Agenda Item No: 11

OFFICE FOR STANDARDS IN EDUCATION, CHILDREN'S SERVICES AND SKILLS (OFSTED) EVALUATION OF SERIOUS CASE REVIEWS IN CAMBRIDGESHIRE.

To: **Cabinet**

Date: **7th September 2010**

From: **Adrian Loades,**
Executive Director; Children and Young People's Services

Electoral division(s):

Forward Plan ref: **N/a** *Key decision:* **No**

Purpose:

To inform Cabinet of the outcome of OFSTED evaluations with respect to Serious Case Reviews in Cambridgeshire.

To update Cabinet on the progress of the Action Plans arising from the Serious Case Reviews.

Recommendation: **Cabinet are asked to note the progress and action taken in respect of the Serious Case Review Executive Summaries published on the Local Safeguarding Children's Board website on the 7th September 2010.**

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1.0 BACKGROUND

1.1 In December 2009 Cambridgeshire Local Safeguarding Children's Board (LSCB) submitted four completed Serious Case Reviews (SCRs) to OFSTED for evaluation as part of the requirement under "Working Together to Safeguard Children – A guide to Inter Working to Safeguard and Promote the Welfare of Children".

1.2 The Serious Case Reviews related to children who had died in a period from 2006 to 2009. Baby A who died December 2006, Child C and Child E who died June 2007, Child G who died January 2009 aged 17 and Child F who died June 2009 aged 10 weeks. The circumstances surrounding the tragic deaths of these children were very different in each case. Three of the four cases have been subject to criminal proceedings against specific parents who were found to be responsible for their children's death. The fourth case was of a young man who tragically committed suicide at the age of 17.

1.3 The prime purpose of a Serious Case Review is for agencies and individuals to learn lessons to improve the way in which they work, both individually and collectively to safeguard and promote the welfare of children. It is not a process to apportion blame but to identify any lessons that could be learnt to improve practice in the future.

1.4 With all four cases there has been a multitude of agencies involved and respective agencies will be implementing their own action plans. This report identifies the learning for Children and Young People's Services arising from these reviews.

1.5 The Serious Case Review process is managed under the auspices of the Local Safeguarding Children's Board (LSCB) and the Chair, Felicity Schofield, who has ultimate responsibility for ensuring that agencies met the requirements of serious case review process.

1.6 All Serious Case Reviews in Cambridgeshire are completed by an independent author and the Serious Case Review Panel of the LSCB has also been chaired by an independent chair (previous LSCB Chair, Jane Held).

1.7 Today the LSCB will publish three of the four Serious Case Reviews' Executive Summaries on the LSCB Website:
http://www.cambslscb.org.uk
The fourth relating to Child F is already on the website following conviction of her mother on 16 June 2010.

2.0 THE SERIOUS CASE REVIEWS

2.1 Whilst the Executive Summaries were submitted to OFSTED in December 2009, evaluation of three of the four Serious Case Reviews has only just been received. An Adequate evaluation was received for the Baby A Review, an Adequate evaluation for the Child C and Child E Review and an Adequate evaluation for the Child G review. We await the evaluation of the Baby F Review. The evaluation is a judgement on the quality of the report, not a judgement on the quality of work that was undertaken with respect to each individual case. Each Serious Case Review is made up of a number of reports, including Agencies' Individual Management Reviews (IMRs), a Report Overview and an Executive Summary. Each of these individual reports is assessed and an overall evaluation is reached. In addition, there are individual Action Plans for each agency and an overall Action Plan.

2.2 In two of the cases, the production of the Review was delayed because of Court proceedings, which included evidence that formed part of the Review. Despite the length of time the Reviews took to be completed, the Action Plans of individual Agencies have been progressed during the review process in order to apply learning.

3.0 LEARNING FROM SERIOUS CASE REVIEWS

3.1 Working Together clearly sets out the requirements that "where possible, lessons should be acted upon quickly without necessarily waiting for the Serious Case Reviews to be completed". With regard to the most recent Serious Case Review of Child F, a comprehensive training and development plan for staff in both Children's Services and Adult Mental Health has been put in place. This has improved understanding around parental psychosis and ensured that in cases of issues of parental mental health Child Protection Plans fully cover both when the parent is well and for periods of ill health. In addition, an audit of cases where parental mental health is a component has been reviewed by an independent expert to ensure that the learning has been taken on board and to increase staff awareness.

3.2 Changes have also been made to the case conference process with a focus on ensuring that the history of the child and family is fully understood. Specific seminars have been arranged within each of the Areas to ensure that staff have an understanding of the risk factors that were evident within this case.

3.3 With respect to Baby A who died in 2006, Children's Services had no prior knowledge of the child prior to her death and the actions that are recommended with respect to Children's Social Care relate to the need for improved practice around process, i.e. a Child Protection medical on the older sibling taking place within 48 hours and improving record taking of Strategy Meetings.

3.4 During the murder trial of the mother of Child C and Child E, the judge specifically said that their deaths were neither predictable nor preventable. The recommendations within the Executive Summary relate to the need to improve practice regarding assessment and listening to the voice of the child as part of this assessment process. At the time of contact with Children's Social Care in 2005, it is acknowledged that the quality of the assessment was not good enough but this would not have, in itself, prevented contact with their mother.

3.5 With respect to Child G there is a clear view by the independent author that it was unlikely that Child G's suicide could have been prevented. However the Review did identify a number of critical periods in Child G's life where things could have been done differently which might have helped to improve the support provided to Child G and his family.

3.6 All of the actions outlined within the Serious Case Reviews with respect to CYPS are monitored through specific groups set up for this purpose, e.g. the Education Advisory Group (also a sub-group of the LSCB), the Children's Social Care Performance Board and the Area Safeguarding Committees (multi-agency sub-committees held in each of the areas).

3.7 Evidence from this monitoring demonstrates that action has been taken and improvements are in place to minimise risk factors in protecting children. For example, the vacancy rate within Children's Social Care is at the lowest point (6%) in many years and changes in Children's Social Care structures in 2009 have helped to ensure clear lines of accountability and responsibility throughout the organisation.

4.0 FINANCIAL IMPLICATIONS

4.1 The requirement for independence within the SCR process means that there has been a significant cost to agencies producing detailed reports. However, the learning from the management of previous Serious Case Reviews and recent guidance from OFSTED will reduce risk. The Action Plans will be delivered within existing resources.

5.0 RISK MANAGEMENT IMPLICATIONS

5.1 The impact of a child's death, no matter what the circumstances, can be devastating for the families and the communities in which the children live. The focus of this report has been on children who have died in tragic circumstances, three of which at the hands of their parents.

5.2 The County Council cannot ensure a risk free environment for children and it can be expected that Serious Case Reviews will need to be undertaken in the future. However, the learning from Serious Case Reviews should and does play an important role in reducing risk and improving service delivery.

6.0 RECOMMENDATIONS

6.1 Cabinet are asked to note the progress and action taken following the publication of the Executive Summaries on the Local Safeguarding Children's Board website on the 7th September 2010.

Source documents	Location
Working Together to Safeguard Children – A guide to Inter Working to Safeguard and Promote the Welfare of Children	http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/
Serious Case Review Executive Summaries (published 7th September)	http://www.cambslscb.org.uk