

The voice of the child: learning lessons from serious case reviews

A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010

This report provides an analysis of 67 serious case reviews that Ofsted evaluated between 1 April and 30 September 2010. The main focus of the report is on the importance of listening to the voice of the child. Previous Ofsted reports have analysed serious case reviews and identified this as a recurrent theme which is considered in greater detail here.

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Executive summary

This report covers the evaluations carried out between April and the end of September 2010 of 67 serious case reviews. The main focus of this report is on the importance of listening to the voice of the child. Previous Ofsted reports have analysed serious case reviews and identified this as a recurrent theme. This report provides an opportunity to explore this key issue in more depth and draw out detailed practice implications.

Key findings

There are five main messages with regard to the voice of the child. In too many cases:

- the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
- agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
- parents and carers prevented professionals from seeing and listening to the child
- practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child
- agencies did not interpret their findings well enough to protect the child.

Background

Ofsted has been responsible for evaluating serious case reviews since 1 April 2007. The review of child protection by Professor Eileen Munro is considering possible changes to the serious case review process. Professor Munro has recommended in her interim report¹ that in due course Ofsted should cease to have responsibility for the evaluation of serious case reviews. The reviews and the evaluations under consideration here were conducted in accordance with the current statutory guidance set out in Chapter 8 of *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*.² Annex A, sets out the circumstances in which a Local Safeguarding Children Board must consider conducting a serious case review.

Ofsted has previously published four reports on the lessons to be learnt from serious case reviews. These reports have covered serious case reviews evaluated by Ofsted between April 2007 and the end of March 2010.

¹ *The Munro review of child protection: Interim report, the child's journey*, Department for Education, 2011; www.education.gov.uk/munroreview/.

² *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, DCSF, 2010; www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010.

Many of the lessons identified in previous reports have been similar. Rather than repeat the same messages this report provides a thematic analysis drawn from evaluations completed during the six months from April to the end of September 2010. This report does not focus on the data behind the reviews, or the Ofsted evaluations of those reviews, but instead provides an in-depth focus on one theme: the voice of the child, drawing out practice implications for practitioners and for Local Safeguarding Children Boards.

Learning lessons: the voice of the child

1. This section focuses on the lessons to be learnt by the key safeguarding agencies from the 67 serious case reviews which were evaluated by Ofsted between the beginning of April and the end of September 2010, focusing specifically on the voice of the child.
2. Of these serious case reviews, 65 concerned a total of 93 children. Twelve of these 65 reviews were about two or more children, including one case involving a family of seven children and another which concerned a family of six children. The first of these two cases spanned two generations. Annex B contains the data relating to the profiles of the children and their families.
3. The principal focus of the other two serious case reviews was on adult perpetrators rather than on individual children and their families. The reviews examined the lessons to be learnt about local agencies' failure to identify abuse carried out over an extended period of time. These cases are therefore not included in this thematic report.
4. Six main messages were set out in the most recent Ofsted report, *Learning lessons from serious case reviews 2009–2010*.³ Those messages continue to recur in the reviews covered by this report. They are about the importance of:
 - focusing on good practice
 - ensuring that the necessary action takes place
 - using all sources of information
 - carrying out assessments effectively
 - implementing effective multi-agency working
 - valuing challenge, supervision and scrutiny.
5. Above all, previous Ofsted reports have identified that too often the focus on the child was lost; adequate steps were not taken to establish the wishes and feelings of children and young people; and their voice was not heard sufficiently. This report provides an opportunity to consider in more detail the

³ *Learning lessons from serious case reviews 2009–2010* (100087), Ofsted, 2010; www.ofsted.gov.uk/publications/100087.

practice implications of these themes for practitioners and for Local Safeguarding Children Boards.

6. Five key themes about the voice of the child have been identified in the serious case reviews evaluated between April and the end of September 2010. In too many cases:
 - the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
 - agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
 - parents and carers prevented professionals from seeing and listening to the child
 - practitioners focused too much on the needs of the parents, especially vulnerable parents, and overlooked the implications for the child
 - agencies did not interpret their findings well enough to protect the child.
7. These five messages about the importance of listening to the voice of the child are illustrated in the following pages by examples from the 65 cases involving children. All the material is drawn from published executive summaries.

Seeing and hearing the child

8. Serious case reviews highlighted the importance of seeing, observing and hearing the child. However, in some of the reviews they found that the child was not seen by the professionals involved or was not seen frequently enough. In other cases, even where the child was seen, they were not asked about their views and feelings. Serious case reviews also stressed the importance of ensuring that practitioners' observations are clearly recorded and the consequences which can arise when this does not happen.
9. Many of the cases concerned babies and young children who were too young to express their feelings in words. One serious case review highlighted good practice in addressing this issue. Attention had been given to reporting and recording observations of the parents' interaction with their baby during his time in the neo-natal unit. Staff were aware of risk factors and early indicators in the context of safeguarding. In this case, staff observations did not make them concerned as both parents seemed appropriately involved in caring for their baby.
10. However, other serious case reviews concluded that alternative approaches were not always used. For example, while the subject of one review was a baby who had died following non-accidental injuries, there was concern that no-one had spoken to the three-year-old half-sibling when she was in distress. The serious case review found that: 'No consideration was given to the impact of the adult's capabilities on the children or on what the older children had to say.'

The impact was that assessments about the children's needs missed a vital component.'

11. Although some reviews underlined the importance of observing the child's behaviour with the parent, others also stressed the need for children to meet on their own with practitioners. In a case involving a teenager who committed suicide, one of the lessons learnt was that the young man was rarely seen on his own and the majority of professionals did not seek his views. The review concluded: 'Children must be seen alone by professional staff working with them, and their wishes and feelings recorded.'
12. Another finding was the importance of the location chosen for seeing the child. In some cases, this meant that the children needed to be seen in places that were familiar to them. This was illustrated by the case of a boy with autism who died as a result of smoke inhalation from a house fire. He had been left on his own in the building, trapped in a room with no internal door handle. Although assessments had taken place, the review found:

'Most of the assessments undertaken directly with the child were made at the respite carer's home, the respite unit or the school. He was rarely seen at home. Some professionals involved in his care never saw the child.'

13. By contrast, one serious case review highlighted the difficulties that children faced in revealing their concerns when they were seen in their home environment. In this family, the children had suffered from neglect, physical and sexual abuse over many years. It was only when the children were removed from the home environment that they were able to speak about the abuse which they had suffered. A lesson from the review was that priority needed to be given to providing a safe and trusting environment, away from the carers, for the children to speak about their concerns.
14. In one case, one of the children had revealed small pieces of information about his life at home while at school. However, the key professional who received this information, saw it as a priority that the parents be informed. As the review stated:

'The emphasis on sharing information with parents must not override the rights of a child to privacy and the provision of a safe way to discuss their concerns with professionals.'

15. Serious case reviews involving disabled children commented on the importance of practitioners using appropriate means of communication. One case concerned a disabled girl who was found dead in her bedroom, which had been locked overnight by her parents. A conclusion of the serious case review was that:

'Disabled children have the right to receive a comprehensive child-focused assessment of their needs in which their views and expectations are

central, with the full participation of all agencies involved so that the needs of the disabled child are not allowed to mask safeguarding and child protection concerns.'

16. In 'seeing and hearing the child' there are a range of adults that have both the opportunity and the information to help the child be 'seen' and 'heard'. These include grandparents, neighbours and members of the public. For very young children, this may be by simply sharing their perceptions and observations. The failure of agencies to take account of information that is held by others is explored in more detail in the next section: 'listening to adults who speak on behalf of the child'.

Practice implications:

Practitioners should:

- use direct observation of babies and young children by a range of people and make sense of these observations in relation to risk factors
- see children and young people in places that meet their needs – for example, in places that are familiar to them
- see children and young people away from their carers
- ensure that the assessment of the needs of disabled children identifies and includes needs relating to protection.

Listening to adults who speak on behalf of the child

17. A recurring message in these serious case reviews is the important role of adults who are in a position to speak on behalf of the child. The adults include parents, grandparents, neighbours and members of the public. This section considers examples where the adults put forward important information, but their views were not taken seriously enough.
18. In many cases there were risks from an over reliance on what parents said and this is addressed in the next section of this report. However, there were also important messages when professionals overlooked the views of parents. One such case involved a family in which the mother and father were separated. One of the children, living with the mother, was sexually abused by the mother's partner. The father passed information many times to Children's Services and to the police that the mother's partner was a registered sex offender and had unrestricted access to the children. Although the agencies took some steps to monitor or restrict access, the serious case review concluded that the child's father 'was not properly listened to and it is essential that safeguarding professionals who come into contact with the public never

forget how it feels for people when they are trying to penetrate what to them is an apparently impervious wall'.

19. A common theme in these serious case reviews, which has also been highlighted by Local Safeguarding Children Boards in previous serious case reviews, has been the tendency for agencies to overlook the role of fathers, male partners and other men living within the families. In many instances, the concern related to the risk that the men posed for the children, but in other cases the men had information that agencies would have found helpful in understanding the child's situation, especially when the child concerned was too young to speak for itself.
20. In one example, a baby aged two months suffered head injuries when in the sole care of his mother. She had been drunk at the time and had a history of alcohol misuse, the impact of which had been underestimated by the professionals involved. Despite the fact that information was gathered from other relatives in this case, this did not include the father, even though he was living with the mother. A finding from the review was that the father had been marginalised.
21. In four of the cases covered by this report, lessons were learnt about the failure of agencies to recognise the role of grandparents in representing the voice of the child. One or more of the grandparents in each of these cases reported their concerns about the care of their grandchildren but this did not lead to effective action to prevent the serious incident. The Local Safeguarding Children Boards found that the views of the grandparents should have been taken more seriously and should have contributed to a more complete understanding of the problems in the families.
22. One of these reviews concerned a family of seven children over two generations. The grandmother had contacted social care on a number of occasions, alleging sexual and physical abuse of the children by the children's stepfather. She had also written to the Director of Social Services.⁴ This did not trigger child protection procedures. It was over a decade later that disclosures were made by the eldest children in the family, revealing the long-standing abuse that had taken place.
23. Eight reviews also commented on the role of neighbours and members of the public, concluding that there was a need to facilitate channels for the public to speak up on behalf of children when they had serious concerns. One Local Safeguarding Children Board said:

'This review highlights the fact that often the agencies have to rely on members of the public as their "eyes and ears". Neighbours, family and

⁴ The letter to the Director of Social Services pre-dated the establishment of Directors of Children's Services.

friends are often in a better position to see or become aware of possible child protection issues. The potential value of the general public in the child protection task needs to be better exploited. Some thought and attention needs to be devoted to development of strategies to unlock the potential.'

24. In some instances, where a parent committed a serious act against a child, the reviews commented that no concerns had been reported by members of the public, even though people had witnessed bizarre behaviour by the parent. By contrast, in other cases concerns reported by members of the public had not been followed up adequately by the safeguarding agencies. One review concluded that it was a salutary lesson that the best practice came from neighbours and family friends who had raised alarms about the family. This Local Safeguarding Children Board recognised the barriers that neighbours may face in terms of disbelief from professionals and sometimes intimidation from the families of the children whom they are trying to protect.
25. However, one case illustrates the very valuable, and fortuitous, role of a member of the public. A two-year-old boy was taken by his mother to a supermarket. A member of staff in the supermarket noticed that the child was severely emaciated and that the mother was buying food suitable for a child aged only three to six months. Recognising the uniform of the boy's sibling, the staff member passed on the concerns to the school. Staff at the school identified the family and conveyed the information to children's social care. The boy was found to be suffering from severe malnutrition and developmental delay. These concerns had not previously been noticed by the agencies involved with the family.
26. Agencies which have regular access to the family home may also be in a good position to represent the child's perspective. For example, in one review a housing organisation recognised its potential role identifying situations or observing indicators that suggest children might be at risk. As a result of the review, the organisation introduced a reporting system to be used by housing repair staff if they wanted to refer a concern.

Practice implications:

Practitioners should:

- routinely involve fathers and other male figures in the family in assessing risk and in gathering all the information needed to make an assessment.

Local Safeguarding Children Boards should:

- consider how they can better engage the general public in safeguarding children.

Being alert to parents and carers who prevent access to the child

27. The third message from the reviews is the importance of practitioners being alert to parents and carers who prevent access to their children. When this happens, agencies are unable to hear the children's views or to make observations about the interactions of parents and carers with them. One review described, for example, how the children had been threatened into silence by the adults in their lives so that they were unable to reveal the catalogue of serious abuse that they had been experiencing.

28. In the most clear-cut examples, when practitioners tried to make contact with the families, the behaviour of parents and carers was aggressive and threatening towards the practitioners. This is illustrated in one case which found:

‘The fact that father was regarded as very volatile and potentially and actually quite violent is also likely to have constrained the effectiveness of practice in this case. On many occasions, professionals were not allowed into the home and/or prevented from seeing mother and the children. There were several periods of up to two weeks when professionals could not see or make contact with mother or see the children.’

29. Serious case reviews found that practitioners failed to make the connection between the difficulties that they themselves experienced in these situations and the likelihood that the children in the family were also undergoing stressful and abusive behaviour. This is summarised in the multi-agency recommendation in one of the reviews:

‘When professionals from any agency have concerns about their own personal safety, they must always consider the implications for children from exposure to the same risk factors.’

30. There were other ways in which the actions of parents and carers resulted in professionals not seeing the children. These included examples in which the mother minimised the impact of domestic abuse or provided false assurance to professionals about the home situation.
31. This is illustrated by a case in which a teenager was shot by his mother. A referral had previously been made to children's social care by a community psychiatric nurse. However, this had not resulted in an assessment because the mother had provided assurance that there was no need for social care to be involved. In this example, the Local Safeguarding Children Board found that the views of the parent or carer had been too easily accepted, rather than professionals seeing and talking to the children directly.
32. Another review concerned a young disabled child who suffered a serious incident of domestic abuse. This case also illustrated the need for professionals to challenge parents. The Children with Disabilities Team saw their role as family support workers to the exclusion of identification of child protection risks. The serious case review found that the need to respect the privacy of parents had led to an inadequate focus on the child. Too much attention had been paid to forming a trusting relationship with the adults at the expense of considering whether good enough care was also being provided for the child.
33. Other ways in which parents and carers prevented agencies from seeing children were through missed appointments for the children or by withdrawing them from school. The issue of children being educated at home was a factor in three of the 65 serious case reviews.
34. One of these serious case reviews was carried out after a teenage girl disclosed to the police that she and her elder sister had been sexually abused by their father. There had been concern over several years about the care provided for the children in the family. The two sisters and two other siblings had been withdrawn from school by their parents to be educated at home. The serious case review concluded that, with the benefit of hindsight, it was clear that the children had been withdrawn from school to avoid the scrutiny of the authorities. A related lesson was that when the children were withdrawn from school, children's social care should have been alerted because of the previous concerns about the family.
35. In another case that involved a child's death due to malnutrition, the child and two siblings had been removed from school to be educated at home. The review concluded that:

'At no point were any of these children given the right to choose the location, the nature of provision, or any right to consultation to express their views as part of this process. There was no independent access to friends, family or professional agencies; they were isolated'

and

‘There are no mechanisms to ensure that a satisfactory education continues to be received, or that young people’s welfare is appropriately safeguarded, except with the express cooperation and participation of parents and carers.’

36. The serious case review found that the unintended outcome of home education legislation in these instances had been to restrict professionals’ access to the children. This worked to the advantage of those parents who wanted to conceal abuse.

Practice implications:

Practitioners should:

- consider the implications of risk to children where they have concerns for their own personal safety
- ensure that respect for family privacy is not at the expense of safeguarding children.

Local Safeguarding Children Boards should:

- consider how children who are home educated can receive the same safeguards as their peers.

Focusing on the child rather than the needs of parents and carers

37. A lesson from some of the serious case reviews was that practitioners had not listened sufficiently to the child or had not paid enough attention to their needs. This was because they had focused too much on the parents, especially when the parents were themselves vulnerable. As a consequence, agencies overlooked the implications for the child.

38. This was well summarised by one Local Safeguarding Children Board which stated:

‘The serious case review identifies the need to maintain a focus on the child throughout any work being undertaken and suggests that there can be a tendency to lose balance and focus more on the needs of the parents, particularly the main caregiver.’

39. An example of this concern was highlighted in a case involving a baby boy who suffered non-accidental injuries. The mother had a history of mental health problems and there were reported issues of domestic violence in the family. The serious case review found that psychiatric professionals had shown sensitivity to the mother’s needs. However, they had discounted the

significance of the domestic abuse and how its interaction with the mother's mental health might increase risks for the baby.

40. There was a similar message from a serious case review that involved another young baby who suffered skull fractures. The family was known to agencies due to the mother's misuse of alcohol. In its conclusion, the Local Safeguarding Children Board found that staff in adult-focused health services should have established the mother's childcare responsibilities and should have assessed the impact of her drinking and depression on the child. The serious case review was concerned that, except on one occasion, some hospital staff had not made a link between the admission of a very drunk mother of a baby and how that affected her ability to care for her child.
41. This lack of attention to the impact of parental needs on the child is even more apparent when the child takes on a caring role for the parent. One case concerned a teenage girl who lived with her mother despite the fact that her seven older siblings had been removed from the mother's care. Concerns about the home situation over a long period included: inappropriate male adults in the home; allegations of sexual abuse; aggression by the mother to professionals and to the children; threats by the mother to take her own and the children's lives; and two apparent suicide attempts by the teenage girl. The review was carried out following disclosure by the girl that she had been sexually abused by a male lodging with the family.
42. In this case, many important lessons were learnt. One of these was that the impact of the mother's mental health on her daughter, and especially the caring role for the mother that the daughter had assumed, was never fully assessed. A finding of the review was that there should be formal consideration whether to undertake a young carer's assessment when there are concerns about parental mental health.
43. A recurring theme within these serious case reviews was the response of agencies, particularly the police, to the implications of domestic abuse on children within the family. One serious case review found that the police had dealt appropriately with the domestic abuse against the mother but had not responded to allegations of assault by the mother's partner on the children in the family. The Local Safeguarding Children Board concluded that the police should have initiated child protection investigations and found that they had failed to include details of these allegations when they notified children's social care about their contact with the family.
44. Even when the reported violence was between the parents and did not physically harm the children, there was a failure in several cases to consider whether the children were also at risk. As one review concluded:

'If the case had been managed with more rigorous attention to the needs of the children, rather than the main focus being on the domestic abuse by the father and on the mother's mental health problems, it is likely that

better arrangements would have been in place to ensure that the children were kept safe.'

45. One case took this concern a stage further. In this instance, the risk assessment did consider the effect of the incidents on the children who had been present but it had not taken account of incidents that occurred while the mother was pregnant. The review found that the unborn child was at great risk but he had not been considered by the agencies involved in the same way as a victim of the incident or as a child that had been present. The concerns were magnified further by the finding that the baby's grandmother had reported her concerns to the police and to health professionals but these had not been followed up sufficiently.
46. In respect of the unborn child, the agencies involved have a key role in representing the child's interests as a proxy for the voice of the child, including any safeguarding implications from their assessment of the family. This was evident in a case which involved the death of a baby on the day that he was born. The mother had concealed the pregnancy. It became apparent after the baby's death that she had concealed the pregnancies, to varying degrees, of her two other children who survived. The Local Safeguarding Children Board found that agencies, in their previous involvement with the mother both before and after the children were born, had had a focus on her rather than on her children. Agencies had not challenged the mother about her lack of engagement with the services they had provided for her.

Practice implications:

Practitioners should:

- recognise the specific needs of children and young people who have a caring responsibility for their parents
- always consider the implications of any domestic abuse for unborn children
- be alert to how acute awareness of the needs of parents can mask children's needs.

Interpreting what children say in order to protect them

47. The fifth message about the importance of the voice of the child is that, even when professionals gathered evidence from the child's perspective, there were too many cases in which they did not really listen to what they were told or did not interpret the evidence in a way that would safeguard the child. There was a difference between hearing the voice of the child and the actions that followed.

48. At the most basic level, children and young people felt that they had disclosed their concerns but these had not been followed up. For example, when family members were interviewed as part of one serious case review, they identified an occasion when one daughter had spoken to a teacher about her father's physical abuse of her and her siblings. They were surprised that no action had been taken and said that this had inhibited the child from reporting her father's later sexual abuse.
49. In another case, the serious case review found that at least twice the children in the family had identified safeguarding issues in front of professionals but neither of these occasions had led to a core assessment. The review referred to a quotation from one of the children that he had been hit by his father, which was contained in the referral that led to an initial assessment. A few years later, when the mother was arrested for being drunk in charge of a child, there was no child protection investigation despite one of the children being reported as saying: 'She's always doing this.'
50. Of particular concern were cases where allegations were made by different family members without this leading to action to protect the children. In the case about a family of seven children spanning two generations, referred to earlier, the serious case review found that one of the subjects of the review had attempted to alert professionals on at least three occasions. Allegations had also been made by the children's grandmother, a family friend and the stepmother but no effective action had been taken to protect the children. The failure of agencies was well articulated by the oldest girl in the family through her contribution to the serious case review. She identified the following missed opportunities for professionals to intervene: not seeing her alone; insufficient enquiry by school staff about visible signs of abuse; lack of curiosity by GPs despite her successive pregnancies; and lack of action by neighbours due to fear or uncertainty.
51. Even when practitioners did listen to children and others who represented the voice of the child, lessons were learnt about the difficulties and sometimes the shortcomings in interpreting what was seen and heard. In individual cases agencies overlooked or misinterpreted:
- signs of grooming by a sex offender
 - the significance of domestic violence and parental aggression
 - the difference between discipline, chastisement and physical abuse
 - the significance of poor school attendance
 - delinquent misbehaviour when it resulted from the offender being the victim of abuse by an adult
 - the impact on the child from fulfilling the role of carer for a parent
 - the impact of the agencies' low expectations about parenting because of local cultural norms.

52. In the lessons learnt from one review there was a recognition that professionals needed to improve their understanding of the available information in terms of assessment and the management of risks. The review found that professionals needed to ask the question, 'What are they trying to tell us?' when analysing children's behaviour.
53. One case that illustrates this concerned a teenage girl who had been the subject of images on the internet in which she was seriously sexually abused. She and her brother had both been ill-treated and neglected by their mother and sexually abused by their uncle. The family had been well known to agencies in three local authorities where they had lived. When agencies reviewed their involvement with the children it became clear that there was sufficient information for the abuse to have been recognised by practitioners long before the internet images were discovered. One of the main lessons for agencies from this review was the importance of practitioners being able to interpret the indicators of sexual abuse, including those potentially related to grooming and coercion.
54. A common theme from the reviews is that, when interpreting evidence about the child's perspective, professionals should not automatically accept what they are told by parents or carers at face value. One review concluded that there is 'a need for respectful uncertainty' when interpreting parental contributions. However, other reviews found that, in some circumstances, there is also a need to override the wishes of children and young people. Although the main focus of this report is about the importance of listening to the voice of the child, a salutary message from two of the reviews is that there are times when professionals should not accept everything that they are told or agree to everything requested by children and young people.
55. One of these two cases concerned an articulate teenage girl whose behaviour at times was very challenging for her mother and professionals. Her death was believed to have been self-inflicted. The review found that, although there were many positive aspects of the services provided for the girl by a range of professionals, agencies had decided not to hold meetings without her involvement. The serious case review concluded that this was an omission and that agencies had gone too far in their efforts to ensure that the girl's wishes and feelings were met. This case underlines the importance of professionals using their judgement, even where this means overriding the views of the young person.
56. In the second case, there had been concerns about abuse in the family over many years. Despite this, the young person had expressed a wish to stay at home, continuing to do so even after care proceedings commenced. Nevertheless, the review recognised that the girl had also demonstrated her unhappiness through her behaviour and concluded: 'What children say is only one dimension of understanding what they actually mean.' There was also support for this conclusion in the young person's own contribution to the

serious case review, in which she recognised that action to safeguard her should have been taken earlier.

Practice implications:

Practitioners should:

- ensure that actions take account of children and young people's views
- recognise behaviour as a means of communication
- understand and respond to behavioural indicators of abuse
- sensitively balance children's and young people's views with safeguarding their welfare.

Annex A: Working together to safeguard children

Working together to safeguard children requires that where a child dies and abuse or neglect is known or suspected, the Local Safeguarding Children Board must conduct a serious case review.⁵ It must also consider conducting a serious case review where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect
- a child has been seriously harmed as a result of being subjected to sexual abuse
- a child's parent has been murdered and a homicide review is being initiated
- a child has been seriously harmed following a violent assault perpetrated by another child or adult

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children.

The purpose of a serious case review is:

- to establish whether there are any lessons to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- to identify clearly what these lessons are both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result
- to improve intra- and inter-agency working and better safeguard and promote the welfare of children.

⁵ *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*, DCSF, 2010;
www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010.

Annex B: The children and the incidents

Of the 67 serious case reviews reported on here, Ofsted's evaluation judged one to be outstanding, 33 were good, 31 were adequate and two were inadequate. By comparison, in last year's report⁶ covering 147 reviews in the full year from April 2009 to March 2010, 62 were judged to be good, 62 were adequate and 23 were inadequate. Fewer serious case reviews have been judged inadequate in the period covered by this report and, for the first time since Ofsted took over responsibility for the evaluations, a review has been judged as outstanding.

The children

Of the 93 children, 39 children died. The other 54 were involved in serious incidents which resulted in a decision by the Local Safeguarding Children Board to carry out a serious case review.

The age profile of the children was similar to that found in previous Ofsted reports, as shown in Table 1. A majority of the children involved were five years old or younger at the time of the incident.

Table 1: Ages of children who were the subject of a serious case review evaluated by Ofsted between 1 April and 30 September 2010

Age range	Number of serious case reviews
Under 1 year	31
1–5 years	18
6–10 years	13
11–15 years	23
Over 16 years	8
Total	93

⁶ *Learning lessons from serious case reviews 2009–2010* (100087), Ofsted, 2010; www.ofsted.gov.uk/publications/100087.

Table 2 compares the age range of those who died and those who were subject to other serious incidents. There is little difference in the two profiles, except that a higher proportion of the children under five years died as a result of the incidents.

Table 2: Number of child deaths and other serious incidents by age group between 1 April and 30 September 2010

	Died	Other serious incidents	Total
Under 1 year	18	13	31
1–5 years	9	9	18
6–10 years	4	9	13
11–15 years	5	18	23
Over 16 years	3	5	8
Total	39	54	93

Forty-seven girls and 46 boys were the subject of the serious case reviews, which is a similar distribution to the findings in previous years.

Ethnicity data were recorded for all except two children. The largest grouping was White British (73 out of 93 children). No children were recorded as Asian; nine were recorded as Black African, Black Caribbean or Black Other; and eight were recorded as Mixed. In one case the ethnic category used (Afghan national) was not a standard census category, and in two cases the child's ethnicity was not stated as only the mother's ethnicity was known.⁷

There were nine disabled children, ranging from those with a learning disability to those with severe and complex conditions. Fifteen children had special educational needs and five of them had a special need statement.

Of the 93 children, 70 were known to children's social care at the time of the incident. There were other children who had been known to the services previously but were not known at the time of the incident.

Twenty-seven children were receiving services as children in need at the time of the incident; nine of these children died. Of the 27 children in need, 12 were the subject of child protection plans.⁸ A further 17 children had previously been the subject of a child protection plan at some stage in their lives.

Four children were looked after by the local authority; two of the children died. Of these two children, one was an unaccompanied asylum-seeking young person who

⁷ Census 2001 ethnic categories are used.

⁸ The children recorded as being children in need but not having a child protection plan included those who were children in need because of their disability, those who were looked after by the local authority and those who had previously been the subject of a child protection plan and continued to be judged to be children in need by children's social care services.

committed suicide while in semi-independent accommodation; the other was a disabled child who died of natural causes while living with foster carers.

The cause of death is shown in Table 3.

Table 3: Cause of death of the 39 children who died

Cause of death	Number of deaths
Homicide	
Murder by parent or carer	11
Other ⁹	11
Other external cause	
Suicide	5
Death from drowning	1
Accidents and adverse events	
Concealed birth	1
Overlay by parent or carer	2
Unknown cause	5
Natural causes	3
TOTAL	39

The deaths recorded as 'unknown cause' included cases where no definite reason could be determined by the coroner or no conclusion had been reached at the time that the serious case review was completed. The category covers instances of 'sudden unidentified death in infancy' and other cases in which young babies died, where overlay by the mother or the effects of parental use of alcohol or drugs may have been factors.

Apart from the 39 children who died, the serious case reviews concerned 54 other children. The most common characteristics of the incidents were physical abuse, sexual abuse or long-term neglect. In some instances there was a combination of factors.

⁹ Includes deaths arising from malnourishment, neglect, physical abuse, shaken baby syndrome or arson.

The above data are based on 65 of the 67 serious case reviews. The remaining two cases were about the perpetrators of abuse, rather than the victims. One case concerned a foster carer who was arrested for sexual offences against children whom he and his wife had been fostering over a 10-year period. The other case was about two perpetrators of physical and sexual abuse at a residential special school. This followed a disclosure by one of the students, which resulted in a major and complex investigation.

Annex C: The 67 Serious Case Reviews

Local Safeguarding Children Board	Serious case review evaluation	Date of evaluation letter
Barking and Dagenham	Good	12/08/2010
Birmingham	Adequate	07/04/2010
Birmingham	Adequate	14/06/2010
Blackburn with Darwen	Good	19/05/2010
Blackpool	Adequate	17/08/2010
Bradford	Good	26/07/2010
Buckinghamshire	Adequate	06/04/2010
Buckinghamshire	Adequate	24/08/2010
Bury	Adequate	09/07/2010
Cambridgeshire	Adequate	23/06/2010
Cambridgeshire	Adequate	28/06/2010
Cambridgeshire	Adequate	12/07/2010
Cambridgeshire	Adequate	27/08/2010
Central Bedfordshire	Good	11/06/2010
Derby City	Adequate	07/05/2010
East Riding	Good	26/07/2010
Enfield	Adequate	24/05/2010
Essex	Adequate	12/08/2010
Essex	Good	13/09/2010
Gloucestershire	Adequate	17/06/2010
Hackney	Good	09/08/2010
Hackney	Good	12/08/2010
Herefordshire	Good	16/08/2010
Hertfordshire	Adequate	14/04/2010
Hertfordshire	Adequate	19/04/2010
Hounslow	Good	06/07/2010
Hounslow	Inadequate	26/07/2010
Islington	Good	19/08/2010
Kent	Good	03/06/2010
Kent	Good	06/07/2010
Kingston upon Thames	Adequate	16/09/2010
Kirklees	Good	26/05/2010

Knowsley	Adequate	11/08/2010
Lancashire	Adequate	31/08/2010
Leeds	Good	13/05/2010
Leeds	Good	12/07/2010
Leicestershire and Rutland	Good	23/09/2010
Lewisham	Adequate	01/04/2010
Liverpool	Good	12/07/2010
Manchester	Outstanding	06/04/2010
Manchester	Good	19/04/2010
Manchester	Good	13/08/2010
Newham	Good	13/05/2010
North Lincolnshire	Adequate	27/08/2010
Nottinghamshire	Good	10/05/2010
Nottinghamshire	Good	17/06/2010
Rochdale	Good	06/04/2010
Rochdale	Adequate	11/08/2010
Rochdale	Adequate	27/08/2010
Rotherham	Adequate	17/06/2010
Rotherham	Adequate	05/07/2010
Rotherham	Adequate	26/07/2010
Sefton	Good	05/07/2010
South Gloucestershire	Good	11/06/2010
Southampton	Good	13/05/2010
Southend	Good	09/07/2010
Southwark	Adequate	20/09/2010
St Helens	Good	10/05/2010
St Helens	Good	23/09/2010
Swindon	Adequate	03/08/2010
Tameside	Good	08/04/2010
Tameside	Adequate	24/06/2010
Wakefield	Good	12/08/2010
West Sussex	Good	27/07/2010
Wirral	Adequate	27/07/2010
Wolverhampton	Adequate	14/06/2010
York	Inadequate	24/08/2010