Learning from serious case reviews

Report of a research study on the methods of learning lessons nationally from serious case reviews

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1   Background

The death of a child from abuse or neglect is of huge public and professional importance. In recognition of this, in England, every such death is subject to a multi-agency Serious Case Review. The purpose of these reviews, which may also be held in cases of serious but non-fatal maltreatment, is to establish 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. These Serious Case Reviews have generated a lot of understanding about interagency working to safeguard children and have been widely used in training and to support practice (Brandon et al., 2009; Brandon et al., 2008; Falkov, 1995; Peter Reder & Duncan, 1999; P Reder, Duncan, & Gray, 1993; Sinclair & Bullock, 2002).

In line with trying to bring clearer standards and more consistent approaches to the process, there has been a move to collate the findings of these reviews through biennial national analyses in order to identify common themes and trends, to draw out key findings and assess their implications for policy and practice both locally and nationally (Brandon, Bailey, & Belderson, 2010; Brandon et al., 2009; Brandon et al., 2008; Rose & Barnes, 2008; Sinclair & Bullock, 2002). However, some of the reviews have been hampered by technical difficulties in accessing and using data and there has been some criticism of a lack of timeliness, and for repeatedly identifying the same lessons.

Along with the ongoing requirement to carry out Serious Case Reviews, *Working Together* (HM Government, 2006, 2010) placed new responsibilities on Local Safeguarding Children Boards (LSCBs) to establish Child Death Overview Panels to review all child deaths in an area with a view not just to identify those cases related to child maltreatment, but also to identify any wider matters of concern affecting the safety and welfare of children and any wider public health or safety concerns arising from a particular death or from a pattern of deaths.   Deaths from maltreatment make up a small but nevertheless significant proportion of all childhood deaths. It is clear from earlier research and experience that they do not form one homogeneous group, but rather fall into a number of distinct but overlapping subgroups (Christoffel, 1984; P Reder et al., 1993; P Sidebotham, 2007). It is important that these deaths are seen in the wider context of childhood mortality from all causes, and of other, non-fatal situations of childhood harm. This broader context would be in keeping with the wider aspects of safeguarding children and promoting their welfare outlined in *Working Together* (HM Government, 2010) and in the National Service Framework for Children, Young People and Families (Department of Health & Department for

Education and Skills, 2004), yet without losing sight of the importance of protecting children from the more severe aspects of child abuse and neglect.

Whilst there is some evidence that numbers and rates of fatal maltreatment in England have fallen (Pritchard & Sharples, 2008), as many as 1-2 children per week continue to die from maltreatment (Brandon et al., 2009; Brandon et al., 2008; Creighton, 1995; Green, 1998; Peter Reder & Duncan, 1999; Rose & Barnes, 2008). It would seem that in many cases, such deaths are difficult or impossible to predict. Focusing solely on aspects of interagency working, to the exclusion of other factors, including factors in the child, parents, family, and wider environment, that may have contributed to risk, may fail to identify issues that could be addressed at a wider community level. In addition, many Serious Case Reviews and Inquiries seem to draw similar conclusions about the systemic and professional shortcomings that fail to protect children. A number of factors may contribute to this:

1. The emphasis on learning lessons rather than apportioning blame, whilst important, may result in avoidance of serious issues when they do contribute;
2. Professional "blindness" to more deep seated systemic failings;
3. A failure to translate findings into specific, achievable goals;
4. A failure to follow up on implementation of recommendations;
5. Poorly focused reviews;
6. The inevitable timeframe involved in completing reviews and in conducting national reviews so that lessons learnt do not lead to timely action.

Within this wider context therefore, there is a need to build on the findings of the previous biennial reviews, and to develop more effective methods of collating the findings of Serious Case Reviews in order to inform the ongoing development of safeguarding policy and practice. Any systems put in place for ongoing monitoring and analysis will need to go beyond basic descriptive data to incorporate more detailed analysis of systems and processes underlying the risks of harm to children, and of outcomes from the reviews and their implementation.

Drawing on a strong research base and experience in relation to both Serious Case Reviews and Child Death Overviews, the University of Warwick and the University of East Anglia have collaborated to undertake a scoping exercise to develop a revised method of conducting national reviews. The research has consisted of a critical appraisal of previous biennial reviews and consultation with stakeholders through focus groups and a Delphi study. All three strands have been analysed together in order to inform our understanding and to develop recommendations on how to improve national approaches to learning from Serious Case Reviews.

2.   Project Objectives

The overall aim of the project was to undertake a scoping exercise in order to inform the development of a revised framework for conducting national reviews. The specific objectives were:

- To critically appraise the approaches to analysis developed and used in the previous biennial reviews, along with the more recent Ofsted reviews, in order to assess their utility in identifying common themes and trends and in auditing the process and outcomes of Serious Case Reviews;

- To ascertain the views of those carrying out Serious Case Reviews, and a wider representative group of practitioners and policy makers, on the validity and usefulness of Serious Case Reviews, the biennial reviews, and the proposed new systems for conducting national reviews;

- To develop a revised framework for analysing the content, process and outcomes of Serious Case Reviews.

3. Methods

Critical appraisal

The research team reviewed the approaches to analysis developed and used in the 2001-03, 2003-05, and 2005-07 biennial reviews, using a structured framework in order to assess their utility in identifying common themes and trends and in auditing the process and outcomes of Serious Case Reviews.

Consultations

Practitioners and policymakers were consulted to gain their views on the Serious Case Review process and how it can best support learning at both a local and national level. Two forms of consultation were used: focus groups and a Delphi study. For both arms three groups of professionals were recruited:

- Individuals who had carried out Serious Case Reviews - authors of Individual Management Reviews and overview reports and Serious Case Review panel members;
- Professionals who had direct involvement in a case that was subject to a Serious Case Review – front line professionals from health, education, children's social care and police;
- Individuals who had received or used Serious Case Reviews - trainers, policymakers, Local Safeguarding Children Board (LSCB) members, professionals who work in safeguarding and previous biennial review authors.

Participants in the focus groups and Delphi were recruited through letters emailed to all LSCB chairs in England. The letter invited chairs to nominate participants. Other participants - individuals and organisations – were invited to participate after being suggested by the project steering group. Individuals nominated by LSCB chairs were informed about the study and invited to participate. Participation was entirely voluntary.

Focus groups

Two half-day focus group sessions were held at the University of Warwick during January 2010. Participants were selected from those who had expressed an interest based on their professional role and, when relevant, their geographical location. The first round focus groups were recruited from LSCBs in the West Midlands, as being local to the study site and therefore more easily accessible for front-line practitioners and managers, whilst the second round were recruited from LSCBs nationally, along with other national experts identified by the project steering group.

At both sessions, participants were divided into three discussion groups, with a balanced spread of professional roles in each group. Each group was facilitated by a member of the project team. Each session lasted for 1.5 hours, with a coffee break half way through and refreshments and lunch provided. The discussion was recorded and subsequently transcribed and anonymised prior to analysis.

Participants were provided with an advance list of the themes the research team were interested in exploring in the focus group discussion, but it was also acknowledged that individuals were likely to have issues they wished to raise themselves. Participants were asked to consider:

- What, in the way Serious Case Reviews are conducted, helps support learning from the reviews;
- What, in the way the national overviews are conducted, helps support learning from the reviews;
- How learning takes place at a local level;
- How learning takes place at a national level;
- How the Serious Case Review and Child Death Review processes relate to each other and support local and national learning.

Facilitators of each focus group initiated the discussion and provided prompts to ensure key themes were covered; they ensured that agreed ground rules were followed and kept time. The facilitators were otherwise non-participatory, allowing the focus group members to define the way in which the discussion developed.

Focus Group Participation

The focus group on 12 January 2010 was attended by 16 participants from across the West Midlands. Those attending were primarily either those who had carried out a Serious Case Review, or professionals who had been involved with a case that had been subject to a Serious Case Review.

The participants were:

- 4 LSCB managers
- 1 independent chair
- 2 education managers
- 1 education frontline worker

- 3 members of the police
- 3 designated or named nurses
- 1 health manager
- 1 health visitor.

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Issues raised by the groups included the challenges of producing timely outcomes from Serious Case Reviews, the tensions between learning lessons from cases and professionals' accountability, gaps between learning lessons and practitioners 'on the ground', and the importance of getting lessons learned into training.

The second focus group on 28 January 2010 had 23 participants from across England. The delegates represented a mixed group of those who had received or used Serious Case Reviews, including policymakers, LSCB members, professionals who work in safeguarding and previous biennial review authors. The participants were:

- 6 policy makers
- 5 academics
- 1 member of the police
- 4 LSCB managers
- 3 independent chairs
- 3 designated or named nurses
- 1 trainer.

These participants had a generally different perspective - as recipients/users of Serious Case Reviews - than participants in the first group. Hence, discussion at the second focus group concentrated much more on broader issues of policy and how lessons could best be learned nationally.

Delphi study

The Delphi approach aims to establish the extent to which consensus amongst a group of 'experts' can be reached on specific issues within the overall theme, and to clarify issues on which consensus cannot be achieved. Delphi participants were sent two questionnaires each consisting of a number of statements to which they were asked to indicate, using a 6 point Likert scale, the degree to which they agreed or disagreed with each statement. Spaces were not limited for the Delphi; everyone who expressed an interest in participating, including focus group participants, were signed up for the study.

The questionnaire for Round 1 of the Delphi was developed based on an initial analysis of issues raised by the focus groups, and the results of the critical appraisal of previous approaches to national overviews. The questionnaire consisted of a number of statements under the headings Local Learning, National Analysis, and Learning Lessons Nationally, plus spaces to add comments about the questions. The draft questionnaire was circulated by email to the project steering group for comments and testing. The questionnaire was then revised following feedback, before Round 1 began.

The Delphi study element was carried out electronically, to make results available more quickly. A webpage was set up for the study with instructions and a link to the questionnaire. Participants were emailed with the webpage link and password for the questionnaire, plus the project manager's contact details in case of any questions or difficulties. Participants who had not completed the questionnaire were emailed a reminder. Each round of the questionnaire was open for a week and a half. The questionnaire for round 2 consisted mostly of the same statements. A small number of statements were amended to reflect the results and comments from round 1, particularly where there was any ambiguity around the question itself, or the responses and comments suggested there may be an alternative statement that might lead to greater clarity. For round 2, participants were able to see both their own answers and the whole group answers to round 1 and were free to return the same answer or amend their answer in the light of the first round results.

Consensus agreement/disagreement with a statement was defined by the research group in advance as having been achieved if:
- ≥75% responded "strongly (dis)agree" or "(dis)agree"; or
- ≥95% responded "strongly (dis)agree", "(dis)agree" or "mildly (dis)agree".

Delphi Study Participation

In total, 114 individuals were signed up for the study. Participants represented a range of agencies and organisations, including health, social care, education, police, LSCBs, local authorities, Government Offices, academic institutions and voluntary organisations.

Round 1 of the Delphi study began on 4 March 2010 and closed on 15 March. Sixty-six individuals completed a questionnaire. There were a considerable number of comments also submitted. Following feedback, the wording of some of the questions was clarified for round 2. Round 2 began on 24 March and closed on 6 April. The cumulative responses to Round 1 were emailed to all participants. Those who completed the Round 1 questionnaire also received a copy of their individual responses. Summary results from Round 2 are presented in the findings chapters, representing final outcomes of the Delphi. Full results of both rounds of the Delphi study are given in appendix 3.

Participation

Round 1

A total of 66 participants responded to Round 1. The breakdown by agency was as follows:

Agency:	Responses for 'Agency – Other'*:
Health: 23	LSCB: 10
Independent: 14	Local Authority: 2
Social Care: 9	Non-departmental public body: 1
Education: 3	Government Office: 2
Police: 3	Academic: 2
Other: 14	Voluntary sector: 1

Some participants gave more than one answer to this question. Responses provided for 'Agency – Other' outnumber the participants who identified their agency as 'Other'.

Round 2

A total of 55 participants responded to Round 2. Of the 66 participants in Delphi Round 1, 43 went on to also participate in Round 2. Hence, of the 55 participants in Round 2, 43/55 = 78% were repeat participants. The breakdown by agency for Round 2 was as follows:

Agency:	Responses for 'Agency – Other'*:
Health: 18	LSCB: 7
Independent: 12	Local Authority: 1
Social Care: 6	Non-departmental public body: 1
Education: 1	Government Office: 1
Police: 3	Academic: 2
Other: 15	Voluntary sector: 4

* Some participants gave more than one answer to this question. Responses provided for 'Agency – Other' outnumber the participants who identified their agency as 'Other'.

Data Analysis

Recordings of the focus groups were transcribed, anonymised and checked for accuracy prior to analysis. The data were coded using both pre-assigned and emergent themes. Some preliminary analysis was undertaken to identify statements for the Delphi study and further thematic analysis was carried out using n-vivo software. Analysis of the Delphi responses was primarily descriptive, providing overall breakdown and assessment of the degree of consensus using pre-determined criteria. Individual comments were coded and analysed along with the focus group data using n-vivo. Triangulation between the three strands of the study was undertaken by the study team once all the data were complete.

Ethics

The consultation arm of the study was approved by the University of Warwick biomedical research ethics committee. Participation in the focus groups was on the basis of signed, informed consent, including consent to audio-recording and transcription. Participants were sent an information sheet prior to the focus group and were reminded of the purpose and nature of participation on the day prior to starting the groups. Participants were asked to adhere to pre-defined ground rules including respecting others' confidentiality. All transcripts were checked for accuracy and anonymised prior to analysis. Participation in the Delphi study was on the basis of implied consent by completion of the questionnaire. Participants were sent an information sheet in advance. All responses were anonymous, with only the project manager having access to identifiable data for the purpose of sending out the questionnaires.

Limitations

This study was a small scoping study conducted in a short time frame and straddled the publication of a revised version of *Working Together to Safeguard Children* (HM Government, 2010). The participants were encouraged to draw on their experience which inevitably would have related to Serious Case Reviews carried out under previous guidance. The results therefore cannot be taken to reflect any changes to the process introduced during the timescale of the project. Although steps were taken to ensure that the focus groups and Delphi study were representative, by sending invitations through all LSCBs and encouraging a wide range of participants, the voluntary nature of the study meant that participants were likely to be those most motivated to take part, either because of a particular interest in the subject or because of personal experience. Thus the results presented here provide a snapshot of the views of some practitioners, managers and other stakeholders at a specific time point. Nevertheless, it is the view of the research team that these

views are in fact representative of commonly held views amongst practitioners and others across the country.

The research team was made up of experienced academics from health and social care, with relevant expertise in this field. Two of the researchers were authors of previous biennial reviews so cannot be assumed to be independent. We were aware of the potential bias introduced by this, both in the possibility of responses being biased and in our interpretation of the data. We have sought to ensure a high degree of objectivity, relying on other members of the research team to undertake the primary critical appraisal of the biennial reviews, and in seeking the views of all research team members and the broader steering group in our analysis and interpretation of the data.

The results presented in the rest of this report attempt to capture the full breadth of the data captured. Inevitably there will be gaps and the results reported reflect our own perceptions, as a research team, of what is important and relevant. Analysis of the qualitative data is reported in summary form as combined data from both the focus groups and Delphi study, with examples drawn from direct quotes and comments. All direct quotes from study participants are presented in italics throughout.

4.   Critical Appraisal Findings

The following reports were reviewed:

- Sinclair and Bullock (2002), *Learning from past experience* (England, 1998 - 2001)
- Rose and Barnes (2008), *Improving safeguarding practice* (England, 2001 - 2003)
- Brandon et al (2008), *Analysing Child Deaths and serious injury through abuse and neglect: what can we learn?* (England, 2003 - 2005)
- Brandon et al (2009), *Understanding Serious Case Reviews and their impact* (England, 2005-2007)
- Ofsted (2008) *Learning lessons, taking action: Ofsted's evaluations of Serious Case Reviews 1 April 2007 to 31 March 2008* (England, 2007 - 2008)
- Ofsted (2009) *Learning lessons from Serious Case Reviews: year 2* (England, 2008 - 2009)

Summaries of each report were produced to determine how the reviews had addressed their aims, and what advantages and limitations each set of research methods and analysis had presented to the research team.   Appendix 1 summarises the aims, objectives and methodology of the main English overviews from 1999.   For simplicity throughout this chapter, the four commissioned national overviews (Sinclair & Bullock, 2002; Rose & Barnes, 2008; Brandon et al., 2008; Brandon et al., 2009) are referred to as 'biennial reviews' and the two Ofsted overviews as 'Ofsted evaluations'.

Following a number of large scale inquiries into deaths from abuse in the 1970s and 80s, the government set out guidance for the conduct of Serious Case Reviews by Area Child Protection Committees (ACPCs) (Department of Health and Social Security & Welsh Office, 1988; Tudor & Sidebotham, 2007).   Two earlier studies by Reder and colleagues attempted to draw together information from known inquiry reports in the 1970s and 80s, and Serious Case Review reports in the early 1990s (Peter Reder & Duncan, 1999; P Reder et al., 1993).   Their research was largely descriptive but used a clear framework within which to assess the information.   The studies used published inquiry reports and did not include any robust method for identifying all reports.   In 1999 the Government expanded on the "Part 8" guidance to include the commissioning of overview reports every 2 years in order to draw out key findings from the local reviews and identify their implications for policy and practice (Department of Health, Home Office, & Department for Education and Employment, 1999; HM Government, 2006).

The study by Sinclair and Bullock explicitly set out to review a sample of Serious Case Reviews both before and after the revised 1999 guidance (Sinclair & Bullock, 2002). The objectives were to explore the process of Serious Case Reviews and whether these had led to changes in policy and practice. The authors used a robust sampling strategy to identify a representative sample from the national database and had clear methods for qualitative analysis of the data. This was informed by a series of clear research questions within the key objectives. The researchers found difficulties in ascertaining the true number of Serious Case Reviews undertaken within the time frame of their study and questioned the accuracy of the national database.

The issue of accuracy of the national database continued in the subsequent 3 biennial reviews, in spite of improvements to the system of reporting and recording notifications. Indeed this was one of the reasons for the long gap between the 98-01 and 01-03 reports. The Rose and Barnes analysis of Serious Case Reviews from 2001 – 2003 set specific objectives within the broad aim of preparing an overview of findings from a selection of these reviews (Rose & Barnes, 2008). The authors, however, found it impossible to adopt a structured sampling approach and relied instead on 40 records provided to them through the regional offices of the then Social Services Inspectorate. As the authors point out, this sample could not be taken to be representative. Similarly their attempts to conduct interviews with key staff proved problematic and in the end only 10 such interviews were carried out.

The first biennial review by Brandon and colleagues set out to learn from the analysis of interacting risk factors present in the cases under review and to transfer this learning to both everyday practice and to the process of Serious Case Reviews (Brandon et al., 2008). The research team specified 4 core objectives and used a mixed methods approach within a clear theoretical framework. The ecological-transactional framework used allowed the research team to approach an understanding of inter-agency working within a dynamic context of the developing child and his or her world. The research included a descriptive overview of all 161 Serious Case Reviews on the notification database with a more in-depth analysis of 47 cases for which more detailed information was available. The research team employed a technique of "layered reading" that enabled research data to be sequentially built on previous layers as more in-depth data were scrutinised on progressively smaller samples. Once again, sampling was pragmatic rather than strategic and limited by the availability of information. Their second biennial review built on the first with a further 189 cases for the descriptive overview and a further 40 cases for in-depth analysis, including interviews with 22 LSCB members who were involved in the Serious Case Review process and with a small number of practitioners (Brandon et al., 2009). The overall research aim was the same, but the team expanded

their objectives with five specific research questions drawn directly from the guidance in *Working Together* (2006). They used the same theoretical framework and similar approaches to analysis. This second study by the same team brought the benefit of an experienced team who were used to working with the data set, consistency in the methodology and the ability to collate and compare data over a longer time frame. All of these were seen as benefits.

In contrast to the government-commissioned biennial reviews, the two Ofsted evaluations set out specifically to evaluate the quality of the Serious Case Reviews themselves and the process and conduct of those reviews. The methods used followed standard audit methodology with measurement against a set of pre-defined standards. The first report was based on an analysis of the outcomes of Ofsted's evaluations of 50 Serious Case Reviews completed between 1 April 2007 and 31 March 2008 (Ofsted, 2008). The second report covered the evaluations of 173 reviews carried out and completed between 1 April 2008 and 31 March 2009 (Ofsted, 2009). The wide discrepancy in numbers between the two years was attributed partly to the fact that Ofsted took over responsibility for evaluating Serious Case Reviews during the year 2007-8 and also to an increase in the number of Serious Case Reviews initiated.

Key findings and recommendations from the recent national analyses (biennial reviews and Ofsted evaluations) are summarised in Appendix 2.

The reports themselves have tended to increase in length. The Sinclair and Bullock main report was 64 pages long with a further 32 pages of appendices and references. The Rose and Barnes report was 91 pages long plus 34 pages of appendices and references. The first report by Brandon and colleagues consisted of 117 + 46 pages and their second report of 119 + 49 pages. In contrast the two Ofsted reports are much briefer running to 43 +6 and 46 +7 pages respectively.

Limitations

All the biennial reviews have been hampered by poor access to and incomplete data. The 2001-2003 review in particular faced great difficulties with achieving access to complete datasets. The incomplete nature of the database records meant that they could not use the national database as a sampling frame, and sections with basic information about the child and family, notably to do with ethnicity within individual reports, were too vague. The studies also identified inconsistencies in the database itself and, particularly with the earlier reports, the numbers of Serious Case Reviews reported cannot be taken to be an accurate reflection of the overall numbers of children suffering serious and fatal maltreatment. The completeness of data was also affected by the time scales for

completion of the final Serious Case Review reports. Rose and Barnes reported that only 12% of reports were completed within the timescales laid down. A further 33% were completed within twelve months of the incident, while 38% of reports took over a year to complete (a further 17% were undated). Delays in reporting continued to be a problem recognised by the subsequent biennial reviews and in the Brandon et al 2005-2007 review, only two of the 106 Serious Case Reviews undertaken in 2005-2006 were completed within the required four month time scale.

The study of 2003-5 reviews managed, for the first time, to include descriptive data on all notified Serious Case Reviews. However, the data available on these remained limited and the researchers, in both this and the subsequent study, considered it essential to include a more in-depth analysis of a subsample. Again, limitations in access meant that the researchers had to rely on a pragmatic rather than a random or stratified sub-sample to examine in depth. The results therefore cannot be taken to be truly representative.

Being based primarily on information available at the time of notification, the database analysis provided only very limited descriptive information on the cases. The content of the overview reports varied, some providing detailed information about the case and context of the maltreatment, along with descriptions and analysis of interagency involvement, whilst others contained only limited contextual information, concentrating solely on the recommendations. The presentation content and style of these reports varied widely, often resulting in the need to gather information from several stand-alone documents. There were notable gaps in some of the information available through the database and overview reports, including limited reporting of ethnicity and disability and an absence of information about fathers in the reports. The overview researchers had no way of checking on the accuracy or completeness of the data in the reports.

Another major issue faced by the authors of all three reports was the difficulty in generalizing the findings of these reports. The lack of any comparator data mean that causal connections cannot be made from the characteristics of the families directly to the outcomes, and as such caution in interpreting these findings has been consistently emphasized. The biennial reviews have tended to be descriptive and exploratory, rather than providing any definitive data on causality. None of the studies were able to include any comparator data, such as characteristics of the base population, control groups, or less serious cases of maltreatment.   All the studies however have been able to ground their research in the context of previous overviews and the wider research base on the knowledge of serious and fatal maltreatment, thus the characteristics found in these studies can be seen as adding to the overall body of knowledge in this field.

Recommendations made in the biennial reviews

In spite of the limitations highlighted above, all the biennial reviews have been able to draw conclusions on and make recommendations about the nature and characteristics of serious and fatal maltreatment; lessons learned from the Serious Case Reviews; and implications for both policy and practice.

Both commonalities and the diversity of case characteristics have been identified, with the implication that we can recognise some factors which repeatedly occur, but we should be wary of drawing conclusions that may lead to stereotypes or ignoring other, more random, factors. It is acknowledged that the nature and diversity of identified risk factors are such that any attempt to develop screening tools is likely to be counterproductive. This should not however detract from the learning that can take place in relation to risk and vulnerability, and in particular the potential for greater understanding in this area to inform preventive practice. One strong finding to come from the 2005-7 study was that a full understanding of interagency working cannot be achieved without being grounded in the context of the case. There is therefore a need for Serious Case Reviews to gather information on all three domains of the 'Assessment Framework' (The child's developmental needs; parenting capacity; and family and environmental factors) (Department of Health, Department for Education and Skills, & Home Office, 2000) and to integrate and synthesise this information, along with information about interagency working in a case formulation. In addition, the case formulation should include consideration of the organisational culture and climate as well as individual practice.

All biennial reviews refer to the perceived problem of Serious Case Reviews repeatedly identifying the same problems in relation to interagency working, particularly around information sharing and the quality of recording and analysis of information. However, it is important that this does not detract from the very real learning that does take place. In many ways, the fact that such issues come up repeatedly emphasises that these lessons need to be repeatedly learned, and the Serious Case Review process is a means of highlighting the importance of key elements of practice that may otherwise be ignored. The biennial reviews have also recognised that this suggests the need for deeper learning, for example looking at systems issues that may underlie the repeated failure to learn simple lessons. It was striking in reading the biennial reviews how all have included both common and repeated themes, but also new learning that has the potential to influence practice, for example the concept of the "start again syndrome" (Brandon et al., 2008), or the mirroring of family chaos in organisational response (Brandon et al., 2009).

The process of Serious Case Reviews and national analysis

Rose and Barnes (2008) suggested a 7 point plan for improving the process of carrying out Serious Case Reviews involving:

1. *The decision to hold a review – striving for greater consistency between boards;*
2. *Chairing the Serious Case Review – establishing a resource of trained, credible independent chairs;*
3. *Management reviews and the overview report – training and templates for use by both IMR and overview authors;*
4. *The inclusion of chronologies and genograms with tools to assist these;*
5. *The contribution of family members – the need for sensitivity and support in this;*
6. *Formulating recommendations and action plans – requiring reflection and a strategic approach;*
7. *Managing the outcome of the review – careful planning and management of dissemination;*
8. *Costing Serious Case Reviews – a recognition that these are expensive.*

The 2003-2005 study highlighted the difficulties of relying on the notification database and overview reports with limited information. The authors suggested a better understanding might be achieved by ensuring consistently reported minimum information within the notification of critical incidents and a standard framework for overview reports. It was believed that by performing these enhancements to the quality, accessibility and comparability of these overview reports, shared local and national learning would be encouraged.

The Brandon et al 2005-2007 report advocated for improved support and supervision for professionals, illustrating how they were often overwhelmed by the nature and volume of the material associated with the Serious Case Review process. The report also found that the lack of sufficient information from local overview reports contributed to the difficulties faced by professionals in achieving a clear understanding of the case and the incident which led to the child being harmed or killed.

All biennial reviews concluded that Serious Case Reviews are valuable learning tools at both local and national levels. Their value however is enhanced by seeing them as just one potential tool for learning and achieving change. Learning and change should not be driven solely by individual "heavy-end" cases, but rather in the context of a broader understanding of childhood vulnerability, the contexts of children's lives, and good safeguarding practice.

5. Study Findings: Local Learning

This chapter focuses on learning lessons from Serious Case Reviews at a local level and how local teams can most effectively learn from their own cases. Participants in both the focus groups and the Delphi expressed some frustrations about the process of doing a Serious Case Review, perhaps best summed up in the comment of one of the focus group participants that "*the process has become the purpose*". Participants found the emphasis on getting the report right constraining and felt that this tended to detract from learning. Nevertheless, participants from all backgrounds also saw the Serious Case Reviews as providing enormous opportunities for learning and were able to identify ways in which this could be enhanced.

Areas of Agreement

Results from the Round 2 Delphi study in relation to local learning are shown in Figure 1 and Table 1. Only 2 statements achieved consensus (≥75% agreed/strongly agreed; or ≥95% agreed/strongly agreed/mildly agreed):

- "Local learning is most effective when it is embedded in the process of conducting the Serious Case Review, rather than waiting until the review is complete"; and
- "Local learning can be enhanced by keeping the emphasis on learning lessons rather than apportioning blame".

The degree of consensus for the first statement increased between rounds with rewording of the statement to enhance clarity. The degree of consensus for the second statement marginally decreased between rounds.

However there was a degree of agreement/disagreement (i.e. a majority of respondents agreed/strongly agreed/mildly agreed, or disagreed/strongly disagreed/mildly disagreed) on three other statements:

- "Practitioners involved in the case need to be involved throughout the Serious Case Review process" (78% agreed);
- "Local learning can be enhanced by addressing accountability/responsibility as well as learning lessons" (89% agreed); and
- "In most cases relevant learning can be identified through the child death review processes without needing a full Serious Case Review" (76% disagreed).

Figure 1: Delphi Round 2 results on local learning

*** indicates questions where consensus was achieved*

1. ** Local learning is most effective when it is embedded in the process of conducting the SCR, rather than waiting until the review is complete. (≥75% consensus: Agree)

2. Those who collate information and compile the Individual Management Reviews (IMRs) are best placed to disseminate lessons.

3. Practitioners involved in the case need to be involved throughout the SCR process.

4. Including IMR authors as part of the overview panel would help to ensure that appropriate lessons are learned.

5. ** Local learning can be enhanced by keeping the emphasis on learning lessons rather than apportioning blame. (≥75% consensus: Agree)

6. Local learning can be enhanced by addressing accountability/responsibility as well as learning lessons.

7. Having a less detailed approach to SCRs would facilitate local learning.

8. In most cases relevant learning can be identified through the child death review processes without needing a full SCR.

9. Local learning is more likely to be effective if Local Safeguarding Children Boards (LSCBs) are allowed flexibility in the way in which they carry out SCRs.

10. Local learning is more likely to be effective if SCRs are conducted in a standardised manner.

11. The process of evaluation by OFSTED contributes to learning lessons.

12. A focus on implementing recommendations detracts from learning lessons.

13. Involvement of family members in the SCR process enhances learning.

Legend: ■ Strongly disagree ■ Disagree □ Mildly disagree □ Mildly agree ■ Agree ■ Strongly agree □ Unable to answer
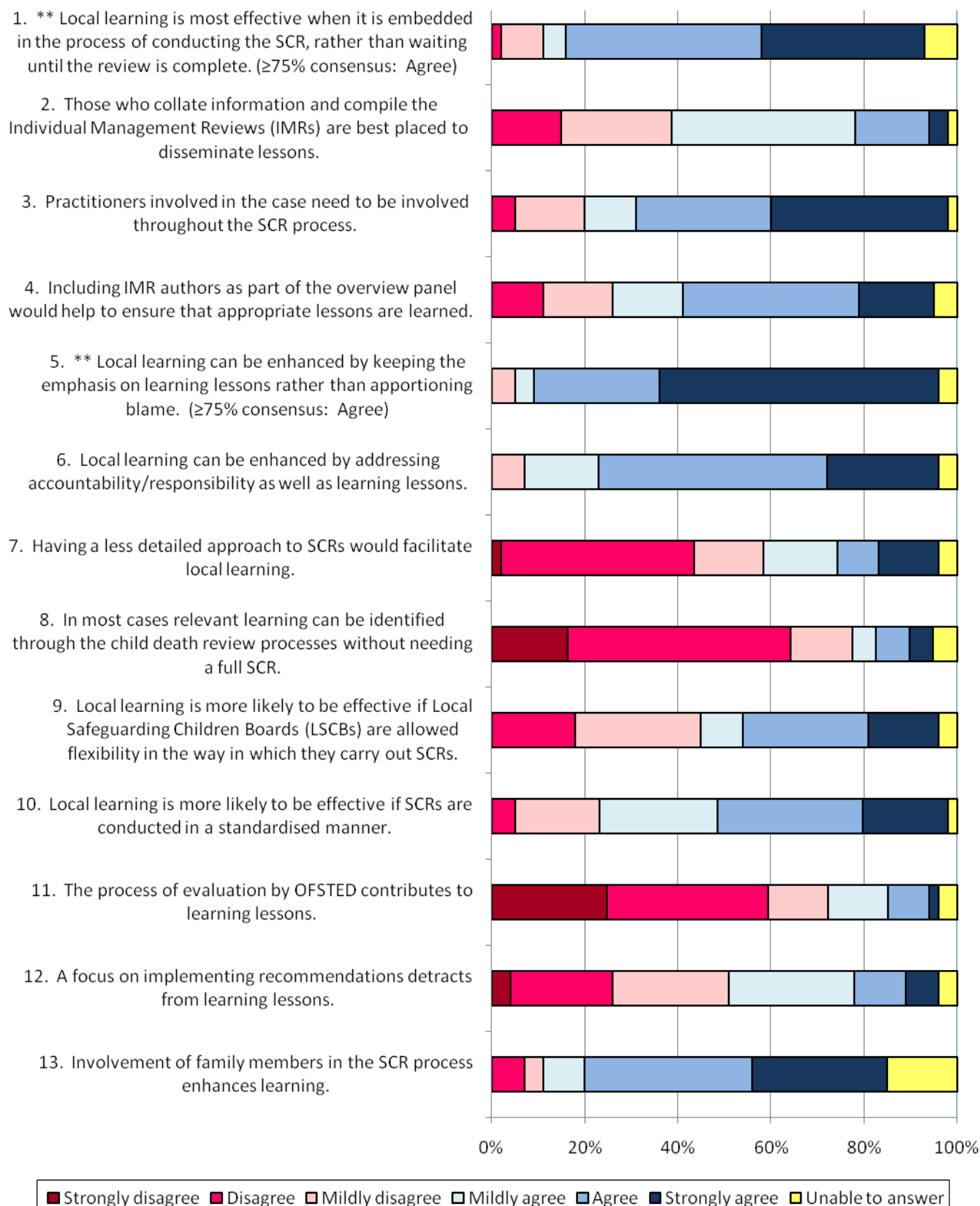
Table 1: Delphi Round 2 results on local learning

Delphi Statement Results from Round 2	% Disagreeing[1]	% Agreeing[1]	% Unable to answer	Consensus Achieved?[2]
1. Local learning is most effective when it is embedded in the process of conducting the SCR, rather than waiting until the review is complete.	11	82	7	yes
2. Those who collate information and compile the Individual Management Reviews (IMRs) are best placed to disseminate lessons.	39	60	2	no
3. Practitioners involved in the case need to be involved throughout the SCR process.	20	78	2	no
4. Including IMR authors as part of the overview panel would help to ensure that appropriate lessons are learned.	26	69	5	no
5. Local learning can be enhanced by keeping the emphasis on learning lessons rather than apportioning blame.	5	91	4	yes
6. Local learning can be enhanced by addressing accountability/responsibility as well as learning lessons.	7	89	4	no
7. Having a less detailed approach to SCRs would facilitate local learning.	59	38	4	no
8. In most cases relevant learning can be identified through the child death review processes without needing a full SCR.	76	17	5	no
9. Local learning is more likely to be effective if Local Safeguarding Children Boards (LSCBs) are allowed flexibility in the way in which they carry out SCRs.	54	51	4	no
10. Local learning is more likely to be effective if SCRs are conducted in a standardised manner.	23	74	2	no
11. The process of evaluation by OFSTED contributes to learning lessons.	73	24	4	no
12. A focus on implementing recommendations detracts from learning lessons.	51	45	4	no
13. Involvement of family members in the SCR process enhances learning.	11	74	15	no

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[1] % agree/disagree includes all those responding agree/strongly agree/mildly agree, or disagree/strongly disagree/mildly disagree
[2] Consensus agreement/disagreement with a statement was defined by the research group in advance as having been achieved if:
- ≥75% responded "strongly (dis)agree" or "(dis)agree"; or
- ≥95% responded "strongly (dis)agree", "(dis)agree" or "mildly (dis)agree".

Approaches to carrying out the reviews

There was a strong sense in both the focus groups and Delphi that learning should be an integral part of carrying out the reviews, rather than something that is developed after the review. This can be enhanced by using approaches which involve practitioners and encourage reflection. The Social Care Institute for Excellence (SCIE) systems approach (Fish, Munro, & Bairstow, 2009) was a popular option. Participants commented that it values the practitioner contribution, is grounded in the context of the case, and provides instant feedback to all involved in the case at all levels. All of these issues were identified in the focus group sessions as important elements of a high-quality and reflective learning experience. Appreciative Inquiry (Cooperrider & Whitney, 1999) and Root Cause Analysis (Wu & Hwang, 1989) were also put forward as good models of helping practitioners to 'grasp the learning moment'.

There was some discussion in the focus groups of the relative benefits of having a clear structure versus allowing local flexibility. Although some benefits were seen in both, on the whole participants preferred keeping the process standardised as this gives confidence to both those carrying out the reviews and to staff who are involved:

> *"I think it's one area where staff, when they are interviewed, they are anxious and have got their own needs at that point and I think if there was a tighter framework and structure then it would make it easier for the IMR author and practitioner."*

This preference for standardisation was highlighted in the Delphi results. Participants also emphasised the importance of having a clearly defined methodology for carrying out and interpreting the findings of Serious Case Reviews, and of not losing the detail by carrying out less rigorous reviews.

The length of time the SCR process takes was considered to hinder the impact of the overall lessons due to a "loss of momentum". Sometimes the process takes months and this inevitably has an impact on learning. Participants felt that the best opportunity for practitioner learning which could have a subsequent and direct impact on practice was immediately after the event. However, there were also conflicts and challenges for the practitioner to be open and receptive to learning at that time. Participants identified a need to engage and support practitioners early in the process and sustain a mechanism of feedback during the process so that practitioners are not "left behind" or their contribution forgotten in the process.

Relationship with the Child Death Overview processes

Participants saw potential for these two processes to be complementary, but with some apprehension about duplication. It was felt that Child Death Overview Panels (CDOPs) (HM Government, 2010) could produce some broader learning, but not at such a deep level, therefore both processes are needed. Participants discussed other processes, for example Serious Untoward Incident investigations (SUIs) (National Patient Safety Agency, 2009) and Root Cause Analysis, considering the use of these tools as very useful on the investigative horizon. Making links between these different processes was seen as valuable. The connections are not viewed as currently well developed but there is scope for these processes to inform each other. Particular emphasis throughout the focus groups was the learning opportunity from the 'near miss'. Many participants felt that this was often a lost opportunity for learning and where some geographical areas were implementing a review of near miss cases they were positively received.

Involvement in the process

It is not unusual for practitioners to feel excluded from, and disempowered by, the process of the Serious Case Review and this does not facilitate learning. This feeling was expressed very strongly by practitioners involved in the focus groups. The importance of involving practitioners throughout the process, including involving them in reflection and analysis and debriefing, was emphasised.

Practitioners want to tell their story where perhaps the process does not facilitate this:

> *"… [she] was desperate to give her version because she wanted to say how awful she felt about what had happened but all the things that she had done weren't necessarily covered in the paperwork"*

IMR authors can also feel excluded in the later stages and yet have much to offer given their knowledge of the context and detail. Some participants, but not all, felt IMR authors should be included in the SCR overview panels.

Independence

Participants identified a tension in the Serious Case Review process between encouraging self-reflection and ensuring objectivity. The involvement of independent authors and chairs was seen to aid objectivity, rigour and standardisation but could also detract from self-reflection and learning. This also raises questions about the perceived ability of competent professionals, working in senior and responsible roles, who are barred from undertaking a Serious Case Review. They may be temporarily disempowered and defer to the independent author/chair until the approval from

Ofsted is received. Participants felt that this could undermine the skills and experience of the practitioners and their intentions to improve practice:

> *"…we have got this massive drive that every level has got to be so independent and actually that reinforces to people that they are not valued, and that their skills are not there and when something goes wrong, somebody else is going to go and sort it out and tell them and point it out to them. I just think we lose that opportunity to use the pool of experience that we've got."*

Evaluating Serious Case Reviews

There were some positive comments about the Ofsted evaluations improving accountability and critique and in improving the standard of IMRs. However, there was also an overwhelming sense that there is now too much emphasis on getting the process right rather than on improving outcomes for children; of the process being driven by fear of getting it wrong; of practitioners and managers feeling more criticised than supported by the process; and that the Ofsted evaluations do not support learning. This was highlighted in the response to one of the Delphi statements with only 24% of respondents agreeing that the process of evaluation by Ofsted supports learning. This suggests that the Ofsted evaluations may influence the quality of the reports themselves, but are not perceived by practitioners as contributing to learning.

> *"One of the things has been very good about the Ofsted process is actually getting the rigour into the IMRs… has been quite useful and that's quite an interesting thing because I think it has made agencies look at themselves."*

> *"I find that the saddest reflection on any learning is 'gosh, my IMR is okay'. When you get the information back and it's always slower, we have to hit a national deadline of 4 months, it's now gone up to 6 months but OFSTED are meant to get the information back to us within 6 weeks and it may be 3 months, 8 months before you get anything but when you do, 'mine was adequate, or mine was…' you know, and you look at that before you look at anything else, and that's sad. And I'll be honest, I do that because if mine was inadequate a) I've got to do it again and b) I'm going to get someone come and criticise me hugely and that's the sad thing."*

Accountability and blame

Participants felt very strongly that we have got it right by moving away from blame to learning lessons. However, many felt that the reality was that learning lessons cannot be divorced from accountability, and therefore there has to be acknowledgement that a Serious Case Review is about both learning and accountability.

> *"I disagree fundamentally that involving the front line in the context of the incident in any type of analysis should be separate from any kind of rigour or accountability."*

There was discussion regarding the engagement of practitioners who may be anxious, upset and defensive and how best to support the practitioner whilst being mindful of their accountability and any potential disciplinary action which may be necessary. Disciplinary action was not necessarily viewed as a wholly negative activity if the practitioner was properly supported and ultimately able to move forward professionally.

> *"You can take somebody through a disciplinary process and they can learn lessons from it and then their practice can change as a result of it."*

Participants agreed that engaging practitioners, and indeed organisations, with the process needs to be done in a constructive and supportive manner. There should be effective mechanisms for feedback and debrief. The nature of the process can also feel threatening to organisations which may have an internal agenda to protect themselves hence quality internal systems analysis may not occur. This supports the argument for an independent reviewer. Participants regarded the media as an often unhelpful messenger:

> *"I think the conflict is in the messages that the documentation is putting out, that it is, you know, not to apportion blame but actually, we have seen from some of the high profile cases that blame is very much apportioned to individuals. I am not convinced that some front line practitioners feel like that. It's about how do we engage front line practitioners in the process to have faith in that process and that we are not supposed to be apportioning blame, and that it is about productive change."*

Relationship between learning and action

Analysis of the focus group data identified a sequential range of potential learning opportunities within the Serious Case Review process:

- An early meeting of the practitioners involved, facilitated by management or an independent facilitator;
- IMR author training and/or briefing;

- Workshops involving IMR authors, front-line workers and managers prior to finalising the IMR;

- Workshops involving front-line workers, managers, IMR authors and overview authors or members of the overview committee prior to or soon after finalising the overview report.

These, along with debriefing and dissemination events at the conclusion of the review were all seen as opportunities for reflection, analysis and feedback where learning can take place in a structured and supported way. Briefings and workshops early in the process also give the opportunity for practitioners and managers to be involved in developing recommendations and action plans without waiting for these to be decided by those remote from actual practice. Participants recognised the importance of the 'learning culture' of an organisation and the influence this would have in creating a positive learning environment and facilitating practitioner access.

Participants also felt that practitioners generally know what went wrong and often what solutions are required. Action taken immediately will have more widespread effect on practice. Action taken at these early stages pre-empts the publication of the formal recommendations at the end of the process, so that practitioners are then reflecting on systems and processes that have already changed, giving the opportunity for the learning to be more deeply embedded.

> "When you go back and talk to the practitioners, they actually are quite clear, they do know.... often do know that 'yes, I know I should have made that referral and I didn't and that was something I should have done'. There is like a critical point when they kind of say 'yes I know, I should have done that, and looking back I can see I should have done that.'"

Following on from these early opportunities to the end point of the recommendations means there can be translation of learning into an effective action plan. There is an overlap between learning and recommendations/action plans, but the two are not necessarily the same. Recommendations can be very complex by the time they are released, and a protracted period of time may have elapsed since the Serious Case Review began. Practitioners may only get to see the recommendations for their organisation, or department, therefore a more comprehensive learning opportunity is lost. It can be difficult to understand the rationale for some recommendations without the context, and yet the context for recommendations is not often presented in the overview report – hence it becomes difficult for practitioners to learn the lessons. Local recommendations need to be understood in the context of the case in order to be relevant and effective: if practitioners do not understand why changes are being made learning is not taking place.

Participants identified that there were different types of recommendations and consequent challenges to effective implementation. Some recommendations were practical and relatively easy to implement, some relating to policy may take a period of time to embed, and others had no readily available solution without further information or research:

> *"I think there is often a leap towards recommendations … when you read the body of the reports, you can really get a sense of what they want but then people seem to feel they have got to come up with a lot of very processy type recommendations and often to me that's where things start to go wrong because I think that is more about defensive practice than it is about the actual lessons. So if we could separate the lessons from the recommendations I think it might be quite helpful."*

> *"We mustn't assume the recommendations are correct because they might be wrong, or they might be impractical, or might be too vague to implement."*

> *"So we broke the recommendations down into different types and different expectations of what you do to evidence the implementation for example a practical recommendation you would expect might be quite quick and is easy to evidence. And then you might say well a policy change might take a year, professional practice – well, that's a bit difficult. And you need different kind of evidence to ensure that you have got there. There would be commissioning recommendations, regional common theme ones in a region, national recommendations."*

It was felt that practitioners and managers need to move beyond just implementing action plans to thinking about what can be learnt from the case. However, learning without action is also not helpful. Therefore there is a need for more careful construction of recommendations and action plans, for these to be limited in number and 'SMART', and for their implementation to be monitored.

Involvement of families and the community

Participants saw this as important: family and community contributions are valuable, but the method and purpose of engagement is not straight forward. There was no clear view as to whether the families and communities can and should be holding agencies to account, and where the responsibilities of bringing up the children lie with the family and the wider community. Communities were considered to have a vital role to play in safeguarding and in that respect, need to be involved in the process and in learning the lessons. A substantial proportion (15%) of Delphi participants felt unable to answer the question about whether involvement of families enhances

learning, perhaps reflecting the uncertainty about how to effectively engage families in the Serious Case Review process:

> *"… perpetrators and their families and victims… often have views on things that should change and things that were wrong, and I think it's really valuable to hear that."*

> *"… one of the fathers involved, he himself said 'I was the ghost of this investigation' because clearly he wasn't mentioned throughout…. you know, he wasn't mentioned in any of the records, he wasn't referred and the absence of men generally in Serious Case Reviews is an issue because they are not considered in records. So yes, I absolutely think it's crucial because that completely changed our focus, we thought 'well yes, we have got to really do something with men here'. And so it completely changed the kind of route we were going to take for lessons learned."*

Supporting professionals

Participants repeatedly emphasised the emotional impact of Serious Case Reviews on practitioners, and the need to support professionals through the process, so that they are able to learn from it. This dual emphasis on learning and support needs to be clearly embedded in the process:

> *"I think that that's absolutely critical, that the individual is held and contained through the process. However, it is also really important that we do the learning so there has to be a way of holding them through it that still allows the messages to come through"*

> *"During the process you sort of forget this happened to a family, it's happened to practitioners and these people are going to react and because of their anxiety they are very unlikely to learn because they are not feeling comfortable, supported and emotionally open minded enough to learn"*

> *"There is no opportunity really for that group of practitioners to sit down together and say 'what do we think went wrong here'. It's really disabling, isn't it? And then you go to a training session where somebody tells you what was wrong with your practice. I mean there is something wrong about that process, isn't there in terms of how we learn, whereas if you had some safe space to reflect with colleagues yourself on your own practice, that's going to change the way you deal with a similar case the next time, isn't it?"*

Training

Participants identified a need for more training for staff who might be engaged with the Serious Case Review process, authors of IMRs, and particularly authors who may not be involved in conducting IMRs regularly. There were suggestions of a requirement for different levels of training dependent on a person's role and likelihood of involvement, and of the importance of including the Serious Case Review processes early in practitioner training to 'normalise' the procedure, so that practitioners know what to expect and their role within the process should they become involved:

> *"I think actually we do need to train people to understand what is the nature of Serious Case Reviews in the way that you did with child death processes, and you have to update that regularly."*

> *"...there is no real good practice disseminated about 'this is what a good IMR looks like, this is what a good action plan looks like'. And usually IMR authors, it is the first time they have done, maybe the last time they have done it, so there is not usually the opportunity to learn from how you've done it differently or to talk to people who have done it before and I think that's quite a simple thing to solve".*

Content

Participants felt that the emphasis at local level should be on exploring systems and management rather than a wider look at risk factors. We already know a great deal about risk factors and the context of serious abuse, and the local level is not the place to repeat that. However, a local Serious Case Review can set the context of this broader learning and help to inform a deeper analysis, for example around issues such as missing perspectives (such as family structure and neglect). There is a need to focus around the individual case but avoid getting too bogged down in detail that obscures the learning.

There was a sense amongst participants that it would be beneficial to move to a deeper level of analysis, to include issues around staffing, compliance, supervision, record keeping, roles and responsibilities; and the organisational cultures that prevail at the time:

> *"One of the things that I do think is often missing in Serious Case Reviews are sorts of issues about sort of how systems are managed and what good management is."*

The Serious Case Reviews should be set in the context of good practice and a broader spectrum of safeguarding, not just the severe end of the spectrum and when things go wrong. Discussion in the

focus groups suggests that the learning opportunities of examining 'near miss' cases can be valuable but has inevitable resource implications which may influence how many of these cases are reviewed.

Dissemination and impact

Participants felt there is a challenge for organisations in how to engage with practitioners and ensure lessons are learned locally. Local dissemination and debriefing of staff involved is important. Dissemination needs to incorporate support as well as learning, as practitioners feel very vulnerable. Some participating practitioners stated that they may never get the full findings of review, usually only receiving the recommendations, and then often just the recommendations relating to their own organisation. This was viewed as a missed opportunity for learning:

> "M*y own experience is that we were never really appraised of the full findings of the review and I felt there were real missed opportunities for learning."*

Dissemination needs to be directed at different levels: for example, staff groups, managers, community and media. For staff groups there are advantages to multi-agency approaches to feedback, but also a need for some single agency / team based dissemination. Dissemination can take place through briefings, publishing on organisation intranet sites, incorporating in routine training and embedding in supervision. There are clear advantages to keeping briefings and recommendations short and focused.

Participants discussed the challenges of disseminating the learning to large numbers of practitioners. Participants expressed a preference for small groups to deliver a quality message, feeling that delivery to larger groups presented challenges to the quality of the deeper learning, and more often equating to a "bums on seats and ticking an audit box" exercise. Cascade training was viewed as ineffectual as it can dilute the message, or never reach the rest of the team if there is no structured mechanism for feedback. Delivering a consistent training message to whole teams was thought likely to have a better impact on practice. Providing opportunities for quality learning to happen, reflection, networking and building inter-agency relationships are all important factors in learning, and are much more difficult to achieve on a large scale.

The value of publishing the Serious Case Review executive summary, and indeed the value and purpose of the executive summary itself, were discussed. Participants raised the issue that the media may not be satisfied with the level of information contained within it and that cases with a lot of media interest will be identifiable locally. This raised questions about how we effectively disseminate information beyond the professional networks involved:

"...in terms of different levels of dissemination and who is this meant for and how do we, appropriately, get messages out to the public, the media, parents themselves? How can we facilitate that as a learning process? Should we be?"

"...maybe there is a task out there to actually train the communities and all the families, especially communities – to give them permission to intervene"

Dissemination should focus on recommendations and action plans, but these need to be set within the context of the case and should create opportunities for staff to reflect on and learn from the case. Dissemination may be most effective if carried out by those who did the IMRs or were involved in reviewing the case, but this is time consuming and may not be achievable, so there may a need to delegate some aspects to specific working groups or trainers. Participants commented that to incorporate the lessons well in training required good educational leadership and people to actually take the messages and develop these into relevant, quality training and competently deliver the messages:

"One of the most important things for me that produces the best outcome for learning is... the number of people that are involved from the beginning to the dissemination of the lessons to learn... if, at each stage, different people are involved... there is a greater capacity for interpretation around what the lesson was and where the recommendation came from... some of the recommendations are actually very complicated and by the time they come out as recommendations it can be quite difficult to go right back to 'well what did this come from in the first place'. And you have to go back to that to make it meaningful."

6. Study Findings: National Analysis

This chapter considers how information from Serious Case Reviews is collated and used at a national level, and looks forward to consider any changes to the national analyses that might support learning and change at a national level. There was a clear sense in both the Delphi and the focus groups that the system of national collation of Serious Case Reviews provides a unique opportunity for ongoing research and understanding of the patterns and context of serious and fatal maltreatment. Whilst there was some frustration that many of the lessons were the same, there was also agreement that the national analyses do generate useful information and can influence both policy and practice.

Participants emphasised that the national analysis should focus on looking at patterns, rather than simply describing and repeating local level issues. However, there is also a role for collating local issues in order to identify issues of national relevance. Using individual cases to provide a window on the system provided a useful metaphor for trying to capture what is best from local learning (Vincent, 2004).

While the focus groups indicated that it was beneficial to have some continuity in the way that the national studies are completed to build up an evidence base, these groups pointed out that there is a lack of consensus in the national safeguarding community about what kind of lessons are useful to learn and how they are best presented. This lack of certainty about what learning is helpful and how best to garner it underlined many of the findings.

Areas of Agreement

Results from the Round 2 Delphi study in relation to national approaches to analysis are shown in Figure 2 and Table 2. Three statements generated consensus agreement (≥75% agreed/strongly agreed; or ≥95% agreed/strongly agreed/mildly agreed):

- "National analysis should address both national policy issues and issues for front line practitioners";
- "National analysis would be more relevant if it combined a regular (annual or biennial) overview and specific thematic analysis"; and
- "National analysis should combine both looking at services and looking at characteristics of children and families".

All three of these were worded as either/or statements in round one and failed to achieve consensus. The change to "both/and" in round 2 achieved consensus agreement, suggesting for all three statements that the combination of both aspects is important.

In addition there was a degree of agreement or disagreement[1] on a further seven statements:

- "The biennial reviews of Serious Case Reviews have had an impact on safeguarding policy" (90% agreed);

- "National analysis should seek to analyse the outcomes of recommendations and action plans" (88% agreed);

- "National analysis should combine data from Serious Case Reviews and child death overview panels" (82% agreed);

- "The study of Serious Case Reviews provides a unique opportunity for understanding the nature of serious and fatal maltreatment" (82% agreed);

- "The biennial reviews of Serious Case Reviews are failing to generate useful information on serious and fatal maltreatment" (78% disagreed);

- "The biennial reviews of Serious Case Reviews have been helpful to practitioners" (76% agreed); and

- "National learning is more likely to be effective if Serious Case Reviews are conducted in a standardised manner" (76% agreed).

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[1] i.e. a majority of respondents agreed/strongly agreed/mildly agreed, or disagreed/strongly disagreed/mildly disagreed

Figure 2: Delphi Round 2 results on national analysis

*** indicates questions where consensus was achieved*

1. The biennial reviews of SCRs have had an impact on safeguarding policy.

2. The biennial reviews of SCRs have been helpful to practitioners.

3. The biennial reviews of SCRs are failing to generate useful information on serious and fatal maltreatment.

4. The study of SCRs provides a unique opportunity for understanding the nature of serious and fatal maltreatment.

5. The quality of national analysis of SCRs would be improved if it included an analysis of chronologies and IMRs, not just overview reports.

6. National analysis of SCRs would be improved if it included comparisons with control data (such as data on children who have not been fatally abused).

7. The Child Death Overview Panel process will provide a more accurate measure of the incidence of fatal maltreatment.

8. National analysis should combine data from serious case reviews and child death overview panels.

9. National analysis should seek to analyse the outcomes of recommendations and action plans.

10. ** National analysis should address both national policy issues and issues for front line practitioners. (≥75% consensus: Agree)

11. ** National analysis would be more relevant if it combined a regular (annual or biennial) overview and specific thematic analysis. (≥75% consensus: Agree)

12. ** National analysis should combine both looking at services and looking at characteristics of children and families. (≥75% consensus: Agree)

13. National learning is more likely to be effective if SCRs are conducted in a standardised manner.

14. National learning is likely to be richer if LSCBs are allowed flexibility in the way in which they carry out SCRs.

Legend: ■ Strongly disagree ■ Disagree ■ Mildly disagree □ Mildly agree ■ Agree ■ Strongly agree □ Unable to answer

Table 2: Delphi Round 2 results on national analysis

Delphi Statement Results from Round 2	% Disagreeing[1]	% Agreeing[1]	% Unable to answer	Consensus Achieved?
1. The biennial reviews of SCRs have had an impact on safeguarding policy.	7	90	2	no
2. The biennial reviews of SCRs have been helpful to practitioners.	21	76	2	no
3. The biennial reviews of SCRs are failing to generate useful information on serious and fatal maltreatment.	78	22	0	no
4. The study of SCRs provides a unique opportunity for understanding the nature of serious and fatal maltreatment.	18	82	0	no
5. The quality of national analysis of SCRs would be improved if it included an analysis of chronologies and IMRs, not just overview reports.	27	70	4	no
6. National analysis of SCRs would be improved if it included comparisons with control data (such as data on children who have not been fatally abused).	29	64	5	no
7. The Child Death Overview Panel process will provide a more accurate measure of the incidence of fatal maltreatment.	42	50	7	no
8. National analysis should combine data from serious case reviews and child death overview panels.	13	82	5	no
9. National analysis should seek to analyse the outcomes of recommendations and action plans.	7	88	4	no
10. National analysis should address both national policy issues and issues for front line practitioners.	2	92	5	yes
11. National analysis would be more relevant if it combined a regular (annual or biennial) overview and specific thematic analysis.	2	92	5	yes
12. National analysis should combine both looking at services and looking at characteristics of children and families.	8	91	2	yes
13. National learning is more likely to be effective if SCRs are conducted in a standardised manner.	21	76	4	no
14. National learning is likely to be richer if LSCBs are allowed flexibility in the way in which they carry out SCRs.	40	56	4	no

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[1] % agree/disagree includes all those responding agree/strongly agree/mildly agree, or disagree/strongly disagree/mildly disagree

Thematic analysis

The complexity of these cases was recognised and this requires a deeper approach to analysis, including looking at system issues. There is a role for descriptive statistics, but this should not be the prime focus. Thus there was backing for the concept of having both a regular overview and thematic analyses that are able to address issues in greater depth. Several specific topics were suggested as possibilities for thematic reviews:

Suggestions for thematic reviews	
Hostile resistance and non-compliance	Child sexual abuse
Domestic violence	Recognised risk factors
Mental health	Age themes / profiles
Excluded children	Assessments
Young parents	Children on child protection plans
5 ECM outcomes	Thresholds
Good practice	Looked after children
Contact and family breakdown	Neglect of older young people
Executive summaries	Tracking LSCBs for lessons learnt
Education	

Additional comments from the Delphi process about thematic reviews included the usefulness of identifying numbers of cases where there has been family breakdown leading to conflict. Another participant noted that it would be helpful to see themes according to age:

"A*gencies complain about the dearth of resources/services for teenagers/16+ but there is nothing available nationally to support this. Neglect focuses on the under 5s (for obvious reasons) but there are issues around neglect for NEETs that are just coming to the fore and the data seems to be lagging behind.*"

A more general point about the exclusion of education from the process of national analysis was flagged up in the focus groups – the emphasis having been on health, social care and the police. Thus a particular focus on education could supply a topic for thematic analysis.

Making sense of the local from the national (and vice versa)

There were a number of discussions in the focus groups about the connections between local and national learning and moving from the general to the particular and the particular to the general. The importance of linking local and national learning was summed up well by one comment, "*How*

do we make one case act as a window on the system?" Although there was a sense that you cannot extrapolate from one local review that things need to change nationally, there was also a feeling expressed that the real learning which takes place locally is not properly recognised or captured nationally. It was felt that the cumulative learning that does take place locally is not reviewed nationally in any systematic way. Tracking LSCBs to see what lessons have been learnt was thought to be a useful inclusion for national analyses: "*Somebody has got to start tracking what people have done and whether it's making a difference.*" Indeed this aspect is identified as a key task of LSCBs to report on in their annual reports (HM Government, 2010, p95, paragraph 3.36).

A focus on recommendations

A focus on recommendations and their follow through might shed some light on LSCB activity and the learning that some felt had, hitherto, received little attention in the national analyses. The focus groups discussed the many problems encountered in determining what constitutes an appropriate recommendation and similarly the difficulties of turning recommendations into actions. Findings from both the Delphi and the focus groups indicate some scope for national analysis of recommendations and the implementation and outcomes of action plans. This however would carry significant resource and methodological implications. There were mixed views in the comments from the Delphi and the focus groups. Some indicated that the analysis of the outcomes of recommendations and action plans is the only way of knowing the impact on practice and demonstrating learning. Others in the Delphi process voiced concerns that analysis of recommendations and action plans implies that outcomes in terms of improved services are measurable. There were worries that this exercise would be overly simplistic and "*far too costly for the dubious benefits that would accrue.*"

Deep learning

The quest for 'deep learning' was represented in the focus groups in a number of ways. It related to reflective considerations which needed to accompany "*ticking off actions*" and to understanding at an analytical rather than a merely descriptive level. For one participant, deep learning was associated with a theoretically informed approach (a post-modern constructionist perspective) which emphasises the need for multiple explanations, meanings and solutions. Deep learning was considered by some to be more likely to occur when practitioners stayed close to the issues and owned the learning through their own reflections:

"*There are many ways [of learning] and they will be defined by context. They will be defined by people and so it isn't about necessarily presenting one right solution, which I suspect is what the*

national publications seek to do – present 'the' way to do it. I think that people really need to be empowered at a deeper level, that they can themselves extract the learning."

A barrier to this deeper learning for those most closely involved was the distance created by each new layer of reporting and analysis. It was pointed out that each stage of the local Serious Case Review process and then the national analysis pushed practitioners further and further away. It was suggested that separating practitioners from the learning in this way does not encourage workers to think deeply about these issues for themselves. In contrast, however, one advantage of the distance created by the national analyses was the capacity to calm the emotional impact of Serious Case Reviews making them less raw, less emotionally charged and rendering the learning potentially more accessible, to "*extract the learning out of the particular into perhaps a less emotive arena*."

 A number of discussions emphasised the emotional content and impact of Serious Case Review work: "I*f we are talking about compliance issues and the non-compliance ... we're getting into really deep stuff of an emotional kind aren't we, about people's fears and being afraid to admit to being frightened…*"

The need to shift the learning to concentrate on supporting the work force was also brought out in the Delphi comments: "*We can have as many policies and procedures as we like - it's the skills, wisdom, resilience and capacity of the workforce which makes the real difference*."

Good practice

Good practice, good initiatives and ways of conquering particular difficulties were identified in focus groups as linked themes that could be addressed in biennial reviews or other national studies. Discussions about good practice reflected a broader debate about the extent to which Serious Case Reviews are representative of practice in general. It was felt that not enough is known about good practice, "*that we don't really know when we are doing a good job,*" and that there needs to be a shift to learning from good practice.

There was some frustration in the focus groups about the continuing emphasis on cases that have gone wrong:

"*And I can't help wondering whether we should be looking at cases that don't end up in a crisis and say 'well, why don't they?' Find the good stuff…*"

"Serious Case Review is one way of looking at it - but our experience is that for every time something has gone wonky there would be a hundred cases where it hasn't, so there is room for a national study of good practice."

Process

In common with the findings around local level processes, there was general agreement in both the Delphi and the focus groups that standardised processes for carrying out the Serious Case Reviews would enhance national analysis. The focus groups and the Delphi indicated that whilst there might be flexibility in the way local teams actually carry out their reviews, *"one size does not fit all"*, these should at least be reported within a standardised framework. This would make reading reports easier and make it simpler to discern both national and local patterns:

"a simple organising framework… would make the collation of reviews and the findings much easier. They would link in, you could spot that these findings were coming up regularly."

"There should be a broad structure, standardised with plenty of room within it for local variation."

There could be some overlap in this with the four domains ('the diamond') used in the child death overview processes (P Sidebotham et al., 2008). The potential link with child death overview processes was flagged up in the focus groups as well as the Delphi. It was suggested that the national analysis of Serious Case Reviews could be enhanced by linking it with a national analysis of child death overviews so as to provide a broader focus. Comments from the Delphi process indicated that this would give some purpose to the child death review recommendations and that *"It doesn't make sense to keep them separate but care would need to be taken not to imply they are the same thing."* Concerns related to the need for a consistency of method to avoid mayhem; the importance of not merging the information too quickly; and a worry that there may be just too much information and hence a risk that anything meaningful could be lost, a sense of not being able to see the wood for the trees.

The importance of having a clear theoretical framework for analysis and rigorous methodology for the Serious Case Review process was highlighted. Some specific approaches were suggested including the use of Systems Theory, Root Cause Analysis, and adopting the methodology of the national confidential enquiries (Appleby et al., 2001; Cooper et al., 2009; Lewis & CEMACH, 2004; Shaw, Appleby, & Baker, 2003).

The principle of a more inclusive, immediate approach to the national overview process was mentioned in the focus groups, for example bringing large groups of interested people together - particularly at the dissemination stage:

"*To do something together around understanding what the lessons are because I believe that people who are involved in those discussions learn the quickest and will start to work out together what needs to change… there are ways of involving children in things like this and parents, and what they have to say is absolutely crucial. .. I think it takes a bit of a leap of the imagination to think how we could do that.*"

There were some notes of caution in the focus groups about replacing the current process and warnings that we need to consider carefully what it is that works now and what makes a difference at the national level - "*what are the things that actually we would like to celebrate and hang onto within this process*" - before changes are made.

Future National Studies

When asked about changes to the national studies the Delphi process produced less agreement on the potential for incorporating analysis of IMRs and chronologies, and of seeking comparator data. While both of these developments were, on the whole, seen as potentially enhancing the value and depth of data, the logistics were generally felt to be a huge barrier. For instance one participant stated, "*I'm not sure if the analysis of the complete Serious Case Review would be any more helpful. For me the key difficulty is the lack of context. Maybe it would be helpful to include links to Executive Summaries.*"   It was suggested that biennial reviewers could and should contextualise the reviews and that this could be done as a separate exercise, for example examining six years' of reviews.

Some Delphi comments suggested that future studies should examine wider populations since retrospective analysis of tragedies tends to overemphasise causal factors and explanations that result in too many false positives when applied prospectively. This means that studies as they are now have little chance of influencing policy and practice in a positive way. Others were sceptical about learning from comparator groups:

"*We seem to have moved as a society into being able to test and predict and foresee problems and part of the problem with Serious Case Reviews is that we didn't do any of the above and the child was either seriously injured or died. I don't think that we will ever be able to produce a programme that will allow us to predict because of the complex interactions of the variables within each child's 'system'.*"

There was however a willingness to consider new approaches to learning from Serious Case Reviews nationally: "*there is another way to look at it as opposed to just the strict case study way.*" There was guarded enthusiasm from some for expanding the learning and study from Serious Case Reviews not only to combine child death review processes but also to consider combining learning from enquiries across mental health and domestic homicides (Appleby et al., 2001).

7. Study Findings: Learning Lessons Nationally

The theme of learning lessons from analyses of Serious Case Reviews is threaded throughout the findings of this study. This chapter, on learning lessons nationally, builds on the discussions of the previous section and draws on the findings of both the Delphi study, and the focus groups, to consider how information from the national reviews may be used to support learning. In the Delphi study consensus (as previously defined) was achieved in seven of the 12 statements in this section. In all cases this was a consensus of agreement. Where there was a trend towards disagreement there was a failure to achieve a consensus (i.e. the view of the participants were somewhat divided). The focus group outputs, as well as the free text comments from the Delphi participants, provide interesting insight into the nature of these differences of opinion and may be as important in guiding the recommendations of this study as those areas where there was a consensus of agreement.

Areas of Agreement

The results from the Round 2 Delphi study in relation to national learning are shown in Figure 3 and Table 3. There was consensus of agreement for the following seven statements:

- "Biennial reviews are helpful to trainers enabling them to set local lessons in a national context";
- "National learning should be made immediately available through a dedicated website";
- "Brief newsletters or fact sheets in addition to longer research reports would facilitate ongoing learning";
- "National lessons should be directly incorporated into learning material to support learning at a local level";
- "Safeguarding children training should incorporate both common issues and lessons from the severe and fatal end of the spectrum";
- "Safeguarding children training should incorporate both learning from positive examples and learning from what goes wrong"; and
- "Learning about Serious Case Reviews should be incorporated into initial professional training".

The strength of the consensus of agreement with the above statements increased between rounds, with 5 of the 7 consensus statements achieving 97-100% agreement in Round 2. However, it is important to add that this may have been influenced by the re-wording of statements 3, 8 and 9 (on

brief newsletters and safeguarding children training [2 statements]), to increase clarity. As discussed earlier, these revisions were made in light of participants' comments received from Round 1.

The statement that "Individual Serious Case Reviews can provide examples to guide practice in a similar way to the development of case law" achieved a reasonable level of agreement (77%) but also attracted commentary suggesting that there were some fundamental obstacles to comparing case law with the Serious Case Review process. For example, one participant noted that they would "*agree with first part of sentence, but not second*" and another suggested that "*case law is built up of years of tested trials and is not comparable*."

No areas achieved a consensus of disagreement. Where there was a failure to achieve consensus, the ratings reflect a number of contentious views. For example, in relation to the statement suggesting that "Policy makers, trainers and managers need different information from Serious Case Reviews", there were those that suggested that they would agree as "*they all work in different contexts*" and those who thought that the information needed to be the same, but that "*what they do with it is different*".

The strongest level of disagreement, verging on consensus, was in relation to the statement that "The only real measure of the effectiveness of learning from Serious Case Reviews is a reduction in the number of serious and fatal cases." Some participants suggested that this would be a dangerous assumption to make, as in the comment "*That is like saying the effectiveness of the law against murder can only be measured by the abolition of murder*."

In summary, the Delphi statements on learning lessons nationally achieved high levels of agreement where consensus was achieved and these statements can be used with some confidence to inform recommendations, especially those pertaining to the central production of learning materials. Where there were disparate views, and a lack of consensus, there are issues raised that may be worthy of further exploration. Examples here include an evaluation of how best to use national learning to inform policy and how best to use the learning to inform research as to the predictability and prevention of serious or fatal child maltreatment.

Figure 3: Delphi Round 2 results on national learning
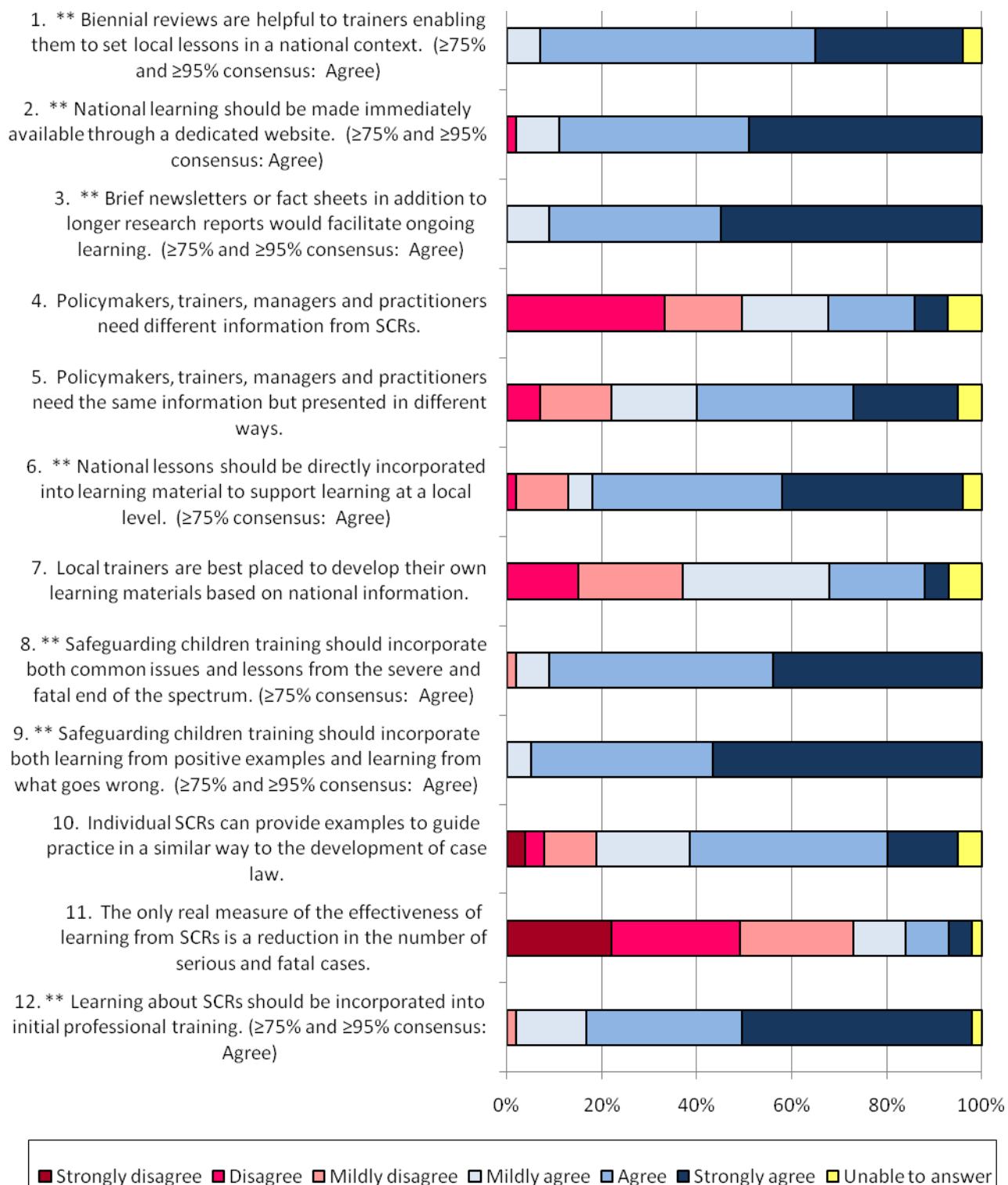
*** indicates questions where consensus was achieved*

1. ** Biennial reviews are helpful to trainers enabling them to set local lessons in a national context. (≥75% and ≥95% consensus: Agree)

2. ** National learning should be made immediately available through a dedicated website. (≥75% and ≥95% consensus: Agree)

3. ** Brief newsletters or fact sheets in addition to longer research reports would facilitate ongoing learning. (≥75% and ≥95% consensus: Agree)

4. Policymakers, trainers, managers and practitioners need different information from SCRs.

5. Policymakers, trainers, managers and practitioners need the same information but presented in different ways.

6. ** National lessons should be directly incorporated into learning material to support learning at a local level. (≥75% consensus: Agree)

7. Local trainers are best placed to develop their own learning materials based on national information.

8. ** Safeguarding children training should incorporate both common issues and lessons from the severe and fatal end of the spectrum. (≥75% consensus: Agree)

9. ** Safeguarding children training should incorporate both learning from positive examples and learning from what goes wrong. (≥75% and ≥95% consensus: Agree)

10. Individual SCRs can provide examples to guide practice in a similar way to the development of case law.

11. The only real measure of the effectiveness of learning from SCRs is a reduction in the number of serious and fatal cases.

12. ** Learning about SCRs should be incorporated into initial professional training. (≥75% and ≥95% consensus: Agree)

Legend: ■ Strongly disagree ■ Disagree ■ Mildly disagree □ Mildly agree ■ Agree ■ Strongly agree □ Unable to answer

Table 3: Delphi Round 2 results on national learning

Delphi Statement Results from Round 2	% Disagreeing[1]	% Agreeing[1]	% Unable to answer	Consensus Achieved?
1. Biennial reviews are helpful to trainers enabling them to set local lessons in a national context.	0	96	4	yes
2. National learning should be made immediately available through a dedicated website.	2	98	0	yes
3. Brief newsletters or fact sheets in addition to longer research reports would facilitate ongoing learning.	0	100	0	yes
4. Policymakers, trainers, managers and practitioners need different information from SCRs.	49	43	7	no
5. Policymakers, trainers, managers and practitioners need the same information but presented in different ways.	22	73	5	no
6. National lessons should be directly incorporated into learning material to support learning at a local level.	13	83	4	yes
7. Local trainers are best placed to develop their own learning materials based on national information.	37	56	7	no
8. Safeguarding children training should incorporate both common issues and lessons from the severe and fatal end of the spectrum.	2	98	0	yes
9. Safeguarding children training should incorporate both learning from positive examples and learning from what goes wrong.	0	100	0	yes
10. Individual SCRs can provide examples to guide practice in a similar way to the development of case law.	19	77	5	no
11. The only real measure of the effectiveness of learning from SCRs is a reduction in the number of serious and fatal cases.	73	25	2	no
12. Learning about SCRs should be incorporated into initial professional training.	2	97	2	yes

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[1] % agree/disagree includes all those responding agree/strongly agree/mildly agree, or disagree/strongly disagree/mildly disagree

The focus group outputs were used in the development of the Delphi statements and generally accord with the findings described above. The notion of how the lessons can impact on 'deep learning' has been discussed in chapter 6; and is key to supporting a process whereby practitioners on the front-line are supported both in their learning and in delivering excellence in practice. 'Bite-sized' learning and learning quickly were seen to be useful, but at odds with the current system of biennial national reviews which take time but are consequently able to go into much greater depth. There was a sense that both approaches are valuable.

Concerns were raised in relation to the repetitiveness of the lessons learnt and the impact of this on practitioners' ability to learn. This was described as follows:

"We don't actually need another Serious Case Review for years. We have got enough lessons out there to learn, we actually don't need the process anymore …. Somehow we inoculate ourselves against learning by learning the same things every time. It is as if we have got used to it."

Development and dissemination of national learning materials

Both focus group and Delphi participants seemed to recognise the importance of achieving a depth of learning in the national analysis, as well as producing easily understood messages that can get out to practitioners. One Delphi respondent commented that "*national learning needs some digestion, which is a strength of the biennial review process*". There was also strong support for the production of the 'digested' read i.e. a dedicated web-site and a newsletter or fact sheets. Nevertheless, concerns were also raised about the degree to which key practitioners were aware of the reports: "*the sad thing is a lot of trainers probably are not aware of them*".

There was a strong sense that national analysis of Serious Case Reviews can be helpful in supporting training and that professional training should incorporate learning from Serious Case Reviews from the outset, including initial undergraduate and postgraduate education. This should however be in the context of a broader understanding of child maltreatment and safeguarding practice, not just the severe and fatal end of the spectrum. This broader learning should embrace the suggestion from participants that it is also important to promote positive practice. This notion is further developed in relation to the high levels of agreement with the statements that "Common issues, as well as lessons from the severe and fatal end of the spectrum, needed to be incorporated into safeguarding children training" and that "Learning should be from positive examples as well as what goes wrong". Many supportive comments in relation to the balanced learning engendered by these two statements were received with the Round One returns. However, it was also suggested that "*Severe cases often*

reveal common issues in the history. They are hard hitting and have a big and lasting impact on practitioners."

Recommendations could thus include a focus on producing 'digestible' learning materials such as newsletters and fact sheets which can be disseminated via a dedicated web-site or on-line learning. There was also recognition of the value of national materials produced centrally, with supportive trainers' notes. There was some discussion in one focus group of the benefits of using the resources of those skilled in marketing techniques to help disseminate messages appropriately. The use of case examples and real stories was seen as key; and a balanced approach to national learning materials that includes the full spectrum of safeguarding could include stories from children and young people who had been successfully protected from harm.

The issue of expertise in trainers was reflected in the comments made in responses to Delphi statement 7 that "Local trainers are best placed to develop their own learning materials based on national information". However, unlike the previous statement (6) that arguably asked the same question in a different way, consensus was not achieved and the responses were seen across the spectrum of agreement/disagreement. Comments included the concern that training can be "*formulaic and misinterpreted*", perhaps reflecting the importance of another comment that "*Child protection trainers should be experienced practitioners who are also skilled educators*."

Participants also acknowledged the fact that it can be difficult to use material prepared by others, suggesting that training needs to be presented in a style familiar to the trainer and have a local feel. This point is perhaps the other side of the coin of the first statement concerning the helpfulness of biennial reviews in contextualising local lessons.

In developing and disseminating learning, it is also important to recognise some of the challenges. These include concerns raised by participants about levels of knowledge and skills at a number of levels, including those of students, frontline staff and trainers. Learning in the context of the busyness of practice was recognised to be potentially problematic. There were concerns about ownership both in terms of embedding local learning in a national context and in the delivery of material that had been produced elsewhere/by others. Nevertheless, the findings do appear to support the importance of national learning from biennial reviews of Serious Case Reviews and the development of new ways of promoting the messages.

8. Conclusions and Implications for Policy and Practice

Serious Case Reviews provide a valuable tool for learning and for improving practice and policy in relation to safeguarding children. Their value comes, at least in part, from the opportunity they provide to critically examine safeguarding practice within the context of an understanding of the circumstances of a child's world and his or her suffering. The importance of Serious Case Reviews and the centrality of the child's experience was clearly recognised by participants in this research project and is summed up in the opening paragraph of chapter 8 of *Working Together to Safeguard Children* (HM Government, 2010):

> *The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations.*

The results of our research, both reviewing previous national overview reports and ascertaining the views of a wide range of practitioners and managers, suggest that the potential learning opportunities provided by Serious Case Reviews are not being fully realised either at a local or a national level. There would appear to be more scope for embedding learning throughout the process through strengthening the current procedures for carrying out Serious Case Reviews (HM Government, 2010) and through some changes to the way in which Individual Management Reviews and overviews are conducted locally. In addition, much deeper learning could be achieved through strengthening and broadening the scope of national analysis of Serious Case Reviews, and through changes to the way in which lessons are disseminated.

Local Learning

The starting point for learning from this process, and indeed the place where most learning can take place is with the front-line workers in local organisations, and particularly with those professionals who were directly involved in the case. At present, the emphasis in Chapter 8 of *Working Together* is on a documentary review with or without interviews of involved practitioners (paragraphs 8.34, 8.38). Although the stated aim of Serious Case Reviews is to learn lessons, rather than to apportion blame, this appears to be only partially achieved. Many of the front-line workers participating in our study commented how they felt anxious about the process, unsupported through the process, often disempowered, and as though they were under scrutiny. This feeling was also reflected in the practitioner interviews in the 2005-7 overview.

Working Together emphasises that the purpose of a Serious Case Review is to learn lessons, not to inquire into how a child died or was seriously harmed, nor to determine who was culpable (paragraph 8.6). In addition they are not part of any disciplinary process against individual practitioners (paragraph 8.7). However, whilst this focus on learning lessons is important and should remain, it cannot be totally divorced from a recognition of accountability and responsibility. Acknowledging that individual and organisational practice will be subject to critical reflection, and that there may be a need for parallel disciplinary action, need not detract from the emphasis on learning, and indeed can enhance this by being stated openly and up front with practitioners.

The discussions in the focus groups and comments from the Delphi study suggest that there is scope for much greater practitioner involvement in the Serious Case Review process and for direct learning to be built into the process of conducting the review. This could be achieved by including, in the initial scoping of the Serious Case Review, consideration of how learning will be promoted throughout the process. Approaches to learning should be built in from the early stages and be an ongoing process, not left till the completion of the IMR or overview report. A number of different opportunities for practitioner learning could be included in the scoping of the review:

- An early meeting of the practitioners involved, facilitated by management or an independent facilitator;
- IMR author training and/or briefing;
- Workshops involving IMR authors, front-line workers and managers prior to finalising the IMR;
- Workshops involving front-line workers, managers, IMR authors and overview authors or members of the overview committee prior to or soon after finalising the overview report.

The emphasis for any of these should be to get the front line workers involved in the case, their managers and the IMR authors to collectively reflect on the case at an early stage and to identify learning points and possible recommendations. As the Serious Case Review progresses, further meetings with those staff involved, other frontline staff and managers can be beneficial, providing opportunities to discuss the emerging findings and any analysis of the case. Such workshops or briefings require careful facilitation and appropriate methods to involve and support practitioners. The SCIE systems approach may provide one such approach but requires further testing in this context, alongside other possible methods.

Practitioners and managers who have been directly involved in a case need considerable support throughout the Serious Case Review process. Consideration should be given as to how best this can be achieved within each agency.

The participants in this study highlighted the impact of the Ofsted evaluations on the way Serious Case Reviews are conducted and in seeming to generate a judgemental rather than a supportive or learning culture. It would appear that these evaluations have led to an improvement in the overall quality of the Serious Case Reviews and this is welcomed. Nevertheless, having listened to front line workers and IMR and overview report writers, it is our view that this process could be scaled back in a way that would enhance learning and support without losing necessary quality assurance. In their evaluations, in their two reports, Ofsted graded Serious Case Reviews as 'outstanding', 'good', 'adequate' or 'inadequate' on the basis of a wide range of descriptors against which each review was measured. A move away from grading the reports to simply providing feedback on a smaller number of key standards could take the pressure off LSCBs feeling that they need to compile the report solely to achieve an adequate or good grading, and enable them to focus more on local learning.

Whilst there are benefits to flexibility in the way Serious Case Reviews are conducted, the participants in our study indicated that the process is enhanced more by having a clear structure and framework. *Working Together* provides some guidance on this (paragraphs 8.37, 8.40 and 8.42) with outline structures for the IMRs, overview reports and executive summaries. The importance of these frameworks needs to be re-emphasised and may be supported by additional training materials or the provision of standardised templates similar to those produced for the child death review processes.

It needs to be recognised that effective learning from cases takes time and the process cannot be rushed. Previous overview reports had recognised the difficulties faced by LSCBs in trying to meet the 4 month deadline for Serious Case Reviews set in previous versions of *Working Together*. This deadline has been extended to 6 months with the recognition that there may be situations where further delays are inevitable. This 6 month timescale would seem to be more realistic. It is important to recognise that learning does not need to wait for the conclusion of the Serious Case Review, a point that is emphasised in paragraph 8.1 of *Working Together*. Learning must be seen as an ongoing process rather than a one off event, and it continues even after the conclusion of the review.

A final point that was raised in this research in relation to local learning is that, whilst the two overlap, learning lessons and implementing recommendations are not necessarily the same thing. One of the concerns raised by participants was that a focus on making recommendations and implementing action plans can be a barrier to deeper learning. There is a danger that practitioners and managers can become focused on implementing action plans that only address superficial aspects of procedures, rather than taking time to reflect on and learn from deeper issues in the systems, attitudes and practices of the organisation or individuals within it. Not all learning points need to lead to recommendations; indeed *Working Together* (paragraph 8.40) stresses that recommendations should be few in number, focused and specific.

Implications for policy and practice

1. This research has highlighted the value of a more participative approach to conducting Serious Case Reviews, rather than a focus solely on documentary review and one-way transfer of information through practitioner interviews.

2. There are many ways in which learning can be embedded throughout the process of carrying out a Serious Case Review; this may include workshops for involved practitioners, other front-line workers and managers at an early stage in the IMR process as well as subsequent briefing / workshop events. Approaches to learning can be included in the scoping of a Serious Case Review.

3. Clear briefings for IMR authors as to their role, along with training in facilitating learning as part of the process would enhance the value of learning at a local level.

4. Serious Case Reviews are stressful events for both practitioners and managers. They therefore need support throughout the process. Approaches to support can be included in the scoping of a Serious Case Review.

5. Learning from a Serious Case Review can be enhanced if all involved practitioners understand, from the beginning, the need for and purpose of the review. They should be informed that the emphasis is on learning lessons, but that this will include a critical reflection on both individual and organisational practice, and that if issues are identified requiring disciplinary action, these will be addressed through parallel processes. This briefing needs to be done with sensitivity and support for the individual.

6. Whilst there is flexibility in the methods used for analysis in Serious Case Reviews, the validity of the lessons learnt is enhanced if the methodology is clearly described in the review.

7. There is a need for further research to explore different methods of improving practitioner involvement in and learning from the Serious Case Review process.

8. Training materials and standardised templates for carrying out Serious Case Reviews can enhance standardisation and opportunities for national learning.

9. A scaled back approach to evaluating and reporting on Serious Case Reviews would make the process more supportive of learning. This could include abolishing the summative grading of Serious Case Reviews in favour of more supportive formative feedback.

National Analysis and Learning

The importance of linking local and national learning was summed up well by one comment, " *how do we make one case act as a window on the system?*" (Vincent, 2004). Although there was a sense that one cannot know from one local review that things need to change nationally, there was also a feeling expressed that the real learning which takes place locally is not properly recognised or captured nationally. One of the key elements of this is that issues arising from these reviews can only be fully understood within the context of the case. Thus it is important that individual Serious Case Reviews do not just focus on interagency working, but also provide sufficient description and analysis of the circumstances of the case, and the capacity of the agencies involved to respond to those circumstances. This will enable those reading the review to understand where specific learning points or recommendations have come from.

The current approach of biennial reviews of all Serious Case Reviews is proving helpful, but could be revised to enable a much greater depth of analysis. The importance of methodological rigour was stressed a number of times, and it was clear that learning needs to be based on sound and reproducible analytic approaches. This was seen in our appraisal of the previous national overviews. The two most recent biennial reviews have benefited from the consistency provided by a single

research team and from the inclusion of a larger number of cases over a longer time frame, although this needs to be balanced against the benefits of a fresh approach and new eyes.

The quality of the national analysis could be enhanced by expanding the breadth of data available for analysis. The earlier biennial analyses of Serious Case Reviews relied on a relatively small selection of SCR overview reports analysed in depth while later biennial reviews combined this approach with limited information collated from the national notification database. There was some improvement noted in the most recent biennial reviews, both in the completeness and quality of data on the notifications database, and in access to overview reports, but this remained incomplete. The process of LSCBs notifying Ofsted of possible SCRs should facilitate greater access to relevant data for analysis. This does however require that those responsible for such analysis have access to the database and to all overview reports. The analysis could be enhanced further by the inclusion of Individual Management Reviews, chronologies and action plans as well as the overview reports themselves. This would provide a much richer dataset for analysis and potentially enable a far greater understanding of the context of serious and fatal maltreatment in this country. Participants in our research pointed out that expanding the dataset in this way could potentially make it unwieldy and would pose logistical and resource challenges. However, electronic reporting with the use of qualitative analytic software, particularly if supported by national templates, would open up further possibilities and would enable large amounts of data to be coded and used in analysis. It is our view that the current processes would allow for the creation of a unified dataset of Serious Case Reviews to include anonymised genograms, chronologies, IMRs and action plans in addition to the overview reports themselves; that this could be achieved with minimal extra resources; and that this would greatly increase the potential for learning nationally.

The current notification database, together with a dataset including all overview reports, provides a strong base for a reporting or observatory function in relation to Serious Case Reviews. This is already partly provided by Ofsted's reports on Serious Case Reviews. The quality of this reporting could be improved further if it were incorporated within the system for national analysis. In particular, the database could provide the opportunity not only for a descriptive breakdown of the cases, but also for time trend analysis and comparative and thematic analysis within the database. This would be enhanced by a single research team having responsibility for reporting on an annual basis over an extended period. Such reporting would also benefit from being linked with the child death overview process as suggested in *Working Together* (paragraph 8.56) and with wider data on safeguarding children. This latter point could help to address the dangers seen in focusing solely on the severe and fatal end of the maltreatment spectrum and on cases where things go wrong, rather

than seeing this in the wider context of the large numbers of children who are effectively protected, and on examples of good practice. Participants pointed out the potential for a national study of good practice that could complement the national analysis of Serious Case Reviews.

Establishing a robust national dataset would open up opportunities for more in-depth thematic analyses and linked studies. These should be seen as supplementing rather than replacing a regular reporting function. A wide range of possible themes for exploration were suggested by research participants. The potential for such thematic analysis could be maximised by making the dataset or subsets of the data available to research teams who are able to demonstrate relevant projects with appropriate methodology, rather than relying on a single research team to undertake all the analysis. This could be achieved by a combination of commissioned research on priority themes identified nationally, and responsive research in which teams with specific proposals request access to data. Any such approach would need to be carefully regulated to ensure that the data are used appropriately.

The Rose and Barnes study of 2001-3 Serious Case Reviews included a focus on analysing recommendations and their implementation. This was felt to be an important area for ongoing national analysis by our study participants. The approach to analysis of outcomes and implementation of action plans is however different to that required for analysis of the content of the reviews. It is recognised that Local Safeguarding Children Boards and individual agencies across the country can learn from Serious Case Reviews taking place elsewhere. One of the limitations of the current approach to national analysis is that each stage of the process takes the learning further away from the initial context of the case. However, it also builds in a more considered reflection on the issues and the ability to identify broader patterns and trends. There has been a move recently to circulate executive summaries to all LSCBs. It is our view that this is likely to detract from learning and carry the expectation that other LSCBs should learn from and perhaps implement recommendations from another area, without understanding the circumstances behind those recommendations or consider whether they are relevant within a different context. We would suggest that a better approach would be for an analysis of recommendations to be included in the regular observatory function of the national learning, and that these should be analysed within an understanding of the full context of the case.

Implications for policy and practice

10. The breadth and depth of learning from national analyses of Serious Case Reviews could be enhanced by an expansion of the current notification database to include an electronic

repository of anonymised overview reports together with IMRs, chronologies, genograms and action plans for all Serious Case Reviews.

11. The authors of this study suggest a revised system of national analysis which we believe would provide a more robust and flexible approach to national learning along the following lines:

- A research team commissioned for a longer period of at least 5 years to provide an observatory / reporting function on all Serious Case Reviews; this research team would have responsibility for annual reporting of the numbers, patterns and key learning from Serious Case Reviews, and would have access to data that would enable data on Serious Case Reviews to be linked to and compared with data from Child Death Overview Panels and wider data on children's safeguarding; this research team would also have responsibility for reviewing any national implications of recommendations from Serious Case Reviews;

- A national steering group established to oversee the work of the research team and to advise on further thematic analysis of the data;

- The data or subsets of the data would be made available to bona-fide researchers with relevant and appropriate proposals to undertake thematic analysis, under the direction and approval of the national steering group; the national steering group could recommend specific themes for analysis that are considered to be of national importance; these could then be commissioned by the Department for Education, or funded proposals sought from elsewhere.

12. There was considerable enthusiasm for national studies of good practice in safeguarding. This is currently part of an ongoing Safeguarding Children research programme within the Department for Education. Results from this programme should help to balance the negative impact of focusing on what goes wrong.

Dissemination of Learning

One of the strong messages to come out of this study is that, whilst the biennial analyses of Serious Case Reviews have produced some good and worthwhile material, in their current format they are not reaching as many people as they could and therefore the potential impact on national learning is diminished. The results from our focus groups and Delphi suggested a number of approaches that could improve dissemination without lessening the depth of learning gained by the national analysis.

Many participants highlighted the value of brief, 'digested' learning, for example through a high quality accessible web-site, newsletters, briefings, and/or specific fact sheets. These should not replace longer and more in-depth research reports, but could be made available in a regular and timely fashion and in a way that is accessible to front line workers and managers from different agencies, as well as policy makers and trainers. Such an approach would be facilitated by the

'observatory' approach suggested above, and would be enhanced by collaboration between any involved research team, the Department for Education and Ofsted. Alongside this there is an ongoing need for more in-depth research reports. The quality of these could be improved further if the research was published in peer-reviewed scientific journals as well as through government research reports.

There was also a call for the development of training materials to come out of the national analysis of Serious Case Reviews. This could include the development of sample case studies, standard training packs and material that could be adapted for use locally. Participants were clear that learning from Serious Case Reviews needs to be included in professional training at an early stage. As with the analysis itself, training should include learning from positive examples as well as from what goes wrong.

Implications for policy and practice

13. Timely and accessible dissemination of learning from Serious Case Reviews would be enhanced by open publication of the key lessons learned from national analysis on a website. This would require close collaboration between the Department for Education, Ofsted, and any research team involved in national analysis.

14. Findings from research on Serious Case Reviews need to be presented in a variety of formats to reach different audiences, including practitioners, policy makers and researchers. This could include easily readable newsletters or briefing papers, more substantive research and publications in peer reviewed scientific journals. A strategy for dissemination should form a substantial part of any research proposal.

15. Learning from Serious Case Reviews should be embedded into a range of training materials that could be made available to local trainers.

This research into methods of learning lessons from Serious Case Reviews has highlighted a range of good practice and ways in which Serious Case Reviews lead to learning both locally and nationally. It has identified ways in which this positive learning can be further enhanced and has suggested possibilities for improving both local practice and national analysis. At the heart of all of this lie the horrendous experiences of children who are subject to serious and fatal maltreatment. Effective learning needs to take place within that context and to recognise the reality of these children's lives. As one participant pointed out, it is very easy to "*forget this happened to a family*". We owe it to the children and their families to ensure this does not happen and to do all we can to learn from these tragic events.

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Appendix 1 Summary of previous national analyses

Report	Aim	Objectives	Methodology
Sinclair & Bullock (2002) *Learning from past experience* (England, 1998 - 2001)	To scrutinise a sample of Case Reviews undertaken between 1998 and 2001 - that is before and after the 1999 guidance	1. To identify what helps and what hinders the Serious Case Review process, as revised by *Working Together to Safeguard Children* 1999 2. To ascertain if the revised Serious Case Review processes have led to any changes in policy or practice at a local level 3. To identify from the reviews any lessons for policy and practice at a national level	*Data Collection*: 40 cases were taken from the notifications recorded on the National database selecting cases based on stratification to ensure balanced representation of geographical spread, type of local authority and the status of the review author. *Case Reviews*: All the Serious Case Review reports were read and a comprehensive framework was constructed to analyse their contents *Interviews*: In order to assess the effectiveness of the process and to examine the impact of guidance in respect of expected the authors of the review and the chair of the local ACPC in half of the cases were asked to participate in interviews. Qualitative Analysis of nominated variables and emerging themes
Rose & Barnes (2008) *Improving safeguarding practice* (England, 2001-3)	To prepare an overview of the findings from a selection of the case reviews undertaken during 2001-2003.	1. To identify key themes common to the recommendations 2. To ascertain whether case review reports resulted in action plans derived from findings and were implemented in the recommended time scales. 3. To consider what helped or hindered their	Planned use of national database 45 SCR reports/ cases provided – 40 eventually used. Other sources of information used: Documentary sources 10 telephone interviews with key staff involved Qualitative Analysis of nominated variables and emerging themes

		implementation 4. To ascertain if review processes led to changes in policy and practice at both a local and a national level.	
Brandon et al (2008) *Analysing Child Deaths and serious injury through abuse and neglect: what can we learn?* (England, 2003-2005)	To use the learning from Serious Case Reviews to improve multi-agency practice at all levels of intervention. It also aimed to analyse the ecological-transactional factors for children who became the subject of Serious Case Reviews.	1. To provide descriptive statistics from the full sample 2. To scrutinise a sub-sample of cases, and chart thresholds of multiagency intervention at the specified levels 3. From 1 and 2, seek a meaningful analysis by identifying ecological-translational factors within the sub-sample. 4. To provide practice tools for use by LSCB's	The total sample available for the period was 161 from the notification database. Use of the full sample for descriptive statistics and a sub sample of 47 cases for more intensive analysis. Selection was on the basis of more detailed information from overview reports and chronologies being available. Mixed methods Quantitative description and charting of background characteristics Qualitative reading, use of emerging themes: Layered reading
Ofsted (2008) *Learning lessons, taking action* (England 2007 – 2008)	To outline practice issues raised by Ofsted's first year of evaluating Serious Case Reviews and to consider how the process of conducting Serious Case Reviews could be improved.	The report 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.	An audit based on an evaluation of 50 Serious Case Reviews carried out between 1 April 2007 and 31 March 2008. LSCBs provide Ofsted with a complete set of papers on each Serious Case Review, including the terms of reference, overview report, individual management reports, recommendations and action plan. Each review is evaluated against a set of grade descriptors and in accordance with an evaluation template.
Brandon et al (2009) *Understanding Serious*	To learn from the analyses of interacting	1. To identify common themes and trends across review reports	Same methodology as 2003-2005 Descriptive analysis of all 189 notifications, including

Case Reviews and their Impact (England, 2005-2007)	risk factors present in the cases under review and to transfer this learning to everyday practice and to the process of Serious Case Reviews.	2.To explore the use of classifications of child deaths-linking with CDOP work. 3.To explore the commissioning, scoping, and publication of reports. 4.To discover what mechanisms are put in place locally to implement the findings and monitor their implementation 5.To ensure learning is captured so that it can feed into a longer term project to develop and implement a revised method of conducting national reviews.	comparison with the 2003-05 cohort. In-depth analysis of a sub-sample of 40 cases selected to represent all regions in England and to reflect the demographic characteristics of the full cohort. Analysis of emerging themes within 3 domains: the child and child's experiences; the family and family's environment; and factors linked to agency practice. Interviews with practitioners exploring the process and impact of Serious Case Reviews
Ofsted (2009) *Learning lessons from Serious Case Reviews: year 2*	To bring together findings in relation to the practice issues arising from the reviews, the process of conducting them and the emerging lessons.	The objectives were set in response to Lord Laming's call for Ofsted to focus its evaluation of Serious Case Reviews on the depth of the learning a review has provided and the quality of the recommendations it has made to protect children	The report covers the evaluations of a further 173 reviews. These evaluations were carried out and completed between 1 April 2008 and 31 March 2009. Methodology as per the 2008 report. Included an in-depth sample of 17 cases to explore issues of race, language, culture and religion, but no indication of how this sample was selected.

Appendix 2 Key findings from national overview reports

Report	Key findings	Implications
Sinclair & Bullock (2002) *Learning from past experience* (England, 1998 - 2001)	• The report outlined characteristics of the children, the incidents, the carers and wider situational factors. • The study highlighted the wide variety of circumstances in which children suffer fatal child abuse or serious injury and emphasised the value of the Assessment Framework (2000) in understanding these circumstances. • Explored previous agency involvement with the child or family including family engagement with services. Classified the incidents into 10 distinct groups. • Considered findings on practice and organisation and identified six common practice shortcomings including inadequate information sharing, poor assessments, ineffective decision making, lack of interagency working, poor recording and a lack of information on significant males. • Evaluated how lessons were learned and the recommendations made in reviews. • Compared reviews before and after the 1999 change in guidance. The guidance was considered to be helpful in setting the scope and terms of reference for Serious Case Reviews and in shifting the balance from an inquisitive agenda to a spirit of learning. It highlighted difficulties in the time scale, gathering of information, confidentiality, involvement of families and the publication of executive summaries.	Six implications for practice were highlighted in the report: 1. for practitioners to check whether they are focusing on a dominant theme or over- concentrating on some factors at the expense of recognising others; 2. to move beyond a simple uni-dimensional categorisation of ethnicity to incorporate a deeper understanding; 3. for practitioners to be sensitive to indicators of the child's social situation that suggest that the child is socially excluded; 4. for all agencies to be alert to ways of informing others when children they are working with and for whom there are concerns no longer seek or receive services; 5. that assessments should be analytical not merely descriptive; 6. for joint agency protocols to support information sharing. The authors suggested three research initiatives that would enhance the value of Serious Case Reviews: they call for good epidemiological and clinical evidence on factors associated with children suffering significant harm; knowledge about how to implement effective services; and practice tools to improve decisions and practice consistency.
Rose & Barnes (2008) *Improving safeguarding practice* (England, 2001-3)	The study concluded that Serious Case Reviews make an important contribution to understanding what happens in circumstances of significant harm, and can bring about improvements in safeguarding practice. Their effectiveness can be improved if LSCBs develop a much	The authors of this report identified four key questions in their conclusions: • How can the Serious Case Review process be made more effective so that reviews can fulfil their purpose?

stronger learning culture within which Serious Case Reviews are but one important source of knowledge for improving safeguarding practice.

The authors identified some emerging themes from the reviews:
- Emphasised the risks to older children and those with additional needs, as well as to young infants.
- Highlighted the importance of children living in complex home circumstances, of domestic violence, substance misuse and parental mental ill-health.

The report also explored aspects of the process and value of the Serious Case Reviews themselves:
- Identified differing thresholds in the decision as to whether to undertake a Serious Case Review.
- Highlighted difficulties in the appointment of independent chairs and authors.
- Emphasised the importance of agency management reviews and chronologies.
- Recognised the value of and difficulties in involving families in the review process.
- Stressed the importance of the overview report, recommendations and action plans but found that these were often unplanned, poorly coordinated or done in a rush.

They also identified divergent views as to whether the operational difficulties or failures identified in the reviews were more the result of systemic problems or individual error.

A major part of the study explored the nature of recommendations and action plans and how they related to the findings of the reviews,

- How can the findings of Serious Case Reviews be used to create sustainable change and improvements in safeguarding policy and practice?
- Are there alternative approaches which Local Safeguarding Children Boards might explore to assist agencies to improve their safeguarding practice?
- Are there emerging themes from overviews that require careful monitoring and attention by Local Safeguarding Children Boards so that agency policy and practice can respond more effectively?

In each of these areas, the authors made a number of suggestions for improving practice. In line with standard policy in government research reports however, these suggestions did not translate into actual recommendations.

	highlighting different categories of recommendations and evaluating their potential efficacy.	
Brandon et al (2008) *Analysing Child Deaths and serious injury through abuse and neglect: what can we learn?* (England, 2003-2005)	Described characteristics of the children and families and the circumstances of the incidents, highlighting the importance of domestic violence, parental mental ill-health and substance misuse. Although these features were common, the absence of control data meant that the researchers could not demonstrate any clear causal link between these parental behaviours and the outcomes of death or serious injury. Described characteristics of service provision and professional practice, including concepts of the "start-again syndrome" and "agency neglect". In-depth analysis of the intensive sample focused around three core themes: neglect, physical assault and 'hard to help' older children. Included a selected literature review of three areas pertinent to the study: thresholds of intervention; Serious Case Reviews; and interacting risk factors. Included a number of descriptive case studies.	The report included a large number of learning points for agencies throughout, including 10 "practice pointers" in the executive summary. These covered issues such as an emphasis on reflective and analytic practice; recognising vulnerability; personal communication; along with pointers to preventive and public health initiatives. The authors drew two specific implications in relation to the Serious Case Review process: - The use of a systematic approach to gathering and assessing information based on an ecological framework; - The use of an ecological-developmental framework for case formulation.
Ofsted (2008) *Learning lessons, taking action* (England 2007 – 2008)	The report summarised characteristics of the children, families and agency involvement with children and families identified through the reviews, including which agencies were involved, professionals' failure to consider the child's perspective and poor risk assessments. Concluded that there were 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. Specifically explored issues arising from 5 Serious Case Reviews relating to chronic neglect and 7 reviews relating to child sexual abuse.	The report made some suggestions for remedying the weaknesses still apparent in the Serious Case Review process such as: adhering to the timescales for completion; mproving 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. The report included 8 recommendations for LSCBs, 2 for DCSF and 5 for agencies completing individual management reviews to improve practice in relation to Serious Case Reviews; in addition there was one further recommendation for health agencies in

	The report also evaluated the reviews against preset criteria. 20 out of 50 were judged to be inadequate. These were mostly due to failure to meet the timescales; poor, inappropriate or absent terms of reference; poor quality of individual management reviews; and poor quality of the recommendations and action plans. Concluded that Serious Case Reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why.	relation to basic safeguarding practice.
Brandon et al (2009) *Understanding Serious Case Reviews and their Impact* (England, 2005-2007)	Provided an overall description of the 189 cases including comparisons with the 2003-05 cohort providing an overall cohort of 350 cases. Information on the children, their circumstances, the families, and agency involvement was analysed in relation to the nature of the incidents. Made a number of observations on professional practice, and the interaction between families and professionals, including perspectives on the mirroring of chaotic family situations, professionals feeling overwhelmed by the volume and nature of the work, fixed thinking and silo mentality. The ecological transactional perspective demonstrated how complex and multi-faceted the cases are which in turn makes interpretation of the findings equally complex. Emphasised that the local overview reports often provided insufficient information to achieve a clear understanding of the case and the incident which led to the child being harmed or killed. Service provision and inter-agency working cannot be fully understood in isolation from a full analysis of the case and of the agencies' capacity and organisational climate. Specific case studies were used to illustrate particular themes and included analysis of the interacting risk factors.	Highlighted a number of practice implications in relation to safeguarding practice generally and specifically in relation to the process of Serious Case Reviews: - The four month time scale for the completion of reviews is considered to be too short and not to be manageable. A six month timescale would be more achievable. - Reviews need to be scoped over a sufficiently long period of time to make sense of the child's circumstances and the services offered. To keep within a reasonable timescale, early history can be summarised in a 'light touch' chronology. - The overview author is well placed to highlight agency context and the capacity of staff to carry out their roles effectively. The overview author can also request that Individual Management Reviews which do not include sufficient information, for example about men in families, are revised. - Reasons given by some areas for not involving family members included ongoing court proceedings which caused delay. Reviews should be more actively managed by LSCBs and delay caused by court proceedings should be challenged. - No practitioner interviewed in this study felt adequately involved in the serious case review process. The learning must start with these practitioners.

Ofsted (2009) *Learning lessons from Serious Case Reviews: year 2* (England 2008 – 2009)	The report provided an evaluation of Serious Case Reviews against standard criteria as well as a description of some of the key findings from the reviews themselves. The report demonstrated some improvements in the quality of Serious Case Reviews, although 34% were still judged to be inadequate. Commented that there were no substantial changes in practice and service delivery and the practice issues identified in the reviews were almost identical to those in the 2007-8 report. Specifically explored issues in 17 reviews relating to looked after children and 19 relating to disabled children. Also specifically explored issues relating to race, language, culture and religion, and other practice issues within an in-depth sample of 17 reviews.	Identified a number of key learning points for future practice.

Appendix 3 Results of the Delphi study

Local learning

This section is about learning lessons from Serious Case Reviews at a local level and how local teams can most effectively learn from their own cases.

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
1. Local learning is most effective when it is embedded in the process of conducting the Serious Case Review, rather than waiting until the review is complete. *(Revised for round 2)*	Round 2	0	2	9	5	**42**	**35**	7
Local learning is most effective when it is embedded in the process of conducting the Serious Case Review.	Round 1	0	6	5	15	36	32	6
2. Those who collate information and compile the Individual Management Reviews (IMRs) are best placed to disseminate lessons.	Round 2	0	15	24	40	16	4	2
	Round 1	3	15	17	24	29	9	3
3. Practitioners involved in the case need to be involved throughout the Serious Case Review process.	Round 2	0	5	15	11	29	38	2
	Round 1	0	5	9	9	36	39	2
4. Including IMR authors as part of the overview panel would help to ensure that appropriate lessons are learned.	Round 2	0	11	15	15	38	16	5
	Round 1	5	11	12	17	30	23	3
5. Local learning can be enhanced by keeping the emphasis on learning lessons rather than apportioning blame.	Round 2	0	0	5	4	**27**	**60**	4
	Round 1	0	2	0	2	21	73	3

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
6. Local learning can be enhanced by addressing accountability/responsibility as well as learning lessons.	Round 2	0	0	7	16	49	24	4
	Round 1	0	3	6	12	44	33	2
7. Having a less detailed approach to Serious Case Reviews would facilitate local learning.	Round 2	2	42	15	16	9	13	4
	Round 1	5	29	20	11	14	18	5
8. In most cases relevant learning can be identified through the child death review processes without needing a full Serious Case Review.	Round 2	16	47	13	5	7	5	5
	Round 1	12	38	23	6	14	3	5
9. Local learning is more likely to be effective if Local Safeguarding Children Boards (LSCBs) are allowed flexibility in the way in which they carry out Serious Case Reviews.	Round 2	0	18	27	9	27	15	4
	Round 1	3	14	11	9	36	24	3
10. Local learning is more likely to be effective if Serious Case Reviews are conducted in a standardised manner.	Round 2	0	5	18	25	31	18	2
	Round 1	2	8	35	17	24	12	3
11. The process of evaluation by OFSTED contributes to learning lessons.	Round 2	25	35	13	13	9	2	4
	Round 1	24	35	11	9	11	5	6
12. A focus on implementing recommendations detracts from learning lessons.	Round 2	4	22	25	27	11	7	4
	Round 1	3	18	27	24	20	6	2

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
13. Involvement of family members in the Serious Case Review process enhances learning.	Round 2	0	7	4	9	36	29	15
	Round 1	0	3	0	14	33	41	9

National analysis

This section is about how information from Serious Case Reviews is collated and used at a national level, and looking forward to consider any changes that might support learning and change at a national level.

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
1. The biennial reviews of Serious Case Reviews have had an impact on safeguarding policy.	Round 2	0	2	5	25	58	7	2
	Round 1	2	6	8	29	41	9	6
2. The biennial reviews of Serious Case Reviews have been helpful to practitioners.	Round 2	0	5	16	25	44	7	2
	Round 1	3	8	8	33	33	8	8
3. The biennial reviews of Serious Case Reviews are failing to generate useful information on serious and fatal maltreatment. *(Revised for round 2)*	Round 2	4	58	16	9	11	2	0
The biennial reviews of Serious Case Reviews are failing to generate new information on serious and fatal maltreatment.	Round 1	6	18	18	15	35	5	3

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
4. The study of Serious Case Reviews provides a unique opportunity for understanding the nature of serious and fatal maltreatment.	Round 2	0	7	11	11	49	22	0
	Round 1	2	6	11	23	38	21	0
5. The quality of national analysis of Serious Case Reviews would be improved if it included an analysis of chronologies and IMRs, not just overview reports. *(Revised for round 2)*	Round 2	4	16	7	24	33	13	4
National analysis of Serious Case Reviews should incorporate chronologies and IMRs, not just overview reports.	Round 1	5	17	18	17	26	12	6
6. National analysis of Serious Case Reviews would be improved if it included comparisons with control data (such as data on children who have not been fatally abused). *(Revised for round 2)*	Round 2	2	16	11	13	35	18	5
National analysis of Serious Case Reviews in the absence of any control data (such as data on children who have not been fatally abused) is misleading.	Round 1	5	15	11	27	24	8	11
7. The Child Death Overview Panel process will provide a more accurate measure of the incidence of fatal maltreatment.	Round 2	2	25	15	20	25	5	7
	Round 1	3	12	14	20	21	12	18

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
8. National analysis should combine data from Serious Case Reviews and child death overview panels.	Round 2	0	9	4	13	47	22	5
	Round 1	2	3	6	20	35	20	15
9. National analysis should seek to analyse the outcomes of recommendations and action plans.	Round 2	0	5	2	16	45	27	4
	Round 1	0	6	5	17	44	26	3
10. National analysis should address both national policy issues and issues for front line practitioners. *(Revised for round 2)*	Round 2	0	2	0	7	**38**	**47**	5
National analysis should focus on identifying national policy issues rather than issues for frontline practitioners.	Round 1	9	24	26	20	9	12	0
11. National analysis would be more relevant if it combined a regular (annual or biennial) overview and specific thematic analysis. *(Revised for round 2)*	Round 2	0	2	0	16	**45**	**31**	5
National analysis would be more relevant if it picked up specific topics or themes rather than a broad overview every two years.	Round 1	0	18	11	21	30	14	6

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
12. National analysis should combine both looking at services and looking at characteristics of children and families. *(Revised for round 2)*	Round 2	0	4	4	4	**40**	**47**	2
National analysis should concentrate on looking at services rather than looking at characteristics of children and families.	Round 1	5	18	30	21	11	9	6

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
13. National learning is more likely to be effective if Serious Case Reviews are conducted in a standardised manner.	Round 2	2	15	4	16	31	29	4
	Round 1	2	14	18	23	20	21	3

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
14. National learning is likely to be richer if LSCBs are allowed flexibility in the way in which they carry out Serious Case Reviews.	Round 2	0	16	24	13	25	18	4
	Round 1	5	12	18	15	29	14	8

Learning lessons nationally

This section is about how information from national reviews can be used to support learning.

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
1. Biennial reviews are helpful to trainers enabling them to set local lessons in a national context.	Round 2	0	0	0	7	**58**	**31**	4
	Round 1	0	3	0	9	58	26	5
2. National learning should be made immediately available through a dedicated website.	Round 2	0	2	0	9	**40**	**49**	0
	Round 1	0	3	5	12	50	29	2

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
3. Brief newsletters or fact sheets in addition to longer research reports would facilitate ongoing learning. *(Revised for round 2)*	Round 2	0	0	0	9	**36**	**55**	0
Brief newsletters or fact sheets would be more helpful to practitioners than longer research reports.	Round 1	2	9	5	14	39	32	0
4. Policymakers, trainers, managers and practitioners need different information from Serious Case Reviews.	Round 2	0	33	16	18	18	7	7
	Round 1	6	18	20	17	26	11	3
5. Policymakers, trainers, managers and practitioners need the same information but presented in different ways.	Round 2	0	7	15	18	33	22	5
	Round 1	2	8	15	14	39	15	8
6. National lessons should be directly incorporated into learning material to support learning at a local level.	Round 2	0	2	11	5	**40**	**38**	4
	Round 1	0	3	8	12	45	27	5
7. Local trainers are best placed to develop their own learning materials based on national information.	Round 2	0	15	22	31	20	5	7
	Round 1	2	15	20	29	23	8	5

Question		Strongly disagree	Disagree	Mildly disagree	Mildly agree	Agree	Strongly agree	Unable to answer
8. Safeguarding children training should incorporate both common issues and lessons from the severe and fatal end of the spectrum. *(Revised for round 2)*	Round 2	0	0	2	7	**47**	**44**	0
Safeguarding children training should focus on common issues rather than the severe and fatal end of the spectrum.	Round 1	0	11	23	20	23	17	8
9. Safeguarding children training should incorporate both learning from positive examples and learning from what goes wrong. *(Revised for round 2)*	Round 2	0	0	0	5	**38**	**56**	0
Safeguarding children training should focus on positive examples rather than on what goes wrong.	Round 1	2	14	24	29	18	9	6
10. Individual Serious Case Reviews can provide examples to guide practice in a similar way to the development of case law.	Round 2	4	4	11	20	42	15	5
	Round 1	3	5	5	33	30	15	9
11. The only real measure of the effectiveness of learning from Serious Case Reviews is a reduction in the number of serious and fatal cases.	Round 2	22	27	24	11	9	5	2
	Round 1	20	29	21	17	11	0	3
12. Learning about Serious Case Reviews should be incorporated into initial professional training.	Round 2	0	0	2	15	**33**	**49**	2
	Round 1	0	0	3	12	50	35	0