



CHILDREN AND FAMILY COURT ADVISORY AND SUPPORT SERVICE

Paper for the Board Meeting on 30 October 2009

SERIOUS CASE REVIEW: 6 MONTHLY UPDATE

1 AIM AND PURPOSE

1.1 This report summarises and analyses Serious Case Reviews to which Cafcass inputted between April and September 2009.

2. RECOMMENDATIONS/ACTION FOR THE BOARD

2.1 The Board is asked to note the information and position in relation to serious case reviews.

3. SHORT SUMMARY

3.1 This report provides statistics about child deaths and cases for those Serious Case Reviews where Independent Management reviews from Cafcass have been ordered. It also provides a summary of lessons learnt. .

4 SERIOUS CASE REVIEWS APRIL – SEPTEMBER 2009

4.1 Appendix A sets out the activity levels in relation to serious case reviews. There is no identifiable trend pattern in respect of notifications of child deaths. We saw a sharp rise in the first 6 months of 2008-2009 (35 notifications) but this was probably linked to a more consistent application of procedures by local authorities following revised governmental guidance rather than an actual rise in the number of children dying in circumstances warranting such a review. However there were only a further 7 notifications in the second 6 months. In the first 6 months of the current year we have had 12 notifications but in the 2 weeks following the close of the period have already had 7 more. In a significant number of cases Cafcass' only involvement post dates the death of the child and is as a result of subsequent Care Proceedings in respect of siblings. In one case where reports have been requested Cafcass had no knowledge of the child who had died nor of the family, but had been involved with another child living in the same foster home.

4.2 The ages of children and circumstances of the deaths show the vulnerability of younger children and of teenagers – the latter being most often linked to suicides.

4.3 From its inception Cafcass has struggled to provide writers of Internal Management Reviews who were independent of line management and who had the space to complete the necessary work. This became increasingly difficult with the tight timescales now required and the introduction of new standards issued by Ofsted in early 2009. The role largely fell to operational service managers who found it increasingly difficult to balance their core workload with these additional demands. In addition Government Offices throughout England introduced a system based on Ofsted Standards for "scoring" all reports, both those of the individual agencies as well as the overview reports, and taking account of these scorings in overall performance assessments. In response it was agreed that it would be better for non-operational managers to undertake the role. 45 such staff completed the necessary first stage of training in January and June 2009. These managers are now the first port of call as cases come in. The second stage of their training will take place in the new financial year.

4.4 Lessons learnt from Serious Case Reviews are followed up both via Service Area 6-weekly Improvement Meetings and by the Cafcass Learning Action Panel to ensure Action Plans are implemented and any national implications picked up and reflected in revisions to policies or procedures. Cafcass' Safeguarding Framework has recently been revised and updated and has taken account of all

necessary policy or procedural changes required up to the end of September 2009. It now serves as the core document for practice guidance, includes new material around Serious Case Reviews and sets out a procedure to ensure effective management and quality assurance of the processes involved.

4.5 Four out five Internal Management reviews commissioned in have been completed and one is ongoing. The circumstances of the deaths of the children in the four completed cases were as follows:

- Amphetamine ingestion and bruising (2 year old)
- Suicide in Secure Accommodation (15 year old)
- Death of a disabled child from natural causes where there were concerns about multi-agency working
- Unknown cause of death of a child in foster care - also with concerns about multi-agency working

4.6 Inevitably the reviews consider historic practice and the issues raised often reflect inadequacies in policies and procedures at the time that have since been remedied. Significant issues/ lessons emerging in the last six months are as follows (action taken is added in italics):

- The importance of ensuring staff have adequate training in respect of Safeguarding, Risk Assessment; Domestic Violence, Substance Misuse and Diversity;
There has been compulsory training in respect of Safeguarding, and Domestic Violence, guidance has been added to the practice pages of the Intranet in respect of work with Substance Misusing Parents. Equality Impact Assessments are being completed in all Service Areas, which will result in plans being developed, including any further need for Diversity training
- Effective line management/supervision and staff to manager ratios and the need to audit management processes and quality of supervision;
A practitioner::manager ratio of 10:1 people in post has been established as part of the 2009 restructure; the Supervision Policy was updated in 2009 and now includes observation of practice, including observation of the supervision function. Assessment of the quality of supervision practice is recorded on Q4c and improvement/development plans put in place where required
- The importance of ensuring policy compliance and managing performance;
All policies are now launched via an On-line policy centre which requires staff to sign off acceptance of policy and completion of sign off of new policies is monitored and reported via Area Service Improvement Meetings. The Q4C system introduced in 2008 records issues around compliance with policy.
- Accuracy of CMS data entry;
In preparation for the introduction of changes to CMS to enable progress towards the implementation of ContactPoint and to add increased functionality, data assurance exercises have been completed to improve data accuracy.
- The need for updated guidance around Risk Identification in Public Law cases; and
- The need to ensure appropriate information is sought from the police in Private Law cases.
The safeguarding Framework has been updated – re- launched 14th October 2009 and incorporates full guidance in respect of these issues. The National protocol with the police is under review.

5 KEY STRATEGIC ISSUES FOR THE BOARD TO CONSIDER

5.1 The Board needs to be able to demonstrate that there are robust responses when issues are raised in serious case reviews.

6 BENEFITS FOR CHILDREN

6.1 The action taken as part of follow-up of serious case reviews will assist with improving our overall safeguarding response and service to individual children.

6.2 Reporting of the outcomes of Serious Case Reviews also ensures the Board can satisfy itself that all lessons have been learnt and any necessary changes to practice and procedure completed.

7 FINANCIAL ANALYSIS

7.1 There are no direct financial implications arising from this report.

8 RISK ANALYSIS

8.1 Failure to effectively manage Cafcass' role in respect of safeguarding risks placing both children and their families at risk. Unacceptable performance in this area also risks bringing Cafcass into disrepute and increases the risk of criticism in inspections.

9 DIVERSITY ANALYSIS

9.1 **Research shows that children in minority ethnic groups or with disabilities are likely to be doubly vulnerable in respect of safeguarding issues; however data relating to serious case reviews currently shows no specific issues re diversity.**

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23 October 2009**