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## Learning from serious case reviews

### Report of a research study on the methods of learning lessons nationally from serious case reviews

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#### Key Findings

- Serious Case Reviews provide a valuable tool for learning and for improving practice and policy in relation to safeguarding children.
- Serious Case Reviews provide an opportunity to critically examine safeguarding practice within the context of an understanding of the circumstances of a child's world and his or her suffering. It is important that any learning is embedded within this wider context.
- The national analysis of Serious Case Reviews can identify new issues that have the potential to change practice, and also emphasises lessons that need to be repeatedly learned; the Serious Case Review process is therefore a means of highlighting the importance of key elements of practice that may otherwise be ignored.
- This research suggests that the potential learning opportunities provided by SCRs are not being fully realised either at a local or a national level.
- There would appear to be more scope for embedding learning throughout the process through strengthening the current procedures for carrying out SCRs. In particular at the scoping stage, panels can consider the support needs of practitioners and plan for opportunities for learning to be included in the review.
- Much deeper learning could be achieved through strengthening and broadening the scope of national analysis of SCRs, and through changes to the way in which lessons are disseminated.

#### Background

In recognition of its huge public and professional importance, every case of fatal child abuse or neglect in England is subject to a multi-agency Serious Case Review (SCR). The purpose of these reviews, which are also carried out in some circumstances following serious but non-fatal abuse, is to establish whether there are lessons to be learned about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. For several years, the government has commissioned national research studies to identify and disseminate common themes and trends from SCRs. These biennial analyses have been highly influential in supporting both national and local training, policy and practice. They have also, however, been criticised for a lack of timeliness, and for repeatedly identifying the same lessons.

#### Aims

In view of this, the former Department for Children, Schools and Families commissioned the Universities of Warwick and East Anglia to undertake a review of these analyses, to ascertain their validity and usefulness, and in the light of this, to propose any appropriate amendments to the ways in which SCRs are conducted and lessons learnt.

## **Methodology**

The research involved three interrelated methods:

- a) a critical appraisal of previous biennial analyses;
- b) a series of focus groups exploring the views of relevant stakeholders;
- c) a Delphi consultation process with a view to developing a consensus view on any proposed amendments to the systems for national analysis.

Participants were recruited through Local Safeguarding Children Boards across England to include professionals who have been involved in cases that have been subject to a SCR; those who have previously compiled SCRs; and practitioners, trainers and policy makers who have drawn on lessons learnt from SCRs. The outcomes of all three stages were analysed using qualitative approaches.

## **Findings**

Three main themes emerged from the study:

### ***1. Learning lessons from Serious Case Reviews at a local level***

Participants in both the focus groups and the Delphi expressed some frustrations about the process of doing a Serious Case Review, perhaps best summed up in the comment of one of the focus group participants that *“the process has become the purpose”*. Participants found the emphasis on getting the report right constraining and felt that this tended to detract from learning. Nevertheless, participants from all backgrounds also saw the SCRs as providing enormous opportunities for learning and were able to identify ways in which this could be enhanced. Participants felt that the emphasis at local level should be on exploring systems and management rather than a wider look at risk factors. Study participants also emphasised that SCRs should be set in the context of good practice and a broader spectrum of safeguarding, not just the severe end of the spectrum and when things go wrong.

Participants felt that learning should be embedded in the process of conducting the SCR rather than waiting until it is complete. The emphasis on learning lessons rather than apportioning blame was considered appropriate, but it was also acknowledged that this should not remove accountability. Although participants saw benefits in both standardisation and flexibility in the approach to carrying out SCRs, preference was given to keeping the process standardised as this gives confidence to both those carrying out the reviews and to staff who are involved. It is not unusual for practitioners to feel excluded from, and disempowered by, the process of the SCR and this does not facilitate learning. Going through a SCR is stressful for frontline practitioners, but with appropriate support and engagement, those involved can learn from the review.

### ***2. National analysis of Serious Case Reviews***

There was a clear sense amongst study participants that the system of national collation of SCRs provides a unique opportunity for ongoing research and understanding of the patterns and context of serious and fatal maltreatment. There was some frustration with the perceived problem of Serious Case Reviews repeatedly identifying the same problems in relation to interagency working, particularly around information sharing and the quality of recording and analysis of information. However, it is important that this does not detract from the very real learning that does take place, including new learning that has the potential to change practice. In many ways, the fact that some issues come up repeatedly emphasises that these lessons need to be repeatedly learned, and the Serious Case Review process is a means of highlighting the importance of key elements of practice that may otherwise be ignored.

National analysis should focus on looking at patterns, rather than simply describing and repeating local level issues. However, there is also a role for collating local issues in order to identify issues of national relevance. Within this there seems to be a role both for a regular summary of SCR findings and for more specific thematic analyses. It was suggested that the national analysis of SCRs could be enhanced by linking it with a national analysis of child death overviews so as to provide a broader focus. A broader analysis incorporating data from IMRs and chronologies, or using comparator data could increase the depth of learning in these national analyses. However such approaches add to the complexity and carry significant logistic issues.

Both commonalities and the diversity of case characteristics have been identified in previous national analyses. This highlights that we can recognise some factors which repeatedly occur, but should be wary of drawing conclusions that may lead to stereotypes or ignoring other, more random, factors. It is acknowledged that the nature and diversity of identified risk factors are such that any attempt to develop screening tools is likely to be counterproductive.

### ***3. Learning lessons from Serious Case Reviews at a national level***

There was agreement amongst study participants that the current biennial reviews of SCRs provide a valuable national context within which to set local learning. However, there is scope for improving the dissemination of national learning. Within this, there are advantages to having both readily accessible “bite-sized” learning, and the more in-depth learning provided by a detailed research report. Particular suggestions included having a dedicated website on which learning points could be made rapidly available; short ‘fact sheets’ or briefings for practitioners, managers and policy makers; a newsletter; and case-based learning materials that can be made readily available to LSCB trainers.

#### **Implications for policy and practice**

1. This research has highlighted the value of a more participative approach to conducting Serious Case Reviews, rather than a focus solely on documentary review and one-way transfer of information through practitioner interviews.
2. There are many ways in which learning can be embedded throughout the process of carrying out a Serious Case Review; this may include workshops for involved practitioners, other front-line workers and managers at an early stage in the IMR process as well as subsequent briefing / workshop events. Approaches to learning can be included in the scoping of a Serious Case Review.
3. Clear briefings for IMR authors as to their role, along with training in facilitating learning as part of the process would enhance the value of learning at a local level.
4. Serious Case Reviews are stressful events for both practitioners and managers. They therefore need support throughout the process. Approaches to support can be included in the scoping of a Serious Case Review.
5. Learning from a Serious Case Review can be enhanced if all involved practitioners understand, from the beginning, the need for and purpose of the review. They should be informed that the emphasis is on learning lessons, but that this will include a critical reflection on both individual and organisational practice, and that if issues are identified requiring disciplinary action, these will be addressed through parallel processes. This briefing needs to be done with sensitivity and support for the individual.
6. Whilst there is flexibility in the methods used for analysis in Serious Case Reviews, the validity of the lessons learnt is enhanced if the methodology is clearly described in the review.
7. There is a need for further research to explore different methods of improving practitioner involvement in and learning from the Serious Case Review process.
8. Training materials and standardised templates for carrying out Serious Case Reviews can enhance standardisation and opportunities for national learning.
9. A scaled back approach to evaluating and reporting on Serious Case Reviews would make the process more supportive of learning. This could include abolishing the summative grading of Serious Case Reviews in favour of more supportive formative feedback.
10. The breadth and depth of learning from national analyses of Serious Case Reviews could be enhanced by an expansion of the current notification database to include an electronic repository of anonymised overview reports together with IMRs, chronologies, genograms and action plans for all Serious Case Reviews.
11. The authors of this study suggest a revised system of national analysis which we believe would provide a more robust and flexible approach to national learning along the following lines:
  - A research team commissioned for a longer period of at least 5 years to provide an observatory / reporting function on all Serious Case Reviews; this research team would have responsibility for annual reporting of the numbers, patterns and key learning from Serious Case Reviews, and would have access to data that will enable data on Serious Case Reviews to be linked to and compared to data from Child Death Overview Panels, and to wider data on children’s safeguarding; this research

team would also have responsibility for reviewing any national implications of recommendations from Serious Case Reviews;

- A national steering group established to oversee the work of the research team and to advise on further thematic analysis of the data;
  - The data or subsets of the data would be made available to bona-fide researchers with relevant and appropriate proposals to undertake thematic analysis, under the direction and approval of the national steering group; the national steering group could recommend specific themes for analysis that are considered to be of national importance; these could then be commissioned by the Department for Education, or funded proposals sought from elsewhere.
12. There was considerable enthusiasm for national studies of good practice in safeguarding. This is currently part of the ongoing Safeguarding Children research programme within the Department for Education and the Department of Health. Results from this should help to balance the negative impact of focusing on what goes wrong.
  13. Timely and accessible dissemination of learning from Serious Case Reviews would be enhanced by open publication of the key lessons learned from national analysis on a website. This would require close collaboration between the Department for Education, Ofsted, and any research team involved in national analysis.
  14. Findings from research on Serious Case Reviews need to be presented in a variety of formats to reach different audiences, including practitioners, policy makers and researchers. This could include easily readable newsletters or briefing papers, more substantive research and publications in peer reviewed scientific journals. A strategy for dissemination should form a substantial part of any research proposal.
  15. Learning from Serious Case Reviews should be embedded in a range of training materials that could be made available to local trainers.

### **Additional Information**

Copies of all of the reports can be downloaded free of charge at  
<http://www.education.gov.uk/research/>

Further information about this research can be obtained from Julie Wilkinson,  
Sanctuary Buildings, Great Smith Street, London, SW1P 3BT.

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This research report was written before the new UK Government took office on 11 May 2010. As a result the content may not reflect current Government policy and may make reference to the Department for Children, Schools and Families (DCSF) which has now been replaced by the Department for Education (DFE).

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.