

Early help: whose responsibility?

This thematic inspection evaluates the effectiveness of the early help services for children and families provided by local authorities and their partners. The report draws on evidence from inspection, from examining cases in 12 local authorities and from the views of children and young people, parents, carers, practitioners and managers.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk

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Executive summary

It is estimated that over two million children in the UK today are living in difficult family circumstances. These include children whose family lives are affected by parental drug and alcohol dependency, domestic abuse and poor mental health. It is crucial that these children and their families benefit from the best quality professional help at the earliest opportunity. For some families, without early help difficulties escalate, family circumstances deteriorate and children are more at risk of suffering significant harm.¹

Independent reviews and research have long championed approaches that provide early help for these children and their families. As Professor Eileen Munro highlighted in her review of child protection, 'preventative services can do more to reduce abuse and neglect than reactive services'.² It is only right that local authorities and their partners are focusing increasingly on early help and prevention services for families. Many are now establishing a more coordinated and structured approach to this crucial role.

Her Majesty's Chief Inspector commissioned this thematic inspection to gain a more accurate picture of how effectively local partnerships' early help services are improving children's circumstances, reducing risk and taking further action when needed.

Inspectors considered 56 early help cases in 12 local authorities. Encouragingly, they found that the partner agencies in all the local authorities visited were committed to improving and coordinating their early help services. In nearly all of the cases, early help was the right approach. However, in over a third, partner agencies had missed earlier opportunities to provide help, leaving these children with no support when they needed it.

In just under half of the cases reviewed, early help professionals had undertaken sound assessments of children's needs. Over half, however, were of poor quality. In some instances, professionals gave limited or no consideration to family history. In other cases, they did not collect or analyse information about fathers or male partners, even when they were part of the child's household. Inspectors were particularly concerned that, in many cases, professionals failed to speak to the child and relied solely on what parents told them.

Inspectors found evidence of effective planning in only a third of cases. These plans focused strongly on improving children's lives and were regularly reviewed to ensure

¹ In this report, 'early help' means 'providing support as soon as a problem emerges, at any point in a child's life'.

Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children, Department for Education, 2013;

www.gov.uk/government/publications/working-together-to-safeguard-children.

² Professor Eileen Munro, *The Munro review of child protection: final report – a child-centred system*, Department for Education, 2011; www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

sustained progress. Yet in two thirds of the cases plans were ineffective. Many did not sufficiently take into account children's individual circumstances when deciding what action was needed. Plans often lacked objectives and were not regularly reviewed, so it was not always clear how actions would achieve any improvements. Inspectors found that reviews focused too much on whether actions had been completed, rather than whether they had the intended impact on the child's life.

Overall, inspectors identified serious weaknesses in the management oversight of early help cases. A small number of cases had no formal arrangements in place at all. In others, arrangements were significantly underdeveloped. Worryingly, inspectors found that Local Safeguarding Children Boards (LSCBs) were not monitoring the management oversight of early help practice.

More generally, local authorities and their partners were not fully evaluating the impact of their early help work. The majority of their audits focused too much on process and compliance and not enough on the quality of the service and the extent to which it helped improve children's lives. Many partnerships had not yet developed systems to evaluate whether the right children were receiving early help at the right time.

LSCBs were complying with their duty to produce a threshold document that sets out the different types and levels of early help for families and makes clear when any professional should refer cases to children's social care. However, very few had audited whether children were receiving the right type and level of help when they needed it. Most LSCBs were not providing enough training on early help, or working with challenging families, to those practitioners who needed it.

More encouragingly, few workers felt isolated and most said they could access a range of formal and informal support. Where they existed, early help coordinators were highly valued.

This thematic inspection also considered 84 children's cases referred to local authorities by various professionals. In most cases, local authority managers made sound decisions that these children did not need the statutory services of a social worker. However, some of these children were not directed to early help services from which they would have benefited. As a result, their circumstances deteriorated and the same, or in some cases other, professionals in the partner agencies later referred them back to children's social care. Despite training, some professionals were not sure when they should make referrals and found it difficult to interpret the local guidance. Too often, referrers did not receive feedback on the outcome of their referral and did not follow up on this.

Inspectors found considerable variability in how well local authorities and their partners were sharing accountability and coordinating early help services. The evidence indicated that the current statutory powers do not make clear the roles and responsibilities of the different agencies involved in early help provision. Without this clarity, none of the partners can give early help the priority that it requires.

Many of these findings mirror those in serious case reviews that looked at early help services. This highlights a concerning lack of progress. Many local authorities are failing to learn the lessons from serious case reviews to improve early help services. It is hoped that the findings from this thematic inspection will trigger the critical progress required to ensure that children and families receive the help they need at the earliest opportunity.

Key findings

- In all the local authority areas visited, arrangements were in place to provide early help to children and their families.
- Partner agencies in those places inspected were committed to an early help approach and improving the coordination of the local early help offer.
- Opportunities to provide early help for children and their families were missed by all statutory partners with a responsibility for this.
- Many assessments were ineffective because they failed to sufficiently analyse or focus on what the child and family needed.
- Professionals did not always identify or meet the individual needs of children within a family. Early help plans did not focus sufficiently on the child, often lacked clear objectives, failed to specify what needed to change and were not regularly or robustly reviewed.
- Management oversight of early help was often underdeveloped and failed to identify or rectify weaknesses in the work being undertaken.
- When children were referred to social care services because there were concerns about their welfare, the service or referrer often did not consider or follow through the need for early help. As a result, nothing was put in place to prevent the child's circumstances from deteriorating. This led to further referrals for statutory social care support.
- Too often, feedback on referrals was neither sought nor offered.
- Partner agencies did not fully evaluate the impact and effectiveness of their early help services.
- The planning of local services did not sufficiently recognise or address the needs of children living with parental substance misuse, mental ill health or domestic abuse.
- LSCBs were not effectively overseeing or challenging partner agencies with regard to effective early help.
- The current statutory framework does not give sufficient clarity and priority to the roles and responsibilities of individual agencies for early help provision.³

³ *Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children*, Department for Education, 2013;
www.gov.uk/government/publications/working-together-to-safeguard-children.

- The inability to sufficiently prioritise and resource early help across agencies meant that lessons learned from serious case reviews were not being fully addressed.

Recommendations

The government should:

- strengthen and specify the roles and responsibilities of local authorities and statutory partners, setting out that they must secure sufficient provision of local early help services for children, young people and families and require that an annual plan is published by the partnership and aligned with the local joint strategic needs assessment
- require LSCBs to evaluate the quality and effectiveness of early help services and to publish their findings in the annual LSCB report.

Local authorities and partner agencies delivering early help to children and families should:

- improve the quality and consistency of assessment and plans by:
 - promoting the use of evidence- and research-informed assessment practice
 - improving the quality of analysis in assessments
 - ensuring that assessments reflect the views and experience of the child and family
 - making the purpose clearer and improving the intended outcome
 - ensuring plans are regularly reviewed and that these reviews evaluate the child's and family's progress
- provide professional supervision to all staff delivering early help and ensure that their work receives regular management oversight, particularly in respect of decisions about whether families need more formal help
- ensure that all early help professionals have access to effective training
- ensure that children's needs for early help arising from parental substance misuse, mental ill health and domestic abuse are addressed in commissioning plans.

LSCBs should:

- critically evaluate the effectiveness of early help and publish these findings in the LSCB annual report
- monitor the quality of early help assessment, planning and management oversight through effective audit arrangements
- develop and monitor local quality standards to ensure that early help professionals have access to effective supervision and management oversight

- evaluate the effectiveness of the LSCB threshold document to ensure that it is understood and used appropriately by all partner agencies and that children and families are helped effectively as a result
- monitor and evaluate whether children's emerging needs are appropriately met elsewhere when referrals to children's social care do not meet the locally agreed threshold for statutory intervention
- ensure that all professionals working with families receive effective early help training.

Local authorities should:

- ensure that when a child is referred to local authority children's social care the referrer is consistently given good-quality feedback about the outcome of the referral
- establish effective processes for evaluating the overall impact of early help.

Introduction

1. Large numbers of children and young people live in challenging family circumstances:
 - 2.6 million children in the UK are living with parents who drink hazardously; 705,000 of those are dependent on alcohol⁴
 - 110,123 adults who were parents or lived with children were treated by the National Agency for Substance Misuse in 2013–14⁵
 - 130,000 children are living in families where family life has been damaged by past or present domestic abuse⁶
 - 17,000 children are living with parents with a severe and enduring mental illness⁷
 - 657,800 concerns about children were referred to children’s social care services during 2013–14⁸, an increase of 10.8% compared with the previous year.

2. Ofsted’s inspections of local authority help and protection arrangements since January 2012⁹ have found evidence that many local areas have begun to establish early help services for families. The need for an increased focus on early help, intervention and prevention within the family was reinforced by Professor Eileen Munro¹⁰ in her review of child protection. Other supporting reviews include the work of Graham Allen¹¹ on the benefits of early intervention

⁴ *Swept under the carpet: children affected by parental alcohol misuse*, Alcohol Concern and The Children’s Society, 2010; www.childrenssociety.org.uk/sites/default/files/tcs/swept_under_the_carpet_briefing_paper_oct_2010.pdf.

⁵ *Drug treatment in England 2013–14*, Public Health England, November 2014; www.nta.nhs.uk/uploads/drug-treatment-in-england-2013-14-commentary.pdf.

⁶ *A place of greater safety*, Co-ordinated Action Against Domestic Abuse (CAADA), 2012; www.caada.org.uk/policy/A_Place_of_greater_safety.pdf.

⁷ *Parents with mental health problems*, Mental Health Foundation, 2013; www.mentalhealth.org.uk/help-information/mental-health-a-z/P/parents/.

⁸ *Characteristics of children in need in England, 2013-14*, Statistical First Release SFR 43/2014, Department for Education, October 2014; www.gov.uk/government/uploads/system/uploads/attachment_data/file/367877/SFR43_2014_Main_T_ext.pdf.

⁹ *Inspecting local authority children’s services: the framework*, Ofsted, 2014; www.gov.uk/government/publications/inspecting-local-authority-childrens-services-framework. *Arrangements for the protection of children; Inspection of services for children in need of help and protection, children looked after and care leavers; Review of the effectiveness of the local safeguarding children board*, June 2014, Ofsted; www.gov.uk/government/publications/inspecting-local-authority-childrens-services-framework.

¹⁰ Professor Eileen Munro, *Munro review of child protection: final report – a child-centred system*, Department for Education, 2011; www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

¹¹ Graham Allen, *Early intervention: smart investment, massive savings – the second independent report to Her Majesty’s Government*, Cabinet Office, July 2011; www.gov.uk/government/publications/early-intervention-smart-investment-massive-savings.

programmes, Dame Clare Tickell¹² on the Early Years Foundation Stage and Frank Field's¹³ review on poverty. These reviews identified a growing body of evidence of the effectiveness of early help for children and their families.

3. In setting out the principles of an effective child protection system, Munro highlighted that 'preventative services can do more to reduce abuse and neglect than reactive services',¹⁴ making a strong argument for local agencies to provide early help to strengthen families and reduce risk. Professor Munro's recommendation for a duty to be placed on local authorities and statutory partners to provide an 'early offer of help' was not accepted by the government, as it considered the existing duty to cooperate set out in sections 10 and 11 of the Children Act 2004 to be sufficient.¹⁵
4. The revised 'Working together to safeguard children'¹⁶ guidance re-emphasises the crucial role of effective early help. It focuses on the collective responsibility of all agencies, including adult services, to identify, assess and provide effective targeted early help services. It places a duty on LSCBs to ensure that an agreed threshold document is in place so that all professionals are clear when it is their responsibility to help children and families as difficulties emerge.
5. The Department for Education's 'Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services' refers to these important leadership roles in relation to early help, intervention and prevention with children and families. According to the guidance, Directors of Children's Services and Lead Members for Children's Services:

'should understand local need and secure provision of services taking account of the benefits of prevention and early intervention and the importance of cooperating with other agencies to offer early help to children, young people and families.'¹⁷

¹² Dame Clare Tickell, *The early years: foundations for life, health and learning*, Department for Education, 2011; www.gov.uk/government/collections/tickell-review-reports.

¹³ *The foundation years: preventing poor children becoming poor adults*, Frank Field, 2010; www.frankfield.com/campaigns/poverty-and-life-changes.aspx.

¹⁴ Professor Eileen Munro, *Munro review of child protection: final report – a child-centred system*, Department for Education, 2011; www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

¹⁵ *Full response to named day question by Tim Loughton 13 December 2011*, Department for Education; www.gov.uk/government/news/munro-review-of-child-protection-government-response.

¹⁶ *Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children*, Department for Education, March 2013; www.gov.uk/government/publications/working-together-to-safeguard-children.

¹⁷ *Roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services*, Department for Education, 2013; www.gov.uk/government/publications/directors-of-childrens-services-roles-and-responsibilities.

6. Further research¹⁸ identifies that neglect and emotional abuse are associated with the most damaging long-term consequences for children. The research found a range of challenges for practitioners in providing help when concerns for children begin to emerge. These included the following:
- there was no shared threshold for intervention across partnerships
 - professionals found it difficult to identify these types of abuse and to decide when a threshold for action had been reached
 - these forms of harm to children were rarely acted on without a trigger incident
 - professionals often had high thresholds for recognising emotional abuse and neglect and were reluctant to act
 - thresholds for access to children’s social care were high, which may deter referrals.

The research provided extensive evidence that thresholds for access to children’s social care were too high. It also reported that professionals gave parents ‘too many chances’ to demonstrate that they could look after a child, often in the face of substantial evidence to the contrary and regardless of the further harm to children.

7. The National Foundation for Education Research¹⁹ conducted a series of research studies focusing on the development of early help across local authority partnerships. Its findings identify both challenges and good practice and recognise that more work is needed by local authorities and their partners to establish consistently strong early help arrangements. They note that individual practitioner skills and knowledge varies and that this is pivotal in identifying children’s early help needs. ‘Working together to safeguard children’ places a clear responsibility on LSCBs to ensure that professionals are engaged in effective training to help them identify children’s needs early.
8. Ofsted has included the inspection of early help provision by local authorities and their partners within the inspection arrangements since January 2012. Inspection reports since that time show clearly that a wide range of professionals are engaged in supporting children early as concerns emerge. For some children, outcomes are improving as a result of early identification and assessment, and the help provided has reduced risks. For others, early identification has led to children being referred promptly so they are appropriately protected by statutory children’s social care services.

¹⁸ Carolyn Davies and Harriet Ward, *Safeguarding children across services: messages from research*, Department for Education, 2011; www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research.

¹⁹ *We should have been helped from day one: a unique perspective from children, families and practitioners*, Local Authorities Research Consortium, Research in Practice and National Foundation for Education Research, September 2013; www.nfer.ac.uk/publications/LRCF01/LRCF01_home.cfm.

9. However, inspection findings reflect much of the research evidence. Local authorities and their partners face significant challenges in maintaining consistency and quality of practice, and in understanding roles and responsibilities for early help provision. The strategic vision of local authorities and their partners and their response to the early help needs of children require strengthening in many local authorities. The quality assurance of early help work, including the quality of early help assessments and plans, needs to improve. The effectiveness of the response to identified needs, management oversight and application of locally agreed thresholds should be more consistent. In addition, there is very little evidence about the impact of early help where there are concerns about children and their families.

Methodology

10. This report summarises the findings of the thematic inspection, exploring the responses of professionals when they identify that children and their families need help.
11. Inspectors visited 12 local authority areas, which varied in size and included counties and metropolitan areas with a range of rural and urban features. They examined 56 early help cases for children in total. For each of the early help cases considered, inspectors met at least one professional from a partner agency providing support to the individual family. They also met 31 parents and six young people across the 56 cases.
12. Inspectors examined an additional 84 cases referred to children's social care alongside the social workers responsible for decision making on these cases. Of these, 47 cases received no further statutory intervention. In the remaining 37, a social worker completed either an initial or core assessment before taking the decision that no further statutory intervention was required. Inspectors also spoke to the 62 workers in partner agencies who made these referrals.
13. Inspectors met LSCB members, local authority and partner agency staff in connection with local early help commissioning and quality assurance arrangements.
14. The key areas that the thematic inspection considered were:
 - the arrangements in place in local areas to ensure that children and families needing early help are identified at the earliest opportunity
 - whether professionals use locally agreed thresholds effectively to provide an appropriate response to concerns about children
 - arrangements to assess children's needs and plans made in response
 - the extent to which professionals seek to understand the individual experiences of the child living in the family

- whether the early help provided is routinely reviewed to ensure that individual children’s circumstances are improving, risk is reducing or that further action is needed
 - the extent to which professionals working with families understand their role and how to effectively escalate their concerns
 - the extent to which professionals work together to monitor and evaluate the impact of early help for children and families and how this information is used strategically
 - how effectively LSCBs evaluate multi-agency early help and whether they oversee professional training and support
 - whether professionals are aware of and use research and learning from serious case reviews in relation to early help and the impact this has on professional practice.
15. Good practice in a range of authorities is highlighted in this report. These examples illustrate particular aspects of the work; they are not intended to suggest that practice in a local authority was exemplary in every respect.
16. This report brings together themes identified across all local authorities visited for the purpose of this inspection. Not all findings in this report were evident in each local authority visited.
17. Where case studies are referenced, contextual details such as the child’s age and/or gender may have been changed to maintain confidentiality.

Findings from practice

Early help provision

18. A wide range of professionals working in universal services are identifying additional needs for children and families.
19. Inspectors considered 56 early help cases. The children concerned had a variety of needs that led to professionals from different disciplines working together to support them and their families. These needs included:
- parents struggling to manage their child or children’s behaviour
 - children with a learning difficulty, such as an autistic spectrum disorder
 - a child displaying inappropriate sexualised behaviour
 - parental or child isolation
 - low-level parental mental or physical ill health
 - vulnerable young parents
 - bereavement
 - parental alcohol misuse

- financial difficulties/debts
 - parental learning difficulty
 - early neglect
 - housing difficulties (overcrowding and homelessness)
 - risk of school exclusion
 - poor attachment between child and parent
 - child's low self-esteem.
20. Inspectors found that thresholds were appropriately considered and used in all but three of the early help cases examined. These cases were referred back to the local authority for further assessment as children were considered to be experiencing significant harm.
21. Inspectors closely reviewed early help cases alongside a professional involved in working with the family. They found that opportunities to intervene earlier were missed in over 40% of the cases. In a very small number of cases, despite the efforts of professionals, parents had refused offers of help and professionals appropriately judged that this refusal did not warrant referrals to children's social care at that time.
22. These missed opportunities were attributed to a number of factors, including delays in information-sharing between agencies, delays in providing services following assessment and parents not being given support when they first asked for help. Most significantly, in six of the cases, the families had long-standing identified needs that, historically, individual agencies had only responded to in a crisis. In these cases, until the current early help intervention, agencies had failed to work together to support these families at an earlier point.
23. In one case, a family was known to children's social care and received child in need services in 2011. The social work assessment at that time did not robustly assess the parents' long-term ability to respond to the children's changing needs as they got older. As the children got older, the parents, who had moderate learning difficulties, were not able to manage the children's changing needs. No one agency had a good oversight of the family's circumstances after the case had been closed. As a result, different schools responded reactively to the issues as they arose with each individual child in school rather than supporting the family and understanding the child's experiences in the family home environment. The parents always responded to schools and accepted any help willingly. This masked and deflected attention from the experiences and neglect of the children.
24. The quality of the early help assessments undertaken with families was too variable. Inspectors considered fewer than half of the assessments to be of good quality. Poor assessments routinely:

- failed to analyse information
 - were overly descriptive and so not clear about strengths and concerns
 - relied heavily on one parent's self-reporting, with limited or no input from professionals
 - did not consider the family's history nor consider the significance of the current issues
 - focused too much on the parent rather than the impact of the parent's difficulties on the child
 - contained limited information about the father or other partners even when they were part of the household.
25. Too many assessments did not include the views of children. In almost a third of cases, the inspector specifically noted the absence of the child's voice or sufficient understanding of their experiences, where this would have been expected given the child's age. In almost all of these cases the assessment was also found to be too focused on the adults' needs and not sufficiently child-focused. For example, an inspector noted:

`... the young person was not consulted despite being 15 years old. There was a lot of information about his behaviour in the assessment which attributed a sense of blame to the child. I would be uncomfortable with this young person reading the assessment as it was not child centred'.

26. Good assessments were characterised by:
- a professional speaking to the child about their experiences and asking for their thoughts and feelings about their circumstances
 - consideration of brothers' and sisters' needs individually
 - the participation and consent of both parents
 - the family's history informing the findings and decisions
 - all professionals known to the family contributing to the assessment
 - comprehensive information
 - needs, risks and strengths being clearly identified
 - sound conclusions based on good analysis of information.

In areas where professionals used a standardised assessment tool, assessments were generally of better quality. For example, in Milton Keynes, professionals

used the Signs of Safety²⁰ model for early help assessments. In one case, an inspector noted that:

'... the use of this model assisted professionals to identify strengths, needs and risks within the family ... information is gathered from the professionals who know the children and the parents; history has been considered well (which leads to a time limited emphasis to the plan); the children have all been spoken to alone and despite the very low levels of speech of the five-year-old, efforts were made to communicate with her at school by those who know her well.'

27. In another local authority, some professionals conducted early help assessments using an 'Evaluation Wheel'. This is a graphical tool that invites parents to rate their level of confidence in areas such as 'using services in the community', 'parenting skills' and 'feeling good about myself'. The areas to work on are drawn from these ratings. The exercise is then repeated when the intervention is reviewed in order to measure impact. Although simple, this tool is effective in both engaging parents and in measuring the impact of work.
28. Inspectors saw some good practice with proactive steps being taken to ascertain the child's wishes and feelings as well as understand what life was like for them in their household. In just over a quarter of assessments, inspectors found that the child was spoken to directly and that this contributed to a good assessment. In other assessments, there were good observations of very young children from professionals who knew them well. One inspector noted that:

'the worker clearly has engaged the child and you get a sense he is at the centre of the assessment. His voice can be clearly heard in the narrative.'
29. Engaging fathers or male partners living in the household, was a significant failing of early help work. Both parents were sufficiently included in the assessment and plan in only two fifths of the early help cases. Of the remaining cases, a further two fifths of fathers were excluded without rationale. A third were available but not sufficiently engaged. One fifth of fathers were not involved in early help work because they were no longer in contact with the child or as a result of significant domestic abuse.
30. In over two thirds of cases, the subject child had brothers and sisters. The majority of cases paid good attention to siblings who were also the subject of an early help assessment, high numbers of which also had an early help plan. Others were appropriately deemed not to require a plan following assessment. Some assessments grouped children's needs and did not provide details about the children's individual needs. In others, brothers and sisters were not considered. This meant that for almost a quarter of cases opportunities were

²⁰ The Signs of Safety model is a strengths-based and safety-organised assessment and planning framework for child protection practice and was originally developed in Western Australia by Turnell and Edwards; www.signsofsafety.net/signs-of-safety.

missed to assess and support these other children in the family. In one local authority, the standard early help policy, which was well known by professionals, required them to assess the needs of all children in the family. This assisted professionals to think holistically about families.

31. In just over a third of the early help cases, inspectors saw effective planning that was contributing to improving outcomes for children. This included regular reviews of plans focused on outcomes and good use of 'distance-travelled' tools that attempted to measure and evaluate the desired outcomes. Practitioners were able to evidence a wide range of improvements in the child's circumstances. These included:
 - improved school attendance
 - reduced short-term school exclusions
 - reduced inappropriate sexualised behaviour
 - reduced isolation
 - improved presentation
 - immunisations being up to date where they had been absent previously
 - improved progress in meeting developmental milestones
 - academic improvements
 - improved housing and home conditions
 - care arrangements stabilising
 - improved speech and language.

32. Practitioners were also able to evidence improved parental behaviours that were having a positive impact on the child. These included:
 - more consistent behaviour management and routines
 - parenting that had improved after attending a parenting course
 - increased emotional warmth demonstrated to the children
 - parents engaging with and taking advice from professionals
 - improved mental health
 - a reduction in debt
 - a reduction in drug/alcohol misuse
 - gaining employment.

33. In almost all cases, practitioners were able to verbally articulate that outcomes for children had improved, although this was often absent from written records. Written plans were not sufficiently outcome-focused so they did not assist professionals in knowing when a goal had been reached or in measuring progress towards a goal. In almost half of the early help cases, inspectors

reported deficiencies in the plan and in ongoing work. Four cases had no written plan. Some plans did not feature the needs identified in assessments. Most significantly, inspectors found that in almost three quarters of the deficient plans actions were overly focused on parents and it was not clear how the action would improve the child's outcomes. A large majority were not sufficiently specific or measurable, did not set achievable goals, contained no plans to review and did not set timescales in which changes needed to be achieved.

34. Too many plans and subsequent reviews did not clearly establish whether the child's circumstances were improving, neither did they hear from children. While almost all cases had plans, in too many instances plans were not being reviewed regularly. Because plans were not outcome-focused, where reviews took place the meetings did not effectively consider progress in relation to the plan. Plans were too often a list of actions that did not identify the outcome to be achieved for the child or how these actions would improve the child's circumstances. Many made the assumption that the issue would be remedied with the action taken; for example, many required a parent to attend parenting sessions. While the parents may have attended, there was rarely subsequent analysis about whether this attendance had improved either the parenting or the child's circumstances and experiences.

Referrals to the local authority

35. In order to consider the application of local thresholds, inspectors examined referrals to the local authority. These included cases that did not progress beyond the point of referral and those that progressed to a formal assessment followed by statutory intervention then ceasing. Inspectors spoke to 62 referring professionals as well as social work staff who made decisions about these specific referrals. Over a quarter of these professionals said they struggled to understand and apply local thresholds. They were not always sure which cases should be referred to the local authority.
36. In just over three quarters of the cases closed at the point of referral, this decision was considered to be appropriate. Professionals highlighted concerns about the child in the vast majority of these referrals. Children's social care appropriately judged that the level of concern raised did not reach the threshold for statutory intervention. However, while statutory intervention was not required, children and families would have benefited from an early help offer. The opportunity to put this in place was missed for some.
37. Almost a quarter of cases were closed inappropriately by children's social care at the point of referral. In these cases:
 - risk was not well considered and action was not taken when it should have been
 - there was a re-referral for the same issue in the subsequent three months that could have been addressed with the information known originally

- the referral quality was poor and the referral was closed without children’s social care speaking to the referrer to establish the reason for their decision
 - the case was closed without the completion of identified tasks.
38. The quality of referrals varied, although most provided sufficient information alongside information already known by children’s social care. However, in a small number it was not clear why the referral was being made and what the concerns were about the child. This required further follow-up by children’s social care and demonstrated that not all professionals had a sufficiently well-developed understanding of how to make referrals. Where referrals were of a good quality they:
- were timely
 - contained the following features:
 - concerns about the child and a rationale for referral
 - references to the locally agreed threshold document
 - clarity about how the concerns impacted on each child in the family
 - evidence that concerns had been discussed with the parent and consent had been sought and obtained
 - context and historical information, including the effectiveness of previous help
 - a balance between positive factors and risk
 - a summary of the views of other professionals
 - identification of any language barriers or the need for an interpreter.
39. Almost two thirds of the referrals that progressed to a formal assessment and were then closed involved children who had been referred previously. In the 12 months before these referrals, one fifth of children had more than one referral with one child having been referred four times. This child had not been the subject of an early help assessment and no plan was in place to meet previously identified needs. Despite previous referrals and ongoing involvement of single or multi-agency work for a small number of children at the time of the referral, only one referral from the sample was supported by an early help assessment. This indicated that early help assessments were not being used effectively to assess and identify needs for all children.
40. Professionals making these referrals clearly understood their responsibility²¹ to refer concerns about children’s welfare to local authority children’s social care. They understood that this was the basis of good information-sharing. What was

²¹ *Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children*, Department for Education, March 2013;
www.gov.uk/government/publications/working-together-to-safeguard-children.

not often explored was the consideration given to locally agreed thresholds and what support the child needed as a result of the identified concerns. Almost half of the referring professionals indicated that they took no further action when children's social care closed the case. They saw their duty ending with making the referral and they did not seek to secure early help for the child. One professional indicated that they 'keep referring until children's social care accepts the case'; this was not an unusual response. In some cases, professionals referred issues that did not meet the statutory threshold and did not accept or understand the decision from children's social care. In others, professionals did not understand how to escalate concerns appropriately when disagreeing with decisions made by children's social care about next steps.

41. Local authority staff and partners were overwhelmingly positive in their verbal accounts about training that enabled them to identify and respond to children's needs. Almost all were confident about when referrals should be made to children's social care. This confidence, however, was not apparent in practice where too many referrals were made to children's social care without professionals considering the locally agreed thresholds and whether early help intervention would be more appropriate.
42. When children's social care undertook formal assessments and decided that statutory intervention was not required, practice in regard to securing support for early needs was insufficiently robust. For some children, social care took proactive steps to negotiate agreement from partner agencies to offer specific support to the family. In too many cases, children's social care ended their involvement without securing appropriate support for children. Either partners were not advised of these needs or weak arrangements were tentatively agreed. Such examples of poor arrangements included partners agreeing to 'keep an eye on things and re-refer if we are worried again' or 'school will monitor'. Such responses did not reduce the risk of future escalation and left children's needs unmet.
43. These examples demonstrate continued confusion about partnership roles and responsibilities. Some professionals are not always clear about their role and responsibility to intervene and support families when the threshold for statutory intervention is not met. Neither is it clear what role and responsibility statutory services have to ensure that children and families receive the help they need when it is not their statutory duty to provide those services.
44. 'Working together to safeguard children' requires that for referrals:

'Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold to be considered by local authority children's social care for assessment and suggestions for other sources of more suitable support.'

This element was considered as part of the thematic inspection and we found significant inconsistency in practice.

45. Inspectors examined 84 referrals made to children's social care that ended in no further statutory involvement. Of these, almost two thirds of referrers were provided with the outcome of their referral; a third were not. What was equally significant was that partner agencies did not hold children's social care to account and seek feedback on referrals. Almost one third of these referrers confirmed to inspectors that they had not been informed of the outcome of the referral they made. Many had no expectation that they would be informed of the outcome. They saw it as their role to pass information to children's social care to make decisions. A picture of poor cooperation, a lack of shared accountability by local agencies and poor compliance with statutory requirements compounds Ofsted's concern about the lack of clarity of the levers available to pursue help for families with additional needs to those provided in the universal services. Our evidence from this inspection indicates that in 30% of cases examined not all children and families with additional needs were given help when they did not meet the threshold for statutory intervention. A question remains about who is responsible in such a scenario?
46. Children's social care identified half of all children referred as having needs that did not meet the threshold for ongoing statutory intervention but who would benefit from an early help offer. Some help was offered to many of these children through interagency discussion with professionals and with parents' consent. For over a quarter of them, this opportunity was lost due to the poor coordination and shared accountability between agencies to ensure that children who need help are given support that meets their needs.

Monitoring and evaluating the effectiveness of early help

Management oversight

47. Overall, there were significant weakness in the quality and focus of supervision and management oversight of early help cases. In the large majority of cases, professionals verbally reported that they received some formal management oversight of individual cases. A small but concerning number reported that there were no formal arrangements.
48. Despite the positive verbal feedback from professionals, inspectors only saw written records of management oversight in just over half of the early help cases. In a third of these cases with a manager overseeing them, written records of management oversight were held separately from the child's file. Of those that had a written account of management oversight, fewer than half considered the effectiveness of the child's plan. Even fewer considered whether the plan was improving the child's circumstances and experiences. Managers also missed opportunities to challenge poor professional practice.

49. None of the local areas had developed a multi-agency process for the standard and quality of management oversight that should be offered to professionals who contribute early help. Each professional had different arrangements depending on the agency that employed them.
50. The significant variability and quality of management oversight across agencies meant that the effectiveness with which concerns for children were being managed and reduced across agencies was limited. One LSCB conducted a systems review and found that early help cases were not consistently reviewed by a manager. Other LSCBs were often unaware of the level and consistency of management oversight offered to individual staff on early help cases. Most LSCBs relied on section 11 audit returns to confirm that appropriate supervision and management oversight arrangements were in place. None had given sufficient scrutiny to these returns to be assured that effective management oversight, specific to early help cases, was in place.
51. All professionals felt that they were able to access a range of formal and informal support both internal to their own organisation and externally. Very few described feelings of isolation in dealing with early help work. They regularly used their peers and professional networks to seek advice. For example, in one area, a practitioner described meeting with her peers on a weekly basis to discuss cases where workers felt that they may be 'stuck'. The worker was assisted by the wide variety of skills and knowledge in the team.
52. Where early help coordinators existed they were highly valued. The large majority of professionals identified that they had good access to social workers within children's social care or within multi-agency safeguarding hub arrangements and welcomed the opportunity to test out the application of thresholds in early help cases where the child's situation did not seem to be improving.

Quality assurance

53. Quality assurance and audit activity of early help work was not well established or developed. Workers in just over a quarter of the early help cases reported that the case had been subject to a quality assurance process or audit. Some audits only looked at process and compliance factors rather than the quality, impact and outcomes of the early intervention for the child and family. Other workers reported that, although they had been aware that an audit had been undertaken, they had received no feedback on how their practice could be improved.
54. A few examples of good audits were seen. In one local authority, an audit of the initial early help assessment and plan had been undertaken approximately six weeks after the early help plan had been put in place. The audit template was good in that it sought to identify and evaluate the quality and impact of the multi-agency intervention on the experiences of the child. The audit was appropriately challenging of the lack of management oversight recorded on the

file. It made appropriately positive comments about the assessment, plan and the impact to date of the plan on the child's experiences. It sought to ensure that the children's experiences were being considered and reviewed and how the parents contributed to the plan. The audit was shared with the professional with responsibility for coordinating the early help plan and the manager so that the improvements could be embedded into the service.

55. The current approach to quality assuring and monitoring the effectiveness of early help is disparate, disjointed and significantly underdeveloped. Some LSCBs have undertaken audit activity that has a specific focus on the effectiveness of early help, although it is acknowledged by most that audits are overly process-focused and do not adequately focus on outcomes for children. Five LSCBs were yet to commission audit work that examined the quality and effectiveness of early help work.
56. Local authorities and their partners have limited information on how early help is improving children's circumstances. Local areas can point to individual targeted services that have improved outcomes for a particular group of children in relation to specific needs, for example the high take-up of the nursery offer for two-year-olds or the reduction in the number of young people not in education, employment or training. Increasingly, commissioning arrangements are including outcome measures that seek to demonstrate the impact of the service on the child and family.
57. A range of creative early help initiatives indicate a level of awareness and a commitment to respond flexibly to the diverse needs of communities, with specific instances of success for some families. Examples from different local authorities include:
 - the Freedom Programme, which supports those who have experienced domestic abuse, was adapted to meet the needs of the local South East Asian community
 - early help health professionals worked with the Traveller community to build trust and relationships, which resulted in an increase in teenage girls from the community having the HPV vaccination
 - a culturally matched worker was employed to work within and engage the Polish community, which resulted in increased numbers of Polish mothers attending specific groups
 - the joint strategic needs assessment (JSNA) identified that 57% of children with autism had limited access and support – this led to specific work to obtain the views of children with autism, which resulted in a clear autism strategy and action plan.
58. The local authority and/or partners have not developed systems to identify whether success is sustained in the long term for children and their families. Furthermore, analysis by the local authority and/or partners does not yet sufficiently focus on whether the 'right' children are receiving early help and

whether early help is reducing the numbers of children that require a statutory response. This is likely to mean that, even where outcomes for individual children can be seen to be improving through early help provision, there is no way of knowing whether early help services are targeting the most vulnerable children in the area. Partnerships find it more difficult to link success, or otherwise, between early help and those children who go on to receive statutory services or require children's social care intervention. Impact for children who receive early help and those who receive a statutory service are often seen separately and in isolation. Improved analysis that encompasses both early help and statutory services is needed to ensure that the 'right' children are receiving help when they need it and that the responsibility for help does not fall unfairly on the local authority.

Roles and responsibilities

59. The evidence on this inspection indicated that current statutory powers do not provide a sufficient focus for any one agency or partners collectively to give early help the priority that it requires. For example, referrals that did not progress to statutory intervention were not analysed to understand whether children's early help needs were met. Evidence further showed that children's needs were sometimes left unmet and no agency had overall responsibility to provide help. Again, in the absence of a duty for agencies to hold each other to account for early help arrangements, it is not known if they are effective.
60. The Munro Review recommended that the government should place a duty on local authorities and statutory partners to secure sufficient provision of local early help services for children, young people and families.²² The government's response was that 'there is sufficient legislation to realise Professor Munro's vision of a transparent and coordinated offer of early help.'²³
61. Munro recognised the need for a legal framework to secure 'shared accountability for the early help offered to children and families whose needs do not meet the threshold for a social care service.'²⁴ This thematic inspection demonstrated significant variability in the effectiveness of local shared accountability and coordination of early help services. Little has changed for many children in the absence of this duty because there is no statutory duty to enforce the shared accountability needed to deliver an effective early help offer. In many areas, a disconnect remains between statutory service provision and an early help offer for children.

²² Professor Eileen Munro, *Munro review of child protection – a child centred system*, Department for Education, 2011.

²³ *Progress report: moving towards a child centred system*, Department for Education, May 2012; www.gov.uk/government/publications/progress-report-moving-towards-a-child-centred-system.

²⁴ Professor Eileen Munro, *Munro review of child protection – a child centred system*, Department for Education, 2011; www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

62. Not all partnerships had developed a shared early help strategy. In some, the early help strategy was led by the local authority and the local authority employed staff or commissioned services to coordinate, assess and deliver early help where needs were identified by partners. In others, a multi-agency early help strategy was in place or being drafted. None, however, had scrutinised the effectiveness of the delivery of the strategy and its impact on improving outcomes for children at the earliest point or reducing the need for higher cost, more coercive help.
63. For partnerships, the JSNA was the starting point and the statutory process by which they identified current and future health and well-being needs.²⁵ Many JSNAs failed to focus sufficiently on and prioritise potential child protection issues. For example, JSNAs did not routinely identify the prevalence of parental mental ill health, drug or alcohol misuse or domestic abuse. Furthermore, even fewer identified the numbers of children living in such households. These issues are well known indicators of potential future child protection issues.²⁶ Despite this extensive research, these indicators were not yet a key focus in JSNAs and were not used as a basis for early help provision. Without this shared information, early help services cannot be targeted to the children who need them most.
64. 'Working together to safeguard children' requires the LSCB to publish a threshold document that includes an outline of the process for the early help assessment and the type and level of early help services to be provided. In all the areas visited, the LSCB either had an agreed or a draft multi-agency threshold document. 'Working together to safeguard children' places no requirement on the LSCB to evaluate the effectiveness of the application of the threshold document. Without such a duty, this inspection found that while LSCBs have complied with the duty to have a threshold document, only two areas could confirm that specific audit work had occurred to test out whether thresholds were appropriately applied for early help work. Most audits focus on the application of thresholds on statutory work and do not consider early help thresholds.
65. Many LSCBs recognised that they had not yet developed data to enable them to 'assess the effectiveness of the help being provided to children and families', as required by 'Working together to safeguard children'. Many were still working to secure regular reporting regarding early help and, at best, measurements of impact were still in the very early stages of development. Evaluation across the continuum of early help and statutory services required further significant development.

²⁵ *Joint Strategic Needs Assessment and joint health and wellbeing strategies explained*, Department of Health, 2011; www.gov.uk/government/news/jsnas-and-joint-health-and-wellbeing-strategies-explained.

²⁶ Brandon *et al.*, *Building on the learning from serious case reviews: A two year analysis of child protection database notifications 2007-2009*, Department for Education, 2010; www.gov.uk/government/publications/building-on-the-learning-from-serious-case-reviews-a-2-year-analysis-of-child-protection-database-notifications-2007-to-2009.

66. 'Working together to safeguard children'²⁷ identifies specific groups of children who would benefit from early help. Professionals should, in particular, be alert to the potential need for early help for a child who:
- is disabled and has specific additional needs
 - has special educational needs
 - is a young carer
 - is showing signs of engaging in anti-social or criminal behaviour
 - is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence
 - is showing early signs of abuse and/or neglect.
67. Only in one area did professionals have some awareness of this list. Not one of the 52 professionals identified young carers as a specific group. Only just over half were able to identify a specific group of children that they recognised as vulnerable. It is a cause for concern that professional awareness about such vulnerable groups was so weak and that this poor awareness could prevent them from identifying and providing early help to families.
68. LSCBs indicated that specific focus on early help training was underdeveloped. Only a quarter stated that they had delivered specific early help training across the partnership. Most advised that early help awareness was integrated into basic safeguarding training. Most early help training was facilitated on a single agency basis or by the local authority. No LSCBs were able to confirm whether all those who needed to be trained on early help had received appropriate training. Only a quarter had developed processes for monitoring and evaluating the impact of training on practice. Few professionals were able to make reference to specific early help training that they had received. As a result, professionals were limited in describing examples of the impact of training on their early help work. This meant that many LSCBs were failing to take sufficient account of the statutory duty to:
- 'monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. This should cover how to identify and respond early to the needs of all vulnerable children, including unborn children, babies, older children, young carers, disabled children and those who are in secure settings'²⁸

²⁷ *Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children*, Department for Education, March 2013, pp. 11–12;
www.gov.uk/government/publications/working-together-to-safeguard-children.

²⁸ Ibid.

Learning from serious cases reviews

69. Brandon,²⁹ et al., reviewed the cases of children subject to serious case reviews during the period 2009–2011. The research identified that 42% of cases were receiving a service from children’s social care at the time of the incident and that 23% had previously been known to children’s social care. These figures suggested that some cases were being closed prematurely by children’s social care. In a further 14%, referrals were received but not accepted for assessment by children’s social care. The research noted that thresholds to children’s social care were set too high, particularly when neglect was the primary concern. This raised significant issues about children being provided with the right help at the right time. The help and protection of children relies on all professionals being able to identify triggers that may indicate children are at risk of harm or being harmed and taking appropriate action to protect them.
70. Almost all professionals had an awareness of serious case reviews and what they were. Social work professionals working within children’s social care were most able to give practice examples of how findings from serious case reviews had informed their individual work with children or how findings had been used by the organisation to inform practice changes to whole services. While they had an awareness of serious case reviews, non-social-work professionals were less able to demonstrate the impact, with just over a quarter indicating that findings from serious case reviews had impacted directly on their practice. A small but significant group of non-social-work professionals, working with children, indicated that they had no real awareness of findings from serious case reviews.
71. A sample of the most recent findings from serious case reviews,³⁰ which relate to early help, reflect the findings of this thematic inspection. This confirms that insufficient attention is given to serious case review findings and how these inform and improve practice. In relation to early help, serious case review findings tend to identify either that early help was provided but was not successful for a variety of reasons or that the need for early help was not identified. The following is a summary of issues that relate to recent findings from the serious case reviews considered:
- a lack of focus on the child that in some cases resulted in children’s views and voices not being heard or being given value
 - thresholds not understood across partnerships and set too high, which prevented the necessary support being offered

²⁹ Brandon *et al.*, *Building on the learning from Serious Case Reviews: A two year analysis of child protection database notifications 2007-2009*, Department for Education, 2010; www.gov.uk/government/publications/building-on-the-learning-from-serious-case-reviews-a-2-year-analysis-of-child-protection-database-notifications-2007-to-2009.

³⁰ See Annex B.

- adherence to procedures over common sense protection of children and young people, even where there was clear evidence of concerns about abuse
- poor understanding and assessment of the circumstances, including a failure to re-assess when new information became available
- poor communication and interagency working, especially in relation to challenging decisions made by other agencies
- workers from across the agencies lacking a suitable level of understanding of key factors relating to particular cases, such as cultural norms, mental health, legislation and domestic abuse – specialist advice was not sought where it would have improved decisions
- delays to early help services being provided and a lack of follow-up if a child did not take up the use of the service
- a lack of satisfactory management oversight of practice in relation to early help
- a lack of critical analysis, which sometimes led to professional ‘personal bias’ not being challenged or professionals not adopting sufficient sceptical enquiry into issues which arose; accepting information at face value
- risks from fathers/partners not sufficiently considered.

72. Almost all of this evidence reflects findings from our thematic inspection. Attention given to improving practice from the findings of serious cases reviews is not robust enough.

73. Specifically, and reflecting findings from serious case reviews, inspectors asked professionals about the training they had received to support their work with families who are reluctant or resistant to engage with professionals. Almost two thirds of professionals had received some training. As a result, they reported that their confidence in this area had improved; they felt empowered to be more questioning rather than accepting of parental responses. Training had helped them to identify triggers and warning signs, had highlighted good practice in speaking to the child and in hearing and understanding the child’s experience, and had assisted in sharing concerns and information with other professionals. However, one third of professionals had not benefited from such specific training. Many commented that it would be welcome, particularly on a multi-agency basis. One professional commented:

‘I find it difficult to talk to parents. My heart sank when dad answered the phone. We need more support in how to talk to parents about allegations.’

Conclusion

74. Evidence from Ofsted’s single inspections of local authorities and from this thematic inspection shows clearly that the offer of help to families when concerns first arise is increasingly prioritised by local authorities and their

partners. As a result, more children are benefiting from better focused and coordinated support earlier. Early help workers increasingly feel part of professional networks and therefore are less isolated and more supported. The quality and effectiveness of early help services however remains too variable both between areas and within the same services. Children's need for additional support is often not identified or acted on at the right time, with earlier opportunities to provide support often missed. The assessment and planning of services for individual children are too often insufficiently focused on improving outcomes for the child. Plans are not consistently or effectively reviewed and management oversight is not rigorous enough.

75. Planning for early help services is not informed by robust needs assessments. Neglect, parental substance misuse or ill health and domestic abuse are key factors undermining the welfare of children but not enough priority is given to understanding the nature and extent of these needs in local communities. It is therefore unclear whether early help services are being commissioned effectively to best address these needs. More generally, evaluation of the overall impact of early help services is not well developed.
76. LSCBs have become more engaged in monitoring early help and in most areas have ensured the adoption of an agreed threshold framework. However, they are not routinely monitoring the application of these thresholds or, more generally, holding each other to account for their early help work.
77. At the heart of these difficulties, however, is a lack of clarity about statutory roles and responsibilities for the provision of early help. For many agencies, early help continues to appear as an add-on rather than central to or required as part of their core business of improving the life chances of children.
78. In the current scenario for local areas, where demand for help for families is increasing alongside the more formal and coercive child protection work, it is critical that there is clarity about the responsibilities of local agencies to help families early. The recommendations from this thematic inspection should be urgently considered by government so that the costs and poorer outcomes of later intervention can be avoided.

Annex A. Local authorities subject to this thematic inspection

Buckinghamshire

Bury

Gloucestershire

Harrow

Hertfordshire

Leicestershire

Lewisham

Milton Keynes

Southend-on-Sea

Walsall

Warwickshire

York

Annex B. Serious case reviews considered

Child D – Death of three-week-old baby girl in October 2012 following injury by her mother. The child’s mother had multiple overlapping needs such as learning difficulties and mental health problems.

Serious case review: Child D. Published by the NSPCC on behalf of an unnamed local safeguarding children board, 2012; [Read full overview report \(PDF\)](#).

Child J – Suicide of adolescent girl in January 2013; victim of sexual assault and history of bulimia and self-harm and suicide ideation.

Muir, M., *Serious case review: Child J*, Cumbria Local Safeguarding Children Board, 2013; www.cumbrialscb.com/eLibrary/Content/Internet/537/6683/6687/6700/4182185614.pdf.

Child C – Death of 17 week old baby girl in November 2013; teenage mother significant maternal history of domestic abuse.

Haley, A., *Serious case review: Child C*, Dorset Safeguarding Children Board, 2014; [Read full overview report \(PDF\)](#).

Family A – Neglect, physical and sexual abuse of seven brothers and sisters (aged six to 14 years) between 2004 and 2011. Father from Traveller community.

Harrington, K., *Serious case review: Family A*, Southampton Local Safeguarding Children Board, 2014; [Read full overview report \(PDF\)](#).

Child H – Death of a three-year-old Somali boy and serious injury to his two-month-old brother in March 2013.

Trench, S. and Miller, G. *Serious case review: Child H*, Lambeth Safeguarding Children Board, 2014; [Read full overview report \(PDF\)](#).

Family S11– Death of a 15-year-old boy in March 2013 as a result of overdose of drugs prescribed to father.

Tudor, K., *Serious case review: overview report: in respect of Family S11*. Dorset Safeguarding Children Board, 2014; [Read full overview report \(PDF\)](#).

Young person: suicide of 14-year-old boy in April 2013 who had moved to the UK from China.

Wonnacott, J., *Overview report on the serious case review relating to: Young Person: Hiers*, Surrey Safeguarding Children Board, 2014; [Read full overview report \(PDF\)](#).

Child FW – death of a baby who suffered cardiac arrest. Family well known to wide range of family services. Report final version 12 February 2013.

Baker, G., *Serious case review: executive summary: in respect of the death of FW [executive summary]*, Worcestershire Safeguarding Children Board, 2014; [Read executive summary \(PDF\)](#).

'Daniel': Death of 14-year-old boy in November 2009 who was exposed to many risk factors.

Gallagher, C., *'Daniel': the overview report from a serious case review*, Kent Safeguarding Children Board, 2013; [Read full overview report \(PDF\)](#).

Baby H – death of four-month-old baby boy in November 2010 from serious head injury; significance of mother's young age on parenting capacity and lack of agency engagement.

Maddocks, P., *A serious case review: 'Baby H': the overview report*, Lancashire Local Safeguarding Children Board, 2013; [Read full overview report \(PDF\)](#).