghamshire	Good	23/03/2009
Calderdale	Adequate	23/01/2009
Calderdale	Good	18/02/2009
Cambridgeshire	Adequate	26/03/2009
Camden	Adequate	25/11/2008
Cornwall	Good	26/01/2009
Coventry	Adequate	24/09/2008
Coventry	Adequate	16/09/2008
Coventry	Good	16/09/2008
Croydon	Inadequate	05/11/2008
Croydon	Good	29/12/2008
Cumbria	Inadequate	03/02/2009
Derbyshire	Adequate	05/11/2008
Derbyshire	Inadequate	02/02/2009
Devon	Inadequate	08/08/2008
Devon	Inadequate	28/08/2008
Devon	Adequate	04/09/2008
Devon	Inadequate	01/12/2008
Doncaster	Adequate	06/02/2009
Doncaster	Inadequate	24/03/2009

Durham	Adequate	27/06/2008
Durham	Good	14/05/2009
Ealing	Adequate	11/11/2008
Enfield	Good	09/09/2008
Enfield	Good	23/03/2009
Enfield	Adequate	26/03/2009
Essex	Inadequate	09/12/2008
Essex	Adequate	04/03/2009
Gloucestershire	Adequate	26/01/2009
Greenwich	Good	29/12/2008
Hackney	Adequate	12/12/2008
Hackney	Good	13/02/2009
Halton	Adequate	06/02/2009
Hammersmith & Fulham	Adequate	09/02/2009
Hampshire	Adequate	16/04/2008
Hampshire	Inadequate	23/04/2009[8]
Hampshire	Good	12/01/2009
Hampshire	Adequate	20/01/2009
Haringey	Good	07/04/2009
Havering	Adequate	02/05/2008
Herefordshire	Good	14/04/2008
Hertfordshire	Adequate	14/08/2008
Hounslow	Inadequate	17/09/2008
Hull	Adequate	23/01/2009
Isle of Wight	Inadequate	30/01/2009
Kent	Good	14/08/2008
Kent	Adequate	18/09/2008
Kent	Good	20/01/2009
Kent	Good	23/03/2009
Kent	Good	24/03/2009
Kingston	Adequate	12/01/2009
Kingston	Inadequate	17/02/2009
Kirklees	Adequate	14/08/2008
Kirklees	Inadequate	20/01/2009
Kirklees	Adequate	23/04/2009
Lambeth	Good	18/09/2008
Lancashire	Inadequate	27/11/2008
Lancashire	Inadequate	17/02/2009
Lancashire	Inadequate	19/02/2009
Leeds	Adequate	06/10/2008
Leeds	Adequate	30/03/2009
Leeds	Good	06/05/2009
Leicester City	Adequate	20/03/2009
Leicestershire	Inadequate	03/10/2008
Lincolnshire	Adequate	26/01/2009
Lincolnshire	Adequate	28/01/2009

[8] Although all 173 reviews were fully evaluated during the period concerned, a small number of letters were issued or reissued after 31/03/09.

Liverpool	Inadequate	01/10/2008
Liverpool	Good	10/12/2008
Manchester	Inadequate	05/08/2008
Manchester	Adequate	22/08/2008
Manchester	Adequate	17/10/2008
Manchester	Inadequate	17/10/2008
Manchester	Adequate	13/02/2009
Manchester	Adequate	03/03/2009
Middlesbrough	Inadequate	26/08/2008
Newcastle	Adequate	11/11/2008
Norfolk	Adequate	19/11/2008
Norfolk	Inadequate	05/01/2009
Norfolk	Adequate	04/09/2008
North East Lincolnshire	Inadequate	11/08/2008
North East Lincolnshire	Inadequate	27/04/2009
North Somerset	Good	28/01/2009
North Yorkshire	Adequate	29/12/2008
Northamptonshire	Inadequate	05/09/2008
Northamptonshire	Inadequate	22/10/2008
Northamptonshire	Adequate	30/01/2009
Northumberland	Adequate	26/09/2008
Nottingham City	Adequate	16/04/2008
Nottingham City	Good	21/04/2008
Nottingham City	Adequate	26/06/2008
Nottingham City	Adequate	25/02/2009
Nottingham City	Adequate	17/03/2009
Nottinghamshire	Adequate	17/10/2008
Nottinghamshire	Adequate	07/11/2008
Oxfordshire	Adequate	23/04/2008
Oxfordshire	Inadequate	23/09/2008
Peterborough	Inadequate	06/05/2008
Peterborough	Inadequate	20/01/2009
Plymouth	Inadequate	02/09/2008
Poole	Adequate	06/02/2009
Portsmouth	Inadequate	03/07/2008
Portsmouth	Good	30/01/2009
Reading	Inadequate	09/09/2008
Redbridge	Good	29/08/2008
Rochdale	Inadequate	27/02/2009
Rochdale	Inadequate	12/03/2009
Rotherham	Inadequate	18/04/2008
Rotherham	Inadequate	22/04/2008
Rotherham	Adequate	14/08/2008
Rotherham	Good	26/01/2009
Salford	Inadequate	18/09/2008
Salford	Inadequate	25/11/2008
Sandwell	Adequate	31/10/2008
Sandwell	Adequate	17/03/2009
Sandwell	Adequate	29/04/2009
Sefton	Adequate	28/01/2009

Sheffield	Good	23/03/2009
Sheffield	Good	23/03/2009
Shropshire	Good	21/07/2008
Shropshire	Inadequate	23/02/2009
Somerset	Adequate	27/06/2008
Somerset	Good	19/12/2008
Somerset	Good	19/12/2008
South Tyneside	Good	14/08/2008
South Tyneside	Adequate	17/10/2008
Southampton	Adequate	18/02/2009
Southampton	Inadequate	27/02/2009
Southwark	Adequate	24/04/2008
Staffordshire	Adequate	13/03/2009
Staffordshire	Inadequate	30/04/2009
Stockport	Inadequate	22/07/2008
Stockport	Adequate	08/12/2008
Suffolk	Adequate	30/01/2009
Surrey	Inadequate	05/08/2008
Surrey	Inadequate	05/08/2008
Surrey	Inadequate	05/08/2008
Surrey	Adequate	28/01/2009
Thurrock	Adequate	01/10/2008
Tower Hamlets	Adequate	18/07/2008
Tower Hamlets	Good	25/07/2008
Tower Hamlets	Good	20/01/2009
Wakefield	Adequate	01/10/2008
Wakefield	Adequate	06/05/2009
Waltham Forest	Adequate	09/09/2008
West Berkshire	Adequate	05/08/2008
Westminster	Good	28/10/2008
Wigan	Adequate	21/10/2008
Wirral	Good	06/02/2009
Wiltshire	Inadequate	26/01/2009
Wokingham	Inadequate	28/11/2008
Wolverhampton	Good	18/09/2008
Worcestershire	Good	29/10/2008
Worcestershire	Adequate	04/02/2009
York	Adequate	29/12/2008

Appendix 3

Resubmitted statements of action

Resubmitted serious case review statements of action evaluated by 31 March 2009	Local Safeguarding Children Board	Statement of action addresses previous weaknesses
1.	Barnsley	Yes
2.	Bexley	Yes
3.	Birmingham	Yes
4.	Birmingham	Yes
5.	Birmingham	Yes
6.	Birmingham	Yes
7.	Bolton	Yes
8.	Bournemouth	No
9.	Bournemouth	Yes
10.	Bradford	Yes
11.	Bristol	Yes
12.	Bristol	Yes
13.	Cornwall	Yes
14.	Cornwall	Yes
15.	Cornwall	Yes
16.	Croydon	Yes
17.	Derbyshire	Yes
18.	Devon	Yes
19.	Devon	Yes
20.	Devon	Yes
21.	Doncaster	Yes
22.	Hammersmith & Fulham	Yes
23.	Hampshire	Yes
24.	Haringey	Yes
25.	Hertfordshire	Yes
26.	Hounslow	Yes
27.	Lambeth	Yes
28.	Lancashire	Yes
29.	Leicestershire	Yes
30.	Lincolnshire	Yes
31.	Liverpool	Yes
32.	Manchester	Yes
33.	Manchester	Yes
34.	North East Lincolnshire	Yes
35.	Northamptonshire	Yes
36.	Northamptonshire	Yes
37.	Northamptonshire	Yes
38.	Northamptonshire	Yes
39.	Northamptonshire	Yes
40.	Nottingham City	Yes
41.	Oxfordshire	Yes

42.	Peterborough	Yes
43.	Peterborough	Yes
44.	Plymouth	Yes
45.	Portsmouth	Yes
46.	Reading	Yes
47.	Rotherham	Yes
48.	Rotherham	Yes
49.	Salford	Yes
50.	Salford	Yes
51.	Sandwell	Yes
52.	Shropshire	Yes
53.	Shropshire	Yes
54.	Somerset	Yes
55.	South Tees	Yes
56.	Staffordshire	Yes
57.	Stockport	Yes
58.	Suffolk	Yes
59.	Surrey	Yes
60.	Surrey	Yes
61.	Surrey	Yes
62.	Thurrock	Yes
63.	Wokingham	Yes