

Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008

This report outlines practice issues raised by Ofsted's first year of evaluating serious case reviews. It is based on an evaluation of 50 serious case reviews carried out between 1 April 2007 and 31 March 2008.

The report also considers how the process of conducting serious case reviews could be improved.

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Executive summary

The 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*) was transferred to Ofsted from the Commission for Social Care Inspection in April 2007.¹ This report is based on an analysis of the outcomes of Ofsted's evaluations of 50 serious case reviews between 1 April 2007 and 31 March 2008. It brings together findings in relation to the conduct of serious case reviews and the main practice issues arising. It considers how the process of conducting serious case reviews affects the quality of the outcomes, and the lessons learned. It also makes recommendations about practice issues and how the process of conducting serious case reviews could be improved.

The death, abuse or neglect of any child is a matter of great concern to all of us. As serious case reviews are only undertaken in circumstances where a child has died or has been seriously injured or harmed and abuse is known or suspected to have been a factor, it is important that lessons are learned and that action follows. This report suggests that, despite Every Child Matters² and an increased focus on partnership working within Children's Services, much remains to be done; especially to ensure that effective learning and action result from every serious case review and that all services fully appreciate the role they play in ensuring this happens. The report underlines the key role that 'universal' services play in ensuring that children are kept safe. Although many of the children who were the focus of these reviews were known to social care agencies, all were known to universal services such as education and health.

The report highlights continuing weaknesses in record keeping and communication in universal services that allow children to fall into the gaps between services, and the lack of training for staff to help them identify and report the signs and symptoms of abuse and neglect that they witness in their different roles. The report also makes some suggestions for remedying the weaknesses still apparent in the serious case review process such as: adhering to the timescales for completion; improving the quality of individual management reviews; ensuring more independent representation on serious case review panels; better involvement of families in the process; and an improvement in the way in which issues of race, language, culture, religion and disability are addressed both in practice and in serious case reviews. However, the most important issue highlighted in this report is the need for all reviews to focus much more closely on the child concerned – and not, as is the case at the moment, predominantly on the agencies involved.

This is the first year that Ofsted has undertaken responsibilities in this area and it is recognised that Local Safeguarding Children Boards require more guidance and

¹ *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, DfES, 2006; www.everychildmatters.gov.uk/resources-and-practice/IG00060/.

² www.everychildmatters.gov.uk/.

support. Given the important findings in this report, Ofsted will produce further annual reports of our evaluations in order to support continuous improvement in practice and in the way reviews are conducted.

Key findings

- Most but not all the children (35 out of 50) whose tragic circumstances were subject to a serious case review in the sample analysed were known to social care agencies. All were known to universal services, usually education and/or health.
- Staff working in universal services play a key role in keeping children safe. It is vitally important that these staff have the necessary skills and knowledge to identify and respond to signs of abuse.
- A large proportion of the serious case reviews which were evaluated in this first year (20 out of 50) 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.
- Most serious case review panels consisted solely or mainly of representatives from agencies that were also responsible for preparing individual management reviews. This calls into question their independence and ability to adequately challenge the quality of individual management reviews.
- 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 learned. A fundamental shift of approach is required with a greater emphasis on the practice of individual members of staff and managers. This might be more possible if panels had a greater level of independent representation.
- There was little in the practice issues emerging from the reviews that had not been covered in earlier analyses.³ The main findings related to the failure of staff to identify and report signs of abuse; poor recording and communication, and poor knowledge, and application, of basic policies and procedures.
- There was little evidence of involving or working with families in the serious case review process. Issues of race, language, culture, religion and disability were not

³ *Improving safeguarding practice: study of serious case reviews 2001–2003 and Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*, Department for Children, Schools and Families; www.everychildmatters.gov.uk/socialcare/safeguarding/seriouscasereviews/.

covered well either in the serious case reviews or in the way professionals had worked with the families.

- Professionals failed to consider the situation from the child’s perspective: they failed to see the child and, where possible, talk to them to find out what they thought and felt about the issues; and to take action based on this information. In a number of serious case reviews (nine out of 50) this would seem to have been the obvious thing to do but professionals either did not consider it; did not regard it as relevant; or did not know how to do it.
- Too often professionals took the word of parents at face value without considering the effects on the child. There were factors in the families involved related to drug and alcohol misuse, domestic violence, mental illness and learning difficulties which were often not properly taken into account in assessing risk and considering the impact on the child.
- Agencies were 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 subject to serious case reviews the problems in the family had been evident for some years.

Recommendations

Local Safeguarding Children Boards should:

- ensure that all serious case reviews start from the experience and views of the child, and address how these were sought and taken into account by all the professionals involved
- introduce a greater element of independence into the membership of panels by including a wider range of professionals from agencies not involved in the serious case review
- ensure that staff working in universal services are included in multi-agency training programmes, and that these services are well represented on the Local Safeguarding Children Board
- ensure that all multi-agency training programmes include the teaching of basic skills in communicating with children
- include diversity and equality issues in multi-agency training programmes and ensure that, as far as possible, membership of the board reflects the profile of the local community
- tackle the issues affecting timescales for completion of serious case reviews and adopt a more robust approach in negotiating with Coroners’ Courts and the Crown Prosecution Service to enable information to be used for serious case reviews
- provide local guidance and templates for the completion of individual management reviews which support the process in line with *Working together* and include explicit quality standards

- ensure action is taken, especially where failings are serious.

The Department for Children, Schools and Families should:

- clarify further the meaning of 'independence' in *Working together*, including providing guidance as to the degree of independence required of Chairs of Local Safeguarding Children Boards and Chairs of serious case review panels
- provide quality standards for record keeping in schools and guidance to staff on expectations for maintaining and sharing records.

Agencies completing individual management reviews should:

- make an explicit statement about the involvement of family members and the child, and give reasons if they do not involve them
- provide a detailed chronology of the involvement of that agency including information about when the child was seen and the details of that meeting
- address issues of race, language, culture, religion and disability explicitly
- focus more attention on why procedures were not followed, as well as identify what procedures had not been followed or were lacking
- ensure any recommendation about improving or developing new procedures is couched in terms of the expected practice outcomes and is followed through to ensure it happens.

Health agencies should:

- ensure there are effective mechanisms in place to coordinate and maintain a comprehensive record of a child's engagement with health services – particularly for children under five.

Background

1. The management of serious case notifications and evaluations of serious case reviews under chapter 8 of *Working together* changed with effect from 1 April 2007. Prior to this responsibility for working with local areas on such matters rested with the Commission for Social Care Inspection.
2. From 1 April 2007 regional Government Offices assumed responsibility for on-going monitoring, advice and challenge to local councils. Ofsted assumed the responsibility for briefing ministers on serious cases, forming a view as to whether a serious case review was necessary, and carrying out an evaluation of the quality of any review undertaken. It also took on the responsibility for maintaining the child protection database on behalf of the Department for Children, Schools and Families.

3. Chapter 8 of *Working together* 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.
4. Chapter 8 of *Working together* defines the purpose of a serious case review as follows:
 - 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.
5. The review should be conducted by someone independent of all the agencies and professionals involved and should be completed within four months of the decision to conduct a review.
6. Local Safeguarding Children Boards must send the completed review to Ofsted for evaluation. The outcome of the evaluation is shared with Local Safeguarding Children Boards and forms part of the evidence used for the annual performance assessment of a local area.⁴

Ofsted's role and contribution

7. Ofsted's authority to evaluate serious case reviews is covered by section 20 of the Children Act 2004.⁵ Ofsted carries out this function on behalf of the Secretary of State. This was further confirmed by the Local Authority Circular

⁴ Annual performance assessments (APAs) and joint area reviews (JARs) evaluate and report on the outcomes for children in an area, and assess and judge the contributions made by public services, including the council, towards sustaining and improving those outcomes.

⁵ The Children Act 2004, section 20; www.opsi.gov.uk/Acts/acts2004/ukpga_20040031_en_3#pt2-pb4-l1q20.

LAC 2007/25.⁶ The duty of the local authority through the Director of Children's Services is to ensure the establishment of the Local Safeguarding Children Board and its effective working as set out in paragraph 3.46 of *Working together*. As such, the work of the Local Safeguarding Children Board, including the evaluation of any serious case review, is taken into account in both joint area reviews and annual performance assessments of the local area.⁷

8. Ofsted requires Local Safeguarding Children Boards to provide a complete set of papers for evaluation, including the terms of reference, overview report, individual management reports, recommendations and action plan. One of Her Majesty's Inspectors evaluates the review against a set of grade descriptors and in accordance with an evaluation template.
9. The individual aspects of a serious case review considered in the evaluation include the following.
 - whether it was appropriate to instigate the review
 - the scope and time period covered by the review
 - the terms of reference and whether the author is suitably independent of the agencies involved
 - whether the review was completed within recommended timescales
 - the quality of the individual management reviews
 - whether the ethnic, cultural, linguistic and religious needs of the child and family were met by services, and are addressed within the review
 - whether the family were invited and enabled to contribute to the review process
 - the quality of the overview report, including:
 - background information
 - rigour of analysis and challenge of information in individual management reviews
 - joint chronology
 - appropriate recommendations
 - reference to research and previous review findings
 - joint agency action plan with clear targets and timescales
 - monitoring arrangements by the Local Safeguarding Children Board

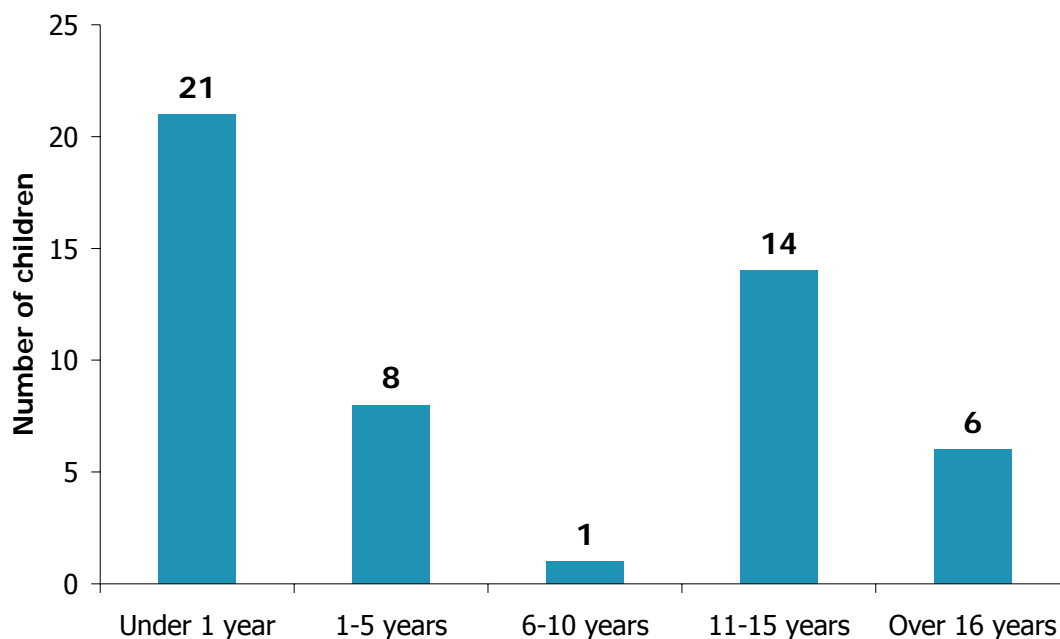
⁶ A letter from the DCSF to all local authority Chief Executives and Directors of Children's Service outlining arrangements for the notification to Ofsted of serious incidents and the evaluation of serious case reviews

⁷ Explained above in footnote 3.

- the quality of the executive summary, including whether it is suitably anonymised to protect the family's identity, and whether it is yet published.
10. The findings of the evaluation and the overall judgement are sent to the chair of the Local Safeguarding Children Board and the Director of Children's Services, if different. A meeting with the inspector is offered in order that the findings of the evaluation can be further explained and discussed. If the chair and the Director of Children's Services wish, the meeting can also include the Children's Services Adviser from the Regional Government Office who is responsible for supporting and advising the local authority and partners in taking forward the findings of the review.
 11. Approximately one in four Local Safeguarding Children Boards has not undertaken a serious case review. Many were unaware of the new role for Ofsted in April 2007, despite the publication of LAC 2007/25 and a letter from Her Majesty's Chief Inspector in April 2007.
 12. Between 1 April 2007 and 31 March 2008 Ofsted evaluated 50 serious case reviews on 50 children who were the primary subjects of the reviews and, in several instances, their siblings also. This report is specifically about the outcomes of the evaluations of these serious case reviews.

The children

Figure 1: Number of children who were the primary subject of serious case reviews by age group April 2007 to March 2008



Children aged under 1 year

13. Of the 21 children aged under one year, 16 died; 14 of them where a parent or a parent's partner was suspected or found guilty of abuse or neglect. Two babies died at birth following a concealed pregnancy. The most common cause of injury and/or death was physical assault by a parent or parent's partner.
14. In five cases the baby had been found dead after sleeping with a parent. In all these cases there was evidence of, or suspected, drug and/or alcohol misuse by the parent sleeping with the baby.
15. Only two of these 21 babies were on the child protection register at the time of their death or injury. Fourteen were known to social care agencies, but three of these only very briefly.

Children aged one to 10

16. Of the nine children in the one–10 age group, three were from large families known to agencies over a considerable period of time where signs of serious and chronic abuse or neglect had not been appropriately assessed and addressed. One child died in a house fire; another due to scalding in a hot bath; another suffered physical abuse and neglect where there was a history of

fabricated illness. The implications of long term neglect are considered in more detail in the Practice section of this report (paragraph 34).

17. Three of the nine children were on the child protection register at the time of the serious incident or death. Six were known to social care agencies. Two were known to be children with long term disabilities.

Children aged over 11

18. Of the 20 children and young people in the 11–16+ age group, nine committed suicide, two of them while on remand in secure training centres, and one while being looked after by the local authority. Three were murdered by another young person and two were convicted of murder. One young person died as a result of anorexia.
19. Other features illustrated in the reviews included long standing family problems and/or behaviour problems concerning the young person. Allegations of, or evidence of, sexual abuse were a feature in six cases. The failure of professionals to identify and act on signs of sexual abuse is addressed in the Practice section of this report.
20. Three of these 20 young people were on the child protection register at the time of the incident or death, although more had previously been on the register at some stage in their lives. Six were looked after, and a further two had previously been looked after. Fifteen of the 20 were known to social care agencies. A notable feature of this group of young people is that almost all of them had a history of family and personal problems which were known to agencies, often dating back to their early childhood. An extract from a review evaluation letter below is useful in illustrating some of these issues.

The overview report highlights the complexity of work with child x who exhibited disturbed and disturbing behaviour from an early age and the difficulties throughout his life in making professional judgments about risk and self harm. Notwithstanding this the report is rightly critical of the failure of agencies throughout his childhood to address manifest child protection concerns.⁸

⁸ All shaded sections are excerpts from relevant serious case review evaluation letters exemplifying relevant issues.

The families

Key messages

Concerns about **drug and alcohol misuse** were identified in 17 reviews.

There was a failure of agencies to adequately assess the risks posed by drug and alcohol misuse, particularly to very young babies.

Concerns about **domestic violence** featured in 15 serious case reviews.

The failure of agencies to understand, accept and assess the impact of domestic violence on children was a frequent finding.

Mental illness featured in 14 serious case reviews and was not always appropriately considered as part of the risk assessment to children.

The cooperation of mental health NHS Trusts and other specialist services with serious case reviews varied from good to poor.

Learning difficulties and/or disabilities were often linked with mental health issues for both parents and the children.

There was insufficient assessment of the impact of the learning difficulties of adults on their capacity as parents and on their own mental health.

21. A pattern of characteristics emerged in the families of the 50 children, the most common being issues of 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.

Drugs and alcohol

22. Concerns about, or actual evidence of, drug and alcohol misuse were identified in 17 serious case reviews, including all five cases where babies died after sleeping with a parent. Another baby died after being given drugs by its father.
23. Agencies did not adequately assess the risks posed by drug and alcohol misuse, particularly to very young babies. Individual management reviews from drug and alcohol teams were provided in only two serious case reviews. It is not clear from the evaluations whether this was because the teams were not asked, or because they were not involved with the families.

Domestic violence

24. This was a feature in 15 serious case reviews and linked to drug and alcohol concerns in eight of these cases.
25. A feature of these cases was that agencies failed to understand, accept and assess the impact of domestic violence on children. In three cases domestic violence was known about and the adults dealt with by police, without

consideration of the impact on the children. The following extracts from evaluation letters are typical of such cases.

A further visit was made following a referral from neighbours who heard screaming and shouting. The mother was reluctant to speak to the police officers or let them into the property. They spoke to her at the door and reported that neither mother nor child appeared to be injured. There is no indication that the child was examined (the child had in fact been severely injured).

Police and health agencies were involved with the family but failed to communicate concerns about the risk of harm to the children arising from domestic violence.

26. Where policies and procedures existed, agencies did not always follow them. This was of particular concern in relation to police forces. In seven of the 50 reviews evaluated, there were serious concerns expressed about elements of police practice. Issues identified in relation to domestic violence included poor police training, poor attention to recording and failure to report concerns to domestic violence units. In one case the same police force was operating different procedures in two different local areas.

Mental illness

27. Mental illness was identified as an issue in 14 serious case reviews. This covered the mental health of parents and also of some of the young people subject to serious case reviews. It was a feature in families where there were long-standing concerns, and also in the background of families where there were no current concerns. Again, it was not always appropriately considered as part of the risk assessment to children as can be seen from the following extracts.

Assessment of parenting capacity was not a routine feature of (adult) mental health assessments at that time.

There was a failure to report the involvement of mental health services with (the father) when he was an adolescent. It also refers to his learning disability which compounded his behavioural outbursts.

The overview report refers to two root causes... one being the fact that the health visitor and midwife were not made aware of the mother's mental health history or the father's learning difficulties, which would have informed their assessments.

28. The level of involvement of mental health NHS Trusts and other specialist services varied. In some cases they had been very involved in assessments and treatment programmes, and were key contributors to the serious case review. In others they were notable by their absence either because they had not been

identified as key partners or because of an unwillingness to get involved as illustrated by these extracts.

The psychiatric risk assessment had a significant impact on later decisions about placing the children with mother, but the service refused to provide an individual management review for the serious case review.

CAMHS were working with the children due to behavioural difficulties. A number of concerns were expressed to social services in relation to the harsh parenting regime of the parents. Social services took no action because they regarded the parents as cooperative.

The [mental health NHS Trust] report identifies a lack of pro-active follow up. However, they also rightly note that they were not invited to the pre-birth conference, which was an omission.

29. For a number of troubled young people subject to serious case reviews the analysis of their history revealed issues of mental health which had not been included in previous assessments.
30. There were examples of delays in assessing and treating young people in need of mental health services, and of repeated failure to recognise its impact. In one case agencies had failed over a long period of time to assess and coordinate the assessments of the effects of Asperger's Syndrome on a young person and his behaviour.

Learning disability

31. Seven cases involved both mental health issues and learning difficulties/disabilities. There was an absence of any real assessment of the impact of parents' learning difficulties on their capacity as parents and on their own mental health. One serious case review focused on the mental health needs of parents with hearing impairment and acknowledged that agencies had not been aware of the important government guidance about deafness and mental health. It also underlined the importance of ensuring that parents with children who have complex needs also have their own needs assessed, including mental and emotional ones, in order to provide support for them as parents.
32. In one serious case review children were subject to chronic neglect by parents with known learning difficulties. The review provides an excellent analysis of the issues involved. It identifies the challenge of coordinating the different approaches in child protection teams and disability teams, the unrealistically positive view of the parents and the failure to consider the impact of the parents' disabilities on the children. As a result the effects on the children were underestimated and the mother's capacity to change was unrealistically assessed.

33. In another serious case review a young girl with learning difficulties had been known to agencies since birth but the individual management reviews made little reference to the impact of her learning difficulties on her development, or whether previous assessments had taken this into account. Again there were differences of approach between professionals; school records were poorly kept and there was little exploration of her frequent changes of school or her prolonged period of absence. There is no doubt that her vulnerability was not sufficiently recognised.

Practice issues

34. This section sets out the main practice issues identified in the evaluations of the serious case reviews. An important feature is that only a small minority of the children (13 of the 50) were on the child protection register at the time of the incident. The younger the child, the less likely they were to be on the child protection register. Seven children were, or had been, looked after and 35 were known, or had been known, to social care services.
35. However, the children were all known to universal services. A key message of this survey is that the practice and expertise in universal services is critical to the safety of children. The most vulnerable children are those on the margins of the child protection system about whom there are some concerns, but either universal services have not identified concerns appropriately and/or have not understood their responsibilities for referring these concerns to the relevant service for assessment. Overall there is little here which has not been identified in previous analyses of serious case reviews, but there are some specific points to note.

Key messages

Poor understanding of basic child protection signs, symptoms and risk factors by staff in mainstream services.

Agencies responded reactively to each situation rather than seeing it in the context of the case history.

No single agency had a complete picture of the family and a full record of all the concerns.

Staff accepted standards of care that would not be acceptable in other families.

Little direct contact was made with the children to find out what they thought about their situation.

Professionals were uncertain about the significance of issues in complex and chaotic families and too much reliance was placed on what parents said.

Families were often hostile to contact from professionals and developed skilful strategies for keeping them at arms length.

Little evidence of assessments to evaluate the quality of the attachments between parents and children.

Families were subject to multiple assessments and plans without any clear expectation of what needed to change for the children, and what the consequences would be if these changes were not forthcoming.

Focus on the child

36. This is possibly the single most significant practice failing throughout the majority of the serious case reviews – the failure of all professionals to see the situation from the child’s perspective and experience; to see and speak to the children; to listen to what they said, to observe how they were and to take serious account of their views in supporting their needs. This failing was replicated in the way serious case reviews were conducted. As explained in the ‘process’ section of this report, serious case reviews rarely saw or included the views of the children and young people (or their families). Three evaluations record good practice examples of children being included in the review and their views taken into account.
37. More often, reports noted that the child was not seen; that there was no record of when, or if, the child was ever seen alone; no record of how they looked and what they said; no account was taken of their wishes and feelings. A very basic and obvious course of action in many cases would have been to ask the child what was happening and what they felt about it but professionals either did not consider it; did not regard it as relevant; or did not know how to do it, as shown below.

Despite the young person himself seeking help and identifying the alleged abuser, the assessment started with a visit to the alleged abuser; the views of — [aged 15] were not sought, and the assessment was not shared with him.

The report highlights that the views of — were only really recorded by the educational psychologist and the social work student, and had not been taken into account when considering future action. The review rightly recommends all agencies should consider how they can record the views of children and young people in their records.

— had himself recognised his need for help but his requests for help were not taken up.

The chronology sets out allegations made by — and his wishes and feelings particularly about his residential placement, but does not say why these were not acted on.

38. An accompanying feature, illustrated below, was the undue reliance placed on what the parents said.

Parents, and particularly the mother, appear to have had the ability to persuade professionals of their commitment to parenting and convinced them that they had genuinely learned from experience and matured to a point where the risks [of abuse] were low.

The role of universal services

39. There are three areas where universal services play a crucial role in protecting children and keeping them safe:

- **Preventing children being abused.** Many of the serious case reviews noted lost opportunities for universal services to intervene and prevent abuse occurring. This most often involved schools and health services, but other services, such as housing, Connexions, and Surestart were also found to have held important information but had not recognised its significance and had not understood their responsibility, as shown below, for informing the appropriate agency.

The report refers to the fact that [housing] staff had not understood the significance of information held on the family, and were not aware of child protection procedures.

It is a serious flaw that the conclusions and recommendations do not touch on the key preventive role of midwives and health visitors. There is little critical analysis of the poor risk awareness in ante-natal services.

- **Identifying signs and symptoms.** This is closely linked to the level of understanding and awareness of staff in universal services. This was of particular note in cases of chronic neglect and child sexual abuse, where children were seen regularly, for example by school staff, who did not recognise the significance of what they were seeing.

In nine of the cases involving very young babies health staff had missed, or misinterpreted, signs and symptoms of abuse. This included A&E staff, midwives, health visitors and ante- and post-natal staff.

- **Recording incidents, issues, and concerns over time.** This is also considered below under Recording practices. There were some good examples of schools keeping a record over time, but the significance of the information had not been recognised. In other cases school records were poor even when a child was subject to a formal monitoring process, such as those with a statement of special educational needs. In two other cases basic recording tools such as percentile charts were not used properly and interrogated by health professionals to help them understand what was happening to the child. A particular issue in health and education services, as shown below, was the fragmentation of records between the various different agencies.

The school records begin to give a picture of what it was like for — to live in that family. There is a clear analysis of her presentation over the years. However there is no analysis of her special educational needs and how this may have affected her family situation or of the school's role in her daily life.

The school records were inadequate in providing a comprehensive picture about the life experiences of this child, and her needs, despite concerns being expressed over a number of years, and despite the fact that the child had special educational needs.

Policies and procedures

40. The revision, introduction or improvement of policies and procedures was a common recommendation in most serious case reviews. However, apart from the identified need for some very specific procedures, the issue was not the absence, or inadequacy, of procedures, but rather staff failure to adhere to existing procedures. This was most usually the case in relation to social care staff and is exemplified by the following extracts.

—'s mother had been convicted of child cruelty before — was born. Child protection procedures should have been invoked on every occasion of pregnancy/birth of any subsequent children. The reason for not invoking the procedures remains unclear.

The initial contact from the baby unit to the social care team describing —'s mother as schizophrenic with a history of being in care should have been sufficient to check social care records to explore if a pre-birth assessment had been undertaken. It is not clear why this was not done.

The decision by social care staff not to undertake a check on the child protection register when requested to do so, according to the procedures, is not addressed and explored sufficiently.

The strategy discussion was seriously criticised for its lack of rigour and focus on —. The failure to convene the appropriate (strategy) meeting was the result of a particular, and wrong, interpretation of the internal procedures.

- Policy and procedures were on the whole adequate and appropriate. A few very specific areas were identified for development, but the key issue is that established policies and procedures had not been known about or had not been followed by front line staff.
- There was poor practice in implementing basic procedures. This included assessments, planning and decision-making.

- There was poor understanding of basic child protection signs, symptoms and risk factors, which meant staff were not alert to the possibility of child abuse in the situations they were dealing with.
 - Poor communication between and within agencies, particularly with health agencies, continued to be a common finding, including how individual staff responded to information once it had been received.
 - Records were poorly kept, particularly in health services and in schools.
 - There was a common failure among all agencies to see children and/or to record how they were, what they said and how they looked, and any changes in their behaviour and/or appearance.
 - And critically, a widespread failure to ensure that there was sufficient attention paid to the child as the central focus of the review.
41. Recommendations about specific procedures, either already in existence but not well known, or needing to be developed, included:
- bullying and links to child protection, both in relation to the child being bullied and the child who is the bully
 - support for staff working with hostile and aggressive parents
 - transfer of school records, particularly to schools in other areas; although there are national guidelines in place these were frequently not followed
 - support for vulnerable young people who lack family support, particularly in relation to the responsibilities of organisations such as housing and Connexions to increase their awareness of this issue
 - impact of disability, both in relation to the parents and the child, on the mental health of parents and their parenting capacity
 - safe sleeping practice guidance for babies
 - reinforce the Kennedy Principles in relation to Sudden Infant Death Syndrome and make sure all relevant staff are aware, including ambulance staff⁹
 - ensure that Care Pathways for young people with anorexia include explicit accountabilities in relation to child protection concerns
 - reinforcing and publicising the guidance on deafness and mental health.

⁹ A multi-agency protocol for the care and investigation of Sudden Infant Death Syndrome: *Sudden unexpected death in Infancy*, Baroness Kennedy, 2004; www.rcpch.ac.uk/Policy/Child-Protection/Child-Death-Review-processes.

Communication

42. Poor communication within and between agencies continued to be a very common finding and was a factor in almost all the serious case reviews. It was a particular issue when families or children moved between council areas and information was either not passed on or, when it was, the receiving area did not act on it, as is shown below.

A number of agencies were involved with — in both areas, but no one person had responsibility for ensuring information was collated and transferred. As a result no-one had the complete picture, which, had it been available, would almost certainly have changed the outcome of the assessment.

A key issue was the failure to pass on school records when the children moved schools, particularly between council areas, and the consequent failure to provide the new schools with significant information.

43. Failure of health professionals to share information with each other was also a common finding, as noted below.

The report identifies numerous examples of failings to share information among health staff, and different views about child protection and thresholds for referral to social services.

Hospital staff had failed to inform the health visitor that there had been concerns about the parents' attitude to feeding when the baby was in hospital.

The overview report notes that the GP failed to read the letters sent by the paediatrician, and the health visitor was unaware of this.

44. Poor communication between all agencies often based on ignorance, lack of understanding or misguided judgement, featured in almost all serious case reviews. The result was that for most families a great deal of information was known but it was not coordinated and evaluated until the serious case review was completed.

The [probation manager] did not think it necessary to refer concerns to social services because his own staff were well qualified and able to do assessments.

The police did not believe it necessary for social services to be involved (in the assessment of a sibling) because the matter had been dealt with.

45. One example illustrates the difficulties.

The midwife was covering for a colleague and had not been told that the children were on the child protection register; the police were also not aware of this when called by the ambulance service; the ambulance service was not sufficiently knowledgeable about child protection procedures and its role; the probation officer was unaware of the domestic violence issues and Connexions had not been included in the multi-agency child protection process.

46. In some cases staff failed to recognise the significance of information available to them and so did not pass it on.

Although it is not possible to be certain about who said what in retrospect the report concludes that staff were not sufficiently skilled and/or alert to understand the significance of what they were being told, and therefore did not act on it.

Management oversight

47. This was specifically identified as an issue in approximately half of the evaluations and most concerns were in relation to social care managers. In several cases decisions about case closure were questioned and challenged, for example when there was a failure to consult with, or inform, other agencies.

The chronology shows that no contact was made with the health service to gain further information and that the case was closed without informing other agencies of this decision.

48. There were general criticisms about the absence of management overview, especially in cases of chronic neglect where the role of managers should be to 'stand back' and see the bigger picture. Instead they tended to be reactive and make decisions on the basis of specific incidents as they arose. One manager decided it was not appropriate to remove four children on the basis of one minor injury and that instead a full assessment should be undertaken, without taking into account the catalogue of previous incidents and concerns, and the fact that the family had already been assessed four times.
49. A number of serious case reviews noted the absence of supervision notes, and a failure to record discussions and decisions.

Individual staff error

50. This was referred to specifically in a small number of serious case review evaluations. The few examples related to police, health and social care staff. In just two evaluations there was a reference to staff being disciplined as a result of practice failings.
51. It is worth considering this in the context of the 'process' issues, in relation to the composition of serious case review panels. If panels consist of

representatives of the same organisations involved in the serious case review, and if individual management reviews are conducted by managers from those organisations, then it is less likely that the practice of individual managers and staff will be critically examined.

52. Moving the focus of serious case reviews from a consideration not just of what happened, but also why it happened, requires more rigorous attention to individual management and staff practice and why they acted the way they did on that particular day in those particular circumstances. Striking a balance between the basic purpose of a serious case review – to learn lessons – and the need for individual managers and staff to challenge and address poor practice is a particularly difficult issue which would benefit from further discussion and consideration by Local Safeguarding Children Boards.

Staffing capacity/resources

53. This was referred to less often than might be expected. Some individual management reviews explained the impact of staff changes (five midwives in one case), staff sickness (health visitor), inexperienced staff (Youth Offending Team), and lack of qualified staff (social care). Some also addressed management capacity (manager on secondment; on sick leave; needing to cover for colleague).
54. Lack of resources was identified as affecting the provision of drug counselling, and education for children out of school.
55. Generally, staffing capacity and resources were not presented as the main reasons why failings occurred.

Staff training

56. The need for additional staff training was a recommendation in most serious case reviews. It is of concern that basic awareness of signs and symptoms of abuse, including child sexual abuse, was still lacking in some key staff groups including teachers, health visitors, midwives, GPs, accident and emergency and probation personnel.
57. As with the recommendations about policies and procedures, it was not always easy to see how the Local Safeguarding Children Board would know that the additional training had made a difference to practice. This difficulty is clearly exemplified in the following extract.

There is a particular emphasis on improving training... it is difficult to see how conclusions were reached regarding shortcomings in the quality of training staff had received in the period in question.

58. Some specific training needs were identified relating to:

- impact of both child and parental disabilities on parental well-being and parenting capacity
- understanding and responding to fabricated illness
- identification and management of child sexual abuse
- understanding and responding to chronic neglect
- identifying 'shaken baby' symptoms.

Child protection concerns not identified

59. It is still the case that, despite most local areas having well established multi-agency training courses, staff did not always recognise the signs and symptoms of abuse. A number of the babies subject to serious case reviews were seen on several occasions by health staff and serious abuse was not identified.
60. In other cases staff had developed a particular perception of a case, for example as being about housing and finance, which prevented them seeing evidence of abuse which was outside this framework.
61. Universal services still did not always understand the thresholds for referral to social care, nor did they understand the role of social care in child protection enquiries.
62. The current practice of working within the Common Assessment Framework and its focus on 'children in need' makes it even more critical that all staff are aware of child protection issues and how to identify early indications of harm or abuse.¹⁰ This was not always evident and significant risk factors were missed as can be seen from the extracts below.

The fact that — was being supported as a child in need meant that agencies failed to see the significance of his escalating and difficult behaviour, including use of drugs, running away and self harm. Added to which, the council was in the process of 're-focusing' its services away from looking after children to supporting them in the community. This also had an impact on how —'s needs were defined.

The LSCB chair will ensure, as a result of this serious case review, that through the development of the Common Assessment Framework, criteria are agreed to help staff in deciding when a child is vulnerable and in need of additional support or intervention.

63. There were several examples of professionals taking the word of parents at face value and not questioning their account of events. In two cases there were

¹⁰For more information on the Common Assessment Framework visit:
www.everychildmatters.gov.uk/delivering-services/caf/

additional concerns that parents were colluding with their children's abusive and destructive behaviour but this was not challenged by the professionals concerned.

64. The general failure of all agencies to focus on what was happening to the child and assess the circumstances from the child's point of view was a fundamental and significant practice failure which was at the heart of many of the serious case reviews.

Poor assessment/planning

65. This was a concern in nearly all the evaluations. Pertinent issues such as parenting abilities, mental health problems, and drug and alcohol dependence were not addressed and taken into account effectively when deciding whether or not assessments should be done.
66. Universal services were not good at undertaking risk assessments in order to decide whether or not to refer a case to social care agencies. They were not good at listening to children, questioning what they were seeing, and being open minded about the possibility of abuse. A 'rule of optimism' prevailed, making it hard to be curious and challenging about what was happening to the children.
67. Social care services failed to follow their own procedures in relation to assessments and planning, and seven evaluations noted that no assessments were ever done, with no explanation as to why this was the case. In others, assessments were of poor quality; they failed to take account of the child's situation and wishes and feelings, and failed to obtain information from other agencies.
68. For older children there was a general failure to include them in the assessments and to share the outcome with them. In three evaluations it was noted that young people had expressed a view about what should happen to them but it was not acted upon.
69. For the relatively small number of looked after children in the sample, basic procedures were not followed in relation to placement plans and reviews.
70. Plans were not framed in a way which set out what needed to change for the child, and how that would be demonstrated; nor did they spell out what the consequences of non-cooperation by the parents would be.

No core assessment was ever completed and child protection procedures were not invoked, despite these three children being born to a mother who was a schedule 1 offender and who had been diagnosed as being a danger to her children.

Recording practices

71. Poor record keeping was noted as a particular failing in 33 evaluations. Specific concerns about school records were noted in 15 evaluations, and in 11 evaluations health records were of concern. For schools there were issues about the adequacy and accuracy of records, and in four cases it was noted that school records had been lost. For health the issue was the fragmentation of records among different health agencies. This meant that individual health staff misunderstood the significance of particular events or episodes, or simply did not know of previous events and concerns. The failures in the recording of school information are illustrated by these extracts.

None of the schools had a comprehensive record of these children, despite the family history being well known, and despite the fact that the children had special educational needs.

The issue of non-school attendance of — 's teenage mother is not addressed. The report rightly identifies deficits in the recording of events by the school, and the failure to make an appropriate referral to social care.

There is an outline of the mother's school history noting injuries sustained as far back as 1989, with descriptions of 'scrappy' recording and no record of action taken and outcome ... there are some clear recommendations intended to improve recording of significant events in schools.

Issues of neglect

72. Five of the serious case reviews related to cases of chronic neglect, where the families had been known to agencies for considerable periods of time. The particular practice issues in these cases are worth considering separately.
73. All the cases reviewed had common themes.
- No single agency had a complete picture of the family and a full record of all the concerns.
 - Agencies tended to respond reactively to each situation as it arose, rather than seeing it in the context of the case history.
 - Staff became resigned to, and accepting of, standards of care that would not be acceptable in other families.

- Little direct contact was made with the children to find out what they thought and how they felt about their situation.
 - On the occasions when the children tried to tell agencies they were not understood or taken seriously.
 - Schools had a critical role to play in recording how children were over time, both generally – whether children were dirty, tired, hungry and so on – and any specific changes in their behaviour and demeanour.
 - Professionals became confused and uncertain about the significance of issues in complex and chaotic families.
 - Too much reliance was placed on what parents said, and on supporting parents, rather than seeing the situation from the child’s perspective and experience.
 - Families were often hostile to contact from professionals and developed skilful strategies for keeping them at arms length.
 - Families were subject to multiple assessments and plans without any clear expectation of what needed to change for the children, and what the consequences would be if these changes were not forthcoming.
 - There was little evidence of any attempt being made in any of these assessments to evaluate the quality of the attachments between parents and children, a critical feature of ‘good enough’ parenting’.
74. The important key messages from one of the serious case reviews, applicable more generally, are as follows.
- A family support perspective can obscure the need to ensure children are properly protected. (The serious case review concluded that the outcome of the massive amount of support provided to this family was to ‘simply prop up and perpetuate a profoundly abusive situation’.)
 - The collective view of professionals that to remove the children from their parents would be even more detrimental to their welfare – a form of secondary abuse – distorted their judgement.
 - Agencies should be aware of the concept of professionals unwittingly colluding in the ongoing abuse of children. In this case the review panel believed that the mother’s learning disability led to a tendency to minimise the experiences of the children and the mother’s inability to change and improve.
 - Crucially:
 - when there is insufficient evidence of demonstrable change in relation to the children’s circumstances and well-being, agencies must act decisively to safeguard the children

- in order to make their judgement, professionals need a sound and accurate understanding of how children form attachments to their care givers
- regular inter-agency meetings are not sufficient to safeguard children if they do not involve high quality analysis which includes assessment of attachments and a comprehensive chronology of events.

Child sexual abuse

75. In three of the chronic neglect cases, and three others, plus one involving a baby, there were unrecognised and unreported examples of possible or actual sexual abuse of the children.
76. Professionals were even less likely to consider sexual abuse than other forms of abuse; they did not recognise some very common signs and symptoms, and did not know what to do with the information provided by children themselves. A particularly distressing feature of these cases was that the children had tried to tell, either by giving specific information, or in their behaviour and demeanour, but this was not acted upon. Several of the children exhibited significant changes in behaviour – running away, deteriorating school attendance and deteriorating physical appearance – which were not considered in the context of possible abuse. One young person had chronic soiling problems which had been addressed in a number of ways but not in the context of possible abuse. Some of the children had learning difficulties and their particular vulnerabilities were not recognised.
77. Perpetrators of child sexual abuse were powerful and persuasive individuals and in two cases the child was actually placed with the perpetrator.

Patterns of engagement with services

78. A small number of serious case reviews highlighted the importance of understanding patterns of engagement with services, particularly with health and with schools. The patterns included the following.
 - **Families not keeping appointments.** This was a feature in five cases of very young babies and also in three families where there was chronic neglect. The missed appointments were recorded, but no-one collated the information or questioned its significance. In one case the drug and alcohol service had a policy of discharging new patients if they failed to keep two appointments.

It catalogues a long history of failed medical appointments for all three children over a long period, but does not consider how professionals should collate this information, and how it should be considered as part of a wider risk assessment.

- **Families not engaging with professionals when being supported by a child in need plan.** Good practice requires that this should always be written into a child in need plan as a trigger for possible concern which could lead to a child protection referral, and explained as such to parents.
- **Families who move, or whose children go missing.** Children being taken off school roll, or whose patterns of attendance change in some way. There were examples of schools accepting at face value parents' explanations and children being out of school for considerable periods of time without any follow up. This was in some cases linked to families who moved, where services lost track of what was happening to the children. An issue in one serious case review was the lack of oversight of children receiving home education.

There was a failure [by the school] to record and track the movements of the surviving child when she was taken off the school roll. She was latterly found to be registered in a school in [another council area] which had no record of her previous school or history.

- **Families having an unusually large number of appointments with health services.** In one case the serious case review identified 93 separate health appointments.

The serious case review catalogued 93 separate health appointments for –. These should have been analysed with reference to the mother's mental health problems, but they were accepted at face value.

Siblings

79. Contrary to the requirement of basic child protection procedures, five serious case reviews recorded the failure of agencies to act to protect siblings once abuse was suspected or confirmed in the subject child.
80. In one case the sibling had been removed from school and placed in a school elsewhere that knew nothing about the abuse before action was taken. In another a decision was made by children's social care services, without any assessment taking place, that there was no risk to the sibling.
81. In another case police decided that there was no need for social care services to get involved in the assessment of risk to the sibling, again in direct contravention of child protection procedures.

The review process

Introduction

82. An unexpected, and concerning, feature of our first year's evaluations was the number of serious case reviews judged to be inadequate. The outcomes of the 50 serious case review evaluations were as follows:

Figure 2: Judgements on serious case reviews evaluated by Ofsted between April 2007 and March 2008

Outstanding	Good	Adequate	Inadequate
0	12	18	20

These judgements were made in line with the grade descriptors set out in Appendix A.

83. The main factors contributing to the inadequate judgements were as follows:

- **Timescales.** Only two of the inadequate serious case reviews had been completed within the *Working together* timescale of four months. Some had taken as long as three years to complete.
- **Terms of reference.** Two of the serious case reviews judged to be inadequate had no identifiable terms of reference. Other concerns emerging from our analysis included a too narrow focus; not following *Working together* requirements; not identifying key issues and lessons to learn; not covering the relevant timeframe. This had a significant impact on all that followed in the review, and particularly on the quality of individual management reviews.
- **Individual management reviews.** The poor quality of individual management reviews was the single most significant reason for an inadequate judgement. Issues included:
 - no analysis or critique of practice
 - narrow, simplistic approach
 - defensive stance rather than open and critical approach to learning lessons
 - seeking to protect agency from criticism
 - authors not competent to judge practice failings
 - poor presentation reflecting a casual approach to the task (for example no date, no author, document still contained track changes)
 - absence of basic information such as who knew what
 - absence of, or inadequate, chronologies
 - no agreed format for completion, making it difficult to compare reports with one another
 - no clarity about terms of reference – individual management reviews devising their own or not having any at all

- key issues missed, not recognised or not addressed
- inadequate recommendations, or, in some cases, no recommendations.
- **Overall recommendations.** These were judged to be too limited, inappropriate, vague and unspecific, and not addressing the key issues. In some cases recommendations from individual management reviews were not picked up in the overview report.
- **Action plans.** There was no clear process for monitoring the action plan and demonstrating what will have changed and improved in inter-agency working. In particular, no formal role was identified for the Local Safeguarding Children Board in monitoring and evaluating the process and outcomes of the action plan.

Analysis of process issues

Participation of agencies

84. *Working together* paragraph 8.3 sets out the process of serious case reviews as:
- **establishing whether there are lessons to be learned** from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - **identifying clearly what those lessons are**, how they will be acted upon and what is expected to change as a result
 - as a consequence, **improving inter-agency working** and safeguarding of children.
85. In addition, section 10 of the Children Act 2004 sets out the duty of agencies to cooperate to **improve the well-being of children.**
86. The Local Safeguarding Children Board should set up a serious case review panel to oversee the process, and request individual management reviews from agencies involved. The following table sets out the extent to which agencies participated in the serious case review panels and submitted individual management reviews.

Table 1: Agencies participating in serious case review panels and submission of individual management reviews

Agency	Panel	Individual agency management review
Children's social care	44	39
Police	44	35
Primary care trust	41	41
Education	33	23
NHS trust	23	24
Probation	11	7
Youth offending team	6	8
Housing	2	11
Connexions	4	7
Voluntary organisation	5	5
Health authority	4	2
Cafcass	5	1
Legal adviser	11	0
Independent agencies	0	7
Local Safeguarding Children Board officer	8	0
Adult social care	1	1
Drug and alcohol action team	0	2
Crown Prosecution Service	1	1
Youth Justice Board	2	0
Secure training centre	0	2

87. Local authority social care services contributed to most panels, and prepared most individual management reviews; this was despite approximately 15 of the children not being known to social care at the time of the incident. The next highest contributors to both panels and individual management reviews were the police, then health services, then education services, which were usually represented by local authority education officers rather than the schools themselves.

88. Serious case review panels are important in providing an overview and the necessary professional expertise to guide the process. However, in many instances there was too close a correlation between the membership of panels

and those providing individual management reviews, raising questions about the level of independence in serious case review panels.

89. Eleven housing associations and district council housing departments submitted individual management reviews which contained valuable information that underlined the importance of housing services in the safeguarding process. The Connexions service was also a valuable contributor to a number of serious case reviews. Despite the prevalence of drug and alcohol related issues, drug and alcohol specialist teams were identified as having submitted individual management reviews in only two serious case reviews. Adult social care was also notable by its absence from the process.

Independent authors and chairs

90. Paragraph 8.20 of *Working together* requires that 'the overview report should be commissioned from a person who is independent of all the agencies/professionals involved'. Feedback from Local Safeguarding Children Boards and local areas has highlighted the difficulty they have in obtaining the services of a sufficiently independent and skilled author for overview reports. Some Local Safeguarding Children Boards have interpreted the requirement as meaning 'independent of the particular case' and have used members of the Local Safeguarding Children Board with no direct involvement. This is questionable practice, given the collective responsibility of the Local Safeguarding Children Board for all safeguarding issues, and the fact that some recommendations are likely to be directed at the Local Safeguarding Children Board as a whole. In addition, the Board has a monitoring role for the implementation of the action plan. Ofsted interprets 'independent' in paragraph 8.20 as meaning independent of all agencies and the Local Safeguarding Children Board.
91. The chair of a Local Safeguarding Children Board plays a vital role in coordinating and ensuring the effectiveness of action by partner agencies in safeguarding children in local areas. Some Boards have considered that to carry out this role effectively it is essential that the local Director of Children's Services should undertake this role. However, another important aspect of the chair's work is to hold local services to account when things go wrong. The lack of analysis or critique evident in a significant number of the serious case reviews evaluated highlights the dangers in this approach and points to a need for the chair of a Local Safeguarding Children Board to be more independent of the services involved.
92. Despite the difficulties, 36 serious case reviews were able to ensure a degree of independence in the overview report writer. Independent authors included barristers, academics, private consultants and social care professionals from neighbouring councils.

93. There was no correlation between the quality of the overview report and the independence of the author. Some authors appointed for their knowledge and expertise in a particular area were unable to apply this effectively to the overview report. Some academics focused too much on academic research and not on the practice issues relevant to that particular case and locality.
94. Conversely, some of the best reports were written by authors employed by the local authority. Although no full review report was judged to be outstanding, one overview report was judged to be so. This was written by a local safeguarding officer.
95. The critical attributes of a good report writer are:
 - the ability to bring an open minded, independent approach to the evidence
 - the ability to stand back and critically analyse all the information
 - the ability to collate and coordinate a large amount of information from which to distil the key findings
 - writing skills
 - crucially, knowledge and expertise in child protection.
96. Some of the independent authors 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.

Terms of reference

97. The fundamental purpose of a serious case review is to identify what went wrong and to learn lessons. The terms of reference are therefore critical to this process. Paragraph 8.12 of *Working together* sets out clear and detailed advice about setting the terms of reference. A significant number of serious case reviews had not followed this advice, particularly in relation to: the timeframe for the review; the breadth of enquiry; the agencies that should be involved; and the participation of family members. They should in addition set out which records should be secured and made available for the review, and who should be interviewed. These omissions had a direct impact on the quality and value of the ensuing process, particularly in relation to the individual management reviews. In a number of cases the independent author had made up for deficits in the terms of reference by adding areas for consideration and formulating recommendations from additional work that had not been covered by the original terms of reference and individual management reviews.

Comment has been made elsewhere about the need for specific terms of reference ... three recommendations in the police report support this... it points out that no parameters had been set for the review and so the police decided to limit their review to events after an arbitrary date... and

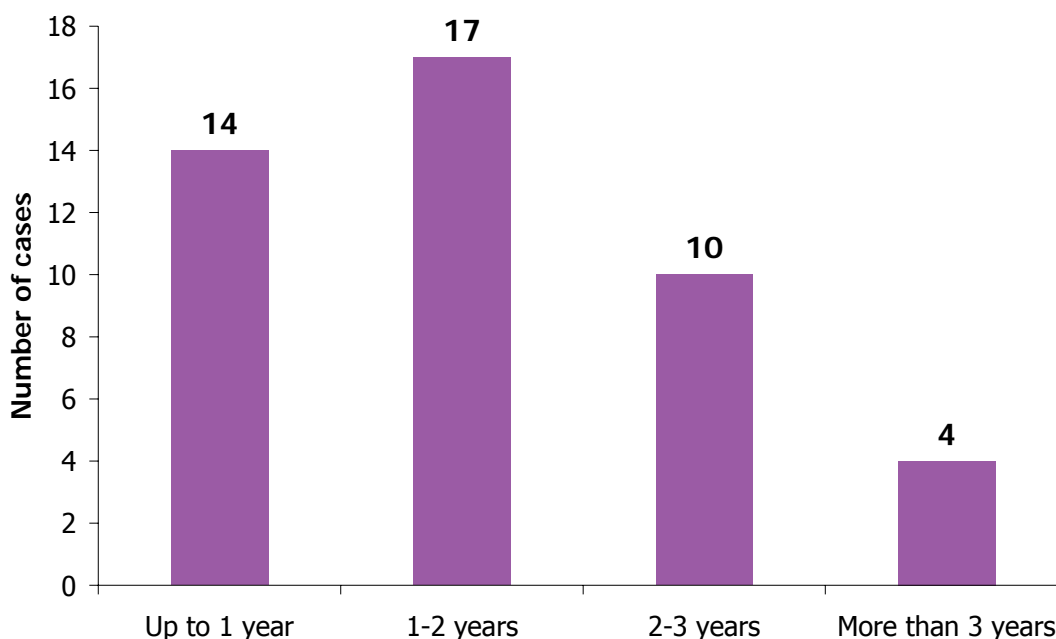
that the 'commissioning document' should specify how family members are to be identified (initials, etc.).

The terms of reference were inadequate in that they did not cover the time immediately following —'s death, when significant concerns arose in relation to the protection of the sibling.

Timescales

98. Paragraph 8.14 of *Working together* requires the Local Safeguarding Children Board to decide whether or not to conduct a serious case review within one month of a case coming to its attention, and paragraph 8.15 requires that any review should be completed within a further four months. Of the 50 serious case reviews evaluated, only five were completed within four months, and in two of these there were delays in starting the process. Most took significantly longer, meaning lessons were often not learned quickly enough and remedial action was delayed.

Figure 3: Length of time for completion of serious case reviews evaluated between April 2007 and March 2008



99. Reasons for the delays were not always given, despite paragraph 8.15 of *Working together* requiring discussion with the Government Office Children's Services Adviser (prior to 1 April 2007 with the Commission for Social Care Inspection) to negotiate a revised timescale. Where reasons were given, they included:

- inability to appoint an independent author
- internal staffing pressures preventing work being done

- delays in obtaining agreement to conduct serious case reviews and their completion when other agencies cannot be compelled to cooperate
 - complexities of coordinating serious case reviews which cover more than one local area, and a number of different agencies
 - different processes for conducting internal reviews in different agencies (such as police, youth justice, health, education and social care)
 - inexperience of staff conducting individual management reviews
 - the need for additional guidance and support from the Local Safeguarding Children Board
 - delays caused by coroners' courts and criminal proceedings
 - delays in agreeing a final set of recommendations and action plan among agencies.
100. These delays reduce the impact of the findings, when many of the key participants may have moved on and the issues been forgotten, and also the speed at which lessons learned can be implemented and practice improved.
101. One example illustrates the impact of these delays. In one local area a serious case review took three years to complete. In the intervening period another child died in similar circumstances. Had the first serious case review been completed on time and lessons learned identified and put into practice, the death of the second child might have been avoided.
102. A significant number of reviews were delayed because they were awaiting the outcome of coroners' courts and/or criminal proceedings. *Working together* paragraph 8.16 states specifically that serious case reviews should not be delayed because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. It goes on to advise that 'it may not be possible to complete or publish a review until after the coroners' or criminal proceedings have been concluded but this should not prevent early lessons from being implemented'. It is not always stated how far Local Safeguarding Children Boards attempted to negotiate with coroners and the Crown Prosecution Service to enable information to be used and shared, at least internally. There were a few examples where a robust approach had been taken by senior managers and information was available to be used for the purpose of the serious case review.

Individual management reviews

103. The poor quality of individual agency management reviews was the single most serious area of concern. The deficits are set out in paragraph 34 above, and agencies' failure to comply with the requirements of *Working together* in this respect are in direct contravention of their duty to cooperate under Section 10 of the Children Act 2004.

104. It was rare to see any mention of a framework provided, or guidance given, for the completion of individual management reviews. Chapter 8 of *Working together* provides clear guidance on the framework to be used, but it was clearly not followed in many cases. All agencies found it difficult to prepare these documents, particularly agencies not normally involved in child protection issues.
105. As these are the basic documents on which the quality of information, analysis, and lessons learned depend, the poor quality is a considerable deficit in the process. The poor quality or absence of individual management reviews was rarely challenged by panels. Just two serious case review evaluations noted that the panel had sent inadequate reviews back to the agency for further work. Some agencies failed, or refused, to deliver reviews. Again, this is in direct contravention of their duty to cooperate and should be challenged.

It is noted that individual management reviews were requested of — Mental Health Trust and from previous psychiatrists who had treated the parent, but none of them agreed to supply information.

The documentation provided to Ofsted referred to nine individual management reviews. None was submitted with the original documentation. Four were later sent on request, and after further enquiries it emerged that the other five did not exist.

106. Of particular note was the absence of comprehensive chronologies within the individual management reviews which made it difficult to determine who knew what, and when. Where chronologies were included it was rare to see one setting out explicitly when the child was seen, what their condition was, and what they said.
107. Despite these limitations, most individual management reviews identified what happened and what needed to change in general terms, such as in relation to policies and procedures. They were not so good at exploring why it happened, and how it should be avoided in the future, which requires, among other things, a detailed analysis of the actions of individual staff members and an honest self-appraisal on their part as to why they acted in the way they did.
108. For example, where reviews identified the failure to follow basic procedures the recommendation was invariably to reissue procedures, provide additional training, and so on. It was rare to see any analysis of why staff failed to follow basic procedures.

The ... report identifies the failure of the emergency duty staff to check the Child Protection Register when requested to do so by the out-of-hours GP. It acknowledges that this was a fundamental failure to follow well-established procedures. It does not provide an explanation as to why this happened.

Overview reports

109. Overview reports were generally of a higher quality than individual management reviews. There were many examples of authors seeking additional information, conducting interviews with staff and requesting additional work from individual management review contributors, to ensure that the final report was of suitable quality. One overview report, completed by an officer of the local authority, was judged 'outstanding'.
110. Chapter 8 of *Working together* sets out the framework for an overview report. Overall, the key features of good overview reports include:
- well set out with clear headings and sections
 - detailed combined chronology which includes when the child was seen
 - a genogram, and flow chart of the child's moves, where appropriate
 - summary of family history
 - whether any staff or family members were interviewed as part of the process
 - whether issues of race, culture, language, religion and disability were covered and addressed
 - the wishes and feelings of the family and the child, where appropriate
 - information from previous serious case reviews, enquiries and research to inform conclusions
 - an analysis of actions and interventions, focusing on what went wrong and why, and whether different actions would have led to different outcomes
 - a critical appraisal of the individual management reviews and their contribution to learning the lessons
 - the lessons to be learned set out clearly, providing valuable learning for all professionals
 - a coordinated set of specific and well structured recommendations, such as:
 - an action plan clearly setting out targets, outcomes, responsibilities and how practice is expected to change as a result
 - a monitoring and evaluation process that involves individual agencies and the Local Safeguarding Children Board as a whole
 - overall conclusions and whether they have wider implications for national policy and practice.

Recommendations from overview reports

111. A good set of recommendations usually followed from a good overview report and a good set of individual management reviews, based on appropriate terms of reference. Where these were not in place then recommendations were also less good. There were examples where very relevant recommendations were contained within individual management reviews but then not picked up by the overview report. In others, the overview report contained additional recommendations without any explanation as to where these came from. A common failing was to focus recommendations on policies and procedures and not on practice, and what needed to change. Some were just too vague or too complex to be achievable, or for anyone to know when they had been achieved.

Action plans

112. Similarly, good action plans followed from a good set of recommendations. These contained targets, timescales, lead responsibilities and expected outcomes. Critically, they included clarifying the monitoring role of the Local Safeguarding Children Board as well as the responsibilities of individual agencies for delivery.

The report explains why the recommendations are significant... however some are long and cover a number of actions. For the action plan they have been converted into outcomes. Then consideration has been given to what actions will be required to achieve that outcome. This approach can miss capturing elements within the original recommendations.

Involvement of family members

113. Paragraph 8.12 of *Working together* recommends that the review panel should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'. On the whole this was not well covered in the reviews evaluated. There was a small number of examples of excellent practice but it was rare to see family members included and their views recorded even where they played a critical role in the events. Examples of omission included grandparents who had expressed concern about the care of their grandchildren; others who had cared for their grandchildren; and, where relevant, the children themselves.
114. Eight evaluations recorded that families had made a contribution. A further eight noted that families were invited to contribute but declined. In 19 evaluations the issue was not covered at all. In a further 11 there was a statement that family members were not involved. A positive decision not to involve family members was noted in three evaluations.

—’s parents are not aware that a serious case review has been completed. The reason given is that it could exacerbate the mother’s mental health difficulties. However there is no contribution to the serious case review by the child’s father and grandparents. —’s grandparents were important family members as they had a residence order and care of —. Given that one of the key questions for the serious case review was why the grandparents’ views were not listened to it is regrettable that their views were again not sought and taken into account in the serious case review.

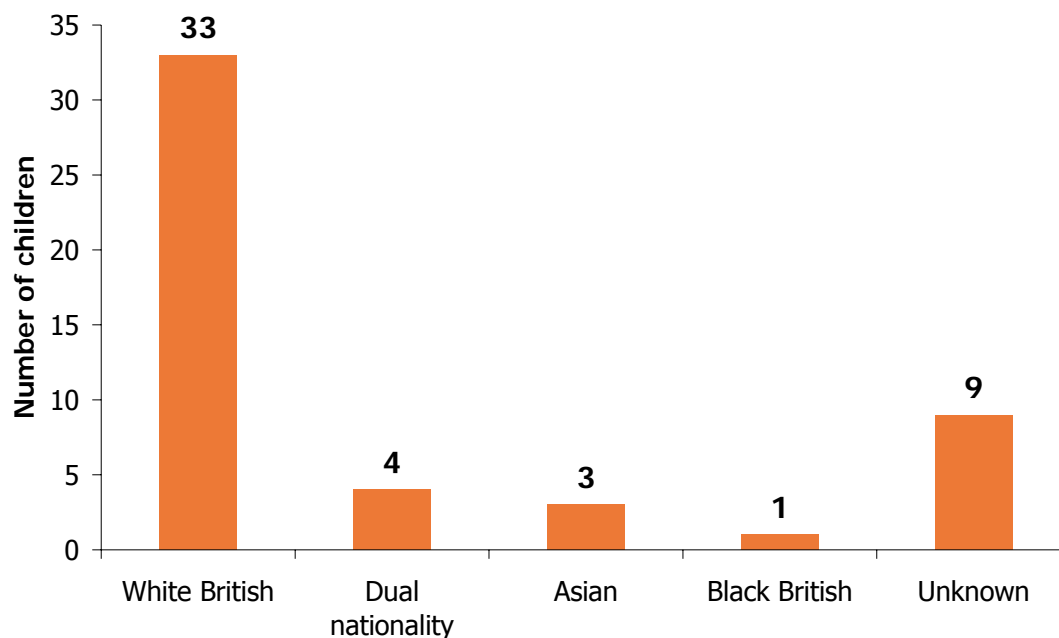
While there is reference to the mother and maternal grandmother being unhappy about the previous involvement of social care there is no information regarding their response to the serious case review and subsequent views.

The views of family members are not included. The overview report does not address this and no reference is made to seeking their views.

115. There were three good examples of older children contributing to the serious case review. In one case the overview report included a detailed chronology and analysis of events, drawing on quotations from relevant agencies, parents and the young person. Other older children were not asked to contribute and it was not always clear if they were aware that a review had taken place.
116. It is hard to extract from the evaluation documents the reasons why serious case reviews found it so difficult to include family members. Many simply did not cover it at all. Some included a statement that the family had been asked to participate, but declined. It is not clear how much effort had gone into seeking their participation.
117. This failure to work with, consult, and include the views of families, and of the young people themselves, is also a key issue in the Practice section of this report. It is a critical message in terms of improving both the process of conducting serious case reviews and professional practice in protecting children.
118. Consultation with families and children is also not emphasised sufficiently in Ofsted’s current evaluation process and grade descriptors.

Issues of race, language, culture, religion, and disability

Figure 3: Number of children who were the primary subject of serious case reviews by ethnicity April 2007 to March 2008



119. Serious case reviews were on the whole notable in the absence of any real analysis of these issues, even in cases where they clearly had an impact, such as a child being out of school because of racist comments; a family with language difficulties not understanding the services provided; the disabilities of both parents and child impacting on the parents' mental health and parenting capacity.

The report refers to the fact that the parents often did not fully understand all the issues raised by medical staff – but there are no recommendations as to how this might be addressed differently in any future cases.

120. Issues of race and culture were clearly at the centre of one serious case review where the young person committed suicide. These had not been addressed either in the way the agencies had worked with the young person, or in the ensuing individual management reviews. This was neither criticised nor addressed in the overview report.
121. One young person well known to agencies was a member of a Traveller family. The implications of this were never considered as part of the assessments undertaken with the family; they were not picked up in the individual management reviews and only latterly addressed in the overview report.
122. A feature of services provided for children with special educational needs identified in a number of serious case reviews was the poor quality of recording

by schools and other agencies. This impacted on the assessment of the child's needs and on the services provided.

123. This area is not well covered by Ofsted's current evaluation process, and needs to be more explicitly addressed both by Local Safeguarding Children Boards and by Ofsted as part of the evaluation process.

Key messages

Strong correlation between membership of panels and the providers of individual management reviews.

Lack of involvement of adult services and drug and alcohol teams in panels in most serious case reviews.

Most delays caused by: inability to appoint independent authors; internal staffing pressures preventing work being done; difficulties in securing the co-operation of relevant agencies; complexities of coordinating serious case reviews which cover more than one local area or a number of different agencies; inexperience of staff conducting individual management reviews; parallel investigations such as coroner's courts and criminal proceedings; delays in agreeing final set of recommendations and action plan between agencies.

Reasons for inadequate judgements included: terms of reference unclear; no agreed format for completion of individual management reviews; presentation poor with a complacent approach to the task; absence of basic information; insufficient analysis or critique of practice with a defensive stance rather than open and critical approach to learning lessons; key issues not recognised or addressed; lack of recommendations that clearly specify how lessons learned will be translated into practice; recommendations limited, not relevant to findings, vague and unspecific about time scale for implementation; action plans with no clear process for monitoring the implementation or impact of the action plan, in particular no formal role for the Local Safeguarding Children Board in monitoring and evaluating the impact of the action plan on inter-agency working.

Annex A. Serious case reviews listed by local authority and Ofsted evaluation April 2007 to March 2008

It is Local Safeguarding Children Boards that are required to undertake reviews of serious cases.

Local authority	Serious case review evaluation	Date of evaluation letter
Barnsley	Adequate	29/11/2007
Bristol	Adequate	27/11/2007
Bristol	Inadequate	04/01/2008
Bromley	Adequate	01/04/2008
Bury	Good	19/11/2007
Bury	Adequate	22/01/2008
Cheshire	Adequate	26/02/2008
Cornwall	Inadequate	04/04/2008
Cornwall	Inadequate	07/04/2008
Cornwall	Inadequate	11/04/2008
Derbyshire	Adequate	17/09/2007
Derbyshire	Adequate	22/10/2007
Derbyshire	Adequate	05/02/2008
Derbyshire	Inadequate	06/03/2008
Doncaster	Adequate	21/02/2008
Doncaster	Inadequate	29/02/2008
Durham	Good	17/09/2007
Essex	Adequate	26/10/2007
Hampshire	Good	31/01/2008
Hampshire	Adequate	05/02/2008
Hampshire	Adequate	09/04/2008
Hampshire	Inadequate	09/04/2008
Havering	Good	10/02/2008
Hertfordshire	Inadequate	28/01/2008
Lambeth	Inadequate	23/08/2007
Lancashire	Good	04/10/2007
Leicestershire	Adequate	20/12/2007
Lincolnshire	Adequate	23/10/2007
Lincolnshire	Inadequate	15/01/2008
Northamptonshire	Inadequate	21/12/2007
Northamptonshire	Inadequate	03/03/2008
Northamptonshire	Inadequate	03/03/2008
Northamptonshire	Adequate	10/04/2008
Nottingham city	Inadequate	08/04/2008
Sandwell	Inadequate	04/10/2007
Sheffield	Good	27/12/2007
Shropshire	Inadequate	26/11/2007
Somerset	Inadequate	24/07/2007
South Tyneside	Adequate	26/02/2008
Southend	Good	19/02/2008
Staffordshire	Inadequate	16/11/2007

Suffolk	Good	26/02/2008
Suffolk	Inadequate	07/04/2008
Surrey	Good	17/09/2007
Thurrock	Inadequate	11/12/2007
Trafford	Adequate	21/12/2007
Walsall	Good	29/01/2008
Warwickshire	Good	25/03/2008
Warwickshire	Adequate	21/04/2008
Worcestershire	Good	11/03/2008

Annex B. Descriptors used for the evaluation of serious case reviews in this report

These are currently being revised in light of a year's experience and feedback from local authorities and Local Safeguarding Children Boards.

Judgement	Descriptors
<p>Outstanding</p> <p>The review was very well managed, is outcome focused and promotes a culture of learning. It fully addresses the terms of reference and requirements of chapter 8 of <i>Working together</i>.</p>	<p>The scope of the review is unambiguous, outcome focused and supported by clear terms of reference which ensure that all relevant information can be obtained and analysed within the agreed timescale. The contribution of all relevant agencies is secured. A high level of independence is built into the process, including the appointment of an independent author of the overview report and access to expert advice on critical or complex aspects of the case. Arrangements to involve relevant family members are effective. All other parallel investigations including criminal investigations and coroner's enquiries are considered, and, where appropriate, effective communication processes or jointly commissioned review arrangements have been agreed. Contingency arrangements help to ensure timely responses to new information or changes during the process of the review. Any delays in completion of the report within four months are unavoidable and have not delayed implementation of identified actions for improving practice. The review is completed within an agreed timescale.</p> <p>All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the child(ren) and family. The review takes full account of the outcomes for the child(ren) concerned in light of their individual needs and their racial, cultural, linguistic and religious identity. Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Good practice is highlighted. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.</p> <p>The overview report coherently brings together the findings of all individual management reviews and other relevant investigations, reviews or enquiries. It summarises the facts of the case succinctly, including a clear genogram and a comprehensive and well-organised chronology which maintain a clear focus on the child(ren) concerned throughout. Outcomes for the child(ren) are considered against all the information known to the agencies and professionals concerned about the parents, child(ren) and perpetrators, the family history and home circumstances. The report is based upon a critical analysis of the facts and a strong evaluation leading to convincing conclusions for how and why events occurred and actions or decisions by agencies were or were not taken. The benefits of hindsight and evidence from research are used deftly by reviewers to judge whether</p>

	<p>different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are specific and supported by achievable recommendations for improving practice and a comprehensive action plan for implementation. The action plan is underpinned by a clear process for monitoring and evaluation of its implementation and impact.</p> <p>An executive summary is completed and includes succinct information about the review process, practice issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary. The executive summary includes a synthesis of the lessons learned and it is written in a style that is accessible to a wide range of readers and is jargon free.</p>
<p>Good</p> <p>The review fully addresses the terms of reference and requirements of chapter 8 of <i>Working together</i>. It identifies relevant lessons for improving practice.</p>	<p>The scope of the review is unambiguous, outcome focused and supported by clear terms of reference which ensure that nearly all relevant information can be obtained and analysed. The contribution of all relevant agencies is secured. Independence is built into the process, including the appointment of an independent author of the overview report and access to legal advice on critical aspects of the case. The contributions of relevant agencies are clearly defined and clear arrangements have been put in place to secure the involvement of relevant family members. Other parallel investigations, including criminal investigations and coroner’s enquiries, are considered and, where appropriate, effective communication processes are in place. Any delays in completion of the review are unavoidable and it is completed broadly in line with an agreed timescale</p> <p>Relevant agencies produce a comprehensive management review of their full involvement with the child and family. Any gaps in information are minor and do not impact directly on the outcome for the child(ren) concerned. The review takes into account the individual needs of the child(ren) and is sensitive to their racial, cultural, linguistic and religious identity. Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Good practice is highlighted. Areas for changes in practice are clearly identified and supported with measurable and relevant recommendations for improvement.</p> <p>The overview report coherently brings together the findings of the individual management reviews and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a clear genogram and a comprehensive chronology of events relating to the history of the child(ren) and family and agency involvement. Outcomes for the child(ren) are considered against the available information known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances. The report reflects a critical examination of the facts and provides credible explanations for how and why events occurred and actions or decisions by agencies were or were not taken. The benefit of hindsight is used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are clearly identified and supported by specific and</p>

	<p>achievable recommendations for improving practice and a comprehensive action plan for their implementation.</p> <p>An executive summary is completed and includes succinct information about the review process, key issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary.</p>
<p>Adequate</p> <p>The review does not fully address the terms of reference or meet the full requirements of chapter 8 of <i>Working together</i>. However this shortfall does not impact adversely on the outcome of the review in identifying the relevant lessons to be learned.</p>	<p>The scope of the review is defined and supported by terms of reference which support the collation of the relevant information for the review. Independence is built into the process through the appointment of an independent author of the overview report and access to legal advice on critical aspects of the case. The relevant agencies are identified and arrangements have been put in place for the involvement of relevant family members. Other parallel investigations, including criminal investigations and coroner's enquiries, are considered and, where appropriate, communication processes are agreed. Where there are delays in the completion of management reviews and the overview report, these are explained and do not significantly impede timely dissemination of the lessons learned.</p> <p>Most relevant agencies produce individual management reviews of their involvement with the child and family. Most reviews take into account the individual needs of the child and family and record their racial, cultural, linguistic and religious identity. Practice is analysed by most agencies openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Gaps in information are identified and explained. Areas for changes in practice are mostly identified and supported with measurable and relevant recommendations for improving practice.</p> <p>The overview report brings together the findings of all reports from agencies and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a genogram and a chronology of the family history, circumstances of the child(ren) and agency involvement. Reference is made to what information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child. The report includes examination of the key facts and provides credible explanations for any gaps in information and how and why events occurred and actions or decisions by agencies were or were not taken. The benefit of hindsight is used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are identified and supported by specific and measurable recommendations for improvement and a relevant action plan for their implementation.</p> <p>An executive summary is completed and includes relevant information about the review process, key issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary.</p>

<p>Inadequate The review does not fully address the terms of reference or meet the requirements of chapter 8 of <i>Working together</i>. A lack of rigour in the management of the review impacts adversely on its capacity to ensure that lessons are identified and learned.</p>	<p>The scope of the review is unclear and supported by imprecise terms of reference which fail to ensure that the relevant information can be obtained and analysed. The contributions of some relevant agencies are not secured. Insufficient independence is built into the process such as the appointment of an independent author of the overview report. The involvement of relevant family members has not been agreed. Some parallel investigations including criminal investigations and coroner’s enquiries have not been considered within the scope of the review and processes for communication are unclear. There are substantial and avoidable or unexplained delays in the completion of the review which impede timely dissemination of lessons to be learned.</p> <p>Not all relevant agencies produce a management review of their involvement with the child(ren) and family. Some reviews do not take into account the individual needs of the child(ren) and family including their racial, cultural, linguistic and religious identity. The extent to which practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance is inconsistent across agencies. There are gaps in information which are not fully explained. Some areas for changes in practice are identified but are not always supported with measurable and relevant recommendations for improvement.</p> <p>The overview report brings together most of the findings of the individual management reviews and other relevant investigations, reviews or enquiries. There are some gaps in the genogram and chronology of information relating to the family history, circumstances of the child(ren) and agency involvement which impact adversely on the coherence of the report. Reference is not always made to what information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child(ren). The report lacks rigour in its examination of the facts and explanations on how and why events occurred and actions or decisions by agencies were or were not taken. The use of the benefit of hindsight by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events is not convincing. Some lessons to be learned, nationally and locally, are identified but not always supported by specific recommendations for improvement and a relevant action plan for implementation.</p> <p>An executive summary is completed but there are gaps in information about the review process, key issues arising from the case and recommendations which have been made. Arrangements for the publication of the review are not secure.</p>
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