
IMPROVING SAFEGUARDING PRACTICE: STUDY OF SERIOUS CASE REVIEWS 2001-2003

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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 1.999). 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.

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Additional Information

The full report (DCSF-RR022) can be accessed at www.dcsf.gov.uk/research/

Further information about this research can be obtained from Nigel Gee, 6S22, DCSF, Sanctuary Buildings, Great Smith Street, London SW1P 3BT.

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