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A study of recommendations arising from serious case reviews 2009-2010

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EXECUTIVE SUMMARY

Introduction

This small study presents a critical, thematic analysis of recommendations from 33 of the serious case reviews (cases of child death or serious injury through abuse or neglect) completed in 2009-2010. The central aim of the study was to consider what part recommendations can play in aiding agencies and individuals *'to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children'* (HM Government 2010:246).

Key findings

- Overall, our impression of reading recommendations from the 33 cases is that they are indeed becoming tighter and more clearly focused, although rarely are they few in number.
- In the 20 serious case reviews examined in depth, there were a total of 932 recommendations with an average of 47 per review. This is in spite of repeated calls to make recommendations few in number.
- Breaking down recommendations into achievable actions has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity leaves little room for professional judgement.
- Most recommendations concerned procedures and training. The route to grappling with practice complexities like engaging hard to reach families, was usually more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.
- There was rarely a research evidence base cited for the recommendation made: they tended, instead, to be based on learning from the single case which was assumed to have wider implications.
- Action plans were thoughtful, well considered documents that tracked the implementation of recommendations carefully. However, those recommendations that were easy to implement rarely addressed complex matters of professional judgement.
- The interface between societal issues like deprivation and maltreatment rarely featured in recommendations or action plans. Wider issues tended to be thought of as beyond the scope of the review despite *Working Together* (HM Government 2010:248) inviting consideration of national policy and practice issues.

- Local Safeguarding Children Boards need to take responsibility for curbing this self-perpetuating cycle of a proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews. Recommendations may not be the best way to learn from these cases.

Background

To enable lessons from serious case reviews to be disseminated and implemented effectively, *Working Together* (HM Government 2010) advises that recommendations should be few in number, focused and specific. Most analyses of recommendations assess whether they are or can become Specific, Measurable, Achievable, Relevant and Timely (SMART). Other learning about recommendations reflects more of a tension between, on the one hand, finding ways to act quickly on easy to audit learning before the impetus dissipates, and on the other hand, striving for more considered, deeper learning to overcome the perennial obstacles to good practice.

Methodology

We used a staged approach in the analysis of recommendations. The first stage involved a qualitative analysis of recommendations from all 33 cases to identify major themes. A sub-sample of 20 reports was then analysed to ascertain the number of recommendations made and the extent to which they reflected the themes of the cases. The final stage of analysis involved a scrutiny of five action plans.

Findings

The number of recommendations

- Numbers of recommendations ranged from 10 to 94, with an average of 47 per review. In total, across the 20 reviews, there were 932 recommendations. The majority were targeted at children's social care services (179), community health services (161), hospital trusts (92) or the police (85).
- The recommendations which occurred with the greatest regularity concerned training and other aspects of managing the case and inter-agency working. Overall, the recommendations appeared to be more wide ranging than in previous studies.

Recommendation Themes

- To explore recommendation themes we developed a framework which focused on the child at the centre of the serious case review, working outwards to consider the child's family and environment, and out further to consider managing the case and the services which were (or were not) put in place to meet the child's needs. Working outwards yet further, we considered recommendations which addressed wider issues, or had regional and national implications for practice and/or policy.
- Recommendations which focused on the **child and their family** advocated taking a broad view of the family's circumstances, history and networks and taking account, for example, of 'hidden men'. They included seeing, hearing and keeping the child in mind especially when very young, disabled, missing from home, educated at home, or overshadowed by parents' needs.
- Aspects of **managing the case** highlighted the need for timely, careful decision making at each stage of the referral, assessment and the ongoing safeguarding process. Avoiding drift in decision making about neglect cases and addressing problems of high thresholds and access to children's social care services, especially in neglect cases, were recommendation themes.
- The importance of understanding the limits of **professional knowledge** and the need to seek and share expertise, for example about child development, were features in a small number of recommendations. Insufficient professional challenge of parents and other professionals was emphasised in some recommendations. However, the route to achieving more robust challenge and to grappling with other practice complexities like engaging hard to reach families, tended to be more training and the compliance with or creation of new or duplicate procedures. There were few recommendations that considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.
- A small number of recommendations highlighted the previously under explored issues of **staffing and workforce knowledge and capacity**. This included criticism of the use of unqualified staff, particularly in children's social care, but also in the police force and health visiting.
- **National issues** of 'public health' and more general messages from serious case review recommendations included 'safer sleeping' advice, particularly avoiding co-sleeping where alcohol or drugs had been consumed, and the danger to babies from being shaken.
- National level recommendations included calls for more national policy, guidance or protocols on a wide range of issues, for example redrafting standards for children's

homes, information sharing between children and adult services, disabled children and vulnerable migrant children. There were calls for increased participation of the armed forces in safeguarding, and better discussions with the Crown Prosecution Service about plea bargaining and the impact of reduced sentences on children's safety.

Do the recommendations match the themes of the case?

Most recommendations connected clearly to the case (and therefore were relevant). Common themes which mostly translated into recommendations were domestic violence, parental substance misuse and parental mental ill health as well as the theme of 'hidden men'. Regularly occurring themes which rarely translated into recommendations included premature or low weight babies and teenage parenthood. Wider themes like poverty and poor quality living environments scarcely appeared in recommendations. Where there were many recommendations they mostly included the kind of professional issues (like quality of recording) which lend themselves readily to crisp and measurable recommendations. However there were often repetitive messages. While messages may need to be reinforced, the imperative to fix everything may result in little getting or staying fixed.

Are the action plans 'SMART'?

Action plans are the means by which recommendations are translated into workable actions and followed through. The analysis of five action plans showed that all had a range of transparent methods for making sure that progress could be tracked. Where there were high numbers of recommendations, the action plans were accordingly long and detailed (they ranged in length from 10-40 pages).

- ***Specific:*** The sub-division of recommendations produced greater clarity, but also encouraged a proliferation of tasks to be achieved.
- ***Measurable:*** Easily measurable actions tended to be concrete activities like training events and changes to procedures or demands for information. Moving recommendations beyond the concrete appeared to be difficult, for example gauging *how* the quality and impact of awareness raising/training sessions will be measured.
- ***Achievable:*** Each plan contained delegated responsibility for ensuring that actions were completed, suggesting that earlier criticisms (Rose and Barnes 2008) had been addressed.
- ***Relevant:*** Although recommendations mostly connected clearly to the case, many regularly occurring themes seldom translated into recommendations. While some

recommendations had wider ranging validity, others were pertinent only to the single case. There is a risk of making potentially inappropriate or irrelevant decisions or procedures on the basis of a single case. Recommendations rarely drew explicitly on wider research based evidence to substantiate their validity.

- ***Timely:*** The need for timeliness had been heeded in the action plans we saw. Recommendations were accompanied by a timescale for implementation, and none of the action plans gave themselves a time frame beyond one year.

Recommendations have become more 'specific, measurable, achievable, relevant and timely' but this has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity appears to leave little room for professional judgement. However, it is easier to be critical of the SMART approach than to create an alternative. Where recommendations need to be made there is still value in this structured, methodical model but LSCBs should free themselves to construct a proportion of recommendations that are not easy to audit or make SMART that might encourage deeper learning and take longer to embed. Perhaps more importantly, LSCBs should be less reliant on recommendations being the central plank of the learning process in serious case reviews.

Although, on the whole, action plans and recommendations were found to be well considered, Local Safeguarding Children Boards need to take responsibility for curbing what has become a self-perpetuating cycle of a proliferation of recommendations and tasks.

Chapter 1: Literature Context, Aims and Methods

INTRODUCTION

The aim of this small study is to undertake a thematic and critical analysis of recommendations from the overview reports of 33 of the serious case reviews (SCRs), which had been completed and were available from the year 2009-2010. Through an analysis of these recommendations we consider what part they might play in aiding 'agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children' (HM Government 2010).

LITERATURE CONTEXT

Before outlining the methodology of this small study and considering its findings, a brief literature review is provided of analyses of recommendations stemming from reviews of child death or serious injury. The national study of learning from serious case reviews (Sidebotham et al 2010) revealed mixed views about the value of recommendations. Some respondents indicated that the analysis of outcomes of recommendations and action plans is the only way of knowing their impact on practice; others were concerned that emphasising recommendations and action plans was too simplistic, casting doubt on the fact that the impact on practice was necessarily measurable. These contrasting views reflect the tension that exists between, on the one hand, finding ways to act quickly on easy to audit learning before the impetus dissipates, and, on the other hand, wanting slower, more considered responses and deeper learning to overcome the perennial obstacles to good practice (Sidebotham et al 2010, Munro 2011b).

Earlier studies of cases from Wales (Brandon et al 1999, 2002) and England, (Sinclair and Bullock 2002, Rose and Barnes 2008) found that recommendations tended to focus primarily on procedures and compliance with procedures. There was some suggestion from Rose and Barnes' study of cases from 2001-2003, that increasing the number and scope of procedures might serve to provide a sense of security to managers and agencies and perhaps offer the illusion of a degree of control over unexpected future circumstances (Rose and Barnes 2008:45). The criticism of procedurally driven recommendations and the emphasis on compliance rather than professional judgement has been echoed by later studies (for example Hyland and Holme 2009, Ofsted 2008, Sidebotham et al 2010) and

particularly by the three reports that make up the Munro Review of Child Protection (Munro 2010, 2011a and 2011b). Rose and Barnes noted that beyond procedural matters, other recommendations grouped around improving communication, assessment of practice and training needs – findings replicated, to a large degree, by most other published studies. Far fewer recommendations concerned organisational issues of management including supervision and staffing (Rose and Barnes 2008, Devaney et al 2011, Hyland and Holme 2009).

Most analyses have focused on grouping and classifying types of recommendations and assessing whether they are, or can become, Specific, Measurable, Achievable, Relevant and Timely (SMART) (Handley and Green 2004, Hyland and Holme 2009, Johnston et al 2011, Wirtz et al 2011, Douglas and Cunningham 2008, Devaney et al 2011). Recommendations which have come to be expected from serious case reviews are those where solutions are clear cut and straightforward and can be implemented at a local level in this kind of way (Fish et al 2008). Devaney and colleagues note from their Delphi study of the process of serious case reviews in Northern Ireland (carried out in 2008) that recommendations did not always flow clearly from the review, could be repetitive, and concern matters already being addressed (Devaney et al 2011). Lack of relevance of recommendations or missed recommendations were also found in Ofsted's 2008 report of English serious case reviews.

It appears that some types of recommendations do not always readily fit into a SMART type of framework. For child death review teams they include prevention strategies (Johnston et al 2011). For serious case reviews, they tend to cluster around actions linked to professional knowledge and skills (Handley and Green 2004) and wider issues that require further thought and enquiry and perhaps a longer time scale to find national level solutions (Fish et al 2008). Handley and Green suggest that 'difficult to audit' recommendations should be made sparingly even though they claim they could make the most difference to children (2004). Overall, Fish and colleagues criticise the current system for focusing too heavily on factors at an individual level (Fish et al 2008), a point which is taken up in the final report of the Munro Review (2011b).

In relation to deriving benefit from recommendations in particular, the national study of learning from serious case reviews (Sidebotham et al 2010) noted that there had been relatively little focus on recommendations in the biennial analyses of serious case reviews in England. This small, document-based study is an attempt to redress this imbalance.

AIMS

The following research questions were identified:

- How many recommendations are there, and to which agencies do they relate?
- What kind of recommendations are they, in terms of themes addressed?
- On an individual case basis, do the recommendations match the issues the case raises? Are they the 'right' recommendations for the case?
- Are recommendations focused, specific, and capable of being implemented in a timely way?
- Can recommendations easily translate into improving practice?
- Is there, on the other hand, learning from (some of) the cases which doesn't necessarily translate into recommendations?

METHODOLOGY

We examined the recommendations contained in 33 serious case reviews, completed between 2009-2010, supplied in anonymised form by the Department for Education. The information initially made available varied in its completeness - while overarching Local Safeguarding Children Board (LSCB) recommendations were available for all 33 cases, accompanying individual agency recommendations were available for 20 of these, five of which also contained LSCB (agency) action plans. The methodological approach taken here reflects the varying completeness of the data and was designed to ensure we utilise all the information available to us. Figure 1 (page 9) illustrates the 'layered' approach to analysis.

Layer 1

Key characteristics of the child and family, and details of the incident and agency involvement were ascertained for the full sample of 33 cases. A qualitative analysis focusing on the recommendations sections from all 33 reports was then undertaken using Nvivo, a specialist software programme for organising qualitative data and identifying underlying themes.

Layer 2

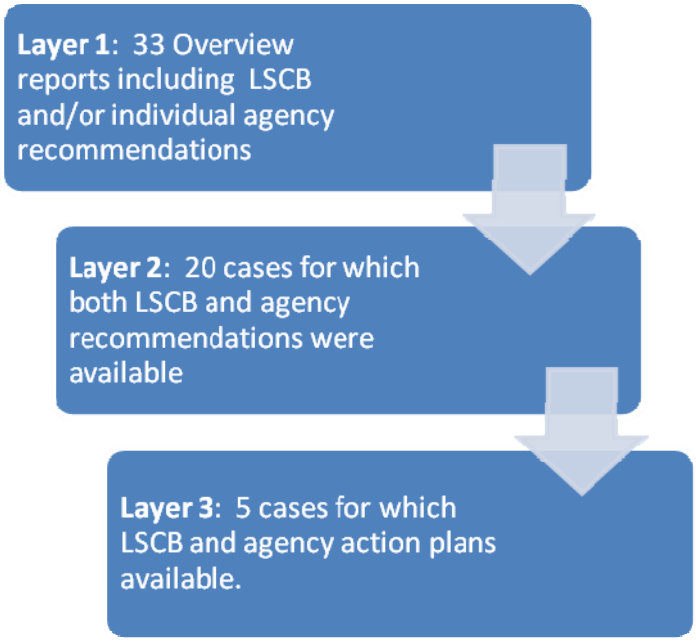
For some elements of the work, it was appropriate to consider only those 20 reports where individual agency recommendations were provided, in addition to the broader LSCB recommendations. This sub-sample was utilised to assess:

- total numbers of recommendations and to which agency they related;
- the frequency of major themes arising in the recommendations; and
- the extent to which recommendations reflected the themes of the case.

Layer 3

The recommendations and action plans for the five cases for which full information was available were scrutinised in more detail, with a view to providing a critical appraisal of the extent to which recommendations were 'SMART' (Specific, Measurable, Achievable, Relevant and Timely).

Figure 1: Numbers of overview reports included in each stage of analysis



The initial sections of this report consider recommendations from two different viewpoints; firstly which agency they relate to (irrespective of the subject matter of the recommendation) and, secondly, the subject matter or theme they were addressing (irrespective of the agency concerned). Later sections try to assess whether the themes of the case were translated into relevant and achievable recommendations, and whether the recommendations might reasonably be expected to lead to better practice in safeguarding children.

Chapter 2: The number of recommendations

The Sample

Although only 33 reports were analysed, the cases are typical of those discussed in the three biennial reviews which cover the period 2003-2009 (Brandon et al 2008, 2009, 2010), and the demographic characteristics of the children at the centre of the 33 reviews are broadly similar to those from previous years. The 33 cases comprised 21 fatal incidents (64%) and 12 instances of serious injury to a child (36%). A total of 18 cases (55%) concerned girls and 15 (45%) concerned boys. While 14 (42%) of the children were babies under one year, 7 (21%) were aged between 1-5 years, 6 (18%) were aged 6-10 years and a further 6 (18%) were aged 11 years and over. This representativeness lends validity to this small study.

The number of recommendations and agencies concerned

To enable the lessons to be disseminated and implemented effectively, *Working Together to Safeguard Children* (HM Government 2010) advises that recommendations should be few in number, focused and specific. Indeed one LSCB commented on 'agencies swimming in a sea of recommendations' and made efforts to restrict the number and nature of recommendations it made to critical areas that it thought would help agencies to make significant changes.

The first research task was therefore to consider the total number of recommendations made in each overview report. In the twenty SCRs we examined, where LSCB and specific individual agency recommendations were included (Layer 2), there was considerable variation in the total number of recommendations in each overview report, ranging from 10 to 94, with an average of 47 per review. In total, across the twenty reviews, there were 932 recommendations. The majority of these were targeted at children's social care (179), community health services (161), hospital trusts (92) or the police (85). Table 1 presents a breakdown by review and broad agency category.

Given the repeated exhortations to produce only a small number of recommendations, this begs the question of why some reports contain not far short of one hundred? There were a number of possible explanations, outlined below.

Some of the variation in number is accounted for by stylistic differences between report authors, with some writers grouping a number of related recommendations into a single one, whilst others craft each separate required action into different recommendations. Of more significance is the fact that in some reviews there are a larger number of agencies contributing to that review. The following are examples of reviews which concerned many agencies and contained a high number of recommendations:

- the SCR concerned two victims and the perpetrator who was also aged under 18. The recommendations relate to agencies involved with all three young people;
- the family at the centre of the SCR moved frequently, and therefore recommendations were often repeated to more than one local authority, hospital trust or police force; and
- another SCR concerned a disabled child who had required help from a number of health services (for example community paediatrics, health visiting, general practice, school nursing and hospital trust). This generated a high number of health recommendations.

We also noted that the ten reviews relating to the death of a child tended to contain more recommendations (mean=55) than those ten concerning a non-fatal injury (mean=38).

Many of these cases were complex, which contributed to the high numbers of recommendations. The tendency towards these high numbers may also be linked to LSCBs wanting to be seen to be taking the learning forward from the review very thoroughly. Additionally, the pressure to be more focused and more specific may encourage the practice of breaking down each recommendation into actionable parts. This causes a proliferation not only of recommendations but also of actions.

Table 1: Number of recommendations made in each of 20 Serious Case Reviews, together with the agencies addressed

Serious Case Review our reference number	LSCB / applicable to all agencies involved	Children's Social Care	Early years and nursery	LA or private housing	Health overview	Hospital trusts and Ambulance trusts	Community health, HVs, School Nurses, CAMHS	Adult mental health, drug & alcohol team	Education	Connexions	Youth Offending	Police	Probation	Voluntary provider	Miscellaneous: e.g. Cafcass, employer	Regional or national recommendations	**Total**
1	8	17		3	1	4	8					12					**53**
2	11	5				5	6	4	2	4	3	3					**43**
4	9	4															**13**
8	2	5			8	4	1	3	6		2	3		5	8		**47**
10	4	18		1	3	15	22	7				3	5	6			**84**
12	6	11	7			7	23	5	5			1	4	4			**73**
13	5	12	2	9		3	2		6	6		4					**49**
16	4	2				1							2			1	**10**
17	1	3		1		2	1					2					**10**
21	9	11			4	14	10					4					**52**
22	9	7	5				9					3		2	2		**37**
23	7	11		5	9	13	9			3	4	3	4				**68**
24	7	16			3	3	5				12	7			1		**54**
25	7	2	2			1	2		3								**17**
26	4	9	3	2	2	1	7	6				4			5	3	**46**
29	9	12		9	12	11	22					4		5	4	3	**91**
30	8	2	3	1			4		3			7	3		2	1	**34**
31	13	18			8	4	17		6	4	5	14		3		2	**94**
32	8	6					1					1					**16**
33	4	8				4	12					10		3			**41**
Total	**135**	**179**	**22**	**31**	**50**	**92**	**161**	**25**	**31**	**17**	**26**	**85**	**18**	**28**	**22**	**10**	**932**

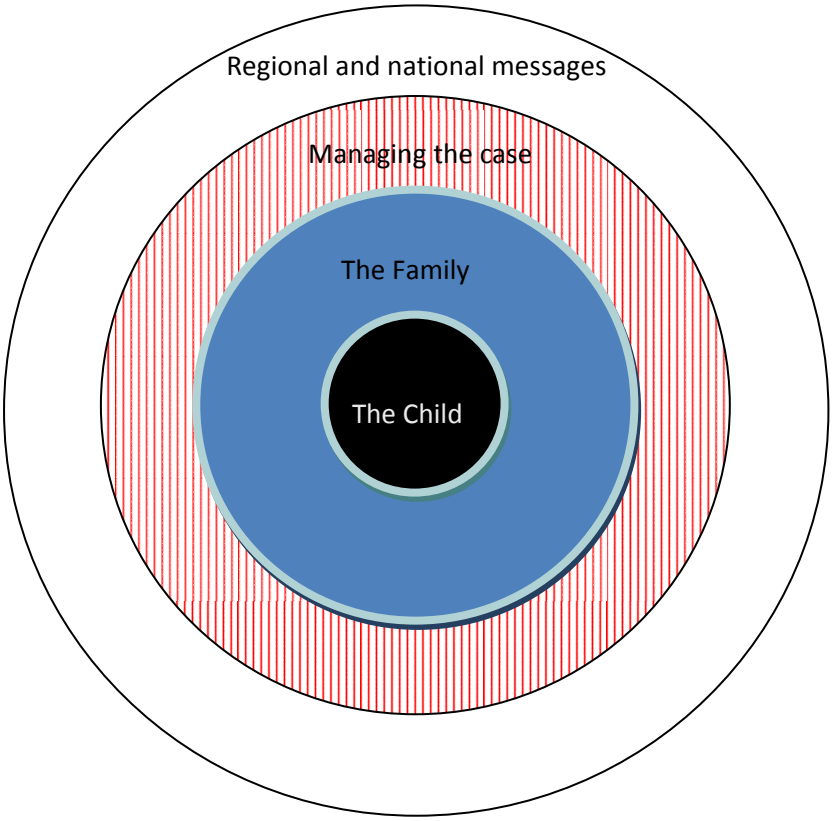
*Shaded cases indicate serious injury rather than death.

Chapter 3: Thematic analysis of recommendations

We examined recommendations from all 33 serious case review overview reports, but paid particular attention to those twenty reports where individual agency recommendations were given in addition to LSCB recommendations.

In exploring thematically the recommendations made, we developed a framework which focused on the child at the centre of the serious case review. The framework then worked outwards through to a consideration of the child's family and environment and subsequently to managing the case and the services which were (or were not) put in place to meet the child's needs. Finally those recommendations which addressed wider issues, or were deemed to have regional and national implications for practice and/or policy, are considered.

Figure 2: A layered approach to a consideration of recommendation themes



In Figure 2 , the recommendations are grouped as to whether they concern:

- the child as the primary focus;
- working with the family, to ascertain the whole picture of the family's circumstances and environment;
- the management of the case, including referral, assessment, procedures, recording, multi-agency working together and sharing of information, staffing levels, staff skills and training; or
- regional and national recommendations.

When analysing overview reports where individual agency recommendations were available, it became apparent that some themes occurred with great regularity irrespective of the precise context and the specific agency concerned. These themes are set out in Table 2, alongside the frequency with which they were addressed in the twenty reports studied.

Table 2: The number of overview reports addressing specific themes in the recommendations (maximum=20)

Training and awareness raising	20
Information sharing between and within agencies	19
Quality of recording	18
Management and supervision	18
Clarification of staff roles	16
Ascertaining the 'whole picture' regarding the child/family	16
Referral process	16
Audit	15
Responsibility for case or avoiding case 'drift'	14
Use of Common Assessment Framework	13
Ensuring adequate professional representation at meetings	13
Maintaining a focus on the child	12
Need to keep to timescales	12
Hard-to-engage families and non-attendance procedures	11

When compared with previous analyses of recommendations, for example Rose and Barnes' 2008 study of reviews in England from 2001-2003 and Devaney et al's 2008 Delphi study of the review process in Northern Ireland (Rose and Barnes 2008, Devaney et al 2011), it

appears that more attention is now being paid to management, staffing and organisational issues. The recommendations in the serious case reviews we examined were much more wide ranging and encapsulated these previously under-explored areas.

There were additional themes, pertinent to fewer cases, which will also be discussed in this report. The list of themes is not exhaustive, but topics have been selected which are of particular interest or which may introduce a new slant to the discussion. Topics include the importance of challenge to both colleagues and parents, a number of issues around staffing levels and competency, out of hours and weekend/school holiday provision and issues which contain a 'public health' message or have particular regional or national resonance.

In the following sections a number of recommendations from the SCR overview reports are quoted to illustrate the points being made, and to give examples not only of the themes covered in the recommendation sections but also the means by which the concern is translated into, for example, training, documentation and practice.

Focus on the child

Many sets of recommendations stressed the importance of practitioners, across many different professions, employing a focused, child centred approach which demonstrated "*an understanding of the child's experience*" and the ability to undertake a holistic assessment of the child's needs:
"LSCB must satisfy itself that those processes of assessment and review are always informed by attempts to understand the situation from the viewpoint of the child".

Maintaining a focus on the child was specifically mentioned with regard to:

- occasions when the child went missing from home;
- the child was being educated at home;
- the importance of separate communication with children to ascertain their wishes and feelings;
- the added importance/challenge of ascertaining wishes and feelings when the child is very young, or when disability hinders him or her from communicating clearly; or
- keeping the unborn child in mind (especially when the service is addressing the parent's needs):

"*organisations must ensure that staff working with children always focus on the needs of the child, and never allow themselves to be distracted by the problems of the adults.*"

The child's family and environment

Many sets of recommendations explicitly mention the importance of considering the 'whole picture'. One LSCB notes the need to ensure that: "*a broad view of the family's circumstances is taken into account.*" Among the recommendations the following sub-themes concerned aspects of the family and their environment:

- Cumulative concerns: "*the threshold document be reviewed to ensure inclusion of cumulative concerns*". "(*Police) officers should be reminded that incidents should not be taken in isolation.*"

- Family history: that "*professionals understand the importance of family history and how this must be taken into account in assessment and planning*". Likewise, "*the Council make it a procedural requirement that historical information held by them in respect of the families of children about whom there are child protection concerns is accessed and used to inform case management decision.*" "…*This will require a strategy that includes training and skills development, audit of assessments and also cultural changes to existing practice*."

- Wider family members: many overview reports acknowledge the need to be aware of the composition of the family, and this concern is addressed across all agencies: "*information must be updated about wider family networks*" (in Probation Trust recommendation in relation to offenders). An NHS Care Trust recommendation related to reviewing records to ensure that details of all household members are recorded; while a voluntary agency wished "*to reinforce to all practitioners the importance of including all relevant information in the Helpline service request form*". Health visiting records needed "*to reflect assessment based on the framework and the recording of all essential data/family details to be contained within the child's file*."

- Males in the household: "*assessments must always include fathers and other significant males in the household.*"

- Siblings: "*Sibling groups known to the (Youth Offending) service should be case managed by either the same practitioner, or co working should be introduced to improve consistency of information gathering and the sharing of information*."

- Home environment, poverty and multiple house moves: these factors were rarely explicitly mentioned in the sets of recommendations. This recommendation occurred in an information sharing context. "*It is therefore important that universal services are alert to the possibility of very poor housing and its potential safeguarding implications for children. Arrangements for information sharing of concerns must be in place*."

- Observation: "*to ensure that formal assessment of children's needs must include evidence of professional observation of the child and family in different environments, especially home.*"

- Realism: "*midwives must extend their investigations to ensure that the risk assessment is based on solid information as opposed to promises of support. The tensions within the family and the inherent dynamics must be fully considered*." In one case a presumption of the grandmother's ability to care for her grandchild had been unduly optimistic.

Upon reflection, it appeared that recommendations arising from various aspects of the family's circumstances and environment could often be divided into two main groups. Firstly there were recommendations which addressed awareness raising within agencies and training of staff around issues such as domestic violence, substance abuse, 'hidden men' and cultural considerations. Secondly, and numerically greater, there were recommendations around managing the case, where these family characteristics were present. These included referral and threshold procedures, assessments, protocols and audits, case management and supervision of practitioners, the quality of recording and information sharing both within and between agencies. Some illustrative examples are presented below.

Illustrative examples of recommendations relating to family circumstances

Awareness raising / training

- *In its publicity and training materials the LSCB and all member agencies should emphasise that it is not acceptable to tolerate lower standards of care or welfare on the part of any child on the grounds that he or she lives in a rural setting or comes from a family which has rural values or expectations.*

- *That the LSCB undertake or commission work to ensure that written guidance and training in respect of conducting assessments in child protection enquiries highlight the importance of establishing and understanding the role of male partners, or the fathers of any children, in the lives of those children.*

- *The LSCB to review whether or not there is sufficient and relevant multi-agency training provision in respect of how domestic violence and substance misuse can impact upon parenting. Such training should enable professionals to take on an approach of sensitive enquiry in order to elicit information that could be pertinent to identifying risk factors.*

Managing the case

Assessment:

- *GPs to undertake risk assessments on clients presenting with history of violent behaviour; this is particularly important if the client is also abusing drugs or alcohol or has know mental health problems. The risk assessment should consider the inter-relationship of identified health and social problems and how this was impacting on the risk to themselves or others (especially children / pregnant women).*

Procedures

- *The Ambulance Service to review policies and procedures in the Access and Response Communication Centres with specific reference to the handling of 999 calls involving mental illness, domestic violence and alcohol abuse.*

Recording

- *All 'Care First' document templates should include ethnicity, religion and disability. It is a requirement that practitioners record the ethnicity and language of service users.*

- *The impact of relationship breakups/new partners should be fully considered and explored. The details of new partners should be entered on each child's record; this entry to be dated and signed.*

Information – creating a web resource

- *LSCB should explore the feasibility of setting up a web-based information system where staff from any agency can obtain information about specialised services for non-British service users from ethnic minorities.*

Information sharing

- *Review (Police) information sharing policy with Children's Services in relation to screening information sharing of domestic abuse incidents at which children are present, or known to reside in the home.*

Managing the case

This section discusses selected aspects of recommendations related to managing cases, including dominant themes such as referral, assessment, procedures, recording, multi-agency working, sharing information, staffing levels, staff skills and training. In addition we have considered some more specific issues pertinent to this sample of twenty cases.

Referral and assessment

- ***Timeframes and feedback***

The issue of a timely response to children in need or child protection referrals was raised in a number of the recommendations, with a need to ensure that: "*referrals are processed, prioritised and reviewed as efficiently as possible*", and should be in line with agency procedures. Other recommendations included a reminder that referrals from one agency to another, initially made by telephone, must subsequently be confirmed in writing and the relevant forms completed. It was advocated that one route to verify that referrals were being made and handled appropriately was by way of a routine audit of case files.

The importance of feeding back to the referrer the progress of the referral was addressed in a number of recommendations, particularly when the referral was not accepted, as in the following instance:
"…the LSCB procedures should be modified to ensure that the local authority provides written feedback to referrers of the reasons that a child protection referral will not be acted on. The feedback should always give the name of a manager with whom the decision can be discussed further."

Assessments needed to be undertaken to a high standard, by suitably qualified staff, and "*completed within timescales and in line with procedures.*"

- ***Which assessment?***

Of some concern in a number of overview reports was the decision making around the thresholds for undertaking a pre-birth, initial or core assessment by children's social care and the common assessment framework (CAF) by other agencies. Use of the CAF had not been a significant feature of practice when our earlier biennial reviews of serious cases were undertaken in the period up to 2007. However there was evidence in overview reports that,

in some areas, there had been significant recent investment in and promotion of the use of the CAF, as a means of holistic assessment, earlier identification of need and a basis for intervention.

Questions were however raised about staff awareness of the framework, clarity of roles and responsibilities of the CAF team, how the assessment fitted with the referral process to Children's Social Care (CSC) Services, the CAF process where a child protection plan was being discontinued, and the means by which the effectiveness of the CAF assessment could be evaluated.

"The Safeguarding Children Board and its constituent members should ensure that practitioners in all agencies have clarity about their responsibilities and the appropriate levels of training and guidance to undertake competently an assessment using the Common Assessment Framework and should ensure that mechanisms are in place for evaluating the effectiveness of these assessments."

It was particularly in neglect cases that thresholds for referral to children's social care (CSC) appeared not to be met, and referrals were less likely to be accepted or did not progress. Cases might have been 'drifting' for years – and as one overview report writer notes: "*at what stage did the level of neglect suggest child protection procedures should have been invoked*?"

"Where assessments indicate a child is suffering or likely to suffer significant harm through neglect, joint Section 47 investigations, involving CSC and the police, should be a requirement."

Some overview reports stressed the need to update assessments, and to capture the family's changing circumstances, particularly with regard to a significant adult moving into the household. Often this need was translated via the recommendation into a new or a revised procedure.

Recommendations were made with respect to the development and implementation of assessment tools by, amongst others, children's social care, health visitors, paediatricians, Child and Adolescent Mental Health Services (CAMHS), probation, the youth offending team and the police. The question of what might be required to enhance the currently used

assessment tools was also raised. Some further discussion of assessment occurs in the later section on recording.

Professional challenge and curiosity

As highlighted by Lord Laming (2009), the importance of 'respectful challenge' of parents, colleagues and professional in other agencies, needs to be an integral part of professional practice. A number of the SCR Overview Reports make reference to this concept, and indeed to Lord Laming, and around half of the recommendation sections address this at some point:

"Health professionals will be reminded of their responsibilities to question and challenge other agencies, as well as health professionals, if they have reason to believe that the child protection process is not robustly safeguarding a child."

This responsibility to challenge is reinforced through recommendations about training, through both supervision and procedures on thresholds, assessments, decision making and rigorous follow up where there is a lack of response:

"The standards of training agreed by the Board (both single- and multi-agency) must immediately reinforce the messages from the Victoria Climbié Inquiry Report about challenging other professionals, and must equip delegates with the confidence to contribute to Initial and Core Assessments and challenge a lack of response, or decisions and assessments made by other agencies."

Although the need for professional challenge is already set out in *Working Together*, extra (duplicate) procedures were considered necessary to reinforce this point in at least two reviews. This included questioning the decision not to call an Initial Child Protection Conference, or in ensuring that a particular staff member has a responsibility to challenge other professionals:

"The LSCB Inter-Agency Safeguarding Procedures should include a specific system whereby a constituent agency, or an operational Children's Services manager, can request or challenge the decision not to convene a Child Protection Conference."

In addition professionals should recognise the limits to their own knowledge, and know when to refer for a more specialist opinion, and to whom to refer in those circumstances. This was particularly emphasised in relation to paediatric expertise in unexplained injuries in young children:

"The admission of children under 2 years, with unexplained injuries / unsatisfactory explanation of how injury occurred, to paediatric wards by specialities other than paediatricians (i.e. via opthalmics; dental etc.) needs to be revised to include access to a paediatric assessment."

Challenging parents, not just colleagues or other professionals, was alluded to in a small number of recommendations, as in a case of bruising to a pre-mobile baby:

"If a bruise is sustained to a baby who is pre-mobile the health visitor must gain a full history of how the bruise occurred and record the reaction of the care giver."

Hard to engage families

The majority (14 out of 20) of cases in this sample featured at least some degree of poor family and child engagement with services, and eleven of the reports contained recommendations relating to this theme. Various strategies were proposed to improve practitioners' ability to respond to the challenges associated with working with hard-to-engage families. A number of reviews proposed further training and guidance to develop professionals' ability to work with hostile or hard to engage families:

"That the LSCB commission or undertake work to develop definitive practice guidance to support practitioners working with families who are highly resistant to intervention, using the evidence from this and other Serious Case Reviews to promote the guidance."

Recourse to revision of procedures was again apparent in relation to this issue and included the need for clear contingency plans and protocols relating to follow-up of non-attendance of appointments and refusal of services. The need for prompt action was stressed, so the case was not allowed to drift.

Other recommended responses to non-attendance at appointments, were supervision (including for health professionals) and the perennial exhortation for effective and timely communication between professionals. The need for clear recording of these discussions,

plans of action and the reasons for non-engagement or a failure to engage was also emphasised:

"Staff must consider which engagement strategies would best enable a young adult (aged over 16) to attend appointments following a referral to the service and ensure that these are clearly recorded within the young person's records."

A further step recommended in one report was an audit of cases where poor engagement had been identified, to ensure compliance with procedures:

"That the LSCB undertake a consultation with local agencies to identify a sample of those families that currently met the definition of 'highly resistant' and confirm that the welfare of children in those families is adequately safeguarded notwithstanding the difficulties experienced in working with their parents."

Another review drew attention to the related, but separate, issue of obtaining more information about migrant families living in the local area who are hard to reach simply by not being visible to agencies:

"The inability of agencies to address the needs of migrant families is hampered by the lack of data about numbers in each area. There is an additional safeguarding issue both in the inability to plan appropriate support services and ensure these are accessible but also for families who may choose to avoid scrutiny by remaining 'below the radar'."

'Gaps' in continuity of service provision

A number of recommendations addressed times of heightened vulnerability of children for whom services were either not available (weekends, bank holidays, school holidays) or not accessed because of lack of clarity about the provision of out of hours services. Brief examples of recommendations concerning these gaps in continuity of service are outlined below:

- ***School holidays***

Recommended strategies for dealing with this issue included training for schools and school-based services about managing safeguarding processes in holiday times, as well as the

implementation of new mechanisms to ensure school representation at all child protection meetings during school holidays.

- ***'Out-of-hours' services***

Improved provision and awareness-raising about availability of 'out of hours' services also featured in the recommendations. This included ensuring that all [Police] front-line staff and supervisors were aware of the provision of "out of hours – at risk" intelligence checks. A further example concerned the process by which CSC accessed Magistrates' Court Clerks outside of normal office hours when seeking Emergency Protection Orders.

- ***Transition between services***

This issue was well illustrated in one review, concerning a young baby, which drew attention to an 11 day gap between midwifery discharge and the subsequent initial health visitor visit. A review of the arrangements between health visiting and midwives was therefore recommended, with the aim of providing a continuity of support for families, and ensuring: *"that there is professional health advice and support available at key transition times when mothers are vulnerable to developing post-natal depression and need support to establish breast-feeding. It is necessary to reinforce safer sleeping messages and help to reduce the incidence of SUDI (Sudden Unexpected Death in Infancy)."*

Record keeping

Many recommendations focused on upgrading systems or changes to forms to be made in the light of the learning from the SCR. Most usually, these advised the gathering of particular additional details, to better inform the assessment process, for instance to *"amend records to include specific question on ethnicity, religion and first language".* Other recommendations surrounded the recording of information on adults involved with the child, for example guidance to GPs to highlight documentation on parents/carers suspected or convicted of child abuse within the medical record, or in another case to record the identity of the adult accompanying a child to the Emergency Department.

Some SCR recommendations also stressed the need for children's social care to comply with the requirement to include, and keep updated, a chronology of events in the top sheet of records. If the serious case review is not able to answer the question of *why* there was not

compliance with procedures, a recommendation reinforcing that this should be done may not be successful. Furthermore, it can only be checked if all records are regularly scrutinised.

In some cases, a recommendation was made to introduce an entirely new form of record, for instance a 'social risk assessment form' for midwives to complete with all antenatal patients, or, in another review of a case featuring neglect, the devising of a tool: "*that can be used by professionals to identify and record signs and symptoms of the neglect of children in an objective way, including the physical conditions in which children are living where this is the subject of concern. Individual agencies should modify the agreed template so as to make it available to staff in a convenient format, linking to their own recording systems."*

The importance of full, accurate and up-to-date information was a frequent theme, across all agencies. Overall, these recommendations reinforced the need to ensure records were completed fully, relevant information included and any missing information was accounted for. More specifically, one recommendation drew attention to the difficulties arising from inaccurate spelling of names when inputting information.

Other recommendations placed emphasis on making records readily accessible, as in the following Health recommendation:

"There should be a review of maternity records and action plan to ensure all safeguarding information is easily identifiable and accessible. This should include ensuring a copy of all safeguarding information such as referrals, minutes and reports from child protection meetings are stored within the records."

Issues surrounding retention and disposal of records were also evident including a policy on retaining and improving records of supervision, especially in safeguarding cases, with systems put in place to retain records.

A further, related, theme surrounded the need to ensure good use of information that was already available. In one example, the review recommended that the LSCB should review the arrangements for collating information on children who go missing, to ensure that this information is seen as a whole rather than as a series of separate incidents.

- ***Shared information***

The need for better information sharing, both between and within agencies, was central to many of the recommendations made, and was addressed in some respect in 19 out of the 20 reports. This included a plea for a shared record for children who are receiving service from a variety of agencies:

"The IMR author considers that the use of a shared record…would enhance communication and improve care afforded to the child. The shared record could contain a basic log of actions and interventions that have been carried out so that the family and the professionals are aware of each other's actions ... this would provide greater continuity of care for the child and the family."

Inter-agency information sharing was mentioned, with some frequency, in relation to a large number of agencies, teams and organisations in children's social care, in many health settings, in education and youth services, and in the criminal justice sector. The issue arose, but was mentioned less frequently, with regard to housing services, homeless projects, a number of voluntary providers of children's services, and with the Children and Family Court Advisory and Support Service (CAFCASS).

The need for better sharing of information within an agency was often cited regarding a specialist group or team in respect of the organisation as a whole; for example between the leaving care team or the emergency duty team within the same service, between Education Welfare Officers and the Education Service and between the Child Abuse Investigation Unit and the police force of which it was part. Of particular concern, in a number of instances, was the transfer of information when the patient/client/user moved; for example the transfer of children's records between schools, patients' records when changing GP practice or between the out of hours GP service and the family GP. The handover between shifts in Accident and Emergency could be a key point at which information was not adequately passed on.

A further issue which arose, and in relation to a number of organisations, was cross-boundary information sharing. In this context access to records was mentioned with regard to police forces in neighbouring areas, ambulance trusts in neighbouring areas, and children's social care provision in nearby authorities or when an out-of-area provision was being used.

Other issues which were addressed included; the desirability of a web-based information sharing resource for professionals (in the context of service provision for ethnic minorities), and protocols which needed to be established when it was felt that: *"other professionals were inappropriately withholding information",* and in complex confidentiality situations "*how to ensure that relevant information is shared….even when the young person has expressed a desire for the information not to be shared at meetings."*

Linked to the concern around information sharing between agencies was an issue of attendance at meetings, to ensure that "*all those who should be invited are invited*", and that the key people do indeed attend so that participants can contribute to meetings and "*share information first hand.*"

"Failures to consistently attend or provide reports should be monitored and raised at appropriate management levels to ensure compliance."

In one of the reports, a police recommendation reminded staff in the Public Protection Unit that attendance at all child protection conferences is mandatory. In one locality the recommendation noted that "technology permits video conferring and multi-person telephone conference" and required attendance, even if remote attendance, to become the accepted norm. Other recommendations noted that attendance should be monitored by senior management, to ensure compliance with policies and facilitate effective information sharing.

Staffing

Recommendations were made with regard to staff in various contexts, including general staffing levels, the desirability of a new post or service, caseloads, delegation and the use of unqualified staff, clarity of staff roles and staff competencies.

- ***Workforce capacity***

Overview Report writers note that agencies have a duty to ensure that they have sufficient capacity and resources to safeguard children. Agencies need to be mindful both of their statutory responsibilities and constrained budgets, and: "*fully cognisant of areas of pressure that may affect their ability to safeguard children i.e. staffing levels, workloads, and the provision of supervision, and have in place systems to address any concerns."* Moreover the report authors are aware that many recommendations have "*significant implications for*

resources for the designated and named child protection professionals" and, particularly at a time when budget reductions are in force, that recommendations need to be realistic and achievable.

No doubt with financial constraints in mind, recommendations were not often made about the desirability of new posts. Specific instances where they were included a paediatric radiologist, a CAMHS specialist intervention for Looked After children presenting with post traumatic stress disorder, and a senior post within the leaving care team.

- ***Caseloads***

Recommendations, on occasions, addressed caseloads, particularly with children's social care, where it was important to ensure that they were 'within reasonable limits'. A specific recommendation was: *"to review the health visitor caseload weighting tool, which should reflect vulnerability and disadvantage not numbers of children…This should help to reduce staff stress levels in areas of high deprivation and need."*

- ***Use of unqualified staff***

Delegation and the use of unqualified staff was addressed in a small number of serious case reviews. There was emphasis on the need to ensure that competencies for each role are clearly identified, and that staff have these necessary competencies:

"Non Social Work qualified staff, regardless of experience and knowledge, must not be undertaking the Duty function in the Referral and Assessment Team."

"Children's social care's children with complex health and disabilities team should re-examine their use of unqualified workers. "

"The Police (authority) should review the current allocation of Child Protection Referrals to ensure that all officers investigating these cases are appropriately qualified and experienced."

- ***Clarity of roles and responsibilities***

There were a number of recommendations, addressed to a variety of agencies and organisations in both the statutory and voluntary sectors, which called for greater clarity about staff roles and responsibilities within and across agencies. Overall, this issue was to

be improved through the usual recourse to the establishment of guidelines and procedures, and more training:
"The Education Support Team to develop a protocol with the Leaving Care team and relevant educations establishments (e.g. schools) to allow a greater understanding of each others' roles and responsibilities."

- ***Knowledge and skills of staff***

Having clarified and codified the responsibilities of the post, other recommendations addressed the need to ensure that the post-holder has the knowledge and skills to carry out their role in safeguarding vulnerable children:

"The LSCB should examine the duties of the Named Doctors and Named Nurses for Safeguarding to ensure that the post holder has the mandate and capacity and systems to carry out the full role as envisaged by the Royal College of Paediatrics and Child Health.

Another recommendation called for a skills audit of the relevant staff: *"Assessment of the individual member of staff's performance, knowledge and skills forms part of their annual appraisal or performance review, and can be an opportunity to judge whether any further training or updating is required."*

Training and Awareness Raising

Recommendations about training and awareness raising were identified in all 20 reports resulting in some one hundred and twenty recommendations between them. Many of these related to general awareness raising regarding safeguarding and case management. However, other recommendations suggested training about single issues which had been relevant to the particular case, such as substance abuse, mental health, cultural issues, 'hidden males' and the identification of physical signs of abuse.

Recommended approaches to training and awareness raising identified within the 20 reports are outlined below:

- Implementation of new training programmes, or a review of existing training programmes to incorporate the learning from the SCR, or ensuring attendance of professionals at existing training programmes.

- Induction training for newly appointed staff, for example: *"Police Community Support Officers in the area should be given a safeguarding input as part of induction training….a directive could be made to ensure that every appointed PCSO spends at least one week attached to their local Family Crisis Intervention Unit department where knowledge can be shared with them."*

- Leaflets and bulletins to provide guidance and reminders, for example: *"Create and launch a leaflet providing guidance on the roles and functions of Designated Doctors and Designated Nurses; and also provide their contact details."*

- Creation of a web-based training resources, for example: [a website] "*which will be accessible to all staff 24 hours a day. It will contain case studies to provide practical examples of cases like these."*

- LSCBs to develop systems or tools to monitor types of training offered, uptake and impact of training.

- Refresher training/ regular training (as recommended 'at least every 3 years' in Working Together 2010). For example: "*It is essential that professionals receive refresher training in safeguarding at a level relevant to their post... This will provide an opportunity for professionals to renew their own learning in the light of their own practical experience.*"

- Ensuring that Safeguarding Awareness training is tailored to meet the specific needs of staff depending on their roles and responsibilities: For example: "*Visiting Officers should be targeted for a more intensive level of training because of their face to face contact with customers, consideration should be given to providing this level of training to officers who undertake assessments when the only form of contact is a telephone call or the receipt of an application form."*

- Staff briefings and meetings regarding specific issues such as completion of a CAF or Risk Management planning.

No recommendations were found, including those about training, which specifically addressed the meaning or application of professional judgement. This was implicit, however,

in a recommendation which required multi agency safeguarding training to emphasise that procedures alone will not protect children and that professionals need to consider the wider implications of each situation.

Public Health messages

A number of recommendations included what could be called 'public health' or more general messages. These related to how parents, carers and the community in general could be made more aware of:

- 'safer sleeping' messages, particularly regarding co-sleeping where there are concerns about alcohol and drug use;
- the 'hidden harm' to children of any age arising from parental drug or alcohol misuse;
- the danger to babies from being shaken; and
- dangers arising from inappropriate babysitting and child care arrangements.

To achieve this awareness raising, mention was made of targeted communication and advice, written guidance for professionals and commissioning of publicity material for the public, including information on the internet. One LSCB raised the particular issue of running such campaigns in a largely rural county.

Recommendations for a wider regional or national audience

Some report authors take the opportunity to use the recommendation section to suggest imaginative ways of extending the learning beyond the local setting, directing some of their recommendations at a wider audience than the LSCB or any of the agencies involved in their specific local serious case review. This audience divides between government departments, professional bodies and other organisations. The government departments referred to include the then Department for Children, Schools and Families, including Government Offices (at time of serious case review), the Department of Health, the Home Office and the Crown Prosecution Service and the Ministry of Justice; the professional bodies were for example two Royal Colleges (of General Practitioners, and of Paediatrics and Child Health), and other organisations were Ofsted and C4EO.

While they are a rather disparate group of recommendations, there are some elements among them which are common to a number of LSCBs. The need for further research was addressed by two LSCBs, one requesting a national review of adolescent suicide and para-suicide in 'looked after children', and the second requesting (through C4EO) further research in working with young people who are hard to engage.

- ***Incorporating messages into government thinking or policy***

Some LSCBs considered that issues they had raised required cross-departmental discussion within Government, or that a particular message needed to be relayed to a specific forum. Topics addressed, which were considered to merit consideration within a Government department, included increased participation of the armed forces in safeguarding processes, the need for the then Department for Children, Schools and Families (now Department for Education) to issue guidance and direction on the coordination and delivery of services to children with a disability and the lack of guidance on the safeguarding of vulnerable migrant children. Two LSCBs recommended making representations to the Munro review, one concerning the need to reflect 'Think Family' in the re-write of Working Together and the other to clarify information sharing between adult mental health services and additional support children's services:

"….what information adult mental health services can provide to children's services where there are safeguarding concerns, rather than child protection concerns, and they do not have parental consent to share information."

A specific point was raised by one LSCB about categorisation of ethnicity, and they wished to raise nationally the issue of mixed Asian ethnicity classification. It was thought that a better awareness by professionals of the different cultural backgrounds of the parents might have alerted them to the vulnerable position the child was placed in.

Another very specific recommendation concerned the need for discussion with the Crown Prosecution Service around the subject of plea bargaining and the subsequent sentence, and the impact of this on safeguarding children issues. This related to a case where an offender posed a significant risk of harm to children, but the reduced sentence he received did not make him subject to Multi Agency Public Protection Arrangements. A different case, which posed some similar issues, led to concerns about bail conditions for alleged sex offenders:

"The Government Department for Education should initiate discussions with Home Office and the judiciary about the circumstances when young people who are remanded in custody because of allegations of serious sex offences are given bail conditions within the community."

Another example of a recommendation with a wider significance relating to the criminal justice system, was the promotion of the CALM offending behaviour programme offered by HM Prison Service, which aims to assist offenders to control and manage anger in situations relating to relationships, and when dealing with the demands of children in their care**.**

- ***Recommendations directed at regional bodies and the Royal Colleges***

There were a number of specific issues which various LSCBs thought should have a higher profile at the regional level, or should be drawn to the attention of one of the Royal Colleges:

"The Strategic Health Authority clinical lead for safeguarding should use the existing regional health networks to ensure that awareness is raised regarding the effects of drug ingestion in infants and children presenting with acute symptoms / illnesses particularly where abuse or neglect could be factors."

In one serious case review, the LSCB considered that valuable information that the GP held about a child and his family had not been adequately utilised nor adequately shared. They recommended that the overview report, with its recommendations, be sent to the Royal College of General Practitioners, and that the College should be asked to address issues of information sharing by GPs.

A different LSCB proposed that the learning from the SCR be shared: "*with the Officer for Child Protection at the Royal College of Paediatrics and Child Health in order to consider how the effects of adult substance abuse on children can be included in training for medical staff of all grades through national health networks."*

- ***The development of guidance and protocols***

The Munro Review (2011b) has challenged the culture of procedural, compliance driven practice. As in previous studies, it was apparent here that a number of the recommendations

sought the development of guidance or protocols (at a regional or national level) to cover specific circumstances. These included, for example, the prescribing and safe storage of methadone, the managing of CAF and child protection procedures in holiday times – particularly with regard to schools and school based services, and a need for protocols regarding young sex offenders, or alleged sex offenders, if they moved between different geographic and administrative areas.

There were a number of recommendations relating to residential homes for children, with national implications:

"That the redrafting of national minimum standards for residential homes, which has been delayed over the past two years, be accelerated and contain learning from this review. That these national minimum standards state that where there are two sets of standards (school and care for example) in a unit which provides both services, that the higher set of standards be applied for children."

The development of a national template was recommended to assist those conducting regulation children's homes visits. This same review recommended that Ofsted inspectors should interview children in a residential setting not only when children themselves make a complaint, but also when a representative makes a complaint on behalf of that child.

A very different template was suggested in one report, which recommended that the then Department for Children, Schools and Families be invited to prepare a standard template to assist agencies in preparing individual agency reports for the purposes of serious case reviews.

Summary of Chapter 3

The recommendations which occurred with the greatest regularity concerned training and other aspects of managing the case and inter-agency working. Overall, the recommendations appeared to be more wide ranging than in previous studies.

To explore recommendation themes we developed a framework which focused on the child at the centre of the serious case review, working outwards to consider the child's family and environment, and out further to consider managing the case and the services which were (or

were not) put in place to meet the child's needs. Working outwards yet further, we considered recommendations which addressed wider issues, or had regional and national implications for practice and/or policy.

Recommendations which focused on the **child and their family** advocated taking a broad view of the family's circumstances, history and networks and taking account, for example, of 'hidden men'. They included seeing, hearing and keeping the child in mind especially when very young, disabled, missing from home, educated at home, or overshadowed by parents' needs.

Aspects of managing the case highlighted the need for timely, careful decision making at each stage of the referral, assessment and the ongoing safeguarding process. Drift in decision making about neglect cases and problems of high thresholds and access to children's social care, especially in neglect cases, were recommendation themes.

The importance of understanding the limits of professional knowledge and the need to seek and share expertise, for example about child development, was found in a small number of recommendations. Insufficient professional challenge of parents and other professionals was emphasised in some recommendations. However, the route to achieving more robust challenge and to grappling with other practice complexities like engaging hard to reach families, tended to be more training and the compliance with or creation of new or duplicate procedures rather than an encouragement to engage in reflective practice or exercise greater professional judgement.

A number of recommendations highlighted the previously under explored issues of staffing and workforce knowledge and capacity. This included criticism of the use of unqualified staff, particularly in social care, but also in the police force and in health visiting.

National level 'public health' or more general messages from serious case review recommendations included 'safer sleeping' advice, particularly avoiding co-sleeping where alcohol or drug have been consumed, and the danger to babies from being shaken.
National level recommendations included calls for more national policy, guidance or protocols on a wide range of issues, for example redrafting standards for children's homes, information sharing between children and adult services, disabled children and vulnerable migrant children. There were calls for increased participation of the armed forces in

safeguarding, and better discussions with the Crown Prosecution Service about plea bargaining and the impact of reduced sentences on children's safety.

Chapter 4: Matching the themes of the cases to the recommendations made

Recommendations are an important conduit for lessons from the serious case review flowing into the practice community. Rose and Barnes (2008), Devaney et al (2011) and Ofsted (2008) found in their analyses of serious case reviews that recommendations did not always link clearly to the review's findings. If recommendations are not capturing the essence of the learning from the case then opportunities are being missed. This part of the analysis is therefore an attempt to gauge whether, on an individual basis, the recommendations did appear to match the issues raised by the case.

We already know from our previous biennial reviews that domestic violence and drug and/or alcohol misuse feature frequently in the lives of the families where fatal or serious incidents have occurred. It is the combination of these factors and practitioners' ability to judge the impact that they have on parenting capacity, which is particularly challenging to child protection practice and to children's welfare and safety. These were again recurrent themes, and led to a number of recommendations. A close study of the twenty cases where full recommendations were available has enabled us to consider some other factors which feature, with varying degrees of frequency in the lives and circumstances of the families at the centre of the reviews, and Table 3 matches the extent to which these themes are addressed by recommendations in the respective reports.

Table 3: Extent to which themes in 20 cases are reflected in the recommendations

Serious Case Reviews (banded by age of the child)	Prematurity and/or low birth weight (<2.5kg)		Young mother (or at time of 1st baby's birth) or highly vulnerable		Learning disability – mother or father		Mental ill health of parent (**or older child if CAMHS involvement)		Fathers or significant male in household – including 'Hidden Male'		Hard to engage		Disguised compliance		Professional challenge of parent / colleague	
		Rec		Rec		Rec		Rec		Rec		Rec		Rec		Rec
Age < 1																
			✓				✓								✓	✓
	✓		✓	✓					✓	✓	✓	✓				
									✓	✓	✓		✓		✓	
							✓	✓								
	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓		✓	✓
			✓		✓	✓			✓	✓	✓	✓			✓	✓
							✓	✓	✓	✓						
			✓		✓		✓	✓					✓			
Age 1–5																
	✓*	✓			✓	✓					✓	✓				
									✓	✓	✓	✓			✓	✓
			✓	✓					✓	✓	✓	✓			✓	
			✓						✓	✓			✓	✓	✓	✓
	*	✓	✓		✓						✓	✓	✓		✓	✓
									✓	✓						
									✓	✓	✓	✓	✓	✓		
Age 6–10																
	✓*								✓	✓	✓	✓				
							**	**			✓					
	✓*										✓				✓	
Age 11 +																
							**	**			✓	✓				
							**	**			✓	✓				
All cases	**6**	**2**	**8**	**3**	**4**	**2**	**8**	**7**	**11**	**11**	**14**	**11**	**6**	**2**	**9**	**6**

*No ante-natal care, or very late presentation for ante-natal care
** Child and Adolescent Mental Health Service for the young person, rather than adult mental health service for the parent(s)

The twenty cases where full recommendations were analysed have been grouped in Table 3 according to the age of the child at the centre of the review. The sub set of factors selected for closer consideration were teenage parenthood, prematurity and/or low birth weight,

mental health problems or learning disability of one or both parents, the issue of men in the household, the parents' engagement with services and professionals' need to challenge both parents and their fellow colleagues. These factors mostly encompassed the interaction between family characteristics and practitioner working.

Each of these factors is tracked across the 20 cases, with the first of the two columns recording whether the theme was noted in the overview report, while the second, shaded column records whether there was a recommendation related to the theme. The totals at the bottom of the table allows for a comparison as to what extent the recommendations address the theme in question.

Thus when parental (or the young person's own) mental health problems were an important factor in the case, there were, in nearly all cases, recommendations made which related to that issue. The one exception was an instance of post-natal depression, which had no 'matching' recommendation.

The issue of the 'hidden man' in the household, and who was living in the home and acting as care-giver to the children, to whom he may or may not have been related, seems to have been taken on board by many agencies. It emerged as a theme but also led generally to recommendations, often around raising awareness of the issue, and of accurate recording of the man's presence, and sharing of this information appropriately. Sharing of information was of real concern when the man had a history of violent offending or had assaulted a child in the past.

An example of a theme which appeared to not lead to many recommendations was that of pre-maturity and/or low birth weight. Previous biennial reviews of SCRs have discussed the impact that the needs of an extra demanding pre-term baby place on the parents, often compounded by time spent apart from the new baby who is in a special care baby unit (Brandon et al, 2009:55). Worth noting is the fact that in these twenty cases there were four instances of the mother presenting either very late during the pregnancy for ante-natal care (for example at 24 or 32 weeks) or in one case reporting that she had been unaware of her pregnancy, receiving no ante-natal care at all and giving birth at home without any medical assistance.

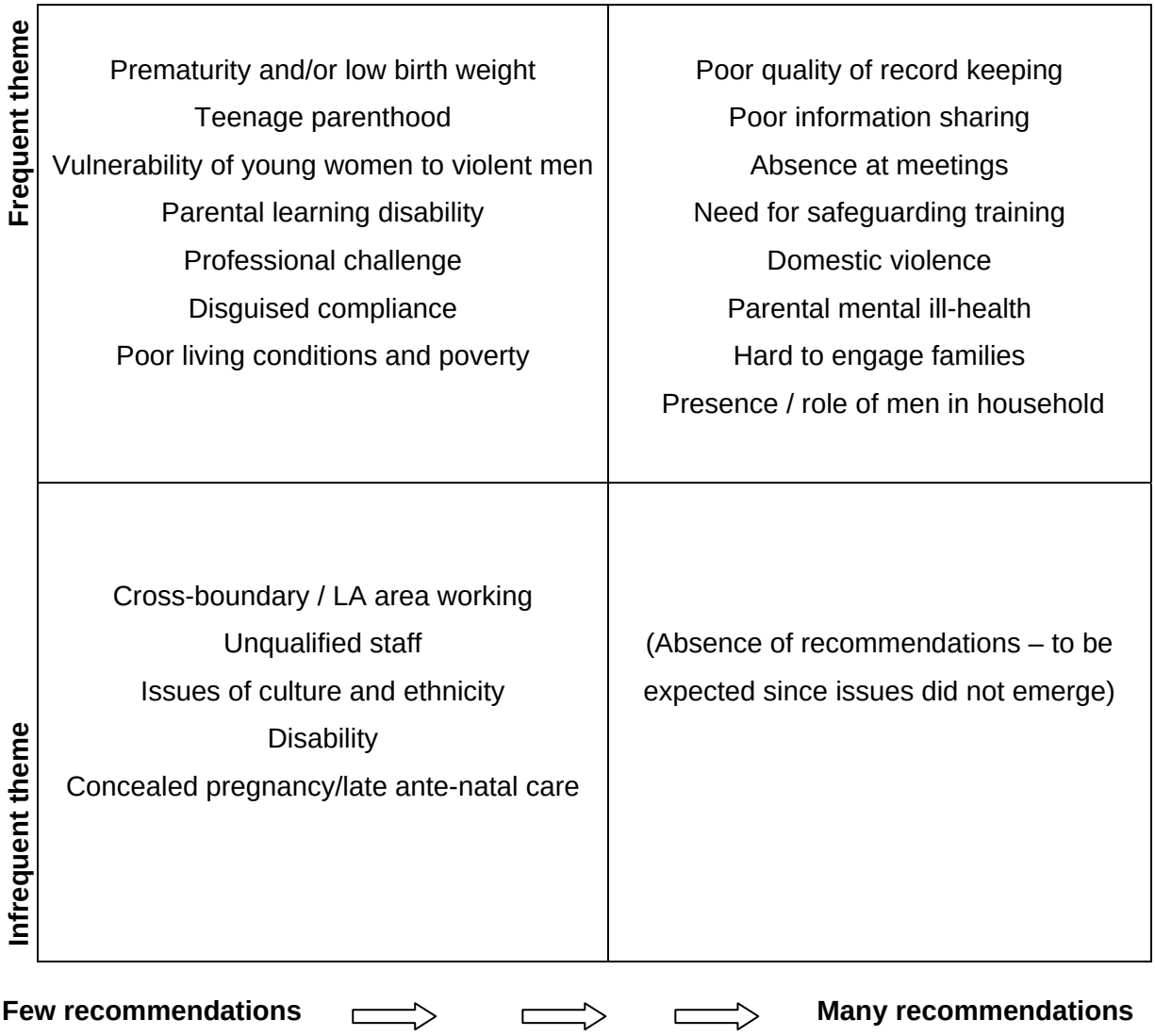
Another theme which arose is that of teenage parenthood. Young parenthood was a factor in seven of the twenty cases (the age of the parents was not always given, so the proportion

may have been higher). In some cases the young mother's vulnerability had been compounded by her background of special educational needs (SEN), a troubled childhood including time spent in care, and a succession of volatile, violent and often exploitative adult relationships. However, the needs of young teenage parents and the challenges that they may face rarely lead to any specific recommendations. As one overview report writer noted: "*the particular vulnerability of teenage mothers must be considered at all times*" while another commented on the fact that that there had been: "*a lack of recognition by professionals of the fact that the parents were young, the mother a teenager and father barely an adult, who were having an unplanned pregnancy. Professionals need to recognise and have a multi-agency service approach to try and engage with young parents who may be a Child in Need themselves*." In this latter report the development of a comprehensive, multi-agency teenage pregnancy strategy was advocated, and it was clear that many community health trusts have a specialist teenage pregnancy midwifery team.

The issue of 'disguised compliance', discernible in a number of reviews, was rarely specifically addressed in terms of recommendations (unlike the similar theme of 'hard to engage' families). This was perhaps surprising since all these SCRs were completed after the issue of disguised compliance was given prominence in the debate about the Peter Connelly case. However, one report did note the mother "*actively colluding with (father) to distract and divert professionals from investigating concerns about the children*". Likewise the need for respectful professional challenge, of colleagues and also of parents, was often noted in the analysis and concluding sections of the overview reports, but appeared much more difficult to translate into actual recommendations.

The information in Table 3 is extended to include issues of intra and inter-agency working and is represented in a grid, or quadrant, format (Figure 3). Along the horizontal axis one can represent the number of recommendations made on a topic, from few recommendations at the left hand side of the diagram, to many recommendations on the right hand side. The vertical axis plots whether the theme is one which occurs frequently or, while still being important, arises in relatively fewer cases.

Figure 3: Frequency of Recommendations and Serious Case Review Themes



Taking all the twenty reports together, one would expect, intuitively, there to be many recommendations made around topics which arose frequently (top right hand quadrant). Similarly themes only pertinent to a few cases would be expected to lead to fewer recommendations (bottom left hand quadrant). It is encouraging that there are no themes in the lower right-hand quadrant as that would indicate many recommendations being made about topics rarely arising out of the reviews.

Of particular interest, however, is the upper left-hand quadrant, where themes occur frequently, but few recommendations are made. This contains 'within family' themes like premature births, teenage parents, parental learning disability and some wider themes such as poverty, inadequate housing and poor living environment. It is, in many respects,

appropriate to be cautious when making specific case-based recommendations about 'within family' issues since they may have little relevance for most other vulnerable families. If, for example, issues such as teenage parents are used as 'risk factors' for abuse or neglect they are likely to prompt false alarms and false positives.

The impact of such potential vulnerabilities on child safety, especially in combination, need to be understood on a case-by-case basis and require careful professional judgement. The kind of recommendations most likely to bring this about would be those addressing staffing levels and supervision which would help practitioners to make sense of complex cases. Robust supervision should also help practitioners to recognise disguised compliance and prompt professional challenge (also in this quadrant of few recommendations) provided workers are able to see families often enough to get to know them and make relationships with them. Wider societal issues like poverty and poor environments do have a clear impact on deepening vulnerability and hence threatening child safety, beyond the level of the individual case. These factors require a more strategic national level response, beyond what is achievable locally through the LSCB.

The top right hand quadrant, in contrast, where there are many themes and many recommendations, includes primarily professional issues, particularly concerning training and aspects of communication but also some 'within family' themes such as domestic violence, and mental ill health (for which the earlier caveat about use as a wide ranging risk factor also applies). These professional issues lend themselves more readily to crisp and measurable recommendations but often include repetitive messages. This may be appropriate if messages need to be repeated and reinforced or it may mean that the imperative to fix everything results in little action or nothing getting fixed.

It would seem therefore that there are there some lessons which emerge from SCRs which rarely lead to specific recommendations. The introductory paragraph to the recommendations section in one of the overview reports explicitly states "*the review does* not *make a recommendation for every point of learning that has been identified*". Indeed, this would seem to be the only reasonable approach to take if reviews are to make few recommendations.

The extent to which recommendations match the themes raised in their respective overview reports is further explored in the discussion on 'relevance' which forms part of the next section on whether recommendations are 'SMART' .

Chapter 5: A critique of the 'SMART' approach to recommendations and action plans

This brief section offers an analysis and critique of the Specific, Measurable, Achievable, Relevant and Timely (SMART) approach of translating recommendations into learning, which is illustrated from the overall findings on recommendations and in particular from an examination of five available action plans. Overall, our impression of reading recommendations from the 33 cases has been that they are indeed becoming tighter and more clearly focused, although rarely are they few in number. The Rose and Barnes report of reviews from 2001-2003 (Rose and Barnes 2008) and Devaney and colleagues' 2008 Delphi study of reviews from Northern Ireland (Devaney et al 2011) found that many action plans had been completed in a rush. These few action plans appeared, in contrast, to be thoughtful, well considered documents.

The brief literature review pointed to the now well established view, that recommendations should be produced which can be easily translated into action and learning. Working Together states that to learn lessons locally, recommendations should focus on a small number of key areas, with 'Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes' (HM Government 2010:245). Handley and Green's audit tool was produced to help LSCBs apply a SMART analysis to assess serious case review recommendations (Handley and Green 2004). We have summarised these authors' definition of SMART as follows:

- **Specific** (exactly what should be done, best limited to single action);
- **Measurable** (how much, how many, how well);
- **Achievable** (can it be done, can the person identified do it);
- **Realistic** (what is possible in the real world);
- **Timely** (what is a realistic timescale).

Their interpretation of the 'R' in 'SMART' as 'realistic' differs from the *Working Together* (HM Government 2010) interpretation as 'relevant'. Here we have adopted the term 'relevant' particularly since 'realistic' can be subsumed in 'achievable'.

Action plans are the means by which recommendations are translated into workable actions and followed through. *Working Together* states that the action plan should highlight which recommendations are relevant to which agencies, the agency/ies responsible for taking

forward specific recommendations, how action will be monitored and by whom. The action plan should also set out the progress that has already been made in implementing or completing recommendations and plans to evaluate the impact of these changes (HM Government 2010:251).

The five action plans all had a range of transparent methods for making sure that progress could be tracked. All were constructed in similar ways, setting separate recommendations against actions, evidence, outcomes and progress, in varying degrees of detail and specificity. Where there were high numbers of recommendations, the action plans were accordingly long and detailed (they ranged in length from 10-40 pages). The action plans are analysed, here, briefly, in the five SMART domains.

Specific

There were varying degrees of clarity and specificity in the recommendations as listed in the action plans. On the one hand, things could become blurred and confusing when one recommendation had multiple threads. On the other hand, very complex recommendations could be divided into numerous very specific aspects. Although this sub-division produced greater clarity, it also encouraged a proliferation of tasks to be achieved. These numerous, highly focused recommendations appeared to leave little room for professional judgement by adding new layers of prescriptive activity to follow.

Measurable

Easily measurable actions tended to be concrete activities like training events and changes to procedures or demands for information, for example:

- Change in wording of a protocol; letter to be sent; sending an "*email about procedures for child protection checks"; "leaflets updated";*
- Numbers attending courses: *"The PCTs to provide updates as to the number of GPs attending training and awareness events.*"

Merely tracking the numbers of GPs attending courses, however, is unlikely to promote a higher level of attendance and disregards the need for action when GPs do not attend.

'Evidence' of action and/or outcome was interpreted somewhat differently in the action plans. There were also some gaps in the 'evidence' sections and sometimes the 'evidence' listed

was just a name or title, for example " *Designated Nurse and Doctor*" suggesting perhaps that finding and specifying a measurable outcome was just too hard.

Moving recommendations beyond the concrete appeared to be difficult, for example gauging *how* the quality and impact of awareness raising/training sessions will be measured. One plan noted that lessons learned from the serious case review were: "t*o be presented to all the teams in Social Care through the Children and Families Team and cascaded down by Heads of Service"* with the evidence of outcome being: "*Staff able to recall lessons and how practice will change."* This still leaves the question of how staff recall would be measured let alone discerning its trickle-down effect on practice. While it is clear that some tasks are easier to tick off as done, these easily achievable tasks, as other studies have noted, are not necessarily those that make most difference to practice (Handley and Green 2004).

Achievable

Within each plan it was possible to discern delegated responsibility for ensuring that actions were completed, suggesting that earlier criticisms in this respect (Rose and Barnes 2008) had been taken on board. This was done through either naming an accountable individual or specifying a named role to check the follow through, for example a designated nurse or a training manager. Handley and Green (2004) and Hyland and Holme (2009) make the point that the named individual must have sufficient authority to be able to implement the recommended action.

There are other parameters surrounding what is achievable and realistic – not least the thorny issues of resources and capacity. Passing responsibility for achieving results higher up the chain to national bodies was rarely seen in action plans and recommendations but extends the achievability of a recommendation beyond the remit of individual agencies or LSCBs, for example a suggestion that: "*national ethnicity categories are altered*". This is a valid activity and *Working Together* (HM Government 2010) states that "national implications should be highlighted and the information sent to the relevant government department." It also addresses the suggestion in the study by Fish and colleagues (2008) that complex national level issues are pursued and given further thought.

Relevant

Although, on the whole the recommendations did connect clearly to the case (and were therefore relevant), there were a number of regularly occurring themes from cases which rarely translated into recommendations. Overall, recommendations rarely drew explicitly on wider research based evidence to substantiate their validity. Where research was referred to, this was mostly in the 'Lessons Learned' or 'Analysis' sections of the Overview Report but there was not a clear link from here to the later recommendations, nor was there any evaluation of whether the recommendation would be likely to lead to improved outcomes.

Perhaps in some instances LSCBs shied away from making recommendations because they were unsure about the evidence base or doubted the usefulness of a recommendation. For example, perhaps few recommendations were made about the common theme of teenage parenthood because LSCBs were aware of the evidence that the age at which pregnancy occurs has little effect on social outcomes (Duncan 2007, Alexander et al 2010). While this issue had a significant impact on a single case it might have had limited transferable learning to the general population. On the other hand, the combination of adversities usually suffered by teenage parents who feature in serious case reviews increases their vulnerability and agencies need to be alert to this.

From the five action plans studied here, the key point to emerge was the degree to which the learning from a recommendation from a particular case was transferable and could be generalised to other circumstances. Some recommendations were relevant to a single case only, others had meaning solely to the particular LSCB, while others had much wider, far reaching messages and applicability. Earlier studies of serious case reviews pointed out that the narrower the applicability of the recommendation, the greater the risk of making potentially inappropriate or irrelevant decisions or procedures on the basis of a single case (Sinclair and Bullock 2002, Brandon et al 1999, 2002).

Timely

Most of the recommendations contained within the sub-sample of five action plans were accompanied by a timescale for implementation. Sometimes these actions had already been completed, and most actions were expected to be implemented within less than six months. Some longer term recommendations, for example concerning the audit of

safeguarding training, had a timescale which extended a year ahead. When the timescale becomes drawn out, both the momentum and the learning risk getting lost. This point was made strongly by respondents in the recent study of the learning from serious case reviews (Sidebotham et al 2010). The few action plans that we saw did not give themselves a time frame beyond one year.

Two reports had assigned recommendations a level of urgency - low, medium or high. However, the definitions in each differed somewhat, serving to illustrate how expected timescales for development and implementation of recommendations may vary between LSCBs. The range was as follows:

- 'Low' priority: 6-12 months;
- 'Medium' priority: 3-6 months;
- 'High' priority: 0-3 months indicating 'urgent and immediate action'.

What next for recommendations?

Recommendations have become more 'specific, measurable, achievable, relevant and timely' but this has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity appears to leave little room for professional judgement. However, it is easier to be critical of the SMART approach than to create an alternative. Where recommendations need to be made there is still value in this structured, methodical model but LSCBs should free themselves to construct a proportion of recommendations that are not easy to audit or make SMART that might encourage deeper learning and take longer to embed. Perhaps more importantly, LSCBs should be less reliant on recommendations being the central plank of the learning process in serious case reviews.

Chapter 6: Conclusion

Key learning points:

- Overall, our impression of reading recommendations from the 33 cases is that they are indeed becoming tighter and more clearly focused, although rarely are they few in number.
- In the 20 serious case reviews examined in depth, there were a total of 932 recommendations with an average of 47 per review. This is in spite of repeated calls to make recommendations few in number.
- Breaking down recommendations into achievable actions has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity leaves little room for professional judgement.
- Most recommendations concerned procedures and training. The route to grappling with practice complexities like engaging hard to reach families, was usually more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.
- There was rarely a research evidence base cited for the recommendation made: they tended, instead, to be based on learning from the single case which was assumed to have wider implications.
- Action plans were thoughtful, well considered documents that tracked the implementation of recommendations carefully. However, those recommendations that were easy to implement rarely addressed complex matters of professional judgement.
- The interface between societal issues like deprivation and maltreatment rarely featured in recommendations or action plans. Wider issues tended to be thought of as beyond the scope of the review, despite *Working Together* (HM Government 2010) specifically inviting consideration of national policy and practice issues.
- Local Safeguarding Children Boards need to take responsibility for curbing this self-perpetuating cycle of proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews.

The most startling findings to emerge from this analysis of recommendations have been not only the sheer volume of recommendations to emerge from reviews but also that the

endeavour to make them specific, achievable and measurable has resulted in a further proliferation of tasks to be followed through. Carrying through these, often repetitive, recommendations consumes considerable time, effort and resources – but there appears to be growing evidence that the type of recommendations which are the easiest to translate into actions and implement may not be the ones which are most likely to foster safer, reflective practice. Having a fully staffed, well supported workforce where regular and challenging supervision is an expectation, is not a simple recommendation to write or follow through.

A number of studies, like this analysis of recommendations, have found that action plans which are easy to implement tend to be ones that address the more superficial aspects of procedures and concrete tasks. This focus on creating or adapting local procedures, or arranging training for which the LSCB has the responsibility and capability to monitor and implement via the action plan, can mean that the deeper and wider issues, like professional judgement, get sidelined or diluted. An interviewee in Sinclair and Bullock's much earlier study of serious case reviews from 1999-2001, made a comment which in some respects resonates with this study ten years later: "There's a tendency to translate a rather big issue (*parents who are hostile and lie*) into something that can be measured and ticked …(*like)*...awareness training" (Sinclair and Bullock 2002:43).

This should not imply that training and reinforcing knowledge is no longer needed but that LSCBs should have the freedom to think of other ways to learn from serious case reviews that may not be easy to track and measure, and may not focus on recommendations. The post Munro Review climate encourages a move away from targets towards reflection. LSCBs should allow themselves to think differently about how to learn from, and beyond, serious case reviews.

The interface between societal issues like deprivation, poverty and maltreatment are only very occasionally reflected in recommendations or action plans. These big issues – like sub-standard housing and poor quality environments tend to be thought of as beyond the scope of the review. LSCBs may consider that these are issues over which they have little influence but conversely, they may want to use the serious case review to raise and illustrate important national issues.

Raising national level issues may be more effective if there is a research evidence base to draw upon. It was rare for a research evidence base to be cited for the recommendations made. Research evidence can be difficult to interpret and is not fixed, but the lack of any evidence beyond the individual review begs the question of the extent to which

recommendations were thought to be likely to deliver change, and whether there was a clear rationale for making or deciding not to make a recommendation.

The Munro Review has recommended a “fundamental rethink” of the way to learn about professional practice from serious case reviews and pointed out, as we have argued before, that serious case reviews have their limitations and are not necessarily the best sources of learning. The Munro Review recommends a new typology for serious case reviews and emphasises the advantages of a systems approach and learning from deeper underlying issues and local rationalities (Munro 2011b:60-64). A systems approach goes to the heart of the important organisational context and support structure for the staff of agencies working together to safeguard children and support families but learning from the story of individual children and their families risks getting lost. We cannot know the appropriate professional response if we do not understand the needs of the child at the centre of the review and how they were similar to or different from other children in similar circumstances.

Putting the child at the forefront of our thinking and understanding is crucial. However there is always a tension in trying to learn from serious case reviews about whether we focus on the powerful learning from unique features of interactions in the individual case or whether we concentrate on the wider transferability of lessons and learning.

To address broader learning, Sinclair and Bullock have stressed the importance of accurate epidemiological data to help to identify children vulnerable to abuse and predicting those at risk of violent death or injury (Sinclair and Bullock 2002:62). Attempts are being made in the development of an observatory function of serious case reviews to combine what is known about serious case reviews with whole population studies (Sidebotham et al in progress). This, like the systems approach, will help us to learn more but may still leave gaps in understanding individual family/practitioner level factors which will defy predictability. Practitioners will still need help in making difficult professional judgements about individual cases. Reflecting on and learning from deeper issues in the systems, attitudes and practices of the organisation and individuals takes time and resources (Sidebotham et al 2010). These deeper issues can prompt more questions than solutions and so cannot fit comfortably within a SMART framework.

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