

# **Serious Case Review Protocol**

## **1 The reviewing and investigative functions of Local Safeguarding Children Boards (LSCBs)**

- 1.1 LSCBs are required to undertake reviews of serious cases. They should be undertaken in accordance with the procedures set out in chapter 8 of *Working Together to Safeguard Children (2006)*. This protocol is intended to help relevant agencies in the planning, implementation and administration of a Serious Case Review. The same criteria apply to disabled children as to non-disabled children.

## **2 Introduction**

- 2.1 When a child dies, and abuse and neglect is known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (eg siblings, or other children in an institution where abuse is alleged). Thereafter, organisations should consider whether there are any lessons to be learnt about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a Serious Case Review into the involvement with the child and family of organisations and professionals.

- 2.2 Additionally, LSCBs should always consider whether a Serious Case Review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated; or
- a child has been killed by a parent with a mental illness; **and**
- the case gives rise to concerns about inter-agency working to protect children from harm

- 2.3 Where more than one LSCB has knowledge of a child, the LSCB for the area in which the child is/was normally resident should take lead responsibility for conducting any review. See Para 9.

- 2.4 In the case of children in care, the Responsible Authority (para9) should exercise lead responsibility for conducting any review, involving other LSCBs with an interest or involvement.

## **3 The Purpose of Serious Case Reviews**

- 3.1 The purpose of Serious Case Reviews carried out under this guidance is to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and

- as a consequence, improve inter-agency working in safeguarding and promoting the welfare of the children

3.2 Serious Case Reviews are not inquiries into how a child died, or who is culpable. That is a matter for Coroners and Criminal Courts, respectively, to determine as appropriate.

3.3 Any professional may refer a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case. In addition, the Secretary of State for Department for Children, Schools and Families has powers to demand an inquiry be held under the Inquiries Act 2005.

## **4 Role of Serious Case Review Committee**

4.1 LSCBs should establish a standing committee – the Serious Case Review (SCR) Committee – involving at least the local authority's children's social care, health, education and the police, to consider whether a Serious Case Review should take place.

4.2 If there are criminal, care or Coroner's proceedings underway or pending, the implications of these and the process for dealing with a Serious Case Review alongside these should be discussed within the SCR Committee, in collaboration with the appropriate professionals in the relevant agencies. When a Serious Case Review is being undertaken under different guidance, eg mental health/homicide, Multi Agency Public Protection Arrangements (MAPPA), Youth Offending Team (YOT), and Young Offenders Institute (YOI), a similar discussion should take place within the SCR Committee in collaboration with the body commissioning the other review, about the process and other relevant issues.

4.3 The SCR Committee should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference. (These should be set out in the LSCB Chair's letter, and to be reproduced within the IMR reports to ensure consistency across agencies):

- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
- Who should be appointed as the independent author for the overview report?
- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?
- Over what time period should events be reviewed, ie how far back should enquiries cover, and what is the cut-off point? What family history/background information will help to better understand the recent past and present?
- Which organisations and professionals should contribute to the review? For example, the proprietor of an independent school or playgroup leader may be asked to submit reports or otherwise contribute.
- Will the case give rise to other parallel investigations of practice – eg independent health investigations or multi-disciplinary suicide reviews, a homicide review where a parent has been murdered, a Youth Justice Serious

Incident Review and a Prisons and Probation ombudsman investigation where the child has died in a custodial setting? If this is the case, consideration to be given to conducting a co-ordinated or jointly commissioned review

- Is there a need to involve organisations/professional in other LSCB areas (see Para 9), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Who will make the link with relevant interests outside the main statutory organisations eg independent professionals, independent schools, voluntary organisations?
- When should the review process start and by what date should it be completed

4.4 In some cases, criminal proceedings may follow the death, serious injury, sexual assault or neglect of a child. Those co-ordinating the review should, at an early stage, discuss with the relevant criminal justice agencies, how the review process should take account of such proceedings. For example, how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations, and who should contribute at what stage. Serious Case Reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases, it may not be possible to complete or to publish a review until after the Coroner's or criminal proceedings have been concluded, but this should not prevent early lessons learnt from being implemented.

4.5 The initial scoping of the review by the SCR Committee should identify those agencies/professionals who should contribute, although it may emerge, as information becomes available, that the involvement of others would be useful. In particular, information of relevance to the review may become available through criminal proceedings or other review processes.

4.6 Where a child dies in a custodial setting (prison, YOI or Secure Training Centre (STC)) the Prisons and Probation Ombudsman investigates and reports on the circumstances surrounding the death of that child. The investigation examines the child's period in custody and assesses the clinical care they received. The report is normally made available to assist any Serious Case Review process.

## **5 Instigating a Serious Case Review**

5.1 The following questions should be considered when deciding whether or not a case should be subject of a Serious Case Review in circumstances other than when a child dies. The answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons.

- Was there clear evidence of a risk of significant harm to a child that was:
- Not recognised by organisations or individuals in contact with the child or perpetrator or;
- Not shared with others; or

- Not acted on appropriately?
- Was the child killed by a mentally-ill parent?
- Did the child die in a custodial setting (prison, Young Offenders' Institution (YOI) or Secure Training Centre (STC))?
- Was the child abused in an institutional setting (eg school, nursery, family centre, YOI, STC, children's home or Armed Services training establishment)?
- Was the child abused while being looked after by the Local Authority
- Did the child commit suicide, or die while absent having run away from home?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?
- Was the child the subject of a child protection plan, or had they previously been the subject of a plan or on the Child Protection Register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?

- 5.2 The professional who identifies a case where the circumstances appear to comply with Para 2 above should contact the named person in their agency. The named person should then ensure that the Board Manager is notified, by email, setting out details of the child and family members, ie names, addresses and dates of birth along with an account of the circumstances of the case. (NB: Files, including electronic files should be secured at an early point in a Serious Case review – see para7)
- 5.3 The Board Manager should collate other relevant information that will assist the SCR Committee in its decision making.
- 5.4 Once the Board Manager has notified the SCR Committee, the named person in social care should advise Ofsted where it is clear that a Serious Case Review will be needed. Each agency should similarly notify the appropriate body for its discipline/organisation.
- 5.5 The information provided to the Board Manager should be passed on to the members of the SCR Committee as soon as possible. Normally the SCR Committee will meet to consider the circumstances of a case but in some cases the information provided will indicate that the criteria are clearly met. The SCR Committee should agree the recommendation to the LSCB Chair (or nominated Deputy in his/her absence), including if the criteria are *not* met.
- 5.6 The SCR Committee's recommendation should be forwarded in writing (see Appendix A) to the Chair of the LSCB who has ultimate responsibility for deciding whether to conduct a Serious Case Review and commission Internal Management Reviews (IMRs) from any involved agencies/professionals (a copy should be sent to the legal advisor to the LSCB).
- 5.7 If the LSCB Chair considers that the criteria for a Serious Case Review have not been met this should be conveyed in writing to the SCR Committee with reasons for this

decision. If any member of the LSCB has concerns about this, this should be raised with the LSCB Chair in writing.

5.8 When the decision of the LSCB Chair is that a SCR should be undertaken, a written request should be sent by the Board Manager, on behalf of the LSCB Chair, to LSCB members (see [Appendix B](#)) to establish whether the child was known to their agency during the timescales set out in the terms of reference and asking that agency to secure its records. This should be effected within a month of the case coming to the attention of the LSCB. Agencies should respond in writing indicating whether they have had involvement or not.

5.9 The letter from the LSCB Chair ([Appendix B](#)) will set the timescales for the IMR to allow compliance with the 4 month requirement of Working Together (2006) for the whole Serious Case Review and these will be included in the terms of reference. The letter will include:

- The reason for the Serious Case Review;
- The terms of reference
- The timescales being considered within the IMR
- Initials to be used for each family member to ensure consistent use in each of the IMRs and the subsequent chronology
- Information about all children, siblings, parents/adults, being clear whether they are living as part of the household and stating who is subject to the review process; whether either of the parents have other children and whether they are subject to the review process
- Clarification about anonymity of professionals and members of the family and friends and how they are each to be referred to;
- A genogram (see [Appendix D](#)) as far as is possible

5.10 If agencies have had involvement within the timescales outlined in the terms of reference, they should initiate their process. If they have had information or involvement outside the prescribed timeframes, they should contact the Board Manager as soon as possible to discuss the relevance of this. The Board Manager will liaise with members of the SCR Committee to agree a way forward.

5.11 Where an agency from another Local Authority has had any involvement during the identified timescales for the Serious Case Review, contact should be made with the LSCB for that Local Authority (see [Para 9](#))

5.12 Following the decision by the LSCB Chair, the Local Authority (via the designated Children's Services representative) will inform Ofsted of every case that becomes the subject of a Serious Case Review. The Primary Care Trust and Acute Trusts should also inform the children's lead within the Strategic Health Authority of this decision.

5.13 Where a Serious Case Review is recommended the SCR Committee should meet to agree the composition of the SCR Panel, including who will write the overview report and to ensure any other relevant issues or information are considered (see [para6](#)). Once the overview report is completed, the SCR Panel will submit the overview report to the SCR Committee for the purpose of Quality Assurance.

#### **5.14 SCR Committee actions on receiving the reports:**

- The SCR Committee should be assured that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report
- The SCR Committee, in liaison with the chair of the LSCB can approve this report, along with the executive summary and action plans, on behalf of the LSCB.
- The SCR Committee should ensure that recommendations have been translated into an action plan which has been signed up to at a senior level by each of the organisations that need to be involved. The plan should set out who will do what, by when and with what intended outcome. It should set out by what means improvements in practice/systems will be monitored and reviewed.
- The Chair of the SCR Committee should report the status of Serious Case Reviews and of any significant issues regarding specific or significant issues to each LSCB meeting

## **6 Role of Serious Case Review Panel**

- 6.1 Each LSCB is required by Working Together 2006, to commission an overview report that brings together and analyses the findings of the various IMR reports from organisations and others, and makes recommendations for future action. The SCR Panel will undertake this role. The SCR Panel should normally be chaired by a member of the LSCB. It should include representatives from social care, police and health and education as a minimum and should normally be made up of members of the LSCB and its sub-committees. It should also include an agency representation by any agency which has produced an IMR.
- 6.2 The overview report, as outlined in Appendix H, should be written by a person who is independent of all the agencies/professionals involved. If one of the members of the SCR Panel is independent because his/her agency has not had any involvement in the case being reviewed, s/he can assume responsibility to write the report. Otherwise, the appointed author should attend the SCR Panel meetings. In some cases, s/he may be requested to chair the SCR Panel to ensure independence.
- 6.3 The first SCR Panel meeting to consider the IMRs should be arranged for approximately two weeks after the date set for submission of the IMRs.
- 6.4 Once the IMRs have been submitted, the chronologies should be merged as soon as possible so that the SCR Panel has time to consider an integrated inter-agency chronology before its first meeting. Individual agency's chronologies could be submitted when completed, ie ahead of the IMR report if possible, to facilitate them being merged in time for the Panel.
- 6.5 The SCR Panel should consider the following:
- It should be determined how the family members should contribute to the review, and who should be responsible for facilitating their involvement? A decision to not include the family should be clearly recorded. (See para10 )
  - How should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?

- How should the Serious Case Review process fit in with the processes for other types of reviews – eg for homicide, mental health or prisons?
- How should any public, family and media interest be managed before, during and after the review
- Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

- 6.6 Some of these issues may need to be revisited as the review progresses and new information emerges
- 6.7 The chair of the SCR Panel must ensure that agencies' IMR reports are carefully read, fully discussed and assessed by members; IMRs recommendations are evaluated to see whether they fully address the concerns; and any apparent contradictions are identified. If further clarification is required in respect of one or more IMR report(s), the SCR Panel should identify what clarification is required, the timescales to be applied, and adjourn pending further reports. This may include reports from other LSCB areas.
- 6.8 The IMR report author(s) should attend the SCR Panel if required and present the IMR report, and/or be prepared to clarify specific issues and/or make further enquiries in order to do so. Alternatively they may be asked to make further enquiries and submit this information without being required to attend.
- 6.9 If the SCR Panel considers that the IMRs or their recommendations are inadequate to address the concerns, the SCR Panel chair may request the Panel representative for that agency to pursue the matter and/or the matter will be pursued by the Board Manager. Any contradictions between IMRs should be clarified as far as possible. The SCR Panel may request the IMR authors to add, amend or delete recommendations; the authors should liaise with their own agencies if they amend the report. The SCR Panel can make recommendations over and above the IMR recommendations.
- 6.10 The chair of the SCR Panel should record in the minutes any expressed dissatisfaction with individual agency's reports and setting out the reasons for this, in order to:
- formally record the SCR Panel's view of a specific report, rather than to allow it to lie on record without crucial comment;
  - promote and encourage learning and improvement in the quality of all agencies' IMR reports.
- 6.11 The chair of the SCR Panel should decide what information should be shared with IMR authors in each case. However, individual agencies may agree to share IMRs amongst themselves. Normally the integrated chronology should be shared with the IMR authors.
- 6.12 If the agencies' reports and recommendations are felt to be appropriate the Chair of the SCR Panel will ensure that the overview author will produce a draft overview report. This should be agreed by the members of the SCR Panel before being shared with those who contributed IMR reports, for accuracy, prior to being finally agreed by the SCR Panel and presented to the LSCB.
- 6.13 The SCR overview report should bring together and draw overall conclusions from the information and analysis contained in the IMR reports, information from the child death

review processes, and reports commissioned from any other relevant interests. Overview reports should be produced according to the outline format, (see [Appendix H](#)), although, as with IMRs, the precise format will depend on the features of the case. This outline is most relevant to abuse or neglect that has taken place in a family setting. The SCR Panel should consider the appropriateness of it for each case and adjust/adhere as necessary. The recommendations from the overview report should be translated into an action plan using the agreed format at [Appendix 1](#). Action plans should include timescales for implementation. An executive summary should be presented to the LSCB for approval and for agreement regarding wider circulation of the report(s), to include family members. These three documents should be seen by the legal advisor to the LSCB.

6.14 Recommendations and areas of good practice should be identified to share with other LSCBs working to the 4LSCB procedures

## **7 Role of the Agency**

7.1 Each agency should have a procedure for securing papers and electronic files at the earliest possible opportunity to preserve the integrity of the files and guard against loss or interference. The lead in each agency represented on the LSCB should be accountable for ensuring that records are properly and speedily secured. Agencies may become aware of a serious incident that will probably require a Serious Case Review and should be prompt and proactive in securing their own files, without waiting for the confirmation letter from the LSCB Chair. Prior to the decision by the LSCB Chair being received, the agency's nominated representative on the SCR Committee should decide when files should be secured within that agency.

7.2 In setting up the IMR process, each agency must identify an appropriate officer (the IMR Author) to carry out the review, and allow him/her sufficient time and support to complete the task effectively within the timescales set by the SCR Committee, usually approx 2 month period. More than one person within an agency may be appointed to undertake an IMR as it can be an onerous task, especially if there has been substantial involvement.

7.3 The following points should be taken into consideration when appointing an IMR Author(s):

- S/he should have appropriate expertise and knowledge about child protection policy, practice and procedures pertinent to that agency and across the LSCB and should possess evaluation skills and sufficient independence and objectivity;
- S/he must not have any previous or current personal or professional involvement and must not be the immediate Manager or Line Manager of any professional involved. Equally, IMRs should not be conducted by any person likely to be perceived as too closely associated with the child and/or family, the relevant operational or service unit, nor by anyone involved in the case or incident under review. The IMR author(s) should be given the opportunity, before undertaking any work on the IMR, to declare any interest which would affect his/her objectivity or impartiality, or which might be perceived as doing so, to their representative on the SCR Panel. In the event of such interest

being declared the SCR Panel representative will be responsible for deciding who conducts the IMR.

- Where there is a difficulty in identifying an IMR author within the agency a reciprocal arrangement within the four local LSCBs may be sought. However an officer from the agency should be involved to advise on local practice, even if the independent person takes the lead.
- Where there has been joint work and/or joint documentation within an agency, those responsible for carrying out the IMR for that agency should identify a strategy for communication between the different services which are being reviewed within the overarching agency's IMR and report. This should take place throughout the review process to ensure comprehensiveness and accurate joint analysis of the contribution of all the services within the agency.
- Where more than one NHS trust has an involvement in the case in question, each one of them may choose to conduct its own IMR and produce its own IMR report. However a person nominated by local agreement within Health should amalgamate these reports (eg NHS Direct, Ambulance Service, CAMHS) into one overarching IMR report.

7.4 If during the process of securing records an agency identifies that some are missing, the IMR Author should contact the appropriate Senior Manager in that agency, who should, without delay, contact the Board Manager advising:

- which files appear to be missing;
- what formal steps are being taken to locate the missing material;
- what is believed might have happened to the files.

7.5 Each relevant service should undertake an IMR of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual organisation.

7.6 The involvement of independent professionals including GPs should also be subject to the IMR process. Designated professionals should review and evaluate the practice of all involved health professionals providers within the PCT area. This may involve reviewing the involvement of individual practitioners and Trusts, and advising named professionals and Managers who are compiling reports for the review. Designated professionals have an important role in providing guidance on how to balance confidentiality and disclosure issues. Where a children's guardian contributes to a review, the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived to the degree necessary.

7.7 Each agency should be clear about which representative on the LSCB is responsible for accepting and signing off its IMR report.

7.8 All agencies should effectively contribute to the Serious Case Review process, including membership of the SCR Panel and progressing action plans. Each agency should agree an action plan to implement the recommendations arising from its IMR as soon as it has been completed.

- 7.9 If an agency is unable to meet the agreed IMR timescales, this should be reported back to the Chair of the SCR Committee by the Chair of the SCR Panel as soon as possible. The SCR Committee should determine when delays need to be reported to the LSCB Chair and/or to the LSCB. The Board Manager should ensure that Ofsted is contacted if the 4 month timescale cannot be met so that alternative timescales can be negotiated.
- 7.10 The death or serious injury of a child inevitably involves grief, pain and distress. Those who primarily suffer are usually the child's family, but the effects are often felt beyond the immediate family. While there is public concern to be satisfied, there are also issues of staff support and care to be considered. Serious cases involving child abuse or a child's death give rise to feelings of anxiety, guilt, distress and grief in those who have worked with the child or the family. All agencies must consider how best to support and assist staff so affected.
- 7.11 On completion of each IMR report, there should be a process for feedback and debriefing within that agency for staff involved as soon as possible and in advance of the overview report being completed. There may also be a need for a follow-up feedback session if the overview report raises new issues for the organisation and staff members

## **8 The IMR Process**

- 8.1 The aim of IMRs should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about. The IMR should adhere to the specific terms of reference for a particular Serious Case Review. It is useful to include a summary of key events that occurred outside of the timescales. Any particular issues that arise during the IMR process, which are outside the time-scales or other terms of reference, should be discussed with the Chair of the SCR Panel before including these points in the IMR report. The SCR Panel Chair should alert the SCRC of any request to change the Terms Of Reference.
- 8.2 Any unsafe practice identified should be alerted immediately to the operational Senior Manager for that agency to ensure this can be appropriately dealt with in that agency, without waiting for the IMR to be completed.
- 8.3 Once the chronology has been compiled, the IMR Author should identify key individuals within the agency who need to be interviewed, using the agreed format (See Guidance for Interviewing Staff, [Appendix E](#)). Where staff, or others, are interviewed by those preparing the IMR, a written record of such interviews should be made and this should be shared with the relevant interviewee. Opportunity should be given for anyone with a legitimate interest to make information available to the IMR Author(s). Participation in the IMR process is not optional for staff, though not all staff involved in a case may need to be interviewed. Guidance for staff being interviewed ([Appendix F](#)) should always be given to them. The outline format in [Appendix G](#) should guide the preparation of Internal Management Reviews to help ensure that the relevant questions are addressed and to provide information to LSCBs in a consistent format to help with preparing an overview report.

8.4 Having completed the stages set out above, the IMR Author should add to or amend the chronology if necessary, analyse the collated information and prepare the IMR report in the format advocated by Working Together 2006, reproduced in Appendix G, within the identified timescales. The anonymised report should provide an index of roles and responsibilities as an appendix. There should always be an opportunity for staff involved in the case to check the accuracy of the facts contained in the report.

## **9 Involvement of other LSCBs**

9.1 If agencies from another Local Authority area have been or are involved in the case, the LSCB Chair should write to the Chair of the relevant LSCB. This is to notify them of the incident, to determine the need for a Serious Case Review, and to identify which agencies in that Local Authority area should be requested to undertake an IMR or provide information, as appropriate. There should be agreement about which LSCB should lead the Serious Case Review, the terms of reference and the process. The LSCB in whose area the child is ordinarily resident, should normally take the lead in a Serious Case Review: this LSCB should be responsible for communicating with the other LSCBs with involvement in the case.

9.2 When another LSCB takes the lead, each LSCB should take responsibility for commissioning an IMR for any local agencies within their area. This will ensure that each LSCB is aware of the case, and has ownership of any recommendations and action plans arising from it.

9.3 Arrangements should be made between the two or more LSCBs, about who will sit on the SCR Panel, the process of receiving the IMRs and considering the findings within them.

## **10 Involvement of the family**

10.1 Each case should consider, on an individual basis whether to involve the family, considering each of the adults and children individually. There is an expectation that the family (or any appropriate person) would be made aware of the review and asked to make any comments about what has happened and what would have helped them. However, care should be taken in approaching family members directly where there are pending prosecution and/or care proceedings in which an adult and/or children are involved.

## **11 LSCB Action on Receiving Reports**

11.1 On receiving an overview report the LSCB should:

- Confirm acceptance of the overview report, executive summary and action plans (if provided)
- Be assured that recommendations have been translated into an action plan which should be signed up to at a senior level by each of the organisations that need to be involved. The plan should set out who will do what, by when, and with what intended outcome. It should set out by what means improvements in practice/systems will be monitored and reviewed. The plan should be presented to the SCR Committee within 3 months.
- clarify to whom the report, or any part of it, should be made available

- disseminate report or key findings to interested parties as agreed. Ensure arrangements are made to provide feedback and debriefing to staff, family members of the subject child and the media as appropriate
- ensure that a copy of the overview report, action plan and internal management reports are provided to Ofsted.

11.2 As per the terms of reference for the SCR Committees across the 4LSCBs, the SCR Committee has responsibility for monitoring the implementation of all action plans identified from the overview report. The SCR Committee should highlight delays to the LSCB.

11.3 The LSCB's Board Manager will send a copy of the executive summary to:

- the other three LSCB chairs for inclusion in their LSCB Committee agendas.
- to those responsible for planning and delivering LSCB training to incorporate into agency and inter agency programmes.
- those responsible for reviewing and updating the LSCB inter-agency procedures.
- the website administrator for inclusion on the 4 LSCB website, where this is agreed by the responsible LSCB, and in accordance with para12.

## 12 Accountability

12.1 LSCBs should consider carefully who might have an interest in reviews – e.g. elected and appointed members of authorities, staff, members of the child's family, the public, the media – and what information should be made available to each of these interests. There are difficult interests to balance, including:

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
- the accountability of public services and the importance of maintaining public confidence in the process of internal review
- the need to secure full and open participation from the different agencies and professionals involved
- the responsibility to provide relevant information to those with a legitimate interest
- constraints on public information-sharing when criminal proceedings are outstanding, in that providing access to information may not be within the control of the LSCB.

12.2 It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. In all cases, the LSCB overview report should contain an executive summary that will be made public and that includes, as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made. The publication of the executive summary needs to be timed in accordance with the conclusion of any related court proceedings

The content needs to be suitably anonymised in order to protect the confidentiality of relevant family members and others.

12.3 The chair of the LSCB, in conjunction with the relevant LSCB members, is responsible for ensuring that public concern is allayed and should ensure their services are not undermined, and media comment addressed in a positive manner, in terms of the review, process, recommendations, actions and outcomes. The LSCB should ensure that the Strategic Health Authority and Ofsted are briefed, so that they can work jointly to ensure that the Department of Health and the Department for Children, Schools and Families, respectively, are fully briefed in high profile cases and also in advance about the publication of the executive summary.

## **13 Learning lessons locally and nationally**

13.1 Reviews are of little value unless lessons are learnt from them. At least as much effort should be spent on acting on recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- as far as possible, conduct the review in such a way that the process is a learning exercise in itself, rather than a trial or ordeal
- consider what information needs to be disseminated, how and to whom, in the light of a review. Be prepared to communicate both examples of good practice and areas where change is required
- focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes. PCTs should seek feedback from SHAs, who should use it to inform their performance-management role
- the LSCB should put in place a means of auditing action against recommendations and intended outcomes
- seek feedback on review reports from the Ofsted, who should use reports to inform inspections and performance management.

13.2 Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- establish a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed
- have in place clear, systematic case-recording and record-keeping systems
- develop good communication and mutual understanding between different disciplines and different LSCB members
- communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies
- make sure staff and their representatives understand what can be expected in the event of a Child Death/Serious Case Review.

- 13.3 Member agencies should have a process for identifying any issues for children and families relating to child protection arising from other inquiries such as mental health, domestic violence or the abuse of vulnerable adults.
- 13.4 Taken together, Child Death and Serious Case Reviews should be an important source of information to inform national policy and practice. The Department for Children Schools and Facilities (DCSF) is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF commissions overview reports at least every two years, drawing out key findings of Serious Case Reviews and their implications for policy and practice. It is considering how best to disseminate the findings from the work of the local child death overview teams.

**Suggested letter to LSCB Chair from SCR Committee**

Date *(to be inserted)*

Dear *(name of LSCB Chair)*,

Re: *(child's name)* and *(dob)* and *(date of death or incident)*  
*(address to be inserted)*

On *(date to be inserted)* the SCR Committee considered the circumstances of the death *(or serious injury or incident)* of *(name)* and make the recommendation that a Serious Case Review is undertaken because the following criteria in chapter 8 of Working Together 2006 are met.

*(Information to be inserted outlining the circumstances of the child's death or incident(s) and which criteria are met in Chapter 8 of Working Together 2006)*

*(If child has not died, information to include the extra dimensions of the case that meet the criteria.)*

*(Name to be inserted)*

*(Date to be inserted)*

Chair of SCR Committee

**PRIVATE & CONFIDENTIAL**

Dear LSCB Member

**Re: Internal Management Review – \*\*\*\*\***

**Child** \*\*\*\*\*  
**DoB** \*\*/\*\*/\*\*  
**DoD (if appropriate)** \*\*/\*\*/\*\*

**Mother** \*\*\*\*\* (DoB \*\*/\*\*/\*\*)  
**Father** \*\*\*\*\* (DoB \*\*/\*\*/\*\*)  
**Sister** \*\*\*\*\* (DoB \*\*/\*\*/\*\*)

**Address** \*\*\*\*\*

**Circumstances** \*\*\*\*\*

**SCR protocol final doc 10.12.07.doc**

### **Timescale of Review**

The timescale of the review is \*\*/\*\*/\*\* - \*\*/\*\*/\*\*, with a requirement to provide a chronology and detailed analysis of agency involvement during this period. Please provide a summary of key events prior to this timescale.

### **Terms of Reference**

The terms of reference for the review are:

- Identify and evaluate decision, assessments and plans made by the agency in relation to members of the household and family.
- Examine the level and effectiveness of the exchange of information within and between agencies.
- Examine and comment on practices and processes identified and compare them with local policies and procedures and with central government guidance.
- Highlight ways in which practice can be improved and make recommendation as appropriate.
- *Add any specific Terms of Reference as necessary for this particular IMR.*

### **Abbreviations to be Used in IMRs**

For anonymity, abbreviations should be used to describe persons in the IMR and chronology. The following abbreviations should be used to ensure consistency between agencies:

## **Family**

\*\*\*\*\* = Child 1

\*\*\*\*\*= Child 2

M = Mother

F = Father

MGM = Maternal Grandmother

MGF = Maternal Grandfather

PGM = Paternal Grandmother

PGF = Paternal Grandfather

## **Professionals**

Social Worker should be shown as SW1 SW2 etc;

Health Visitors as HV1, HV2 etc;

General Practitioners as GP1, GP2 etc;

School Nurse as SN1, SN2

Police Officers as PO1, PO2 etc

Teacher as T 1, T2 etc

Cafcass as Cf 1, Cf 2 etc

Probation as P1 P2 etc

Housing as H1 etc

Managers' posts should be explained, i.e. team manager 1 then referred to as TM1, TM2 etc. The same for police, police sergeant PSgt 1, PSgt 2. etc.

## **Timescale for Completion**

To comply with national timescales for the completion of SCRs each agency's IMR must be completed by \*\*/\*\*/\*\*. Completed IMRs should be sent electronically to \*\*\*\*\* by the \*\*/\*\*/\*\* so that the Serious Case Review Panel can meet and consider the reports.

As the LSCB representative for your agency please confirm the following within 7 working days of receipt of this letter:

1. Whether your agency has or has not had any involvement with this family during the dates of the review.
2. If your agency has had involvement that you will be commissioning an IMR within

- your agency.
3. Details of the IMR author (name and contact details including telephone and e mail details)
  4. The name of the Senior Manager of your agency who will 'sign off' their report on completion, prior to submission.

Please reply to \*\*\*\*\*

Yours sincerely,

Chair of LSCB Serious Case Review Sub-Committee

## Genogram

Board Manager to insert a genogram for each case, guidance for which is contained in Appendix D

**INTERNAL MANAGEMENT REVIEW**

Chronology of events relating to .....

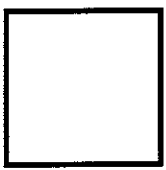
Produced by .....

Date	Time of Action	Agency & Designation	Contact type e.g. letter, phone, e-mail and Source of Information, eg residential file, health visitor notes	Description. This should be a Summary of the record to include any actions taken, unless the entry or words used are significant when the relevant exact wording should be reproduced.	Was Child seen or spoken to? What was observed or communicated by the child?	Comments by IMR author re significance

1 N.B - it is vital that the chronology is completed to this format and that whenever abbreviations are used a glossary is provided

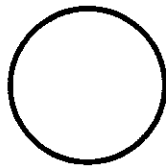
# Genogram

## 2 Genogram symbols

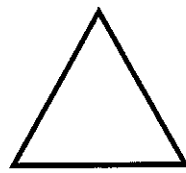


**Male**

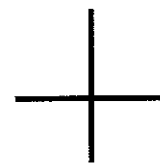
3



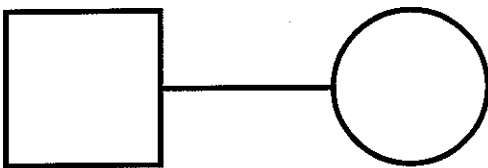
**Female**



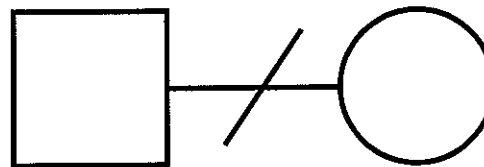
**Gender unknown**  
(e.g. Pregnancy)



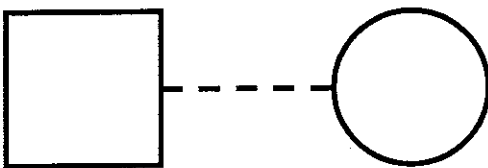
**Death**



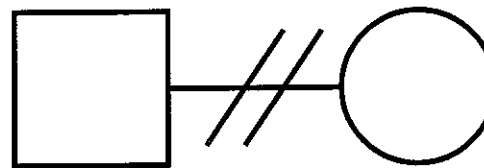
**Enduring relationship**  
(Marriage or cohabitation)



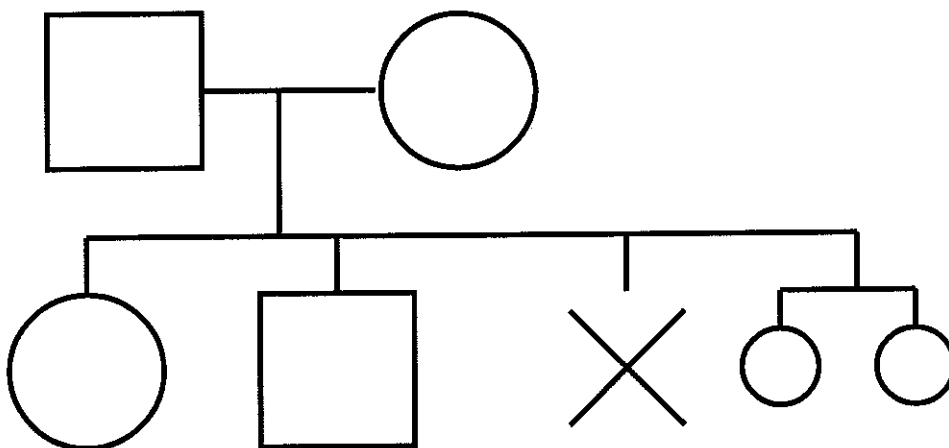
**Separation**



**Transitory relationship**



**Divorce**



**First child**

**Second child**

**Miscarriage or abortion**

**Twins**

A dotted line should be drawn around the people who currently live in the same house. A genogram covering three or more generations may be compiled using these symbols. Other relatives can be included.

**Genogram continued...**

**The following abbreviations should be used when referring to members of the family**

<b>Eldest child</b>	<b>child 1</b>
<b>Next child</b>	<b>child 2 etc</b>
<b>Mother</b>	<b>M</b>
<b>Father</b>	<b>F</b>
<b>Step parent</b>	<b>SM or SF</b>
<b>Grandparent</b>	<b>MGM or MGF</b>
<b>Aunt</b>	<b>A</b>
<b>Uncle</b>	<b>U</b>

**Child 1's friend A, Child 1's friend B**

**social worker should be shown as SW1 SW2 etc;**

**health visitors as HV1, HV2 etc;**

**general practitioners as GP1, GP2 etc;**

**school nurse as SN1, SN2**

**police officers as PO1, PO2 etc**

**teacher as T 1, T2 etc**

**Cafcass as Cf 1, Cf 2 etc**

**Probation as P1 P2 etc**

### Guidelines for IMR Authors interviewing staff

This is guidance for those who are planning to interview staff within their agency, relevant to the case being reviewed

- The IMR author will identify those key staff members to be interviewed.
- Staff will be informed of the purpose of the interview
  - A copy of the terms of reference and scope of the review will be shared prior to interview
  - A copy of the staff guidance regarding the process will be shared prior to interview (appendix F)
- A written record of each interview will be made and shared with the member of staff, so that it can be checked for accuracy prior to the IMR's submission to the Serious Case Review Panel.
- In order to maintain a fair and consistent approach, all interviews will consider the following points:
  1. Involvement in the case, including knowledge of the history of the case, prior to their involvement.
  2. Knowledge of the LSCB Inter agency Safeguarding Procedures and individual agency's policy and procedure in relation to safeguarding children.
  3. Adherence to relevant policies and procedures.
  4. Knowledge of the potential indicators of child abuse and the impact of abuse and neglect on a child's health and development.
  5. Comment regarding inter agency working and communication.
  6. Record keeping in this case.
  7. Quality of supervision received including case management and any other relevant identified concerns.
  8. Evidence of training received, both within and outside the agency, in the last two years and previously.
  9. With the benefit of hindsight, would staff member have acted differently.
  10. What lessons could have been learnt from the experience.
  11. Recommendations for future practice.

## Information & Guidance for Staff

### 1. Introduction

The following guidance has been produced to advise staff involved in a Serious Case Review and / or IMR. It should be read in conjunction with the 4 LSCB "Safeguarding Our Children" procedures.

### 2. Reason for undertaking a Serious Case Review

- 2.1** Serious Case Reviews are undertaken under Regulation 5 of the Children Act 2004, in accordance with the statutory guidance 'Working Together to Safeguard Children, 2006.'

When a child dies and abuse or neglect is known or suspected to be a factor in the death, local organisations should consider whether there are any lessons to be learnt about the ways in which they (organisations) work together to safeguard and promote the welfare of children.

Additionally LSCBs should always consider whether a Serious Case Review should be conducted where:

- a child sustains a potentially life threatening injury or serious and permanent impairment of health and development through abuse or neglect or
  - a child has been subjected to particularly serious sexual abuse or
  - a parent has been murdered and a homicide review is being initiated or
  - a child has been killed by a parent with a mental illness
- and**
- the case gives rise to concerns about interagency working to protect children from harm.'

- 2.2** The purpose of a Serious Case Review is to:

- establish whether there are lessons to be learnt from the case
- identify how they will be acted on
- improve interagency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child died or who is culpable. That is a matter for Coroners and Criminal Courts.

- 2.3** All agencies represented on the LSCB have a duty to cooperate and participate in the Serious Case Review.

- 2.4** The LSCB and its member agencies recognise that any incident of child abuse and or neglect leading to significant harm or the death of a child is bound to have a considerable impact on all staff involved. When this is accompanied by a Serious Case Review, staff may experience additional anxiety and stress.

- 2.5** If you are to be interviewed as part of the IMR, you will be informed of the purpose of the interview and a copy of the terms of reference and scope of the review will be shared with you prior to interview. By explaining the process and providing information about what will be required it is hoped that such associated stress will be kept to a minimum for you.
- 2.6** Each agency, as part of its IMR, produces a chronology of events, a summary and analysis of involvement, decision making and adherence to policy and procedures, as well as identified good practice. Information that identifies you by name will be anonymised within the IMR and the subsequent Serious Case overview report.
- 2.7** The following points will be considered in your interview:
- Involvement in the case, including knowledge of the history of the case, prior to your involvement.
  - Knowledge of the LSCB inter- agency Safeguarding Procedures and individual agency's policy and procedure in relation to safeguarding children.
  - Adherence to relevant policies and procedures.
  - Knowledge of the potential indicators of child abuse and the impact of abuse and neglect on a child's health and development.
  - Comment regarding inter agency working and communication.
  - Record keeping in this case.
  - Quality of supervision received including case management and any other relevant identified concerns.
  - Evidence of training received, both within and outside the agency, in the last two years and previously.
  - With the benefit of hindsight, would you have acted differently.
  - What lessons could have been learnt from the experience.
  - Recommendations for future practice.
- 2.8** A written record of each interview will be made and shared with you, so that you can check it for accuracy,- prior to the IMR submission to the Serious Case Review Panel.
- 2.9** Should areas for improvement be identified the IMR author and or the Overview author will make recommendations which will be considered by the Serious Case Review Panel
- 2.10** If there are any serious breaches of procedures or potential disciplinary concerns, the IMR author will advise your line manager, so that appropriate support and guidance can be offered to you.
- 2.11** It is the responsibility of each agency undertaking an IMR to provide any necessary support to you and other staff. The source of this support should be made clear to you at the beginning of your involvement. This is a matter for your agency, not the LSCB.

- 2.12** The process can take several months from start to finish (i.e. when the LSCB has signed off the final overview report). The IMR should be completed within approximately 2 months as the Serious Case Review itself should be completed within 4 months.
- 2.13** It is important to remember that the purpose of Serious Case reviews is about understanding what happened and why, it is about learning from what we have done well, in addition to reducing the risk of a similar event happening in the future.
- 2.14** It is hoped you will feel supported throughout the process and enabled to contribute to the recommendations and actions that will improve practice and safeguard children more effectively.

### Format for IMR reports

#### What was our involvement with this child and family?

Construct a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference, using the format in Appendix C. Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

#### Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why. Consider specifically the following:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making revisions about children's services. Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers or other organisations and professionals involved at points where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

# LSCB Overview Report

### Introduction

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to the Serious Case Review and the nature of their contributions (for example, management review by LA, report from adult mental health service).
- List SCR Panel members and author of overview report.

### The facts

- Use the genogram provided by the Board Manager showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen and the child's wishes and feelings sought or expressed.
- Prepare an overview that summarises what relevant information was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

### Analysis

This part of the overview should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. The analysis section is also where any examples of good practice should be highlighted.

### Conclusions and recommendations

This part of the report should summarise, in the opinion of the SCR Panel, what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action. Recommendations should include, but not limited to, the recommendations made in individual reports from each organisation. Recommendations should be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted.

### What do we learn from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single- and inter-agency); management and supervision; working in partnership with other organisations; resources?

### Recommendations for action

What action should be taken by whom and when? What outcomes should these actions bring, and how will the organisation evaluate whether they have been achieved?

**INTERNAL MANAGEMENT REVIEW AND/OR SERIOUS CASE REVIEW ACTION PLAN**

**NB - For the purpose of the subsequent amalgamation of agency chronologies for the Serious Case Review, it is essential that this format be used.**

**The SCR Sub-Committee will require specific evidence that these actions have been completed e.g. numbers trained, copies of revised procedures etc.**

Recommendation	Action	Evidence	Person responsible & designation	Target date	Date completed

