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## CLiCP Seminar (2)

# Learning from Review of Child Deaths and Serious Abuse Cases in the UK

*Hosted by The University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP)  
Held Wednesday 25th March 2009, Macdonald Holyrood Hotel, Edinburgh*

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## Seminar Report

March 2009



Summary Report .....	2
1 Introduction .....	2
2 Headline Messages from the seminar .....	2
3 Summary Learning points from the Seminar .....	3
3.1 Serious Case Review Processes throughout the UK .....	4
3.2 Terminology and Guidance .....	4
3.3 The Purpose of SCRs .....	4
3.4 Analysis of SCRs .....	4
3.5 Findings from Analysis of SCR Reports Across the UK .....	5
3.6 Effectiveness of SCRs .....	6
3.7 Wider Processes: Review of all Child Deaths .....	7
3.8 Developments in SCR Processes since the Seminar .....	7
Main report .....	8
4 Background .....	8
5 Overview of Child Deaths and Serious Case Review Processes in the UK - Sharon Vincent .....	8
6 The Challenges in Learning from Serious Case Reviews - Marian Brandon .....	12
7 Reviewing the Process of Case Management Reviews in Northern Ireland – John Devaney .....	15
8 Review of Child Death and Serious Abuse Cases in Scotland – Sharon Vincent.....	17
8.1 Findings from a Review of Child Death and Serious Abuse Cases in Scotland – Sharon Vincent .....	17
8.2 Learning Lessons from Significant Case Reviews in Glasgow - Gillian Buchanan.....	20
9 Serious Case Reviews in Wales .....	22
9.1 Serious Case Reviews in Wales - Lesley Williams.....	22
9.2 Serious Case Review: a case for serious review - Jonathan Corbett.....	24
10 Summing Up: Wendy Rose .....	25

## Summary Report

### 1 Introduction

The focus of the second CLiCP Seminar, held in March 2009, was on Child Death and Serious Case Review, specifically: examining similarities and differences between key themes emerging across the UK; processes in different parts of the UK; their efficacy; their effectiveness as a learning tool.

The recent high profile child death cases - Baby Peter in England, Brandon Muir in Scotland and cases elsewhere in the UK - have again brought into sharp relief the issue of how best to review child deaths and serious cases; and effect learning from their findings.

Presentations were given by senior academics and government officials from across the UK. There were 50 invited delegates from academia, government and practice.

This report comprises a summary report with headline findings, and a full seminar report

### 2 Headline Messages from the seminar

Below we set out headline messages distilled from the Seminar presentations:

- SCRs have provided greater recognition and understanding of the circumstances of the lives of the most vulnerable families and the nature of the relationships within homes where children may be at risk of death or the most serious harm.
- However, basing system, policy and practice change mainly on recommendations from serious, complex and fatal cases may not be the most effective way to shape future policy and practice; and it may not offer the best protection for children. This is because SCRs represent a selective group of child deaths and serious cases: they do not include near miss information; and findings are made on the basis of incomplete data. More complete information may be obtained from research comparing and contrasting child deaths as a whole; child deaths from abuse and neglect; serious injury cases; near misses; comparing child death and serious abuse cases with other routine cases.
- Children can be particularly at risk where a number of risk factors co-exist. In particular, neglect and the co-existence of parental domestic abuse, mental ill-health and substance misuse, increases the risk of harm to children. However, while these are indicators of heightened risk to children; they are not predictive of death or serious injury. Most cases subject to SCR are too complex to be able to predict death and serious injury.
- Arguing about thresholds and looking for ways to avoid providing services can leave vulnerable children adrift. Child protection should be seen as part of the safeguarding continuum, and not as a separate sphere of activity. An important message is the need to intervene early to support the most vulnerable families. It highlights the important role of prevention and of universal services in identifying need early. It also emphasises the key role adult services play in identifying and acting on need early.
- There is a need for greater understanding of the needs of a highly vulnerable group of older adolescents who may be neglected by agencies. For them, there may be factors associated with self-neglect, chronic illness, sexual exploitation, going missing, bullying and suicide.
- Expanding reviews beyond a focus on child abuse and neglect towards a wider public health approach to looking at all child deaths might enable the identification of preventable deaths; and in addition, to better identification of the factors and causes of child deaths.
- A focus on changing and creating a more positive work place culture may be important in preventing child deaths. Protecting children should not simply be about waiting for things to go wrong before trying to learn how to do things better. Challenging and learning from practice should be an integral part of daily work. It is important to have a work place culture where staff are constantly vigilant, are able to question, challenge and constantly review practice. Staff working in a supportive, dynamic environment, may be best placed to be able to pool collective knowledge and use it to best protect children.
- The smaller countries of the UK might usefully consider the possibility of setting up a system which established a core team of standing professionals able to conduct independent reviews and provide feedback to aid agency learning quickly, clearly and efficiently.

### **3 Summary Learning points from the Seminar**

In this section we set out some key points highlighted from speakers presentations which may be worthy of future consideration

### **3.1 Serious Case Review Processes throughout the UK**

Each part of the UK has its own mechanisms in place to review child death and serious cases. There are strong similarities between them; also some differences. Some of these are set out below.

### **3.2 Terminology and Guidance**

Terminology used to describe these processes differs. England and Wales refer to 'Serious Case Reviews' (SCRs); Scotland has 'Significant Case Reviews' (SCRs); and in Northern Ireland the process is called 'Case Management Review' (CMR).

England and Wales have had national mechanisms and guidance in place to review child death and serious cases since 1988. The guidance was updated in 1991, 1999 and in 2006, legislative change was introduced with the Children Act 2004. This put the review process on a statutory basis and, where previously Area Child Protection Committees' (ACPCs) responsibilities for conducting SCRs had been a matter of government guidance, SCRs now became the function of the new Local Safeguarding Children Boards (LSCBs). Detailed guidance was issued on this in England and in Wales in 2006. In England, SCR reports have been evaluated by OFSTED against a set of grade descriptors.

In Northern Ireland ACPCs have had responsibility for undertaking Case Management Reviews (CMRs) since 2003. Guidance is broadly similar to that operating in England and Wales.

Scotland has had national guidance in relation to Significant Case Review since 2007. Prior to this, each local authority had its own process for reviewing and learning from child deaths and serious abuse and neglect cases. The Scottish Guidance contains grounds similar to that in England and Wales.

Currently, reform, or discussion about reform of these processes is underway in each part of the UK.

### **3.3 The Purpose of SCRs**

The stated purpose of SCRs is broadly consistent across the UK and is:

- To establish whether there are lessons to be learned from these cases about the way local professionals and agencies work together to safeguard children
- To identify lessons from the reports; how they will be acted upon; and to note what is expected to change as a consequence
- To improve inter-agency working to better safeguard children
- To identify examples of good practice.

Slight differences exist in relation to circumstances and grounds set out in guidance for conducting a review.

### **3.4 Analysis of SCRs**

Across the UK, mechanisms for analysing findings and identifying messages from SCRs differ.

In England, government funded biennial analysis of SCR reports has been undertaken since a commitment was made in government guidance in 1999 (Sinclair and Bullock, 2002; Rose and Barnes; 2008; Brandon et al 2008; Brandon et al, 2009).

In Wales a number of analyses of SCR reports have been undertaken (Colton et al, 1996; Brandon et al, 1999; Brandon et al 2002; Morris et al 2007).

In Northern Ireland there has not yet been systematic analysis of CMR reports. This is currently planned. There has been an evaluation of the CMR process and a consultation held with key stakeholders.

In Scotland, there has been no analysis of SCRs. Research reviewing major cases in Scotland, where published reports are available, was jointly commissioned by CLiCP and the Scottish Commissioner for Children and Young People (SCCYP) and conducted by CLiCP (Vincent et al unpublished 2007; Vincent forthcoming 2009).

### **3.5 Findings from Analysis of SCR Reports across the UK**

Information from analysis of review reports is available in some form in three of the four parts of the UK. This information formed the basis of several of the presentations at the Seminar.

Speakers reported on risk factors and characteristics common to the children, families and agencies in cases subject to a SCR.

Factors reported seemed remarkably consistent and congruent across the UK.

Risk factors commonly associated with children in these cases included:

- Younger children are most at risk, with most child deaths occurring in children younger than one
- In older children who are 'hard to help' there were common factors associated with self neglect, chronic illness, sexual exploitation, going missing, bullying and suicide
- A prior history of abuse or neglect.

Common factors associated with parents/carers included:

- Violent and/or dangerous men living with vulnerable young women
- Abuse in parents' /carers' own family backgrounds or a personal history of having been in care
- Alternating patterns of hostility and cooperation with agencies and agency staff
- Factors associated with parental mental health
- Factors associated with parents/carers learning or other disability
- Poor living conditions, frequent house moves, and a range of other housing difficulties
- Parents/carers who were socially isolated or with poor support networks
- Financial difficulties
- Families going missing in the weeks leading up to the death of a child.

Risk factors common to agencies included:

- With regard to very young babies there were issues of agencies' capacity to address difficulties and climate in organisations creating barriers to professionals being able to act
- A preoccupation with thresholds: and about whether or not a case met child protection thresholds
- Families living on the margins; many of the families were living on the margins of society; they were also to be found on the margins of the child protection system.
- While the majority of families had had contact with services and agencies, most of this contact was with universal and adult services, rather than child protection services. Where children were known to children's organisations they did not tend to be on the child protection register and most were categorised as 'children in need cases' rather than 'child protection cases'
- Professional anxiety, leading to reluctance among workers to act and to challenge
- Challenges for professionals working with child protection and ethnicity issues
- Procedural issues were common and included, issues with supervision, following procedures while dealing with neglect, keeping track of families, children not being seen and/or heard. There were difficulties with recording information and record keeping, Inter-agency communication, information sharing and decision making. There were problems with assessment of need and risk. There were challenges for professionals dealing with the mental health and emotional issues of parents; paternal criminality; and domestic abuse.

Children may be at most risk of abuse and neglect where a number of the above risk factors co-exist. The co-existence of domestic violence, parental mental ill health and substance misuse increases the risks of harm to children. However, care needs to be taken. While these factors may heighten risk, they are not predictors of abuse.

### **3.6 Effectiveness of SCRs**

Speakers reflected on the pros and cons of SCR processes across the UK.

On the positive side, there was consensus that the existence of SCR processes had been positive in providing relatively good information about what happened to individual children; in having improved knowledge of the factors that leave children exposed to greater risk of harm; and of how different risk factors interact with each other. This has created the possibility of improving the system as a result.

There was also discussion about the difficulties currently facing SCRs. As currently constituted, they may not be the most effective mechanism from which to promote timely and effective learning. At the moment there is considerable emphasis on the process of conducting the reviews, with not enough emphasis on outcome, practice, and on what needs to change as a result. SCR processes absorb significant amounts of time and resources. Reports can be of variable quality. There are often difficulties in completing reviews. For these reasons, it can be difficult to disseminate learning and to translate recommendations quickly into action.

While SCR processes may be effective in identifying what happened to children, they may be less effective in addressing why the death occurred. SCRs regularly identify the same problems and make similar recommendations. This also raises questions about their effectiveness as a learning tool. Even if the process of conducting SCRs is improved, individual practice or inter-agency working may not improve as a result; and it may not lead to better outcomes for children.

### **3.7 Wider Processes: Review of all Child Deaths**

In addition to processes for reviewing child deaths from child abuse and neglect, parts of the UK have introduced, or are thinking about introducing, new processes to review deaths of all children (0-18).

In England, since 2008, LSCBs have a duty to review all child deaths. This process, known as Child Death Overview Panels (CDOPs), runs parallel to SCRs. An early pilot of these (Sidebotham et al 2008) identified some benefits; also some challenges. For example, while practitioners reported that there could be benefits for wider learning and prevention; there was also potential for confusion about links between these and other processes. However, expanding reviews beyond a focus on child abuse and neglect towards a wider public health approach to looking at all child deaths might enable identification of preventable deaths and better identification of the factors and causes of child deaths.

### **3.8 Developments in SCR Processes since the Seminar**

Since the seminar, the Laming Report in England, set up following the Baby Peter case has made further recommendations to strengthen and clarify arrangements in England and Wales for conducting SCRs (Laming 2009). Recommendations included the tightening of lines of responsibility and accountability; enhanced recruitment and selection; improved preparation and support available to Review Panel members, Review Chairs and Report Writers. OFSTED will now focus their evaluation of SCRs on the depth of learning and quality of recommendations: it will now have responsibility for sharing SCR reports with relevant agencies to promote learning; for producing reports at 6 month intervals, and for summarising lessons from Serious Case Reviews.

In Scotland, the Government has set up a working group to review the 1989 Interagency Child Protection Guidance; with a number of working groups taking forward sub themes. The process of conducting and learning from SCR will be reviewed in the course of this.

Wales is currently considering the way SCR operates, with research and consultation planned for later in 2009.

Northern Ireland has recently commissioned research on CMRs conducted in Northern Ireland. The process of implementing recommendations from the evaluation of the CMR process continues.



## Main report

### 4 Background

This is the Report of the CLiCP Seminar held in the Holyrood Hotel in Edinburgh on Wednesday 25<sup>th</sup> March 2009. Its focus was Child Death and Serious Case Reviews, specifically: examining similarities and differences between key themes emerging across the UK; processes in different parts of the UK; their efficacy; their effectiveness as a learning tool.

Presentations were given by senior academics and government officials from across the UK. There were 50 invited delegates from academia, government and practice. The day was chaired by Professor Pamela Munn for the School of Education at the University of Edinburgh.

The aim of the seminar was to address the following questions:

- How similar or different are the processes for reviewing child deaths and serious cases across the UK?
- How effectively are these processes working in each part of the UK?
- How well are different parts of the UK using and learning from review processes; how effectively are findings from reviews making their way into practice?
- What is the best way to learn from the outcomes and findings from SCRs?
- Are SCRs as currently structured throughout the UK 'fit for purpose'?
- Are the same themes emerging from SCRs across the UK?
- To what extent are the outcomes and recommendations from SCRs different or similar in each part of the UK?
- Is there a need to shift the focus away from evaluating and improving processes to learning from outcomes?

At the time of the seminar, the Baby Peter case had recently ended and press reporting of the case had been extensive. Lord Laming had been tasked with examining what had happened in the case; re-examining it in the light of the recommendations in the report of the Victoria Climbié case which had occurred in the same London Borough. A similar case in Scotland, yet to report, was uppermost in the mind of delegates from Scotland.

### 5 Overview of Child Deaths and Serious Case Review Processes in the UK - Sharon Vincent

Dr Sharon Vincent, Senior Research Fellow at CLiCP opened the day. Sharon has worked extensively in child protection. As a researcher in the Social Work Inspection Agency (SWIA) for 4 years she was a member of the team who undertook the National Audit and Review of Child Protection. She also worked as a researcher in the voluntary sector.

In this presentation Sharon provided a basic outline and comparative overview of the child death and SCR processes currently operating in each part of the UK where there are varying degrees of similarity and difference.

Terminology differs; in England and Wales the processes are called 'Serious Case Reviews'; in Northern Ireland they are known as 'Case Management Reviews' and in Scotland 'Significant Case Reviews'.

With regard to the system in England and Wales. Guidance for conducting local reviews was introduced for England and Wales in 1988 as Part 8 of the new child protection guidance on inter-agency working which set up Area Child Protection Committees. The then Area Child Protection Committees (ACPCs) had to undertake a review when a child died and abuse or neglect was known or suspected to be a factor in the death with a view to establishing what lessons could be learned.

The term 'Serious Case Review' (SCR) was used for the first time in 1999 in the revised version of *Working Together to Safeguard Children* in England and in the National Assembly of Wales version of *Working Together*.

Further changes were introduced under the 2004 Children Act which made it mandatory for the new Local Safeguarding Children's Boards (LSCBs) to conduct a SCR if a child dies and abuse or neglect is suspected to be a factor in the death. Whereas ACPCs were responsible for conducting case reviews as the result of government guidance, SCRs now became a statutory function of LSCBs.

Guidance on this was provided in 'Working Together to Safeguard Children' (HM Government 2006) in England and in 'Safeguarding Children: Working Together Under the Children Act 2004 (Welsh Assembly Government 2006) in Wales. This outlined the circumstances where conducting a SCR should be carried out as follows:

A SCR should be considered

- Where a child sustains life threatening injury or serious impairment of health and development through abuse or neglect
- Where a child has been subjected to particularly serious sexual abuse
- Where a child has been killed by a parent with a mental illness
- Where the death is a suicide
- Where the case gives rise to concerns about inter-agency working to protect children from harm
- In England, where a parent has been murdered and a homicide review is being initiated.

Other changes were also introduced under the 2004 Act. The guidance in England specified the SCR panel should involve representatives from at least – LA children's social care, health, education and police. This was not specified in the Wales guidance.

Each agency was to produce its own report; a composite overview of all the reports was then to be produced by an independent author.

In England, reports have been evaluated by OFSTED against a set of grade descriptors In Wales, SCRs are sent to the Welsh Assembly Government (WAG) but are not rated. In England and Wales there is a requirement to include family members in the review and it is specified in current guidance that reviews should be completed within 4 months in England [now subject to consultation proposing 6 months from the date of the decision to proceed] and 6 months in Wales.

In Northern Ireland, ACPCs have had responsibility for 'case management reviews' since 2003.

Guidance 'Co-operating to Safeguard Children' specifies when and how a review should be undertaken.

These grounds are similar to those for undertaking reviews in England with some differences. The guidance does not state that a review should be undertaken where a parent has been murdered and a homicide review is being initiated; or where a child has been killed by a parent with mental illness. In NI it is the responsibility of the Chair to consider whether family members are invited to contribute. The Panel should include representation from at least social services, health, education and police. Reviews should normally be completed within 5 months and Review Reports should be sent to DHSSPS.

In Scotland, prior to 2007 there was no national system for reviewing child deaths and serious cases. Local areas had their own processes organised mainly through Child Protection Committees, who undertook single or joint reviews where there were concerns about abuse and neglect. The report of the audit and reviews of child protection in Scotland, published in 2002, 'Its everyone's job to make sure I'm alright' recommended the need for guidance on how reviews of child fatalities were conducted and in 2007 new interim guidance for conducting SCRs was issued to Child Protection Committees (CPCs). The Scottish guidance had guidelines similar to England; with some exceptions. They did not include where a parent had been murdered and a homicide review initiated.

The Scottish guidance states that family members/carers should be kept informed and it was stated that it might be useful to assign a member of staff as a liaison person for families. The involvement of family/carers and the child's views and wishes should be documented. The guidance provides information on supporting staff through the process. It does not specify agencies which must be involved; nor are the skills and competence of the lead reviewer and review team set out. Timescales are not specified and reviews have to be sent to SWIA.

With regard to other wider reviews of child deaths across the UK, Sharon highlighted that across the UK there are long standing health based approaches to infant and child mortality review.

Until recently, all parts of the UK had processes in place for reviewing deaths from child abuse and neglect. However, unlike countries like the US, Canada and Australia, no part of the UK had in place wider child death review processes. There have been developments in relation to the introduction of processes for the wider review of child deaths in different parts of the UK very recently.

In England, since April 2008, LSCBs now have a duty to review deaths of all children (0-18) through a Child Death Overview Panel (CDOP) not just those children whose death was deemed to be the result of abuse or neglect. There is also a duty to respond rapidly to individual, unexpected deaths of all children (not just those in contact with organisations responsible for safeguarding their welfare) through a rapid response team (RRT).

Since 2008, CSCBs also have a responsibility to use the aggregated findings from all child deaths, collected through a nationally agreed data set, to inform local strategic planning on how best to safeguard and promote the welfare of children in their care.

An early pilot of the working of these processes was conducted by Sidebotham and colleagues and reported on in 2008. This highlighted a number of issues for consideration in relation to their early working including practitioners reporting some confusion about the links and relationships between child deaths and SCR processes; confusion between multi-agency child death overview and other hospital based mortality reviews which were already being undertaken. Respondents generally felt that CDOP should consider cases only after the conclusion of any rapid response processes, criminal investigation or SCR.

In Wales, LSCBs have not been given responsibility to review all child deaths or respond rapidly to individual unexpected deaths. However, at the time of the seminar the WAG is considering an all-Wales approach; with a pilot study to inform the development of child death reviews in Wales running from August 2008, with the aim of introducing a full child death scheme in April 2010.

In Northern Ireland, the 'Case Management Review' (CMR) following the death of David Briggs in 2003 recommended a multi-agency approach to all cases of sudden unexpected child death. The proposed Regional Child Death Review protocol process is currently being consulted upon. It outlines the responsibilities of statutory agencies and professional staff when dealing with the sudden or unexpected death of any child (0-18) whether the death occurs at home, or in the community or in hospital. At a very early stage after a child's death the professionals who have been involved with the child have to meet and share information about the child, including details about the death and other circumstances.

At the end of her comparative analysis of SCR and wider processes across the UK, Sharon discussed the extent to which local and national learning from the reviews and their findings and outcomes seem to have been picked up and addressed in different parts of the UK.

Sharon pointed out that while SCRs were generally regarded as important, there was also some compelling information about whether this is the best (or only) vehicle for generating information and learning. SCRs regularly identify the same problems and make similar recommendations which in itself raise questions about effectiveness as a learning tool, despite this being the stated purpose for their being set up.

20 out of 50 reviews evaluated by OFSTED (2008) were judged to be inadequate. While they were effective in identifying what happened to the children, they were less effective in addressing why the deaths had occurred. Recommendations tended to focus on policies and procedures rather than on practice and what needs to change.

Approaches enabling learning from effective safeguarding practice rather than mistakes may be a better way to proceed.

Attempts to expand child death reviews beyond the focus of child abuse and neglect towards a public health model may enable identification of preventable death

Information from other countries suggests that review of all child deaths might enable better identification of the causes of child death and lead to the introduction of initiatives to prevent some deaths.

The pilot study (Sidebotham 2008) provided some information about the effectiveness of the new processes.

The CEMARCH child death review study (Pearson 2008) concluded that a multi-disciplinary approach provides the best opportunity to examine the major environmental influences in a child immediately prior to death and to identify why the child died. However, the report also mentioned that such inquiries are costly, time consuming and resource dependent.

There is a need to ensure that different processes for reviewing child deaths fit together.

## **6 The Challenges in Learning from Serious Case Reviews - Marian Brandon**

Marian Brandon is a senior lecturer in Social Work at the University of East Anglia. Marian is Director of the research team who conducted the 2003-05 and 2005-07 biennial analyses of SCRs in England for DCSF. Marian presented information from these analyses. She outlined the main research questions driving both reviews; they included:

- What are the themes and trends across the reviews/reports?
- What can we learn from interacting risk factors?
- What are the lessons for policy and practice (and can these types of cases be prevented or reduced)?

An additional question of the 2005-07 review was:

- What can we learn about the process of SCRs to inform new guidance?

Marian highlighted the importance of these reviews in the 'need for scientific rigour not tragic anecdote'.

Marian highlighted some methodological challenges involved in conducting such reviews; analysis combined looking at both fatalities and serious injury cases.

SCRs are selective; they do not represent all homicides or all serious cases. They do not include near misses. This perhaps highlights a need for comparative studies of child death; serious injury and near misses.

While there are similar studies conducted internationally; these tend to have a small sample size. There is no solid international body of knowledge about full cohorts.

Assessing the data was a challenge. There was a broad range of information (e.g. spanning children 0-18).

The methodology for analysing the review was layered. Layer 1 was mainly quantitative, providing basic information about all 131 cases from the notification data base in 2003-5; and 189 cases in 2005-07. Layer 2 was mainly qualitative; looking at a sub sample of 47 cases in 2003-05 and 40 cases in 2005-07.

Problems with quantitative data included that there was scope for the data to be unreliable, inconsistent and inaccurate; information could be missing. On the other hand it is the first national study to provide findings on a near full sample of these cases.

Problems with qualitative data included the overwhelming quantity of data. On the other hand the structured mapping of each case using a template did reveal themes and trends; and the existence of the 2005-07 analysis provides the possibility of comparison between the two cohorts.

Marian provided an overview of characteristics of the sample.

Sample (s)	Age
47% + 46%	younger than 1
20% + 23%	aged 1-5
16% + 11%	aged 11-16
9% + 11%	aged 16+
16% + 10%	aged 6-10

In the 2003-5 cases, from layer 1, only 12% of the children were on the child protection register. 21% of 161 cases featured neglect including: house fires, accidents or injuries and poor housing conditions.

Information from layer 2 data included the following:

Caregiver issues included: domestic abuse (66%); mental ill health (55%); substance abuse (57%). There was a high level of co-morbidity. There was co-morbidity of all 3 of the above in one in three of the cases.

In 32 of 47 cases there was a lack of cooperation or overt hostility from families to workers.

There was volatility, 'one-off' assaults and bubbling anger. There was some evidence of harm occurring because of the demands new babies make on violent men.

There was lack of support to 'hard to reach' teenagers and of agencies giving up on them.

With regard to the categorisation of layer 2 cases 2003-05, Marian identified factors relating to the child; the family and professionals and agencies.

With regard to very young babies there was evidence of prematurity; hospital admissions. There was co-morbidity of domestic abuse; substance misuse; mental ill-health. In relation to fathers there was evidence of hostility and criminal convictions. With regard to agencies in the case of young babies there were issues of capacity and organisational climate; a preoccupation with thresholds and whether or not the case met the child protection threshold.

With regard to older children who may be 'hard to help', factors associated with the children were self-neglect; chronic illness; sexual exploitation; going missing; bullying; suicide. Family and environmental factors included; pattern of hostility and cooperation; family history of neglect; previous child death; poverty; poor living conditions; frequent house moves and accidents.

Factors associated with professionals and agencies included professional anxiety and reluctance to act and challenge supervision; ethnicity challenges; understanding and dealing with neglect; keeping track of families and the child not being seen or heard.

With regard to the stage 2 categorisation of the Layer 2 cases; one in three cases were of neglect; these cases tended to be known to many agencies; long term neglect; 1 in 3 cases were physical assault; these were known to few agencies; most were shaken baby cases; context was one of known violence and volatility (87%).

One in three was agency neglect – often these were older children (over thirteen) with features of: long agency history; self neglect; suicide; assault of others; hard to help; and agencies had given up.

It was felt that most cases were too complex for serious injury or death to be predictable.

The co-existence of domestic violence, parental mental ill health and substance misuse increase the risks of harm to children but do not predict death or serious injury. Family volatility and a history of previous admission to A&E for the child present warning signs of abuse.

Marian said the team were able to draw a number of conclusions from their work. It had become clear that early intervention and working with need is part of the safeguarding continuum - and is not a separate sphere of activity.

Arguing over thresholds and looking for ways to avoid providing services can leave vulnerable children adrift.

There were a number of messages contributing to Inter agency working.

With regard to neglect: risks of recurring maltreatment are higher with neglect than other types of abuse. Practitioners need support to stop them becoming overwhelmed and to help them think and act systematically to avoid the 'start again' syndrome.

Marian reflected on what has been learned so far. The quantitative data provides baseline data and descriptive statistics for a (near) full cohort. Future studies can build on and be matched with this. A more rigorous knowledge base can be established. This could be split into serious injury cases and child death cases for other comparison.

The qualitative data provides possibilities for cautious interpretations including that neglect and coexistence of parental domestic abuse, mental ill health and substance misuse increases the risk of harm to children but does not predict death or serious injury.

Most cases are too complicated to predict death or serious injury but better recognition and prevention is possible if long term neglect and low intervention physical assault cases are understood better.

There is a need for further awareness of a highly vulnerable group of older adolescents neglected by agencies.

## **7 Reviewing the Process of Case Management Reviews in Northern Ireland – John Devaney**

Dr John Devaney is a lecturer in Social Work at Queen's University Belfast. He was previously a professional advisor to the Eastern Area Child Protection Committee and Principal Social Worker for the Eastern Health and Social Services Board.

In his presentation, John presented work conducted jointly with Dr Anne Lazenbatt and Dr Lisa Bunting which evaluated the process of Case Management Review in Northern Ireland. As yet there has been no analysis of content of CMR reports.

The case management review system has been operational in Northern Ireland since 2003. To date around 20 reviews have been completed. There is some evidence of the process not functioning optimally with delays reported in completion of reviews; variable quality in the standard of reporting; difficulties in translating recommendations into action.

In 2009 the Area Child Protection Committees (ACPCs) will be replaced with a single Safeguarding Board for Northern Ireland.

The study by John Devaney et al was commissioned by the Department of Health, Social Services and Public Safety and conducted between June and December 2008. Its purpose was to gain the views of key stakeholders about the strengths and weaknesses of the CMR process and to scope other suitable processes for investigating adverse incidents; and then to make recommendations for the refinement of the current CMR process.

The study used the 'Delphi Technique' as a method of consulting stakeholders and structuring a group communication. A 3 level process was used. In Round 1 a panel of experts was selected and a first round of semi-structured interviews completed to generate qualitative data. In round 2 a second sequential (iterative) questionnaire, a review of experts' opinions was undertaken to prioritise and rate issues identified, looking for areas of desirability and feasibility. In Round 3 the experts' responses were evaluated and the results communicated to all stakeholders for consensus opinions.

Round 1 identified the key stakeholders as Chairs of the 4 ACPCs; a sample of Chairs of completed CMRs; Directors of Children's Services in 5 HSC Trusts; a sample of Senior Managers from organisations/disciplines represented on ACPCs; Senior Officials from DHSSPS and the Department of Education; the Chief Coroner; the Director of Legal Services.

The Stakeholders disciplines were Social Work (10); Civil Servants (4); Nursing (3); Education(2); Paediatricians (2); Legal (20); Police (1); Adult Psychiatry (1); Chairs (4).



Stakeholders were asked a number of questions at interview including:

- What involvement have you had in the current CMR process?
- What do you think the purpose of such a review process should be?
- What do you think are the strengths of the current process?
- What do you think are the weaknesses of the current process?
- How helpful have the recommendations been to date for improving policy and practice?
- Do you think the current CMR process could be improved, and if so, how?
- What are the key features you would like to see in any new review process?
- Who should have overall responsibility for any new review process?
- Who should commission any new review process?
- Who needs to be involved in the Review process (organisations; individuals; professionals; family)?
- How should any new process interface with other investigatory processes, such as the disciplinary process, criminal investigations, care proceedings and coroners inquiries?
- How could the quality and effectiveness of a review process be ensured?
- What could be done to ensure that the outcome of a review improves practice?

Stakeholders were also asked about:

- Ownership of process and outcomes
- 'One size fits all' approach
- The degree of independence
- Lines of responsibility
- Recruitment, selection, preparation and on-going support for Chairs, Panel Members and those completing Individual Agency Reviews
- Resources
- Compare and Contrast 'near miss/safeguarding incident type cases each year to compare with findings from CMRs
- Quality of reports and recommendations
- Link with wider governance processes
- Dissemination of Learning
- Involvement of family members and staff in informing process

In Round 2 there was almost full consensus for the following themes and issues:

- All Panel members must undergo some initial training in preparation for their role
- Staff who will have responsibility for completing an individual agency review should receive training to assist them in their role
- A standardised format for the presentation of chronological data in individual agency reviews should be developed
- Staff should ordinarily be expected to make themselves available to be interviewed if required
- Regional trends and commonalities should be identified and disseminated regularly by the Safeguarding Board

There was least consensus for the following measures:

CLiCP Seminar: Learning from review of child deaths and serious abuse cases in the UK

- The new Health and Social Care Regional Board should ultimately be responsible for the CMR process
- The current criteria are too narrow and other types of cases or situations should be covered by CMR processes
- The individual agency review should be purely a summary of agency involvement in a case gleaned from records
- The report and its findings should not be made available publicly

The key results that have been submitted for consultation and consensus building are:

- That responsibility for commissioning; conducting; reviewing and dissemination of CMR findings should be invested in the new Safeguarding Board of Northern Ireland
- Better preparation and support is required for key individuals involved in the CMR process in order to improve the quality and consistency of reports
- That a copy of any report produced should be shared with all appropriate agencies and departments to assist in the formulation of legislation and policy and to inform performance management processes.

## **8 Child Death and Serious Abuse Cases in Scotland**

In the absence of national data from SCRs in Scotland, Sharon Vincent from CLiCP highlighted findings from her research analysing major child abuse inquiries and reviews where there has been a published report in Scotland. Gillian Buchanan, Lead Child Protection Officer for the City of Glasgow Child protection Committee, provided information based on her analysis of cases in Glasgow. Together the papers provide some useful information and learning from child death and significant cases in Scotland.

### **8.1 Findings from a Review of Child Death and Serious Abuse Cases in Scotland – Sharon Vincent**

Sharon highlighted that the aim of her research was to review, summarise, analyse and compare inquiry and review reports relating to major child protection cases in Scotland between 1960 and 2007. The criteria for inclusion in the study were cases where one or more children had been killed or suffered significant abuse; where there had been some kind of inquiry or review process resulting in a publicly available report.

While some local authorities in Scotland were conducting their own reviews of child deaths during this time, these reports were not accessible nor were they in the public domain. The focus then was on cases of national significance that had had implications for shaping child protection policy nationally.

Sharon was aware of findings from analysis of reviews based on English cases. The research examined whether or not there were notable differences between major cases in Scotland and elsewhere. Research questions addressed were:

- What were the key inquiries/reviews?
- What were the main circumstances surrounding the inquiries/reviews being set up?
- What is the nature of the inquiries/reviews?
- Are there consistent messages?

## CLiCP Seminar 2: Seminar Report

- Is there a pattern to the findings and conclusions?
- How do the themes compare with those identified in other parts of the UK?
- What impact have the findings had on policy?

The 10 cases selected for inclusion in the study were as follows:

- Richard Clark – 1975
- Orkney 1991
- Dunblane 1996
- Edinburgh 1999
- Kennedy McFarlane 2000
- Caleb Ness 2003
- Carla Nicole Bone 2003
- Eileen Siar 2005
- Colyn Evans 2005
- Danielle Reid 2006

Limitations to the study included that the numbers of cases were small. Some reports were published some time ago; they represented a broad spectrum of kind of cases; some information was missing. The cases fell into 3 inquiry types:

- Inquiry ordered by a secretary of State for Scotland
- Independent Inquiry/Review
- Inspection Agency Review

Across the 10 cases, a number of coherent themes and factors were identified. Factors associated with children included the following:

- Young children were most at risk
- Girls were at more risk than boys
- Only children or youngest children were most at risk
- Children with special needs, with health problems; with behavioural or learning difficulties were also at more risk
- Children with previous experience of neglect, physical or emotional abuse were more at risk

There were a number of common themes relating to families. In 4 of the 10 cases analysed, the perpetrator or alleged perpetrator was the mothers' partner. In 2 cases parents were among the perpetrators. Family friends were implicated in 3 cases; residential care staff in one case; and a stranger in 2 cases.

All the children were killed or abused by men; co-habitees of mothers in most cases (although women were also implicated in some cases).

There was a theme of dangerous men living with vulnerable women.

It was not always known that there were dangerous men in the households.

The age of adults in the families could not always be established from the reports; but parents were not always young.

There was a theme of adults having come from abusive families themselves, or having been in the care system.

Socio-economic data was often missing but there was evidence of financial problems.

Housing was a significant issue with families often having frequent house moves; housing agencies could potentially play an important role in protecting children and young people.

A high proportion of adults had been involved in criminal behaviour; some had convictions for violent crimes or crimes of a sexual nature; police and criminal justice social workers may hold important information that can protect children.

There was a high prevalence of mental illness; mainly depression among the adults involved; also of substance misuse.

There was a theme of adults with a learning or other disability.

There was evidence of adults suffering from social isolation, with poor support networks. Parents were often viewed as loving but the presence of risk factors reduced their capacity to care for and protect their children.

In many cases there was evidence of multiple risk factors.

There was limited evidence of domestic abuse but this was not always recorded. Where it was not explicitly recorded, there was sometimes evidence of it in the body of reports. There was some evidence of women being scared of partners and some men were known to police as violent individuals. Mothers were often vulnerable because of disability, mental health issues, lack of social support.

The incident that was the cause of the Inquiry or review was rarely a one-off episode – there was often a history of abuse and neglect.

In these 10 cases, social work had had contact with most of the families; however, most were 'children in need' rather than 'child protection' cases.

Children on the margins of the child protection system may be particularly vulnerable.

There was a high level of contact with universal services who may have an important role to play in identifying children at risk.

Many of the adults involved had contact with adult services.

Most families were co-operative and willing to receive help – there is a need to ensure that co-operation is not automatically viewed as progress being made.

Some families and individuals could not be contacted in the week(s) heading up to the incident – there were missed appointments, failure to attend school – these may be signs that something is wrong.

Sharon drew a number of conclusions about the risk factors identified from major Scottish cases:

- The prevention of child death and serious cases requires professionals to prioritise the most serious and concerning cases.
- We need to understand more about what characteristics of family relationships might place children at increased risk
- While the factors that may increase the likelihood of harm have been identified, it may be unrealistic to expect professionals to identify in advance all children who are at increased risks.

Sharon then made concluding remarks:

- Inquiries and reviews have had a substantial impact on child protection policy and practice; they have probably been the most influential factor in bringing about policy and practice change in Scotland and the rest of the UK.
- Many changes in legislation have followed inquiries and reviews and some reports have had a major influence on the development of the child protection system.
- There is much to be gained from a review of tragic cases and there is clearly a need to improve practice
- Some changes which have been made as a result of recommendations in inquiry and review reports have been positive
- Inquiries often lead to structural change
- The process of conducting a review/inquiry into such cases is expensive and resource intensive
- There is no evidence that policy change introduced as a result of inquiry/review has reduced the number of child death or significant abuse cases or led to better outcomes for children
- Most practice is good and most children are protected
- Emphasis should be on sharing good practice and not on reacting to examples of bad practice.

## **8.2 Learning Lessons from Significant Case Reviews in Glasgow - Gillian Buchanan**

Gillian Buchanan qualified as a Social Worker in 1990 and is currently Lead Officer for Glasgow Child Protection Committee. She has held a variety of posts specialising in child protection for the past 15 years. As part of her remit for Glasgow Child Protection Committee, Gillian has undertaken a number of significant case reviews, exploring inter-agency and single agency practice. She has also undertaken a review of significant case reviews conducted in Glasgow since 1999 and identified a number of recurring themes.

Gillian began by outlining the process for reviewing child deaths in Glasgow. She discussed some of the themes beginning to emerge from her analysis of case reviews there. Glasgow does have a procedure for reviewing child deaths and significant cases. The process is that any service can refer a case for Significant Case Review. A Significant Case Review Panel is then set up; with parameters for the review set up and timescales agreed. The role of the working group is also agreed. A composite report with recommendations is produced.

Since 1992, 22 Serious Case Reviews have been instigated in Glasgow with numbers increasing substantially in the past three years. In 2008 Glasgow reviewed the recommendations from all previous reviews.

The findings of recommendations from all of the previous reviews can be broken down into a number of themes. These are:

- Recording issues
- Assessment issues
- Communication and information sharing issues
- Procedural update requirements
- Decision making issues
- Issues with addiction services
- Training issues.

With regard to recording issues, the review highlighted issues with data input and accuracy; minute taking and level of analysis.

With regard to assessment, the review highlighted that there was little analysis of family chronology; poor assessment of children's needs; lack of focus on the impact on the child and a lack of clarity around desired outcomes; and poor planning.

With regard to communication and information sharing: within services there were often issues around communication between different services; between agencies there were issues with minute taking and attendance at meetings was often not all inclusive.

There were issues relating to non compliance with procedures; there were gaps in procedures – eg sometimes agencies did not have in place a vulnerable young person's protocol.

With regard to decision making, reasons for decisions were often very poorly recorded. This included the decision to take action as well as the decision not to act.

With regard to addiction services, a number of reviews included involvement of addiction services. There were issues relating to methadone clinics; around assessment and links between children and families service and addiction services.

There were issues around training. Some reviews resulted in a very specific recommendation about the need for training on a particular point. A more generic point to emerge was around the dissemination of learning from the reviews.

With regard to learning lessons from the review, given that many of the issues emerging from the reviews were recurring, this raises questions about what difference reviews make; about how best to implement recommendations and how to manage expectations.

## **9 Serious Case Reviews in Wales**

There were 2 contributions to the Seminar from Wales.

### **9.1 Serious Case Reviews in Wales - Lesley Williams**

Lesley Williams is a lecturer in Social Work at the University of Wales (Newport). Her career in Social Work spans 35 years and has involved managing a Family Centre. She has spent several years as an inspector and managing inspector and has spent six years in a Community Care Trust where she line managed registered care and nursing homes. She has also had responsibility for policy development and implementing and monitoring a quality assurance system. She currently lectures on the BA Social Work Programme at the University of Wales (Newport).

Lesley's presentation was based on an analysis of 12 SCRs in Wales from 2001. The study built on previous analysis of SCRs in Wales conducted by Colton et al 1996; Owers et al 1999; Brandon et al 2002. Of the 12 cases, 10 related to child deaths; 2 related to serious injury; one related to suicide.

The aim of the study was to consider whether there were lessons to be learned in relation to 'Working Together'; and to assess whether the previous report has led to any changes in practice and identify common themes and lessons from those reports since June 2001. The specific objectives were to identify recurring themes; consider the action plans arising from the reports; highlight any actions that should be taken to address issues raised by the reports; highlighted examples of good practice. A literature review was conducted as part of the study.

31 themes were identified from the Case Reviews; these can be grouped under 5 headings; parental factors; family factors; child factors; agency factors; factors relating to individual professionals. The most common features shared by cases were:

- Poor inter-agency communication
- Lack of adherence to procedure
- Inadequate record keeping
- Poor assessment of need and risk
- Mental health/emotional issues of parents
- Paternal criminality
- Domestic violence
- History of parental child abuse/neglect
- Lack of attention to the voice /behaviour of the child

There were a number of themes identified that had not been adequately addressed since the previous review. These were:

## CLiCP Seminar 2: Seminar Report

- In a number of cases there were either no assessments or inadequate assessments
- In one case an independent assessment was not critically evaluated for its implications, nor did the assessment take account of historical factors
- In 2 cases there was neither a sufficient analysis of risk or sharing of implications of risk with other professionals
- In one case there was a lack of acknowledgement of additional information which may have provided indicators of parenting potential.

The review made a number of comments on the effectiveness of the action plan arising from the reports as follows:

- Five case reviews had action plans. Of these four had no system for monitoring or reviewing progress
- The framework for recording actions was inconsistent across all five cases. A practitioner who acts as a co-ordinator could assist this process
- Five case reviews had no action plans and no evidence that recommendations from the overview report had been acted on
- Two cases had overall strategic plans which were not sufficiently specific to enable a feedback mechanism

Suggested actions that should be taken to address issues raised by the reports included (only on the 5 cases that had action plans):

- One case clearly reflected recommendations in the review report and how these were to be acted on. Actions were specific and the plan recorded how the action was going to be evidenced
- One case demonstrated how it would respond to 'clearer communication through producing minutes and establishing a task group to provide guidance for health professionals on record keeping
- One case identified the need to ensure measurement of the effectiveness of knowledge of agency protocols and procedures.

The review also highlighted examples of good practice, as follows:

- Three cases noted the Health Visitor records identifying needs at an early stage and made referrals to appropriate resources
- Seven cases noted social workers /social services as recognising good supportive interventions
- One case identified duty systems as offering appropriate communication and follow-up when the duty or senior worker was unavailable
- Two cases acknowledged the way in which the police immediately responded to a domestic violence referral
- In one case, foster carers were noted as providing a high and committed standard of care
- In three cases no examples of good practice were identified within the case reviews

Key suggested actions were:

- Attention to gathering, recording, monitoring and sharing information
- Clearer systems to ensure sound monitoring and evaluation of processes and procedures



- Review of standards of case review recording
- Quality information rather than quantity: consider national guidance for a framework for producing serious case reviews
- Develop learning sets to promote a learning culture

## **9.2 Serious Case Review: a case for serious review: Jonathan Corbett**

Jonathan Corbett is currently Acting Chief Inspector in Wales – his substantive post is Assistant Chief Inspector in the Care and Social Services Inspectorate in Wales where he leads the Children's Services and Improvement Division. He provided reflections on the SCR process in Wales. Jonathan opened his presentation with a number of statements:

- There are few circumstances that engender such strong emotions in the population than the significant harm or death of a child where neglect or abuse is suspected
- People working in the field of child protection have one of the most difficult jobs that exist
- The unpalatable truth may be that whatever we do we will never be able to protect all children all of the time
- Organisations do not kill children, they do a very difficult job in often very difficult circumstances to successfully protect many children
- Organisations and professionals working individually and collectively can and do make a difference to children
- To be effective requires constant vigilance. This is difficult. But working together as a team of professionals from different agencies makes it more achievable

Jonathan then reflected on why mechanisms in place to review child deaths and serious cases in England and Wales were set up:

- To identify whether there are lessons to be learned from the case about the way local professionals and agencies work together to safeguard children
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence
- Improve inter-agency working and better safeguards to children
- Identify examples of good practice

He posed the question 'do serious case reviews achieve the objectives set?': his answer to this is partly 'yes' and partly 'no'. Yes in that as a result of SCRs we have improved knowledge of the factors that leave children exposed to greater risk of harm; and of how these interact with each other; and that systems to protect children can be improved as a result. 'No', in that the focus of SCR as currently constituted may be too much on process and not on the outcomes. They may not facilitate timely and effective learning and may absorb significant amounts of time and resources. They may be of variable quality and there is limited evidence of their efficacy in improving individual practice and inter-agency working. They keep reporting the same problems.

In answer to the question about where we go from here with SCRs, Jonathan suggested there were 2 possible options: (1) improve the system we have, and (2): revisit how and why we conduct SCRs.

Jonathan suggests that the reality is that it is important to continually question and challenge; that constant vigilance has to be the mantra. Protecting children is not about waiting for things to go wrong before we learn how to do things better. He argued that it has to be part of our culture and our daily working lives that we challenge ourselves and each other for it is only by doing this that we will really learn and enable the next social workers or generation of child protection professionals to feel the security of working within a difficult but supportive and dynamic environment where we pool our collective knowledge and use it to best effect in our respective roles in protecting children.

Jonathan posed the question of what this would mean for SCRs. He counterpoints a culture of constant review and challenge with that of serious case reviews. In this system, SCRs would be reserved for those cases where professionals and systems have not protected a child. He suggested that the number of such cases in Wales is relatively low. One option might be to consider establishing a core team of professionals with levels of competence, knowledge and skill to independently review what happened; to quickly feed back outcomes. One drawback to this would be securing ownership of this at local level.

Jonathan concluded by suggesting that SCRs as currently constituted may not best serve children, professionals or organisations well. They can be improved but there is little evidence that this will have better overall impact.

### **10 Summing Up: Wendy Rose**

Wendy Rose is a Senior Research Fellow at The Open University. For 11 years she was a senior civil servant in England advising on children's policy. She is currently a professional advisor working with the Scottish Government on its 'Getting it right for every child' (Girfec) policy. She highlighted that Sharon Vincent had set out the key similarities and differences between different parts of the UK. Professor Pamela Munn had posed a question early in the day about whether or not these differences between countries were the result of clear rationale and strategic decision making or whether it was about something else. Wendy suggested that differences were the result of complex interactions between history and governments.

Marian Brandon had identified 3 categories of abuse that it was important to consider: neglect, physical assault, and agency neglect in relation to older children. Marian had also highlighted the importance of recording the contexts and circumstances that children are living in. While Marian questioned whether we would ever be in a position to predict child deaths and serious abuse, her presentation highlighted the need to be more aware of risk factors. From Sharon Vincent's presentation, Wendy highlighted the importance of considering children on the margins; on the margins of society and on the margins of the child protection system. This brought us to thinking about thresholds. There was perhaps a need for practitioners to keep asking themselves: is this something that I should be concerned about; who do I talk to about it. There is a need to think about each child. The emphasis should be on early intervention and universal services. This highlights the very important role that can be played by universal services, especially health visitors. There was a

need for transparency and accountability with all agencies geared up and acting appropriately in terms of responsibility.

From Jonathan Corbett's presentation, Wendy highlighted that it may be time for a rethink. Lord Laming's reports have placed more and more emphasis on SCR, requiring more resources and with more people caught up in the process. We might now wish to consider different processes. Consideration might be given to setting up a small permanent group of people able to conduct reviews timeously, able to provide speedy feedback to workers. This may be a model for the smaller countries of the UK to consider.

In terms of learning lessons, there is little evidence that they lead to better outcomes for children. There is some evidence that they can lead to positive structural change.

Wendy reminded delegates that Marian Brandon had highlighted the need for care in drawing conclusions from such cases. Also, there is a need for more disaggregation by ages of children, types of abuse and circumstances within which children are living. Two main points struck Wendy. First, is there a possible role for Inspectorates in helping to raise these issues? Second, how do we keep a focus on improvement? There needs to be dialogue and engagement for there to be improvement. We may need to think again about the culture we work in - all of our agencies need to be learning organisations. Inter-agency bodies too need to be learning continually. Professional accountability and professional challenge will always be important but a key issue is how to ensure reviews of cases are reasonable, proportionate and timely. At the same time, it is important to find new ways of learning in a more positive culture if we are to improve our ability to safeguard children.

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