Learning lessons from serious case reviews 2009–2010

Ofsted's evaluation of serious case reviews from 1 April 2009 to 31 March 2010

This report provides an analysis of the evaluations of 147 serious case reviews that Ofsted completed between 1 April 2009 and 31 March 2010.

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Executive summary

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. They are carried out by Local Safeguarding Children Boards so that lessons can be learnt. Ofsted has published three previous reports about serious case reviews, the most recent of which was a report on evaluations completed between April 2009 and September 2009.[1]

This report covers the evaluations of the 147 reviews carried out during the full year from April 2009 to March 2010. As in previous reports, this one brings together findings in relation both to the lessons learnt for improving practice and the conduct of serious case reviews. It identifies issues which require further consideration by Local Safeguarding Children Boards.

Previous reports have criticised the quality of a large proportion of serious case reviews. Of the 147 serious case reviews reported on here, 62 were judged to be good, 62 adequate and 23 inadequate. By comparison, in last year's report covering 173 reviews, 40 were judged to be good, 74 adequate and 59 inadequate. The continuing improvement in the quality of reviews reflects the high level of attention that has been given to them, nationally and by most Local Safeguarding Children Boards. It is, however, still of concern that 23 reviews during this period were found by inspectors to be inadequate. Every review of a serious incident should be carried out to the highest standard.

[1] *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008* (080112), Ofsted, 2008; www.ofsted.gov.uk/publications/080112. *Learning lessons from serious case reviews: year 2* (090101), Ofsted, 2009; www.ofsted.gov.uk/publications/090101. *Learning lessons from serious case reviews: interim report 2009–10* (100033), Ofsted, 2010; www.ofsted.gov.uk/publications/100033.

Key findings

- Of the 194 children who were the subject of the reviews, a majority were five years old or younger at the time of the incident. There were 69 under one year old and 47 between one and five years old.
- At the time of the incident, 119 of the children were known to children's social care services. This is a similar proportion to the findings of the previous year's report.
- The characteristics of the families were also similar to those identified in Ofsted's previous reports. The most common issues were domestic violence, mental ill-health, and drug and alcohol misuse. Frequently, more than one of these characteristics were present.
- Some parents were receiving support from agencies in their own right, including from services for adult social care, adult mental health, substance misuse, housing and probation. These agencies were found to have held important information about the family circumstances, but too often this was not shared early enough.
- Of the 194 children, 90 died. The other 104 were involved in serious incidents, following a history of concern by the agencies involved, including being the subject of a child protection plan. The most common characteristics of the incidents were physical abuse or long-term neglect.
- Local Safeguarding Children Boards identified the lessons to be learnt from the serious case reviews and made recommendations for action and improved practice by agencies in their areas. There are six main messages which recur throughout the reviews. These messages are about the importance of:
  - focusing on good practice
  - ensuring that the necessary action takes place
  - using all sources of information
  - carrying out assessments effectively
  - implementing effective multi-agency working
  - valuing challenge, supervision and scrutiny.
- A consistent finding from the reviews was that there had been a failure to implement and ensure good practice rather than an absence of the required framework and procedures for delivering services.
- Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. They also highlighted concerns about the effectiveness of assessments and shortcomings in multi-agency working.
- Reviews found that there had been insufficient challenge by those involved. The statements of parents or others in the family should not have been accepted at face value; individual professionals and agencies should have questioned their

own and others' views, decisions and actions; and there were shortcomings in the supervision and intervention by managers.

- Local Safeguarding Children Boards also identified failures to ensure that the necessary action was taken because of gaps in the services that were available; decisions which, with the benefit of hindsight, were found to be wrong; insufficient consideration of the child's individual needs; and 'professional drift' resulting in a lack of action.
- Too often the focus on the child was lost; adequate steps were not taken to establish the wishes and feelings of children and young people, and their voice was not sufficiently heard.
- Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. This included information about or from fathers and extended family, historical knowledge, information from other agencies, the cultural background and research findings.
- The overview report has a critical impact on the overall quality of the serious case reviews and the depth of learning. This year, 19 overview reports were judged to be outstanding. These reports provided incisive commentaries and interpretations of the actions taken and those that should have been taken.
- Of the 147 reviews, 60 met the six-month timescale for completing the reviews, which was established in the most recent revision of *Working together to safeguard children* (referred to in this report as *Working together*).[2] Sixty took between six and 12 months, 19 between one and two years, and eight over two years.
- Ofsted's previous reports identified concerns about the lack of consideration by Local Safeguarding Children Boards of race, language, culture and religion. An uneven pattern was found in the reviews covered by this report. Many of the reviews did not consider the issues sufficiently or focused on one aspect to the exclusion of others. In those reviews where race, language, culture and religion were dealt with sensitively, for example, there was increased learning from the review.
- There was evidence of improvement in the involvement of family members in the review process. In the best examples, the views of the family were woven into the final report and had an influence on the findings. However, only 15 reviews indicated clearly that the Local Safeguarding Children Board had tried to involve children and young people in them.

[2] *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, TSO, 2006; updated 2010; www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/.

Background

1. Ofsted has been responsible for evaluating serious case reviews since 1 April 2007. The reviews and the evaluations are conducted in accordance with the current statutory guidance set out in Chapter 8 of *Working together*.

2. An updated Chapter 8 was integrated into the revised version of *Working together* published on 17 March 2010. This report, therefore, deals with reviews that were completed before the new guidance was issued.

3. Annex A sets out the circumstances in which a Local Safeguarding Children Board must consider conducting a serious case review. Local Safeguarding Children Boards are required by *Working together* to send the completed review to Ofsted for evaluation. These are complex documents and include a large volume of separate documentation: terms of reference; individual management reviews from all statutory and voluntary agencies who may have been involved with the child concerned during the period covered by the review; an overview report which draws together the findings from the individual management reviews; recommendations and an action plan; and an executive summary. Ofsted evaluates the effectiveness of all parts of the process, focusing on the depth of learning.

4. The outcome of the evaluation is shared with Local Safeguarding Children Boards and forms part of the evidence used for Ofsted's wider evaluation of the effectiveness of children's services in a local area. These outcomes are also shared with the Department for Education and during the period covered by this report were also shared with the relevant Government Office.

5. Ofsted has published three previous reports about serious case reviews. The first two of these reports, *Learning lessons, taking action* and *Learning lessons from serious case reviews: year* 2, covered serious case reviews that had been evaluated by Ofsted between April 2007 and March 2009.

6. In April 2010 Ofsted published a report which provided an analysis of evaluations completed between April 2009 and September 2009.[3] The current report looks at findings from the evaluations of serious case reviews completed during the full year 2009/10. All the case examples are drawn from executive summaries that are already in the public domain.

The children, their families and the incidents

7. This report covers 147 serious case reviews which were evaluated by Ofsted between the beginning of April 2009 and the end of March 2010.

[3] *Learning lessons from serious case reviews: interim report 2009–10*, Ofsted, 2010; www.ofsted.gov.uk/publications/100033.

8. Of the 147 reviews, 145 serious case reviews concerned 194 children. Twenty-five of the reviews were about two or more children, including one case involving a family of six children, another a family of eight children and a third a family of 10 spanning two generations.

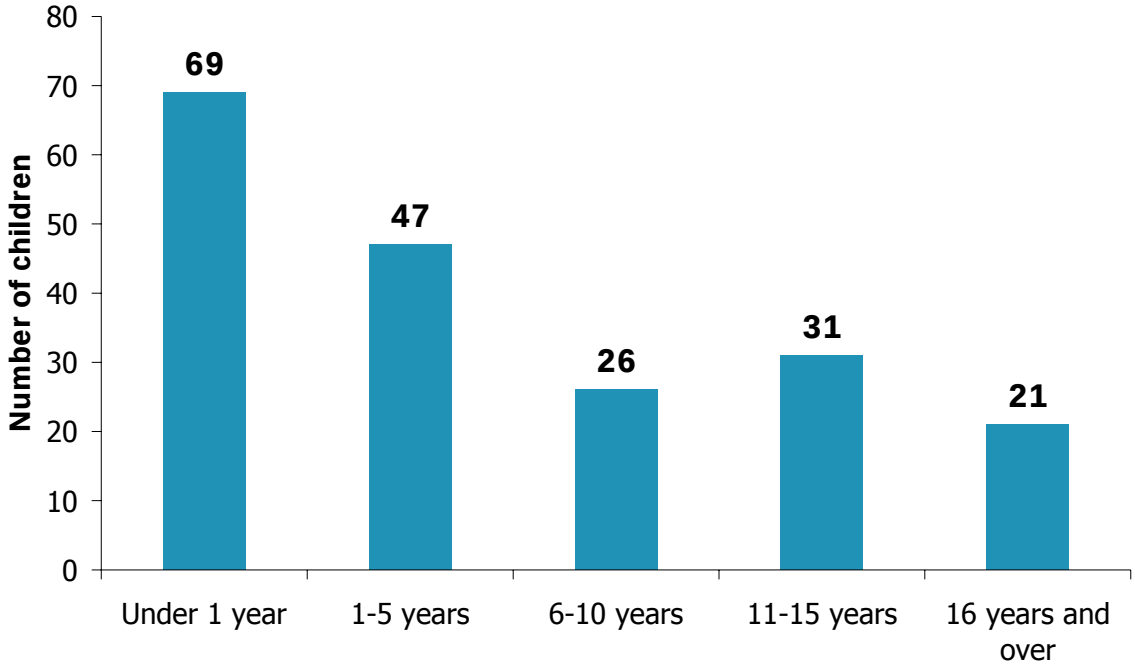
9. The two cases that are not included in the data relating to children and families were different from those which have been evaluated for previous Ofsted reports and from the other 145 cases in this report. The principal focus of these two reviews was on adult perpetrators, rather than on the details of individual children and their families. They examined the lessons to be learnt about local agencies' failure to identify abuse carried out over an extended period of time. These cases are, therefore, summarised separately. They are included in the sections of this report on lessons learnt and on the serious case review process.

The children

10. Of the 194 children, 90 children died. The other 104 were involved in serious incidents which resulted in a decision by the Local Safeguarding Children Board to carry out a serious case review.

11. The age profile of the children was similar to that found in previous Ofsted reports, as shown in Figure 1. A large majority of the children involved were five years old or younger at the time of the incident.

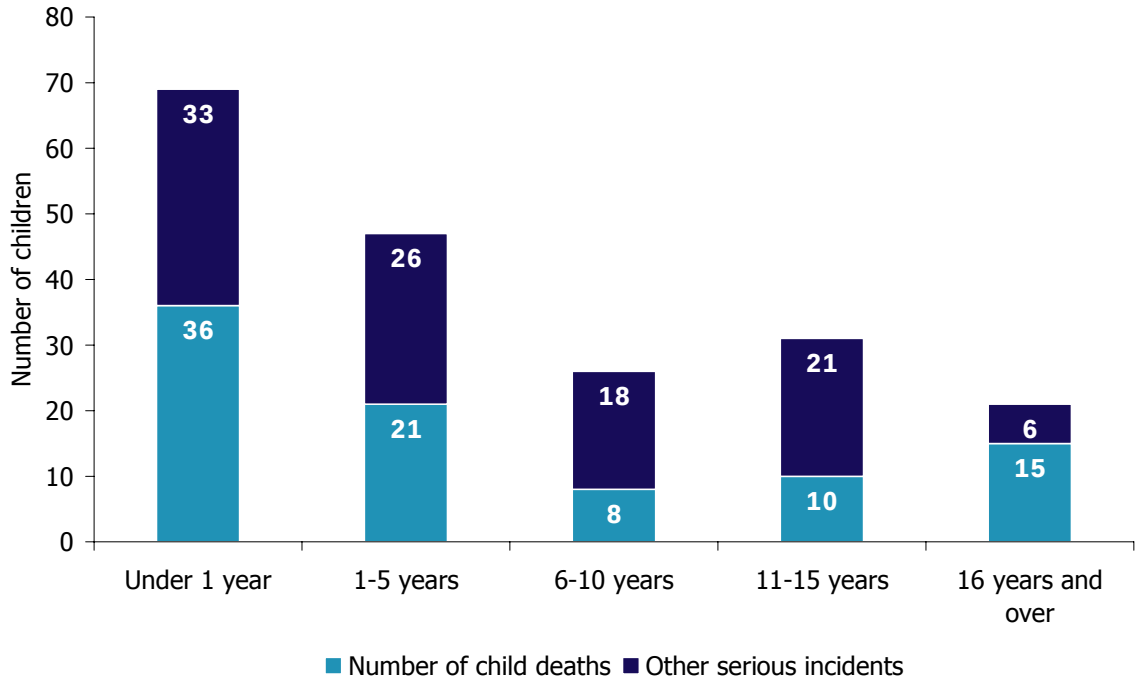
Figure 1. Ages of children who were the subject of a serious case review evaluated by Ofsted between 1 April 2009 and 31 March 2010



12. Figure 2 compares the age range of those who died and those who were subject to other serious incidents. There is little difference in the two profiles,

except that a higher proportion of the young people aged over 16 died as a result of the incidents.

Figure 2: Number of child deaths and other serious incidents by age group, April 2009 to March 2010



13. In terms of gender, there were 91 girls and 103 boys in this year's serious case reviews. The fairly even balance is similar to the findings in previous years.

14. Ethnicity data were recorded for all except one child. The largest grouping was White British (156 out of 194 children). Ten children were recorded as Asian Bangladeshi, Asian Pakistani or Asian Other; five as Black African, Black Caribbean or Black Other; eight as Mixed; and two as White Other. In eight cases the ethnicity was not recorded using the standard census ethnic categories, and in another case the child's ethnicity was not stated.[4] There was a higher proportion of White British children than in the previous year's report.

15. There were 23 disabled children, ranging from those with partial hearing to severe and complex conditions. The number of disabled children included seven children from one family.

16. Of the 194 children, 119 were known to children's social care services at the time of the incident. This is a similar proportion to the findings of the previous year's report. There were other children who had been known to the services previously but were not at the time of the incident.

[4] Census 2001 ethnic categories are used. Non-standard ethnic categories include: Black British; Tamil Sri Lankan; White Polish; and African-Caribbean.

17. There were 90 children who were receiving services as children in need at the time of the incident. Of these, 49 were the subject of child protection plans. Of the 90 children in need, 31 died.

18. There were 21 children who were looked after by the local authority. In addition, one was subject to an interim supervision order and one had previously been detained under the Mental Health Act. There were several children who had had short periods in care but were not looked after children at the time of the incident.

19. Nine of the looked after children died. Of these, three committed suicide; one was killed by another young person; one died as a result of an incident involving substance misuse; two died from natural causes associated with their disability or medical condition; and the cause of death in the remaining two cases was unexplained.

The children's families

20. Common characteristics of the families were similar to those identified in Ofsted's previous reports. The most common issues were domestic violence, mental ill-health, and drug and alcohol misuse. Frequently, more than one of these characteristics were present. Overall, domestic violence was a factor in cases involving 61 children, mental ill-health for 44 children, drug misuse for 36 children and alcohol abuse for 27 children. Other family risk factors reported in this year's reviews included previous or current offending behaviour by the parents, family homelessness, suicide or attempted suicide by a parent, self-harming behaviour either of the parents or of the children, death of the mother by natural causes, and disability of a parent.

21. Of the 194 children, 26 had been born to teenage parents. In some of these cases the parents were, or had recently been, children in need themselves.

22. Some parents were receiving support from agencies in their own right, including from services for adult social care, adult mental health, substance misuse, housing and probation. These agencies were found to have held important information about the family circumstances, but too often this was not shared early enough.

23. The combination of contributory factors is illustrated by one of the serious case reviews. It concerned three children aged five, 11 and 14. Their mother had had a long history of being abused as a child herself and had been in care. She married young and had children by three different partners. The mother began to take illicit drugs and then developed an alcohol problem. She moved into various houses, often because the former house was in such poor condition that she requested a move. The young woman suffered violence from each of her partners. As her children began school, concerns arose about their behaviour and often the children arrived hungry and dirty. The serious case review was in fact triggered by sexual abuse of one of the children by a

neighbour. However, the review concluded that there had been missed opportunities for the children to have been removed and placed in care, and protected from further preventable abuse and neglect.

24. While this example illustrates the cumulative impact of characteristics often found to have contributed to serious incidents, other cases showed that professionals also have to be alert to family situations that do not fit these patterns of behaviour. For example, one case concerned a small baby who suffered a fracture to the skull which was likely to have been a non-accidental injury. Subsequently, concerns also arose about the baby's older sister that led to her being made the subject of a child protection plan. In that family there had been none of the risk factors mentioned above.

The incidents

25. Of the 194 children who were the subject of the serious case reviews, 90 died. The cause of death is shown in Table 1.

Table 1: Cause of death of the 90 children who died

Homicide	
Murder by parent/carer*	10
Other**	5
Total	**15**
Other external cause	
Killing by another young person	2
Suicide	11
Other***	4
Total	**17**
Accidents and adverse events	
Concealed birth	1
Result of accident but neglect a factor	5
Overlay by parent/carer	1
Substance misuse	5
Other	1
Total	**13**
Undetermined	
Unexplained cause	25
Unknown cause	3
Parent died in same event	7
Other	1
Total	**36**
Natural causes	**9**
Total	**90**

* Parent/carer was convicted of murder of child.
** Includes deaths arising from malnourishment, neglect, physical abuse, shaken baby syndrome or arson.
*** Includes deaths from fire or drowning.

26. The deaths recorded as unexplained include cases where no definite reason could be determined by the coroner. The category covers instances of 'sudden

unidentified death in infancy' and other cases in which young babies died, where overlay by the mother or the effects of parental use of alcohol or drugs may have been a factor. Other deaths that were categorised as unexplained included those where parents had died in the same incident and also a case where a pregnant teenager had jumped from a high place without there being a definite finding that the cause was suicide.

27. Nine serious case reviews concerned cases where it was found that the death had resulted from natural causes. These cases included children and young people who were disabled or who had long-standing illnesses, where there had also been concerns that neglect might have been a contributory factor.

28. There were 15 deaths that resulted from murder by a parent or as a result of their actions or lack of action. There were also two instances of killing by another young person. Five of the children died as a result of accidents following previous concerns about neglect, which were key factors in the decision to carry out a serious case review.

29. Apart from the 90 children who died, the serious case reviews concerned 104 other children. In most of these cases the serious incident, for example an injury to a child or an attempted suicide, followed a history of concern by several agencies, often evidenced by current or previous child protection plans. The most common characteristics of the incidents were physical abuse or long-term neglect.

30. A serious case review involving two young children illustrates the kind of reasons that Local Safeguarding Boards carried out serious case reviews when no child had died as a result of the incident. The two children in this case were living with their mother, who was separated from their father. Following a long history of domestic violence, the father stabbed the mother to death while the children were in the house. Both children were the subject of child protection plans at the time and two older children in the family had previously been removed from the parents' care. The decision to carry out a serious case review in order to learn lessons from the involvement and decisions of the agencies involved was in accord with the guidance in *Working together.*

31. Two of the total of 147 serious case reviews, not included in the above statistical data, focused on the lessons to be learnt from agencies' involvement with adults convicted of abuse against child victims. One Local Safeguarding Children Board carried out a review to consider the measures that agencies and organisations had put in place to prevent dangerous adults having access to children, following sexual abuse carried out by a previously convicted perpetrator of similar offences. The other review concerned a known sex offender who had abused a number of vulnerable young adolescent boys.

Learning lessons from the serious case reviews

32. This section focuses on the lessons to be learnt by the key safeguarding agencies from the 147 serious case reviews. Caution is necessary when generalising from the reviews. Reflecting on learning in the serious case review process enables agencies to identify good practice in safeguarding children by agencies and individual members of staff. However, there were also important issues identified by the Local Safeguarding Children Boards, which led to recommendations for action and improved practice by agencies.

33. Many of the lessons are similar to those set out in the previous Ofsted reports. There are six main messages which recur throughout the reviews. These messages are about the importance of:

- focusing on good practice
- ensuring that the necessary action takes place
- using all sources of information
- carrying out assessments effectively
- implementing effective multi-agency working
- valuing challenge, supervision and scrutiny.

This summary of lessons learnt focuses on what the implications of these messages meant in practice for the children and families who were the subjects of this past year's reviews. Examples have been drawn from the 147 cases, using the lessons which the Local Safeguarding Children Boards themselves set out in their executive summaries. Some of these examples illustrate more than one of the six main messages.

Focusing on good practice

34. A consistent finding from the reviews was that there had been a failure to take the necessary action and implement good practice rather than an absence of the required framework and procedures for delivering services. Examples of lessons from this year's reviews included failings in:

- the use of systems for flagging up concerns
- the application of thresholds for referrals
- the transfer of information between authorities
- the use of legal powers when concerns needed to be escalated
- the tailoring of procedures to meet the individual needs of families.

35. One serious case review following the death of a three-week-old baby illustrates the lessons which were learnt by one Local Safeguarding Children Board when established procedures had not been implemented. The mother was well known to children's social care services. A child of the father by a

previous partner was the subject of care proceedings. Despite this, there had been no pre-birth assessment and the baby who was the subject of the review was not known to children's social care. The child's grandparents had raised some concerns but this information had not been acted upon by the mother's social worker or by the health visitor. One of the multi-agency learning points for the Local Safeguarding Children Board was that its system for identifying vulnerable children had not been followed. It had an appropriate system, using a Hazard Warning Flag, but the necessary action had not been taken.

36. A message from many of the reviews was the lack of clarity about thresholds for referrals to children's social care and inconsistency in applying them by some practitioners. Some GPs, who were often one of the first points of contact for families, were uncertain about the levels of concern that should have prompted a referral. Reviews also commented on the importance of decisions about the need to refer concerns to social care needing to be taken by staff with sufficient knowledge and experience.

37. This concern about the application of thresholds was one of the findings from a review in which the parents had a history of substance misuse. The Local Safeguarding Children Board concluded that more immediate referrals to children's services and, in this particular case, to the community drug team would have enabled information-sharing, assessment and planning to be more effective. The Local Safeguarding Children Board identified differing views within the services about thresholds for referral. The review highlighted the need for work to ensure clarity across agencies about thresholds, including a shared understanding about the boundaries of family support and child protection, and the nature of the roles and responsibilities of key staff in the relevant services.

38. Some of the reviews also highlighted concerns over transferring case files when families moved from one authority to another. One of this year's cases illustrated the dilemmas that can be posed in these situations and the danger of professionals using procedures to delay taking action, rather than addressing the needs of children. The authority concerned had requested background information from another authority where the family had previously lived. This did not arrive. A finding of the review was that the request should have been sent by the authority's legal services to ensure release of the documents, but this had not happened. A lesson learnt was that the handling of the transfer of case management had been inadequate. The review stated: 'There was a preoccupation with transferring the case, which deflected attention away from the child protection plan and a focus on the children.'

39. The role of legal services was also the subject of findings of other serious case reviews. In particular, there were cases in which the authority did not use its powers to take the action necessary to protect children, did not do so early enough or did not review whether further escalation was required.

40. One example of this concerned a young woman who committed suicide following a history of self-harming and a previous incident in which she had taken an overdose. She had been voluntarily accommodated for two years. A lesson learnt by the Local Safeguarding Children Board was that the voluntary nature of this arrangement did not provide the legal framework to make the level of decisions necessary for this young person. The review reached the view that there had been insufficient consideration by lead agencies, in particular by social care and health services, of the use of legislation and statutory powers to support interventions and to provide protection.

41. Another message from this past year's reviews was the importance of considering whether the standard procedures were appropriate in each circumstance. The normal arrangements did not always take account of individual needs, whether in terms of the level of understanding, the language and cultural background, or the special needs of the children and families who were the subject of the reviews. Communication by letter was frequently not the best way of making contact with families, even though this was often the main method used.

42. One example where procedures should have been adapted concerned a young boy who had been taken by his mother to the GP because the child was not gaining weight. The mother was registered as a blind person. She had needed encouragement and a reminder by the health visitor to go to the GP. The doctor initiated a referral to a paediatrician using the 'Choose and Book' system. This required the parent to contact the hospital using a password which she received in a letter. In this case, she did not activate the referral and neither the GP nor the health visiting service followed up the referral.

43. A lesson from this review was that the booking system had placed too much responsibility on the parent and had assumed that the mother would be able to access letters and respond to them. The doctor had not taken account of her visual impairment. The Local Safeguarding Children Board felt that the system could have national implications and they therefore raised this with central government in one of their recommendations.[5]

44. One review related to a serious incident affecting a young baby. The mother and a second young woman, who also had a young baby, were both looked

[5] Ofsted reported a similar finding in its review of special educational needs and disability: 'Support for some young people with behavioural, emotional and social difficulties and for their families depended on their attending appointments in unfamiliar places that were not always nearby, such as a specialist health centre. There were instances where families had not attended appointments and so they had been removed from the waiting list of the service. The best services actively sought to prevent this happening by working in different ways, for example by offering appointments at a familiar school site.' *The special educational needs and disability review: a statement is not enough* (090221), Ofsted, 2010; www.ofsted.gov.uk/publications/090221.

after and were both living with the same foster carers. The serious case review reflected the complex set of inter-weaving challenges for the professionals involved in meeting the needs both of the two vulnerable mothers and of their two babies. The review recommended that an additional process should be developed in the authority's formal system for reviewing looked after children. This would ensure that, when looked after young people become parents, their own specific needs should be reviewed while also addressing separately the issues of parenting.

Ensuring necessary action takes place

45. In the reviews examined this year, there were four common reasons why the necessary action was not taken:

- gaps in the services that were available
- decisions which, with the benefit of hindsight, were found to be wrong
- insufficient consideration of the child's individual needs
- 'professional drift' resulting in a lack of action.

46. Some reviews identified gaps in local provision. These included, for example, a lack of suitable mental health support to meet the needs of vulnerable adolescents in some areas; variation in the arrangements between police and social care services to provide suitable care to safeguard children at immediate risk of harm; a shortage of appropriate housing for young parents; and insufficient alternative schooling for pupils not attending full time. [6]

47. An important message about making sure that local provision is suitable was made in a review which stated that there was 'the danger of an approach which fits the family to the resources available rather than using the assessment and care planning process to re-evaluate the impact of interventions and make adjustments to the care plan accordingly'. In this case, the approach to case management had relied upon repeating the same interventions, even though they had failed to lead to change.

48. Even where appropriate support did exist, there were lessons to be learnt about the impact on children and young people if wrong decisions had been made. Sometimes there had been a failure to tackle root causes, such as the lack of suitable housing for women with children in one authority, because of an over-emphasis on addressing the symptoms of the case. In other instances, the eventual decision may have been the correct one but it had been made too late.

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[6] Ofsted's report on children missing from education said: 'Children and young people who are not being educated quickly become at risk of failing academically and socially. If their whereabouts then become unknown, they may be particularly at risk of physical, emotional and psychological harm.' For further information, see: *Children missing from education* (100041), Ofsted, 2010; www.ofsted.gov.uk/publications/100041.

49. This was the finding of a review about a 15-year-old boy who died in a street gang incident, after absconding from a care placement. A series of placements had been made for him and he had also spent a period in custody. A key theme of the review was that there had been avoidable delay in bringing him into public care. Among the lessons learnt, the review concluded: 'Some placement decisions were ill-judged and did not offer sufficient structure or activity. Agencies did not always work well together and arrangements for his health and education were adversely affected. This was compounded by a lack of compliance on his part and the consequences of his moving between placements and custodial establishments.'

50. A further lesson was the importance of providing services that met the individual needs of the child. This is illustrated well by a review about a young teenager. She had been subject to prolonged sexual abuse within her family and had been sexually exploited by a number of older adolescents. She also had special educational needs, particularly in terms of speech and language difficulties. For three years, professionals had attempted to give her advice about sexual health, safe sex and relationships. A lesson from the review was that, because of her special needs, the girl would not have grasped or remembered more than a small fraction of what she had been told and that the impact on her understanding would have been negligible.

51. The executive summary of that case expressed the message clearly: 'It is striking how infrequently any special steps were taken to ensure that staff assessed her competency, took special measures to tailor what was being said to her level of understanding or took the time to find out if what they had said had made any impact.'

52. In other cases the findings of the review were about a lack of action or insufficient clarity about what had been agreed. Where decisions had been taken, there was an expectation by practitioners that something was happening. Instead, there was no follow-up of the decisions or no take-up of the support by the families involved. Too often the practitioners involved waited to react to individual incidents rather than being proactive, which might have reduced the likelihood of further incidents happening.

53. This lack of action was a key finding from a case review about twins who had been born prematurely to a vulnerable teenage mother. After their discharge from hospital, evidence had accumulated that the parents were not cooperating in meeting social workers and were unwilling or unable to accept health visitors' advice about caring for the babies. A child in need plan was developed but, when the family did not comply with it, there was no follow-up. One of the twins subsequently died from sudden unexpected death in infancy.

54. Similar lessons concerned referrals within the health service. Some reviews found that systems were not in place to ensure that the service or support was being delivered. Those making the referral assumed that the service or support was taking place and the provider took the view that, if the child or the family

did not attend an appointment, the service was not needed. Too much responsibility was placed on parents and carers to make appointments and to act as the key link for transferring information between health agencies.

55. This was a finding from a review in which the mental ill-health of the mother of a young child was a significant factor. The serious case review highlighted difficulties that had arisen because the mother had not taken up the services that had been offered. Among the lessons learnt was the recognition that agencies should have reconsidered the level and form of interventions for the mother. The review acknowledged what it described as 'professional drift'. It concluded that the intermittent contact with the family was accepted as being adequate when, with hindsight, it had not been good enough.

56. A rather different criticism from one review was that professionals' decision-making relied on choices made by the young person and that this was 'usually justification for a lack of action'. The case concerned a teenager who died after choosing to live on the streets rather than with her grandparents or her father. The review considered her right to make decisions but concluded that she should not have been allowed to make a choice that was so obviously damaging. It found that what it called 'self-determination' by the girl was often limited to situations where the young person made a choice about not having a service. These were decisions that did not involve any resources being provided. The review felt that 'self-determination' had been applied inconsistently and only when it justified a lack of action.

Using all sources of information

57. Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. In particular, there were gaps in considering:

- the child's views
- information from or about fathers, whether living in the home or elsewhere, and other adults living in the home
- contributions from the extended family
- historical knowledge about members of the family
- relevant information from other agencies involved with the family
- the cultural background of the family
- research findings about abuse, neglect, domestic violence and substance misuse, where they were relevant to the particular case.

58. Sometimes the lessons were about gathering information, but at other times they were about its accuracy, its availability to those involved with the families or to those attending meetings about the families, how it was shared or the ways in which it was used. There were also lessons about whether the correct

balance had been achieved when there were different, and sometimes conflicting, sources of information.

59. Previous Ofsted reports have highlighted what has too often been the lack of focus on the child. This continues to be one of the lessons learnt. One case provides a good example of missed opportunities for listening to the views of young people. The case concerned a 12-year-old girl whose mother had a long history of drug misuse. The girl suffered a serious sexual attack by an adult male known to her mother. A key lesson from the review was that staff had not taken adequate steps to establish the wishes and feelings of the girl.

60. The writer of the overview report from this case found that the girl 'was only consulted on one occasion and she made her feelings known very clearly, stating that she wanted her mother to be off drugs so that she could go to school properly, not have to look after her mother and not be bullied about her mother's drug use. The fact that her views shout out so clearly from this one intervention highlights the importance of making concerted efforts to talk to children on their own and making sure that their views are given proper weight. As a result of these shortcomings, she was left in circumstances where she was vulnerable to the serious sexual attack.'

61. By contrast, there are instances of contrasting conclusions from other reviews, where too much attention had been paid to the child's views, without sufficient consideration of other factors. One young person, who had been asked to leave the family home by his father and had been living in hostels following a period of homelessness, took his own life. He had also made a previous suicide attempt. Agencies had taken a decision not to approach his family, and in particular his father, as the young man had insisted that he did not want his father to be informed about his whereabouts or his circumstances. All agencies had respected his wishes. The review found that staff should have struck a balance between his wishes and his position as a vulnerable young person who was increasingly at risk.

62. Many of the serious case reviews commented on the lack of attention to the role of fathers and what was known about them. This concern also related to fathers who were not living in the family home and to other male adults involved with the family.

63. A serious case review that illustrated this concern was about two boys whose mother acknowledged that she had a problem relating to misuse of alcohol. However, this was not assessed to see whether it was a significant issue. The link was not made between her alcohol misuse and her capacity to act as a parent to the children. The review found that agencies involved had not taken sufficient notice of the father's concerns about his partner's drinking.

64. Another common theme from many of the reviews was that there was a tendency to 'start again' and not give sufficient weight to what had already been known about the families, despite many indicators that the parents were

themselves vulnerable, had long histories of involvement with local services and posed risks in bringing up their children.[7]

65. One example concerned a family in which both parents had a long history of drug misuse. Support, advice and clinical services had been provided by the local drug service. A serious case review carried out after the death of their baby concluded that 'whenever any professional is working with an adult, they must see the adult as a parent also and consider the needs of their children and the impact of the parent's or carer's circumstances. Understanding the background history and context of the adult should enable the professionals to assess the needs of the child more effectively and to share information appropriately.'

66. A related finding from this year's reviews was about agencies working with the parents which had concentrated on the adults' own needs and had not given sufficient consideration to the adults' roles as parents. Probation services, drug and alcohol services and housing services, in particular, had often overlooked the parenting capacity of their clients or had not recognised the service's important potential contribution to decision-making about the safeguarding of their clients' children.

67. One such case was about a baby who died from sudden unexpected death in infancy. The mother had suffered domestic violence, was misusing substances and had mental health difficulties. One of the review's key findings was about the involvement of professionals with the baby's mother. The Local Safeguarding Children Board concluded that 'the adult mental health services took little account of the fact that she was a parent or of how her mental health difficulties would have had an impact upon her parenting abilities. Instead of taking a holistic approach, and looking at safeguarding in a wider context, the mental health services had a predominantly adult focus.'

68. The summary of the family backgrounds in this report (paragraphs 20–24) underlines the complex range of factors in many of the cases. The cumulative effect of these factors was seen in many of the cases and was reflected in the lessons learnt. For example, one of the reviews echoed the findings about the importance of professionals understanding the relationship between alcohol misuse, domestic abuse, violent offending and the risk of harm to children. The review found 'information was held separately by professionals and concerns tended to be viewed as separate events rather than as an emerging picture…

[7] Ofsted reported similarly about timeliness of assessment in *The special educational needs and disability review*: 'Timeliness was often adversely affected when re-assessments were carried out because of a lack of trust in an assessment undertaken by colleagues or previous providers… This lack of professional trust often led to full re-assessments rather than work with the original assessment and review of it when appropriate. Full re-assessment was time-consuming; it also diverted resources away from what might have been quicker, more flexible interventions, as well as improvements to existing provision.'

Early opportunities to coordinate a multi-agency response and provide support, which may have helped to prevent the escalation of problems, were missed.'

69. A similar message was that agencies did not take into account the whole picture because of a focus on information about one element of a child's needs at the expense of others. For example, in one serious case review about a disabled girl who was from a Pakistani background, the executive summary commented on the fact that the professionals never seemed to explore or understand the meaning of disability in a family recently arrived from Pakistan.

70. In a different case, the focus was on a young boy's disability rather than on the associated neglect. He had complex health needs due to cerebral palsy. In the review carried out following his death, a key area of learning was about the lack of identification of signs of possible neglect. There had been a failure to attend appointments for essential therapies and for review of his needs. The review considered this to be neglect by his parents. It was felt that professionals had been so focused on his complex health needs that they had not been attuned to the possibility of neglect.

Carrying out assessments effectively

71. Lessons about the use of relevant information, set out in the previous section, also had an impact on the effectiveness of assessments. Previous reports by Ofsted on serious case reviews have highlighted concerns about assessment. Many of these concerns were also found in this year's reviews. Findings included:

- cases where no assessment had been carried out, but where there should have been one
- poor-quality assessments which overlooked some information, did not take account of everything that was available or did not balance the information appropriately when assessing risk and making decisions
- a tendency to respond to each situation individually rather than assessing the whole context or looking at the cumulative effect of a series of incidents or pieces of information
- a lack of a dynamic response to new and changing information
- assessments which resulted in inappropriate plans or did not lead to action to tackle the concerns.

72. As this report has highlighted, a large proportion of serious case reviews are about serious incidents affecting babies and very young children. Consideration of the pre- and post-birth assessments features strongly in many of these reviews, including cases where no such assessment had been carried out.

73. One such case concerned a young child who suffered a serious injury. The mother was a teenage parent. She and her partner were vulnerable young people with complex personal histories. They had both been excluded from

school and exhibited a large number of adolescent anti-social and risk-taking behaviours, including a resistance to some interventions from services which had tried to offer support. The review found that agencies had not sufficiently recognised and responded to the mother's vulnerability, especially as she was also contending with the care of an infant and the risk of violence from her partner. One of the lessons learnt was that a mistake had been made in viewing the case as low-level. There should have been a comprehensive pre- and post-birth parenting assessment and the baby's father should have been part of this assessment.

74. In other instances an assessment had been carried out but it had been of poor quality. One of the serious case reviews followed the fatal stabbing of the mother by the father. Two children in the family had previously been taken into care but the two younger ones had remained with the mother. The review concluded that a fundamental failure was that those involved in taking decisions had not asked what had changed since the older two children had been taken into care. A lesson learnt was that a poor assessment had led to an ineffective child protection plan. The assessment had overemphasised the parenting abilities of the mother and had not paid sufficient attention to the non-compliance of the father, who had a history of domestic violence, in staying away from the mother.

75. There were also assessments which failed to consider the racial, cultural or religious background of the family. For example, a review about the death of a Black British child, who had been found hanging in his bedroom, concluded that these aspects of the case had largely been ignored. The review found that there had been no assessment of how or if these factors had had an impact on the care of the children. The mother described herself as a strict parent and it was clear that she was ambitious for her children. Part of the learning from the review was that these features had brought her into conflict with her children.

76. In another case, the lesson learnt also included an issue about equalities, but this time it arose from the young person's disability. The review process revealed concerns about the nature of some professionals' attitudes about work with disabled children. It concluded: 'The evidence of a reluctance to feed the young person appropriately in order to keep her weight down so she could be carried [by parents] was not responded to with the urgency and robustness that would have been the case for non-disabled peers… Although similar concerns continued to mount, it took another three years before she was made the subject of a child protection plan.'

77. A common finding, also reported in previous Ofsted reports, was that none of the main agencies had a complete picture of the child's family or a full record of the concerns. Holistic assessments of risk were not made routinely in these cases and agencies tended to respond reactively to each situation rather than having seen the whole context.

78. This concern was illustrated in a review about a family of six children who had all been made the subject of care orders. The Local Safeguarding Children Board recognised that the needs of individual children had sometimes become lost in this large family, which had complex needs. At key points the professionals had not obtained and evaluated the full case history. They had repeatedly made assessments relating to the one child they were dealing with at that point, rather than analysing the overall pattern of care provided for all the children in the family. A finding of the review was that the agencies involved had often gone over the same ground rather than taking decisive legal intervention at an earlier stage.

79. While the previous example concerned a large and complex family, there were similar findings in cases that involved only one child or young person. Assessments needed to consider the cumulative effect over a period of time of a series of incidents or pieces of information. In the case of a pregnant girl who died as result of injuries when jumping from a bridge, a lesson learnt was that the full profile of risks had not been properly understood and practice had tended to focus on managing incidents rather than analysing the whole picture. The girl was a looked after young person; she had been excluded from school; she had self-harmed and abused alcohol and drugs; and there had been numerous placement breakdowns. The review recognised that the social workers had always gone 'the extra mile', but they had not been able to stand back, understand the meaning of the young person's behaviour and move beyond an incident-led approach.

80. A further finding was the need for assessments to be responsive to new information and to be alert to changing circumstances. One case concerned a family in which the children were subject to child protection plans because of sexual abuse by a previous partner of the mother. The oldest child gave birth to a baby who had been fathered by the mother's latest partner. A key lesson learnt in this review was the danger of assuming that because one perpetrator of abuse had been imprisoned, the children would be safe from further harm.

81. Assessments also needed to be revised when existing support was not making a difference. One of the cases concerned the drowning in a bath of a young girl. The review was critical of agencies for failing to recognise the extent of the mother's mental ill-health and for not devising more appropriate interventions when the family support measures were not working. The overview report commented upon 'the failure to understand that assessment is a dynamic process and that new information needs to be constantly analysed to allow reconsideration of the original assessment'.

Implementing effective multi-agency working

82. The reviews highlighted the need for effective multi-agency working and the important shortcomings when things went wrong. Where practice was found to be inadequate, concerns included:

- poor communication
- failure to include key professionals or agencies
- insufficient training or engagement of some professionals
- ineffective meetings
- incomplete record-keeping
- a lack of follow-up of the agreed actions.

83. Previous Ofsted reports have commented on concerns about poor communication either within agencies, for example between different parts of the health service, between different agencies, or from one local authority to another. When serious incidents occurred, weaknesses were found in the systems used by agencies to communicate information at key points in children's lives. For example, the transfer of information from the GP to the midwifery service and then to the health visiting service was not sufficiently reliable. There were also concerns about poor communication between specialist children's services, such as child and adolescent mental health services, and universal services such as individual schools.

84. The impact of poor communication was illustrated in one of the serious case reviews: 'There was a lack of effective and consistent communication by the police with children's social care, arising from contacts the police had with various family members. There were many occasions when incidents that suggested the children were at risk of immediate or potential harm were either not communicated strongly enough or were not communicated at all. Each incident was seen by the police as a one-off event.'

85. Among the lessons learnt was the importance of ensuring that all the relevant professionals were invited to meetings and the need to keep under regular consideration the list of those invited to attend for each specific case. Although GPs, for example, often find it hard to attend, this was not a reason for failing to request information from them.

86. One review where this had been a significant concern summarised what had gone wrong: '…the child protection conferences were poorly organised and equally poorly attended. Some agencies were not invited that should have been, others were invited and did not attend and there is little or no evidence to suggest that those who failed to attend supplied reports to inform the conference. Because of lack of commitment, conferences were adjourned through lack of attendance… and were often in breach of local and national guidance to form the required quorum.' The review noted that there was no quorum at the meeting which decided that the teenager who was the subject of the review no longer needed to be the subject of a child protection plan.

87. Another essential element of good meetings and conferences is effective chairing. Where this was not sufficiently robust, it had a significant effect on multi-agency working. For example, the conclusion of one serious case review

found that child protection case conferences had not been chaired with the level of expertise expected. The Local Safeguarding Children Board recognised that the role of the chair is crucial in ensuring that there is expert guidance, adherence to procedures, and assessments of the highest quality which have children as the central focus. A lesson learnt from the review was that this had not been the case and that the conference chair had been wrong in not considering the child concerned as a child at risk. One of the recommendations from the review was a skills audit of the child protection conference chairs.

88. Another message from this year's reviews was the need for some agencies, particularly the probation service and housing services, to recognise their important role in contributing to the safeguarding of children.

89. The importance of the probation service's contribution was seen, for example, in a case in which the service had not informed some of the professionals working with the family about the father's previous custodial sentence for violence at an early enough stage. Work by the probation service had been carried out separately from attempts by other services to tackle the parents' alcohol problems. The Local Safeguarding Children Board recommended that the probation service should reinforce its responsibility to contribute to the safeguarding of children when carrying out its primary responsibility for the supervision of offenders in the community. The recommendation underlined the need to assess offenders who are parents or carers on the risks to their parenting capacity and to the safety of children, and to consider joint work with others involved in safeguarding children.

90. An extension of this key message was that contributors from different agencies needed to do more than simply be involved; they needed to be fully engaged in the case. One executive summary gave a good analogy. 'Child Protection is like a relay race: a professional's responsibility to communicate information, or transfer a responsibility only ceases when they are satisfied that not only have they passed on the "baton" (be it information, a referral or feedback) but they have also ensured that it has been received by someone who has acknowledged and accepted the responsibility for taking things forward, and is confirmed to be doing so.'

91. A related message was that those receiving information and referrals also have a responsibility for following them up. This was the finding of a review carried out after the death of a disabled girl following what was expected to be a routine operation. Practitioners from health and education had made previous referrals to children's social care raising concerns that the girl was experiencing neglect. These had not initially met the thresholds for intervention under child protection plans.

92. One of the lessons learnt in this case was that there needed to be a consistent approach in such circumstances. 'Any referrer to children's social care should be informed of what action is being taken as a result of their referral and where no action is considered appropriate. There can be a tendency for professionals to

believe that once they have passed on their concern to social care, the need for their vigilance can be reduced. They may also fail to refer again if they believe their concerns are not being taken seriously.'

93. In some cases, there were lessons learnt about several elements of multi-agency working which had a cumulative effect. For a young man who was found hanged in a youth offender institution, a range of concerns emerged from the serious case review. A key finding was that there was little evidence that agencies had worked collaboratively in an organised fashion. There was a recognition that there had been: a failure to consider early intervention to prevent offending when the boy first got into trouble; long delays before a child in need meeting was convened; the absence of any systematic follow-up to the child in need meeting despite requests by agencies to the children and young people's service; and poor inter-agency communication, understanding and sense of shared responsibility.

Valuing challenge, supervision and scrutiny

94. A recurring theme in the reviews is that there had been insufficient challenge by those involved in the case. There were four interrelated aspects of the need for greater challenge:

- not accepting at face value what the parents or others in the family said
- questioning by individual professionals and agencies of their own and others' views, decisions and actions
- ensuring that there was effective supervision and intervention by managers
- monitoring and scrutiny of work by the Local Safeguarding Children Board.

95. The first of these has been highlighted in previous Ofsted reports. Parents' explanations for bruising and other injuries were too readily accepted by health practitioners, without further examination of the child or consultation with named child protection doctors or nurses. This failing particularly applied to very young children, especially babies who were not yet at the stage of walking. Similarly, social care staff often found it difficult to identify chronic neglect because of parents' feigned compliance with social work interventions.

96. A frequent lesson from the reviews was that practitioners had been affected by what is known as the 'rule of optimism'. This is a tendency by social workers and healthcare workers towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on adults' strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view. They confuse participation by parents with cooperation.

97. One such lesson was found in a review where those involved with the family had mistaken the limited evidence of good interaction between the caregiver and her children as demonstration of secure attachment. The Local Safeguarding Children Board reached the view that: 'Objectivity was lost,

scepticism was decried and professionals allowed their hopes and positive beliefs to countermand the evidence before their own eyes.'

98. The effect of the rule of optimism in such cases was that parents were not challenged sufficiently. This was a lesson from a review that followed the death of a baby whose family was part of a culture of drug misuse. The mother was well presented, articulate and described by some professionals as 'a lovely girl'. This led them to accept at face value statements that she made about her level of drug misuse and her ability to care for and protect her children. The review concluded: 'Professionals must be prepared to challenge information, whether from a parent, carer, relative or other professional in order to establish the difference between facts, hearsay and opinion. Records should state clearly what the evidence is for any statement or assessment.'

99. A related finding was the need for practitioners to maintain a dispassionate view. One executive summary illustrated this: 'The parents were very young and had some very troubled personal family histories. This meant that some workers in some agencies tended to over-empathise with the parents and believe what they said, rather than checking their statements out thoroughly. This was particularly true in terms of believing what these young people said about where they were living and with whom they were living. Some agencies were too optimistic about how this family could manage their difficulties and lost sight of the risks that they posed.'

100. One review gave a revealing explanation of why parents' statements and actions had not been challenged sufficiently often and why, as a result, the abuse had continued over two generations, affecting three children who were now adults and their seven children. The executive summary expressed the view that: 'Professionals worked hard to be accepted by the family and to stay on the right side of them in the belief that only by doing so would they gain access to the children to be able to provide the necessary services to them.'

101. Some of the reviews identified a second form of challenge which had been inadequate. This was the absence of rigorous questioning by professionals of accepted views about the family, of the decisions being taken and of the action being planned. These shortcomings related to a lack of challenge both within and between agencies, insufficient persistence if the initial questioning did not receive the necessary response, and a failure to hold others to account for doing or not doing what they said they would do.

102. The review mentioned above about abuse within a family over two generations also illustrates the importance of this form of challenge and the impact when it did not take place. In this case, nearly all of the services involved with the family suspected, or were aware of the suspicions, that incest was taking place. One of the lessons learnt was about the need, in the words of the review, 'to respectfully challenge' and to have the tenacity to see things through. The executive summary said: 'It only needed one person to have analysed the situation effectively and recognised the need to take the appropriate action and

to have the tenacity to ensure that it happens... The necessary action to protect a child or vulnerable young person or adult was to escalate concerns at a managerial level between agencies. This option was not used as much as it should have been in this case and all too often practitioners failed to challenge their colleagues.'

103. This case also mentioned a third kind of challenge that had sometimes been missing. Agencies found instances where there had been a lack of management oversight and supervision. These gaps were significant because they could have provided opportunities for those involved to reflect on their practice, for professional challenge to the practitioners, and for influencing changes in decisions about individual children and their families.

104. The absence of this kind of challenge by a manager was a factor, for example, in a review about a baby who had suffered multiple fractures. One of the conclusions was that the social care and health services had not engaged effectively with the father and knew very little about him. Services had 'assumed, without question or any evidential basis, that he was a responsible and stabilising influence on the mother… It is likely that, with the benefit of a high-quality professional practice, supported by robust management oversight and good agency systems, it would have been difficult for risks to the child to be so seriously misjudged.'

105. There was a similar finding from a review in which one of the lessons was the need for more sophisticated understanding of cultural issues. In this case the family had been seen as 'Muslim'. Workers had failed to detect or understand the significance of the tensions within the family as a result of the husband's rejection of various aspects of the religion which were important to his wife. A conclusion of the review was that: 'All professionals need to be challenged within supervision to ensure that they are not making assumptions about culture or religion and are taking account of differences within family units.'

106. The fourth type of challenge is the need for Local Safeguarding Children Boards to play a vigorous role in monitoring, scrutinising whether action is being taken and taking further action themselves if they identify any failings. This was well expressed by one Serious Case Review Panel in its executive summary. It stated that its principal concern in framing its recommendations had been 'to ensure that the role of the Local Safeguarding Children Board is strengthened so that it can monitor the work of all agencies with safeguarding responsibilities; that reforms that have already been made are consistently implemented; and that the further improvements that are needed in the work of agencies to protect children are made'.

The quality of the serious case reviews

Overall judgements

107. Ofsted's previous reports on serious case reviews highlighted concerns about the quality of the reviews. This section focuses on the evaluations of the reviews completed between April 2009 and March 2010 and on some of the factors that have contributed to the judgements. Table 2 shows the overall judgements made for all reviews evaluated since April 2007.

Table 2: Number of judgements for serious case reviews evaluated by Ofsted 2007–2010

Period	Outstanding	Good	Adequate	Inadequate	Total SCRs
April 07 - March 08	0	12	18	20	50
April 08 - March 09	0	40	74	59	173
April 09 - March 10	0	62	62	23	147

108. For the reviews covered by this report, 124 out of the 147 reviews (84%) were judged as adequate or better; 23 (16%) were judged to be inadequate. Sixty-two reviews (42%) were judged to be good. There were no outstanding reviews. Although it is not appropriate to make statistical comparisons with previous years, the table indicates an improving situation.

109. While this progress reflects the high level of attention that has been given to serious case reviews, nationally and by most Local Safeguarding Children Boards, it is still of concern that inspectors found 23 reviews evaluated during this period to be inadequate. The depth of learning in those serious case reviews that were judged inadequate was limited by a number of factors. In a majority of them, the terms of reference were not sufficiently focused and were judged inadequate; the quality of the individual management reviews was variable; and the majority of the overview reports were judged inadequate, mainly because the information considered was not analysed or challenged sufficiently.

Terms of reference

110. Ofsted's previous reports have emphasised the importance of good terms of reference for serious case reviews. Appropriate and clear terms of reference are an essential base for effective reviews. During the period covered by this report, there were seven examples of terms of reference which were judged to be outstanding.

111. There is a strong relationship between the quality of the terms of reference and the overall judgement. In 97 of the 147 reviews, the overall judgements were the same as those given for the quality of the terms of reference. Only 23 overall judgements exceeded the terms of reference judgements and, with one exception, this was by one grade only.

Overview reports and individual management reports

112. The overview report has a critical impact on the overall quality of the serious case review. The skills of the author of the overview report in challenging the content and findings of individual management reports, and also in ensuring that the overview report compensates for any identified deficiencies, can be the key to maximising the depth of learning from the review.

113. This year, 19 overview reports were judged to be outstanding. These reports provided incisive commentaries and interpretations of the actions taken and those that should have been taken. They highlighted omissions in practice and were also critical about matters that should have been dealt with in the individual management reports.

114. In the best examples, the overview report explored the terms of reference in depth and made good use of research and learning from other serious case reviews. This year there have been examples of Local Safeguarding Children Boards making recommendations which were based on the findings of more than one review from their authority and auditing the outcomes of all their recent serious case reviews.

115. Previous Ofsted reports have commented on concerns about the independence of elements of the process, including the selection of the overview report writers, the chairs of the Serious Case Review Panels and the writers of individual management reports. In the majority of cases, this is no longer a concern. Local Safeguarding Children Boards have found a variety of ways of achieving the required level of independence.

116. Occasional concerns have sometimes arisen when one or more of the individual management report writers had previously been involved with the case or had had line management responsibility for a practitioner. For example, there was a lack of independence in cases where individual management reports had been written by a GP from the same practice as the doctor who had been dealing with the families concerned.

117. However, there have also been innovative approaches to deal with the challenges of ensuring sufficient independence, such as the approach taken by a teenage pregnancy service which was too small to be able to have a wholly independent report writer. Instead, the service ensured that there was peer oversight of the individual management report, followed by independent external validation.

118. The quality of individual management reports was variable. Some of the best features of the reports this year were when there was:

    - a common format provided by the Serious Case Review Panel to each agency (for example, a template with a front sheet which had to be signed off by the senior manager of the agency)

- evidence that was based on, or supplemented by, interviews with those involved, rather than depending upon information in case files
- a child-focused approach (for example, a report from a police service which analysed the effect of domestic violence from the child's viewpoint)
- the use of independent specialist advice when this provided something additional to the other reports, for example in relation to cultural background, disabilities or medical conditions
- a comprehensive and rigorous analysis of events
- an integrated report from health services (sometimes referred to as a health overview report), especially where there were many separate health reports (the best examples being not simply collations of the individual reports, but drawing out the important messages from them)
- a willingness to be self-critical, to acknowledge what had gone wrong and how this would be corrected to reduce the likelihood of any repetition of the mistakes
- good use of research and the findings of previous serious case reviews, including those carried out by the same Local Safeguarding Children Board, to help reach appropriate conclusions
- involvement of the family in the review process (considered in more detail below)
- consideration of the family's ethnic, cultural, linguistic and religious background, and of any factors relating to disability (also considered in detail below).

Timescales

119. Previous Ofsted reports have highlighted concerns about the time taken to complete serious case reviews. Local Safeguarding Children Boards are required to decide whether a serious case review should be conducted and to begin the review process within one month of being informed of the incident. The review should be completed within six months of the date when it was started.

120. The standard for beginning the serious case review within one month of the notification of the incident was met in 87 of the 147 cases. In some instances, the decision was made within a few days of the death of a child or other serious incident; in one case it was made on the same day.

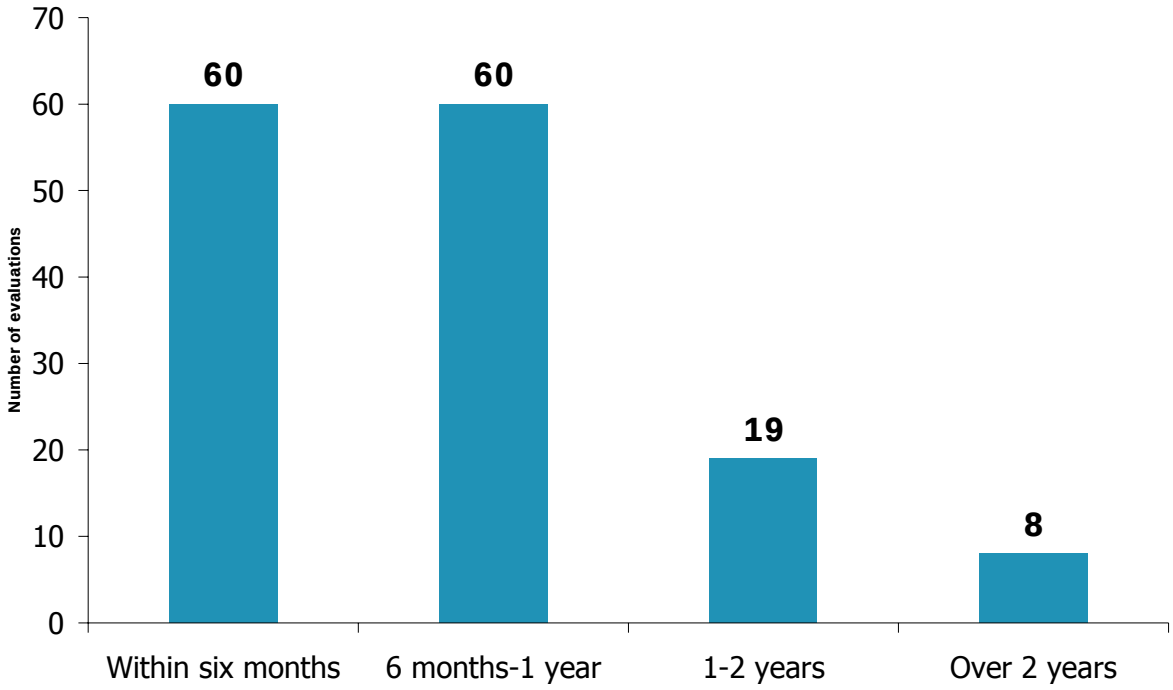
121. The two main reasons for not making a decision within a month were:

- delays while the outcomes of police investigations, forensic tests or inquest findings were awaited
- the arrival of new information which changed the original decision of the Local Safeguarding Children Board. (Sometimes there was initial uncertainty

about whether the criteria for carrying out a review had been met and the Serious Case Review Panel decided to await further information.)

122. Figure 3 shows the time taken for completion of the reviews. Sixty out of the 149 reviews met the six-month timescale established in the most recent revision of *Working together*; 60 took between six and 12 months; 19 between one and two years; and eight over two years.

Figure 3: Time taken to complete serious case reviews, April 2009–March 2010



123. There were four main reasons for delay in completing the reviews.

124. In some cases there were unresolved formal processes arising from the incident that instigated the review, including criminal proceedings, delayed inquests and pending care proceedings. There was concern that the serious case review might prejudice the hearings and it was felt that the family might be more willing to contribute once other matters had been concluded. In some cases, the overview report recognised that too much weight had been given to this consideration and that the review should have been completed more speedily.

125. In other cases, the delay resulted from the complexity of the case. In the more complex ones, there were often many individual management reports, or it was necessary to coordinate the process across more than one Local Safeguarding Children Board.

126. Some delays resulted from a concern about ensuring that the overview report and the individual management reports were of sufficiently high quality. There were reviews where the Serious Case Review Panel changed the overview report writer during the review process as a result of its concerns, and others

where writers of individual management reports were asked to improve or amend what they had submitted.

127. Practical difficulties, such as delays in finding a suitable writer for an overview report, some agencies' problems in obtaining access to necessary records, illness of writers of reports, and infrequency of meetings of the review panel or the Local Safeguarding Children Board, resulted in delays in some cases. These delays, which had a knock-on effect on the overall process, are a significant cause for concern.

128. Table 3 shows the relationship between the time taken to complete the reviews and their quality. The figures show no significant pattern. A longer period did not necessarily lead to an improvement in quality. There were also 11 reviews that met the timescale but were judged to be inadequate.

Table 3: Time taken to complete reviews and their quality, April 2009–March 2010

SCR evaluation	Under 6 months	6 months to 1 year	1 to 2 years	2+ years
Good	30	24	7	1
Adequate	19	30	9	4
Inadequate	11	6	3	3

Equality and diversity

129. Ofsted's previous reports on serious case reviews identified concerns about the lack of consideration of race, language, culture and religion. An uneven pattern was found in the reviews covered by this report. Many did not consider the issues sufficiently; others focused too much on one aspect, for example not giving attention to religion or culture. Individual management reports were found not to have dealt with relevant matters of equality and diversity in sufficient detail. There were examples where this shortcoming was recognised by the overview report, which attempted to compensate for the omissions in the reports from individual agencies.

130. In the best examples, the terms of reference were clear about how the review would consider equality and diversity. In some cases, these were included as part of a template for individual management report writers and consideration was given to the need for interpreters. In a review about a family of mixed race, the Local Safeguarding Children Board decided, as there was no appropriate minority ethnic representative on the Serious Case Review Panel, to commission an independent report to consider issues of ethnicity, language, culture and religion.

131. There were examples where race, language, culture and religion were dealt with sensitively, which increased the learning from the review. One such case

examined whether the parents' alleged racism had affected how services had been provided. In another case, a report from a council's legal service looked at whether cultural issues may have diverted practitioners' attention away from concentrating on basic welfare concerns about the child. A further example of good practice was a review which considered how the matching process had been followed for a White British girl who was fostered by a Black foster carer.

132. One positive example concerned a Polish family. Extra reports were commissioned by the Serious Case Review Panel to provide background information about the development of the Polish community in the local area, as well as a report explaining maternity services and benefits in Poland, in order to increase the understanding of the family's perspective when reaching conclusions.

133. In other reviews, there was a general assumption that, if the family was White British, there were no cultural issues to be considered. This approach overlooked consideration of the norms and traditions of particular families or communities, the role of the extended family, and the use of language in the families. Good examples included consideration of the low expectations of the area in which the family lived. One review gave particular attention to the desensitisation of practitioners who worked in areas with a high level of domestic violence, substance misuse and mental ill-health, and the importance of being able to identify the most vulnerable children and families as a result.

134. As found in previous Ofsted reports, the disability of children or family members was usually considered only when the subject of the review was a disabled child. There was little consideration of the full impact when siblings were disabled or when parents had a learning disability or suffered from mental ill-health. This was particularly the case for families where older children were young carers.

135. Where disability was addressed well, there was consideration of the need to improve communication with disabled children, of the impact of parents' mental ill-health on their children, of the implications of children's special educational needs and/or disability or long-term medical conditions, and of the effect of poor attendance at therapy sessions or at school.

Family involvement

136. *Working together to safeguard children* recommends that serious case review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'.

137. Previous Ofsted reports, including the mid-year report for 2009–10, found that this aspect of the process was underdeveloped, especially in the way that the contribution of family members was recorded. The position is now improving. In the first half of the year covered by this report, just over a third of the reviews made no reference to family involvement. By contrast, of the 63 serious

case reviews completed in the second half of the year, October 2009 to March 2010, there were only three reviews in which there was no reference to the involvement of the family.

138. In 16 out of 147 reviews this year, a clear decision was made not to involve family members in the process. This was usually because criminal or care proceedings were still in progress and, in one case, because the parent was compulsorily detained under mental health legislation.

139. When parents and other family members were invited to contribute, many did not respond or made a decision not to give their views. Again, there is evidence of some progress. Whereas in the first half of the year only 11 parents responded positively to the opportunity to participate, in 32 out of 63 cases in the second half of the year there were responses from family members.

140. Contributions were made not only by parents but also by grandparents, a step-father, a brother and a respite carer. In some cases there were omissions in contacting other family members who might have been able to make useful contributions, including siblings, the extended family and ex-partners of the parents. It is not always clear why some family members were not invited to participate, particularly when grandparents had played a significant part in children's lives.

141. The effort that Local Safeguarding Children Boards put into encouraging family involvement varied considerably. The methods ranged from letters inviting contributions to more personal contact by the overview writer. Repeated offers for a meeting sometimes secured a positive response. Reliance on letters to obtain a response was often insufficient.

142. In cases where participation by family members happened early in the review process, it sometimes raised matters that were addressed in individual management reports. For example, questions put forward by the grandmother of one of the children helped to shape the questions that were considered as part of that serious case review.

143. There were examples that showed the great efforts of some Serious Case Review Panels and overview report writers to involve the family. In one case the father was interviewed by the chair of the panel in prison; in another case the brother's interview took place at a young offender institution; one family chose to give their views to the social worker with whom they had established a relationship; with another family, a home visit was arranged with a community paediatrician, a family health visitor, the police and an interpreter.

144. One case illustrated the achievement of outstanding family engagement in the review process. The family was informed and consulted about the review as soon as the process began. The review analysis benefited from contributions by the mother, the stepfather, the child's father and the child himself. The contributions were based on the overview report writer's direct contact with

each individual. The author also considered matters relating to the family's ethnic, cultural, linguistic and religious needs and reached conclusions about how the services had met these aspects of the family's background.

145. In the best examples, there was far more than a tokenistic response to the requirements of *Working together*: the views of the family were woven into the final report and had an influence on its findings. It was not sufficient, as happened in one serious case review, to add parental views as an appendix without referring to these views in the body of the report. By contrast, in a case where the overview report was judged to be outstanding, there was an excellent account of the parents' contributions, including the mother's retrospective views about being allowed to care for her baby. Information from a meeting with the father provided an account of his background. This filled in many of the gaps that the individual management reports had been unable to address. The overview report was able to reflect on the comments made by the father about the involvement of services.

146. Only 15 reviews indicated clearly that the Local Safeguarding Children Board had tried to involve children and young people. In nine cases this opportunity was taken up, including three instances as part of the wider involvement with other members of the family. Two of the children wished that they had been removed from home earlier. Another young person made useful contributions to the review and made a request that his father and stepmother should not be asked their views because of his fear of retribution. This request was respected.

147. Where there was good practice, the Local Safeguarding Children Boards also arranged to explain the outcomes of the serious case review to family members in advance of the publication of the executive summary and provided appropriate support during this part of the process.

Annex A: Working together to safeguard children

The previous guidance on *Working together to safeguard children* said that where a child dies and abuse or neglect is known or suspected, the Local Safeguarding Children Board must conduct a serious case review.[8] It must also consider conducting a serious case review where:

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

The purpose of a serious case review is:

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

[8] *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, TSO, 2006; updated 2010; www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/.

Annex B: The 147 serious case reviews

Local Safeguarding Children Board	Serious case review evaluation	Date of evaluation letter
Barnet	Adequate	09/02/2010
Bexley	Good	29/07/2009
Bexley	Good	17/11/2009
Birmingham	Adequate	01/05/2009
Birmingham	Adequate	01/05/2009
Birmingham	Adequate	17/09/2009
Birmingham	Inadequate	11/01/2010
Blackburn with Darwen	Inadequate	30/04/2009
Blackburn with Darwen	Inadequate	14/05/2009
Blackburn with Darwen	Good	05/10/2009
Bolton	Good	07/12/2009
Brent	Adequate	13/05/2009
Brent	Good	28/01/2010
Bromley	Adequate	30/04/2009
Buckinghamshire	Adequate	29/12/2009
Buckinghamshire	Adequate	05/03/2010
Calderdale	Good	25/11/2009
Camden	Adequate	06/07/2009
Cheshire	Inadequate	20/05/2009
Cheshire East	Inadequate	12/06/2009
Cheshire West and Chester	Inadequate	26/03/2010
Cornwall	Good	12/03/2010
Cornwall	Adequate	25/03/2010
Coventry	Adequate	15/05/2009
Cumbria	Inadequate	30/06/2009
Derby City	Adequate	16/03/2010
Devon	Inadequate	09/04/2009
Doncaster	Good	20/05/2009
Doncaster	Good	21/05/2009
Doncaster	Adequate	27/10/2009
Doncaster	Good	15/01/2010
Dorset	Good	01/05/2009

Dorset	Adequate	15/06/2009
Dudley	Good	15/05/2009
Durham	Good	14/05/2009
Durham	Adequate	21/09/2009
Durham	Good	15/12/2009
Ealing	Adequate	05/10/2009
Ealing	Inadequate	18/02/2010
East Sussex	Inadequate	12/06/2009
East Sussex	Inadequate	12/10/2009
Essex	Adequate	29/04/2009
Essex	Adequate	04/08/2009
Gateshead	Adequate	13/01/2010
Gloucestershire	Adequate	09/04/2009
Greenwich	Good	03/08/2009
Greenwich	Good	14/08/2009
Halton	Good	06/07/2009
Hampshire	Adequate	14/07/2009
Hampshire	Good	04/01/2010
Hampshire	Inadequate	23/04/2009
Haringey	Good	07/04/2009
Haringey	Adequate	10/09/2009
Haringey	Good	18/12/2009
Haringey	Good	05/10/2009
Hartlepool	Good	22/10/2009
Havering	Good	23/09/2009
Herefordshire	Good	18/03/2010
Herefordshire	Adequate	29/03/2010
Hertfordshire	Adequate	15/09/2009
Hertfordshire	Adequate	11/03/2010
Hertfordshire	Good	11/03/2010
Kent	Good	09/10/2009
Kent	Good	16/12/2009
Kirklees	Adequate	23/04/2009
Kirklees	Adequate	11/08/2009
Kirklees	Good	15/09/2009

Kirklees	Good	23/09/2009
Knowsley	Good	08/06/2009
Knowsley	Adequate	08/06/2009
Lancashire	Adequate	03/08/2009
Lancashire	Adequate	18/09/2009
Lancashire	Adequate	28/09/2009
Lancashire	Inadequate	08/02/2010
Lancashire	Adequate	02/03/2010
Leeds	Good	05/05/2009
Leicester City	Adequate	12/10/2009
Leicester City	Adequate	30/11/2009
Leicestershire	Adequate	27/04/2009
Leicestershire	Adequate	29/12/2009
Leicestershire	Good	08/03/2010
Leicestershire	Good	12/03/2010
Lewisham	Good	06/10/2009
Lewisham	Good	06/10/2009
Lewisham	Adequate	01/03/2010
Lincolnshire	Inadequate	30/07/2009
Liverpool	Good	14/05/2009
Liverpool	Adequate	08/02/2010
Luton	Adequate	30/06/2009
Manchester	Good	15/05/2009
Manchester	Good	23/02/2010
Middlesbrough	Good	06/05/2009
Middlesbrough	Adequate	01/12/2009
Middlesbrough	Inadequate	04/03/2010
Middlesbrough	Good	09/03/2010
Milton Keynes	Good	27/04/2009
Newham	Good	02/10/2009
Newham	Good	17/03/2010
Norfolk	Adequate	30/04/2009
Norfolk	Good	11/01/2010
North East Lincolnshire	Inadequate	27/04/2009
North East Lincolnshire	Adequate	13/05/2009

North Somerset	Good	25/06/2009
North Tyneside	Adequate	15/04/2009
North Tyneside	Inadequate	04/06/2009
North Tyneside	Adequate	12/01/2010
Northumberland	Adequate	15/09/2009
Nottingham City	Adequate	21/01/2010
Oxfordshire	Adequate	12/10/2009
Oxfordshire	Adequate	25/11/2009
Oxfordshire	Good	05/03/2010
Peterborough	Adequate	07/08/2009
Poole	Good	14/08/2009
Reading	Adequate	17/03/2010
Reading	Adequate	24/03/2010
Redbridge	Adequate	01/12/2009
Redcar & Cleveland	Inadequate	06/07/2009
Redcar & Cleveland	Adequate	05/02/2010
Royal Borough of Windsor and Maidenhead	Good	25/06/2009
Salford	Adequate	03/07/2009
Sandwell	Adequate	29/04/2009
Sheffield	Good	03/02/2010
Shropshire	Good	03/08/2009
Slough	Good	09/02/2010
South Gloucestershire	Good	05/10/2009
Southampton	Adequate	30/04/2009
Southampton	Adequate	07/05/2009
Southend	Good	11/03/2010
Southwark	Good	29/07/2009
St Helen's	Good	19/11/2009
Staffordshire	Inadequate	30/04/2009
Stockton-on-Tees	Inadequate	26/06/2009
Sunderland	Adequate	08/06/2009
Surrey	Good	30/06/2009
Surrey	Good	15/09/2009
Sutton	Inadequate	26/08/2009
Sutton	Inadequate	26/08/2009

Tameside	Inadequate	30/07/2009
Torbay	Adequate	25/09/2009
Tower Hamlets	Good	30/04/2009
Wakefield	Adequate	06/05/2009
Wakefield	Good	15/05/2009
Waltham Forest	Good	03/03/2010
Westminster	Good	13/05/2009
Wigan	Good	12/08/2009
Wirral	Adequate	03/08/2009
Worcestershire	Adequate	11/08/2009