

Improving safeguarding practice

Study of serious case reviews
2001–2003

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Acknowledgements

We owe an enormous debt to many people who have worked with us in producing this second biennial analysis of serious case reviews, but we particularly wish to thank our commissioners, Jenny Gray OBE, policy adviser on safeguarding, and Caroline Thomas, Carolyn Davies and Nigel Gee, research managers in the Department for Education and Skills (now the Department for Children, Schools and Families), who gave us extensive support, and Colin Green, formerly Deputy Director, Child Protection Division of the Department for Education and Skills.

The research team was augmented by the expert assistance of Geoff Gurney in the analysis of reports, and by the technical expertise of Stewart Berry and Adam Seeley. We received generous responses from all those professional staff in children's services or (then) Area Child Protection Committees we approached for telephone interviews, to whom we are very grateful. Participants in a national study seminar on the emerging issues and in follow up discussions gave us stimulating, reflective and creative contributions from their wide experience and wisdom. The many people who have helped us include Ann Black, Stuart Bond, Mike Burns, Christine Christie, Helen Elliott, Barbara Firth, Nicola Francis, Ruth Gardner, Veronica Grant, Andrea Hickman, Christine Humphrey, Debbie Jones, David Lambert, Peter Maddocks, Jill Pedley, Claire Phillips, Arran Poyser, Sue Richards, Nigel Thompson, Catherine Warren, Katy Young and colleagues at NSPCC. Penny Wilkinson gave invaluable help during the study and in organising the study seminar in 2006, and Lesley Henderson provided ever willing administrative support from the Open University. The list is not exhaustive.

We shall always remember the children and families of the serious case reviews whose lives were contained in the pages of the reports we read, and we acknowledge with respect those professionals we encountered who are committed to improving safeguarding practice.

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Executive Summary

Introduction

The Government announced in 1999 that it would be commission overview reports of serious case reviews on a biennial basis to draw out key findings from the local reviews and identify their implications for policy and practice (Department of Health et al 1999). The overall aim of this second biennial study was to prepare an overview of findings from a selection of case reviews undertaken during 2001-2003.

Specific objectives were: to identify the key themes common to the recommendations; to ascertain whether case review reports resulted in action plans derived from the findings and if plans were implemented within the recommended timescales; to consider what helped or hindered their implementation; and to ascertain if review processes led to any changes in policy or practice at a local level. Finally an important objective was to identify from the reviews any lessons for policy and practice at a national level.

Key findings

- Serious case reviews make an important contribution to understanding what happens in circumstances of significant harm. Their effectiveness can be improved and there are examples of promising approaches using the findings of serious case reviews to bring about improvements in safeguarding practice. However, achieving such improvements require Local Safeguarding Children Boards to develop a much stronger learning culture within which serious case reviews are but one important source of knowledge for improving safeguarding practice.
- Older children as well as young children and babies, and children with additional or specific needs such as disabled children and their families are all subject to death or serious injury and their circumstances require careful monitoring by Local Safeguarding Children Boards.
- A notable number of children who were experiencing neglect in the context of a range of other family difficulties, and children living in circumstances where domestic violence prevailed, co-existing with other problems in their families such as substance misuse and mental ill health were the subject of Serious Case Reviews, indicating challenges for effective service provision to safeguard the welfare of children.
- A serious case review is likely to entail the expenditure of immense resource and effort. It was clear that Area Child Protection Committees operated very different thresholds in making such a decision, despite the criteria laid down in national guidance.
- A critical decision in commissioning a review is the appointment of an independent chair or author of the overview. Local Safeguarding Children Boards currently rely on a system of informal contacts to find suitable people. Consideration has to be given to how a resource of trained, credible experts in this field can be developed and operate in an open and transparent way.
- The quality of the overview report is dependent on the agency management reviews and their chronologies. Acknowledgement is not always given to the time this may take, the training needs of those preparing reports and to the management issues required

- Chronologies and genograms serve discrete purposes to assist the analysis of agencies' contact with the family, particularly the child, and the direction of enquiry. On occasions in the study these were found to have been overlooked or poorly presented.
- The requirement to invite family members to contribute to case reviews is a major development and their involvement requires appropriate facilitation, planning and resources. There was evidence of some family involvement and the consequential issues in the case reviews studied.
- The formulation of recommendations and the creation of action plans at the conclusion of the overview were sometimes described as being done in a rush due to other constraints. They require reflection and a strategic approach.
- The completion of the overview report was often described as being accompanied by some uncertainty and confusion at a time of a high level of activity to handle the outcome of the review. This part of the process requires as much planning and management as the initial stages of commissioning the review.

Methods

The planned use of a national database as a sampling frame proved problematic because of the incomplete nature of the database records. An alternative strategy was employed in which records of all reviews conducted, together with their action plans were requested to be supplied to the Department of Health through regional offices of the then Social Services Inspectorate. Whilst an estimated number of 180 reports were expected, only 45 were received and some reports contained no action plans. The final sample of the 40 records included in the study was therefore not a representative sample but was the best available in the circumstances.

Use was also made of documentary sources (reports of serious case reviews, the action plans and progress reports on implementation). Planned interviews with key staff associated with half the serious case reviews and with Social Services Inspectorate staff proved more difficult to arrange due to staff turnover and reorganisation. Ultimately ten telephone interviews were finally successfully carried out. As an alternative an invited national study seminar was organised. Additional interviews were also carried out with a number of key people who had direct responsibility for managing the outcomes of serious case reviews, which were not subject reviews of the study.

Detailed findings, conclusions and implications

Some strong themes have emerged at the conclusion of this study about the effectiveness of the current serious case review process. The analysis of forty serious case reviews raised some recurring issues which were reinforced by evidence from other sources and by discussion with a range of key stakeholders.

They fall into four main areas:

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

Emerging themes from the serious case reviews

The study of forty serious case reviews revealed a number of issues which will continue to require careful monitoring and attention by Local Safeguarding Children Boards, not least the vulnerability of older children as well as young children and babies, and children with additional or specific needs such as disabled children and their families. It is a matter of concern that there is still poor recording about ethnicity of family members. The absence of specific expertise to assist serious case reviews in their knowledge or understanding of issues relating to families from different cultures and languages suggests that thought should be given to such engagement at the commissioning stage.

Two features stood out strongly from the cases read: the number of children who were experiencing neglect in the context of a range of other family difficulties and children living in circumstances where domestic violence prevailed, co-existing with other problems in their families such as substance misuse and mental ill health. These situations continue to pose major challenges for the providers of services, particularly in terms of early identification, timely and appropriate intervention, and co-ordination of services. Finally, those professionals from agencies charged with the delivery of co-ordinated multi-agency plans bear a fundamental responsibility for ensuring effective information sharing and consideration of the impact on the child in promoting and safeguarding the welfare of the child. There was evidence that the views of the child were not always sought and that communication was more likely to take place between practitioners and parents rather than with children.

Making the serious case review process more effective

The decision to hold a review: There would be benefit in striving for more consistency across the new Boards about the decision, an area where the government offices in regions and Ofsted could have different roles to play. Boards also need to be clear from the beginning about the purpose of each review and to have anticipated the likely outcomes.

Chairing the serious case review: The appointment of external chairs of overviews has a number of merits. However, Boards should not have to continue to rely on the current arbitrary system of informal contacts to find suitable people. Consideration should be given as to how a resource of trained, credible experts in this field can be developed and operate in an open and transparent way. The Department for Children, Schools and Families, in collaboration with the government offices in the regions, may need to take a lead in addressing these issues.

Management reviews and the overview report: During the study, a general desire was expressed for more training for those who would be preparing agency management reviews and for those carrying out overviews. Exemplars or templates of agency and overview reports, it was suggested, would be helpful. These are obviously matters requiring further consideration at both central government and regional government office level.

The inclusion of chronologies and genograms: Chronologies and genograms serve discrete purposes and on occasions in the study were found to have been overlooked or poorly presented. There was almost no record in the chronologies examined of when a child or children of the family were seen or whether children had expressed any views; the focus was mainly on parental and inter-agency contact. These omissions may be a reflection of the state of agency records and require review by Local Safeguarding Children Boards.

The contribution of family members: The new Working Together (2006) requirement to invite family members to contribute to case reviews is a major development and their involvement requires appropriate facilitation, planning and resources. It is likely that family members will find the process

far less stressful if a key worker is appointed to work with them throughout, provide information and explanation, help them contribute and take them through the executive summary at the end. It is not a task that can simply be added on to existing job descriptions but the necessary expertise, time, training and support should be secured. Care must be taken that family interests are sufficiently covered during the review but that other important matters for scrutiny are not lost in the process. Sensitive issues about confidentiality will need careful handling.

Formulating recommendations and action plans: The formulation of recommendations and the creation of action plans at the conclusion of the overview were sometimes described as being done in a rush due to other constraints. Rarely were action plans specific about what needed to change and how the outcome would be identified. It was suggested that auditing progress on implementing action plans was an important part of ensuring drift and fatigue did not set in; the NSPCC audit framework (Handley and Green 2004) was one of the tools found useful for this purpose as well as those developed 'in house' by Area Child Protection Committees.

Managing the outcome of the review: This part of the process requires as much planning and management as the initial stages of commissioning the review. There were judgments to be made about those who would have access to the report, those who needed to be briefed and handling issues of confidentiality. Executive summaries were often found to be difficult documents to write as they would be made public, balancing a sufficiently detailed analysis of what had happened without fuelling inappropriate public interest in matters sensitive to family members and, in some cases, individual professional staff. These summaries had to serve a number of purposes within agencies as well as the wider community, and this led in one review to a further professional summary being prepared for staff information and training purposes. Some of these process matters could be addressed by more sharing of information and experience between Local Safeguarding Children Boards.

Costing serious case reviews: Serious case reviews are undoubtedly very resource intensive. However, there was no evidence from the reviews of any consideration of cost being a factor in the decision to undertake a review or of cost influencing the conduct of the review. In that respect, it is difficult to comment on whether the serious case reviews provided value for money. Similarly, there was no indication of cost being a factor in determining the recommendations or action plans. Some of these would have been very expensive to implement, such as new members of staff or some comprehensive training programmes, and would require a high level of agencies' commitment to do so. This would seem to be an issue for further exploration as the new Local Safeguarding Children Boards become more fully established.

Using findings of serious case reviews to learn lessons

Translating findings into recommendations and action for change: The findings on the whole reflected the analysis of information presented in the reports. However, the recommendations did not always follow from the findings. There were obviously divergent views at this point about whether the operational difficulties or failures that had been identified were the result of systemic problems requiring more holistic solutions or the result of individual error – acts of either commission or omission. What was marked was the emphasis in the recommendations on reviewing or strengthening existing procedures or developing new procedures. There was less emphasis than might have been expected on issues of management, supervision, staffing resources and staff knowledge, skills and experience. The organisational context, which in some agencies at the time was undergoing major change, resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed.

Implementing recommendations and action plans: A range of factors were identified by respondents which either promoted or hindered implementation. Those that helped implementation included recommendations which were in line with other national or local developments so that the outcome of the review could act as a further lever for change, particularly in securing higher priority or additional resources. In some areas, the shock factor of the circumstances of the case or the authority ascribed to a serious case review were important in ensuring recommendations were taken seriously. Overall it was clear that strong and confident leadership from the Area Child Protection Committee played an important role in taking action forward.

Learning lessons locally, regionally and nationally: Serious case reviews were generally regarded as a valuable and important response to child deaths or serious injuries where there were suspicious or concerning circumstances but there were a range of views about their impact locally and how far lessons from the reviews were being learned. However, there were some promising and creative examples of different approaches being developed locally to ensure findings from reviews had impact. Examples are given in the text. There was also potential for collaboration between Local Safeguarding Children Boards regionally and some promising examples of how this could be done effectively by providing a sound knowledge base on which to draw as well as the opportunity to learn from others' experiences. The argument for government offices in facilitating these developments was strongly made. Government offices were also identified as having a role in assisting communication between local and central government so that policy makers could be informed by local experiences.

Alternative approaches to safeguarding practice

There were, however, some compelling debates about whether serious case reviews were the best or the only vehicle for generating lessons to be learned. There was evidence of alternative approaches being explored. These included taking a measured, whole system approach and establishing a culture of a learning organisation by engaging agency staff regularly in examining practice in cases of 'near misses', where there had been concerns. Another and perhaps more radical example was an approach that aimed to learn from evidence of what worked well in multi-agency safeguarding practice and to develop policy, practice and training building on best practice.

Conclusion

Serious case reviews make an important contribution to understanding what happens in circumstances of significant harm. Their effectiveness can be improved and there are examples of promising approaches using the findings of serious case reviews to bring about improvements in safeguarding practice. However, achieving such improvements requires Local Safeguarding Children Boards to develop a much stronger learning culture within which serious case reviews are but one important source of knowledge for improving safeguarding practice.

Chapter 1: Introduction

The Department for Education and Skills will commission overview reports at least every two years, drawing out key findings of serious case reviews and their implications for policy and practice. (HM Government 2006a, p.154)

This report is titled *Improving Safeguarding Practice*. There are a number of dimensions to the idea of improving safeguarding practice from a study of case reviews of child deaths and serious injuries. At one level, it is hoped that study of the circumstances of the children and families involved, and their contact with professionals, will create an opportunity to reflect and will contribute to the development of more knowledgeable and skilled practice in working with children and families, as well as to improved collaboration between agencies. At another level, it is hoped that by exploring a number of overviews, the processes of reviewing child deaths and serious injuries might be revealed, appraised and improved, and more attention given to ensuring such reviews bring about local change in the best interests of vulnerable children. Finally, by examining the themes and patterns emerging from the reviews in association with evidence from other sources, including research and inspection, there can be messages for national as well as local policy and practice. It is the intention of this study to reflect some of the new challenges being faced by those who carry responsibility for establishing and undertaking serious case reviews, and to encourage increased openness and dialogue about contemporary experiences.

This study is the second since the Government announced in 1999 that it would be commissioning overview reports of serious case reviews on a biennial basis. The aim was that such studies would draw out key findings from the local reviews and identify their implications for policy and practice (Department of Health et al 1999, p.95). The commitment to learning lessons locally and nationally has been reinforced in the most recent government guidance (HM Government 2006a).

The biennial reviews

The first study by Sinclair and Bullock (2002) was a broadly based review which focused particularly on examining the characteristics of the children and families who were the subject of serious case reviews and on exploring the review process. It also produced a valuable overview of the research literature, which will not be repeated in this study. Instead, a detailed chapter has been included on the changing context in which serious cases reviews are undertaken.

As part of their review, Sinclair and Bullock had asked respondents about the value of serious case reviews. They reported that all respondents stressed their value. However, among the negative comments they received, *‘there was a feeling that the process can be so exhausting that once the report is complete, people sit back and say “that’s it!”’* (Sinclair and Bullock 2002, p.53). It was decided, therefore, when the second overview was commissioned, to explore the impact of serious case reviews and to see whether they made a difference and, if so, why some did and others did not. What were the particular features or conditions that made some serious case reviews more effective than others? Axford and Bullock (2005) comment in their study of international approaches to significant case reviews that there is very little material about the effectiveness of reviews:

While there is a large body of research on child abuse and neglect and on child death rates generally, there is very little published material on the case review process and even less on its effectiveness. Most available evidence comes from England. (p.3)

Exploration of the factors influencing the case review process and the impact of the findings on local policy and practice has, therefore, been the particular focus of the second biennial study. Do the resources invested in the conduct of serious case reviews make a difference to local safeguarding practice? This study has also included an analysis of the characteristics of the children and their families who have been the subject of forty overviews during the period 2001-2003. Some of the emerging patterns and themes which might have relevance to local and national policy have been examined in more detail, thus providing continuity with the first study and contributing to the cumulative development of a body of evidence. Serious case reviews inevitably reflect the prevailing policy, public and professional interests of their time. Making sense of the impact of these factors requires an understanding of the changing context of serious case reviews, considered in a separate chapter.

A third biennial study in the series was commissioned from Brandon and her colleagues at the University of East Anglia by the government department then holding overall responsibility for safeguarding children, the Department for Education and Skills (Brandon et al 2008). The third study looks at serious case reviews of child deaths and serious injuries undertaken between April 2003 and March 2005. Brandon and colleagues first explore information about a large cohort of children and their families gathered from the revised national notification database (see discussion in Appendix 1). In a more detailed study of 47 serious case reviews, the study then focuses on interagency working, charting thresholds of recognition, early intervention and safeguarding actions.

Chapter 2:

Children in the study

The profile of children in the study

There were 45 children in this study whose deaths or injuries became the subject of 40 serious case reviews between April 2001 and March 2003. Most of the incidents (73%) involved the death of a child, and a further 23% involved serious injury. This was similar to Sinclair and Bullock's earlier study (2002).

Nearly two thirds of the children in this study were boys: 28 (62%) were boys and 17 (38%) were girls. Their ages ranged from under two months to 16 years old and can be grouped into broad age bands:

- 47% were children aged 2 years or under, of whom two-thirds were less than one year;
- 9% were aged three to four years;
- 24% were in the five to ten year age band; and
- 20% were children and young people aged 11 years or older.

Compared with the previous study, in which 80% of the sample were aged five and under, more of the children in this study were older (Appendix 2).

Only eight children (18%) had their names on the local child protection register and were, therefore, the subject of an interagency child protection plan at the time of the incident, and in one case it was not recorded whether the child was registered or not (Appendix 2). One of the eight children on the child protection register was on an interim care order. There were a further three children on interim care orders but not on the child protection register. Another child was currently being accommodated by a local authority under section 20 of the *Children Act 1989*, and one child had been adopted and was living with her adoptive parents (Appendix 2). An extensive range of statutory services, in addition to health, education and children's social care, had been involved with the children and their families at one time or another, including youth justice, housing, and adult services in health and social care. In addition, a further range of professionals from services such as the British Transport Police, hospital accident and emergency departments, and paramedic services had come in contact with the children or their families, usually at times of crisis. A complex network of interagency involvement often existed.

Three quarters of the children in this study had died but not all the deaths were the result of deliberate maltreatment or harm by carers. The toddler who drank his mother's prescription of methadone and the baby who died because treatment was not sought in time were two of the children where harm was not intentional. Two deaths were suicides by adolescents. A quarter of the children were seriously injured and/or seriously neglected. None of the children was abused in an institutional or a community setting, or was abused by a stranger. Concern as the result of two high profile cases at the time (Victoria Climbié, who died in February 2000, and Child B, found tortured in 2003) led to an examination of circumstances of maltreatment 'where adults believed that a child in their care was a "witch" or "possessed by evil spirits"' (Stobart 2006, p.4). A study of thirty-eight cases occurring since 2000 was commissioned by the then

Department for Education and Skills (Stobart 2006) and national guidance was subsequently issued (HM Government 2007a). However, none of the children within this biennial study of serious case reviews suffered abuse linked in anyway to such accusations.

Ethnicity

Information about the ethnic background of children in this study was often incomplete or vague (echoing findings in the earlier study by Sinclair and Bullock, 2002). Ethnicity of the children was not recorded in a third of the serious case review reports (a higher proportion than in the previous study). Of the remaining children, twelve were recorded as being Black/Black British, Asian/Asian British or of dual heritage. However, even where the children were identified as having a minority ethnic background, parental ethnicity was rarely identified (only in five cases). The impact of culture, language, religion and race was not explored in the overviews, nor the consequences these factors might have had on the children's development, family or wider circumstances, or on the children's or family's contact and relationships with different agencies' practitioners. There were no indications in these reviews of specialist expertise being brought in to assist those undertaking the serious case review to gain a better understanding of what might have been happening or how agencies might have responded more sensitively or appropriately. There are a number of independent consultants or organisations with such expertise, for example AFRUCA, Africans Unite Against Child Abuse, which may be called upon to give advice and assistance.

Disabled children

The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and the presence of multiple disabilities appears to increase the risk of both abuse and neglect. (HM Government 2006a, p.198)

Five children in the sample were identified as disabled, although in 20% of the reviews this information was not recorded. In addition, a small number suffered from poor health and were vulnerable as the result of being born prematurely. The most severe consequences of the parental pressures that can arise from bringing up a child with a major and enduring disability were graphically reported in a review of the death of a boy of 10 with autism. The report described his mother struggling with his care, searching and sometimes fighting for appropriate services, and then, at the point when circumstances seemed more settled, she killed her son and committed suicide. In the five cases in the study, the child's disability rarely existed in isolation from other family pressures. The reviews often described situations where disability was linked with a combination of other factors such as a young or single mother coping alone, further pregnancy, domestic violence, substance misuse or depression.

Some of the overview reports identified concerns about the extent to which there appeared to be weaknesses in the scope of assessments of disabled children by practitioners and how far they encompassed all aspects of the child's welfare, particularly consideration of whether there was any risk of harm. Others drew attention to the operation of the "rule of optimism" with society's most vulnerable children'. These concerns were succinctly summed up in one overview report:

Children with Disabilities are under represented on the Child Protection Register both locally and nationally. This case has highlighted why this maybe so. A number of experienced practitioners reviewed the issues that were presenting in this case and did not trigger the Child Protection system, there is little doubt that if a child without a disability was presented with some of the similar circumstances, the Child Protection system would be triggered. There are clearly attitudinal and training issues which need to be addressed.

Issues for policy and practice of disability

The analysis of this small number of cases of disabled children reinforces some important messages for effective practice that apply generally to work with disabled children and their families (see Marchant and Jones in Department of Health 2000). First, since a child's disability is likely to have a widespread impact on the family's functioning, there is an overwhelming need for comprehensive multi-agency assessments to take account of all the strengths and pressures a child and other family members may be experiencing. Assessments need to acknowledge a disabled child's changing needs over time. They also need to take account of the long term nature of disability and the potential need for continuing professional support and services. Assessing what is happening to a child and family is likely to require the involvement of a range of both adult and children's services, including universal and specialist services, and assessments will therefore be more complex to co-ordinate and manage. Analysis of information gathered should always include consideration of whether there is risk of significant harm to the child or other children of the family.

Good practice would suggest that coherent and detailed plans should result which focus on the child, and the process should fully involve the family throughout. A lead professional should be clearly designated to co-ordinate the implementation of the plan and to communicate with other agency practitioners involved. Finally, regular review of the plan and services should be undertaken with family members and other agencies to see how the plan is working and whether it needs to be amended according to changing circumstances. None of this is new but the experience of isolation and of fragmentation of services by disabled children and families in the cases in this study underlines the vulnerability of families in such situations when insufficient priority is given by agencies to the impact of child disability. Policies, training programmes and resources for disabled children and their families need to be developed in a context of promoting welfare and safeguarding children who may be particularly vulnerable (HM Government 2006a, pp.198-199).

The abuse of older children

This study has taken a particular interest in older children who were the subject of serious case reviews, including those who were in their mid or late teens but still under the age of 18. Previous studies in the UK and elsewhere have emphasised the vulnerability to abuse and neglect of new born and very young children, and early studies focused on the 'battered baby' syndrome (Scott 1973; Smith et al 1974; Greenland 1987; Sobotta and Davis 1992, for example). UNICEF confirmed the greater risk to very young children in a recent research report on Child Maltreatment Deaths in Rich Nations:

The risk of death by maltreatment is approximately three times greater for the under-ones than for those aged 1 to 4, who in turn face double the risk of those aged 5 to 14. (UNICEF 2003, p.2)

In this study, nearly half the children were aged two years or younger, and 29% were under the age of one. The public image of child abuse has, understandably, become associated with the deaths of infants or young children. Indeed, not just among the public but also among professionals. The chair of one Area Child Protection Committee in Sinclair and Bullock's study commented 'I always remind myself we are talking about dead babies' (Sinclair and Bullock 2002, p.1). The focus of the media also contributes to this public image of child abuse, particularly in local press accounts and the coverage of inquiries acquiring national interest.

Nine (20%) of the children in this study were aged 11 years or over, and five of these children were young people aged 15 or over. In an earlier study by Arthurs and Ruddick (2001), involving 33 children who had been the subject of 'Part 8' Reviews over a two year period in the South East Region of the NHS, 4 children were over the age of 10. In Sinclair and Bullock's study of the same period, there were

six aged over 11 out of a total of forty children. The numbers in these studies are small and should be regarded with caution. It would be premature to say there is any discernable trend towards older children becoming the subject of serious case reviews. However, there is increasing interest in this older age group. Brandon and her colleagues discuss some of these issues in the third biennial study (Brandon et al 2008).

Perhaps it should not be surprising that this study found 20% of children were aged over 11 when the numbers of children on the child protection register in England in this age range are taken into account. Generally they constitute almost a third of the total age range: there were 7,720 and 8,110 aged 10 years or over on 31 March 2002 and 2003 respectively (Department for Education and Skills 2006a). The proportion of older children who are on the child protection register has not altered significantly over the last decade but the proportion subject to serious case review may be changing. The total cohort of serious case reviews needs careful monitoring over time before any conclusions can be drawn. There may be several reasons why serious case reviews were held on the nine older children in this study. The circumstances in which these children died or were seriously injured may have caused an unusual level of concern. Another reason could be that the Area Child Protection Committees had become more sensitive to the deaths or serious injury of older children and broadened their grounds for holding a serious case review. In all nine cases, the decision was deemed entirely consistent with government guidance about holding a serious case review.

It was decided, therefore, that older children and their needs merited further comment in reporting this study. This was partly because it was apparent their circumstances were different from those of younger children in the study and partly because of the absence of attention given elsewhere to older children experiencing abuse and neglect. Rees and Stein, in a systematic review of national and international research evidence in 1999, noted the neglect of adolescent abuse in the UK and observed that at the time of their review '*not a single journal article or book dealing specifically with the abuse of adolescents was identified*' (Rees and Stein 1999, p.3). They concluded that this constituted a significant gap in overall knowledge about child abuse in the UK, which is being remedied through a major research study on the subject by Stein and colleagues as part of the joint Department for Children, Schools and Families and Department of Health Safeguarding Research Programme. This is not a new concern. As early as 1974, during the discussion session at a government conference, comment was made along these lines:

It was suggested that although the Department of Health's memorandum on Non-Accidental Injury, which had been issued in April 1974, encouraged agencies to look at children of all ages discussion at the Conference had centred on very young children ...From the psycho-social point of view what was known about young children was not necessarily equally applicable to the older child at risk. (Department of Health and Social Security 1974, p.47)

The reasons for this neglect in the UK are complex. There has been concern about children who abuse other children, particularly adolescents who, having themselves experienced abuse, then abuse other often younger children in foster care, children's homes and schools (explored in studies such as by Farmer and Pollock 1998). However, in this study of serious case reviews, there were only two adolescents who were the perpetrators of abuse. One adolescent aged 15, with a history of criminal offending and violent behaviour when angry, was responsible for the death of a baby left in his care and another, 16 years old and in foster care, knifed an 18 year old and killed him.

In general, there appear to be a range of assumptions about adolescents in relation to abuse and neglect which lead to different perceptions of them from younger children who are suffering similar significant harm. They are thought to be better able to take care of themselves, avoid physical harm, keep out of the way or ask for help. However, there are also often unspoken assumptions that perhaps they have

brought the abuse on themselves or that they have at least in some way contributed to the situation. In this study, non-attendance at school or involvement in juvenile offending activity appeared to elicit a response amongst professionals which focused solely on the adolescents' behaviour and not on the wider circumstances in which they were growing up. On reflection, these family and environmental factors would have suggested they were at least children in need requiring in-depth assessment and service planning, if not requiring a safeguarding plan. The demonology of adolescents is a facet of the public response in the UK which has been widely aired and discussed by the media. Aspects of this could be found in some measure in the response of practitioners in this study, even in cases where adolescents were experiencing significant harm or demonstrating extreme distress, such as self-harm or suicide attempts.

Chapter 3: Children experiencing harm in the context of neglect and domestic violence

Two themes stood out from the analysis of the reports in this study and had posed major challenges for the practitioners and agencies working with children and their families: these were children who were experiencing neglect and children who were growing up in situations of domestic violence.

Children and neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological need, likely to result in the serious impairment of the child's health or development. (HM Government 2006a, p.9)

Many of the children who suffered significant harm in this study were growing up in complex family circumstances where there was often an intergenerational pattern. Their parents had had similar family histories to their own. Few of the children were living with parents with stable relationships, in settled family households, in adequate housing, with sufficient resources or community support to meet their needs. Parents were often coping with a range of their own problems, including substance misuse, mental ill health, learning disabilities, or domestically volatile or violent relationships. At the same time, lack of resources meant uncertain income, unsuitable and overcrowded accommodation, frequent moves, debts and, for some, the need to find money for drugs and alcohol. In a few cases, this need took parents into criminal behaviour to fund their substance usage.

Their parenting capacity was sometimes further impaired by additional pressures such as acquiring responsibility for caring for a disabled elderly parent as well as their own children, coping with sudden loss of key supports from family or neighbours or experiencing the onset of debilitating depression. Responding appropriately to children's changing needs as they moved from one stage of development to another also posed a challenge for some parents. There is a strong theme from these overviews of (usually) single mothers struggling with chronic and enduring problems to do their best for their children. Some were succeeding against all the odds until a set of pressures accumulated or unexpected incidents occurred and overturned their fragile stability. Numerous studies have provided compelling insights into parenting in these circumstances and the erosion of parenting capacity that can occur (see, for example, Holman 1998; Cleaver et al 1999; Ghate and Hazel 2002; Seaman et al 2005).

The children growing up in these situations in this study fared very differently to each other. Some showed astonishing resilience – they were bright, intelligent, alert and resourceful even as toddlers. It did not mean, however, that they were less prone to danger or harm, sometimes the reverse. Their

very resilience meant that some children placed themselves in potential danger without appropriate parental or other adult oversight. Others did less well. They struggled with chronic ill health, sight or hearing problems which were unidentified, or went to school irregularly where they were noted as *'hungry'*, *'inadequately clothed'*, *'smelly'* and *'shunned by peers'*. In one case, the children in a family were described by the school as *'pathetic little things at times'*. As some of the children grew older and more independent, they stayed out late, got into fights with peers or adults, were injured in accidents, or began to develop violent, antisocial or erratic behaviour. The key adult or adults in their lives, as others have observed, were either emotionally or physically unavailable to them, and unable to offer consistent care or keep them safe (Turney and Tanner 2005). A way of coping was to opt out from the routine of school and some children stopped attending, and drifted into offending behaviour during the day and into dangerous activities, such as playing on the railway line.

What was outstanding about these children was that, even before they suffered the significant harm which led to their being the subject of serious case reviews, they would have been children in need as defined by the *Children Act 1989* i.e. they and their siblings were children whose health and development was being impaired and they were in need of services.

Cleaver and Walker, in their study of assessing children's needs and circumstances, categorised as *multiple-problem* those cases where difficulties had been identified in more than two or three dimensions in all three domains of the Assessment Framework, the child's developmental needs, parenting capacity to respond, and wider family and environmental factors (Cleaver and Walker 2004, p.223). They concluded it would be expected that such cases would result in a core assessment. From such an assessment it would, therefore, be likely that a child's plan would be constructed, co-ordinating multi-agency contacts and services towards a clear set of objectives and timescales for achieving improvement in the child's wellbeing and some signs of change in the family's situation. It did not happen in this way for many of the children in the reviews in this study.

These children were suffering from neglect; they and their families were experiencing multiple problems. Their difficulties were systemic, not one-off incidents and this comes through clearly in the information in the overview reports. The needs of neglected children have been well documented over the last decade, particularly by Iwaniec (1995), Stevenson (1998), Tanner and Turney (2003), Daniel and Taylor (2004) and, more recently, in a research and practice briefing by Turney and Tanner for the Department for Education and Skills (2005). However, in this study, the severity and impact of neglect were not identified by practitioners. The children and their family circumstances were not the subject of careful and co-ordinated multi-agency assessments, nor did they have developed for them coherent and monitored multi-agency children in need plans.

Comment was often made in the analysis section of the overviews that agency contact had been reactive rather than proactive. It was not generally failure to pick up issues of concern. Services had been involved in noting concerns, particularly health workers, teachers and school nurses in circumstances where, for instance, the parent had raised worries or critical appointments had been missed. However, these incidents were often seen in isolation, without the whole picture being taken into account and the family history of dealing with similar situations was not explored. When there was concern, action was taken or advice given but not followed through if the parent failed to respond, and the implications or reasons for the difficulties were not considered nor the consequences for the child weighed up. As a result, the cumulative impact of long term neglect was not understood. Thus, the significance was not identified so other agencies were not alerted or informed and a comprehensive picture was not shared and held by the agencies involved. Key practitioners, such as school nurses, it was noted in one review, were excluded on many occasions from the network of professional liaison and the school was

not informed or contacted for the views or information of its staff, when it could have had made an important contribution.

Speaking to children

A further issue which emerged in these circumstances of neglect was whether practitioners who were visiting families had spoken to children directly to gather information from them. In one review, a chronic level of need had been identified by agencies and questions were being asked about the parents' level of care. However, the overview noted there was no indication of the children having been asked about what was happening to them by the practitioners who were visiting the family:

There is no information that the children were spoken with. Sibling 1 had just turned 16 and sibling 2 was 14 years old and both were fully able to discuss issues of physical chastisement within the family. The accounts from the older children would have been able to inform a decision about speaking with the younger siblings who at age five years and four years would also have been able to express if they were being hit around the head in answer to direct questions.

National guidance states that, as part of an initial assessment of a child's needs, the process should involve seeing the child, and speaking to the child as appropriate to age and understanding (HM Government 2006a, p.110). This statement refers to the responsibilities of children's social care practitioners who are likely to have received training in direct work with children. It is not quite so straightforward for other professionals who may have varying degrees of training and experience in working with children. Observing children, their appearance and behaviour, is obviously an activity which is imperative for all those who have professional contact with children and families. Talking with children, particularly in sensitive situations, is a step further. It requires clarity about roles and responsibilities as well as judgement about when it is appropriate to do so. The principle of a child's age and understanding is important in determining when and how to involve children, particularly in ascertaining their wishes or feelings about actions to be taken or services to be provided. Not all practitioners from all agencies will feel confident or sufficiently skilled in undertaking direct work with children, especially with younger children, in these circumstances.

Effective communication and engagement with children, young people, their families and carers has been identified as a fundamental part of the common core of skills and knowledge essential for the children's workforce (Department for Education and Skills 2005; see also guidance for education staff in Department for Education and Skills 2006b, pp.72-73). Preparation, training and reflection with the support of skilled supervision are critically important dimensions of communication for practitioners working with children and families, and knowing when and who to contact is equally important for those who identify concerns but are not suitably qualified to continue the task of gathering sensitive information from children.

When children's views are sought about these matters, they make it clear that knowing and trusting an adult is important. In a study by the Children's Rights Director for England (2007) on children and safeguarding, a number of discussion groups with children and young people were held:

This group...told us that children and young people need to be able to discuss being harmed informally with someone they know and trust – if it's a formal process, then it's more difficult. (Children's Rights Director 2007, p.10)

These views echo findings from other studies (see Department of Health 2001) and reinforce the great care that needs to be taken in encouraging direct work with children (Aldgate and Seden 2006).

On the whole children, particularly older children, acknowledge there are dilemmas for themselves and for the professionals involved when children are living in potentially unsafe situations. They recognise parents want to keep their children and should get help to do so, but not at the expense of their children's safety. It has been summed up by children in the following terms: *'children should remain with their families if there are just difficulties, but if they are in danger then they should be taken away'* (Children's Rights Director 2007, p.15). However, children and young people require highly skilled work with them when such profound decisions are being made, and they need a trusted relationship, facts and information, and someone to make sense of the issues for them. There is also the continuing responsibility for direct work with children living through difficult and painful family change, *'so that things add up and make some sort of sense and in this way we can prevent and relieve a great deal of distress'* (Winnicott 1964, p.58). Jones (2003 and 2006) recognises how challenging it can be for practitioners to communicate with vulnerable children about adverse experiences and events, and provides helpful guidance. These are important but complex workforce matters that need to be addressed and monitored by Local Safeguarding Children Boards with their constituent agencies.

Assessing the impact of neglect on children

One overview identified the difficulty in circumstances of neglect as lying with the thresholds for decisions about assessment and intervention. This particular overview explored the challenge for professionals of deciding whether the care being provided to the children was *'good enough'*, and noted the different perceptions and different priorities of the professionals involved. In the early period of the family's circumstances, the report concluded, health and education staff collectively had based their decisions on a threshold which *'tolerated a poor level of care of the children'*. In the latter period, the overview identified that it was clear *'a divergence of professional views about the thresholds for intervention'* had emerged, which had a paralysing effect on proactive agency action being taken.

The reasons for this appear to be complex. In some cases, frequent turnover of key professionals was undoubtedly an issue, particularly when new staff had little or no knowledge of the family's history or of the adult members' usual pattern of coping. In other cases, however, there were staff who had known the family for a decade or more, were trusted and in regular contact. In these cases a range of factors emerged as important in shaping the professionals' response: the parent was well intentioned; the standard of care was not all bad – either good or sufficient in some respects and not in others; the level of difficulties varied over time, sometimes worse than at other times, but then improvements were noted; the child seemed to be doing well enough; the parent was coping in similar circumstances and in a similar way to many other families in the local area. This could then lead to two responses by practitioners, noted by reviewers. The first was over-optimism and the second was immunity or insensitivity to deteriorating conditions.

The findings in this study have been echoed in subsequent serious case reviews, such as the review of a case of severe neglect produced by an independent author, Professor Pat Cantrill, in 2005. In the Executive Summary, Professor Cantrill acknowledged that responsibility for the neglect rested with the parents *'as it is their actions by omission and commission that led to them failing to provide their children with the physical, emotional and social care that they had a right to expect'* (Sheffield Child Protection Committee 2005, p.9). In examining the role of public services in the case, she concluded the services involved with the family had acted in good faith but:

A combination of structural, cultural and individual deficiencies resulted in some services failing to have in place an effective benchmark for, or assertiveness in intervening in, the care of the ... children. (Sheffield Area Child Protection Committee 2005, p.9)

Stevenson discusses the dilemmas about thresholds for intervention in circumstances of neglect (Stevenson 1998, p.9). She identifies three main thresholds:

- where some elements of neglect are found and services to the family should appropriately be provided on the basis of the children being in need;
- where the neglect is so serious, the children need to be safeguarded by a child protection plan and registration;
- where it is necessary to take court action which may lead to the removal of the children from their families.

She emphasises the importance of a systematic approach to assessing children's welfare '*at any stage in the process*' in order to facilitate monitoring improvements or deterioration, and to determine when children move from being children in need to being children in need of safeguarding, and ultimately when they are no longer safe at home. One of the overviews in this study identified the importance of undertaking a full and holistic assessment in these circumstances according to the then newly introduced *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000). This would offer the opportunity to take into account:

the complex and long term inadequacies in care before any decisions about seriousness can be made in relation to neglect. The approach taken to assessing the circumstances of [child] and siblings did not however reflect this and as a result the thresholds for intervention, not based on a full assessment, resulted in practice that was at times reactionary and inconsistent.

The need for in-depth assessment was evident in many of the cases where children and their siblings were suffering neglect but, critically, it was also evident that the process of coherent, co-ordinated, child focused assessment had to begin with those professionals in health and education services regularly in contact with the children. The challenge is ensuring health and education professionals have sufficient and appropriate knowledge about child development, understand this is central to their work and can apply it in their daily practice. This is particularly relevant in the context of some of the communities of chronic poverty and disadvantage where practitioners are working.

Some have argued that health visitors as public health practitioners should take on an expanded role in safeguarding children, designating '*the health visitor as the primary health care team's representative and key worker in the child protection process*' which would clarify the responsibilities they often assume (Lupton et al 2001, p.150). It might also ensure a more appropriate level of resources to support their critical role in early identification of need and mobilising a multi-agency approach to providing additional services when required. These aspects of the health visitor's role have been reinforced in the recommendations of the recent report commissioned by the Secretary of State for Health, *Facing the Future: Review of the role of health visitors* (Department of Health 2007).

The need for a common set of skills and knowledge across the children's workforce has been recognised by government and six core areas of expertise have been identified as requirements to practise (HM Government 2005). Their translation into the training, management and supervision of practice has particular relevance to the identification of child neglect and its impact, and requires national and local action. The importance of developing a common approach to identifying and assessing concerns about children's care and welfare (with the appropriate training to underpin it) also emerged as a factor in those situations where children were living in families experiencing domestic violence.

Children and domestic violence

There is a common link between domestic violence and child abuse. Among victims of child abuse, 40 per cent report domestic violence in the home. (UNICEF 2006, p.7)

Domestic violence featured in many of the serious case reviews in the study. The relationship between domestic violence and the risk of harm to children has been well established in the UK (for example, Scott 1974; Bentovim 1992; Reder and Duncan 1993; Mullender and Morley 1994; NCH Action for Children 1994; Mullins 1997; Cleaver et al 1999; Reder and Duncan 1999; Humphreys and Mullender 2000; Humphreys and Stanley 2006, and many others). Furthermore, Cleaver et al (2007), in a recent study for the Department for Children, Schools and Families on the response of child protection practices and procedures to children exposed to domestic violence and parental substance misuse, found that:

domestic violence and parental substance misuse rarely existed in isolation. (Cleaver et al 2007, p.85)

A key factor in children's vulnerability found in their study was the co-morbidity of issues confronting the family. As a result of the recognition of the harm children could suffer in circumstances of domestic violence, during the period when the serious case reviews in the present study were being undertaken, an amendment was made to the definition of significant harm in the *Children Act 1989*. The knowledge of the harm children could suffer in these circumstances was incorporated into new child welfare legislation in 2002.

The *Adoption and Children Act 2002* extended the definition of harm set out in s31(9) of the *Children Act 1989* by inserting the following wording: "including, for example, impairment suffered from seeing or hearing the ill-treatment of another" (s120). The accompanying notes to the legislation stated this was meant 'to make it clear that the harm a child may be at risk of suffering includes any impairment of the child's health or development as a result of witnessing the ill-treatment of another person, such as domestic abuse'. Furthermore, 'it is broader than physical violence and includes sexual abuse and forms of ill-treatment which are not physical' (*Adoption and Children Act 2002, Explanatory Notes, p.67*). Interestingly, however, this extension to the definition of harm was mentioned only once in any of the reviews in this study.

The overviews often draw out very clearly the association between domestic violence and other behaviours children may have been exhibiting, such as poor school attendance, bullying, aggression or offending. However, they also note the lack of significance attributed to the domestic violence which was well known to a number of agencies, and the impact this may have been having on the child or children of the family:

What is clear in this case is that no one single incident gave sufficient cause for concern for any agency to identify; that based on that incident alone there was a risk of significant harm. However this is commonly the situation in cases where domestic violence is prevalent.

It was clear to the Panel from this information that had these details come together on a multi agency basis, a detailed assessment of these boys' needs on the basis of "likely significant harm" would have been warranted.

In these situations, the role of schools as holders or keepers of information cannot be underestimated (in one case, the loss of school and education welfare records meant the history of domestic violence in a family was unknown to a new key member of the school staff until a short time before the children were killed). Schools, together with health visitors for families with very young children, are the services which will normally have contact with all children, and schools will have daily opportunities to observe and

learn of unusual incidents and changes in normal routines. They can become repositories for information gathered from within the school environment as well as from contacts with the family by other agencies. How that information is recorded, how the link is made between that knowledge and the behaviours of children and parents in relation to school and other agency staff, and how that information is then used as a trigger of concern to mobilise multi-agency action are critical to achieving improvements in safeguarding the welfare of children in circumstances of family domestic violence, mental ill health and substance misuse.

It requires schools to provide carefully developed awareness training and clear protocols for teaching staff and to develop agreements in collaboration with Primary Care Trusts or the relevant NHS employer for other agency practitioners in schools, such as nurses. Similar problems face the police and the reviews identified uncertainty about when and how the police should refer incidents of domestic violence. Some of these issues are being addressed through agency specific guidance about responsibilities for safeguarding and promoting the welfare of children, such as *Safeguarding Children and Safer Recruitment in Education* which highlights the serious effect on children of households where there is substance misuse and domestic violence (Department for Education and Skills 2006b pp.73-74), and *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004* (HM Government 2007b).

Assessing the impact of violence on a child

It is to be hoped that government policy on the *Common Assessment Framework* (HM Government 2006b) and the development of ContactPoint (Department for Education and Skills 2007) will assist in standardising the gathering and recording of information between agencies from the point of early concerns about a child, and providing an improved framework for sharing that information. The opportunity offered by the *Common Assessment Framework* for improving early intervention has been reinforced in a recent research and practice briefing by Humphreys (2006). She emphasises, however, that multi-professional training will be required to heighten awareness as well as requiring the development of appropriate service provision for all adult and child family members (Humphreys 2006, p.5).

Comment is made in some of the reviews about the importance of gathering details, such as the timing and exact nature of incidents. For instance:

Particular attention should clearly have been given to the children's whereabouts when the violence took place.

However, the impact on the children in a family can become secondary to the attention focused on the parents (who may be little more than children themselves – in one review, aged 13 at the birth of her child, and in another, read but not included in the study, both parents were barely 17) or focused on other family members caught up in domestic conflict and abuse. One review graphically described what can happen in these circumstances:

Moreover, when some detail was available, the issue of the children's safety appears to have been lost in the concentration on adults. It was noted by the Panel that the children appeared effectively hidden from view. It was apparent no one ever asked the children directly about what they had witnessed and what it had made them feel. In reality no assessment of the children's needs really took place.

The idea of the children becoming effectively hidden has been explored elsewhere (see for example, Reder et al 1993 and Cooper 2005). Cooper (2005) has described the phenomenon as workers both seeing and not seeing 'what was in front of their own eyes' (p.8). 'In other words', Cooper continues,

'sometimes the child exists and sometimes the child doesn't exist – it is not one or the other but both' (Cooper 2005, p.8). Arguments have been made that more attention must be given to the relationship between the emotional impact of deep engagement with children, parents and carers that the work entails and the local policies, procedures and interagency practices that are required, to ensure that they do not become disconnected. Others have drawn attention to the understandable fears practitioners may have about their own safety in situations of resistance, hostility and violence by children's adult carers which may prevent recognition of what is happening to the child or children of the family (for example, Dent 1998; Ferguson 2004).

However, where concerns have been identified, if multi-agency contact is not properly planned and co-ordinated, then it may well reduce the likelihood of important information being shared and the effectiveness of any agency's contact may be severely limited. Agencies are often working with multiple family problems. There were clear examples of children's services expending considerable effort to engage with one or more parent to address the children's issues, such as non-attendance at school, in very difficult and volatile family circumstances and, in particular, where domestic violence and parental substance misuse co-existed. Cleaver et al (2007) note in their study that:

A key factor in supporting collaborative working is the extent to which inter-agency and individual agency plans, procedures and protocols address the inter-relationship of these issues. (Cleaver et al 2007, p.309)

One review decided that the appointment of a senior manager with a strategic leadership role in relation to domestic violence to address all aspects of multi-agency working would give the issue appropriate priority and focus in the area and provide the infrastructure practitioners required to support them in their work. This decision, which became part of the overview's action plan, raises the question of how the impact of that appointment would be evaluated by the particular Area Child Protection Committee (or its successor body, the Local Safeguarding Children Board). How would the Committee know it was making a difference and improving early identification and intervention where there were problems of domestic violence? These matters are explored in later chapters.

Issues for policy and practice of neglect and domestic violence

The overview reports of cases involving neglect and domestic violence in this study clearly identified some key issues for safeguarding practice which require addressing by Local Safeguarding Children Boards and their constituent agencies. Again these issues have been identified in previous studies of serious case reviews and have been explored (and continue to be explored) by a number of writers. However, they have important implications for safeguarding training priorities, policies about agency supervision and other aspects of agency management:

- keeping a child or children in focus when there may be understandable attention being given to complex and pressing adult family members' needs;
- gathering knowledge about family history as an essential part of assessing and understanding what is happening and what may be family patterns of behaviour in stressful situations;
- ensuring that children are seen by practitioners, and that children are acknowledged as important contributors as part of safeguarding work with a family;
- recognising the emotional impact, and its consequences, of work with children and families experiencing severe difficulties, particularly where violence and conflict are inherent in family interactions;

- reinforcing the importance of all practitioners assessing a child within a developmental/ecological framework and ensuring appropriate training;
- addressing issues of risk of harm in the context of evidence from systematic reviews of risk factors, particularly for the recurrence of maltreatment (see Hindley et al 2006);
- giving careful attention to the processes of analysis of information, decision making and planning (see Jones et al 2006);
- addressing interagency communication and the factors which facilitate or inhibit effective interagency working (see Hudson et al 1999).

The issues of safeguarding and promoting the welfare of children who may be particularly vulnerable as the result of domestic violence are discussed in Chapter 11 of the most recent guidance (HM Government 2006a, pp.202-205) and highlighted in practice guidance produced for healthcare professionals by the Department of Health, *Responding to domestic abuse: a handbook for health professionals* (Department of Health 2006).

Chapter 4: Changing context of serious case reviews

Having examined some of the emerging issues about the children and their families in this study, the following chapters focus on the conduct of serious case reviews and explore the factors influencing their impact in bringing about improvements in local safeguarding policy and practice.

The national context in which serious case reviews were being undertaken during 2001-2003 was one of considerable change, as a result of both external events and major policy and legislative developments. These changes have been far reaching and will continue to shape the safeguarding environment in which serious case reviews are an integral part.

Government guidance on reviewing child deaths and serious injuries

In the period of this study, Area Child Protection Committees were expected to conduct serious case reviews in accordance with recently revised statutory guidance (Department of Health et al 1999). This guidance emphasised the importance government attached to the process of reviewing cases of child death and serious injury where child abuse was suspected or other serious concerns were identified, so that lessons could be learned. In this respect, the guidance was restating the original intentions for such local safeguarding bodies. A Government Circular in April 1974, *Non-Accidental Injury to Children* (LASSL(74)13/CMO(74)8) had recommended the formation of area review committees in local areas. The tasks identified for these new joint policy making bodies included that they should '*advise on the need for inquiries into cases which appear to have gone wrong and from which lessons could be learned*'.

Government guidance on the process for local review of serious cases of child abuse was issued in 1988 when work was underway in preparation for the major reforms of the *Children Act 1989*. The responsible government department, the Department of Health and Social Security, had consulted widely in 1985 and proposed a framework and basic general guidelines for the conduct of local *child abuse inquiries* to be used by Child Abuse Review Committees (Department of Health and Social Security 1985). This was in response to a growing demand for formal guidance rather than continuing the departmental practice of giving informal advice to constituent agencies of the Area Review Committees on the action they should take, as and when serious incidents occurred. Inevitably, while this advice was individually tailored to local circumstances, it was acknowledged it could be criticised as being ad hoc and potentially idiosyncratic. This is a tension that can be recognised today as, during the study, requests were made for more specificity about government expectations, more detailed guidance and templates for serious case review reports, whilst at the same time wanting acknowledgement that there needed to be sufficient flexibility to respond to individual circumstances.

The Department of Health and Social Security in 1988 conceived the importance of reviews in terms

of accountability, particularly of public agencies. It was ‘the general management responsibility of any agency to ensure that services are provided to an acceptable level’ (p.7). The Department set about systematising much of what was already good practice in Area Review Committees and drew on the experience of other inquiry processes, such as that outlined by SOLACE (the Society of Local Authority Chief Executives) for ad hoc inquiries in local government. The proposed framework laid the foundation for the conduct of serious case reviews, distinguishing the different types and relationship of inquiry or review in serious cases of child abuse. It identified six underlying principles on which ‘local inquiries’ should be based (p.6):

- Urgency
- Impartiality
- Thoroughness
- Confidentiality
- Co-operation
- Resolution.

The principle of ‘resolution’ is particularly pertinent to this study, with the acknowledgement that change should occur as the result of any recommendations by the review:

Action should be taken to implement any recommendations that may arise and are accepted by the agencies concerned. The Review Committee should establish a mechanism to monitor progress on implementation of the recommendations. (Department of Health and Social Security 1985, p.6)

The framework for the conduct of reviews in England and Wales is substantially still the same: establishing the facts, assessing decisions made and actions taken, checking whether procedures were followed, considering whether services were realistic, and concluding with recommendations for appropriate action in the light of the review’s findings.

The intention had been to issue the guidance separately as a stand alone document. However, at the last minute it was decided to incorporate it into the new child protection guidance, *Working Together: A Guide to Arrangements for Inter-Agency Co-operation for the Protection of Children from Abuse* (Department of Health and Social Security and the Welsh Office 1988). It became Part 8 of that document (and in subsequent government guidance continued as Chapter 8). The interagency guidance was then updated and brought into line with the *Children Act 1989* (Home Office et al 1991).

By 1999 there was a substantial level of experience of local serious case reviews. Sinclair and Bullock (2002) in their study have described the changes between the earlier guidance of 1991 and the revisions made in 1999, noting greater emphasis ‘on learning lessons for improving collaboration and on remedial action within the local agencies’ (p.5). Reder and Duncan (1999) had undertaken a study of fatal child abuse cases drawing on Part 8 Reviews and had made a number of recommendations for the future review process of child deaths:

- *Reviews of children’s deaths would be enhanced by the inclusion on review panels of personnel from relevant professions who are of sufficient seniority and experience.*
- *Standing Child Death Review Teams could improve the identification of maltreatment related deaths and the practice lessons that might be learned from them.*
- *Participants in case reviews at all levels of seniority should be made aware of the remit of the review –*

i.e. whether its primary task is disciplinary, learning, and so on.

- *Case review reports should have a standard format and contain detailed genograms and family histories, together with integrated chronologies of significant events, professional interventions and their outcomes.*
- *Reviewers' recommendations should be clearly based on their understanding of the dynamics of the case and of the different levels of influence on professionals' work, as well as on procedural factors. (Reder and Duncan 1999, pp.118-119)*

Many of these recommendations, in combination with new knowledge gained from other studies (such as James 1994; Department of Health 1995; Falkov 1996) were incorporated into the revised safeguarding guidance (Department of Health et al 1999) contributing to a greater level of clarity and, at the same time, a greater level of prescription (Sinclair and Bullock 2002). Increased specificity about the requirements was also in part a response to requests from Area Child Protection Committees themselves for more guidance about the process. This was because, under the previous guidance of 1991, it still allowed considerable discretion which created uncertainty for some Area Child Protection Committees.

Public concerns about safeguarding children

However, during the period of this study, public interest and concerns about how well children were being safeguarded were heightened by an unusual sequence of tragic incidents and other events. In February 2000, a nine year old child from the Ivory Coast living in London died in circumstances of particular cruelty. The death of Victoria Climbié and the ensuing public outcry about the failure of public services to protect her led to a statutory inquiry established by two government departments, the Home Secretary and the Secretary of State for Health, and chaired by Lord Laming. The Inquiry was charged with making recommendations to the Government about how such events might be avoided in future. The Inquiry reported in January 2003 (Cm 5730 2003).

Public anxieties were also raised about the adequacy of interagency procedures and practice in the employment of staff working with children. This followed the deaths of ten year old Holly Wells and Jessica Chapman who were killed by their school caretaker, Ian Huntley, in August 2002. Two inquiries were commissioned into the circumstances surrounding Ian Huntley. The first was a public inquiry into the effectiveness of intelligence-based record keeping, vetting procedures and information sharing, set up by the Home Secretary and chaired by Sir Michael Bichard (HC 653 2004) and the second was a serious case review into statutory agency responses to earlier incidents involving Ian Huntley, conducted by an independent chair, Sir Christopher Kelly (North East Lincolnshire 2004).

The findings and recommendations of these inquiries led to significant policy changes, as signalled in the Government's response to the Victoria Climbié Inquiry Report, *Keeping children safe*, in which the key features of an effective safeguards system for the 21st century were identified (Cm 5861 2003). However, the deaths of two other children during this time, not the subject of statutory inquiries but both involving criminal proceedings and serious case reviews where there was a high level of public and media interest, were also influential in the Government's deliberations about policy reform. The first was the death of Ainlee Labonte, aged two, in January 2002 after sustained torture by her parents. The second was that of Toni-Ann Byfield, a seven year old, shot dead in a drugs dispute while placed in a kinship care arrangement with her 'great-aunt' in September 2003. The serious case reviews identified profound problems in the thoroughness of assessment, planning and focus by local agencies in meeting the needs of a child in both these cases. The deaths of Victoria Climbié and Toni-Ann Byfield also raised issues about the role of the immigration service and of vulnerable children coming into the UK from other countries. Increasingly attention was turning to how to improve the early identification of

particularly vulnerable children, including those involved in child prostitution and child trafficking, and how key statutory agencies across a much wider field could work more effectively together.

Sudden and unexpected infant deaths

Another set of issues was also preoccupying both media and policymakers during this time in relation to sudden and unexpected deaths of infants, including those who die in hospital. Confidence in expert evidence given in criminal proceedings that some deaths of infants had been the result of deliberate acts of harm had been eroded by a series of judicial decisions resulting in successful appeals against convictions. Recommendations of the inquiry following the deaths of children who had had open heart surgery at Bristol Royal Infirmary, conducted by Sir Ian Kennedy (Cm 5207(1) 2001) and the report of the working group chaired by Baroness Kennedy into the investigation of sudden unexpected deaths in infants (Royal College of Pathologists and Royal College of Paediatrics and Child Health 2004) were influential on the direction of policy on reviewing child deaths.

Other studies reinforced policy thinking about the need for reform, such as Fleming and colleagues' earlier work on sudden unexpected infant deaths (Fleming et al 2000) and May-Chahal and colleagues' study on the relationship between child deaths in hospital settings and child maltreatment (May-Chahal 2004). May-Chahal and her colleagues found that there was little collective learning from the deaths of children in hospitals, and no systematic enquiries to rule in or rule out maltreatment (May-Chahal et al 2004, p.133). The cumulative impact of these findings suggested not just a radical overhaul of the safeguarding system was required but a new and more open approach to quality and performance that would lead to the review of all deaths in childhood.

Safeguarding reforms

The Government addressed the importance of safeguarding children as part of its new overarching reforms, aimed at securing the wellbeing of all children and improving their outcomes, particularly of those likely to experience difficulties, outlined in *Every Child Matters* (Cm 5860 2003). The significant changes in safeguarding policy which have been underway since the study started can be summarised in terms of a range of policy intentions:

- Broadening the concept of child safety to embrace all aspects of children's daily experiences;
- Broadening the range of agencies being involved in safeguarding children and required to work together, making it explicit that 'safeguarding children is everyone's responsibility';
- Locating safeguarding at the heart of improving outcomes for children;
- Addressing the relationship between child vulnerability and social deprivation and exclusion;
- Achieving a more coherent and robust cross-government approach;
- Developing legislation and guidance to ensure children are safe wherever they are and whoever has contact with them, through the Children Act 2004 and the *Safeguarding Vulnerable Groups Act 2006*, the *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills 2004), the revision of guidance on *Working Together to Safeguard Children* (HM Government 2006a) and *What to do if you're worried a child is being abused* (HM Government 2006c), and other measures;

- Improving service delivery by putting new architecture in place, such as Children’s Trusts arrangements, Sure Start Children’s Centres, Lead Members for Children in local government, and Local Safeguarding Children Boards;
- Emphasising the importance of accountability and the interconnection between the different forms of inquiry, investigation and review, and establishing a new system of review of unexpected child deaths;
- Monitoring the effectiveness of the delivery of these reforms in the public services through Annual Performance Assessment, joint approaches to inspection, a combined children’s inspectorate in the new Ofsted (the Office for Standards in Education, Children’s Services and Skills), the Healthcare Commission and other forms of quality assurance;
- Reviewing the knowledge, skills, leadership and readiness to practice required across agencies for working with children.

Serious case reviews and public accountability

During this period, wider public interest in seeking answers about the death of an adult or a child in unexplained circumstances had been given a firmer legislative foundation in the *Human Rights Act 1998*. Article 2 of the European Convention on Human Rights, *Everyone’s right to life shall be protected by law*, had laid an obligation on the state to investigate deprivation of life in circumstances where public authorities might have, by act or omission, contributed to a death. This obligation was raising issues about whether the investigative duty had been satisfied when a child died if there had been a criminal trial, an inquest or a serious case review. Some of these issues were put to the test when, following the death of a nine month old child in July 2002, a Coroner sought to hold a broad inquest which would extend to the role of the statutory child protection agencies in relation to the child’s life and the circumstances of his death. The local authority applied for a judicial review of the Coroner’s decision. The application was upheld and the Coroner’s decision quashed (*R (on the application of Plymouth City Council) v County of Devon Coroner* [2005] 2 FLR 428). The judgement makes, however, a number of interesting points in relation to serious case reviews and in particular that:

the focus of a Pt 8 review is upon inter-agency failure rather than upon breach by agencies, sometimes in combination but surely more often when acting alone, of their duty under art 2 to take all reasonable steps to protect the child’s life. (Para 94)

Experience of recent serious case reviews had drawn attention to the fact that they were not undertaken in isolation from other forms of inquiry or investigation relating to the circumstances of the death or injury of a child. The progress of criminal proceedings or coroners’ inquiries had always been processes which could materially affect the timing, completion and publication of serious case reviews. However, other public services were sometimes involved in their own investigations and reviews, for instance where a parent who had harmed a child was a patient of adult mental health services or where a child who died was in a custodial setting and where an independent inquiry was required. Increasingly, negotiation and accommodation of other processes of inquiry and review were being required. At the same time, some of the uncertainties which existed about independent inquiries set up by government ministers when there were matters of public concern were clarified by the provision of a comprehensive statutory framework in the *Inquiries Act 2005*.

Revised guidance about serious case reviews

In this study, serious case reviews were taking place against a backcloth of impending major policy reform and service reorganisation and in a more complex environment of inquiries, investigations and reviews. Now, following the *Children Act 2004*, they are doing so in the new context of Local Safeguarding Children Boards and developments to establish local systems for reviewing child deaths by 2008. It is inevitable that as the new changes bed in, so they will have repercussions for serious case reviews. They too are likely to evolve and change. However, the revision of guidance on *Working Together to Safeguard Children* in 2006 brought remarkably few changes to the serious case review process (HM Government 2006a, Chapter 8 is included as Appendix 3 to this report). The key changes are:

- the criteria for undertaking serious case reviews are broader;
- an independent author for the overview report is now a requirement;
- there is a need to consider how to involve family members;
- copies of the overview report are to be provided to the Department for Children, Schools and Families (previously to the Department for Education and Skills) as well as to the body responsible for the inspection of children's services (from April 2007 the new Ofsted, the Office for Standards in Education, Children's Services and Skills).

These changes allow for some continuity in the arrangements when serious case reviews are required and the commitment to learning lessons nationally from studying the overview reports at least every two years has been reinforced.

Policy developments in Wales and Scotland

Concerns about the adequacy of safeguarding systems have not been confined to England. In 2002, the Scottish Government (then the Scottish Executive) produced the findings of its child protection review with a set of wide ranging recommendations for change (Scottish Executive 2002). The recommendations included the need for guidance on how reviews of child fatalities should be conducted in Scotland:

The Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness. (Scottish Executive 2002, p.16)

A study of international comparisons of child deaths and significant case reviews was commissioned to inform the Scottish Executive (Axford and Bullock 2005). Extensive consultation then took place during 2006 on draft guidance for conducting significant incident reviews that would ensure there was 'a consistent, transparent and structured approach' (Scottish Executive 2006). There were differences from the serious case review system in England but similar emphasis was placed on the importance of learning the lessons from these reviews, both nationally and locally. National guidance for child protection committees for conducting a *significant case review* was issued in March 2007 (Scottish Executive 2007).

Policy on safeguarding has also been under review in Wales and the guidance on serious case reviews has been subjected to careful scrutiny. Two studies of serious case reviews were commissioned to inform policy in Wales, *Learning How to Make Children Safer* (Brandon et al 1999; Brandon et al 2002) which concluded with recommendations for local Area Child Protection Committees and for the National

Assembly for Wales (there was an earlier study by Colton et al 1996, also reported in Sanders et al 1999, and a study by Morris et al 2007). New guidance on safeguarding children was recently issued, Chapter 10 of which lays out requirements for serious case reviews and reinforces the commitment in Wales to learning lessons nationally (National Assembly for Wales 2007).

A final point made in the report by Brandon and colleagues in 2002 touches on a theme returned to in later chapters in this study:

Learning from isolated incidents of serious abuse or neglect and child abuse fatalities will be limited. Lessons learnt should always be set alongside findings from comprehensive audits of services for children and families throughout Wales. (Brandon et al 2002, p.77)

Chapter 5: Conducting serious case reviews

This chapter explores the conduct of serious case reviews from the point at which a decision is made to hold a serious case review and the arrangements that are then put in hand to undertake the review. Findings from the analysis of the overview reports are examined in terms of their compliance with the outline format provided in national guidance. More detailed examination and comment is made about some of the features of the reports, including aspects such as timescales, confidentiality and involvement of family members in reviews.

Crossing the threshold: the decision to hold a serious case review

The decision to hold a serious case review is not taken easily. As discussed in the previous chapter, the decision carries with it an onerous set of requirements to be fulfilled, set out in government guidance (Department of Health et al 1999; HM Government 2006a), and involves a major commitment of local resources. The criteria for making such a decision are defined but still require the exercise of judgement by the Local Safeguarding Children Board, and ultimately by the Chair of the Board. That judgement has to determine whether abuse or neglect, known or suspected, is a factor in a child's death (including death by suicide). A judgement also has to be made where a child has sustained a potentially life-threatening injury or serious and permanent impairment of health or development through abuse and neglect, **and** there are concerns about inter-agency working in safeguarding and promoting the welfare of children. The guidance poses a number of questions to help in making that decision. Even so, there is considerable discretion evident in the interpretation of the criteria and, as a result, considerable variation in practice about the decision whether or not to undertake a serious case review.

In this study, some of the respondents who were interviewed took a proactive stance to serious case reviews. One described the local Area Child Protection Committee as adopting an approach of *'tending to do reviews rather than not, in order to learn from them'*, even though they were acknowledged to be resource intensive and time consuming. The chair of a large city Area Child Protection Committee estimated there was on average one serious case review being commissioned by the Committee every month, even with strict interpretation of the criteria. Examples of other Area Child Protection Committees were given which suggested to the respondents that some committees were operating to different thresholds, resisting undertaking serious case reviews unless absolutely unavoidable. In these instances, the perception was that the local agencies thought there was a hidden national league table and the fewer reviews the better for the authority's reputation. In the same vein, others thought that the absence of serious case reviews would be likely to attract less external scrutiny or interest from bodies such as the national inspectorate, then the Commission for Social Care Inspection and now the Office for Standards in Education, Children's Services and Skills (Ofsted).

To an extent, they may have been right. Previous serious case reviews can be cumulatively an important source of information about particular local issues which can then be interpreted either positively or negatively by external commentators. In one serious case review, reporting after the period of this

study and not included in the sample, the author commented *'the social services department has been subject to an unusually large number of reviews ...including three other serious case reviews into the death of children'* and he noted the value of being able to cross check the conclusions of his review against the perceptions of others at the time (North East Lincolnshire Area Child Protection Committee 2004, p.5). Similar questions were raised by Arthurs and Ruddick (2001) in their study in South East Region when they found considerable variation in the number of reviews per authority:

The majority of local authorities either had no Part 8 review in this [two- year] period or had just one. We do not know why some authorities had several reviews and others none. This may relate to the threshold for carrying out a review, the robustness of local child protection arrangements or the size and characteristics of the population served by the local authority. (Arthurs and Ruddick 2001, p.21)

It is perhaps inevitable that there will be local concerns about whether the number or rate of serious case reviews in an area will become a performance indicator. However, with the advent of a much more open and transparent approach to reviewing child deaths generally (as outlined in Chapter 7 of *Working Together to Safeguard Children*, HM Government 2006a), the holding of serious case reviews may become part of a new cultural landscape of scrutiny and audit.

Arrangements for undertaking serious case reviews

A sequence of actions follows the decision to undertake a serious case review. The Serious Cases Review Panel of the Area Child Protection Committee (now the Local Safeguarding Children Board) is required to consider the scope of the review. Each relevant service is then required to undertake a separate management review of its involvement with the child and family and the *'Area Child Protection Committee should commission an overview report which brings together and analyses the findings of the various reports from agencies and others, and which makes recommendations for future action'* (Department of Health 1999, paragraphs 8.17 and 8.18).

Arrangements for undertaking serious case reviews were found to be similar across the Area Child Protection Committees in the study. Serious Case Review panels or sub-committees or Safeguarding Quality Assurance sub-groups had been established and carried specific responsibility for producing serious case reviews, for which they reported to the Area Child Protection Committee. In some cases, they reported additionally to the local authority for this task. Lead councillors for children would see either the full report or the executive summary and be briefed at the beginning and end of the process. In line with national guidance, individual agencies carried out their own management reviews including agency chronologies (although not always without difficulties, examples of which are illustrated later in the chapter). These reviews were then brought together into an overview report.

A critical decision at the stage of commissioning a serious case review is who will prepare the overview report. The status of the report writer of the reviews examined in the study was only clear in just over half the reports (25). As in the first biennial study, the status of the author was not recorded anywhere on the report in approximately 40% of the reviews (Sinclair and Bullock 2002). Of those reports where it was recorded, eleven were written by an external, independent author and fourteen were produced internally. Some respondents said they would always aim to appoint an external author, now and in the future, stating that:

It is irrelevant that they may not be familiar with the organisation's culture.

However, finding and commissioning competent external authors was a challenge in some parts of the country, often relying on informal networks for advice or suggestions. A number of respondents wanted a national register of experienced and suitably qualified professionals on which they could draw. There

were issues of availability, cost, specific areas of expertise and credibility to be considered and some had found that external authors sometimes brought their own agendas and their preferred approaches to the overview. Some committees had learned from experience that commissions needed to be rigorous in terms of report delivery working to expected formats, quality and timescales. One respondent reported disappointment with the outcome of an overview and believed that an internal author could have done a far more competent job. Others described the positive benefits of external authors who had not only brought added value to the process and produced high quality reports, but who had also played a more active role than simply that of writer and had, in one example, been prepared to return to provide feedback and reflection to wider audiences as part of the learning process. This had been greatly valued.

An interesting caveat was added to the introduction of one report by an independent author that suggested there were some tensions inherent in the role:

The report is based upon information made available to me and any opinions expressed are personal opinions based upon access to the information available. Any conclusions I reach are for the purposes of identifying and ensuring the application of "best practice" for the future and should not be considered as a judicial opinion based on the rigorous investigation of evidence as required in the Civil Courts.

Where the overview was produced internally, it was emphasised by respondents that this was done by someone outside operational line management, usually in a senior management position or in an off-line quality assurance or policy role. Distinct advantages were cited in terms of the value of internal authors knowing more about the organisational context and culture. However, there were also added pressures in undertaking an overview internally, not least because of juggling existing work with the demands of the review as well as having to handle sensitivities between agencies when they arose.

Views were explored with respondents about the current model for serious case reviews of combining individual agency reports with a wider overview report. All those interviewed emphasised the value of the model. One of the key themes from the responses was achieving and maintaining multi-agency responsibility for safeguarding children and for the practice of their staff. The collaborative approach built into the serious case review model was considered crucial, therefore, in keeping all the agencies in a local area focused on their responsibilities. Even within this model, there was a tendency for agencies when not directly involved in the review to *'back off if another is in the firing line – people don't step out of their territory'*. Working together collaboratively between the constituent agencies of the Area Child Protection Committee was reported to be a continuing challenge and some examples were given of individual agencies being reluctant to share their management reports during the overview process. An example of some of these challenges came from an author who recorded in an overview report:

A review was requested, but not received at the time of writing, from the GP service.

There was consensus among those interviewed about the enormous investment of time and money in producing serious case reviews and the challenge of doing so within extremely busy schedules. In questioning whether equivalent investment was being made in following up the recommendations and implementing the action plans, one respondent struck at the heart of this study by asking *'what is the value and impact of serious case reviews?'*

Compliance of the reports with national guidance

The ACPC overview report should bring together and relate the information and analysis contained in the individual management reviews, together with reports commissioned from any other relevant interests. (Department of Health et al 1999, p.91)

There is guidance in *Working Together to Safeguard Children* (Department of Health et al 1999; HM Government 2006a) about how overview reports should be produced and an outline format is provided. Each of the forty reports was evaluated against this framework. Most of the overview reports followed the format faithfully with variations according to the circumstances of the case. There were, however, some omissions and some more questionable variations. The detailed results are set out in Table 16 of Appendix 2.

Overview report introduction

Whilst all the reports summarised the circumstances that led to the review, and all but one listed the contributors and the nature of their contribution, six reports failed either to set out the terms of reference of the review or to list the review panel members and the author of the report.

Facts

Almost all the reports (93%) summarised the relevant information known to agencies and professionals about the circumstances of the child, the family and home. Most reports included a detailed integrated chronology of involvement with the child and family by the relevant agencies, professionals and others, as required by guidance. Six failed to do so (15%) and three did so only partially. A genogram is also required and twenty-eight reports (70%) included a genogram showing family and household membership and four reports had a more limited or partial one. Issues arising about chronologies and genograms are discussed in more detail below.

Analysis

Most of the reports (85%) had analysed how and why events had occurred, decisions had been made and actions taken, or not. There was evidence in 78% of the reviews that consideration has been given by the review panel or author as to whether different decisions or actions might have led to an alternative course of events. Examples of good practice were highlighted in two thirds of the reviews (25).

The findings about *Conclusions, Recommendations* and *Action Plans* are reported in the following chapter.

Variations in the overview reports

The degree to which the reports varied in length, style and presentation was considerable (see tables in Section Two of Appendix 2), a point also made by a Joint Chief Inspectors' Report on Arrangements to Safeguard Children in the same period as the study (Joint Chief Inspectors 2002). Half of the reports were comparatively short, thirty pages or less. However, almost a fifth of the reports (18%) were more than seventy-five pages long. Some of the variation in length reflected the differing content of the reports, with some containing appendices, recommendations and actions plans as different sections in the overall report. Others were produced with separate, stand alone sections and with four of the overviews it was unclear if a complete report had been received. Some reports were succinct, focused, and followed to the letter the guidelines as laid down in *Working Together to Safeguard Children* (Department of Health et al 1999). They conveyed a sense that this was an Area Child Protection Committee which knew what it was doing and knew how to manage the process of reviewing cases when required.

Others were the reverse: rambling, unfocused, with minimal structure, key information missing, lengthy chronologies, myriad recommendations and no sense of whether any of the action points would be implemented or make a difference. Many explanations for these differences might be suggested. One, however, requires careful consideration. Where the reviews were about families with complicated, messy lives, coping with multiple problems and multiple moves of accommodation, this could be seen in some reviews to lead to complicated agency accounts and, in one review, to a high level of tension between the agencies in their response to the review requirements. The review subcommittee in this case was clearly irritated. Inevitably, it might suggest the reflection process (Mattinson 1975 and others) at work not only in the history of the relationships between agencies and the family (which came through in the management reviews) but also extending to the serious case review itself, which was not always recognised or acknowledged by those undertaking the overview.

Family members as contributors to reviews

A new development in the conduct of serious case reviews has been that of seeking the views and perspectives of family members. This is in line with the more open and transparent approach to public service accountability reflected in the *Human Rights Act 1998*, discussed earlier. The guidance on determining the scope of a case review in *Working Together to Safeguard Children* included for the first time that a Serious Case Review Panel should consider whether ‘family members be invited to contribute to the review’ (Department of Health et al 1999, p.89). This has subsequently been strengthened in the most recent guidance. Review Panels are now asked to consider ‘*how should family members contribute to the review and who should be responsible for facilitating their involvement*’ (HM Government 2006a, p.145). The reports in this study were produced at least two years after the earlier guidance was issued. In eight reviews (20%) there was evidence of family members contributing to the serious case review. However, this may not be the full picture as family members may have declined an invitation to contribute, the circumstances of the case may have made it inappropriate or the report may not have recorded discussions or negotiations about this issue.

It may, however, also be indicative of the complexity this added dimension brings to the review process. Two particular issues stand out. First, the regard that has to be paid to the balance of individuals’ rights (which include the right to be heard and the right to privacy) and the public interest. This is made more complex when there are different family members’ interests to be taken into account, both within and between families involved and some of whom are likely to be children. Some aspects of this dilemma are touched on later in relation to confidentiality. Second, there is the balance to be found between the influence of family members’ involvement on the direction of the review and maintaining a dispassionate inquiry into the events (Masson has an interesting discussion on this subject in her article on *The Climbié Inquiry – Context and Critique*, 2006).

Those who did contribute to reviews included the mother of an adolescent who killed his partner’s baby. There were indications in that review that the focus shifted from the baby who died, and the baby’s sibling and mother, to the adolescent partner’s involvement and his own history of contact with different agencies. This experience suggests that great care must be taken to ensure the focus of the review is maintained firmly on the child. There is also the issue of family expectations about the process. Some respondents suggested that family involvement could be difficult if, for example, parents had been bereaved or family members were expecting the serious case review to be an inquiry.

A further development involving children and young people in contributing to the process was found in a more recent serious case review which was not part of this study. This was a serious case review undertaken by Sir Christopher Kelly on Ian Huntley for North East Lincolnshire Area Child Protection Committee (2004). In that review an attempt was made to contact the young women (most of whom

had been secondary school children at the time of the incidents concerned) to ascertain whether they, or their families, wished to contribute to the review. Two chose to do so and were carefully supported through the process.

It was evident from interviews that the corollary of inviting family members to contribute to serious case reviews was the responsibility it placed on the Area Child Protection Committee to keep them fully informed about the process and throughout the review, almost a *family liaison* role similar to that used by the police. This included taking non-abusing family members through the Executive Summary when it had been prepared, which was described by the former chair of an Area Child Protection Committee in positive terms as being a facilitative part of the work. Others in interviews described positive experiences for both family members and agencies deriving from families' involvement in the process. During the course of the study, it was evident that excellent material giving information to families about serious case reviews was currently being developed which could help to clarify expectations. However, it was also clear that family involvement required the identification of expert and sensitive staff with dedicated time and training to undertake this work. Sometimes these were Policy Officers or other staff of the Area Child Protection Committee undertaking a new task in addition to existing duties.

Timescales

The majority of serious case reviews in the study chronicled complex situations and multiple agency contact with the child or children and the parents. It was, therefore, surprising that as many as five (12%) were completed within the timescales laid down or nearly so, and a further 13 (33%) were completed within twelve months of the incident (seven reports, 17%, were not dated). However, for some Area Child Protection Committees it was a more difficult and protracted process and fifteen reports (45%) took over a year to complete (see Appendix 2). One review commented on the difficulties experienced in keeping to the timescales in *Working Together to Safeguard Children* (Department of Health 1999) when other investigations, proceedings or inquiries were also happening in parallel:

Although timescales exist for the completion of Serious Case Reviews, they do not usually coincide with Criminal Trials. This poses significant problems, as valuable information that could be relevant to the review will not be available. Unfortunately, little guidance exists for ACPCs drawing together the Overview Report in circumstances where a trial hasn't yet concluded.

Similar comments were found in other reviews:

The Case Review Sub Committee also noted that clarification was required regarding the progression of the Part 8 Review in view of the police investigation and criminal proceedings.

These reviews cited external reasons which had had an impact on the timescales for completing the serious case review. However, there were also reasons for delay arising from the internal review processes. One review took eighteen months to complete because of the time taken to produce individual management reports. For example:

The Health Management Review was to be almost a year in its completion and involved examination of twenty sets of agency records.

The overview itself, in this case, was completed in one month, once the individual management reports had been received and outstanding points clarified. Hardly surprisingly, that Review Sub Committee concluded:

In order for agencies and the ACPC to gain the maximum benefit from the investment of time involved in the completion of any future Part 8 Reviews, the provision of a clearer 'model' process and guidance to staff completing the Individual Management Reviews is indicated.

There is no doubt that recent organisational reforms in many public service agencies have added to the complexity of producing what could now be described as 'sector' rather than single or individual agency reports. The health sector in particular encompasses the potential for a plethora of reviews to be undertaken and collated for an *individual management review*. Many agency staff are inexperienced in producing such reviews, and some overview recommendations touched on the need for the provision of guidance and training for staff undertaking reviews, both at the individual agency and overview levels.

Confidentiality

The increased emphasis on openness and transparency has heightened the dilemmas surrounding confidentiality of information concerning family members and others living in the household or significant to the circumstances of the review. The stance that is taken by individual professionals or by agencies can have major consequences for the conduct and outcome of the review. These dilemmas manifested themselves in two particular respects in the review reports and were raised in subsequent discussions held by the research team with stakeholders. The first is explicit: the withholding of information from the review by professionals on the grounds of respect for the confidentiality of key family members or others in the household, still living. There was comment on the challenge faced by those charged with responsibility for undertaking a serious case review when GPs withhold access to records of parents and other household members, and when the Area Child Protection Committee fails to reach agreement with the GP in question. One review noted as a comment in the chronology:

The GP sought advice which advised him not to release his records. The letters received by the Author in response to her requests for the records indicate a lack of understanding regarding the purpose of a Part 8 review. The G.P. held the view that a Part 8 Review was an assessment to predict future parenting ability and as [the child] was safe he need take no action.

The second feature of confidentiality is less apparent but no less important. The involvement of family members in contributing to the serious case review raises delicate issues of what they are prepared to have recorded and considered as part of the review. Whilst they may be willing to talk about contact with agencies and professionals, or to confirm factual family history and the sequence of events in the chronology, there may be understandable reluctance to contribute information which could cast themselves or other family members in a negative light or be perceived as disloyal. As a result, the review team or sub-committee of the Local Safeguarding Children Board may end up in possession of information which cannot be used in the analysis of circumstances nor included in the final report. Dealing with confidentiality about information requested by family members is another challenge for those conducting serious case reviews, which is given added emphasis now by the requirement about family involvement in the latest guidance (HM Government 2006a, p.172).

Genograms

In presenting the facts of the case, the guidance in *Working Together to Safeguard Children* states that the report should have 'a genogram showing membership of family, extended family and household'. The reports showed great variation in the use of genograms. Some omitted a genogram altogether (8), some relied on long lists of family members with initials or using letters of the alphabet to distinguish them, and others provided the simplest of genograms with the nuclear family only. Not all were found to be accurate or correctly constructed when relevant information contained in the report's narrative was carefully read. However, those that showed complicated family membership, including previous

partnerships and children, and the involvement of different generations, in an appropriate way to the circumstances, were a valuable key to understanding the narrative and the chronology.

The purpose of a genogram and the reason for its inclusion as a requirement by government guidance in overview reports is often lost. It is most succinctly expressed and illustrated in an appendix of summaries of cases by Reder et al (1993):

The genogram is a diagrammatic representation of significant information about a family, such as sex, age, familial relationship, household composition, number and order of offspring, etc. (Reder et al 1993, p.138)

James (1994) and others have also demonstrated the strength of genograms to convey visually what may be complex and important factual information as a valuable adjunct to narrative describing these relationships (*Compiling a genogram* can be found as an appendix in Rose and Aldgate 2000, p.29). The added value that genograms bring to overview reports requires more careful attention to their construction.

Chronologies

Several of the overview reports commented on the integrated chronology. One report stated:

Overall, [the chronology] highlighted for the Review Panel that the key issue in this case was the fact that information regarding this family was viewed in isolation. The overall picture did not become apparent tragically, until after the boys' death.

In this case, the integrated chronology contributed significantly in assisting the review panel to understand how information about a family had been viewed and handled by the different agencies involved.

Another review found the task of producing an integrated chronology from single agency chronologies very difficult – there were anomalies because of different agencies' perspectives and accounts, and there were variations in the level of detail. It ended up with an integrated chronology of sixty-six pages covering a period of seven years. Lengthy chronologies were not unusual. Another overview produced an integrated chronology of 148 pages, without any reference to whether the child was seen or not, nor any commentary from the review panel. A further review had a chronology that was 105 pages long, its length redeemed by the illuminating and valuable 'Review Notes' in the final column highly relevant to the analysis of the circumstances.

Few chronologies identified specifically whether the child or children of the family were seen at the time of agency contacts, or whether children were talked to and their views sought, as required by *Working Together to Safeguard Children* (Department of Health et al 1999, p. 93; HM Government 2006a, p.177). More than one chronology appeared to have been compiled by someone other than the author of the report, quite possibly a task undertaken by an administrator. Most of the overview reports had the chronology attached as an appendix. One review incorporated the chronology into the report itself in a narrative form, drawing on information provided by agency management reviews. However, in this form, it was not always easy to follow. How the chronologies were used to inform the review process was generally not clear from the reports.

This raises questions about the value of chronologies. As the consultation paper on *child abuse inquiries* stated in 1985 (Department of Health and Social Security 1985, p.8), '*the initial task of the review will be to verify the facts*'. A key process proposed in that document was for individual agencies to construct '*a diary of events*' in the context of their own review. A comprehensive diary would then need to be

established, reflecting the involvement of all agencies, and would require inter-agency co-operation (p.8). These diaries became known as chronologies.

They gained more public prominence as a valuable aid to the process of conducting a review when the independent report into the death of Sukina Hammond was published, incorporating a detailed 55 page case history chart or chronology in Part One of the report (Bridge Child Care Consultancy Service 1991). Previous review panels had been compiling chronologies as a critical part of their working method but until then had not normally included them within their final reports. An experienced independent chair of serious case reviews commented to the research team that the chronology was an important early step in the review process. It helped to define the direction of inquiry, the issues to be explored and the areas where further information was required.

In conclusion, if chronologies are not simply another task to be completed during a serious case review, more attention is required to how they are compiled and used during the overview. It is important that compiling an integrated chronology does not become an end in itself and a separate process from the rest of the overview. From agencies' perspectives, they are part of a process of accountability for their actions. Their value in the overview is in informing the reviewer's or review team's understanding and analysis of the circumstances. They can provide insights by aggregating information about the child and family's history and contacts with different agencies which can then determine the direction and focus of the review, including areas for identification or exploration about agency practice, procedures and policies. Discrepancies in accounts or meaning attached to events in the agency chronologies are as important as gaps or missing information. They also have an important role in providing a baseline for discussion, as appropriate, with family members during the overview.

Furthermore, the requirement to note in the overview chronology 'each occasion on which the child was seen and the child's wishes and feelings sought or expressed' (HM Government 2006a, p.177) needs to be reinforced. It may require review by some Local Safeguarding Children Boards of whether their constituent agencies record such information as a matter of course in their records and how that information can be retrieved when agency chronologies are compiled.

Attention is now being given to the development of a range of practice tools to assist the processes involved in serious case reviews. These are discussed in more detail in the third biennial study by Brandon and colleagues (2008). One practice tool that is relevant to compiling chronologies is *ChronoLator*, a program for gathering and merging data for multi-agency complex reviews (www.chronolator.co.uk).

The overview report

When the overview report has been completed, together with an action plan and an executive summary, there is the question of who will see the report and how it will be used.

Respondents conveyed a degree of uncertainty and variation in local practice about the use and communication of overview reports. In part this was a reflection of the national guidance which indicated that local judgement was required about use and communication according to the circumstances. Area Child Protection Committees were advised that they '*should consider carefully who might have an interest in reviews ... and what information should be made available to each of these interests*' and clarify to whom the report, or any part of it, should be made available (Department of Health et al 1999, p.93). Providing feedback and debriefing to staff, family members of the child and the media, 'as appropriate', were identified as key actions. Finally, a copy of the overview report was to be provided to the Department of Health (Social Services Inspectorate Social Care Region). From April 2007, reports now go to Ofsted (Office for Standards in Education, Children's Services and Skills) and to the Department for Children, Schools and Families.

The guidance was also clear about the executive summary:

In all cases, the ACPC overview report should contain an executive summary that will be made public, which includes as a minimum, information about the review process, key issues arising from the case the recommendations which have been made. Such publication will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others. (Department of Health et al 1999, p.94)

Producing the executive summary was not always experienced as being so clear cut. Some respondents described it as an enormously complex task requiring reflection, time, judgement and skill. Since the summary would be for publication, it was important to ensure that there was sufficient information in the report to meet the proper requirements for transparency and accountability, to show that a rigorous review had been carried out and to answer the questions likely to be raised. It was argued, however, that it needed to be written so that it did not fuel press and public interest inappropriately, particularly when there were sensitive issues requiring confidentiality of children's and other family members' interests.

In most of the Area Child Protection Committees of the respondents interviewed, the overview report was sent to all the Area Child Protection Committee members and the executive summary was circulated more widely and made public. One exception was a Committee that only met quarterly as a strategic body, and did not receive overview reports but, after scrutiny by a senior manager, full reports were submitted to the serious case review sub-committee for further consideration and action. This particular serious case review committee was reported to have '*a strong ethos of confidentiality and trust which has been built up over years, and they are encouraged to be very frank and open*'. Lead councillors in some local authorities were reported to receive the full overview report but most would certainly have had the executive summary and a briefing, either at the beginning or end of the review. In other authorities, Area Child Protection Committee reports went to local authority members as a cabinet report. Respondents emphasised that when executive summaries went to councillors and were then made public, great care was taken to protect the identities of staff and families. In addition to the executive summary, in one area there was an example of another summary, a *professional summary*, being compiled for wider circulation to staff and also used for training purposes. Anxieties and uncertainty were apparent about the issues of access and confidentiality when there was a high level of media interest, locally or nationally, or other proceedings were still underway, and a range of different interests to be balanced sensitively.

There was no doubt that completion of the review report was experienced as a momentous point in the process and respondents made it clear that the impact on all concerned needed to be acknowledged. There was a strongly held view that the process at this stage required managing. This entailed preparation and planning:

- writing the executive summary and other briefing materials;
- identifying those who needed to be informed or briefed, when and by whom, including family members, senior managers of agencies, elected members and the media;
- handling and preparing staff sensitively and well, and arranging for vulnerable staff whose practice had been exposed by the report to be appropriately protected from harassment or moved;
- anticipating likely responses from different quarters and ensuring senior managers did not retreat to what was described as a '*bunker mentality*'.

How the report was handled was obviously critical in creating the right conditions for learning the lessons and bringing about change as required.

Chapter 6: Overview conclusions, recommendations and action plans

The previous chapter has examined the arrangements for conducting the serious case reviews included in the study and for the production of overview reports. This chapter now looks more closely at the conclusions and recommendations of the reviews and how these were translated into action plans and subsequently implemented.

Overview conclusions

The report should summarise what, in the opinion of the review panel, are the lessons to be drawn from the case and how those lessons should be translated into recommendations for action. (Department of Health 1999, p.93)

Most of the overview reports (80%) contained a summary of the lessons that the reviewer or reviewers considered could be drawn from the case, together with a set of recommendations for action. In a further four of the reviews, this was only partly the case and in another four reports, no such summary was found. A quarter of the reviews highlighted lessons for national policy and practice in addition to local lessons.

The findings identified by authors of the reports were rarely new and often reflected those in previous reports – even within the same local authority. They echoed findings examined in detail in a range of studies (from the first by the Department of Health and Social Security in 1982 onwards) as well as those concluded in the report of the Victoria Climbié Inquiry (Cm 5730 2003). Indeed, some of the authors made reference to findings in previous high profile cases, research and guidance to reinforce the salience of their own findings. However, only one of the reviews in this study indicated that, in hindsight, different decisions or actions might have led to different outcomes. The common themes from the conclusions can be summarised as follows:

Failure to protect vulnerable children as the result of:

- Loss of focus on the child or the child's circumstances and their impact on the child or children.
- Practitioners not seeing the child or children on home visits, or having direct communication with them.
- Focus on the adult family members rather than the child, or agencies taking a single client focus only.
- Lack of overview or reflection about events or about what was happening.
- Poor assessment and analysis, including risk of harm to children, particularly in circumstances of parental or other significant adults' domestic violence, mental ill health and substance misuse.
- Not recognising indicators of risk of harm as the result of chronic neglect.
- Not acting on assessments or allowing loss of case momentum.
- Over optimism particularly about parenting capacity in difficult situations.
- Decisions made in isolation without assessment of the risk of harm.

Practice across agencies:

- Poor information sharing and communication.
- Poor recording, including not recording decisions, and lack of significance identified in notes.
- Not following child protection procedures or s47 processes, such as not meeting regularly, or poor attendance at conferences.

Management and Supervision:

- Lack of management oversight of cases.
- Poorly trained, inexperienced practitioners and managers.
- Insufficient supervision.

The reports suggested that there were particular points of vulnerability for children at times of transition, for example when they moved address, moved schools or moved to another local authority area, or when key workers changed. (*ContactPoint*, when it is available to local authorities in England from 2008, is intended to assist practitioners with a quick way of finding out who else is working with the same child – see www.ecm.gov.uk/contactpoint.)

Reports also found that good practice in some areas of work with the family failed to compensate for poor practice in others. There were examples of extensive inter-agency communication taking place, and yet child protection issues being overlooked and risk indicators not being sufficiently taken into account. In some of the reviews, there were examples of key child protection agencies failing to respond to the request of another agency, such as a school requesting an inter-agency meeting. In other circumstances, critically important professionals were excluded from the information loop. Reports noted there were indications of too much incident-based practice and reactive actions, uninformed by previous events and recording. The reviews concluded there had been too little evidence-based reflective practice that

took account of previous information, that built a more comprehensive, long term picture of what was happening, and that used this to inform a more strategic approach to thinking and planning the work.

Three points can perhaps be made about the reports' conclusions. First, there was an underlying difference in the way the conclusions were addressed, which was confirmed by a number of respondents during interviews. The difference appeared to relate to the particular perspectives or values of the authors or members of the review panels. Some reviewers came to a judgement that the way to understand what had happened was to see it a whole systems failure. Others saw the case in terms of individual non-compliance with policies, procedures and processes, or in terms of individual professional mistakes. This was then further reflected, in some cases, in the way the recommendations were framed.

Second, a number of reviewers emphasised in the cases they were examining *the lack of risk assessments* and the importance of *recognising risk indicators*. The reviews were undertaken at an early stage in the implementation of the *Framework for the Assessment of Children in Need and their Families* (Department of Health et al 2000) in England, and before the *Common Assessment Framework* (HM Government 2006) had been developed for use across all agencies working with children. More confident use by practitioners of a developmental-ecological framework for in-depth assessments, analysing the interactions and transactions between the different dimensions in a child's world, may now result in less emphasis in serious case reviews on risk assessment being undertaken as a separate and unrelated form of assessment measure.

The Assessment Framework places importance on understanding both strengths and pressures in situations, and on both risk and protective factors being assessed and weighed up (discussed by Jones et al 2006). Additionally, there is an important literature on identifying risk factors as the result of systematic reviews which might assist practitioners in considering the circumstances when children may be vulnerable to maltreatment or to the recurrence of maltreatment (for example, Hindley et al 2006). The preoccupation with failure to assess, analyse and understand the consequences of risk of harm repeated in the findings suggests this may be an area that would benefit from further work and exploration in bringing together theory, research and practice (see Brandon et al 2008).

Third, the conclusions reinforced the difficulties experienced in working within and across professional agency boundaries. Without rehearsing again the well covered territory of interagency or cross-boundary working, there is a wealth of literature that emphasises how difficult it is to achieve effective interagency working in practice and yet how fundamental it is to work with children and families, reflected in the title of the national guidance, *Working Together to Safeguard Children*. Writers, such as Bob Hudson, have neatly summed up this dilemma:

*There is a paradox here, with 'collaboration' seen as both problem **and** solution – failure to work together is the problem, therefore the solution is to work together better! (Hudson 2000, p.253)*

The policy framework was already changing during the period of the reviews, with government commitment evident to reducing fragmentation of public services and providing more joined-up working. For children in England, this culminated in the overarching policy framework of *Every Child Matters* in 2003 and the *Children Act 2004*. However, successful implementation requires the translation of such policy aspirations into behavioural change by front line practitioners in the way they work and communicate (Rose et al 2007).

Hudson firmly asserts the importance of recognising that *'inter-organisational relationships are largely built upon **human** relationships'* (Hudson 2000, p.254). Building up trust and nurturing fragile relationships with practitioner colleagues from other agencies are two key components of working together effectively (Hudson et al 1999). It was clear from the reviews, however, that interagency work

was taking place in an increasingly complex and rapidly changing organisational context (examined and discussed by Parton 2004). As commented earlier, this was partly due to policy changes, to organisational reforms and to staffing shortages in many public services. Achieving relationships of trust with known colleagues was infinitely more difficult in these circumstances, a factor which needs to be taken account of by Local Safeguarding Children Boards in their approach to interagency working. It can be argued that the challenges lie not just in learning lessons from the findings of serious case reviews but 'in responding to the enormous changes that have taken place in the contexts and thus the nature of the work involved' (Parton 2004, p.93).

Overview recommendations

The guidance to Area Child Protection Committees suggests that, in order to gain maximum benefit from the review process, the recommendations should be focused 'on a small number of key areas, with specific and achievable proposals for change and intended outcomes' (Department of Health et al 1999, p.94). The recommendations in three quarters of the reviews generally met these expectations. They were relatively few in number (up to twenty), focused, specific and capable of implementation. In twelve reviews, there were up to 40 recommendations, one had between 40 and 60, and one had as many as an overwhelming 80 recommendations (see Table 17 in Appendix 2). These were similar findings to those of the inspection report on *Arrangements to Safeguard Children* (Joint Chief Inspectors 2002).

The focus of the recommendations was surprising. The conclusions had dwelt on lessons to be learned about work with children and families and with other agencies to improve safeguarding practice. These conclusions were generally related to information about the case and to its analysis. The solution to enable these lessons to be learned, however, was not on improving practice by increasing knowledge and skills but on creating more procedures. The focus of the recommendations was predominantly on reviewing existing procedures or calling for new procedures – a total of 198 recommendations in forty serious case reviews. They ranged from the very specific and detailed, relating to the circumstances of a particular case, to the very general, the precautionary and the sometimes quite bland. Axford and Bullock (2005), in their study of international approaches to significant case reviews, identified the conditions 'necessary and sufficient for an effective review process,' and warned about recommendations that led to cumbersome procedures:

The first point to make is that what is deemed a 'good' review might not be good for children's services generally. We have seen that recommendations can create cumbersome and expensive procedures and reinforce an adversarial and forensic approach that is not helpful for the majority of child protection work. (Axford and Bullock 2005, p.57)

The next most commonly made set of recommendations were about improving communication (cited in 81 recommendations) and recommendations aimed at improving information sharing and recording were frequently mentioned in the category of 'other'. Assessment practice either in relation to children and families or addressing risk assessment featured in 74 recommendations, and was closely followed by recommendations about training (72). Far fewer recommendations focused on management (44) and there were even fewer on supervision (20), the roles of staff (18) and decision making (15). Staffing issues scarcely figured in the recommendations. The need for new staff was only identified in 7 recommendations and issues of knowledge, skills and experience of staff only in 5. This seemed at odds with the findings since issues of practice had been so firmly identified in the conclusions which might have reasonably led to more emphasis on training and supervision that would support knowledgeable, skilled and reflective practice in a difficult environment.

It was found, therefore, that there was often a distinct discrepancy between the conclusions reached by the overview and the type of recommendations that followed. Some reasons for this can be offered. One might be the influence of the process for compiling the recommendations. The way the recommendations were structured appeared in some cases to be an endorsement and reiteration of the recommendations of the individual management reviews, with a section added by the reviewer of recommendations for the Area Child Protection Committee. Sometimes there were additions made by the reviewer to the agency recommendations already made by the individual management reviews. Others produced a completely new set of recommendations from the overview, noting that these were in addition to the individual agency recommendations which were not included in the report. Rarely was there a strong sense of an overall strategic approach to the recommendations.

However, another explanation for the discrepancy might be less to do with the process and more to do with concerns about professional practice. Increasing the number and scope of procedures to cover as many eventualities as possible might have given some sense of security to the review panel or senior managers of agencies of the Area Child Protection Committee, of their being able to exert control over unexpected circumstances in the future. These issues were explored in interviews.

Respondents revealed their own sense of frustration in this respect. It was perceived that there was a critical dilemma about recommendations. On the one hand, it was important to use the opportunity brought by the high profile of a serious case review to make an impact, but on the other it was acknowledged that a large number of recommendations could be counter-productive if not implemented. Some tried to minimise the number of recommendations to those that were new and different from previous overviews. Where they were not new, some justified them on the grounds of being reminders. Others acknowledged that it was not always clear that the answer lay in new systems or new procedures. Often adequate systems were in place, they argued, but the problem was perceived to be one of staff compliance. However, reviewers were uncertain how to achieve changes in practice – *'there are good enough training programmes in place but practitioners still don't understand an issue or don't do it in practice'*. Another respondent said:

In the latest serious case review, the issues have indicated that compliance is the issue. We have found this quite shocking and have been circulating to staff information about the need to improve the quality of initial assessments and for them to comply with their statutory responsibilities.

A third respondent commented:

It is unusual to find something remarkably different or new. These are core elements of good practice. We are picking up where people have fallen down.

A lead officer in one case was candid that *'the recommendations were quite bland and fitted with what was already underway through service development'*.

It was clear from the interviews that, in the latter stages of the serious case review process, translating conclusions into viable and constructive recommendations required careful discussion about cause and effect, and agreement needed to be reached about effective strategies for achieving change. There was a mixed picture from the reports, confirmed in subsequent interviews, about how far the recommendations in this study were thought to be the appropriate solutions for the problems the overview had identified. This may be a problem inherent in the serious case review process which is considered further in the final chapter.

Action plans

Reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as on conducting the review. (Department of Health et al 1999, p.94)

Guidance requires that recommendations of an overview are translated into an action plan which should be endorsed and adopted at a senior level by each of the agencies involved. It is expected that the plan will set out who will do what, by when, and with what intended outcomes. Finally, the plan should set out by what means improvements in practice or systems will be monitored and reviewed (Department of Health et al 1999, p.91).

The action plans in this study were generally produced as separate documents (68%) although eleven plans (28%) were incorporated into the final overview report. Just over half the reviews (58%) produced a single action plan covering the actions required by each of the agencies involved. There were four reviews that appeared to be incomplete and it was not possible to say in those cases whether a single action plan had been produced. The number of action points in the plans varied widely, as might have been anticipated from the variation in the recommendations, with nine plans having ten or fewer identified actions to be taken. Twelve plans (30%) had between 21 and 40 action points, one had over sixty and one had over a hundred. The likelihood of those hundred all being implemented, let alone adequately reviewed, seemed very remote.

The relationship between the recommendations and actions was examined. It was not possible to tell what the relationship might have been in four reports as they were incomplete. In all but two of the remaining reviews, the actions appeared linked to the recommendations and in two thirds the actions were judged to be consistent with the intention of the recommendations. Two examples where they were not consistent were recommendations about case allocation and the functioning of the child protection core group, when there had been no indication in the report that these were not working well. A second example was when there were no recommendations about sharing of information after assessments had been undertaken, although the report clearly identified that this had been a major issue. One respondent commented that the creation of action plans at the conclusion of a serious case review could be a rushed process due to other constraints, such as the deadline for publication, political pressures and so forth.

Often recommendations were placed in a left hand column and the actions required spelt out in the next column of the plan, demonstrating the link. Only half the action plans stated who would be the lead officers for each action although sometimes a lead body or committee was identified. Dates for completion or review of the actions were specified in nearly two thirds of the plans. However, although outputs of the actions were usually described, such as new procedures in place or a specific training programme carried out, sometimes they were less specific, such as reviewing a particular set of arrangements, but rarely were the outcomes identified. The question has to be asked again. How would the Area Child Protection Committee know if an action had produced the desired change in policy or practice? Had taking the action produced an improvement in safeguarding policy or practice? What would be the evidence?

Implementing recommendations and action plans

Respondents were asked about whether the recommendations and action plans had been implemented and what had happened as a result. They were also asked to think about what had helped and what had hindered implementation. They described parallel processes of implementation taking place within each of the individual agencies and general monitoring being undertaken by the Area Child Protection Committee or its subgroup or review panel. Some were confident that the recommendations had

been implemented and the actions were now well embedded in their procedures. Others said that the recommendations were implemented and action plans signed off, yet *'I can't say with my hand on my heart that they have all been embedded and have changed people's practice'*. It was also pointed out how difficult it was to find evidence of impact because, for example, as respondents reported:

- *some actions may have been swooped up into the next review;*
- *what was put in place at the time may be lost and changed later;*
- *we need to be more specific about what the outcomes of recommendations will look like;*
- *some basic recommendations get overlooked – we are trying to make them sharper;*
- *we rely on individual agencies to implement their recommendations and some do this in isolation;*
- *there has been much change in personnel – people only see a small part of the practice;*
- *there is a danger that longer term recommendations may get overlooked in early sign off, for instance where procedures are to be rewritten, this may be delayed until there is a major procedural overhaul;*
- *action plan fatigue sets in – plans tend to be signed off when enough recommendations have been met. (Interviews with respondents)*

Examples were given of the introduction of specific provisions or procedures which had taken place *'without question'* and of areas of work being given new priority and focus as the result of issues identified in the review. One respected independent chair of child death reviews in Scotland, in a personal communication with the research team, identified two key features which in her view influenced the impact of a review:

- *the level of commitment of the commissioners of the review;*
- *the profile of the case and the degree of interest from the press, which, if high, could have a galvanising and positive effect.*

Her comments suggest that heightened press interest need not be wholly negative and could have a positive effect on subsequent action, or it could have the negative effect of contributing to a defensive climate among the agencies involved, and thus impeding the progress of implementation.

What helped implementation?

Asked what had helped to implement the recommendations, respondents who had had responsibility for implementation said they had been helped by a number of factors, including:

- *the initial shock of the case and the related authority provided by the serious case review;*
- *making good judgements about what was systemic failure and what was individual non-compliance and/or mistakes;*
- *the recommendations being in line with other national developments;*
- *having a strong and confident Area Child Protection Committee;*
- *regular review and audit of progress. (Interviews with respondents)*

There was no doubt that after the initial crisis, there was often a strong desire expressed across the constituent agencies of the Area Child Protection Committee to do things differently and to prevent the death or injury of a child ever happening in such circumstances again. This climate gave permission

and energy to bring about change, and managers and practitioners were described as *'listening'*. It was acknowledged that crisis could be a two-edged sword. The resultant fear and shock factors could have a very long term debilitating impact on staff, and the case could become absorbed into the history of more than one local agency – *'we still talk about it today'* said one respondent.

The recommendations, however, could become an effective lever for change and justify the pursuit of new priorities previously overlooked or lower down the scale of importance or urgency. It was reported that staff took actions more seriously and were more likely to meet timescales because they had emanated from a serious case review. It was noted by others, however, that it was important to avoid *'shroud waving'* and to continue to be clear about the key messages in order to maintain the momentum. Once again, the issue of whether recommendations reflected systemic failure or individual error was aired. Where there was general agreement with the judgement reached, then this was an important factor in gaining support for implementation of the findings. Respondents considered this was a key issue in addressing overview findings and formulating the recommendations, and then deciding how the message was to be delivered.

When the recommendations were in line with local or national policy developments or initiatives, it was reported that it made it much easier to implement recommendations. Examples were given of recommendations reflecting those in the Victoria Climbié Inquiry or coinciding with local policy or practice developments, such as improving services for disabled children, which allowed considerable progress to be made. Respondents talked about the advantages of *'moving in the same direction'*, *'achieving a collective impetus'* and *'having greater access to available resources'* as a result.

The capacity and cohesion of the Area Child Protection Committee was reported to be an important factor in implementation. The advantage was emphasised of having a strong and confident Area Child Protection Committee which had built trust and good relationships between its constituent agency representatives, and could make the most of its authority and relationships. There was likely to be more effective implementation and more focus on learning the lessons as a result.

The place of audits

Finally, the point was made about the value of having a systematic process for reviewing progress of the recommendations and action plan, tracking through the changes, and keeping the messages alive and strong and focused on practice. The auditing approach had been endorsed in government guidance:

The ACPC should put in place a means of auditing action against recommendations and intended outcomes. (Department of Health et al 1999, p.94)

Several of those interviewed or who attended the national study seminar commented on the importance of following up the serious case review recommendations and action plan by some form of audit. Some had developed their own in-house auditing system, others had adapted models from neighbouring Area Child Protection Committees, whilst a further group referred to their use of the NSPCC auditing framework, *Safeguarding through audit – A guide to auditing case review recommendations* (Handley and Green 2004) which they were finding very successful. The NSPCC guide makes the important point that:

Effective audit is dependent on good quality recommendations. Unless recommendations are SMART they are unlikely to be implemented and will probably prove impossible to audit. It is therefore worth spending some time framing and negotiating recommendations as part of the Case Review process. (Handley and Green 2004, p.14)

The development of such audit frameworks provides a constructive way of integrating the action required after a death or serious injury into the mainstream of agency practice. They also require a re-evaluation of the way in which recommendations and action plans are framed at the conclusion to a serious case review, with the strong message that recommendations must be specific, measurable, realistic, achievable and timely (SMART).

What hindered implementation?

Respondents who were interviewed identified a number of factors that, in their experience, hindered implementation:

- *too little time, money and other resources;*
- *new initiatives or another serious case review overtaking the issues before they were implemented;*
- *staff turnover and the problems of making sure that messages were heard by new staff;*
- *working out how to embed the changes at the front line and making sure it was everyone's business;*
- *the challenge of keeping the messages alive – the danger of issues 'losing their spice', especially with front line workers;*
- *ensuring ownership of the issues by agencies and keeping them engaged in the change process;*
- *finding trainers who owned the material and felt confident about it, otherwise cascade training could become counter-productive. (Interviews with respondents)*

One respondent summed up the challenge of translating recommendations and action plans into changes in practice:

At the time, the fact that this was a serious case review could open doors for me in getting things done but, unless you embed changes in procedures, then there are no guarantees that practice will change.

Such comments raise again the question of the reliance placed by some agency managers on procedures as a means of ensuring improvements in practice, issues that are examined further in the next chapter. The comments also highlight that the respondents in this study were managers and not practitioners, and suggest the importance for any future study of including the practitioners' perspectives.

Costing reviews

In none of the reports was there any indication of the financial consequences of the recommendations or actions. This provided an impetus to the research team to find out what was known about the cost of serious case reviews and the financial implications of the reviews' recommendations. Beecham (2000) has pointed out the importance of developing a better understanding of costs of children's services:

Remote as the world of financial accounting may seem from the difficulties faced by many families, the way the money flows through organisations and feeds into services needs to be more widely understood if the quality of child social care across the country is to be consistently high. (Beecham 2000, p.6)

Increasing attention is being given by government to the costs and effectiveness of public services as part of performance management. This has included recent research into costs and outcomes in children's social care (Beecham and Sinclair 2006). In this respect, it can be argued that serious case reviews should not be exempt from such examination. There are two aspects to the issue of costs in serious case reviews:

- the cost of undertaking the serious case review, including all the resources such as staff time employed during the process;
- the cost to local agencies of the recommendations contained in the serious case review and the resulting action plan, if it were to be fully implemented.

Some work has been done on estimating the cost of public inquiries into child deaths (see earlier examples in Reder and Duncan 1996) but the priority given to the importance of public accountability in these cases has overridden any realistic or detailed costing of the inquiry itself. Figures have sometimes been aired, without any formal confirmation. The situation in relation to public inquiries has since changed. Following the commencement of the *Inquiries Act 2005*, Ministers who cause a public inquiry to be held are now required to fund the inquiry and then publish the total amount paid by government.

Masson comments in relation to Victoria Climbié that *'the resources committed to the inquiry would have funded a substantial programme of research and pilot projects giving a far better basis for new developments than any detailed analysis of one case of failure'* (2006, p.243). Commentators such as Masson, therefore, make the point that the resources invested in the activity of inquiry or review should be proportionate to the benefits:

Understanding what went wrong is a limited activity to which only modest resources should be committed. (Masson 2006, p.243)

The evidence to support or refute this assertion in relation to serious case reviews is hard to find. In the first government consultation paper on *child abuse inquiries* (Department of Health and Social Security 1985), the Department did not anticipate that implementation of its guidance would have *'any measurable resource or manpower implications for local and health authorities or other agencies'* over and above those already incurred when there were serious incidents (p.3). The consultation responses to this assumption were not available for scrutiny in this study. Thereafter, the issue of costs in this respect stayed relatively dormant for the next twenty years.

However, the then Department for Education and Skills took an important step in the matter and gathered some information about the costs of holding serious case reviews in preparation for the most recent revision of government guidance on safeguarding. Questions were included in a survey of Area Child Protection Committee income, expenditure and staffing in 2004-05 (published in *Working Together to Safeguard Children – Draft for public consultation, 2005*). The average expenditure for Area Child Protection Committees on serious case reviews was noted as £1,522 (2% of the total). However, three case examples were more revealing. For one County Council, the cost in the previous year had been £5,761 (3% of expenditure), for a Unitary Authority it had been nil, and for a London Borough it was £6,900 (10% of its total expenditure). This suggests, therefore, there is likely to be considerable variation and there is no further information about the make-up of the costs. In lengthy, highly complex and high profile cases, the cost is certainly likely to be greater than expressed in any of the examples, and some areas may have to find the resources for one or more serious case reviews in a year and, in one authority already cited, as many as ten a year.

However, no comments could be found during the analysis of the reviews about the cost of the process, modest or not, either in terms of individual management reviews or the subsequent undertaking of an overview (although this may have been picked up in local Annual Reports). There were sometimes indications that the process had been costly in terms of time, either because of the complexity of the circumstances or because of the difficulties in obtaining or reconciling agency reviews. It was also obvious that the decision in some cases to use an independent reviewer added considerably to the costs of the local Area Child Protection Committee. However, costing reviews will always remain a

difficult calculation because costs will be absorbed by different agencies in the use of their own staff in contributing to reviews, and much of the work on the overview is undertaken by Area Child Protection Committee staff, such as co-ordinators or policy officers and their administrative colleagues.

The absence of such information raises questions of how far resources may influence the decision to undertake a serious case review, particularly in those circumstances where there have been several reviews occurring in quick succession or being conducted concurrently. If resources are not a critical factor in the decision, then there is the question of how the costs incurred are managed within and between the budgets of the Area Child Protection Committee and the constituent agencies. Axford and Bullock (2005) make similar comments from their international study:

There must be an accurate estimate of the likely costs of the review in terms of staff time and revenue expenditure and agreement about who pays. A sudden need to consult an outside expert, for instance, can radically affect budgets and lead to acrimonious disputes. It should be recognised that some reviews will need to be very expensive, others less so. Agreed cost estimates should be related to the aims and desired effects of the review. (Axford and Bullock 2005, p.58)

In conclusion, it is not possible to comment on how proportionate, cost effective or significant is the expenditure on serious case reviews locally or overall nationally as part of the safeguarding system, but this may be an area where further investigation of costs and outcomes would be worthwhile.

Costing recommendations and action plans

The second element in costing serious case reviews is the cost of recommendations made by the review and the cost of implementing the agreed action plan. Recommendations in the overview, as has already been discussed, on the whole followed those in the individual management reviews and some included further recommendations for the Area Child Protection Committee and all agencies as well as individual agencies. In none of the overviews analysed was the issue raised of whether a recommendation could be afforded, nor was there any indication that resource considerations had influenced the final recommendations, although this might have been part of the review panel discussions. Similarly none of the action plans contained any costs attached to individual items, even where very occasionally the employment of additional staff was being agreed. The variation in the action plans suggested that some which were extensive would be very expensive indeed if implemented in full, and cast doubt on that likelihood.

Chapter 7:

Learning lessons from serious case reviews

Part 8 reviews scare people witless. The challenge is to break down the fear – you have to be held to account and see how you can learn from it too. It is a fine line between working with individuals and seeing what can be learned for the organisation. It is also about holding the reputation of the organisation and the Area Child Protection Committee. (Interview response)

The tensions that have to be managed by those responsible for undertaking serious case reviews have been evident throughout the study and are exemplified by the above statement from one of the study's respondents. This chapter explores whether, at the end of the process of producing a serious case review report and implementing the recommendations and action plan, it was possible to identify changes that had occurred. Had the review made a difference to future safeguarding of children in a local area? Had lessons been learned and how were they being used? Respondents were asked to identify what had been learnt from the serious case review. They suggested to the research team that while lessons could be drawn from the reviews, it was not always easy to know if they had been used to bring about changes in practice. They conveyed mixed messages. The chapter discusses how these comments are reflected in some of the different perspectives about the value of single case reviews and inquiries arising from debates in a wider context. During the study, however, examples were given of promising developments in learning the lessons from reviews locally, regionally and nationally which are included in the chapter.

There is understandable concern at government level that the process of review or inquiry should be more than just an exercise in accountability and should result in tangible improvements in policy, practice and learning in all spheres of public services. Some reasons for this are suggested by Stanley and Manthorpe (2004):

The effort, time, expense, together with professional and personal involvement invested in inquiries, make it important that their aftermath is used positively to inform policy, practice and learning. (Stanley and Manthorpe 2004, p.8)

Government guidance about safeguarding makes it clear that serious case reviews should have an impact locally and nationally (Department of Health et al 1999, pp. 94-95; HM Government 2006a, pp. 179-180). A careful distinction is made in the guidance between maximising the learning locally from one or more reviews and the value nationally of serious cases reviews, when taken together, as an important source of information to policy makers. A further development identified during the study was the importance being attached by the new Local Safeguarding Children Boards to regional collaboration and the potential role of Government Offices in facilitating learning across the regions together with their role in monitoring the implementation of serious case review recommendations.

Learning lessons locally

Respondents had very different views about the impact of reviews locally and the extent to which lessons had been learned. They generally regarded serious case reviews as '*enormously valuable*' and identified their potential to generate learning from mistakes and to act as powerful motivators for change. This reflected views expressed to Sinclair and Bullock in the earlier study (2002). Respondents gave detailed accounts of what they had learned from the particular circumstances of their serious case review about how local policy, practice and interagency collaboration were working. However, many then talked of the challenge of making effective use of the findings and turning these into practical improvements, and here there was less detail and less certainty. It was more difficult to find a direct link between changes that had occurred locally and the findings and subsequent action from serious case reviews. It was stressed that it was critical to identify in very specific terms what needed to change. Training was seen as potentially playing an important part in the process but should be regarded as *continuing professional development*. Some respondents were positive about what had been realised:

There was a tremendous amount of learning for us, and it really changed the culture.

Examples were given of starting new initiatives, achieving new levels of managerial scrutiny of routine practice, developing an interagency report format and quality standards for information sharing, and raising the profile of domestic violence and its impact on the needs of children. Some respondents were less clear how to find evidence of changes in practice and could not be sure what outcomes had been achieved. Comments were made such as '*the impact remains with the group who have done the review*' and '*training was a good product but I'm not sure if it led to good outcomes*'. In some cases, there was a view that the reviews had had only limited impact and that local government responded more readily to external influences, such as central government requirements. One person said that recommendations from serious case reviews had made a contribution to change locally but had been by no means the main cause.

The comments of some respondents suggested they had considerable doubts about the status and authority of the Area Child Protection Committee in their area, a concern also expressed about some Area Child Protection Committees in the first *Joint Chief Inspectors' Report on Arrangements to Safeguard Children* (Joint Chief Inspectors 2002). The second Joint Chief Inspectors' Report (2005) noted improvements in the effectiveness of Committees but also commented:

There is considerable variation in the extent to which they provide active and effective leadership. (Joint Chief Inspectors 2005, p.35)

However, there were examples during the study of determined and positive new leadership in areas that had previously experienced high levels of criticism and scrutiny about their safeguarding practice and the weak functioning of their Area Child Protection Committees/Local Safeguarding Children Boards. These examples were marked by honesty about previous poor performance and the introduction of creative and innovative ideas that were injecting energy, self confidence and a sense of collective endeavour into the boards as they addressed local safeguarding practice.

A respondent made a strong plea that the new Local Safeguarding Children Boards, rather than signing off each overview report and then forgetting them, should look back at local reviews from over a number of years and reflect on the themes in the reports '*to remind ourselves of what we are learning*' and what were still prevailing issues to be addressed. Other respondents considered that they could do more to review the common themes arising from several serious case reviews and link these more deliberately to practice audits. A similar view was expressed in Sinclair and Bullock's earlier study:

Generally, most respondents concurred that the value of Serious Case Reviews was greater if they were seen as a practice audit or as another way at looking at the effectiveness of interagency work. (Sinclair and Bullock 2002, p.56)

All those interviewed had conducted more than one serious case review since the review that was part of the study. For some this amounted only to one or two reviews, while others had had responsibility for as many as three reviews a year between 2001 and 2005. This meant that they constituted an experienced group of chairs, managers or independent reviewers. There was general agreement that more use could be made of the reports by looking at them collectively and reviewing the common and different themes. Only one of those interviewed had done this systematically so far.

Promising local approaches

Axford and Bullock suggest the benefit of reviewing information from serious case reviews on a regular basis in order to build up a sound knowledge base but they did not find much evidence of this happening, particularly at a local or regional level, in their international study (Axford and Bullock 2005, p.58). During the course of this study, a more optimistic view was gained from a number of sources that such practices were being developed locally and there was evidence of enthusiasm among Area Child Protection Committees to find creative and effective ways *'to help people to take on board the lessons'*. Some respondents referred to the value they had found of regular *case audits* being carried out across children's services in their area. This is not a new idea. An example of case audits of work which had gone well or raised interesting issues was observed by Reder and Duncan, being undertaken on an experimental basis in one borough (Reder and Duncan 1996, p.96). However, it is an approach that seems to be gaining support. A respondent described how *case audit groups* had been set up by the Area Child Protection Committee to review cases where there had been concerns or where there had been *'near misses'*. Others stressed the importance of making space so that staff could reflect regularly on multi-agency practice.

Stakeholders who met at an invited seminar during the course of the study echoed these responses and also suggested there were alternative approaches to learning the lessons. Some advocated more attention should be given to scrutinising cases of effective practice and identifying the salient features of such practice; others reinforced the view that reviews of cases of *'near-misses'* along the lines of the medical model might provide more constructive material, as proposed by some respondents. These ideas are discussed further in the final chapter. Two detailed examples of approaches to learning lessons are given below.

An Area Child Protection Committee had identified common issues arising in a number of recent serious case reviews on younger children:

- poor assessment and analysis;
- not using historical information;
- not checking on the male (often changing) composition of households;
- being parent focused rather than child focused;
- taking parental statements at face value and not taking a more 'forensic' approach;
- poor communication between agencies;
- cross boundary arrangements and disputes getting in the way.

The senior managers of the Area Child Protection Committee took a strategic approach and set up a programme of work which included:

- a three-line whip seminar for all managers on the lessons from local serious case reviews;
- quality assurance audits, involving regular case file sampling by service managers as well as detailed cross-departmental quality assurance audits by managers auditing each others' files, and presenting reports (by choice) to elected members;
- multi-agency practitioner and line managers' workshops involving health visitors, school nurses and social workers across the authority's districts addressing obstacles to joint working and how to overcome them;
- multi-agency audits of cases initially by individual agencies of the Area Child Protection Committee and then coming together for meetings about each case, very labour intensive and requiring complete honesty and openness, but very positive and leading to changes in practice;
- regular slots at the meetings and strategy days of team, middle and senior managers.

An independent consultant and author of serious case reviews described how she had worked with an Area Child Protection Committee by facilitating days on cases that did not meet the serious case review threshold but where there were sufficient concerns about injuries or neglect to be causing despair to professionals. She worked with current and past workers on the cases and, as part of the invitation to the day, asked staff to think about certain issues in preparation. Practitioners across agencies and their managers attended. The history and circumstances of the case were then explored from past to present by undertaking a live assessment in the context of collaborative inquiry, making sense for the future and coming up with recommendations for working together and a proposed way forward with the family. It was emphasised that at times it was important for professionals to have opportunities to review and reflect on their own perceptions, responsibilities and actions without the family's participation.

In reviewing the effectiveness of some of these approaches, certain features stand out as important. They include the following:

- active and strategic leadership shown by senior managers of the Area Child Protection Committee;
- commitment of resources to initiatives that may be labour intensive;
- openness and honesty across agencies and between practitioners and managers in reflecting on their practice;
- recognition that one-off events are insufficient and require repetition and reinforcement;
- learning is fed back into regular operational routines;
- candour that some initiatives may work better than others and some agencies be more responsive than others to the joint approaches.

Learning lessons regionally

It became clear during the study that, as a result of changes in organisational arrangements, including the inspection of children's services, Area Child Protection Committees had experienced increasing uncertainty and distance in their relationship with central and regional government officials. The role performed by the former Social Services Inspectorate in its links with local authorities at a regional level had changed markedly. Some respondents reported experiencing very constructive relationships in the past with regional colleagues who had facilitated opportunities for information exchange and dialogue by Area Child Protection Committees across their region on a periodic but regular basis. In this respect, regional officials were in a position to be conduits to central government officials either on individual sensitive and complex cases or where there was a collective view about particular safeguarding issues in a region. This had diminished if not faded out altogether in some regions in recent years.

There were, however, two positive examples of analyses of serious case reviews being carried out at regional level and of that learning being fed back to Area Child Protection Committees. The first was the result of collaboration between a Regional Office and a Social Care Region.

A report by Yvonne Arthurs, Consultant in Public Health Medicine, and the late Jennifer Ruddick, Social Services Inspector for the South East Region, looked at the serious case reviews carried out in the region over a two-year period. It was distributed across the region in 2001 and was highly valued both within and beyond the region. Arthurs and Ruddick set out the aims of their study in the following terms:

At the time when this study began, in Spring 2000, there was no mechanism by which the experience and learning from Part 8 Reviews could be shared in a systematic way beyond the local ACPC. The aim of the work was to examine the recommendations which had been made in a series of Part 8 Reviews from local authorities in the South East Region in order to:

- *understand the nature of recommendations particularly for health and social services;*
- *identify common themes;*
- *disseminate the findings arising from this widely across the region.*

(Arthurs and Ruddick 2001, p.8)

The report concluded with a series of questions and issues for Area Child Protection Committees to consider, which Arthurs and Ruddick thought might be useful in local reviews and auditing processes.

An innovative approach in London Region has been undertaken by Christine Christie, Manager of the London Child Protection Committee of the Association of London Government (ALG), with the aim of helping to bring about improvements in local service responses to safeguarding children. She had been analysing all serious case review reports produced by the local Area Child Protection Committees/Local Safeguarding Children Boards in London authorities in order to build a London-wide database and provide regular feedback to the boards as well as to the Association of London Government's London Child Protection Committee. The work had been undertaken on a rolling basis so that there could be a clear alert to any changes in the profile of information, such as changes in incidence, the circumstances of children and families, service or agency identification or involvement, or other relevant factors. The value for the boards was that the information was current but also set in the context of London as a whole and against nationally available data.

The desire for regional government offices to take an active leadership role in safeguarding children across the region was widely expressed in interviews and discussions and at seminars and conferences during the study. The regional offices were seen as ideal multi-disciplinary vehicles that could assist boards to share issues and experiences, disseminate new and innovative approaches, and address some of the training needs, from developing greater understanding of the impact of domestic violence to chairing serious case reviews. Government offices are now beginning to fulfil this role including through Directors of Children and Learners and Children's Services Advisers.

Local Safeguarding Children Boards have acquired a range of new responsibilities, including reviewing all deaths of children and requiring them to work more extensively across boundaries with other authorities and agencies, and with the Crown Prosecution Service, the Coronial Service and the Courts. Regional officials were identified as being able to facilitate the review of how these new responsibilities were being carried out and help to develop organisational learning. Reviews of findings from serious case reviews were also identified as an activity that could be undertaken at a regional level, using the models provided by the examples already discussed.

Finally, but not least, it was proposed the regions could perhaps assist boards with resolving the vexed

question of finding competent, credible and appropriately expert independent authors for undertaking overviews. These tasks as identified in the course of the study suggest a healthy relationship could develop between local boards and regional government offices, if given sufficient priority and resources at regional level.

Learning lessons nationally

Co-operation and collaboration between different agencies is a difficult and complex process, particularly in an area of work like child protection in which policy and practice are constantly developing to absorb new ideas acquired through experience, research and innovative practice. (Home Office et al 1991)

There has been long standing recognition of the need to learn lessons nationally. In addition to research studies and inspections (for example, Social Services Inspectorate 1986; Department of Health 1995), value has been placed in central government on the learning derived from individual serious case review reports and from commissioned studies of a number of local overviews and public inquiries, as important sources of knowledge to inform policy review and development. The commissioned studies have been used to identify emerging patterns and themes over time, since the first review by the Department of Health and Social Security (1982) as well focusing on particular issues, such as the study of serious case reviews undertaken by Falkov which revealed the significance of parental mental ill health in 100 cases of child deaths (1996). This deliberate approach to learning lessons and accumulating knowledge from such studies was formalised in the commitment to commissioning biennial analyses, made in *Working Together to Safeguard Children* (Department of Health et al 1999; HM Government 2006a). The purpose of wide dissemination of these studies beyond that of relevant policy departments has been to support the development of a sound knowledge base throughout the safeguarding community and to facilitate dialogue between local agencies with safeguarding responsibilities and central government.

Understandable concern has been expressed by professionals, local government and external commentators about the influence of individual high profile serious case reviews and public inquiries. It has been feared that they may lead to knee jerk responses, particularly when they result in media and political pressure, and that their impact may be both disproportionate and inappropriate. The checks and balances within the policy process mediate this danger to an extent. One policy official described the merit of building in a '*gestation period*' so that a considered policy response could be delivered, which could then if required be followed by a Green Paper and widespread consultation, testing out the issues in different forums, before moving into drafting new legislation.

Examples of this process at work can be found in the 1980s with the public and professional concerns raised by the deaths of Jasmine Beckford, Tyra Henry and Kimberley Carlile which were closely followed by events in Cleveland and the Cleveland Inquiry (Cm 412 1988). The government response to the first three inquiries was to fast track the production of guidance to assist professionals with undertaking comprehensive assessments where child abuse had been identified (Department of Health 1988). However, this was accompanied by a process of careful consideration, discussion, consultation and distillation of the issues in the findings of these inquiry reports, in addition to the extensive research and other sources of knowledge already informing the work on the *Children Act 1989*. Similarly, with the report of the Victoria Climbié Inquiry (Cm 5730 2003) at the time of this study, a process of consideration and widespread consultation was established contributing to the Green Paper, *Every Child Matters* (Cm 5860 2003), the *Children Act 2004* and the revision of safeguarding guidance (HM Government 2006a).

Some respondents expressed concern and uncertainty about their links with central government since the Commission for Social Care Inspection (CSCI) had been established early in 2004, anxieties further reinforced by the then forthcoming merger of inspectorates for children's services within the new Ofsted (Office for Standards in Education, Children's Services and Skills) in 2007. They were not clear if the overview reports ever reached the relevant policy division and what happened to them there. Most of those interviewed were not aware of any scrutiny from the Commission for Social Care Inspection and were disappointed that they received no comments or feedback. They had no evidence that the outcomes were being monitored and they were *'not even sure that the reports are read'*. As one respondent said *'it's like feeding a vacuum unless it's a high profile case'*. There were exceptions and some had had contact because they had been reminded the timetable for the overview was falling behind. One respondent reported being impressed by the thoroughness of the CSCI business link inspector and had experienced *'a lot of dialogue with the inspector'*. However, none of those interviewed thought that enough value was being gained from the reports nationally. Since the interviews, the need for more dialogue between central and local government about safeguarding policy and practice has been recognised and followed up in a series of regional conferences throughout England in 2007 on serious case reviews and child deaths but this needs to be carefully monitored. Additionally, the role of regional government offices is developing in relation to Local Safeguarding Children Boards and may assist significantly the communication between central and local government.

Failing to learn lessons

Discussion of how lessons are learned from serious case reviews cannot be concluded without some reference to the wider debate about the apparent failure of public services to learn lessons. There is a widespread perception, publicly, politically and amongst some professionals, that the last thirty years of child welfare is characterised by failure to learn lessons from the findings of local serious case reviews or public inquiries into child deaths, serious injuries or neglect. Parton (2004), in his reflections on public inquiries a generation apart, quotes the words of the then Secretary of State for Health when presenting the report of the Victoria Climbié Inquiry to the House of Commons:

It is an all too familiar cry. In the past few decades there have been dozens of inquiries into awful cases of child abuse and neglect. Each has called on us to learn the lesson of what went wrong. Indeed, there is a remarkable consistency in both what went wrong and what is advocated to put it right. (House of Commons Hansard Debate, 2003, in Parton 2004, p.80)

Inevitably, the question then aired is *'why have the lessons not been learned?'* There are several issues arising from these concerns which require some reflection and comment in the context of this study. The first is about the extent of child deaths and serious injuries in England. The second issue touches on the continuing debate about the value of single case reviews and whether they have undue influence on the direction of national policy about the safeguarding system. The third relates to the changing environment in which safeguarding work is taking place, discussed earlier in Chapter 6, which is ever more complex and challenging. Several respondents referred to their concern about new pressures they were experiencing and the forthcoming changes in arrangements in children's services:

We have made huge strides in the last thirty years and we must not let them slip because of organisational changes.

The negative consequences of high turnover of staff and loss of history and continuity for front line staff working with children and families were evident in a number of the reviews.

The extent of child deaths and serious injuries

Child deaths are relatively rare and the majority of children at risk of harm present relatively low levels of abuse and neglect and are protected at home by means of family support. (Axford and Bullock 2005 p.57)

Bradshaw and colleagues suggest that ‘*child deaths are the most basic indicator for children’s safety*’ and that ‘*children’s death rates are thus both an indicator for the most severe violation of children’s rights and a proxy for the safety of children*’ (Bradshaw et al 2006, pp.46-47). Child deaths in England as the result of accident, murder or suicide are relatively rare, although media coverage when they come to public attention might suggest otherwise. Careful scrutiny of the statistics can give an important sense of perspective.

In the census of 2001, there were almost ten million children living in England under the age of 16. As at 31 March 2002, there were 25,700 children under 18 and 26,600 in March 2003 where there were sufficient concerns for the children to be subject to a multi-agency child protection plan and to have their names placed on the local child protection register (Department for Education and Skills 2006c). Child deaths by homicide recorded for those years were 63 child victims under 16 and 89 child victims in 2001/2 and 2002/3 respectively (Home Office 2007). The numbers of children on the child protection register declined over a ten year period by ten thousand a year (there were 35,000 children of all ages on the child protection register in March 1995). The numbers of child victims of homicide varied year on year between 40+ and 80+ over the decade 1995 to 2005, with over a third of the children each year being under the age of one year.

Arthurs and Ruddick (2001) make a similar observation about the importance of seeing serious case reviews in the wider context of the proportion of the child population on the child protection register, when they discuss the findings of their study:

Child protection “Part 8” Reviews are relatively uncommon. In a two-year period only 33 actual and 14 potential Part 8 Reviews were notified to the Social Care Region (South) from a total of 20 local authorities. To put this in context on 31.3.00 there were 3833 children whose names were on the child protection register in south east region (about 21 per 10,000 children). (Arthurs and Ruddick 2001, p.21)

It has to be remembered that the majority of children who have an agreed and co-ordinated multi-disciplinary child protection plan are generally well served by the child protection processes and the services involved (Department of Health 1995). There are over 25,000 children in these circumstances at any one time. The numbers of children who die or suffer serious injury or neglect are relatively small although each one is always significant. The numbers of serious case reviews constitute, therefore, a small but significant proportion of the child population being safeguarded. Furthermore, not all will have been identified as children about whom agencies have had safeguarding concerns or been assessed as children in need under the *Children Act 1989* and be in receipt of services.

The value of child death reviews and inquiries

As demonstrated in previous chapters, undertaking a serious case review is an important decision, requiring major investment of resources. Reder and Duncan have pointed out ‘*the costs of inquiries go way beyond the financial*’ and involve considerable investment of human resources and expertise, and diversion from other areas of priority (1996, p.86). The question, therefore, has to be asked whether they are worth the effort. Some of the reviewers articulated their hopes in the reports:

The Review Panel hope that the points raised in this Review will be used not as a tool to criticise individual staff or agencies, but that they will contribute to improvement in practice. Moreover the Review Panel hope that the analysis and recommendations contribute in a positive way to professionals' involvement with similar cases in future.

There are inevitably different perspectives about the benefits of commissioning serious case reviews on a regular basis. Questions are asked about whether detailed scrutiny of the circumstances where a child or children have died or could have died is the best way of understanding how well or not the local interagency system is working to safeguard children. This has led to questions about the value of a single case review. In this respect, the debate about child protection serious case reviews is not so different from that about the overall value of inquiries after homicide (helpfully discussed in edited volumes such as Peay 1996; Stanley and Manthorpe 2004). Whilst the majority of child protection inquiries are now undertaken as local serious case reviews, occasionally they are conducted as an independent inquiry required by government when public interest is heightened. The Victoria Climbié Inquiry (Cm 5730 2003), jointly commissioned by the Home Office and the Department for Education and Skills (see Chapter 4), was the last such inquiry into a child death, held in the same period as the serious case reviews in this study. The question remains about how the findings of single case reviews are interpreted and used.

The notion of the findings of a single case influencing radical change of local or national policy is regarded by some commentators as ill-judged: *'bad cases make bad laws'* it is argued. These debates are not restricted to the UK. The Commissioner of New York City's Administration for Children's Services voiced concerns along these lines when discussing the challenges facing New York in 2006:

*System change requires our 'learning from the science of our work rather than tragic anecdote'.
(John Mattingly, Commissioner of New York City's Administration for Children's Services, at Fordham University Conference, 20 September 2006)*

This is in contrast to a more emotive approach to system change in the light of inquiry findings (in this case Feltham Young Offenders' Institution):

The shock that follows a single outrage, which epitomises all that is rotten in a system, can provide the chance to start putting it right by galvanising people to challenge conduct that they would otherwise let pass. (Leader in the Guardian, 1 July 2006, p.34)

Writers on the subject, such as Parton (2004) and Masson (2006), suggest that tragic deaths, and particularly those that become the subject of a public inquiry, have had and continue to have an inordinate and inappropriate level of influence on safeguarding policy:

*Public enquiries have played a major part in shaping law, policy, and practice in child protection since the inception of the Welfare State. They have been a central part of the 'scandal politics' which has shaped the child protection system both in terms of public perceptions and policies and practices.
(Masson 2006, p.221)*

Masson and others do not deny there may be more general problems in the system to be addressed but point out the limitations of the case study method as the approach for their identification:

*Failures in an individual case may be symptomatic of wider problems, but the inquiry or case study method will always give a much more limited picture than other methods of research.
(Masson 2006, p.242)*

This discussion reinforces the importance of seeing findings from serious case reviews as one source of evidence and knowledge about what is happening in local inter-agency working to safeguard children. Research, inspections and other sources of information about how the safeguarding system is working have to be sufficiently resourced, rigorous and up-to-date for confident use to be made of their findings to evaluate current policy. At the same time, the numbers of serious case reviews of children who die or are seriously harmed have to be set alongside the numbers of children being safeguarded at any one time with a multi-agency child protection plan. It is clear that more investment needs to be made in finding new approaches to understanding what leads to effective practice and disseminating that knowledge more widely.

However, finding out what happened when a child dies is a basic human right, now enshrined in the *Human Rights Act 1998* and in this respect serious case reviews have and will continue to have an important function in public and professional accountability. That does not mean that improvements cannot be made both to the process and outcome of serious case reviews, which are considered further in the final chapter. Contemporary concerns, however, are not just about how well agencies have fulfilled their responsibilities and worked together to safeguard the children. There are lessons to be learned from increased understanding of the circumstances of children's deaths to enable system change to be made so that agencies can provide timely and appropriate responses to safeguard children. Understanding the child's world of the child, family and environment and the interaction of factors that may have influenced the course of events in all child deaths has also become important. This broadening interest is reflected in the recent policy guidance of *Working Together to Safeguard Children* (HM Government 2006a). The findings of serious case reviews will, therefore, continue to make a significant contribution to the wider knowledge about safeguarding children locally and nationally but will not be the only source of analysis and evidence about how well children are doing and how safeguarding practice can be improved.

Chapter 8: Making a difference: reflections and conclusions

The aim of this second biennial analysis of serious case reviews has been to explore what happens to the findings and recommendations of overview reports, how they are translated into action plans and whether they are then implemented and make a difference to local safeguarding policy and practice. There has been some evidence of positive and innovative use in generating learning from reviews and of their potential to act as motivators for change, often in combination with other levers of change. The picture has also been one of great variation and, disappointingly, limited evidence of local implementation. Lessons drawn from the individual case findings have been described in some detail by respondents but it has not always been easy for those involved in the review process to identify what precisely has changed locally as a result.

This poses a dilemma when exploring the effectiveness of serious case reviews. There is a strong argument for serious case reviews being carried out when children die or are seriously injured on the grounds of public and professional accountability. Government guidance makes it quite clear that *'reviews are not inquiries into how a child died or who is culpable'* (HM Government 2006a, p.170). However, the process requires an understanding of how and why events occurred, decisions were made and actions taken or not taken. To a considerable extent, this could be said to have been fulfilled by the reviews in this study and increasingly, during the period of the reviews, with members of the child's family participating in the process.

The main purpose of reviews as outlined in government guidance is to learn lessons about how those involved worked together and to identify what needs to be done as a result, with the aim of improving local inter-agency working and better safeguarding and promotion of the welfare of children (HM Government 2006a). The findings of this study suggest there is a gap between learning lessons in individual cases and identifying what needs to change and then doing it. Some Area Child Protection Committees have found it hard to build an effective bridge between the two. This is not a problem peculiar to child protection serious case reviews. Some commentators have identified it as an issue that applies more generally to learning lessons from an inquiry process:

Inquiries can be important learning tools. But, other than their well-known capacity to provoke fear and defensive, risk-averse practice, it is difficult to point to positive messages about what works. Yet examples of good practice are evident in many reports. (Stanley and Manthorpe 2004, pp.38)

The challenge is how to make effective use of the lessons being drawn from the reviews, particularly about good practice, and turn them into sustainable improvements in safeguarding practice.

There were examples of the findings of reviews being used collectively and strategically by some Area Child Protection Committees. A feature of these Committees was that they benefited from committed leadership which took a more systemic approach. Audits or reviews of policy or practice around emerging or recurrent themes were conducted with tangible results. Sound programmes of training and service change were established as a result of reflection, consultation and collective endeavour with the involvement of managers and practitioners across different agencies. Obviously, some case reviews required immediate action at their conclusion, addressing either policy or practice issues to ensure a different set of processes or actions would be followed in future. This will always be the case. On the whole, however, there would seem to be some support for the argument of creating more space and time between the completion of a review and handling its aftermath before beginning a more measured process of responding to the lessons learned. At the moment, the two processes often seem to be conflated, which was well demonstrated by descriptions from respondents of frenzied activity at the conclusion of the overview and the production of some lengthy, complex and unachievable action plans.

This would suggest that during the process of the case review a more strategic approach should be taken to drawing up recommendations and action plans. Not only should there be greater clarity about purpose and achievability, but also a distinction made between those recommendations requiring immediate action and those that present new issues or reinforce themes identified in previous reviews that should be taken forward within a broader framework of change and improvement. However, key to this within the multi-agency forum of the Area Child Protection Committee/Local Safeguarding Children Board is an open, trusting and confident relationship between the agencies and their representatives. This was a point made on more than one occasion by respondents when speaking about what helped implementation of recommendations and action plans. Agencies operating in isolation and with a low level of commitment to a culture of working effectively with other agencies are unlikely to contribute openly and positively to creating a *'learning organisation'*.

Improving safeguarding practice by other approaches

The discussion so far has focused on making more effective use of the findings of serious case reviews to learn lessons:

- first, by distinguishing between the different functions of individual reviews of finding out what happened and learning lessons, and reflecting these in framing recommendations and actions;
- second, by using the findings of reviews around emerging or recurrent themes, either locally or regionally, to develop programmes of local review and improvement, which have been shown to have positive impact.

However, dissatisfaction with the capacity of public agencies to learn lessons is not restricted to those agencies involved in safeguarding children. Health Ministers commissioned a report from an expert group to explore how the capacity of the National Health Service (NHS) to learn from failures could be improved. The experience from a range of sectors other than just health was examined, including industry and aviation. The report, *An Organisation with a Memory* (Department of Health 2000) echoed many of the findings from the various studies of child protection reviews and inquiries over the last two decades. It concluded that there were limitations in an approach which focused only on human error as the cause of failures as this would not achieve desired improvements in practice. This point has also been reinforced by Munro, drawing on lessons learned in engineering (2005):

Human error is taken as the starting point, not the conclusion, and the investigation tries to understand why the mistake was made, by studying interacting factors in the practitioners, the resources available and the organizational context. (Munro 2005, p.531)

Munro reaches the same conclusions for investigating child deaths as those recommended by the NHS report for responding to health care failures: that of adopting a system approach which '*recognises the importance of resilience within organisations and also recognises the process of learning as enhancing such resilience*' (Department of Health 2000, p.24).

In addressing how to ensure that lessons could be embedded in practice, the NHS report made a distinction between passive learning and active learning:

The distinction between passive learning (where lessons are identified but not put into practice) and active learning (where lessons are embedded into an organisation's culture and practices) is crucial in understanding why truly effective learning so often fails to take place. (Department of Health 2000, p.ix)

During this study, there were some examples of *active learning* taking place following a single serious case review or series of reviews but not many. The research team also wondered about the mechanisms for learning and improvement in agency practice in those Area Child Protection Committees that had not had a serious case review during the period of the study. Would those Area Review Committees be able to identify changes taking place and how far practice was improving? What approaches were they using?

At the invited stakeholder seminar held at the conclusion of the study, there was interest in considering learning approaches that were not tied to cataloguing individual practitioner errors in incidents of significant harm and the emotional consequences of '*fear and guilt*', already described in previous chapters by those involved in reviews. The thinking behind the search for alternative approaches has been explored by a number of writers, such as Hammond (1996) and Cooperrider et al (2001). Cooperrider and his colleagues identify a number of problems with trying to learn from what has gone wrong, which is essentially a deficit approach, summarised as follows (2001, p.23):

- it can be a painfully slow process involving '*looking back* [at what happened] *rather than forward*';
- it rarely results in a new vision of what can be done differently because it tends to be about '*closing gaps*';
- it takes place in a climate of defensiveness where there is a reluctance to own problems – '*it's your problem not mine*'.

A fundamental issue, therefore, is what helps agency staff to learn and change their practice and are there transferable models of learning from elsewhere? Two approaches have been identified of relevance to safeguarding practice. The first derives from the model of the NHS National Patient Safety Agency and has been explored by Bostock and colleagues for the Social Care Institute for Excellence, *Managing risk and minimising mistakes* in services to children and families (Bostock et al 2005). They suggest the establishment of a national model of local reporting and analysing '*near misses*' in a culture of professional openness. '*Near misses*' are defined as those cases where something was prevented from going wrong or had gone wrong but no serious harm had been caused. They conclude that an analysis of '*safeguarding incidents*', as well as those subject to serious case reviews, would reveal weaknesses in systems and show ways of correcting them. In this way, children and families would benefit from '*the application of safety management*' (Bostock et al 2005, p.xiii). The strength of this approach is its separation of learning lessons from the serious case review process and its focus on a whole system approach, with the aim of bringing about systematic improvements across agencies involved in

safeguarding children, as advocated by Munro (2005) and others. There were one or two examples of work based on such an approach identified during the study and to some extent, the review of all child deaths may begin to encourage a more open culture and system-based approach.

The second approach comes from a different perspective – that of learning from effective safeguarding practice rather than learning from mistakes. Hammond (1996) sums up the reasoning behind this approach:

We are very good at talking about what doesn't work...We have very little practice in looking toward what works and finding ways to do more of that. It never occurs to us that we can fix an organisation or even our society by doing more of what works well. We are obsessed with learning from our mistakes.
(Hammond 1996, p.9)

Learning from what works well sounds simple and logical but requires a major shift in the prevailing mind set that has inevitably been focused on learning lessons from what has gone wrong. One method of applying this approach is through *Appreciative Inquiry* (see Cooperrider et al 2001) which is beginning to gain interest in different parts of central and local government (see Barnes 2007). An example is given below of its application to safeguarding practice. It suggests that other creative solutions can be found to support improving safeguarding practice by Local Safeguarding Children Boards as well as using the findings of serious case reviews, but undertaken in a more positive and less pressured environment.

Learning from success

Appreciative Inquiry (Cooperrider et al 2001) is a radical way of learning and building on existing good practice and is undertaken in a positive environment of collaborative inquiry. It can be applied to safeguarding practice, and interest is being shown in testing this out by some Local Safeguarding Children Boards. It is a facilitated approach undertaken with managers and practitioners and involves identifying the essential elements of best practice and exploring ways of using this knowledge to improve safeguarding practice across local agencies. It achieves this by:

- exploring essential features of participants' experience of existing best practice;
- collectively developing a shared vision of most desirable practice for the future;
- working together to develop, design and create this practice, with changes occurring from the very first questions asked.

The benefits of this approach are that:

- shared understandings and intentions are made transparent and reinforced;
- staff work constructively in a safe and creative environment;
- existing connections and relationships are strengthened and renewed;
- plans for improving local safeguarding practice and outcomes are agreed and implemented.

Building such approaches into the programmes of work of Local Safeguarding Children Boards requires a high level of commitment to improvement through joint working across the constituent agencies. Such transferable models of learning merit further exploration and could make an important contribution to creating a stronger learning organisational culture in Local Safeguarding Children Boards.

The impact of serious case reviews

This study of serious case reviews cannot be concluded without comment on the impact of reviews on all those involved. In this study, reading 40 serious case reviews was a sobering and unnerving experience. It was very difficult to remain dispassionate about their content. This was partly influenced (but only partly) by the form the reports take for, as Stanley and Manthorpe (2004) observe in their study of 'iconic' inquiries, 'the inquiry report tells a story' (p.2):

It is a narrative account replete with human drama and action. Every inquiry report has its heroes, villains and victims but, for the reader, the outcome of their inter-actions is known at the outset. The dramatic tension of the story told by the inquiry report resides in the judgement delivered by the inquiry team. The reader is invited to identify with the lofty perspective of the inquiry panel and to pass judgement upon the actions of the protagonists with the benefit of hindsight. This is essentially a moral judgement about whether professionals have done the job expected of them and whether they have adequately protected those they were charged to protect. (Stanley and Manthorpe 2004, p.2)

This may be too harsh a view to apply to the serious case reviews in the study. They were not undertaken on the whole under the full glare of national media attention nor with the formality of public inquiries. Generally they were conducted as internal exercises by local statutory agencies commissioned by Area Child Protection Committees, as exercises in accountability and aimed at learning lessons from what had happened in order to improve future practice. However, the process and structure required of serious case reviews produced a report which was telling a story that required a response and reflection from the reader. As a result, the reader was inexorably caught up in the story, asking 'what if...?' or 'why didn't...?' and inevitably making judgements and interpretations about the actions taken or not taken, always with the advantage of distance and hindsight.

At the end of the reports read for this study, there was often an over-riding sense of frustration, of only knowing part of the story, namely of agencies' involvement and such information as they contributed about the child and family members. There were few insights into the child or other family members' perspectives or into the family's history or functioning. In some cases, this could be explained in terms of respect for confidentiality of matters sensitive to family members.

However, overview reports could appear ignorant or unquestioning of the most fundamental issues that were a matter of record in the reports. This was not about the research team apportioning blame or suggesting some events might have been predicted but about wanting more rigorous exploration of the detail of practice through the process of the overview. At times it was as if agency reviews and their accounts were accepted without challenge by the review panel or the reviewer. This raised questions for the research team about whether in some Area Child Protection Committees the serious case review had become formulaic in its process or the reviewers inured to the conditions in which maltreatment took place. The reiteration of findings and recommendations, sometimes within the same authority, suggested that in some reviews there was a lack of energy and curiosity about what had actually happened in the cluster of circumstances unique to that child and family. This suggests that some more attention needs to be given to how the process is undertaken and how the narrative about the circumstances is presented in the overview report.

It will be evident that the research team was not immune to emotional responses to the serious case reviews. Account has to be taken of the impact on all those staff involved in undertaking reviews and on those responsible for taking forward the reports and handling their recommendations so that a balanced and measured view is maintained. This includes politicians and policy makers. It is a dimension which should never be forgotten by those who design and manage the safeguarding system as well as those who study and write about it.

Summary of key issues emerging from the study

At the conclusion of this study, it will be clear that there have been some strong themes emerging about the effectiveness of the current serious case review process. Some recurring issues have been raised from the analysis of forty serious case reviews, albeit not a representative sample, but these issues have been reinforced by evidence from other sources and by discussion with a range of key stakeholders. They fall into four main areas:

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

Making the serious case review process more effective

Inevitably there was great variation in many aspects of the review process and in the presentation of the final report. This could be accounted for by the different circumstances of each case but not entirely so. Many respondents were positive about serious case reviews and their value. Others were less so or had more difficulty in identifying their effectiveness. However, it did appear that it was possible to make improvements to the process and assist staff that had only intermittent experience of reviews or were embarking on a review for the first time.

The decision to hold a review

The death or serious injury of any child where abuse or neglect is suspected is a tragedy for the family and for the practitioners involved, and the context in which a decision is made to hold a serious case review is likely to be pressured, complex and difficult. A serious case review is also likely to entail the expenditure of immense resource and effort. It was clear that Area Child Protection Committees operated very different thresholds in making such a decision, despite the criteria laid down in national guidance. There would be benefit in striving for more consistency across the new Boards about the decision, an area where the government offices in regions could play a role in bringing Boards together to discuss these issues. Boards also need to be clear from the beginning about the purpose of each review and to have anticipated the likely outcomes.

Chairing the serious case review

A critical decision in commissioning a review is the appointment of an independent chair or author of the overview. Those appointed to the task from within the agencies of the Local Safeguarding Children Boards require suitable training, authority, resources and support to undertake the work, with appropriate release from existing responsibilities for the time needed. The appointment of external chairs of overviews has a number of merits. However, Boards should not have to continue to rely on the current arbitrary system of informal contacts to find suitable people. Consideration has to be given to how a resource of trained, credible experts in this field can be developed and operate in an open and transparent way. The Department for Children, Schools and Families, in collaboration with the government offices in the regions, may need to take a lead in addressing these issues.

Management reviews and the overview report

The quality of the overview is dependent on the agency management reviews and their chronologies. The management reviews may be lengthy and complex to prepare according to the circumstances of the case. Furthermore, sectors such as health may have many different trusts, hospitals, clinical departments and professionals that have been involved. Acknowledgement needs to be given to the time this may take and to the management issues required. During the study, a general desire was expressed for more training for those who would be preparing agency management reviews and for those carrying out overviews. Exemplars or templates of agency and overview reports, it was suggested, would be helpful. These are obviously matters requiring further consideration at both central government and regional government office level. However, in the meantime, web-based courses are under development. One example is that produced by Tri-X-Childcare, in association with Paul Tudor, for Devon County Council and the South West Peninsula, *Serious Case (Part 8) Reviews: On-line Training Course* (demonstrated on-line at: www.tri-x-childcare.co.uk/scr.swf).

The inclusion of chronologies and genograms

Chronologies and genograms serve discrete purposes and on occasions in the study were found to have been overlooked or poorly presented. They should not be seen as stand alone activities but contributing to a greater understanding of the circumstances of the family. Integrated chronologies should assist the analysis of agencies' contact with the family, particularly the child, and the direction of enquiry. There was almost no record in the chronologies examined of when a child or children of the family were seen or whether children had expressed any views; the focus was mainly on parental and inter-agency contact. These omissions may be a reflection of the state of agency records and require review by Local Safeguarding Children Boards. Creating a useful and accessible integrated chronology is a skilled task. As has been referenced in previous chapters, there are several useful tools now being developed to assist members of Local Safeguarding Children Boards through the various processes of serious case reviews. Those already mentioned include a programme to assist with the compilation of an integrated chronology (www.chronolator.co.uk).

The contribution of family members

The requirement to invite family members to contribute to case reviews is a major development and their involvement requires appropriate facilitation, planning and resources. It is likely that family members will find the process far less stressful if a key worker is appointed to work with them throughout, provide information and explanation, help them contribute and take them through the executive summary at the end. It is not a task that can simply be added on to existing job descriptions but the necessary expertise, time, training and support should be secured. Care must be taken that family interests are sufficiently covered during the review but that other important matters for scrutiny are not lost in the process. Sensitive issues about confidentiality will need careful handling.

Formulating recommendations and action plans

The formulation of recommendations and the creation of action plans at the conclusion of the overview were sometimes described as being done in a rush due to other constraints. They require reflection and a strategic approach. There needs to be greater clarity in the report about how the overview recommendations relate to those of individual management reviews, and the requirement that they should be *'few in number, focused and specific, and capable of being implemented'* needs to be more strictly observed. It was evident that extensive recommendations resulted in complex action plans and greatly reduced the likelihood of successful implementation. Rarely were action plans specific about what needed to change and how the outcome would be identified. It was suggested that auditing

progress on implementing action plans was an important part of ensuring drift and fatigue did not set in; the NSPCC audit framework (Handley and Green 2004) was one of the tools found useful for this purpose as well as those developed 'in house' by Area Child Protection Committees.

Managing the outcome of the review

The completion of the overview report was often described as being accompanied by some uncertainty and confusion at a time of a high level of activity to handle the outcome of the review. This part of the process requires as much planning and management as the initial stages of commissioning the review. There were judgements to be made about those who would have access to the report, those who needed to be briefed and handling issues of confidentiality. Executive summaries were often found to be difficult documents to write as they would be made public, balancing a sufficiently detailed analysis of what had happened without fuelling inappropriate public interest in matters sensitive to family members and, in some cases, individual professional staff. These summaries had to serve a number of purposes within agencies as well as the wider community, and this led in one review to a further professional summary being prepared for staff information and training purposes. Some of these process matters could be addressed by more sharing of information and experience between Local Safeguarding Children Boards.

Costing serious case reviews

Serious case reviews are undoubtedly very resource intensive. However, there was no evidence from the reviews of any consideration of cost being a factor in the decision to undertake a review or of cost influencing the conduct of the review. In that respect, it is difficult to comment on whether the serious case reviews provided value for money. Similarly, there was no indication of cost being a factor in determining the recommendations or action plans. Some of these would have been very expensive to implement, such as new members of staff or some comprehensive training programmes, and would require a high level of agencies' commitment to do so. This would seem to be an issue for further exploration as the new Local Safeguarding Children Boards become more fully established.

Using findings of serious case reviews to learn lessons

Translating findings into recommendations and action for change

The findings on the whole reflected the analysis of information presented in the reports. However, the recommendations did not always follow from the findings. There were obviously divergent views at this point about whether the operational difficulties or failures that had been identified were the result of systemic problems requiring more holistic solutions or the result of individual error – acts of either commission or omission. These different perspectives were not always explicit in the recommendations and some reviews contained elements of both. What was marked was the emphasis in the recommendations on reviewing or strengthening existing procedures or developing new procedures. This was supported by the views of some of the respondents that the systems were adequate but the problem was one of staff compliance. There was less emphasis than might have been expected on issues of management, supervision, staffing resources and staff knowledge, skills and experience. The organisational context, which in some agencies at the time was undergoing major change, resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed. This may have been a reflection of the variable status or authority of the then Area Child Protection Committees in some areas.

Implementing recommendations and action plans

A range of factors were identified by respondents which either promoted or hindered implementation. Those that helped implementation included recommendations which were in line with other national or local developments so that the outcome of the review could act as a further lever for change, particularly in securing higher priority or additional resources. In some areas, the shock factor of the circumstances of the case or the authority ascribed to a serious case review were important in ensuring recommendations were taken seriously. Overall it was clear that strong and confident leadership from the Area Child Protection Committee played an important role in taking action forward. A strategic and co-ordinated approach helped to prevent individual agencies from responding to recommendations in isolation, action required being overlooked in a plethora of other pressures such as the next case review or changes in personnel, or action plan fatigue setting in. Engaging actively with managers and front line practitioners to review current practice issues and bring about improvements was found to be more likely to embed changes in practice than a more passive learning approach.

Learning lessons locally, regionally and nationally

Serious case reviews were generally regarded as a valuable and important response to child deaths or serious injuries where there were suspicious or concerning circumstances but there was a range of views about their impact locally and how far lessons from the reviews were being learned. However, some promising and creative examples of different approaches were found that were being developed locally to ensure findings from reviews had impact. These included extending the role of the independent chair to disseminate and discuss findings and their implications with staff, the use of practice audits focusing on particular issues, senior managers leading programmes of multi-agency work addressing common themes arising from a number of reviews, and bringing in independent consultants to undertake 'live assessments' with staff groups in a context of collaborative inquiry and provide opportunities for review and reflection.

There was also potential for collaboration between Local Safeguarding Children Boards regionally and some promising examples of how this could be done effectively by providing a sound knowledge base on which to draw as well as the opportunity to learn from others' experiences. The argument for government offices in facilitating these developments was strongly made. Government offices were also identified as having a role in assisting communication between local and central government so that policy makers could be informed by local experiences. The commitment by the Government to national studies of serious case reviews and their wide dissemination was valued. It was hoped, however, for greater clarity about the role of the new Ofsted (Office for Standards in Education, Children's Services and Skills) in relation to notifications of incidents of child deaths and serious injuries, and in any individual serious case reviews that followed. (The role that would be played by the new Ofsted in this respect from 1 April 2007 was spelt out in a letter to Directors of Children's Services from the Department for Education and Skills, 4825.) Overall, there were positive indications that the findings of serious case reviews could be harnessed in a number of different ways and contribute to improving safeguarding policy and practice, locally and nationally.

Alternative approaches to improving safeguarding practice

There were, however, some compelling debates about whether serious case reviews were the best or the only vehicle for generating lessons to be learned. There was evidence of alternative approaches being explored. These included taking a measured, whole system approach and establishing a culture of a learning organisation by engaging agency staff regularly in examining practice in cases of 'near misses', where there had been concerns. Another and perhaps more radical example was an approach

that aimed to learn from evidence of what worked well in multi-agency safeguarding practice and to develop policy, practice and training building on best practice. Both these approaches recognise the limitations of relying on an individual serious case review to set the agenda for a major programme of improvement and suggest there is potential for further development in this respect. It is anticipated that such an organisational culture will be encouraged by the requirement to review all child deaths in an area. However, this is another area where regional collaboration between Local Safeguarding Children Boards may assist those Boards with less confidence and experience to benefit from developments in other Boards.

Emerging themes from the serious case reviews

The study of forty serious case reviews revealed a number of issues which will continue to require careful monitoring and attention by Local Safeguarding Children Boards, not least the vulnerability of older children as well as young children and babies, and children with additional or specific needs such as disabled children and their families. It is a matter of concern that there is still poor recording about ethnicity of family members. The absence of specific expertise to assist serious case reviews in their knowledge or understanding of issues relating to families from different cultures and languages suggests that thought should be given to such engagement at the commissioning stage.

Two features stood out strongly from the cases read: the number of children who were experiencing neglect in the context of a range of other family difficulties and children living in circumstances where domestic violence prevailed, co-existing with other problems in their families such as substance misuse and mental ill health. These situations continue to pose major challenges for the providers of services, particularly in terms of early identification, timely and appropriate intervention, and co-ordination of services. Professionals normally in contact with all children, such as health visitors and school staff, have a critical role in early identification but require knowledge and support. Other agencies that may have contact with members of the family in the community or at times of crisis also require greater awareness and knowledge of how to act, and how to do so in collaboration with other agencies involved.

Finally, those professionals from agencies charged with the delivery of co-ordinated multi-agency plans bear a fundamental responsibility for ensuring effective information sharing and consideration of the impact on the child in promoting and safeguarding the welfare of the child. There was evidence that the views of the child were not always sought and that communication was more likely to take place between practitioners and parents rather than with children. Local Safeguarding Children Boards need to review the knowledge and skill base of their agencies' practitioners to undertake direct engagement with children effectively. However, the challenge involved in developing successful multi-agency collaboration and the impact of organisational upheaval and major changes of key staff also have to be acknowledged as critical contextual factors in working to improve safeguarding practice.

In conclusion, serious case reviews make an important contribution to understanding what happens in circumstances of significant harm. Their effectiveness can be improved and there are examples of promising approaches using the findings of serious case reviews to bring about improvements in safeguarding practice. However, achieving such improvements requires Local Safeguarding Children Boards to develop a much stronger learning culture within which serious case reviews are but one important source of knowledge for improving safeguarding practice.

Appendix 1: Aims and methods of the study

Aims of the study

The overall aim of the study was to prepare an overview of findings from a selection of case reviews undertaken during 2001-2003 with the following objectives:

- to identify the key themes common to the recommendations and to which agencies these related;
- to ascertain if the case review reports resulted in action plans which were derived from the findings of the review;
- to ascertain if the action plans were implemented within the recommended timescales and to identify what helped or hindered their implementation;
- to identify the agencies to which the recommendations were directed, and which agencies did or did not implement the recommendations;
- to ascertain if the case review processes led to any changes in policy or practice at a local level;
- to identify from the reviews any lessons for policy and practice at a national level.

At the same time, the research team was asked to bear in mind the research questions previously explored by Sinclair and Bullock in their study (2002) and to identify any new emerging issues about the case review process in this study and any other patterns or themes in relation to, for example, children's circumstances and needs, case histories or inter-agency working which might have local or national policy relevance. It was also agreed that, rather than produce a further literature review, it would be helpful in this study to include a detailed chapter on the context of serious case reviews, marking the significant policy changes and other external factors influencing the case review process.

Selecting the study sample

Reder and Duncan (1999), in their follow up study of fatal child abuse, *Lost Innocents*, recorded that the Department of Health (then the responsible government department for children's policy) received 112 notifications of child deaths in the year 1993/1994. 54 of those 112 were considered to be '*the result of non-accidental injuries or further inquiry was needed*' (Reder and Duncan 1999, p.22). Reder and Duncan included a table of numbers of notifications to the Department of Health from 1990 to 1995 (1999, p.23, replicated in Sinclair and Bullock 2002, p.3). This suggested little significant variation over the five years, the lowest number of notifications being 112 in 1993/1994 and the highest 122 in 1990/1991. The notifications of child deaths considered to be the result of non-accidental injury and requiring further inquiry varied between 45 in 1991/1992 and 59 in 1992/1993.

Ten years later, the criteria for notifications to the Department of Health had been extended to include not just child deaths but also cases of serious injury of children where there were child protection concerns. Such changes in the criteria for notification make it difficult to obtain a coherent picture of

the epidemiology. Sinclair and Bullock in their review of serious case reviews (2002) noted that the Department of Health had estimated there were now 'about 90 child deaths each year that are the subject of a full Serious Case Review' (p.3), conducted by local Area Child Protection Committees and as laid out in government guidance (Department of Health et al 1999). However, this estimate did not include cases of serious injury which were by then subject to serious case review.

The process at that stage involved an officer of the local authority or the Area Child Protection Committee informing the Department of Health of an incident through the regional office of the Social Services Inspectorate (SSI). A notification would be made to the relevant policy division of the Department of Health and information entered onto a national database. As more information became available following the notification, so additions would be made to the database at the Department of Health. In due course, reports of serious case reviews and action plans would be sent by the Area Child Protection Committee to the regional SSI offices and held there. There were some concerns, however, about the accuracy of the national database and doubts expressed as to whether it contained a complete record of all the serious case reviews being undertaken nationally. This posed some problems for the research team of Sinclair and Bullock in compiling the necessary information for their review. Subsequently, a new and enhanced computerised database of deaths or serious injuries of children was introduced by the Department of Health in 2002. Sinclair and Bullock observed:

There is no public access to the database, but it is hoped that its existence will enhance understanding of the volume and characteristics of such incidents. It will also help in the identification of cases where there have been serious reviews, for future reference. p.2

Sadly, that was not the experience of the research team in undertaking the present study. The period covered by the reviews (2001-2003) incorporated the launch of the new national child protection database in April 2002, requiring transition from one system to another. This led to duplication (some notifications being on both the old and the new system) and the new database was found to be unfit for purpose. It certainly did not allow an incident to be tracked from notification through all its stages to completion of necessary action, nor did it allow a report to be produced indicating progress. There were still doubts that it was a complete record of all the serious case reviews being undertaken. Incidents that were recorded did not always reveal whether a serious case review had been set up, whether it had been completed or whether an action plan had been received or the status of the case in terms of the coroner's service or criminal proceedings. Basic information about the incident, child, family and subsequent action was often incomplete or found to be inaccurate.

The intention of the research team to use the database for analysis of incidents notified to the Department of Health over the two years 2001-2003 proved to be impossible. A number of attempts were made by the research team to analyse the data available but the level of missing or inaccurate information rendered the results unusable. It had also been intended to use the database to identify those cases subject to serious review from which a representative sample could be drawn, designed to reflect geographical spread, type of local authority, author of the review and, in this study, ensuring inclusion of cases involving child disability. This was an area in which policy officials expressed considerable interest, particularly because there was little evidence on the subject available from any other source.

Since the database could not be used as a sampling frame, it was decided to call in all serious case reviews completed in the relevant two years, together with their action plans, for the purpose of the study. Regional offices of the Social Services Inspectorate (which during this process became the Commission for Social Care Inspection) were duly requested to provide copies of reports and action plans to the policy division of the Department of Health. This was a lengthy and frustrating process.

Estimates by the Department of Health suggested there would be at least 180 reports. Finally, after several months, a total of 45 reviews were received from eight of the nine former SSI regions, not all with either their overview reports or their action plans. Some reviews came just as executive summaries. Significantly incomplete reviews were eliminated from selection. Those received could hardly be described as constituting a representative sample, even though they might be described as random. It was not clear why these particular serious case reviews emerged through the system. The 40 serious case reviews and action plans which were studied by the research team should not, therefore, be viewed as a representative sample but they offer some valuable insights into the serious case review process and raise some important issues.

Policy about notifications, the system for gathering and recording information, and the process for monitoring serious cases have changed since 2002. Further rationalisation and streamlining of the system between the Department for Children, Schools and Families, the Office for Standards in Education, Children's Services and Skills (Ofsted) and the Government Offices in the regions has taken place since April 2007. A new national database for recording information has been developed and implemented and is hosted by the Department for Children, Schools and Families, replacing the database that was operating in the children's policy division in the Department of Health at the time of the study.

Research methods: the plan

It was intended that the information required to address the research questions would be obtained from documentary sources (reports of serious case reviews, the action plans and progress reports on implementation) and from interviews with key staff in selected cases and with Social Services Inspectorate staff, such as Business Link Inspectors for the serious case reviews.

The case review reports would all be read in detail and analysed according to a framework devised for the purpose, reflecting the research questions. Interviews would be held with staff that had been associated with half the serious case reviews (20), probably the author of the report and the Area Child Protection Committee chair, to gain first hand perspectives on the case review and its subsequent impact. Interviews would be semi-structured and conducted primarily by telephone, respondents having received copies of the interview schedule in advance. A small number of questions would be included about the process and outcomes of serious case reviews more generally. Interviews would also be conducted with some of the Inspectors of the Social Services Inspectorate who had been involved in monitoring the progress on the action plan with the local social services department.

Research methods: the reality

The documentary material was subjected to analysis as planned. The follow-up of key staff by telephone interviews proved more problematic. This was in part due to the difficulty in tracking down the overview report's author (not always named in the report). At the same time, the level of turnover of senior staff in local statutory agencies meant that the chair of the Area Child Protection Committee was often no longer in post or not available. The most appropriate person to interview usually turned out to be the Committee's business manager, policy officer or co-ordinator (titles varied), and they had not always been involved in the particular serious case review themselves. Fundamental reorganisation of children's services, the formation of children's trusts and the dissolution of the former structures of local social services departments in England had resulted in an unprecedented upheaval in chief social services officers, many of whom had chaired their local Area Child Protection Committee and had now moved on. Ten telephone interviews were finally successfully carried out.

An upheaval of similar proportions was taking place in the infrastructure of inspection of social care services. During this time, the former Social Services Inspectorate was merged with the newly formed National Care Standards Commission (set up following the reforms of the *Care Standards Act 2000*) to become the Commission for Social Care Inspection in April 2004. Many of the former Business Link Inspectors from the old Social Services Inspectorate were replaced by inspectors previously from local authority inspection units, who became the new Business Relationship Managers and were in the process of setting up liaison arrangements with their local authorities according to the new responsibilities. It quickly became clear the timing was not right and this was not going to be a fruitful line of enquiry for the study. However, a member of the senior management of the Commission for Social Care Inspection later provided a valuable briefing on the Commission's guidance for handling serious incidents to children. These organisational changes to the management and inspection of children's services have had an impact in a number of different ways, which are discussed in the study. Further changes have taken place since April 2007 with the creation of the new Ofsted (the Office for Standards in Education, Children's Services and Skills) following the *Education and Inspections Act 2006*. As a result, there has been a revision of the processes for notification of serious childcare incidents and new responsibilities introduced for Government Office staff in following up recommendations and action plans from serious case reviews.

The research team took the decision, therefore, to extend its range of sources of evidence and gain the perspectives of key stakeholders with experience of serious case reviews. This was done by holding an invited national study seminar. The seminar was conducted as an appreciative inquiry (discussed in Chapter 8) and was not only informative but led to a creative exchange of ideas for increasing the impact of serious case reviews. Additionally a further number of key people who had direct responsibility for managing the outcomes of serious case reviews, that were not subject reviews of the study, were interviewed. These respondents also provided valuable insights.

Appendix 2: Analysis of 40 serious case review reports, 2001–2003

Section One: About the Children

Age group	Number n=45*	Percentage	Comparison with 2002 report**
0 to 12 months	13	29%	48%
1 to 2 years	8	18%	
3 to 4 years	4	9%	
5 to 10 years	11	24%	48%
11 to 14 years	4	9%	
15 years	3	7%	
16 years	2	4%	3%
Total	45		
11 and over	9	20%	15% (11-16 years)

* 3 cases involved more than one child of the same family as the subject of the serious case review

**Comparisons are grouped where categories are different from those in Sinclair and Bullock (2002)

Age Group	Number
0 to 2 months	2
3 to 5 months	9
6 to 12 months	2
Total	13

Table 3: Gender of the children

Gender	Number n=45	Percentage	Comparison with 2002 report
Male	28	62%	50%
Female	17	38%	50%
Total	45		

Table 4: Ethnic group of children

Ethnic group	Number n=45	Percentage	Comparison with 2002 report
White British	16	36%	60%
Mixed	2	4%	–
Black/Black British	9	20%	15%
Asian/Asian British	1	2%	–
Not known/stated	17	38%	25%
Total	45		

Table 5: Ethnic group of parents

Ethnic group	Number	Percentage
White British	5	13%
Mixed	2	5%
Black/Black British	2	5%
Asian/Asian British	1	3%
Not known/stated	30	75%
Total	40	

Table 6: Children with a disability

Incidence of disability	Number	Percentage
Child has a disability	5	11%
No disabilities	31	69%
Not stated	9	20%
Total	45	

Table 7: Type of incident

Type of incident	Number	Percentage	Comparison with 2002 report
Death	33	73%	78%
Serious Injury	10	23%	20%
Suicide	2	5%	
Total	45		

Table 8: Children on the Child Protection Register (CPR)

Children on the CPR	Number	Percentage
On register	8	18%
Not on register	36	80%
Not recorded	1	2%
Total	45	

Table 9: Legal status of children in the study

Legal status	Number	Percentage
Interim care order	4	9%
s20 Accommodation	1	2%
Adopted	1	2%
No legal status	38	84%
Not recorded	1	2%
Total	45	

Section Two: The serious case review reports

Table 10: Social Services Inspectorate Region from which reports were received

SSI Region	Number	Percentage
London	7	18%
North West	4	10%
North East	3	8%
West Midlands	4	10%
East Midlands	8	20%
Yorkshire and Humberside	10	25%
Central	1	3%
South West	1	3%
South East	0	-
Not stated	2	5%
Total	40	

Table 11: Year of incident

Year of incident	Number	Percentage
2001	18	45%
2002	17	43%
2003	5	13%
Total	40	

Table 12: Date report was completed

Date of report	Number	Percentage
2001	1	3%
2002	12	30%
2003	20	50%
No date	7	18%
Total	40	

Table 13: Time from incident to completion of report

Time taken	Number of reports	Percentage
6 months or less	5	12%
Over 6 months to 12 months	13	33%
Over 12 months to 18 months	13	33%
More than 18 months	2	5%
Report not dated	7	17%
Total	40	

Table 14: Status of report author

Status of author	Number	Percentage	Comparison with 2002 report
Independent	11	28%	25%
Internal	14	35%	
Not reported	15	38%	
Total	40		

Table 15: Length of the report

Length of the report (pages)	Number	Percentage	Comparison with 2002 report
0–30	20	50%	68%
31–50	6	15%	
51–75	7	18%	
76–100	6	15%	
Over 100	1	3%	
Total	40		

Table 16: Compliance with Chapter 8 requirements of Working Together to Safeguard Children (Department of Health et al 1999)

(Comparison with Sinclair and Bullock report (2002) shown in brackets where applicable)

2.4 Does the report contain the following:	Yes	No	Partly
2.4.1 Introduction			
<ul style="list-style-type: none"> Summarise the circumstances that led to a review being undertaken in this case. 	40	0	0
<ul style="list-style-type: none"> State terms of reference of review. 	34	5	1
<ul style="list-style-type: none"> List contributors to review and the nature of their contributions (e.g. management review by LEA, report from adult mental health service). 	39	1	0
<ul style="list-style-type: none"> Did contributors include family members and any others? Specify 	8	32	0
2.4.2 The Facts			
<ul style="list-style-type: none"> Prepare a genogram showing membership of family, extended family and household. 	28 (12)	8 (6)	4 (22)
<ul style="list-style-type: none"> Compile an integrated chronology of involvement with the child and family on the part of all relevant agencies, professionals and others who have contributed to the review process. 	31(33)	6 (2)	3 (5)
<ul style="list-style-type: none"> Prepare an overview which summarises what relevant information was known to the agencies and professionals involved, about the parents/carers, any perpetrator, and the home circumstances of the children. 	37 (19)	1 (3)	2 (18)
2.4.3 Analysis			
<ul style="list-style-type: none"> This part of the overview should look at how and why events occurred, decisions were made, actions taken or not. 	34	1	5
<ul style="list-style-type: none"> This is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. 	31	2	7

Table 16: Compliance with Chapter 8 requirements of Working Together to Safeguard Children (Department of Health et al 1999) (continued)

(comparison with Sinclair and Bullock report (2002) shown in brackets where applicable)

2.4 Does the report contain the following:	Yes	No	Partly
<ul style="list-style-type: none"> The analysis section is also where any examples of good practice should be highlighted. 	25	11	3 1 Not applicable
<i>2.4.4 Conclusions and Recommendations</i>			
<ul style="list-style-type: none"> This part of the report should summarise what, in the opinion of the review panel, are the lessons to be drawn from the case, and how those lessons should be translated into recommendations for action. 	32	4	4
<ul style="list-style-type: none"> Recommendations should include, but should not simply be limited to, the recommendations made in individual agency reports. 	33	2	5 Not stated
<ul style="list-style-type: none"> Recommendations should be few in number, focused and specific, and capable of being implemented. 	30	4	6
<ul style="list-style-type: none"> If there are lessons for national, as well as local, policy and practice these should also be highlighted. 	10	22	2 6 Not applicable
<i>2.4.5 Action Plan</i>			
Does the overall action plan explain:			
<ul style="list-style-type: none"> What action should be taken by whom, and by when? 	30	5	5
<ul style="list-style-type: none"> What outcomes should these actions bring about? 	15	18	7
<ul style="list-style-type: none"> How the agencies will review whether the outcomes have been achieved? 	12	22	6

Section Three: Overview report recommendations and actions

Table 17: Total number of recommendations

Total number of recommendations	Number	Percentage	Comparison with 2002 report
0–10	15	38%	53%
11–20	10	25%	38%
21–40	12	30%	
41–60	1	3%	10%
61–80	1	3%	
Not known	1	3%	
Total	40	100%	100%

Table 18: Focus of recommendations in order of frequency

Existing procedures (review, reinforce or revise)	104
Need for new procedures	94
Other	93
Communication	81
Training	72
Assessment of children and families	52
Management	44
Risk assessment	22
Supervision	20
Roles of staff	16
Decision making	15
Direct work with children and families	9
Need for new staff	7
Knowledge, skills and experience of staff	5

Table 19: Total number of action points

Total number of action points	Number	Percentage
None	1	3%
0–10	9	23%
11–20	7	18%
21–40	12	30%
41–60	3	8%
61–80	1	3%
81 plus	1	3%
Not known	6	15%
Total	40	100%

Table 20: Action plans

Action plans	Yes	No	Partly	Not clear from report
Part of the overview report	11	27	2	0
Single action plan for all agencies	23	5	2	4
Actions are linked to recommendations	34	1	1	4
Lead officer named for each action	21	15		4
Date by which actions are to be completed?	24	9	3	4
Actions are costed	0	36	0	4

Appendix 3: Reviewing and investigating individual cases: serious case reviews

*Reproduced from: Chapter 8, Working Together to Safeguard Children (HM Government 2006)**

Reviewing and investigative functions of LSCBs

8.1 Regulation 5 requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the procedures set out in this chapter. The same criteria apply to disabled children as to non-disabled children.

Serious case reviews

8.2 When a child dies, and abuse or neglect is known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (e.g. siblings, or other children in an institution where abuse is alleged). Thereafter, organisations should consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a serious case review into the involvement with the child and family of organisations and professionals. Additionally, LSCBs should always consider whether a serious case review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness;

or

- the case gives rise to concerns about inter-agency working to protect children from harm.

* Since Working Together to Safeguard Children was published in 2006, CSCI responsibilities for SCRs have been assumed by Ofsted and with the machinery of government changes, the Department for Children, Schools and Families is responsible for children's services rather than DfES.

The purpose of serious case reviews

- 8.3 The purpose of serious case reviews carried out under this guidance is to:
- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
 - identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
 - as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.
- 8.4 Serious case reviews are not inquiries into how a child died or who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate.
- When should a LSCB undertake a serious case review?
- 8.5 A LSCB should always undertake a serious case review when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether LA children's social care is, or has been, involved with the child or family.
- 8.6 A LSCB should always consider whether to undertake a serious case review where a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children. This includes situations where a parent has been killed in a domestic violence situation, or where a child has been killed by a parent who has a mental illness.
- 8.7 Where more than one LSCB has knowledge of a child, the LSCB for the area in which the child is/ was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the review. In the case of looked after children, the Responsible Authority should exercise lead responsibility for conducting any review, again involving other LSCBs with an interest or involvement.
- 8.8 Any professional may refer such a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case. In addition, the Secretary of State for the Department for Education and Skills has powers to demand an inquiry be held under the *Inquiries Act 2005*.
- 8.9 The following questions may help in deciding whether or not a case should be the subject of a serious case review in circumstances other than when a child dies. The answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons.
- Was there clear evidence of a risk of significant harm to a child that was:
 - not recognised by organisations or individuals in contact with the child or perpetrator or
 - not shared with others or
 - not acted on appropriately?

- Was the child killed by a mentally ill parent?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre, YOI, STC, children's home or Armed Services training establishment)?
- Did the child die in a custodial setting (prison, Young Offenders' Institution or Secure Training Centre)?
- Was the child abused while being looked after by the local authority (LA)?
- Did the child commit suicide, or die while absent having run away from home?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?
- Was the child the subject of a child protection plan, or had they previously been the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?

Instigating a serious case review

Does the case meet serious case review criteria?

- 8.10 The LSCB should first decide whether or not a case should be the subject of a serious case review, applying the criteria at paragraphs 8.5 and 8.6. In making this decision where a child has died, the LSCB should draw on information available from the professionals involved in reviewing the child's death (see Chapter 7). LSCBs should establish a Serious Case Review Panel, involving at least LA children's social care, health, education and the police, to consider questions such as whether a serious case review should take place. In some cases, it may be valuable to conduct individual management reviews, or a smaller-scale audit of individual cases that give rise to concern but that do not meet the criteria for a full serious case review. In such cases, arrangements should be made to share relevant findings with the Serious Case Review Panel.
- 8.11 The Review Panel's decision should be forwarded as a recommendation to the Chair of the LSCB, who has ultimate responsibility for deciding whether or not to conduct a serious case review. Immediately following the making of this decision, the LA should inform the local region of the Commission for Social Care Inspection of every case that becomes the subject of a serious case review.

Determining the scope of the review

- 8.12 The Review Panel should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference. Relevant issues include the following:
- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
 - Who should be appointed as the independent author for the overview report?

- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review? Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, – i.e. how far back should enquiries cover, and what is the cut-off point? What family history/background information will help better to understand the recent past and present?
- Which organisations and professionals should contribute to the review including, where appropriate, for example, the proprietor of an independent school or playgroup leader should be asked to submit reports or otherwise contribute?
- How should family members contribute to the review, and who should be responsible for facilitating their involvement?
- Will the case give rise to other parallel investigations of practice – e.g. independent health investigations or multi-disciplinary suicide reviews, a homicide review where a parent has been murdered, a YJB Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting? And if so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions that need to be asked, in the most economical way?
- Is there a need to involve organisations/professionals in other LSCB areas (see paragraph 8.7), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- How should the review process take account of a Coroner’s inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the serious case review process fit in with the processes for other types of reviews – e.g. for homicide, mental health or prisons?
- Who will make the link with relevant interests outside the main statutory organisations – e.g. independent professionals, independent schools, voluntary organisations?
- When should the review process start, and by what date should it be completed?
- How should any public, family and media interest be managed before, during and after the review?
- Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

8.13 Some of these issues may need to be revisited as the review progresses and new information emerges. The PCT should always inform its SHA of every case that becomes the subject of a serious case review.

Timing

- 8.14 Reviews vary widely in their breadth and complexity but, in all cases, lessons should be learnt and acted on as quickly as possible. Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the Review Panel, whether a review should take place. Individual organisations should secure case records promptly and begin work quickly to draw up a chronology of involvement with the child and family.
- 8.15 Reviews should be completed within a further four months, unless an alternative timescale is agreed with the Commission for Social Care Inspection Region at the outset. Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges that a review cannot be completed within four months of the LSCB Chair's decision to initiate it, there should be a discussion with the Commission for Social Care Inspection Region to agree a timescale for completion.
- 8.16 In some cases, criminal proceedings may follow the death or serious injury of a child. Those co-ordinating the review should discuss with the relevant criminal justice agencies, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations, and who should contribute at what stage? Serious case reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases, it may not be possible to complete or to publish a review until after the Coroner's or criminal proceedings have been concluded, but this should not prevent early lessons learnt from being implemented.

Who should conduct reviews?

- 8.17 The initial scoping of the review should identify those who should contribute, although it may emerge, as information becomes available, that the involvement of others would be useful. In particular, information of relevance to the review may become available through criminal proceedings.
- 8.18 Each relevant service should undertake a separate management review of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual organisation. Relevant independent professionals (including GPs) should contribute reports of their involvement. Designated professionals should review and evaluate the practice of all involved health professionals and providers within the PCT area. This may involve reviewing the involvement of individual practitioners and Trusts, and advising named professionals and managers who are compiling reports for the review. Designated professionals have an important role in providing guidance on how to balance confidentiality and disclosure issues. Where a children's guardian contributes to a review, the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived to the degree necessary.
- 8.19 The LSCB should commission an overview report that brings together and analyses the findings of the various reports from organisations and others, and that makes recommendations for future action.

8.20 The overview report should be commissioned from a person who is independent of all the agencies/professionals involved. Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved.

Individual management reviews

8.21 Once it is known that a case is being considered for review, each organisation should secure records relating to the case to guard against loss or interference.

8.22 The aim of management reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. The findings from the management review reports should be accepted by the senior officer in the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted on.

8.23 On completion of each management review report, there should be a process for feedback and debriefing for staff involved, in advance of completion of the overview report by the LSCB. There may also be a need for a follow-up feedback session if the LSCB overview report raises new issues for the organisation and staff members.

8.24 Serious case reviews are not a part of any disciplinary enquiry or process, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases (e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard and promote the welfare of other children.

8.25 Where a child dies in a custodial setting (prison, Young Offenders' Institution or Secure Training Centre) the Prisons and Probation Ombudsman investigates and reports on the circumstances surrounding the death of that child. The investigation examines the child's period in custody and assesses the clinical care they received. The report is normally made available to assist any serious case review process.

8.26 The following outline format should guide the preparation of management reviews, to help ensure that the relevant questions are addressed, and to provide information to LSCBs in a consistent format to help with preparing an overview report. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of those particular circumstances.

8.27 Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.

The LSCB overview report

8.28 The LSCB overview report should bring together, and draw overall conclusions from, the information and analysis contained in the individual management reviews, information from the child death review processes, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with management reviews, the precise format depends on the features of the case. This outline is most relevant to abuse or neglect that has taken place in a family setting.

LSCB action on receiving reports

8.29 On receiving an overview report the LSCB should:

- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report
- translate recommendations into an action plan that should be signed up to at a senior level by each of the organisations that need to be involved. The plan should set out who will do what, by when, and with what intended outcome. The plan should set out by what means improvements in practice/systems will be monitored and reviewed
- clarify to whom the report, or any part of it, should be made available
- disseminate report or key findings to interests as agreed. Make arrangements to provide feedback and debriefing to staff, family members of the subject child and the media as appropriate
- provide a copy of the overview report, action plan and individual management reports to the CSCI and DfES.

Reviewing institutional abuse

8.30 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply, but reviews are likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if children are abused in a residential school, it is important to explore whether and how the school has taken steps to create a safe environment for children, and to respond to specific concerns raised.

8.31 There needs to be clarity over the interface between the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; and review – i.e. learning lessons from the case to reduce the chance of such events happening again. The three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

Accountability and disclosure

8.32 LSCBs should consider carefully who might have an interest in reviews – e.g. elected and appointed members of authorities, staff, members of the child's family, the public, the media – and what information should be made available to each of these interests. There are difficult interests to balance, including:

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
- the accountability of public services and the importance of maintaining public confidence in the process of internal review
- the need to secure full and open participation from the different agencies and professionals involved
- the responsibility to provide relevant information to those with a legitimate interest

- constraints on public information-sharing when criminal proceedings are outstanding, in that providing access to information may not be within the control of the LSCB.

8.33 It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. In all cases, the LSCB overview report should contain an executive summary that will be made public and that includes, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made. The publication of the executive summary needs to be timed in accordance with the conclusion of any related court proceedings. The content needs to be suitably anonymised in order to protect the confidentiality of relevant family members and others. The LSCB should ensure that the SHA and the CSCI are briefed, so that they can work jointly to ensure that the Department of Health and the Department for Education and Skills, respectively, are fully briefed in advance about the publication of the executive summary.

Learning lessons locally

8.34 Reviews are of little value unless lessons are learnt from them. At least as much effort should be spent on acting on recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- as far as possible, conduct the review in such a way that the process is a learning exercise in itself, rather than a trial or ordeal
- consider what information needs to be disseminated, how and to whom, in the light of a review. Be prepared to communicate both examples of good practice and areas where change is required
- focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes. PCTs should seek feedback from SHAs, who should use it to inform their performance-management role
- the LSCB should put in place a means of auditing action against recommendations and intended outcomes
- seek feedback on review reports from the Commission for Social Care Inspection, who should use reports to inform inspections and performance management.

8.35 Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- establish a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed
- have in place clear, systematic case-recording and record-keeping systems
- develop good communication and mutual understanding between different disciplines and different LSCB members
- communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies

- make sure staff and their representatives understand what can be expected in the event of a child death/serious case review.

Learning lessons nationally

8.36 Taken together, child death and serious case reviews should be an important source of information to inform national policy and practice. The Department for Education and Skills is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The Department for Education and Skills commissions overview reports at least every two years, drawing out key findings of serious case reviews and their implications for policy and practice. It is considering how best to disseminate the findings from the work of the local child death overview teams.

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ISBN: 978 1 84775 095 2

PPSTER/D16(7443)/0108/54

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