Learning Lessons
Improving Practice

Responding to Serious Case Reviews, Part 8 Reports and Public Inquiries

(First edition)

1) Introduction

Welcome to this document 'Learning Lessons – Improving Practice: Responding to Serious Case Reviews, Part 8 Reports and Public Inquiries'. There has long been a concern in Derbyshire that the messages and lessons, findings and recommendations from the analysis of the experience of children and young people in the most difficult of circumstances are shared and used to improve practice and develop the effectiveness of responses to children and young people in the future. The recent national focus on 'safeguarding' services, processes, procedures and professional practice has only heightened this concern.

This document, therefore, seeks to set out the context for understanding the what, when, why and how of 'serious case reviews'; to trace something of their impact; to consider what Serious Case Reviews, Part 8 Reports and Public Inquiry Reports might tell us – and to consider the lessons and messages from: historical trends, patterns and recurring themes; the national picture and the local picture.

Three areas and fourteen key points for practice are identified from the lessons and messages and these are set out in a development process and tool for individuals, teams and groups of staff and volunteers from across the children's and young people's workforce to use to evaluate current practice, identify areas of best practice and highlight areas for further practice development.

It is intended to continue to develop the information in this document and further additions and revisions will be made available on the Derbyshire Safeguarding Children Board website: www.derbyshirescb.org.uk (with the version number marked clearly on the front cover).

2) Serious Case Reviews, Part 8 Reports and Public Inquiries in Context

In the Introduction to the 2003 report following the inquiry into the death of Victoria Climbié, Lord Laming acknowledged that:

> '…those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task. Staff doing this work need a combination of professional skills and personal qualities, not least of which are persistence and courage. Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well-being of a child. Staff often have to cope with the unpredictable behaviour of people in the parental role. A child can appear safe one minute and be injured the next. A peaceful scene can be transformed in seconds because of a sudden outburst of uncontrollable anger.
>
> 'Whenever a child is deliberately injured or killed, there is inevitably great concern in case some important tell-tale sign has been missed. Those who sit in judgement often do so with the great benefit of hindsight. So I readily acknowledge that staff who undertake the work of protecting children and supporting families on behalf of us all deserve both our understanding and our support. It is a job which carries risks, because in every judgement they make, those staff have to balance the rights of a parent with that of the protection of the child.'
>
> Lord Laming (2003:1.14)

In these quotations Lord Laming identifies the balancing act that people involved in safeguarding children frequently undertake ~ a balancing act of judgement and skill, knowledge and values.

The context in which public inquiry reports, 'part 8 reviews' and the more recently established 'serious case reviews' occur is one where it is generally considered that more might have been done to safeguard; where expectations for the protection and safeguarding of children and young people may not have been met; where there are lessons to be learned to improve practice.

The apparent shortfall in the response of those who had a responsibility to safeguard Victoria Climbié is highlighted starkly in these sections of the inquiry report:

> 'Not one of the agencies empowered by Parliament to protect children in positions similar to Victoria's - funded from the public purse - emerge from this Inquiry with much credit. The

suffering and death of Victoria was a gross failure of the system and was inexcusable. It is clear to me that the agencies with responsibility for Victoria gave a low priority to the task of protecting children. They were under-funded, inadequately staffed and poorly led… …The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened.'
(Laming 2003: 1.16)

However, public inquiry reports, part 8 and serious case review reports perhaps inevitably:

- are produced with the wonderful benefit of hindsight…
- provide an account of what happened for *this* child or young person in isolation from the accounts of the very effective responses to other children and young people in need or at risk whose experiences will never be heard about in public (and this may include other particular children or young people who on a particular day and a particular time were considered at greater risk and a higher priority)…
- draw attention to practice in the *exceptional* cases - where things could or should have been done differently.

Unfortunately, there also seems to be an inevitability that the scrutiny of practice and practitioners who are involved in safeguarding work is never so detailed as in these reports and reviews; that practice is appraised and presented to the public apparently in the absence of similarly detailed analyses of effective safeguarding work undertaken with many, many children and young people day in, day out: in Derbyshire and across the country.

3) The Purpose and Process of Serious Case Reviews

'Working Together' 2006 sets out the intention of Serious Case Reviews:

'When a child dies, and abuse or neglect is known or suspected to be a factor in the death… organisations should consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children.'
(DfES 2006: 8.2 p. 169)

In such circumstances or:

- where 'a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse and neglect';
- when 'a child has been subjected to particularly serious sexual abuse';
- when 'a child has been murdered and a homicide review is being initiated';

- when 'a child has been killed by a parent with a mental illness' - then a serious case review should be conducted or considered. (ibid)

Additionally, Local Safeguarding Children Boards should always consider whether a serious case review should be conducted where:

> '…the case gives rise to concerns about inter-agency working to protect children from harm…' (ibid)

Whatever the initial concern and reason for their conduct, an analysis of the professional dimension is the *only* formally stated purpose of all reviews - to:

- 'establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.'

(DoH 2006 8.3 p. 169/170)

The process of a public inquiry, a part 8 review or a serious case review is common:

- the identification of an incident that meets the criteria;
- reporting and gathering information from all appropriate individuals, agencies and services;
- setting out the 'facts';
- analysis, not least of the professional dimensions;
- findings and recommendations;
- national and local responses in relation to policy legislation, statutory guidance, procedures, services and resources and individual, agency and inter-agency practice, processes, systems and structures.

4) Tracing the impact of SCRs, Part 8 Reports and Public Inquiry Reports

The response to the inquiry report following the death of Victoria Climbié indicates the potential impact when practice, services, systems, processes, procedures and their management and legislation are brought under the closest scrutiny.

Many of the developments in child protection and safeguarding have been linked to the lessons from inquiries, reports and reviews (Reder et al 1993:7). In more recent years these have been complemented by lessons from quality assurance processes such as inspections (Social Services Inspectorate, Commission for Social Care Inspection, Joint Area Reviews) and a growing body of evidence about 'what works' built on practice wisdom, 'good practice' initiatives (such as the Quality Protects good practice database and the recent 'Staying Safe' consultation initiative to identify good practice: www.everychildmatters.gov.uk/stayingsafe/) and research, for example see two excellent publications: Macdonald, G. (2001) *'Effective Interventions for Child Abuse and Neglect – An Evidence-based Approach to Planning and Evaluating Interventions'* J.Wiley and Sons; and McAuley, C., Pecora, P.J., and Rose, W. (2006) *'Enhancing the Well-being of Children and Families through Effective Interventions – International Evidence for Practice'* JKP.

Recent major national and local developments in guidance on safeguarding and promoting children and young people's well-being include:

- the 'Every Child Matters' policy initiative and the associated 'five outcomes' for children and young people;
- the Children Act 2004;
- the development of systems to support service provision (such as ContactPoint, the Common Assessment Framework and the Integrated Children's System ~ see the Government's publication 'Making it Happen', for example: www.everychildmatters.gov.uk/search/IG00130/);
- the changes in national and local safeguarding arrangements (from Area Child Protection Committees to Safeguarding Children Boards);
- the publication of 'Working Together' 2006 and 'What to do if you're worried about a child' (2006);

- the Derby and Derbyshire Safeguarding Children Boards' procedures (operational from March 2007 and updated in 2008 – to be found via the DSCB website: www.derbyshirescb.org.uk);
- the government's recent 'Staying Safe' Action Plan published February 2008: http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00151-2008&

5) What can Serious Case Reviews, Part 8 Reports and Public Inquiry Reports tell us?

a) *This* child / young person

The findings from public inquiry reports, part 8 reports and serious case reviews focus understandably on the particular child or young person at the heart of the incident or tragedy. In the information gathering and analysis, the pieces of the jigsaw relating to the life and experience of the child/young person are brought together - sometimes, sadly and significantly, for the first time.

b) *These* parents / carers

Similarly information about this/these particular parent/s or carer/s is also gathered with historical information and information held by other agencies and authorities added to the contemporary knowledge collated from records of recent involvement ~ more pieces added to help understand 'why'?

c) *This* context: wider family, the environment

The third area of information that is generally gathered relates to the wider family, the networks, communities and environmental factors that are thought relevant to understand the experiences of the child and the aetiology of the danger.

Together, a co-ordinated comprehensive picture (perhaps more comprehensive and co-ordinated than ever before) can be built up addressing vulnerabilities, unmet need, rights not upheld or violated and risk factors: dangers and hazards both predisposing/background/chronic (such as poverty, domestic abuse, limited parenting capacity, limited social capital or family/community resources) and situational/more immediate/acute (such as a specific financial crisis, an acute episode of ill-health, a loss of control, a specific incident of violence, an acute period of neglect – such as a child

being left alone). Strengths and resiliences (that could also be predisposing and/or situational) may also be identified.

d) Practice, policy, procedure, systems, structures and services

'Working Together' 2006 (p.169/170) suggests that an analysis of the professional dimension is the main purpose of all serious case reviews, whatever the initiating concern. Whilst the role and actions of one or more individual front-line workers is often spotlighted, the danger with a linear narrative that tells of the experience of a particular child/young person is that it can hide the potentially contributory issues (often organisational, structural and systemic) about resource allocation, workload management, staffing etc.; specific reports and reviews should also be concerned with a whole appreciation of the professional dimension:

- the actions of all individuals (practitioners, managers and those with strategic responsibility);
- the various individual agencies;
- intra- and inter-agency dynamics, roles and responsibilities;
- policies (both those that relate to safeguarding practice directly and those relating to infrastructural or systemic matters such as supervision, support for staff, recruitment and retention, case management, equal opportunities etc.);
- procedures;
- systems;
- structures
- service provision.

A model that seeks to develop an understanding and analysis of the 'professional dimension' and agency and inter-agency dynamics in and across cases has been outlined in chapter 7 of 'Contemporary Risk Assessment in Safeguarding Children' (ed. Martin Calder, RHP 2008). This dimension and dynamic generally tips the balance towards safety for hundreds of children and young people subject to child protection plans (and thousands of children and young people receiving protective services of a universal, targeted and co-ordinated or responsive and reactive nature). However, for a small number of children and young people, the professional/practitioner element may be considered on occasions to tip the balance towards additional danger or risk.

> 'Unfortunately, these dimensions might also serve to focus and structure aspects of analysis in the management of Serious Case Review of the lives and possibly deaths of children where the whole system or network of parents/carers, additional carers, members of households, wide family, friends, neighbours, the community *and* the professional network has failed to protect. The domains could be used to provide a common structure and conceptual framework for the various professional groups' contributory reports to a case review, the full analysis or, indeed, a meta-analysis addressing several inquiries, reports or reviews over a period of time such that any generalised list of potential 'risk factors' (e.g: Greenland 1987 cited in Kemshall and Pritchard 1996) might include the possibly pivotal issue of professional involvement.' (Heasman in Calder ed. 2008)

Elements of this model are included in appendix 2.

e) Generalisations about characteristics and factors

Whilst this information ~ the whole picture brought together ~ can be invaluable in helping to explain the 'what, 'when', 'who', 'how' and 'why' of the *particular* child's experience, it is perhaps unfortunately of limited value in providing information that can be generalised to other children/young people other than to raise an awareness of the *possibility* of dangers. The limits to the value of an analysis of any specific dangerous dynamic between a child, her/his parent, parents or carers and the wider family and community have been acknowledged. For example, the inquiry into the death of Liam Johnson (1989) suggested that:

> 'It was said to us before we started hearing evidence that if we could suggest ways in which families like this, who in no way stand out from hundreds of others with whom the agencies deal, could somehow be identified before the tragedy occurs it would be an enormous help. It will be clear from the pages that follow that although we suggest ways in which practice might be improved, we have been unable to suggest any infallible method of spotting potential child killers,'
>
> (DoH 1991 p. 63)

Eleven years and many inquiries and reviews later, Sinclair and Bullock (2002) concluded their detailed analysis of forty Serious Case Reviews by suggesting that:

> 'Only one of the 40 cases scrutinised was seen as highly predictable and only three as highly preventable' (p.60)

acknowledging that:

> '…unfortunately the factors common to cases have limited predictive value for identifying which children will become victims of child abuse within the general population. The

lessons to be learned… are, therefore, more about processes for handling risk of harm than for identifying vulnerable children.' (p.57)

Sadly, the implication of recognising the limited value of trying to generalise from findings specific to a particular child/young person is that the more inquiry reports, part 8 or serious case reviews that are undertaken, the greater the ability to look for patterns, recurring themes and common characteristics; the more valid and valuable the findings taken together become in helping to safeguard *other* children/young people as knowledge increases: of risk or safety factors, of dangerous or effective practice, of helpful/unhelpful policies, procedures and systems, of functional or dysfunctional structures and effective or ineffective services.

6) Learning lessons

a) Historical trends, patterns and recurring themes

Galilee (2005) suggests that the recommendations of inquiries have generally remained consistent over the last sixty years:

- the need for interagency working
- improved communication between agencies
- better understanding of other agencies and their role
- improved information sharing between agencies
- enhanced recording
- better staff support and supervision

Reder et al (1993:60) reviewed thirty-five inquiries and assert that:

'If one feature … stands out above all others, it is the panel's repeated conclusions that inter-agency communication was flawed.'

b) The recent national picture

So, what information is available from the recent national picture that could both help provide a wider context in which to understand the Derbyshire situation and contribute to the messages that staff and volunteers might carry with them to help make sense of potentially risky situations and to respond as effectively as possible?

i) 'Learning from Past Experience – A Review of Serious Case Reviews' Ruth Sinclair and Roger Bullock (2002)

This study is introduced by Jacqui Smith MP (now Home Secretary) who acknowledges that:

> 'Many of the key messages from these case reviews confirm what we already know. In common with findings from research, some family characteristics such as parental mental health problems and domestic violence, were often identified. The children's circumstances, however, varied greatly. In some cases, the abuse occurred out of the blue, in others it occurred in a context of low level need and occasionally it arose in situations where it seemed to have been 'waiting to happen'.
>
> …unfortunately, the factors common to these cases have limited value in helping to predict with any accuracy which children will become victims of abuse. The lessons to be learned from Serious Case Reviews are, therefore, more about improving the process for managing the risk of harm for identifying vulnerable children.
>
> …we must continue to improve our understanding of the factors associated with harm to children. We must seek better to understand which interventions are most effective in both preventing children from suffering harm in the first place and in helping those children who have suffered harm to recover. We must learn these lessons. We are putting children's lives at risk of harm if we do not.'

Sinclair and Bullock (2002) looked at previous research on Serious Case/Part 8 Reviews (chapter 3) and suggest that the common themes that emerge from the research material that they reviewed can be summarised under broad headings:

- **Inter-agency working**
  - Limited inter-agency co-operation and lack of service integration, especially between child and adult services
  - Poor communication both between agencies and within agencies
  - Health services and child protection: variable levels of knowledge, of both risks of harm and procedures, among different groups, especially GPs and those in adult mental health services
  - Need for specialist forensic paediatric pathologists
  - Great clarity of the relations between criminal proceedings and child protection
- **Collecting and interpreting information**
  - Receiving, recording, interpreting and dealing with referrals appropriately
  - Using information to assess risk factors, understanding triggers, and the need for accumulating evidence

  - Understanding thresholds, especially the importance of neglect and emotional deprivation
  - Importance of comprehensive family assessments, especially histories of male figures
  - Need for medical evidence to be considered within the overall context
- **Decision-making**
  - Need for shared decision-making, especially in respect of not taking action or case closure
  - Moving from data collection and sharing to strategic discussions and clear plans
  - Planning a co-ordinated response across professionals and agencies
- **Relations with families**
  - Seeing the child as the client, focusing on his or her protection and not being distracted by other problems or by adult or sibling concerns
  - Dealing with hostile families or those who withdraw
  - Lack of awareness of the impact of domestic violence on children and their safety.

In Bullock's literature review (2005) relevant studies from other countries are also analysed and Bullock concludes that:

> 'The relevant literature from other countries is less extensive. There are numerous surveys of child deaths, many of them highly sophisticated. The most elaborate is the UNICEF (2001) analysis '*Child Deaths by Injury in Rich Nations*.' This looks at all child deaths due to injury in 26 wealthy nations noting variations in rates per 100,000 young people aged under 15 from 5.2 in Sweden to 25.6 in South Korea. Figures from the Baltic States and Romania are thought to be even higher - in the region of 29-38. The UK figure is the second lowest at 6.1. Within these deaths, 14% are defined as 'intentional', which implies abuse and neglect, but the report acknowledges the difficulties of gathering accurate data on this[1]. Rates for this vary from 0.26 in Greece, 0.33 in Spain 0.5 in Italy and 0.56 in Holland to 2.74 in the US and 2.9 in Mexico. The UK figure is 0.8.
>
> Children aged 1-4 are at much greater risk in the high rate countries but in the low rate countries, the risk is evenly spread across age groups. Boys are also at higher risk than girls but this contrast increases the higher the overall rate for that country. There is also some indication that children from lower social classes are more at risk of accidental death.

[1] 'This' means those deaths defined as 'intentional'

> Whatever the accuracy of the figures, the important finding is that the countries with the lowest overall child death rates also have the lowest rates for 'intentional' deaths.'

In the study of a sample of 40 contemporary cases, Sinclair and Bullock recognised that:

> 'The six most commonly identified practice shortcomings were:
>
> - inadequate sharing of information (25),
> - poor assessment processes (23),
> - ineffective decision making (21), a lack of inter-agency working (17),
> - poor recording of information (15)
> - a lack of information on significant males (9).
>
> Other less frequent but important concerns were the influence of a dominant approach to child protection (8), poor referral procedures (5) and insensitivity to racial or cultural issues (4).'
>
> Bullock (2005:40)

> '…professional competence is the key to protecting children. The elements of this are: knowledge, values and professional identity; skills; professional/clinical supervision and training to enhance knowledge and skills.'
>
> Bullock and Sinclair citing a report by Owers et al 1999DoH 2002:14

ii) Climbié inquiry – points from the recommendations

'Working Together' (DfES 2006: 32) highlights the influence of the inquiry into the death of Victoria Climbié recognising that:

> 'Shortcomings when working to safeguard and promote children's welfare were brought into the spotlight once again… and the inquiry revealed themes identified by past inquiries that resulted in a failure to intervene early enough.'
>
> These included:
>
> - poor co-ordination
> - a failure to share information
> - the absence of anyone with a strong sense of accountability
> - frontline workers trying to cope with staff vacancies, poor management and a lack of effective training.'

The significance of 'supervision' emerges as an important element and in 2008/9 the DSCB is promoting training and development around effective supervision ~ just two references from Laming's report is indicative of the importance of the issue:

> 'Supervision is the cornerstone of good (social work) practice and should be seen to operate effectively at all levels of the organisation. In (London Borough named), the

provision of supervision may have looked good on paper, but in practice it was woefully inadequate for many of the front-line staff. This must change. The same is true for the police and the health services.' (p.14)

'Victoria died because those responsible for her care adopted poor practice standards. These were allowed to persist in the absence of effective supervision and monitoring.' (para 6.94)

iii) The most recent biennial study: 2003-2005

The government is required to undertake and present an overview of all serious case reviews every two years. The full reports (Research Report DCSF-RR022 and Research Report DCSF-RR023) are available in full on the DCSF website at:

a) 'Improving safeguarding practice: study of serious case reviews 2001-2003'
http://www.everychildmatters.gov.uk/_files/7443DCSFImprvingSafegrdngPrctcefinal.pdf
b) 'Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005'
http://www.everychildmatters.gov.uk/_files/7444DCSFAnalysingChildDeaths.pdf

The analysis of a sample of 161 cases with 47 studied in depth covering the period 2003-2005 does indeed provide generalised information about the circumstances and profile of the children and young people, the parents and carers, the wider family and other circumstances as well as aspects of the professional dimension and other emerging themes.

Profile of the children and the circumstances of the reviews – some characteristics to note

- Infants (under 1 yrs of age) 47%
- Young people aged 16+ 11%
- Child Deaths 66%
- Serious Injury 34%
- Young babies, shaking, overlying etc.
- Child not seen/heard
- Older child hard to help
- Sexual exploitation, 'gone missing', bullying
- Disability, chronic illness

Profile of the parents/carers and their circumstances – some characteristics to note

- Domestic violence 50%
- Teenage mothers 28%
- Domestic violence, drug misuse
- Mental ill health
- Fathers, hostility/criminal convictions
- Hostility/disguised compliance/ambivalence to help
- History of neglect

'Environmental' characteristics and circumstances:

- Frequent moves 25%
- Poverty / poor living conditions 23%
- Large families, inc. children previously removed and previous deaths
- Frequent house moves
- Accidents

The study recognises the significance of other factors, for example:

Multiple risk factors:

- '(mother in this case…) had a series of violent partners… suffered with mental health problems, anxiety and depression and was misusing alcohol. The family changed address frequently… all three children witnessed serious domestic abuse… failed to attend a number of medical appointments with the children.'

Interacting risk factors added to the levels of danger:

- Importance of understanding parental psychology
- Importance of historical context and a dynamic, analytical assessment (not incident driven)
- Consider dynamics of engagement with professionals
- Need for all agencies to understand importance of interacting risk factors and to incorporate this thinking into multi-agency practice

Family Cooperation:

- Many factors influence levels of family co-operation e.g: behaviour of professionals toward families, family's suspicion of some agencies
- Need to understand patterns of poor cooperation-hostility, disguised compliance, ambivalence, avoidance of contact etc. as part of interacting risk factors

Levels of interaction/degrees of co-operation

- Spread of work across all levels (N.B: Climbié Report 'child protection does not come labelled as such') – implications for awareness of child protection risks in early intervention and better links with CAF and LP working at lower levels

Practice/Professionals

- Professionals challenging and questioning concerns appropriately
- Child protection thresholds not met
- A reluctance to act
- Neglect issues: not taking account of severe maternal deprivation, multiple losses etc.; 'start again syndrome' that fails to properly take into account past concerns and previous interventions (perhaps with a previous child/children) and their (perhaps limited) impact.

Knowledge of these matters can potentially help 'tune' risk awareness ~ awareness of what is *possible* in situations where similar characteristics and experiences present themselves. This does not mean that the outcome will be the same in *this* case (these are not predictive characteristics) but it should mean that staff and volunteers working together need to think clearly, gather and analyse information (assess) carefully and work hard to establish what are the dangers, hazards and risks in *this* particular case ~ what is *probable* in the light of the *possibilities* highlighted by the findings from previous 'worst case' examples.

The two biennial reports should be read in full for an appreciation of the comprehensive information and analysis that they provide, but the final section of the summary (6) concludes with important points relating to *'Implications for Safer Practice'* including the following (p.98):

Key messages:

- If management structures and staff support systems collapse, the result is often paralysis in the workers, or ill health, or absenteeism or other signs of stress;
- Good support is needed so that practitioners can work effectively with complex cases.
- Practitioners must be self-aware, flexible and sensitive to the factors underlying their own and the family's behaviour and emotions;
- Most serious child abuse is essentially unpredictable – even if the 'whole picture' had been known, it would not have been possible to anticipate serious abuse for most of the children at the centre of the reviews;
- There were numerous childhood adversities (including indicators of recurrence of maltreatment) in the majority of the cases but these were not known to all of the professionals involved prior to the serious case review being undertaken.
- It is crucial for professionals to feel that they and their employing agency have done their best for the child.

- Professionals must be alert to the way in which difficulties and protective factors interact if they are to understand the child's experience and how significant harm might arise.

In relation to **which interventions might be successful** the following messages are given (p.100):

- Early detection of parenting difficulties is crucial so that timely help can be offered;
- Patterns of help seeking can be warning signs of parenting difficulties and abuse. These can include (for babies and young children in particular): admissions to Accident and Emergency, a history of injuries, or a history of illness;
- Accessible early intervention programmes like Sure Start may be helpful in containing parental stress in families with less severe problems, while intensive and focused intervention can be effective for families with more severe problems;
- 'Hard to reach' families need flexible, individually tailored services;
- For older children, including 'hard to reach' young people, the effects of early maltreatment and
- trauma need to be acknowledged and addressed by all agencies working with young people and their networks.

The key points regarding **inter-agency links** reinforce the messages from previous studies (p.101):

- The families of very young children who were physically assaulted tended to have the least, or the briefest, contact with children's social care which puts a greater onus on universal agencies to recognise signs of harm to children;
- Understanding and using an interacting risk perspective will help practitioners to recognize the possible effects and risks of harm to children from a wide range of adult behaviour. This is important for staff carrying out common assessments or acting as lead professionals;
- Staff in specialist adult services like substance misuse services, the police and adult mental health services must also prioritise children and work together with colleagues from children's social care;
- Substance misuse, mental ill health and domestic violence may co-exist. Practitioners should understand that this may increase the risk of harm to children but does not *predict* serious injury or death;

A final area to highlight is the **implications for services** with two sets of key messages:

a) Universal and early needs (p.103):

- *All* practitioners need a holistic understanding of children and families and need training about the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child;
- Early intervention and working with early needs is part of the safeguarding continuum and not a separate sphere of activity;
- There is substantial danger to babies and children from parental volatility and loss of control.
- Parents need strategies for managing babies and young children in particular, if they feel they are losing control;
- To reduce the risks of 'over-lying,' public messages should make it clear that it is safer to share a bed with a baby than to fall asleep on a sofa or chair, but bed sharing with babies should never happen if a parent or their partner is a smoker or has been drinking alcohol or taking drugs;
- To reduce the risk of scalds and burns water temperature at home should be kept down, especially with young children in the household.

b) High level services (p.104)

- Vulnerable, hard to help young people need creative, responsive, long term services. Agencies need a shared commitment to providing these services and there should be a clear transition from children's services to adult services;
- Specialist support should be available for carers (including family) to help them cope with difficult and rejecting behaviour of 'hard to reach' young people.
- Arguing over thresholds and finding ways to avoid providing services, leaves vulnerable people cast adrift. Local Children Safeguarding Boards have a remit to consider thresholds.

The value of **supervision** is identified (p.106) as:

- Supervision helps practitioners to think, to explain and to understand. It also helps them to cope with the complex emotional demands of work with children and their families.

In an 'end note' the characteristics of a **general approach** are set out (p.106):

> 'Our argument throughout this study has been for the need for practitioners and managers to be curious, to be sceptical; to think critically and systematically but to act compassionately. It is not helpful to be sceptical in the absence of compassion. It is our hope that the findings presented here will go some way towards promoting this way of thinking and will safeguard and promote the welfare of children more effectively.'

iv) Lessons from evaluations of serious case reviews April 2007 – March 2008: OFSTED

In addition to 'profile' information relating to the 50 children involved, their families and circumstances, the following practice issues were noted from across the reviews:

- Poor understanding of basic child protection signs, symptoms and risk factors by staff in mainstream services
- No one agency had a complete picture of the family and a full record of all the concerns
- Agencies responded reactively to each situation rather than seeing it in the context of the history
- Staff became accepting of standards of care that would not be acceptable in other families
- Little direct contact was made with the children to find out what they thought about their situation
- On the occasions when the children tried to tell they were not understood or taken seriously
- Schools had a critical role in recording how children were over time, and any specific changes in their behaviour and demeanour
- Professionals were uncertain about the significance of issues in complex and chaotic families
- Too much reliance was placed on what parents said, and on supporting parents
- Families were often hostile to contact from professionals and developed skilful strategies for keeping them at arms length
- There was little evidence of assessments to evaluate the quality of the attachments between parents and children
- Families were subject to multiple assessments and plans without any clear expectation of what needed to change for the children, and what the consequences would be if these changes were not forthcoming
- Where there was insufficient demonstrable change for the child, agencies did not always act decisively to safeguard the children
- Poor understanding of basic child protection signs, symptoms and risk factors by staff in mainstream services
- No one agency had a complete picture of the family and a full record of all the concerns
- Agencies responded reactively to each situation rather than seeing it in the context of the history
- Staff became accepting of standards of care that would not be acceptable in other families
- Little direct contact was made with the children to find out what they thought about their situation

- On the occasions when the children tried to tell they were not understood or taken seriously

c) Derbyshire 2000 – 2005

Between 2000 and 2005, six Serious Case Reviews and Management Reviews were initiated and completed. In addition to specific information about the particular children/young people, their parents/carers, wider family, networks, community and environment, specific findings and recommendations were identified and collated from the reports.

The following themes for the continuing development of practice emerge, featured in several of the cases – all highly important for effective work with children and young people, their parents/carers, families and networks:

- Understanding the whole experience of the child/young person
- Sharing responsibility within the professional network in relation to
    - information management
    - assessment, especially risk assessment) linked to clarity and shared
    - decision-making) understanding of thresholds for
    - care planning) intervention
    - implementation
- Addressing the lack of multi-agency assessments and decision-making
- Record keeping
- Compiling a chronology and analysing it for patterns, critical pathways of risk/concern, recognising critical points on the pathway to abuse; not seeing incidents and indicators in isolation
- Following procedures and local protocols
- Exercise statutory responsibilities
- Training: both agency/profession-specific and multi-professional and inter-agency

d) Derbyshire 2006 - 2007

In 2006 and the first part of 2007, five Serious Case Reviews were initiated and completed (and one SCR was ‘decommissioned’ to a multi-agency management review) with reports, findings and recommendations presented at the DSCB Annual Conference in March 2007, to the Derbyshire Safeguarding Children Board and Partnership Group and at a series of ‘briefings’ for children’s social care staff in June/July 2007.

An analysis of the characteristics and circumstances of the reports reveals information about the particular children, the parents/carers and the wider family and environment, levels of intervention and emerging themes. For example:

Children

- 2 Young people aged 16+
- 2 Infants 2-8 weeks old
- 1 Suicide
- 1 Substance overdose
- 2 Non-accidental head injuries

Parents/carers

- Mental ill health
- Substance Misuse
- Violence and aggression
- Lack cooperation/ambivalence
- Frequent moves
- Domestic abuse

Levels of intervention

- Spread across all levels of intervention:
- Complex needs, additional needs and no additional needs

Emerging themes

- Historical context/chronologies
- Mental health needs of young people
- Psychiatric and psychological assessment of children and young people
- Communication
- Assessment of parental needs
- Role of parents in care planning (LAC)

Future developments have been recognised:

- Child in need practice guidance
- Common understanding of thresholds
- Review current pathways for referrals to children's social care
- Robust system to support CAF
- District safeguarding management team structure
- Improve partnerships with adult services
- Safeguarding training strategy
- Systems and services to enhance multi-agency working

- Implementation of SCR recommendations
- Maximise lessons learnt throughout all agencies

Specific findings and eighty-two recommendations were identified and collated from the reports. Each recommendation was linked to action, lead officer responsibility, agency and a timescale for response to the identified developments in practice, policy, procedure, process or systems.

7) Three areas and fourteen points for Derbyshire

So, what can be identified from the detail of the profile, characteristics, circumstances and experiences of the children/young people who have become the subject of Serious Case Reviews both nationally and in Derbyshire in recent years and the multiple findings and recommendations? What lessons or learning points can be drawn helpfully out of the case specific details that may be of *general* relevance as a focus for improving and enhancing practice?

The findings and the recommendations both specific and general can be analysed and collated in various ways but three overarching areas seem to stand out from all the Derbyshire reports since 2000 and further informed by an appreciation of the messages from decades of analysis of the experience of children and young people for whom the worst has happened:

Three areas:

a) Children, young people; parents and carers; families, communities and networks

b) The 'process' of 'case management'

c) General principles of good practice

Under these three areas, fourteen key points have been identified further and these are recorded in the table below with additional explanatory notes and points, many taken directly from the Derbyshire reviews

Derbyshire Serious Case Reviews ‘plus’

Findings and Recommendations ~ Three areas, Fourteen key points, Additional detail

Three areas ~ fourteen points	Additional detail
1) Children/young people ~ parents/carers ~ wider family/network/community/environment	
1) Keeping the child/young person and her/his health, development, needs, rights, wishes and feelings and well-being as the primary focus of thinking and acting ~ always!	• See the child/young person – engage and communicate • Don’t lose the focus on the child, their circumstances and the impact of these on them • Remember that ‘significant harm’ *turns* on the issue of health and development* – medical assessment and information is vital • Listen to the child/young person, to her/his disclosures, to her/his wishes and feelings and overrule only if convinced and it can be reasonably justified and defended that alternative action is actually in the child/young person’s best interests • Work with the child/young person directly - in partnership • Seek to understand the whole experience of the child/young person, her/his perspective and ‘world’: physical (see where they live, sleep and spend time) and psychological (emotional and relational) • Be mindful of older adolescents who may be beyond the reach of existing services – their vulnerability may not be recognised or taken sufficiently seriously *(CA’89 sn. 31 (10))
2) Working in partnership with parents and carers • **knowing who is ‘parenting’, caring, is around or has responsibility for the child or young person** • **recognising that the limit to partnership is risk of harm to the child/young person’s well-being** • **recognising the impact of parents/carers on professionals’ thinking and action e.g: hostility, threats of violence or aggression; believe-ability v deception; only apparent co-operation; capacity for evasion or manipulation; adults’ needs distracting from child/young person’s needs;** • **maintaining a ‘respectful uncertainty’, an ‘open and inquisitive approach’**	• A joint / multi-agency approach is needed with adequate time for planning, debriefing, analysis and recording where parents/carers are threatening, hostile or aggressive • Consider the effect of circumstances and experiences (e.g: bereavement) on parents/carers and parenting capacity • Be aware of the risk to the child of focussing on the adults in the family especially where they may have learning difficulties and/or disabilities, mental health difficulties, where there is substance use or domestic violence/abuse

3) Recognising the importance of the wider family, network, community and environment around a child/young person as a potential source of problems *and* solutions • **knowing who is in the child/young person's household and who is contact with the child/young person: strengths/weaknesses, supportive/inhibitive factors** • **realistic and rational (not naïve or 'emotional') appraisal of any care actually or potentially provided by extended family members**	• Consider the impact of living in impoverished communities e.g: stress and challenges for children/young people, parents/carers, wider family and networks • Ensure that families (especially vulnerable families) are linked to appropriate general services e.g: GPs, community health, education etc.
2) Process of 'case' management	

4) Assessment:
• **'holistic' understanding of the factors (past, present and future, singly, in combination and cumulatively) that might influence the levels of danger, risk, vulnerability that a child or young person may face**
• **based on shared approaches e.g: 'Framework for Assessing Children in Need and their Families' (DoH 2000) and the 'Practice Guidance' (DoH 2000); needs analysis, rights analysis**
• **information gathered widely, collaboratively and accurately**
• **evidence-based**
• **analysis / making sense of the information**
• **beware pervasive beliefs and the interpretation of new information/incidents in terms of existing understanding**
• **responsive to new and changing information; being aware of the need to re-assess following new or cumulative incidents**
• **remembering that 'the worst' *may* be a possibility**
• **assume nothing; maintain an open and inquisitive approach**
• **informed by 'risk factor' research but mindful of exceptions and child/young person-specific situations**
• **recorded with key points carried through from record to record, meeting to meeting**
• **…an on-going process not a one off event**
	• Chronologies and records of significant and critical events matter:
	    ○ Highlighting history, patterns and critical pathways of behaviour and experience, strengths and vulnerabilities – important as part of an assessment
	    ○ Information from other areas / authorities
	    ○ Separating personal from service histories
	    ○ Combining chronologies across agencies
	• Share information
	• Assessments and analysis to be multi-disciplinary – think creatively about who/which agency have pieces of the jigsaw – seek to put the whole picture together
	• Sharing responsibilities with clear agreements in place and timescales
	• Assessments to focus on the needs of the child/young person including emotional and psychological (depression, attempted/suicidal behaviour)
	• Assessments to include full details of mother and father (particularly where they have or plan to have parental responsibility) and parenting capacity – whether they live with the child or not; particularly of fathers who have had previous children
	• Assessments to include an 'ecological' perspective including housing etc.
	• Checks to be made (managers) about the truth/authority of information
	• Analysis needs to balance strengths and risks (weaknesses), opportunities and threats (SWOT analysis)

5) Decision-making and planning
• **clear understanding of thresholds (CAF, child in need, child protection/significant harm)**
	• Each child/young person to have a clear plan with:
	    ○ measurable aims and objectives that are regularly reviewed
	    ○ clarity about who is responsible for which action between

• **'defensible decisions' based on putting the welfare and interests of the child/young person first** • **clear plans: what, who, with, how, by when…** • **'SMART' goals with anticipated outcomes defined *directly* in relation to specific children's/young people's well-being even if changes are focussed on parents/carers, wider family or environment**	individuals and across agencies o regular contact with service providers (e.g: Independent Foster Placements) o clarity about what to do in emergencies o a clear programme of meetings and reviews • Young people in Young Offender Institutions to have discharge/post-discharge plans
6) Intervention • **linked to a clear plan to achieve the goals and anticipated outcomes defined *directly* in relation to specific children's/young people's well-being even if action is focussed on parents/carers, wider family or environment** • **what needs to change?** • **co-ordinated and agreed with clear roles, responsibilities and action: who, what, by when?** • **accountable, monitored and measured**	• Intervention to be focussed on achieving outcomes set out in the plan for every child/young person • Intervention to be robust and legally supported (where appropriate)
7) Regularly reviewing change • **evidence-based** • **analysis of progress linked directly to goals and anticipated outcomes expressed directly in relation to specific children's/young people's well-being** • **formal process to review assessment** • **informing co-ordinated and agreed changes in intervention / action strategy and plan** • **realistic balance between optimism and realism** • **recorded with an accumulation of information – not losing the old, adding the new** • **keeping thresholds in mind and seeking to see the situation with a 'fresh pair of eyes'**	• Impact of interventions on the child/young person and her/his health, development and well-being (not impact on the agency) to be reviewed regularly • Clear record-keeping required with tracking of positive change, no change, deterioration/negative change • Compliance/non-compliance to be reviewed • Clear thresholds for referral back to social care to be agreed with service providers
8) Evaluating the impact of involvement • **defined directly in relation to specific children's/young people's well-being** • **regular and including all who are part of the child/young person's world**	• Fundamental reference point for evaluating the impact of intervention/involvement is the child's/young person's health, development and well-being

3) Principles of good practice	
9) Information sharing, recording, analysis and management • **driven by a commitment to put the welfare of the child first (the 'public interest' test)** • **mindful of, but not inappropriately inhibited by, 'client confidentiality' or data protection considerations** • **remember that no one agency will have a complete picture or a full record of concerns** • **information received 'tested', checked, corroborated and reviewed critically** • **recorded and reported; key information carried throughout** • **involvement - not lost** • **individual responsibility does not cease when information is passed to another agency**	• Communication, communication and communication! • Share information • Analyse not just record • Track key pieces of information throughout the process of involvement (from minutes of meetings, to minutes of meetings, from report to report etc.) • Critically appraise 'received' or prevailing 'wisdom'/opinion/knowledge/'residual messages' about the child/young person, parents/carers, family, other practitioners circumstances, needs, risks
10) Knowledge-informed and up-to-date practice • **rooted in knowledge about *this* child/young person, *these* parents/carers, *this* wider family, *these* circumstances that can be evidenced** • **practice informed by training and development activities including knowledge of 'what works' and examples of 'best practice' by individuals, agencies, services and inter-agency working locally, nationally and internationally and knowledge of Serious Case Review findings and lessons: national and local** • **linked to the 'Common Core of Knowledge and Skills' for the children's workforce and the 'Working Together' 2006 'safeguarding and promoting' competences**	• Specific knowledge may be required for complex situations • Time is needed to research/understand particular aspects of work with specific children/young people, their parents/carers, networks and communities
11) Strengths-based work • **recognising and promoting resilience** • **accentuating and reinforcing the positive** • **working with signs of safety** • **…but taking care over the possibility of professional over-optimism**	• A more sophisticated understanding of strengths-based work is required and linked to application of this approach in the context of transparent planning and evaluation of outcomes • Strengths (predisposing/background, situational/specific/ more immediate, prospective/future) to be balanced with dangers and hazards (also predisposing, situational or prospective)

12) Shared, clear, complementary, co-ordinated, accountable and agreed roles and responsibilities: • **individuals (professionally and personally)** • **within single agencies / services** • **between agencies / services (especially across service boundaries e.g: children's and adults')** • **effective supervision** • **effective management of communication and meetings** • **individual responsibility does not cease when information is passed to another agency** • **challenging colleagues in own and other agencies if required**	• Respective roles and responsibilities within and between agencies, services, practitioners and managers need to be clear, shared and agreed • Responsibility for services to children/young people and families lie with agencies not individual practitioners • A team approach is required in complex situations and where there is the threat or actual aggression or violence • Roles and responsibilities must be reviewed in supervision
13) Following national and local procedures, protocols and guidance and related thresholds for action • know what to do if you're worried: who to contact, when and where and how	• Clarity and consensus about thresholds for different levels of intervention/action/process and service provision is needed • Work within own agency guidelines and procedures but be prepared to contact other agencies (particularly social care and/or the police) if concerns persist
14) Practice that promotes partnership, anti-discrimination, equality of opportunity and access and that recognises power, perspective and 'position'	• Recognition that working *with* children/young people, parents/carers, family members/significant others, other professionals – in relation to hopes/fears/expectations/wishes and feelings/roles and responsibilities - is likely to contribute to effective outcomes • Recognising that discrimination, prejudice and inequality (individual, institutional, social etc.) may add vulnerability for a child/young person, her/his parents and carers or wider family and community *and* may inhibit an effective response • Promoting anti-discriminatory practice (discrimination as prejudice empowered), equal opportunity and access to services and resources • Recognising that 'power' and its use and abuse may play a part in all dynamics: inter-personal, inter-familial, organisational, institutionalised, inter-professional, inter-agency – consciously or unconsciously • Recognising that everyone may be said to have a unique position linked to personal/professional experience, gender, ethnicity, class, sexual orientation, disability status, beliefs… and that this may inform perspective, power and agency (capacity to act) – consciously or unconsciously

8) Developing and improving practice

The final part of this report promotes an activity that it is hoped all practitioners (in actual teams; in 'virtual' multi-agency teams or groups of people who work regularly together; as individuals) and managers will undertake to help review and analyse current practice and to identify areas for further development in the light of the DSCB recent serious case reviews through:

- self-assessment
- identifying, celebrating and sharing good practice
- recognising areas for development
- making a 'developing and improving practice pledge'
- recognising what would help, what might hinder?
- anticipating signs of success
- evaluating enhanced practice

It is expected that the process will be encouraged and facilitated by line managers who will help practitioners and teams to work towards the goals identified and to review and evidence developments in practice through supervision and other formal workload management processes – whilst also completing the exercise for themselves with their own line manager.

The exercise has two stages and a table/form to complete (Appendix 1). This takes individuals and/or teams through a clear process linked to the three areas and fourteen points that have been drawn out from the Derbyshire Serious Case Reviews as relevant to help focus the development of effective practice:

Stage 1:

i) consider/discuss the three areas and fourteen points and their relevance to your practice

ii) add any other key points of findings/recommendations/lessons from your own reading or awareness of the Derbyshire Serious Case Reviews and other reviews/reports

iii) complete column 2: identifying any examples of current good practice in relation to each of the thirteen and extra points

iv) complete column 3: consider what you can do to improve your practice in relation to this finding/ recommendation – what do you pledge that you will do? *I/we pledge to…*

v) consider column 4: recognising and noting the things that may help you to achieve these pledges and what challenges there might be (things that may hinder)

vi) consider column 5: recognising and noting likely anticipated signs of success ~ I/we will know that things are improving when…

It is hoped that this process will be undertaken within individuals' and teams' management arrangements and that the process will be incorporated into supervision or similar workload quality assurance processes.

The District Safeguarding Children Management Teams may wish to play a part in reviewing the whole 'Developing and Improving Practice Pledge' process; and plans, pledges and related information could be forwarded to the DSCB Training Team to collate information on good practice and details of the plans and pledges.

Stage 2

This stage is a follow up stage: to review and identify the impact of the developing and improving practice pledges approximately 6 months on; and providing evidence of improved practice and outcomes for service users. Again, the process of undertaking this second, evaluative, stage would perhaps be best managed within individuals' and teams' supervision and management arrangements. It would be very interesting and useful for the Information and evidence about the impact of the pledges and plans on practice, services and outcomes for children, young people and their families to be sent to the DSCB Training Team, collated and shared across the county.

It is hoped that this process is clear, will be challenging but strike an appropriate balance between identifying and celebrating current good practice and encouraging a commitment to improving and developing individual and team effectiveness in the area of safeguarding children and young people.

9) Conclusion

We hope that the information in this document is useful, that you will undertake the practice analysis and 'pledge' exercise based on the lessons drawn from the reviews in Derbyshire and beyond and that, above all, it will contribute to the continuing development of effective practice by the many, many committed staff and volunteers, the individuals and teams that make up the children's and young people's workforce in Derbyshire.

Finally, a message from the 2003-2005 biennial analysis and the first of the 'fourteen' points' bear repeating:

Be curious, be sceptical; think critically and systematically but act compassionately

Keep the child/young person and her/his health, development, needs, rights, wishes and feelings and well-being as the primary focus of thinking and acting ~ always!

DSCB Training Team

References, resources and some further reading

Ayre, P. (1998) **Significant Harm: Making Professional Judgements** Child Abuse Review 7 (5): 330-342

Bichard, Sir Michael (2004) **The Bichard Inquiry report** London, The Stationery Office (TSO)

Boushel, M. (1994). **The protective environment of children: Towards a framework for anti-oppressive, cross-cultural and cross-national understanding.** British Journal of Social Work, 24, 173-190.

Brandon, M. et al. (2008) **Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005** London: Department for Education and Skills (DfES)

Calder, M.C. and Hackett, S. (eds) (2003) **Assessment in child care – Using and developing frameworks for practice** Lyme Regis: Russell House Publishing

Martin Calder (ed.) (2008) **Contemporary Risk Assessment in Safeguarding Children** RHP

Corby, B., Doig, A., Roberts, V. (2001) **Public Inquiries into Abuse of Children in Residential Care** London: JKP

Department for Children, Schools and Families (2008) **Staying Safe Action Plan**
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00151-2008&

Department for Education and Skills (2006) **Common Assessment Framework: Practitioners' and Managers' Guides**

Department for Education and Skills (2006) **Safeguarding Disabled Children: A Resource for Local Safeguarding Children Boards**

Department of Health (1991) **Child Abuse A Study of Inquiry Reports 1980-1989** London: HMSO

Department of Health (2000a) **Framework for the Assessment of Children in Need and their Families** London: TSO

Department of Health (2000b) **Assessing Children in Need and their Families: Practice Guidance** London: TSO

Fish, Sheila, and Munro, Eileen, and Bairstow, Sue. (2008) **Learning together to safeguard children: developing a multi-agency systems approach for case reviews**
SCIE Report,19. London, Social Care Institute for Excellence (SCIE)

Galilee, J The Scottish Office **Learning from Failure: A Review of Major Social Care/Health Inquiry Recommendations**

HM Government (2006) **Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children** London: TSO
Hendry, E. and Lewis, P. **Risk and Child Abuse** Practice Vol.4 no. 3

HM Government (2006) **What to Do If You're Worried a Child is Being Abused** www.everychildmatters.gov.uk

HM Government (2006) **Information sharing practitioners' guide:** Cross-Government guidance to improve practice by giving practitioners across children's services clearer guidance on when and how they can share information legally and professionally. www.ecm.gov.uk/informationsharing

HM Government (2007) **Making it Happen** www.everychildmatters.gov.uk/search/IG00130/)

HM Government (2007) **Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004**

Kemshall, H and Pritchard, J (ed) (1996) **Good Practice in Risk Assessment and Risk Management** London: Jessica Kingsley Publishers

Laming, Lord (2003) **The Victoria Climbié inquiry** Norwich: The Stationery Office (TSO)

Madonald, G. (2001) **Effective Interventions for Child Abuse and Neglect – An Evidence-based Approach to Planning and Evaluating Interventions** Chichester: J.Wiley and Sons

McAuley, C., Pecora, P.J., and Rose, W. (2006) **Enhancing the Well-being of Children and Families Through Effective Interventions – International Evidence for Practice** London: JKP

Munro, E. (1999) **Common errors of reasoning in child protection work. London: LSE Research Articles Online.** http://eprints.lse.ac.uk/archive/00000358/

Ofsted, 2008 **Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008**

Ofsted (2008) **The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2007/08** London: The Stationery Office

OFSTED (2008) **Safeguarding children 2008: the third joint chief inspectors' report on arrangements to safeguard children** London

Reder, P., Duncan, S. and Gray, M. (1993) **Beyond Blame – child abuse tragedies revisited** London: Routledge

Reder, P. and Duncan, S. (1999) **Lost Innocents - A Follow-up Study of Fatal Child Abus**e London: Routledge

Rose, W. and Barnes, J. (2008) **Improving safeguarding practice: study of serious case reviews 2001-2003** Nottingham: Department for Children, Schools and Families (DCSF), 2008.

Sinclair, R. and Bullock, R. (2002) **Learning from past experience: a review of serious case reviews** London: Department of Health (DoH)

Takacs, D. (2003) **How Does Your Positionality Bias Your Epistemology** Thought and Action Summer 2004

Appendix 1: Serious Case Reviews: ~ Assessment, Development and Improving Practice Tool

Name **(individual / team):**

Details **(full address of work base / tel. / e-mail):**

Stage 1						***Stage 2***
Findings / recommendations ~ 3 areas 14 points ~	**Examples of current good practice**	**To improve my/our practice in relation to this finding/ recommendation *I/we <u>pledge</u> to…***	**Factors that will help / factors that may hinder**	**Anticipated signs of success ~ I/we will know that things are improving when…**		**Review 6 months on ~ evidence of improved practice *and* source of information** (against each piece of evidence please note the source of the evidence: SR = self report / SUR = service user report / MR = manager report / CR = colleague report)
1) Children - young people / parents – carers / wider family – network - community - environment						
1) Keeping the child/young person and her/his health, development, needs, rights, wishes and feelings and well-being as the primary focus of thinking and acting ~ always! • See details on p. 23-27 above						

2) Working in partnership with parents and carers • See details on p. 23-27 above							
3) Recognising the importance of the wider family, network, community and environment around a child/young person as a potential source of problems *and* solutions • See details on p. 23-27 above							

2) Process of 'case' management							
4) Assessment: • See details on p. 23-27 above							
5) Decision-making and planning • See details on p. 23-27 above							

6) Intervention • See details on p. 23-27 above							
7) Regularly reviewing change • See details on p. 23-27 above							

8) Evaluating the impact of involvement • See details on p. 23-27 above							
3) Principles of good practice							
9) Information sharing, recording, analysis and management • See details on p. 23-27 above							

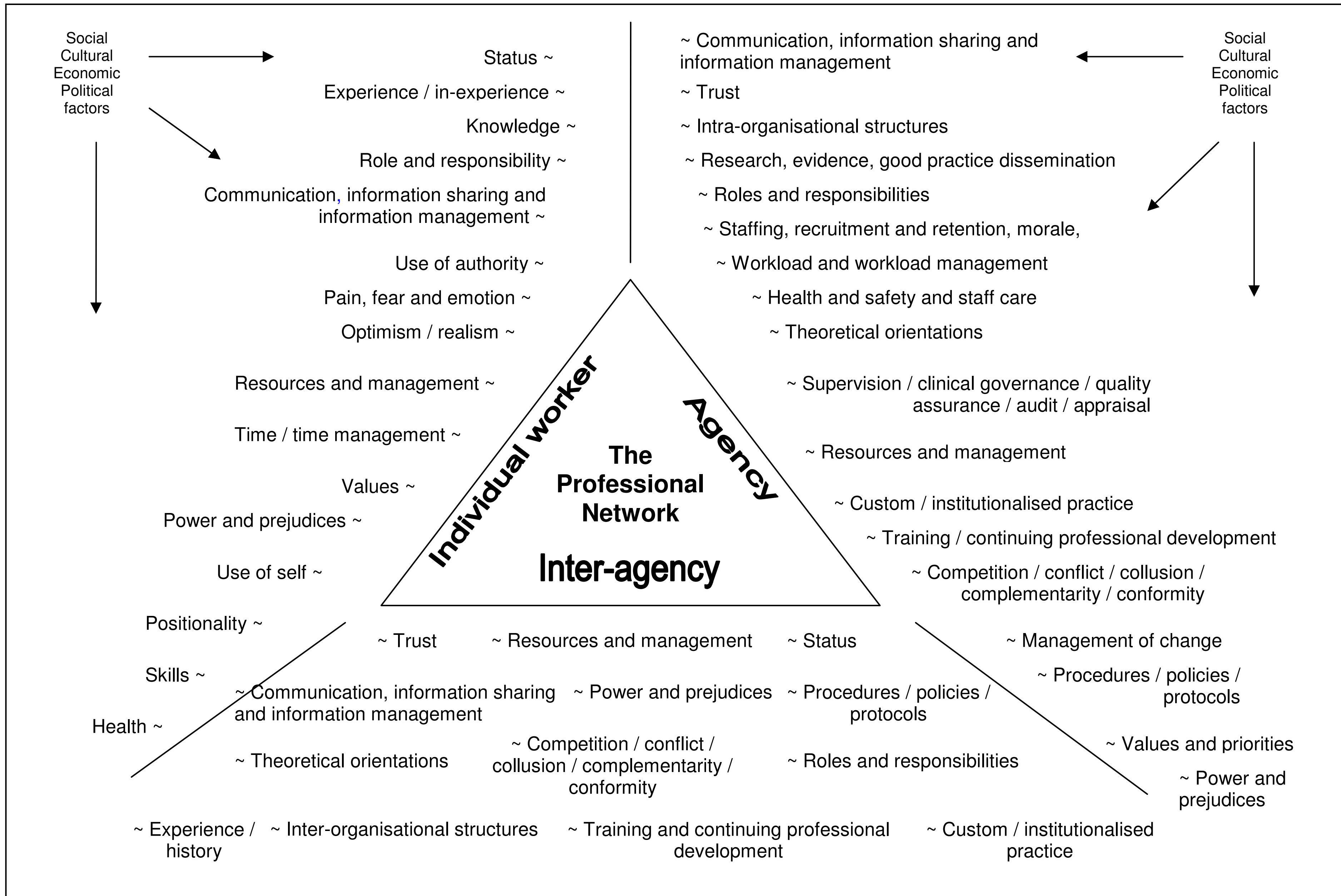
10) Knowledge-informed and up-to-date practice • See details on p. 23-27 above							
11) Strengths-based work • See details on p. 23-27 above							

12) Shared, clear, complementary, co-ordinated, accountable and agreed roles and responsibilities: • See details on p. 23-27 above							
13) Following national and local procedures, protocols and guidance and related thresholds for action • See details on p. 23-27 above							

14) Practice that promotes partnership, anti-discrimination, equality of opportunity and access and that recognises power, perspective and 'position' • See details on p. 23-27 above							
Other relevant findings / recommendations identified from my/our reading of the SCRs (please add below as appropriate)	**Please complete the boxes below (adding more if necessary) for additional relevant identified findings and recommendations as appropriate** **~ in the same manner as for those above ~**						
a)							
b)							

c)							
d)							
e)							

Appendix 2: The Professional Dimension ~ Tipping the Balance Towards Safety or Danger?



Social
Cultural
Economic
Political
factors
Status ~
Experience / in-experience ~
Knowledge ~
Role and responsibility ~
Communication, information sharing and information management ~
Use of authority ~
Pain, fear and emotion ~
Optimism / realism ~
Resources and management ~
Time / time management ~
Values ~
Power and prejudices ~
Use of self ~
Positionality ~
Skills ~
Health ~
~ Communication, information sharing and information management
~ Trust
~ Intra-organisational structures
~ Research, evidence, good practice dissemination
~ Roles and responsibilities
~ Staffing, recruitment and retention, morale,
~ Workload and workload management
~ Health and safety and staff care
~ Theoretical orientations
~ Supervision / clinical governance / quality assurance / audit / appraisal
~ Resources and management
~ Custom / institutionalised practice
~ Training / continuing professional development
~ Competition / conflict / collusion / complementarity / conformity
Social
Cultural
Economic
Political
factors
Individual worker
Agency
The Professional Network
Inter-agency
~ Trust
~ Resources and management
~ Status
~ Communication, information sharing and information management
~ Power and prejudices
~ Procedures / policies / protocols
~ Theoretical orientations
~ Competition / conflict / collusion / complementarity / conformity
~ Roles and responsibilities
~ Management of change
~ Procedures / policies / protocols
~ Values and priorities
~ Power and prejudices
~ Experience / history
~ Inter-organisational structures
~ Training and continuing professional development
~ Custom / institutionalised practice

‘Worker’ domain	
Dimension	**Characteristics / considerations**
Experience	For potential consideration: • Personal and professional experience • An accumulation (and testing/validation) of ‘practice wisdom’; • Levels of confidence in relation to what works; • Levels of competence ~ knowledge, skills and values • A range of working knowledge that informs individual practice in the context of multi-agency work from within a specific agency and in a particular community, in partnership with parents and carers and with children and young people

Knowledge	For potential consideration:
	• A typology of 7 areas of knowledge (e.g: Kent/Medway CCA students 2000):
	  ▪ know what
	  ▪ know when
	  ▪ know why
	  ▪ know how
	  ▪ know who
	  ▪ know self
	  ▪ know others
	• Knowledge that is conscious and articulable; sub-conscious accessible with prompting; unconscious or latent knowledge
	• ‘Residual messages’ (Heasman 2006) informing how a worker: analyses, assesses, ‘makes’ sense’, theorises in relation to the situations she or he is involved in; and how she/he ‘forms a response’ that leads to a plan and actual implementation/intervention to promote change, maintain or ‘manage decline’
	• Levels of commitment to evidence-based approaches – knowledge of ‘what works’
	• Consideration of relevance of *general* evidence-based findings applied to *particular* circumstances

Role and responsibility	For potential consideration: • *Actual* role expectations and responsibility linked to post and position, self and others (both specific to a worker’s agency, legislation, statutory requirements and profession e.g: compliance with professional codes of conduct) • Worker’s *perception* of their role and responsibility
Communication, information sharing and information management	For potential consideration: • Ability to communicate effectively through various appropriate media • Understanding of the boundaries of confidentiality, • Understanding of information sharing protocols: what, when, to who, why • Understanding of data protection issues • Processes of analysis and decision-making
Use of authority	For potential consideration: • Understanding of the authority that they have by virtue of their position (personal and professional), status, legislation (Holder and Corey 1987) • Appropriate exercise of that authority: to maintain a child focus, to communicate and engage appropriately, to ask difficult questions, to respond to threats, to challenge others (including other professionals, colleagues, line managers if required), to ‘make a case’, to influence, to direct others
Status	For potential consideration: • *Formal* status accorded a particular worker linked to job title and role • *Informal* status rooted in either workers’ perceptions and/or others’ perceptions • *Perceived* status resulting from social position

Time and workload / time and workload management	For potential consideration: • Appropriate balance between workload and time to manage it effectively • Realistic identification and recognition of all aspects of work: direct practice, administration, continuing professional and personal development/training, supervision, networking • Skills, strategies and guidance to manage finite (including personal) resources effectively
Resources / resource management	For potential consideration: • Availability of appropriate, quality assured, effective resources (preventative, responsive) • Skills, strategies and guidance to manage finite resources effectively
Optimism / realism	For potential consideration: • Workers' knowledge/understanding of explanations and factors contributing to an 'at risk' aetiology • Workers' knowledge/understanding in relation to protective or safeguarding factors • Workers' knowledge/understanding in relation to the capacity for potential for change and improvement • Consideration of the dynamic of hope and the reality of experience;
Health	For potential consideration: • Workers' own health (physical and emotional – see below) and implications for optimal effectiveness • Levels of stress and the effects
Pain, fear and emotion (vulnerability and resilience)	For potential consideration: • The impact of challenging, complex and potentially distressing aspects of work with children and young people and the circumstances that they face (Simmonds in Adcock and White 1998) • Varying responses from different workers according to the emotional vulnerability or resilience of the worker • Fear of violent or threatening parents/carers (Newham ACPC 2002)
Emotional intelligence / Reflexivity / Use of self / Confidence / Sensitivity / de-sensitivity	For potential consideration: • Empathy, compassion, self awareness, • 'Relational' (Folgheraiter 2004), reflective and reflexive practice • Communicate, engage, work 'in partnership', promote participative approaches, recognise expertise rooted in experience • Ability to respond and adapt in the here and now, in 'dialogue', in congruence • Ability to make a case and persuade • Workers' relative perceptions, feelings ('gut instinct') of 'risk' and 'safety'/'safeguarding' factors • Keeping a focus on 'this' child/young person when characteristics of a situation are shared amongst a number of 'similar' children/young people (CA '89 sn.31 (10)) • The importance of a maintaining a 'fresh pair of eyes' (Ayre 1998) • An ability to recognise changing circumstances
Skills and agency	For potential consideration: • Appropriate and corroborated/endorsed *sense* of competence, confidence and agency – further key element required for effective practice • Workers' *actual capacity* to act, to influence, to respond (proactively, preventatively, reactively) using a range/repertoire of evidence/practice wisdom informed tools and strategies; recognising and making the most of opportunities • Workers' *perceptions* of their capacity to act, influence and respond (proactively, preventatively, reactively)

Values	For potential consideration: • Recognition of the social, cultural, political, professional and personal construction of values • Adherence to professional codes and statements of values (e.g: Nursing Midwifery Council / General Teaching Council / GSCC 2006) • Anti-discriminatory, anti-oppressive practice, promoting equality of opportunity and access, valuing diversity • A key element of competence
'Positionality'	For potential consideration: • Workers' awareness of their own position (gender, class, orientation, ethnicity, culture, disability status etc.) and the potential impact on their understanding and responses (Takacs 2003) • Workers' ability/willingness to consider others' positions and the potential impact on their understanding and responses
Power and prejudice	For potential consideration: • Recognition, understanding and response to power differentials, prejudice and discrimination: personal, organisational, institutionalised, structural, social, political

'Agency / organisation' domain	
Dimension	**Characteristics / considerations**
Communication, information sharing and information management	For potential consideration: • Ability to communicate effectively through various appropriate media • Understanding of the boundaries of confidentiality, • Understanding of information sharing protocols: what, when, to whom, why… • Understanding of data protection issues • Processes of analysis and decision-making
Trust	For potential consideration • Respect and confidence between staff and in relation to competence, respective roles and responsibilities, processes and procedures, etc.
Intra-organisational structure	For potential consideration: • Comprehensive, complementary, coherent, transparent and accountable (checks and balances) levels and layers of service provision and management within the agency
Research, evidence, good practice dissemination for effective policy and practice	For potential consideration: • Effective strategies for dissemination of research findings / good practice initiatives to critique and challenge current policy and practice and to inform, develop and promote effective future policy and practice
Roles and responsibilities	For potential consideration: • Clear, transparent, agreed, negotiated and accepted shared understanding of respective complementary roles and responsibilities between agencies
Staffing, recruitment, retention and morale	For potential consideration: • Realistic appraisal of required capacity • Retention strategy including opportunities for continuing professional development, progression, flexible working arrangements and appropriate benefits

	• Commitment to agreed staffing levels at appropriate differentiated levels • Effective recruitment strategy to minimise vacancies • Recognition that public and voluntary services are probably effectively maintained by goodwill and unpaid overtime
Workload and workload management	For potential consideration: • Appropriate workloads – volume, range of work, using complementary strengths • Sophisticated and responsive workload weighting systems to recognise all aspects of workers' (changing) roles and responsibilities • Effective management, advice and guidance
Health and safety and staff care	For potential consideration:: • Recognition that the workforce is perhaps the most valuable asset that an agency has • Strategies to protect staff, to fulfil 'duty of care', to promote and protect health and welfare (physical and psychological), to prevent health and safety being compromised, to protect and provide support as appropriate
Theoretical orientations	For potential consideration:: • Adoption and promotion of appropriate theoretical approaches underpinning practice and policy – complementary and shared following critical appraisal of effectiveness/what works • Promoting key priorities such as participation, partnership working, anti-discriminatory/anti-oppressive strategies, equal opportunities etc.
Supervision, clinical governance, quality assurance, audit, appraisal	For potential consideration:: • Comprehensive (multi-function), regular, child-centred/focussed supervision including appropriate practice critical analysis, reflection, guidance and direction, decision-making and SMART goals linked to anticipated outcomes and signs of success defined in relation to child/young person's health and development (optimal outcomes), rooted in awareness of 'what works' • Critical, independent (where appropriate) structures and processes for clinical governance, quality assurance, audit and appraisal • Meeting internal and external / local and national standards, benchmarks, priorities and performance indicators
Resources and management	For potential consideration: • Realistic, planned and monitored allocation of resources to achieve goals linked to anticipated outcomes and sign of success defined in relation to child/young person's health and development (optimal outcomes), rooted in awareness of 'what works' • Effective management of resources – with both fixed and responsive capacity
Custom and institutionalised practices	For potential consideration: • Critical recognition of the strengths and especially the limitations of practice (personal and organisational) and policies that may be pursued and perpetuated as a matter of custom or may be institutionalised (including 'hidden', structurally embedded discriminatory practice) • The danger of 'organisational malaise' (Laming 2003)
Training and continuing professional development	For potential consideration: • Opportunities for training and continuing professional development: ▪ A range of courses, activities and events (individual, team, agency, multi-agency) ▪ Differentiated and targeted (linked to roles and responsibilities) ▪ Clear aims, objectives and well-defined learning outcomes ▪ Referenced to contemporary key benchmarks and documents e.g: ECM 'Change for Children Outcomes Framework'; National Occupational Standards and related Statement of Expectations of Service Users and

	Carers; Codes of professional conduct; 'W.T.' learning outcomes; UNCRC; Post-Qualifying / Post-Registration frameworks; legislation; policies and procedures etc. ▪ Promoting ADP, diversity, equal opps. ▪ Promoting children and young people's / parents' and carers' participation ▪ Promoting multi-agency practice and integrated working ▪ Research-informed (including findings from serious case reviews) and promoting research-informed practice ▪ Resulting in realistic (SMART/goal-based) action-plans linked to learning outcomes ▪ Evaluated (baseline, added-value, impact on participants, impact on service users) ▪ Accredited where possible and appropriate
Competition / conflict / collusion 'complementarity' / conformity	For potential consideration: • Recognition that intra- and inter-personal and group dynamics may operate within an agency overtly and/or covertly to impede effectiveness
Management of change	For potential consideration: • Recognition and management of continuing processes of change and development: participatory, transparent, clearly communicated, emotionally intelligent
Procedures, policies and protocols	For potential consideration: • Up to date, clear, accessible, agreed, complied with, embedded and supported by people, structures and processes across an agency • Reviewed and developed
Values and priorities	For potential consideration: • Recognition of the social, cultural, political, professional and personal construction of values • Adherence to professional codes and statements of values (e.g: NMC/GTC/GSCC 2006) • Anti-discriminatory, anti-oppressive practice, promoting equality of opportunity and access, valuing diversity
Power and prejudice	For potential consideration: • Recognition, understanding and response to power differentials, prejudice and discrimination within an agency or organisation: personal, organisational, institutionalised, structural, social, political, cultural etc.

'Inter-agency' domain	
Dimension	**Characteristics / considerations**
Trust	For potential consideration: • Respect and confidence between staff and in relation to competence, respective roles and responsibilities, processes and procedures, etc.
Resources and management	For potential consideration: • Realistic, planned, monitored, allocation of *complementary* resources to achieve shared goals linked to anticipated outcomes and sign of success defined in relation to child/young person's health and development (optimal outcomes), rooted in awareness of 'what works' • Effective management of resources – with both fixed and responsive capacity between and across agencies

Status	For potential consideration: • *Formal* status accorded workers linked to job titles and roles • *Informal* status rooted in either workers' perceptions and/or others' perceptions • *Perceived* status resulting from social positions
Communication, information sharing and information management	For potential consideration:: • Ability to communicate effectively through various appropriate media • Understanding of the limits of confidentiality, • Understanding of information sharing protocols: what, when, to who, why • Understanding of data protection issues • Processes of analysis and decision-making
Power and prejudice	For potential consideration: • Recognition, understanding and response to power differentials, prejudice and discrimination between agencies and organisations: personal, organisational, institutionalised, structural, social, political
Procedures / policies / protocols	For potential consideration: • Up to date, clear, accessible, agreed, complied with, embedded and supported by people, structures and processes across agencies • Individual agency procedures and policies to be complementary and compatible • Reviewed and developed
Theoretical orientations	For potential consideration: • Adoption and promotion of appropriate theoretical approaches underpinning practice and policy – complementary and shared following critical appraisal of effectiveness/what works • Promoting key shared priorities such as participation, partnership working, anti-discriminatory/anti-oppressive strategies, equal opportunities etc.
Competition / conflict / collusion / complementarity / conformity	For potential consideration: • Recognition that intra- and inter-personal, group, agency and organisational dynamics may operate between agencies overtly and/or covertly to impede effectiveness
Roles and responsibilities	For potential consideration: • Clear, transparent, agreed, negotiated and accepted shared understanding of respective complementary roles and responsibilities between agencies
Experience / history	For potential consideration: • The sum of individual experience that may be pooled, shared and accumulated such that the whole is greater than the parts, or may be fragmented and unshared, such that the whole is less than the individual parts. • The accumulated experience of working together
Inter-agency/organisational structure	For potential consideration: • Comprehensive, complementary, coherent, transparent and accountable (checks and balances) levels and layers of service provision and management between agencies
Training and continuing professional development	For potential consideration: • Opportunities for training and continuing professional development: ▪ A range of courses, activities and events (individual, team, agency, multi-agency) ▪ Differentiated and targeted (linked to roles and responsibilities) ▪ Clear aims, objectives and well-defined learning outcomes ▪ Referenced to contemporary key benchmarks and documents e.g: ECM 'Change for Children Outcomes Framework'; National Occupational

	Standards and related Statement of Expectations of Service Users and Carers; Codes of professional conduct; 'W.T.' learning outcomes; UNCRC; Post-Qualifying / Post-Registration frameworks; legislation; policies and procedures etc. ▪ Promoting ADP, diversity, equal opps. ▪ Promoting children and young people's / parents' and carers' participation ▪ Promoting multi-agency practice and integrated working ▪ Research-informed (including findings from serious case reviews) and promoting research-informed practice ▪ Resulting in realistic (SMART/goal-based) action-plans linked to learning outcomes ▪ Evaluated (baseline, added-value, impact on participants, impact on service users) ▪ Accredited where possible and appropriate
Custom and institutionalised practice	For potential consideration: • Critical recognition of the strengths and especially the limitations of practice (personal and inter-organisational) and policies that may be perpetuated as a matter of custom or may be institutionalised (including 'hidden' discriminatory practice) • The danger of inter-'organisational malaise' (Laming 2003)