

Report summary

Learning lessons from serious case reviews 2009–2010

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

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

Key findings

- Of the 194 children who were the subject of the reviews, a majority were five years old or younger at the time of the incident. There were 69 under one year old and 47 between one and five years old.
- At the time of the incident, 119 of the children were known to children's social care services. This is a similar proportion to the findings of the previous year's report.
- The characteristics of the families were also similar to those identified in Ofsted's previous reports. The most common issues were domestic violence, mental ill-health, and drug and alcohol misuse. Frequently, more than one of these characteristics were present.
- Some parents were receiving support from agencies in their own right, including from services for adult social care, adult mental health, substance misuse, housing and probation. These agencies were found to have held important information about the family circumstances, but too often this was not shared early enough.
- Of the 194 children, 90 died. The other 104 were involved in serious incidents, following a history of concern by the agencies involved, including being the subject of a child protection plan. The most common characteristics of the incidents were physical abuse or long-term neglect.
- Local Safeguarding Children Boards identified the lessons to be learnt from the serious case reviews and made recommendations for action and improved

practice by agencies in their areas. There are six main messages which recur throughout the reviews. These messages are about the importance of:

- focusing on good practice
 - ensuring that the necessary action takes place
 - using all sources of information
 - carrying out assessments effectively
 - implementing effective multi-agency working
 - valuing challenge, supervision and scrutiny.
- A consistent finding from the reviews was that there had been a failure to implement and ensure good practice rather than an absence of the required framework and procedures for delivering services.
 - Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. They also highlighted concerns about the effectiveness of assessments and shortcomings in multi-agency working.
 - Reviews found that there had been insufficient challenge by those involved. The statements of parents or others in the family should not have been accepted at face value; individual professionals and agencies should have questioned their own and others' views, decisions and actions; and there were shortcomings in the supervision and intervention by managers.
 - Local Safeguarding Children Boards also identified failures to ensure that the necessary action was taken because of gaps in the services that were available; decisions which, with the benefit of hindsight, were found to be wrong; insufficient consideration of the child's individual needs; and 'professional drift' resulting in a lack of action.
 - Too often the focus on the child was lost; adequate steps were not taken to establish the wishes and feelings of children and young people, and their voice was not sufficiently heard.
 - Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. This included information about or from fathers and extended family, historical knowledge, information from other agencies, the cultural background and research findings.
 - The overview report has a critical impact on the overall quality of the serious case reviews and the depth of learning. This year, 19 overview reports were judged to be outstanding. These reports provided incisive commentaries and interpretations of the actions taken and those that should have been taken.
 - Of the 147 reviews, 60 met the six-month timescale for completing the reviews, which was established in the most recent revision of *Working together to safeguard children* (referred to in this report as *Working together*). Sixty took

between six and 12 months, 19 between one and two years, and eight over two years.

- Ofsted's previous reports identified concerns about the lack of consideration by Local Safeguarding Children Boards of race, language, culture and religion. An uneven pattern was found in the reviews covered by this report. Many of the reviews did not consider the issues sufficiently or focused on one aspect to the exclusion of others. In those reviews where race, language, culture and religion were dealt with sensitively, for example, there was increased learning from the review.
- There was evidence of improvement in the involvement of family members in the review process. In the best examples, the views of the family were woven into the final report and had an influence on the findings. However, only 15 reviews indicated clearly that the Local Safeguarding Children Board had tried to involve children and young people in them.

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