

# Learning lessons from serious case reviews: interim report 2009–10

Ofsted's evaluation of serious case reviews 1 April to 30 September 2009

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This interim report provides an analysis of the evaluations of 85 serious case reviews that Ofsted completed between 1 April and 30 September 2009. A further report covering the full period from April 2009 to March 2010 will be published later this year.

**Age group:** 0–19

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# Contents

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<b>Executive summary</b>	<b>4</b>
<b>Key findings</b>	<b>4</b>
<b>Background</b>	<b>5</b>
<b>The children, their families and the incidents</b>	<b>7</b>
The children	7
The children's families	7
The incidents	8
Involvement of children's social care services	10
<b>Learning lessons from the serious case reviews</b>	<b>10</b>
Health services	11
Education services	12
Children's social care services	13
Police	14
Housing services	14
Issues for more than one agency	14
<b>The quality of serious case reviews</b>	<b>15</b>
Overall judgements	15
Terms of reference	16
Timescales	17
Consideration of race, language, culture, religion and disability	19
Family involvement	20

## Executive summary

Serious case reviews are local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. They are carried out by Local Safeguarding Children Boards so that lessons can be learned. Ofsted has published two previous reports about serious case reviews, the second of which covered the reviews evaluated between April 2008 and March 2009. The report, entitled *Learning lessons from serious case reviews: year 2*, analysed the 173 reviews evaluated during that 12-month period.<sup>1</sup>

This report covers the evaluations of a further 85 reviews completed in the six months between 1 April and 30 September 2009. As in the two previous reports, this one brings together findings in relation to the practice issues arising, the lessons learnt and the conduct of serious case reviews. It identifies issues which require further consideration by Local Safeguarding Children Boards.

Previous reports have criticised the quality of a large proportion of serious case reviews. However, an evaluation of the 85 latest reviews indicates an improvement in the proportion of reviews that Ofsted has judged to be adequate or better, and a reduction in the proportion judged to be inadequate. Of the first 50 reviews completed to 31 March 2008, 20 were judged to be inadequate, 18 adequate and 12 good. Of the 173 reviews completed in the period from 1 April 2008 to 31 March 2009, 59 were judged to be inadequate, 74 adequate and 40 good. The latest period contained a higher proportion of adequate or good reviews. Of the 85 reviews completed in the latest six-month period to 30 September, 17 were judged to be inadequate, 38 adequate and 30 good.

While this progress reflects the high level of attention that has been given to these reviews, nationally and by most Local Safeguarding Children Boards, it is still of concern that 17 reviews during this period were found by inspectors to be inadequate. Every review of a serious incident should be carried out to the highest standard.

Although this interim report covers only half a year, there are some important findings.

## Key findings

- Only 25 of the 85 reviews were completed within six months. Forty-one were completed within a six to 12 month period. Thirteen reviews took between one and two years to complete and six took more than two years.

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<sup>1</sup> *Learning lessons from serious case reviews: year 2* (090101), Ofsted, 2009; [www.ofsted.gov.uk/publications/090101](http://www.ofsted.gov.uk/publications/090101).

- Of the 106 children who were the subjects of the reviews, 45 were under one year old, and a further 29 were aged between one and five years old.
- The characteristics of the families in these reviews were similar to those found in previous reports. The most common issues were domestic violence, mental health problems, and drug and alcohol misuse. It was not unusual for more than one of these characteristics to exist in any one family. The incidence of these factors was more frequent in cases where children had died than in non-fatal cases.
- Some parents were themselves receiving services, especially from adult social care, adult mental health and substance misuse services. Front-line workers in these teams were not always sufficiently aware of child protection procedures and responsibilities in relation to the children of their clients.
- Physical abuse was the most common characteristic of the incidents reviewed.
- Only a minority of the children, 41 out of 106, were in contact with social care services at the time of the incident under review.
- A common finding was that none of the main agencies had a complete picture of the child's family and a full record of the concerns. Holistic assessments of risk were not made routinely. Agencies tended to respond reactively to each situation rather than seeing the whole context.
- There was sometimes a lack of focus on the child when working with the family, including a failure by professionals to communicate directly with, or observe, the child so that they could understand the child's daily experience of life.
- There were examples of poor communication and information sharing between agencies, inadequate identification of child protection needs, errors by individual staff, poor assessments leading to inappropriate plans, and inadequate management oversight and decision-making.
- Local Safeguarding Children Boards are often still not paying sufficient attention in the review process to the race, language, culture, religion and disability of the children and their families. More effort continues to be needed to find effective ways of engaging children and families in the review process where this is practicable and appropriate.

## Background

1. Ofsted has been responsible for evaluating serious case reviews since 1 April 2007. The reviews and the evaluations are conducted in accordance with the guidance set out in Chapter 8 of *Working together to safeguard children* (referred to as *Working together*).<sup>2</sup> An updated Chapter 8 of *Working together to safeguard children* was published in December 2009, and was integrated into

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<sup>2</sup> *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, TSO, 2006; updated 2009 and 2010; [www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/](http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/).

the revised *Working together*, which was published on 17 March 2010. This report, therefore, deals with reviews that were completed before the new guidance had been issued.

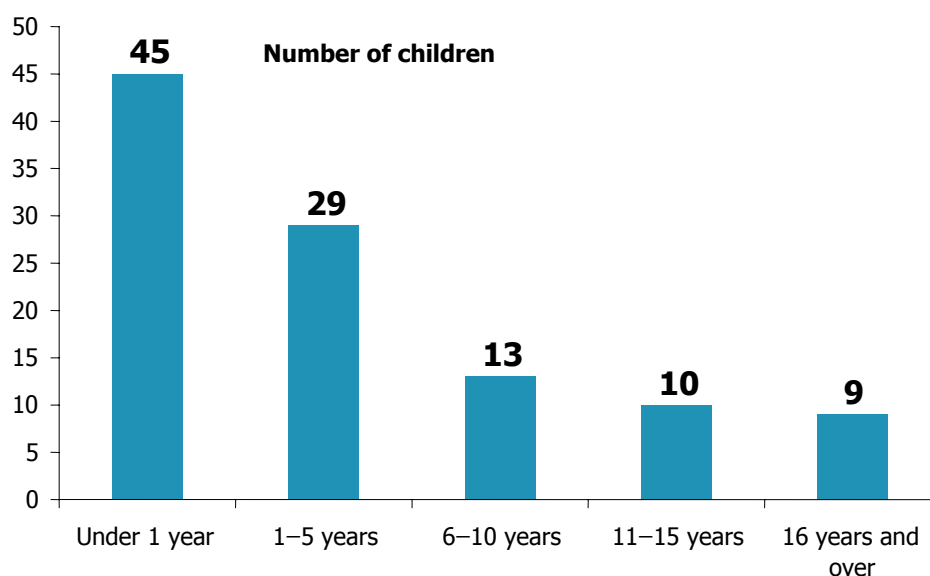
2. The previous guidance said that where a child dies and abuse or neglect is known or suspected, the Local Safeguarding Children Board must conduct a serious case review. It must also consider conducting a serious case review where:
  - a child sustains a potentially life-threatening injury or serious and permanent impairment to health and development through abuse or neglect
  - a child has been subject to particularly serious sexual abuse
  - a child's parent has been murdered and a homicide review is being initiated
  - a child has been killed by a parent with a mental illness
  - the case gives rise to concerns about inter-agency working to protect children from harm.
3. The purpose of a serious case review is:
  - to establish whether there are any lessons to be learned from the case about inter-agency working
  - to identify clearly what these lessons are, how they will be acted upon and what is expected to change as a result
  - to improve inter-agency working and better safeguard and promote the welfare of children.
4. Local Safeguarding Children Boards are required by *Working together* to send the completed review to Ofsted for evaluation. These are complex documents and include a large volume of separate documentation: terms of reference; individual management reviews from all statutory and voluntary agencies who may have been involved with the child concerned during the period covered by the review; an overview report which draws together the findings from the individual management reviews; action plans; and an executive summary, which is the published outcome of the review. Ofsted evaluates the effectiveness of all parts of the process in ensuring that lessons have been learnt.
5. The outcome of the evaluation is shared with Local Safeguarding Children Boards and forms part of the evidence used for Ofsted's wider evaluation of the effectiveness of children's services in a local area. Outcomes of evaluations are also shared with the Department for Children, Schools and Families and the relevant Government Office.

## The children, their families and the incidents

### The children

6. Between 1 April and 30 September 2009, 106 children from 85 families were the primary subjects of serious case reviews evaluated by Ofsted. Of these, 55 children died and the remainder were involved in other serious incidents. The profile of the children was similar to the one in *Learning lessons from serious case reviews: year 2*.
7. A large majority of the children involved were five years old or younger at the time of the incident.

**Figure 1: Ages of children who were the subject of a serious case review evaluated by Ofsted between 1 April and 30 September 2009**



8. Of the 106 children, 52 were girls and 54 were boys. Ethnicity was recorded for all the children. Eighty-five were White British. Another 12 children were from seven ethnic groups, including seven children who were Asian or Asian British. The ethnicity recorded for the remaining nine children was not consistent with recognised ethnic categories.
9. Seven children of school age had statements of special educational needs. There were six disabled children, with disabilities ranging from partial hearing to severe and complex conditions. Four of the disabled children were among the seven who had statements of special educational needs. None of the children was identified as being home-educated.

### The children's families

10. The characteristics of the families were similar to those identified in Ofsted's previous two reports on serious case reviews. The most common issues

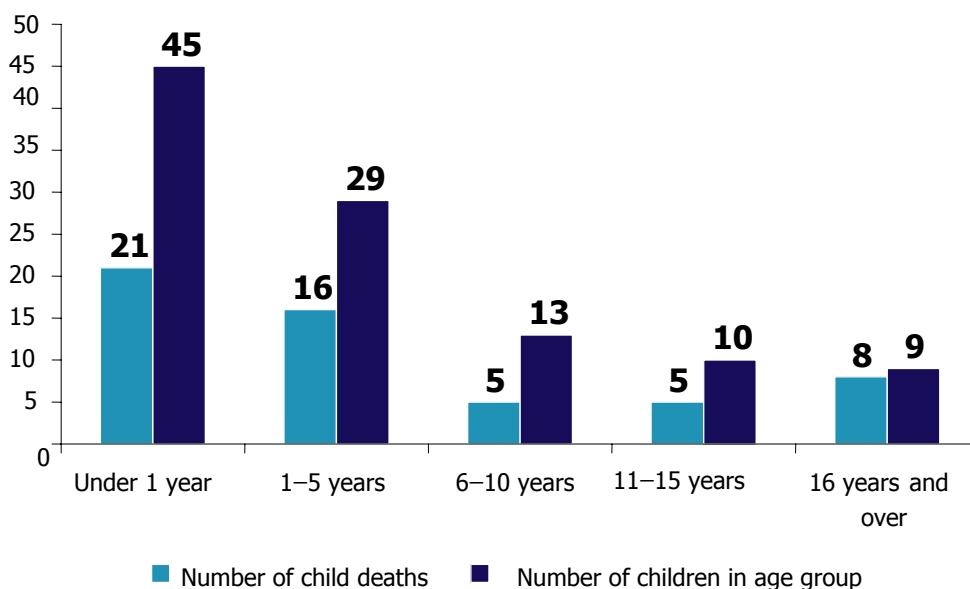
continue to be domestic violence, mental health problems, and drug and alcohol misuse. In some cases more than one of these characteristics was present in the family. Of the 106 children, domestic violence was an issue in 36 cases, mental health problems in 29 cases and drug and alcohol misuse in 27 cases. These factors were more frequent in cases where the children had died than in the non-fatal cases. In 17 cases, the review concerned a child from a teenage pregnancy and in six other cases the parents were in their very early twenties.

11. Many of the families were living chaotic and complicated lives, making it difficult for professionals to obtain a clear picture of the family’s circumstances and dynamics. Some parents were receiving services in their own right from agencies, notably adult social care services, adult mental health services and substance misuse services and, less frequently, housing and probation services. These agencies were found to have held important information about the family circumstances, but too often this was not shared early enough.

## The incidents

12. Physical abuse, including shaken baby syndrome, was the most common characteristic of the incidents. This was a factor identified before or during the serious case review process in 43 cases. There was long-term neglect in 19 cases.

**Figure 2: Number of child deaths by age group compared with total number of children in age group**



13. Of the 106 children who were the subjects of the reviews, 55 died. The balance of the ethnicity and gender of the children who died is similar to the other 51 children. There is little difference in the age profile of the two groups, except

for the children aged 16 and over. Of the nine young people over the age of 16 who were the subject of these reviews, eight died. Three of these eight young people had been diagnosed as being disabled or had a statement of special educational needs or both.

**Table 1: Cause of death of the 55 children who died**

<b>Homicide</b>	
Murder by parent/carer*	10
Other**	5
<b>Total</b>	<b>15</b>
<b>Other external cause</b>	
Killing by another young person	1
Suicide	5
Other***	2
<b>Total</b>	<b>8</b>
<b>Accidents and adverse events</b>	
Concealed birth	1
Result of accident but neglect a factor	3
Overlay by parent/carer	1
Substance misuse	4
Other	1
<b>Total</b>	<b>10</b>
<b>Undetermined</b>	
Unexplained cause	9
Unknown cause	3
Parent died in same event	7
Other	1
<b>Total</b>	<b>20</b>
<b>Natural causes</b>	<b>2</b>
<b>Total</b>	<b>55</b>

\* Parent/carer was convicted of murder of child.

\*\* Includes deaths arising from malnourishment, neglect, physical abuse, shaken baby syndrome or arson.

\*\*\* Includes deaths from fire or drowning.

14. Twelve of the 19 young people over the age of 11 who died did so in circumstances in which no adult was involved. Two young people had sought help as they feared they might self-harm, some had previously self-harmed or had experienced bullying and two were carers for a mentally ill parent and brothers and sisters. Three young people died as a result of substance misuse.
15. Table 1 (above) shows the cause of death for the 55 children of all ages who died. For the largest group of children (20), the cause remained undetermined. This was often because the death could not be explained or because the parent in charge had died in the same incident. Sixteen children were murdered by a parent or their deaths came about as a direct consequence of acts of commission or omission by a parent; 15 were homicides and one was accidental. Nine young people died from suicide or as a result of substance misuse. One child died from ingesting a toxic substance belonging to the parent. Ten children died as a result of accidents or other adverse events, as shown in the table.

### **Involvement of children's social care services**

16. The majority of the children (65 out of 106) had no contact with social care services at the time of the incident under review. Following the incident, social care services were provided for all the families. Protective action, in the form of care proceedings or child protection plans, was instigated for most children and their siblings.
17. Forty-one children were receiving services as children in need at the time of the incident. Seventeen had active child protection plans. Thirteen of the 41 children were five years old or younger, and seven were babies under one year old. Of the 41 children receiving services, 15 died.
18. Six of the children were looked after. Two babies under one year old received injuries while they were looked after, one while in hospital and one while placed in foster care. Two children with severe and complex disabilities died. One died from causes associated with the disability; the cause of the second death remains undetermined. Two looked after young people aged over 16 died. One of them committed suicide and the other died as a result of an incident involving substance misuse.

### **Learning lessons from the serious case reviews**

19. This section focuses on the lessons to be learnt by the key safeguarding agencies from the 85 serious case reviews. It is important to be cautious about generalising from reviews of the relatively small number of cases which result from the most serious incidents. However, there were some common issues which require serious consideration by the agencies involved, and we expect to return to some of these when the full-year report is published in autumn 2010.

20. Many of the lessons are similar to those drawn out in the two previous reports by Ofsted. A common finding was that none of the main agencies had a complete picture of the child's family and a full record of the concerns. Holistic assessments of risk were not made routinely and agencies tended to respond reactively to each situation rather than by seeing the whole context. In some cases there was a lack of focus on the child when working with the family, including a failure by professionals to communicate directly with or observe the child so that they could understand the child's daily experience of life.
21. There were examples of poor communication and information sharing between agencies, inadequate identification of child protection needs, individual staff error, poor assessments leading to inappropriate plans, and inadequate management oversight and decision-making. The reviews evaluated in the most recent six-month period suggest that this indicated a failure to implement and ensure good practice rather than a lack of the required framework for delivering services or an understanding of what constitutes good practice.

## **Health services**

22. In many of the serious case reviews evaluated, health practitioners had noted the signs and symptoms of possible abuse or risk factors but had not acted on them. The practitioners had not taken the observations into account in their work with the child and family or had not communicated their concerns and shared information with other relevant professionals. There were examples of poor communication both within health services and between health services and other agencies.
23. In general, staff who provided health services for the children had received relevant training. This was particularly the case for those delivering universal early life services in the community. However, the reports identified cases where a lack of management oversight, and in particular clinical supervision in health visiting services, led to a failure to identify concerns or to provide professional challenge to practitioners.
24. A common finding of these reviews was that, in the cases concerned, there had been poor communication among primary care practitioners, and information for assessments of risk during the pre-birth period and in the early months of life had not been collated.
25. In the cases examined in these reviews, responses by staff to the signs and symptoms of abuse in very young children, especially non-ambulant babies, were frequently inadequate. Parents' explanations for facial bruising and other injuries were too readily accepted without further examination of the child by a suitable health practitioner or consultation with named child protection doctors or nurses.
26. In some cases, when babies were taken to hospital, their injuries were treated as single events and there was a failure to fully examine and observe the

children. This resulted in their being discharged from hospital after the presenting matter had been attended to without a systematic consideration of the possible causes of the child's condition.

27. When the need for additional services was identified and a referral was made to other specialist health services, reviews found that systems were not in place to ensure that the service was being delivered to meet the child's need. Those making the referral assumed that the service was being provided and, in turn, the provider assumed that, if the child or the family did not attend the given appointment, the service was not needed. When parents and carers themselves were given responsibility for making appointments for their children or for acting as the key link for transferring information between health agencies, professionals could too readily assume that they would do so. This applied particularly to the parents and carers of children who were disabled.
28. A number of the serious case reviews, especially those conducted in relation to very young babies, identified issues related to specialist health services for adults, particularly substance misuse and mental health services. Providers of these services did not always take sufficient account of the service users' role as parents and whether the parents' conditions were likely to place children at risk. Some practitioners in these services were unclear about their brief regarding the children of service users and of the children's safeguarding framework; they had not received safeguarding training and did not challenge sufficiently what the parents told them about their children. They did not pass on relevant information systematically to midwifery and health visiting services.
29. There were weaknesses in the systems that agencies used to communicate information about children as they moved between services because of their age or stage in life or following particular key events, even when these changes could have been predicted in advance. In the cases under review, transferring records from, for example, the general practitioner to midwifery to the health visiting services was not sufficiently reliable.
30. Poor communication between specialist children's services such as child and adolescent mental health services and universal services such as individual schools was another issue that the reviews identified.

## **Education services**

31. The majority of the children were not of compulsory school age. For school-age children in these reviews, the process of using the Common Assessment

Framework was not yet embedded in practice among education professionals in those instances where children's additional needs had been identified.<sup>3</sup>

32. Safeguarding training was provided but child protection processes were not always followed. Named safeguarding leads were not always in place.
33. The terms of reference for some serious case reviews included the need to examine the childhood histories of teenage parents. The ability to do this comprehensively was hampered, in most cases, by the unavailability of school records. These had been destroyed in accordance with local record retention policies.

### **Children's social care services**

34. Reviews raised issues about a lack of social worker and front-line management capacity affecting the cases examined. Inadequacies in the first line management overview of work quality were more frequent than the failure to allocate work or instances of assessments undertaken by unqualified staff. Sometimes the threshold for eligibility for services was found to be too high.
35. Good chronologies were not systematically available in social work records and there was a tendency for social care staff in these reviews to view events as individual occurrences rather than to consider the child's complete experience of daily life.
36. Social care staff often found it difficult to identify situations of chronic neglect, given parents' feigned compliance with social work interventions. Professional challenge, oversight and support by managers for staff working with the families were also issues. In the cases examined, an over-optimistic view too often prevailed about the child's quality of life and whether sufficient change had occurred to reduce the risk.
37. Where parents were given support to improve their parenting skills under child protection plans, this sometimes led to a loss of focus on the child and the quality of her or his daily experience. This was particularly the case with children under five years old. Failures were also identified in the timely provision of continued support through children in need plans, particularly after child protection plans had ceased.
38. Some serious case reviews demonstrated poor communication between different elements of the social work service. For example, services for looked after children did not always identify the information that was available to them

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<sup>3</sup> The Common Assessment Framework is a generic tool for practitioners working across all children's services. For further information see: [www.everychildmatters.gov.uk/deliveringservices/caf](http://www.everychildmatters.gov.uk/deliveringservices/caf). Ofsted noted in its report *Equalities in action* that few of the schools visited for that survey were using the Framework. See *Equalities in action (080272)*, Ofsted, 2010; [www.ofsted.gov.uk/publications/080272](http://www.ofsted.gov.uk/publications/080272).

as being pertinent to assessments of risk undertaken by services for children in need.

39. The response of social care services to information and referrals about domestic violence also varied widely, depending on local policies and thresholds for service. In some cases there was a lack of understanding between social care and police services about protocols, thresholds for action and the impact of domestic violence on children. This concern also extended to procedures for securing safe places for children identified as being at risk.
40. Generic emergency social care duty teams did not always give sufficient priority to responding to child protection referrals. Some of the staff lacked adequate, specialist professional support in child protection.

## **Police**

41. Domestic violence was identified as a significant factor for 36 of the 106 children. There was wide variation in the police's recording of incidents of domestic violence and in identifying children at risk when officers attended households for any purpose. There were also different protocols and practices for passing on information to children's social care services after such visits.
42. Similar variation was found in the ability of police services to access information that enabled them to identify households where children were the subjects of child protection plans. There was also variation in the arrangements between police and social care services to ensure that suitable care was provided to safeguard children at immediate risk of harm.

## **Housing services**

43. Housing services were not consistently members of the Local Safeguarding Children Board. However, 24 serious case reviews included individual management reports from housing agencies. They indicated that there was little training for housing staff on the identification of, and referral to social care services of, safeguarding concerns about the children of tenant and homeless families.

## **Issues for more than one agency**

44. Referrals, primarily by health and social care professionals, were not always followed up sufficiently rigorously. Assumptions were made that families and individual children were receiving services that would meet their assessed needs, such as pre-school day care, services relating to domestic abuse, mental health and family therapy services, when these were not happening.
45. For some families with multiple needs or with several children, all with their own needs, or for families with a disabled child, there were examples of

insufficient communication and coordination between professionals to agree on and support priorities for work with the whole family.

46. Professionals did not always ensure that their communication with families was effective. Letters, the main means of communicating, were not always suitable for parents with limited education, learning difficulties or an antipathy to formal written communications. The social disadvantage of some women was compounded by using other family members as interpreters or by a failure to help them to communicate effectively.
47. In a small proportion of the reviews, a child protection case conference did not work well, because the conference did not have all the available information and because not all the members of the meeting were present. The chairing of the meeting was not sufficiently robust to ensure that all essential contributions were made to encourage professional challenge, to make clear decisions and to formulate meaningful protection plans. Similar issues were found in the core group process for implementing child protection plans: records of case conferences and core group meetings were inadequate.
48. A common finding in the reviews was that universal services such as schools, Connexions and youth services were not working collaboratively. They tended to focus on the presenting behaviour rather than taking a wider overview, and they struggled to meet the young people's needs. The majority of these young people were not seen as being at risk of harm to themselves. In some cases there was a lack of communication and joined up working between universal services and those such as child and adolescent mental health services.
49. There was variation in the use of Multi-Agency Public Protection Arrangements and Multi-Agency Risk Assessment Conferences. When conducting child protection risk assessments, the professionals involved did not always have information about any relevant convictions of adults who were significant in the lives of the children.

## **The quality of serious case reviews**

### **Overall judgements**

50. Ofsted's two previous reports on serious case reviews highlighted concerns about the quality of the reviews. This section focuses on some of the weaknesses identified in the reports to consider whether there has been any improvement in the reviews conducted between April and September 2009. Table 2 shows the judgements made for all reviews evaluated from April 2007 to September 2009.

**Table 2: Number of judgements on serious case reviews evaluated by Ofsted by grade**

Period	Outstanding	Good	Adequate	Inadequate	Total SCRs
April 07– March 08 (12 months)	0	12	18	20	50
April 08 – March 09 (12 months)	0	40	74	59	173
April 09 – Sept 09 (6 months)	0	30	38	17	85

51. The table indicates an improvement in the proportion of reviews that Ofsted has judged to be adequate or better, and a reduction in the proportion judged inadequate. Of the first 50 reviews completed to 31 March 2008, 20 were judged to be inadequate, 18 adequate and 12 good. Of the 173 reviews completed in the period from 1 April 2008 to 31 March 2009, 59 were judged to be inadequate, 74 adequate and 40 good. The latest period contained a higher proportion of adequate or good reviews. Of the 85 reviews completed in the latest six-month period to 30 September, 17 were judged to be inadequate, 38 adequate and 30 good.
52. While this progress reflects the high level of attention that has been given to these reviews, nationally and by most Local Safeguarding Children Boards, it is still of concern that inspectors found 17 reviews during this period to be inadequate. The depth of learning in those serious case reviews that were judged inadequate was limited by a number of factors: in a majority of them, the terms of reference were not sufficiently focused and were judged inadequate; the quality of the individual management reviews was variable; and the majority of the overview reports were judged inadequate, mainly because the information considered was not analysed or challenged sufficiently. In some cases contributions had not been included from other agencies that were involved with the case, which represented a significant loss of potential learning.
53. Evaluations indicate that the quality of the overview report can be critical to the overall quality of the serious case review. The skills of the author of the overview report in challenging the quality and content of individual management reviews and ensuring that the overview report compensates for any identified deficiencies can be key to maximising the depth of learning from the review.

## Terms of reference

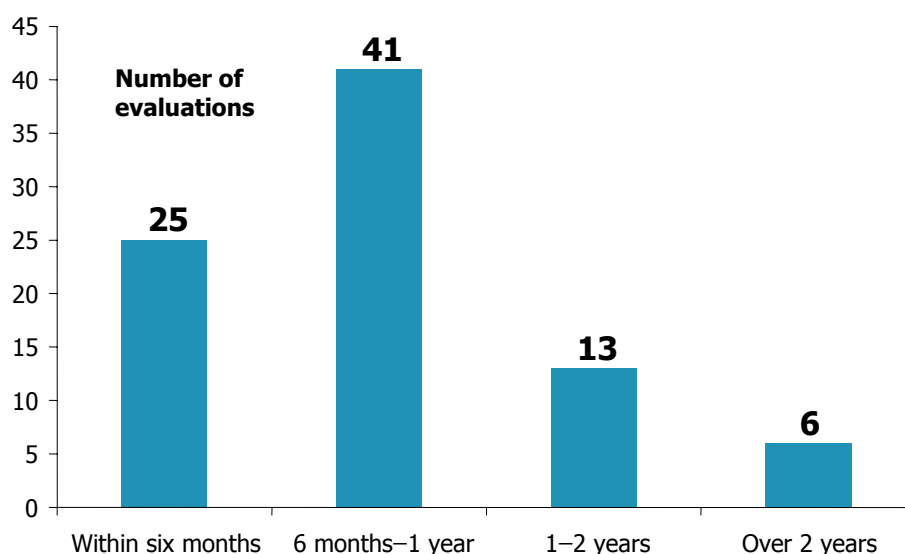
54. Ofsted's previous reports have emphasised the importance of good terms of reference for serious case reviews. Appropriate and clear terms of reference are an essential base for effective reviews. There is a strong relationship between the quality of the terms of reference and the overall judgement in Ofsted's evaluations. During the period covered by this report, there were three examples of terms of reference which were judged to be outstanding.

55. In 56 of the reviews, the overall judgements were the same as those given for the quality of the terms of reference. Only 10 overall judgements exceeded the terms of reference judgements and, with one exception, this was by one grade only.

## Timescales

56. The two earlier Ofsted reports both highlighted concerns about the time taken to complete the process of serious case reviews. Two sets of data were considered for this report: first, the time taken to decide whether to conduct a review and, second, the time taken before the review was completed.
57. Local Safeguarding Children Boards are required to decide whether a serious case review should be conducted and to begin the review process within one month of being informed of the 'incident'. This standard was met in 49 of the 85 reviews.
58. The reasons for the delay in the remaining 36 cases were given either in the evaluation documentation or by direct contact with the Local Safeguarding Children Board. Three main reasons were given.
59. The first reason was that the decision depended upon the conclusion of other formal processes, such as forensic test results and inquest findings that provided information about the cause of death. There were delays in arranging both inquest dates and forensic test results.
60. The second reason was where new information became available which sometimes led to a change in the decision of the Local Safeguarding Children Board in favour of conducting a review and, on other occasions, to extending the planned timetable for its completion. New information arose largely from the process of care proceedings, in particular from 'findings of fact'.
61. The third reason concerned the capacity of agencies and the Local Safeguarding Children Board to identify writers of individual management reviews and of overview reports, including by Local Safeguarding Children Boards which were conducting more than one serious case review at the same time.
62. In terms of the time taken to carry out the reviews, only 25 of the 85 reviews were completed within the six-month timescale. Forty-one were completed within a six to 12 month period. Thirteen reviews took between one and two years to complete and six took more than two years (see Figure 3). These figures indicate that most of these reviews would not have met the new six-month timescale established in the revision of Chapter 8 of *Working together*, published in December 2009.

**Figure 3: Length of time taken to complete serious case reviews**



63. Three main reasons were given for the delays in completing the reviews. The first reason was attributed to the capacity to produce the high number of individual management reviews which resulted from the complexity of the cases, the importance of ensuring that the individual management reviews were of an acceptable quality and the need to coordinate work across a number of Local Safeguarding Children Boards.
64. The second reason for delays related to unresolved formal processes arising from the incident that instigated the review. These included pending criminal proceedings in respect of a parent or carer; unresolved care proceedings in respect of the child who was the subject of the serious case review or her or his siblings; and delayed or current inquests. The process was often delayed because of advice that the process of conducting the serious case review might prejudice the hearings. It was also thought that family members might be more willing to participate in the review once other matters had been concluded.
65. Other reasons given were the infrequency of meetings of serious case review panels and Local Safeguarding Children Boards and delay in producing individual management reviews. Some writers of the reviews by individual agencies were unable to gain access to necessary written records. This was either because records could not be found or because access to medical records presented difficulties. These delays, which had a knock-on effect on the overall process, are a significant cause for concern.
66. Figure 4 shows the relationship between the time taken to complete the serious case reviews and their quality. The figures show that additional time does not necessarily lead to improved quality but that, among those which took between

six months and a year, a larger proportion were adequate or good. A period longer than a year did not lead to improved quality.

**Figure 4: Timescales and quality of serious case reviews, April to September 2009**

SCR evaluation	Under 6 months	6 months to 1 year	1 to 2 years	2+ years
Good	9	17	4	0
Adequate	9	19	7	3
Inadequate	7	5	2	3

67. Local Safeguarding Children Boards which began the serious case review process within one month of the Board learning of the incident were much more likely to complete the process within the six-month timescale. Of the cases completed in six months, a very large majority (20 of the 25 cases) had been started within one month of learning of the incident. In contrast, when the completion was between six months and one year a smaller proportion (20 of the 41 cases) had begun the review within one month of learning of the incident.

### **Consideration of race, language, culture, religion and disability**

68. Ofsted’s 2009 report on serious case reviews identified concerns about the lack of consideration of race, language, culture and religion. A similar pattern was found in the 85 reviews covered by this interim report. Few of the evaluations noted that agencies had addressed these dimensions in a meaningful way. As in the 2009 report, there was a general assumption that, if the family was White British, there were no cultural issues to be considered. This overlooked consideration of the norms and traditions of particular families or communities, the role of the extended family, and the significance of language in the families.

69. Some mothers and their children were isolated as a result of their ethnic background, language and culture. Some reviews considered these factors and ensured that the relevant lessons were learnt.

70. Ofsted’s previous report analysed the impact of the disability of children or family members. In the reviews evaluated for this report, disability was usually addressed when the subject of the review was a disabled child. However, there was little consideration of the full impact when siblings were disabled or when parents had a learning disability or suffered from mental ill-health. This was particularly the case for families where older children were young carers.

## Family involvement

71. *Working together to safeguard children* recommends that serious case review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'.
72. Overall, this aspect of the process continues to be under-developed, especially in the way that the contribution of family members is recorded. In their terms of reference, a small number of reviews specifically tackled how family members should be included. Just over a third of the reviews made no reference to family involvement in the process.
73. In 10 reviews a clear decision was made not to involve family members in the process. This was usually because criminal or care proceedings were still in progress and, in one case, because the parent was compulsorily detained under mental health legislation.
74. In 23 reviews there was evidence that parents were asked to become involved. The parents of only 11 children responded positively. This included one parent who was involved in current care proceedings. In two cases, parents decided not to contribute until care or criminal proceedings had concluded, but the timescale for the serious case review precluded such involvement.
75. A higher positive response rate was found among grandparents and members of the wider family. Invitations were made in 13 reviews for them to contribute to the process. Family members contributed in nine cases. It is not always clear why some family members were not invited to participate, particularly when grandparents had played a significant part in children's lives.
76. The effort that Local Safeguarding Children Boards put into encouraging family involvement varied considerably. The methods ranged from letters inviting contributions, to more personal contact by the overview writer. Repeated offers for a meeting sometimes secured a positive response. Where participation by family members happened early in the review process, it sometimes raised matters that were included in individual management reviews.
77. Only five reviews indicated clearly that the Local Safeguarding Children Board had tried to include children and young people. In three cases this opportunity was taken up. It was recorded in the reviews that two children wished that they had been removed from home earlier. One suggested that the child would have responded to television advertisements for helplines.
78. Even where the executive summaries reported that the views of children and family members had been included and had influenced the findings and recommendations from the review, the summary gave little information about the learning that resulted.