Ages of concern: learning lessons from serious case reviews

A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011

Ofsted reports have consistently highlighted that babies less than one year old and older children have been the subject of a high proportion of serious case reviews. This report provides a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011. The main focus of this report is on the reviews that concerned children in two age groups: babies less than one year old and young people aged 14 or above.

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Executive summary

This thematic report covers evaluations of 482 serious case reviews carried out between April 2007 and the end of March 2011. The main focus of this report is on the reviews that concerned children in two age groups: babies less than one year old and young people aged 14 or above. Previous Ofsted reports have identified that a large proportion of cases concerned babies less than one year old and older children. We have focused on young people aged 14 or above to illustrate the wide diversity of reasons for the serious case reviews and explore their different vulnerabilities. This report does not focus on the Ofsted evaluation of these reviews or the data behind the reviews; instead it provides an opportunity to explore the lessons learnt in relation to specific age groups of children in more depth, drawing out practice implications for practitioners and Local Safeguarding Children Boards.

Key findings

The report has identified recurring messages from the reviews that concerned babies less than one year old. In too many cases:

- there were shortcomings in the timeliness and quality of pre-birth assessments
- the risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
- there had been insufficient support for young parents
- the role of the fathers had been marginalised
- there was a need for improved assessment of, and support for, parenting capacity
- there were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months
- practitioners underestimated the fragility of the baby.

A notable feature of the cases about young people over the age of 14 is the wide diversity of incidents that resulted in serious case reviews. Although the lessons learnt tend to be quite specific to the particular cases, the reviews found that too often:

- agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support
- young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities

- a coordinated approach to the young people's needs was lacking and practitioners had not always recognised the important contribution of their agency in making this happen.

Background

Ofsted has been responsible for evaluating serious case reviews since 1 April 2007. The review of child protection by Professor Eileen Munro recommended that Local Safeguarding Children Boards should use a systems methodology when undertaking serious case reviews and that Ofsted should cease to have responsibility for the evaluation of serious case reviews.[1] The government agrees that systems review methodology should be used by Local Safeguarding Children Boards when serious case reviews are undertaken and will give further consideration to this recommendation. The government has accepted in principle that Ofsted's evaluations of serious case reviews should end but believes that it is important to plan carefully the transition to new arrangements.[2] In the meantime, Ofsted continues to evaluate serious case reviews.

The reviews and the evaluations under consideration here were conducted in accordance with the 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*.[3,4] Annex A sets out the circumstances in which a Local Safeguarding Children Board must consider conducting a serious case review.

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

The reports have all identified similar recurring themes. Rather than repeat the same messages, this report provides an in-depth focus on a consistent finding from previous reports; the age profile of the children who have been the subject of serious case reviews. Of the 482 cases evaluated by Ofsted between April 2007 and March 2011, 471 were related to specific children.[5] A high proportion of the 602 children (35%) were babies less than one year old. In addition 18% were young people over

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[1] *The Munro review of child protection: final report, a child centred system*, DfE, 2011; www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf.
[2] *A child-centred system: the government's response to the Munro review of child protection.* DfE, 2011; www.education.gov.uk/munroreview/downloads/GovernmentResponsetoMunro.pdf.
[3] *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.
[4] This report covers the period from 1 April 2007 to 31 March 2011 and there have been minor amendments to *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children* throughout the time period covered by this thematic survey, but these do not impact on these findings.
[5] Of the remaining 11 serious case reviews, three relate to unborn babies and eight relate to perpetrators or organised abuse. Another six young people have been excluded who were adults at the time of disclosure or recognition of the abuse.

the age of 14. The full age profile is shown in Appendix B. In addition, Appendix B contains the data relating to the children and the incidents, for the time period 1 April 2010 to the end of March 2011. This report draws out the implications for practitioners and for Local Safeguarding Children Boards.

Learning lessons: ages of concern

1. This section focuses on the lessons to be learnt by the key safeguarding agencies from the 482 serious case reviews which were evaluated by Ofsted between April 2007 and March 2011, looking specifically at a sample of cases (approximately one third) of two age groups of children: babies less than the age of one year and young people over the age of 14.

2. The main messages from previous Ofsted reports, which analysed cases concerning children of all ages, remain relevant to these two specific age groups. The Ofsted report, *Learning lessons from serious case reviews 2009–2010*, [6] emphasised 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.

3. Because of the high proportion of cases that concern young babies and, to a lesser extent, young people over the age of 14, this report looks beyond the key messages from previous reports to examine the findings that have particular significance for the safeguarding of these two age groups. These findings are based on the lessons which the Local Safeguarding Children Boards have themselves identified in the serious case reviews. All the material is drawn from published executive summaries.

Babies less than one year old

4. Of the 471 serious case reviews evaluated by Ofsted between 2007 and 2011 concerning 602 children, 210 (35%) children were babies under the age of one year. This has been a consistent pattern across the four-year period. While this reflects the particular vulnerability of young babies, lessons have been learnt by Local Safeguarding Children Boards that are especially relevant to those who have responsibility for the safeguarding of very young children.

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

5. Reviews identified the need for agencies to provide a very quick response to any concerns about the baby's welfare and development. While the speed of response is important for all age groups, the fragility of babies and their rate of development in the early months mean that agencies' swift response is even more essential.

6. Some reviews concluded that the child death or serious incident had not been predictable from the evidence available to the practitioners involved and others did not raise any significant concerns about their practice. There were also examples of good practice where the input of individual practitioners had been beyond the expectations of the commissioned service. However, in other cases, there were important lessons to be learnt, many of which recurred in reviews carried out by different Local Safeguarding Children Boards.

7. These messages have implications for practitioners and also for the Local Safeguarding Children Boards themselves. In too many cases:

   - there were shortcomings in the timeliness and quality of pre-birth assessments
   - the risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
   - there had been insufficient support for young parents
   - the role of the fathers had been marginalised
   - there was a need for improved assessment of, and support for, parenting capacity
   - there were particular lessons for health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months
   - practitioners underestimated the fragility of the baby.

8. These findings are illustrated in the following examples from the serious case reviews, with an emphasis on lessons learnt from more recent reviews.

Pre-birth assessments

9. When agencies are able to anticipate safeguarding risks for an unborn baby, such concerns should be addressed through a pre-birth assessment. The aim of this assessment is to make sure that the risks are identified as early as possible, to take any action to protect the baby, and to support parents in caring for the baby safely. A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, as a consequence, in the resulting actions.

10. These shortcomings ranged from cases where no pre-birth assessment had been carried out, even when agencies were aware of risk factors that would have justified an assessment, to other cases where the pre-birth assessment

was delayed, over-optimistic or of poor quality. Another message is the importance of not closing cases too quickly after the baby's birth.

11. In one serious case review, an infant girl became seriously ill while in the sole care of her father; she died aged less than four weeks and abuse was suspected to have been a factor in her death. There had been previous concerns about the father, which had led to the removal of a child from the care of the father and his then partner because of injuries that were thought to have been non-accidental. In addition, the mother had been looked after for much of her childhood and had experienced a very troubled adolescence. When she became pregnant, the baby's paternal grandparents tried to alert agencies about their concerns for the unborn baby.

12. The main lesson for the Local Safeguarding Children Board was that the established local systems had not been followed, because of failings by individual practitioners. When the practitioners became aware of the identity of the father and the extent of the mother's childhood problems, they should have carried out a multi-agency pre-birth assessment, leading to care proceedings and action to protect the baby as soon as she was born.

13. In other instances pre-birth assessments were not started early enough. An example is a case in which a pre-birth assessment was not begun until the seventh month of the pregnancy, even though the mother was particularly vulnerable as she was a care leaver who had suffered serious abuse and neglect within her family. The agencies involved had decided that the parents should undergo a pre-birth assessment but there was a long delay before this was carried out. As a result, for a period of three months during the pregnancy, the parents had no contact with children's social care.

14. When the pre-birth assessment was finally undertaken, it was interrupted by the early birth of the baby. The incomplete assessment had to be continued as a parenting assessment after the birth. The serious case review was initiated after there had been non-accidental injuries to the baby when in the sole care of her mother. One of the lessons learnt from the serious case review was that there had been a failure to undertake a timely assessment and, as the review stated: '...crucial time was lost for both assessing and supporting a vulnerable young woman in her first pregnancy'.

15. In other cases, the findings were about the quality of the pre-birth assessment. In the family of one baby who died, the parents had had two previous children when teenagers. The eldest child was subject to a care order and the other one had been the subject of a child protection plan. Although the post-mortem could not establish the cause of death, co-sleeping may have been a factor and non-accidental injuries were found.

16. In its findings the serious case review concluded that the assessment of the unborn baby 'was wholly inadequate, relying completely on an assessment undertaken three months earlier following a referral of domestic violence in

relation to the older siblings'. The Local Safeguarding Children Board found that the assessment had been badly flawed and had wrongly concluded that domestic violence was not present. This had resulted in a missed opportunity to reassess the family situation and to take into account the impact of a third child in a vulnerable family.

Practice implications

17. Practitioners should:

- ensure that pre-birth assessments are undertaken in a timely manner
- take early action to minimise the impact of any known risks to the unborn baby
- take care not to minimise risks when reviewing child protection plans for babies.

Local Safeguarding Children Boards should:

- consider carrying out an audit to check that pre-birth assessments are routinely being carried out whenever there may be safeguarding risks to the unborn child
- ensure that there are adequate systems in place for quality assuring pre-birth assessments in their area.

The role of parents

18. As would be expected when considering cases about babies, many of the lessons learnt relate to agencies' involvement with the parents. Although these are often variations on themes that have been set out in previous Ofsted reports about cases covering all age ranges, the role of parents is even more central for the safeguarding of babies. There are four main themes in the findings about parents.

Agency involvement with the parents

19. There are repeated examples of ways in which the risks resulting from the parents' own needs were underestimated, whether these needs related to drug or alcohol misuse, a past history of being looked after, abuse suffered during childhood or being the victim of domestic violence as an adult. Some reviews found that there had been too much emphasis on the mother's needs at the expense of a focus on the baby, either during the antenatal period or after the birth.

Teenage parents

20. Findings from the reviews included concerns about teenage parents who had received inadequate support, or young parents who should have been considered as children in need in their own right. In most such cases the

lessons learnt are not just about the challenges for young parents of bringing up a baby but also about the associated and cumulative risks arising from, for example, a troubled childhood, unsettled parental relationships and a lack of long-term accommodation.

Marginalisation of fathers

21. Previous Ofsted reports have highlighted the lack of attention to the role of fathers or male members of the family. With cases concerning babies this message is a recurrent theme. Again and again, the reviews found that fathers had been marginalised, describing them as ignored, 'invisible' to practitioners or 'the ghost in the equation'. Because generally the mother is the parent who is seen much more frequently by practitioners, the reviews concluded that too often there had been insufficient focus on the father of the baby, the father's own needs and his role in the family.

Parenting capacity

22. The lessons about agency involvement with the parents are not just about risk factors arising from the parents' background and lifestyle; the lessons are also about the practitioners' assessment of parenting capacity. Findings included cases where there had been limited understanding by professionals of the impact of the parents' own experience of being parented; shortcomings in supporting parents both in preparing for parenthood and after the birth; and a failure to recognise that parenting can be a stressful process for which suitable materials and education programmes need to be provided.

23. In some reviews there were findings about shortcomings in more than one of these areas. The following case studies illustrate some of the lessons about agencies' interaction with parents which were highlighted by Local Safeguarding Children Boards.

24. In one of the reviews a baby was taken to hospital at the request of the GP after unexplained bruising was found. Upon examination, 16 separate fractures were found and these were considered to be non-accidental. The baby had lived with his parents who were both teenagers. The mother had been the subject of a care order when younger as a result of her own mother not being able to cope due to mental health problems. The Education Welfare Service had been involved when her school attendance had declined. The mother had become pregnant when still at school, at which point the universal health services became involved.

25. In its conclusions the review recognised that the mother's background was never fully taken into account: 'She was a young person who, due to what she had experienced during her young life, needed to be supported through pregnancy and following the birth of the child.' The review also had similar findings about contact with the father: 'There were assumptions made about him and he was considered to be a supportive partner, but he was never

spoken to and his history was never considered. His offending behaviour indicated that he could be aggressive when he had been drinking. Any potential risk posed to the baby was never considered.'

26. In this case, the Local Safeguarding Children Board identified a number of lessons to be learnt:

- 'Assessments of pregnant teenagers must take into account their family background'
- 'Both parents need to be supported. The father is as important as the mother and they need support to help them to become good parents'
- 'There should be a joined up (multi-agency) approach to teenage pregnancy and teenage parents with every agency understanding their role within it'
- 'Young teenage parents need to be supported in an environment in which they feel comfortable and supported. Adult-centred services may not achieve this without additional teenage-focused support.'

27. A different example illustrates other messages about practitioners' involvement with parents. This review concerned a baby whose mother had a history of mental health problems which deteriorated in the latter stages of pregnancy. A key factor was that the mother had not disclosed to her husband that she had been on anti-depressant medication for much of her adult life and had been reluctant to tell some of the professionals about her mental ill-health. After the baby's birth, because of concerns about her deteriorating condition, mental health services were contacted. Although they arranged an appointment with the mother very speedily, the mother suffocated the baby the following day before the appointment had taken place.

28. The practitioners who knew about the mother's condition had decided not to breach her confidentiality and had not therefore shared important information with other health practitioners. A lesson learnt from the review was that the potential concerns about the welfare of the baby had not been given sufficient weight when the practitioners considered the need to share information. The Local Safeguarding Children Board stated:

> 'There was a strong focus on the needs of the mother, in some instances to the exclusion of the needs of the baby. When working with pregnant women the needs of the unborn baby must always be given paramount consideration and where there are potential safeguarding issues the threshold for information sharing, including without consent, must be lower than would otherwise be the case.'

29. The review also commented on the lack of involvement of the father:

> 'Practitioners need constantly to consider the influence, roles and responsibilities of fathers and wider family members in the care of

children, even before their birth, and seek as far as possible and is safe to involve them in assessment, planning and intervention.'

30. A case following the death of a child of four months demonstrates other lessons about the importance of engagement with parents and support for their parenting capacity. The medical view was that the child had been the victim of shaken baby syndrome. The parents in this case were both teenagers. Contact with health practitioners had been good, the baby had been developing normally and those in contact with the family thought that the parents had been providing appropriate care. Nevertheless the review found that the father had had a troubled life, having received support from several agencies and having been a client for several years of the Youth Offending Service. Although the Local Safeguarding Children Board concluded that it would not necessarily have led to a different outcome for the baby, one of the findings was that:

> 'It is reasonable to conclude that if risks had been more accurately assessed and services had been provided more fully and consistently, he (the father) would have been better prepared for being a parent…Services for teenage parents are not clearly understood across agencies. Knowledge of the services varied between agencies and front-line staff. Information dissemination about the services is an area for improvement. Services for teenage fathers is an area where development is necessary.'

Practice implications:

31. Practitioners should:

- make and record robust decisions about whether a young parent should be considered as a child in need, when practitioners have significant concerns about a young parent's own needs
- maintain a focus on the father of the baby, the potential implications of his own needs and his role in the family
- assess the parenting capacity of both parents.

Local Safeguarding Children Boards should:

- take a strategic overview of the involvement of fathers in assessments of risk and safeguarding concerns, with a particular focus on unborn children and babies, in line with locally determined procedures
- check on the quality, availability and relevance of materials and education programmes which support the development of parenting skills, especially for teenage and young parents.

The contribution of health agencies

32. In previous Ofsted reports covering all age ranges, a frequent message has been the need for improved joint working between different agencies. While this is also one of the lessons in cases that concern babies, the emphasis of the

message is different. Although some cases do have implications for better communication between health, children's social care, the police, housing and other agencies, the agency most frequently involved with babies is health. In some serious case reviews this was the only agency that had involvement with the families.

33. Serious case reviews focus on the lessons that can be learnt, which often leads to a focus on what has gone wrong. However, there are also examples of good practice, some of which relate to health practitioners. For example, one case highlighted the antenatal input by a health visitor, which had gone beyond the standard service specification, and the painstaking contribution of the GP. Similarly, other reviews noted examples of good antenatal care and the effective use of referral systems.

34. The messages for health agencies from cases where things did go wrong are similar to those in previous reports: the importance of understanding and implementing agreed procedures; the need for improved assessment that uses all sources of information; the emphasis on carrying out agreed action; and the value of challenge and support from managers.

35. Two further themes recur in the lessons from cases about babies.

- Where there were failings, this was often because of a need for better coordination between the different aspects of health provision involved with the safeguarding of babies. There is a particular emphasis on the transfer of care between midwifery services, health visitors and GPs.
- In cases where health professionals had had significant opportunities for direct contact and observation of families, too often they had not detected potential risks to vulnerable babies. These cases include findings about hospital staff who had observed parents' interaction with the newborn babies; health visitors who had seen parents and babies in their homes; and GPs who had had frequent contact with families during the antenatal and post-natal phases.

36. One of the reviews underlined the importance of good planning when babies are discharged from hospital. The child in this case was the youngest of six children in a family which had been known to many agencies because of safeguarding issues. Despite this, the review found that there had been very poor information sharing between midwifery, health visitors, the GP and hospital staff. Although the mother's use of alcohol and the presence of many other interacting risk factors were known to most of the teams involved, the potential dangers were not considered in the plan to discharge the baby from hospital. This took place when the baby was only 13 hours old.

37. The Local Safeguarding Children Board concluded that:

> 'The failure to consider the risk factors in the plan to discharge the baby from hospital stems directly from the lack of awareness of these factors by

those responsible for the discharge plan…Health as a whole possessed sufficient information to analyse the risks, yet this information was not collated and made available to the practitioners responsible for the baby's discharge from hospital.'

38. Another case underlined the need for coordinated support and clarity about overall responsibility of all health practitioners involved. The Local Safeguarding Children Board found that communication between health professionals was significantly below the accepted standard and this had left the child exposed to harm. No reference was made by health professionals to others who were known to be visiting the family and there had been an assumption by each of them that the others were managing the situation. Most importantly, the main lesson was the need for an identified lead health professional for the family.

39. There were also cases in which the Local Safeguarding Children Board found that risks could have been identified by carrying out routine procedures during the early months of a baby's life, such as plotting its weight. One young child who was the subject of a serious case review had been born prematurely and was then placed in a neo-natal unit. Hospital staff were concerned about the parents' visiting frequency during this period and also about their parenting capacity. The baby was discharged from hospital by the parents against medical advice. The boy died a few months after discharge from hospital as a result of multiple organ failure, severe malnourishment and dehydration.

40. One of the conclusions of this serious case review was that there should have been regular monitoring of the baby's weight. The GP had had access to the discharge weight when the baby left hospital and also the weight when the staff from the neo-natal unit later stopped carrying out home visits. The Local Safeguarding Children Board stated: 'If the weight had been plotted, notwithstanding any other information that might have been available about the case, it would have shown the falling off in the rate of weight increase and this could have prompted further follow-up action.' One of the recommendations of the review was that GPs, when undertaking an 8-week developmental check-up, should ensure that they plot the birth weight and the current weight on a chart for comparison with other babies.

Practice implications:

41. Practitioners should:

- confidently use and share the evidence from their direct observation and knowledge of parents and their babies to inform assessment of risks
- carry out routine procedures, such as checking on the weight of vulnerable babies

Local Safeguarding Children Boards should:

- scrutinise local systems for transfer of cases between the midwifery service, the health visiting service and GPs.

The particular vulnerabilities of babies

42. Some of the findings from these reviews underline the particular vulnerabilities of very young babies. The lessons learnt include:

- the importance of considering the safeguarding needs of unborn babies
- the risks that are more likely to occur for babies than older children, including co-sleeping with the parents and overlay by one of them, often related to a parent's drug or alcohol misuse
- the need to assess adequately the heightened risks for babies that arise from domestic violence in the home, shaken baby syndrome or drunken parents
- the importance of suitable housing for parents of new babies.

43. One case that illustrates the particular vulnerability of young babies concerned twin boys who were born prematurely. The review found that the parents were themselves vulnerable, principally as a result of alcohol misuse but also domestic violence, poor mental health and unstable lifestyles. As a result of the practitioners' concerns about the risk of neglect, the boys had been made the subject of child protection plans after their births. One of the babies was later found dead after sleeping in the bed of his mother and her partner. Although the post-mortem could not find a cause for the death, the child protection plan had highlighted the dangers from co-sleeping, especially because of the mother's high level of alcohol consumption.

44. The Local Safeguarding Children Board found that there had been some good practice including the holding of a hospital discharge meeting, the decision to make the children subject to child protection plans, and the warnings to the mother not to sleep in a bed with her babies. However the Board also reached the view that the children could have been better safeguarded if the health network had acted more swiftly upon becoming aware of the mother's pregnancy and if there had been contingency plans in case of premature delivery.

45. Among the learning points, the Local Safeguarding Children Board decided that all constituent agencies of the Board should report on how they would ensure that their staff would make use of local guidance about drug and alcohol using parents; and that all child protection conference chairs should be asked to incorporate the guidance into outline child protection plans.

46. The risk for young babies in environments where there is domestic abuse is also a recurring theme. One review concerned a one-month-old baby who had sustained serious head injuries during an incident of domestic abuse between his parents. He survived but was considered likely to have sustained significant brain damage. The family had been known to local agencies because of concerns about violence in the home.

47. The serious case review raised concerns about the assessments by the police when called to domestic violence incidents during the mother's pregnancy. The Local Safeguarding Children Board found that the risk assessments in these situations focused first on the adult victim and second on children who were present during the incident. The Board was concerned that, although unborn children are at great risk, they were not being considered either as a victim or as a child who was present.

48. In the conclusions to this review, the Board recommended the replacement of the risk assessment tool used by the police, to reflect risk more accurately. The lessons learnt also included the need for improvements to the guidance for staff working with domestic abuse. The aim was to ensure an increased awareness of risk for pregnant women and their babies.

49. Some of the serious case reviews reached conclusions about the impact of the parents' drug misuse on their babies and the failure of agencies to assess the risk adequately. One review found a different but equally important lesson. In this instance, although practitioners had had previous concerns about the baby's older siblings, including the impact of the parents' drug usage, those involved had had no concerns when they carried out post-natal home visits to see this baby. The health visitor and drug counsellor continued to visit the family regularly. At three months the baby died after having ingested prescribed drugs which had been administered by the father.

50. In its findings, the Local Safeguarding Children Board reached the view that none of the practitioners had any reason to suspect that either parent was deliberately administering prescribed medication to the baby. During the course of the review it emerged that there may have been a view among some drug users that the practice of giving drugs to babies to calm them down was appropriate and possibly widespread. The key lesson learnt was the importance of professionals giving advice and clear information to drug abusing parents about the dangers inherent in this practice and that this advice should also be included by health professionals in their antenatal discussions with all parents.

51. The last example in this section illustrates the lessons learnt about the need for appropriate housing. While this is an issue for children of all ages, it is a factor with a special importance for young babies. The quality of the housing itself was found to have affected the pressures on parents in some cases; in others, the frequent moves between different temporary accommodation increased the difficulty for health visitors and other practitioners of keeping in contact with the family to monitor the baby's development. This review concerns a child whose death was recorded as sudden unexpected death in infancy. Many of the concerns about the mother were similar to other cases described above: periods in care during her childhood; alcohol misuse; self-harming by drug overdose; and being both a victim and a perpetrator of domestic abuse and assault. In addition a relevant factor was that the mother had been homeless and had been living with her maternal grandmother at the time of the incident.

52. In its findings, the review highlighted the lack of appropriate housing for women with children who are found to be intentionally homeless. The local teams identified the need to review their protocols so that mothers with babies are provided with adequate accommodation and support. A further finding was that the mother's homelessness had made it more difficult for agencies to engage with her. For example there had been unsuccessful visits by health services. Agencies in the area had learnt the importance of considering a family's homelessness as an important risk factor when making referrals for multi-agency coordinated support.

Practice implications:

53. Practitioners should:

- give full consideration to the heightened risks for babies and unborn children when domestic abuse or drug and alcohol misuse is occurring in the family

Local Safeguarding Children Boards should:

- make sure that advice for parents about the risks for babies is sufficiently clear in relation to co-sleeping, overlay, parents' drug and alcohol misuse, and administration of prescribed drugs to babies
- work collaboratively with housing services to ensure appropriate priority is given to parents with babies who present themselves as intentionally homeless.

Young people aged 14 years or older

54. The second part of this report looks at the key messages from cases about young people aged 14 or older.

55. A notable feature of these cases is the wide diversity of incidents that resulted in serious case reviews. Whereas the first part of this report described overarching messages and common lessons from the reviews about young babies, there is no such clear pattern for young people aged 14 or older. Many different incidents led to the decisions to carry out these serious case reviews and there was an equally diverse range of lessons to be learnt.

56. The first part of this section illustrates this diversity by giving a brief synopsis of a selection of cases. These examples show the complexity and range of the risk factors facing teenagers, which in specific reviews encompassed factors such as alienation from their families; school difficulties; accommodation problems; abuse by adults; unemployment; drug and alcohol misuse; emotional and mental health difficulties; domestic abuse in the home; reactions to bereavement; and risks arising from adults' misuse of the internet.

57. Each case study includes one of the main lessons from the review that may be relevant for the work of other Local Safeguarding Children Boards. Although these lessons tend to be quite specific to the particular cases, there are findings which recur in different ways in many of the reviews about young people aged 14 years or older. The reviews found that too often:

- agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support
- young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities
- there was no coordinated approach to the young people's needs and practitioners had not always recognised the important contribution of their agency in achieving this.

Case studies

Disclosure of long-standing abuse

A 14-year-old girl was the youngest of eight children in a family. These half-siblings had been removed from the mother's care, leaving only the youngest girl at home. Concerns about her welfare, including allegations of abuse, continued over many years until she finally disclosed that she had been subjected to sexual abuse by a teenage male lodger.

Lesson learnt: among an extensive range of lessons from this case the Local Safeguarding Children Board found that the girl's mother had been allowed to drive the agenda when practitioners had been working with the family. As a result, they had not made a properly considered assessment of the children's needs. The mother's needs had been prioritised over those of the young girl or her half-siblings. Any challenges at planning meetings had too often been disregarded.

Suicide by a young person

A young person had had a disrupted early life as a result of domestic violence in the home. His behaviour had deteriorated to such an extent that his father had asked him to leave the family home. Living in hostels after a period of homelessness, the young man made a serious suicide attempt and later was found hanging in a park.

Lesson learnt: the Local Safeguarding Children Board concluded that, after the young person had been told to leave the family home, the agencies involved should have taken a more assertive approach to formulating plans to safeguard and promote his welfare.

A teenage perpetrator

One review concerned a sexual assault by a teenage boy on a much younger girl. After a period in custody, he committed further serious sexual offences against a second girl while on bail.

Lesson learnt: the review highlighted as a national issue the problems of supervising alleged young sexual offenders while on bail in the community. It also found that there was a need for improved inter-agency work with young people who are alleged sexual offenders.

Death in a house fire

A 14-year-old boy, with his younger brother, died in a house fire. This had been started deliberately by their father after he had taken part in a drinking session. The two children could not be rescued from the house. The serious case review was carried out because of a history of concerns about domestic abuse, misuse of alcohol, neglect and physical abuse in the family.

Lesson learnt: a key finding was that opportunities had been missed by all agencies concerning what it was like for the children to live in a large family where the parents drank too much and assaults between parents were a regular occurrence.

A suicide pact

One case concerned a teenage girl who died and a second girl who was found in a critical condition. Messages were found from the first girl indicating that she had taken her own life and that the other girl intended committing suicide at the same time. A few days before the incidents the second girl had told school staff that she and her friend had entered into a suicide pact and had shown the staff her self-inflicted wounds.

Lesson learnt: the review concluded that, although suicide pacts are rare, any professional who receives information suggesting that young people may be contemplating such an action should urgently seek advice from their senior managers on the level of response required. The Local Safeguarding Children Board felt that in this case a robust response would have alerted families and professionals to the acute distress of both girls.

A drug user who nearly died

A young person aged 16 was found unresponsive in bed by staff at the children's home where he was a resident. He had been a known user of drugs; after admission to hospital, tests showed the presence of methadone and diazepam. A wide range of agencies had been involved extensively with the young person and his family in the preceding six years.

Lesson learnt: the Local Safeguarding Children Board acknowledged that some troubled and troublesome adolescents can present a significant challenge for those professionals involved in their safeguarding and welfare. It recognised, however, that there can be a temptation for already overworked practitioners to 'pass the buck' and leave another professional to deal with the problem.

Stabbing by other youths in a street incident

One of the serious case reviews concerned a young person who had died in a street gang incident. He had been the subject of child protection planning earlier in his life, was involved in criminal activity from an early age and had had a period living in secure accommodation. Following a series of care placements he absconded from the last home in which he lived and was stabbed in a street incident that involved several other young people.

Lesson learnt: the review found that there had been avoidable delay in bringing the boy into public care. It also concluded that some placements had been ill-judged and had not offered sufficient structure or activity. Nevertheless, although the review found significant failings in the performance of a number of agencies, the Local Safeguarding Children Board was not clear that the death could have been prevented.

Challenging young people or children in need?

58. In the cases involving young people over the age of 14 there is a recurring message that, in different ways, professionals had not treated the young person as a child in need. The failings included those instances where:

- agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support
- young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities.

59. The serious case review about a drug user who nearly died, summarised in the above case studies, illustrated the question of whether a challenging young person should have been designated as a child in need. The review found that agencies had not achieved the correct balance:

> 'The dilemma relates to the way in which problematic adolescents should be approached: to what extent should they be viewed as children in need of protection, and to what extent should they be viewed as perpetrators of crime and/or a risk to others? Plainly there is a role for both views and often, as here, the overall approach will reflect a combination of those views. But the extent to which the overall approach is weighted towards

one or other of those views must always have a rational basis. This was not always the case for this young person. To give a striking example: just at the time when the Initial Child Protection Conference was convened, the young person was made the subject of his first ASBO.'

60. Another review which demonstrated this dilemma concerned a 17-year-old girl who committed suicide. She was a highly vulnerable young person who had suffered physical abuse and domestic violence. When younger, she had been the subject of a child protection plan due to neglect. As a teenager she had self-harmed on two occasions, had a history of running away from home, and had been involved in drug and alcohol misuse. Practitioners also suspected that she had been sexually exploited. Among the significant points of learning, the review stated:

> 'A factor contributing to the lack of application of safeguarding procedures and practice was the inability to identify the young person as a vulnerable child in need rather than a challenging hard to engage adolescent.
>
> Although it was a correct judgement that agencies sought to put boundaries and controls on her behaviour, albeit without good enough coordination between each other, the concentration was on control without enough recognition that underlying factors drove her behaviour.
>
> When she was admitted to hospital following a deliberate overdose and intention to kill herself this should have been sufficient to have convened a strategy meeting.
>
> There was insufficient consideration by lead agencies regarding the use of legislation and statutory powers to support intervention with the young person and provide protection for her.'

61. A rather different message from another review was that, even though the young people had been looked after by their local authority, there were failings in the interpretation of their challenging behaviour. Professionals did not understand the abuse which was causing this behaviour. The case concerned two teenage girls who had been the victims of sexual exploitation. Both were looked after children and had been known to a range of agencies over many years. Their situation came to light as a result of a wider investigation into sexual exploitation and trafficking, led by the police.

62. On reaching adolescence the behaviour of the two girls had become increasingly chaotic and risky. Even when they were looked after, staff were unable to prevent their frequent absconding or to manage their challenging behaviour. The Local Safeguarding Children Board reached the view that, although agencies had worked hard within their own sphere, there had been little evidence of coordinated actions. In particular the statutory agencies on

the whole did not recognise or understand the signs and symptoms of the abuse being suffered. The review stated that:

> 'Staff did not recognise the significance of their behaviour in terms of abuse and they were dealt with as ''rebellious adolescents''. Both young people received criminal convictions for behaviour that should have been dealt with in terms of their status as victims of abuse, rather than as offenders.'

In conclusion the Local Safeguarding Children Board reached the view that:

> 'Safeguarding procedures were not used early enough when there were clear signs that they were at risk of suffering significant harm and this delayed effective action. In particular there was a failure to understand the impact of coercion by the abusers on their behaviour, and to assess their capacity to make informed choices about whether or not they were truly consenting to go with their abusers.'

63. Other cases found that young people had not been treated as children; some adolescents had been viewed as adults rather than as young people. An example was a 17-year-old girl who was diagnosed with Human Immunodeficiency Virus (HIV) after admission to hospital. She died about a week later. The serious case review was instigated in order to establish whether there had been missed opportunities to diagnose HIV earlier.

64. The review found that there had been numerous occasions when testing for HIV could have been considered in response to relevant symptoms, including when she was seen at a sexual health clinic. Expert advice for the review stated that, if the young person had declined HIV testing, this should have been challenged by the clinic and recorded. Instead, practitioners had accepted at face value the young person's statements that she had not engaged in any form of sexual activity. The Local Safeguarding Children Board reached the view that this was because she was treated as if she had been a young adult and had not been afforded appropriate protection as a result. The principal lessons from this review included:

> 'A need for health practitioners to regard 17-year-old young people as young people and not as young adults when considering the use of an HIV risk assessment form at the sexual health clinic and when considering self-reports by a young person aged 17 years old.'

65. Young people aged between 16 and 18 are a vulnerable group who can miss out on receiving appropriate services because they fall between adult and children's services. The case of a 17-year-old boy who attempted suicide illustrated this. There had been previous concerns about his mental health and, following an overdose and threats of self-harming, the young person was taken to hospital by the police and admitted to an adult psychiatric ward. He was subsequently detained under the Mental Health Act in a low security unit.

66. The review found that the police had treated the young person as an adult rather than as a child under the Children Act 1989. In addition, although his identified needs had been met in a sensitive way on the adult psychiatric ward, he was not transferred quickly enough to adolescent facilities for assessment. A result of this was that there had been insufficient time for the planned assessment to be completed in the low security unit and the discharge process did not include all the key agencies that needed to be involved.

Practice implications:

67. Practitioners should:

- seek to understand and act on the causes of young people's challenging behaviour when there is any suggestion that abuse may be a contributory factor
- recognise young people's rights, needs and vulnerabilities as children as well as their rights and responsibilities as young adults.

Local Safeguarding Children Boards should:

- check that all agencies' assessment processes recognise the specific needs of young people up to the age of 18 and provide services appropriate to their age.

Whose responsibility?

68. In the earlier part of this report about lessons for better safeguarding of babies, the agency most frequently involved was health. Cases about older children have implications for a wider range of agencies, a trend which is even more pronounced for teenagers over 14. The recommendations extend beyond the key agencies of children's social care, health, the police and education with lessons for, among others, the Connexions service, the Youth Offending Service, the Probation Service, drug and alcohol misuse services and housing services. There are also findings for teams whose remit focuses on adolescents, such as the Leaving Care Team and the Child and Adolescent Mental Health Service (CAMHS).

69. A recurring message from these reviews was that practitioners should have provided a more coordinated approach to the young people's needs and they had not always recognised the important contribution of their agency in making this happen.

70. Lessons learnt from these reviews often referred to the complexity of the range of practitioners involved. One such case concerned a young person with Asperger's Syndrome who committed a range of sexually related offences.

It illustrates the complex web of services that was involved. In just one of its findings the review stated:

> 'Overall agencies were slow to recognise the significance of the boy's behaviours at home, in school and in the community. An error by children's social care and lack of persistence by the Child and Adolescent Mental Health Service meant that an opportunity for an earlier assessment was lost. A joint assessment by the Youth Offending Service and children's social care was weak in its conclusions. The plan was not properly developed and there was a lack of communication between the Youth Offending Service and the police at key points.'

71. Lessons from the reviews sometimes included the shortcomings of individual agencies. Some teams were the subject of a greater number of lessons learnt than in the reviews of children in other age ranges. For example, many cases contain recommendations for the local CAMHS. In different reviews the Local Safeguarding Children Board found that there had either been no service offered by CAMHS; no full assessment by the service; a lack of persistence in following up families who were not attending appointments; or misjudgements about whether thresholds for involvement had been met. Two reviews described the service offered by CAMHS for adolescents as 'fragmented'.

72. Similar concerns were also raised about other services, including schools, the police and children's social care. In one case that involved serious neglect after a child in the family disclosed that she had been sexually abused by her older brother, the review found a mixture of good and poor practice by the girl's school in terms of safeguarding. While the school had acted correctly and shown some good practice by arranging for the girl to receive much needed treatment for her chronic dental neglect, they did not make a referral to children's social care about the girl's more general neglect, of which the dental concerns were only one symptom. The serious case review stated: 'The connection between dental neglect, significant harm and severe general neglect had not been made by either the dental service or the school.'

73. Reviews also highlighted instances where practitioners thought that other agencies had taken responsibility for addressing their concerns about a young person, but the review had found that this had been an incorrect assumption. Although the Local Safeguarding Children Board reached the conclusion in some cases that the serious incident had either been unpredictable or outside the control of the professionals involved, too often the individual agencies had not taken responsibility for ensuring that everything possible was done to protect the young person.

74. This is illustrated by a serious case review which summarised the failure to work collaboratively:

> 'As the young person's reckless behaviour intensified, with persistent offending associated with drinking and drug misuse, and a breakdown in

relationships with his carers, we looked for evidence of an intensifying response from local agencies. Except that the range of agencies increased to include the Youth Offending Service, the Young People's Drug and Alcohol Action Team and the police, we concluded that there was little evidence that agencies worked collaboratively in an organised fashion.'

75. An equally worrying finding in one case was that, even though most agencies had been in agreement about their concerns, they had not persisted with raising them when they met resistance from children's social care. The review concerned a 14-year-old whose behaviour had deteriorated rapidly from the age of 13 until the time of his death. The post-mortem found high levels of drugs in his body.

76. The young man had been known to several agencies. The serious case review found that some professionals, including the school, the CAMHS and the Adolescent Resource Centre had provided him with the opportunity to be heard and his school had been vigorous in advocating for him. However, when the professionals from these services had encountered resistance from children's social care, they proved ineffective in challenging the decisions. The Local Safeguarding Children Board reached the view that the professionals involved did not appear to understand how to follow up or escalate their concerns, using procedures set out in the local procedures for safeguarding children. While there were many lessons to be learnt in this case by children's social care, the review also highlighted the shortcomings of other agencies in their responsibility for knowing when and how to make referrals.

77. Finally, the findings of one review encapsulate the lessons from cases about young people over 14. The review brings together two messages: agencies in this case had failed to determine the correct status for a young person who had significant safeguarding needs; they had also not fulfilled their child protection responsibilities, resulting in a passing of the buck between them.

78. The case concerned a young Polish national of 17 who accompanied his father to England. The young person was subsequently abandoned by his father so he had to live in this country alone and without recourse to any public funds. During the subsequent months the arrangements for his responsibility remained unclear between children's social care and a team called the No Recourse to Public Funds (NRPF) team which has experience of organising travel for adults to return to their country of origin in such situations. At one point children's social care closed the case and the NRPF team ceased any payment. There was also some confusion about his age with a suggestion that he was in his twenties, which added to delays in decision-making between the agencies that became involved.

79. Over a short period the young person had engagement with a plethora of local services, including charitable organisations for homeless young people, the accident and emergency service at the local hospital, the police, the Youth Offending Service, children's social care, the Youth Court, the homelessness

service, and CAMHS. During the year after he had been left alone in this country, his behaviour deteriorated and an increasing range of different agencies became involved.

80. The serious case review was instigated after the young man was found hanged in bed and breakfast accommodation. One of the key issues identified by the Local Safeguarding Children Board was that agencies had not always perceived the young person as a child; for example the police did not recognise him as a juvenile, which led to the mindset that he should be treated as an adult. One lesson learnt from the review was that he should have been assessed as a child in need. The second lesson learnt was that, despite the fact that the young person was known to a range of agencies, many areas of his life were not addressed: being abandoned in an unfamiliar country; homelessness; lack of financial support; alcohol misuse; deteriorating emotional and mental health; and a lack of opportunities for education, employment, training or leisure. Above all, the review found limitations in how agencies had worked together, with lost opportunities for information sharing, assessment and inter-agency challenge.

Practice implications:

81. Practitioners should:

- demonstrate that clearly risk-assessed decision-making informs all actions in relation to older children
- collaborate fully with other agencies that are working with the young person
- take responsibility for following through any concerns and not assume that someone else is addressing the matter
- challenge other agencies if they have serious concerns which they believe are not being adequately addressed.

Local Safeguarding Children Boards should:

- carry out audits of complex cases involving older children to identify where agencies are working well together and where improvements can be made and disseminate this learning
- ensure that there are robust mechanisms in place to enable agencies to challenge decision-making processes in relation to safeguarding.

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.[7] 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.

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[7] *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 data

The evaluation of serious case reviews from April 2007 until March 2011

The evaluations across the four-year period since Ofsted took over this responsibility are shown in Table 1. The evaluation of a serious case review is not an evaluation of the quality of the professional practice, or the quality of service delivery, in relation to the incident under review. Nor is it about allocating blame. It is an evaluation of the degree to which the review has succeeded in identifying lessons to be learnt from the events and the analysis, and the action that needs to be taken to improve the protection of children in the future. This table illustrates a continually improving picture of the quality of serious case reviews.

Considerably fewer serious case reviews have been judged to be inadequate and over the last full evaluation year, five serious case reviews have been judged outstanding.

Table 1: Evaluations completed between April 2007 and March 2011

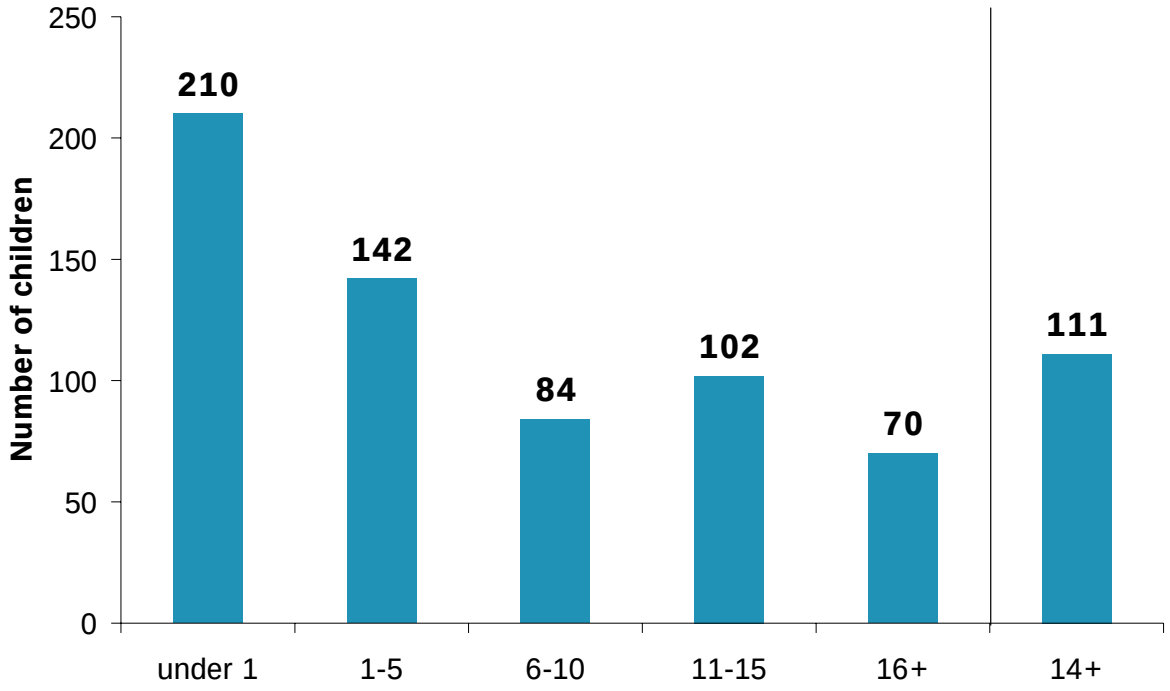
	April 2007 – March 2008	April 2008 – March 2009	April 2009 – March 2010	April 2010 – March 2011	**Total**
Outstanding	0	0	0	5	**5**
Good	13	37	63	66	**179**
Adequate	14	75	64	40	**193**
Inadequate	14	62	23	6	**105**
Total	**41**	**174**	**150**	**117**	**482**

These figures are based on the date of the most recent evaluation letter sent by Ofsted to the Local Safeguarding Children Board, and are consistent with information published on the Ofsted website: www.ofsted.gov.uk/resources/serious-case-review-evaluations-april-2007-onwards.

The age profile of children subject to a serious case review from April 2007 until March 2011

This thematic report focuses specifically on babies less than one year old and young people over the age of 14 years. The table below illustrates that high proportions of these age groups of children have been subject to serious case reviews in the four-year period 1 April 2007 to 31 March 2011.

Table 2: Ages of children who were the subject of a serious case review evaluated by Ofsted between 1 April 2007 and 31 March 2011

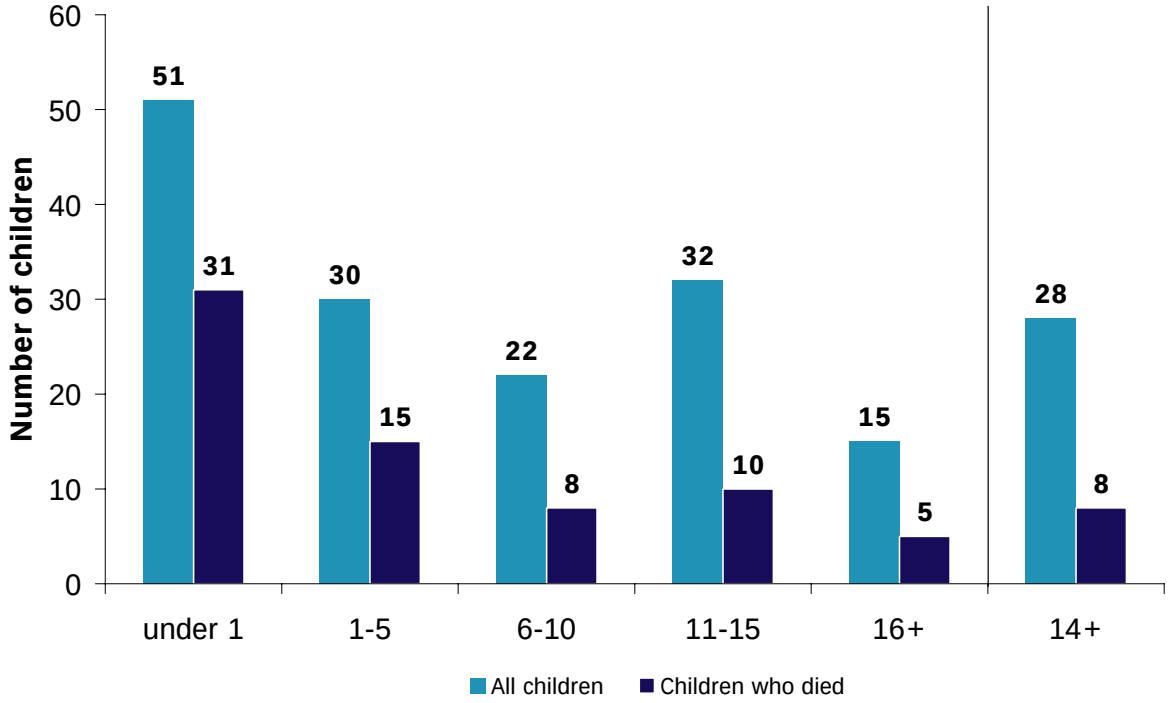


14+ includes children over the age of 16.
These figures are based on 471 serious case reviews. Of the 11 serious case reviews which are not included, three of them concern unborn children, and the remaining eight relate to perpetrators and organised abuse. Six young people have been excluded who were adults at the time of disclosure or recognition of the abuse.

The children and the incidents April 2010– March 2011

Ofsted evaluated 117 serious case reviews between 1 April 2010 and 31 March 2011. This section provides a summary of the data relating to the children and the incidents covered by 113 of these serious case reviews. The remaining four cases were about perpetrators and organised abuse. The analysis below relates to 150 children from the 113 serious case reviews. Five young people have been excluded who were adults at the time of disclosure or recognition of the abuse.

Table 3: Number of child deaths and other serious incidents by age group between 1 April 2010 and 31 March 2011[8]



14+ includes children over the age of 16.

The children

Of the 150 children, 69 children died. The other 81 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 is shown in Table 2. A majority of the children were five years old or younger at the time of the incident. Fifty-one children were under one year old. A more detailed analysis of the older children shows that 28 young people were 14 years or older.

In addition there were four serious case reviews that focused on perpetrators and/or organised abuse.

Table 3 compares the age range of those who died and those who were subject to other serious incidents in serious case reviews evaluated by Ofsted between 1 April 2010 and 31 March 2011. These profiles show that a larger proportion of reviews for children less than 5 years of age followed the death of the child, rather than other serious incidents. In 31 of the 51 cases concerning children less than one year of

[8] Data from 113 serious case reviews. Four serious case reviews related to an adult perpetrator and did not include data on children.

age, the baby had died. For the smaller number of cases about young people over the age of 14, just over a quarter were as a result of their deaths.

Seventy-seven girls and 73 boys were the subjects of the serious case reviews, which is a similar distribution to the findings in previous years.

Ethnicity data were recorded for almost all the children subject to a serious case review. In the first year of Ofsted's evaluations, some reviews did not provide this information but the situation has since improved and ethnicity data is now provided in almost all cases.

The largest grouping was White British (116 out of 150 children). Fourteen children were recorded as Black, Black African or Black-British; 15 as Mixed; one as Asian or Asian-British; one as a non-standard ethnic group; and one young person was Polish. Ethnicity information was not recorded for two children.

Of the 150 children, 119 were known or had been known to children's social care previously. Fifty of these children died.

Thirty-nine children were receiving services as children in need at the time of the incident; 18 of these children died. Of the 39 children in need, 15 were the subject of child protection plans, six of these children died. Seventeen children had previously been the subject of a child protection plan at some stage in their lives, four of these children died.

Nine children were looked after by the local authority.

The cause of death for the 69 children who died is shown in Table 4.

Table 4: Cause of death of the 69 children who died

Cause of death	Number of deaths
Homicide	
Murder by parent or carer	17
Other	16
Other external cause	
Suicide	8
House fire/arson	4
Drowning	1
Accidents and adverse incidents	
Overlay by parent or carer	5
Unknown causes	15
Substance misuse	2
Concealed birth	1
Total	**69**

'Other' includes deaths arising from neglect, physical abuse and murder by another family member.

The deaths recorded as 'unknown cause' include 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 unexpected death in infancy and other cases in which young babies died, where overlay by a parent or the effects of parental use of alcohol or drugs may have been factors.

Apart from the 69 children who died, the serious case reviews concerned 81 other children. The most common characteristics of the incidents were sexual abuse, physical abuse or long-term neglect or a combination of factors.

Annex C: The 117 serious case reviews

Local Safeguarding Children Board	Serious case review evaluation	Date of evaluation letter
Barking & Dagenham	Good	12/08/2010
Birmingham	Adequate	07/04/2010
Birmingham	Adequate	14/06/2010
Birmingham	Good	18/03/2011
Blackburn with Darwen	Good	19/05/2010
Blackburn with Darwen	Outstanding	06/12/2010
Blackpool	Adequate	17/08/2010
Blackpool	Good	22/03/2011
Bournemouth and Poole	Good	05/10/2010
Bradford	Good	26/07/2010
Bradford	Outstanding	19/11/2010
Bromley	Good	22/10/2010
Bromley	Good	07/03/2011
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
Cornwall	Adequate	05/10/2010
Coventry	Adequate	29/10/2010
Croydon	Good	24/12/2010
Darlington	Good	19/11/2010
Derby City	Adequate	07/05/2010
Derby City	Adequate	22/12/2010
Dorset	Good	09/11/2010
Ealing	Good	18/10/2010
East Riding	Good	26/07/2010
Enfield	Adequate	24/05/2010
Essex	Adequate	12/08/2010
Essex	Good	13/09/2010
Essex	Outstanding	04/02/2011

Gateshead	Adequate	28/10/2010
Gateshead	Inadequate	16/11/2010
Gloucestershire	Adequate	17/06/2010
Gloucestershire	Adequate	22/03/2011
Hackney	Good	09/08/2010
Hackney	Good	12/08/2010
Hampshire	Good	03/03/2011
Havering	Adequate	01/10/2010
Herefordshire	Good	16/08/2010
Hertfordshire	Adequate	14/04/2010
Hertfordshire	Adequate	19/04/2010
Hillingdon	Good	03/03/2011
Hounslow	Good	06/07/2010
Hounslow	Inadequate	26/07/2010
Isle of Wight	Good	02/12/2010
Islington	Good	19/08/2010
Kent	Good	03/06/2010
Kent	Good	06/07/2010
Kent	Good	21/10/2010
Kent	Good	22/12/2010
Kingston upon Hull	Inadequate	04/02/2011
Kingston upon Thames	Adequate	16/09/2010
Kirklees	Good	26/05/2010
Knowsley	Adequate	11/08/2010
Lancashire	Adequate	31/08/2010
Lancashire	Good	01/10/2010
Leeds	Good	13/05/2010
Leeds	Good	12/07/2010
Leeds	Good	01/12/2010
Leeds	Inadequate	04/02/2011
Leicestershire	Good	25/10/2010
Leicestershire & Rutland	Good	23/09/2010
Lewisham	Adequate	01/04/2010
Liverpool	Good	12/07/2010
Luton	Good	07/02/2011
Manchester	Outstanding	06/04/2010
Manchester	Good	19/04/2010
Manchester	Good	13/08/2010
Manchester	Good	01/10/2010
Manchester	Outstanding	24/11/2010

Manchester	Good	10/12/2010
Middlesbrough	Good	22/12/2010
Newham	Good	13/05/2010
North Lincs	Adequate	27/08/2010
North Tyneside	Good	09/11/2010
North Tyneside	Adequate	10/11/2010
North Yorkshire	Good	29/10/2010
Northamptonshire	Good	16/11/2010
Nottinghamshire	Good	10/05/2010
Nottinghamshire	Good	17/06/2010
Nottinghamshire	Good	02/11/2010
Oldham	Good	11/03/2011
Plymouth	Adequate	21/10/2010
Redcar & Cleveland	Good	08/10/2010
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
Sandwell	Good	01/10/2010
Sefton	Good	05/07/2010
Sheffield	Adequate	11/03/2011
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
Staffordshire	Good	27/01/2011
Stockport	Good	02/11/2010
Stoke	Adequate	03/12/2010
Swindon	Adequate	03/08/2010
Tameside	Good	08/04/2010
Tameside	Adequate	24/06/2010
Tameside	Good	03/11/2010
Telford &Wrekin	Inadequate	15/12/2010
Torbay	Good	08/11/2010
Torbay	Good	23/12/2010
Wakefield	Good	12/08/2010
Wakefield	Adequate	04/10/2010

West Sussex	Good	27/07/2010
Wolverhampton	Adequate	14/06/2010
York	Inadequate	25/11/2010