Serious Case Review (SCR) & Learning Review Procedure

FINAL June 2015

REVIEW June 2017

Contents

1. Introduction

1.1 A function of LSCBs is to conduct a Serious Case Review (SCR) after a child has died or is seriously harmed as a result of abuse or neglect. This document sets out the arrangements that are in place to respond to Serious Case Reviews (SCRs) and what happens once a referral is made to the PSCB Chairperson under Chapter 4 of Working Together to Safeguard Children (2015).

1.2 A flowchart (see Appendix A) shows the key stages involved.

1.3 Any partner agency may refer a case to the PSCB if they believe that there are important lessons for multi agency working to be learned from the case.

2. Engagement of partner agencies

2.1 The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

3. Purpose of a serious case review (SCR)

3.1 The purpose of a serious case review or any other type of review within the PSCB Learning & Improvement Framework is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

3.2 The lessons learned should be disseminated effectively and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR. This perspective should inform the scope of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations. Reviews vary in their breadth and complexity but, in all cases, where possible lessons should be acted upon quickly without waiting for the SCR to be completed.

3.3 The focus on multi-agency working in SCRs is important to establish the different narratives that each agency may have had about the case, and the family's experience of different services. The purpose should be to understand why differing narratives occur, particularly where there is a pattern which repeats itself in a number of cases or situations. The SCR can support the development of an understanding of why some professionals might have had difficulties meeting their statutory safeguarding responsibilities.

3.4 Serious case reviews are not inquiries into how a child died or was seriously harmed, or who is culpable; that is a matter for coroners and criminal courts respectively to determine, as appropriate.

3.5 Serious case reviews are also not part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a serious case review indicating that disciplinary action should be initiated under established

procedures, the relevant processes should be undertaken separately from the serious case review process. Alternatively, some serious case reviews may be conducted concurrently with (but separately from) disciplinary action. In some cases (for example, alleged institutional abuse) it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children.

4. Safeguarding siblings or other children

4.1 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, local organisations should immediately ascertain whether there are other children who are suffering, or likely to suffer significant harm. This will normally be done through the Rapid Response arrangements or the Strategy Meeting. Immediate action should be considered to safeguard the welfare of siblings or other children in the family or community network, in the institution or social network (including via social media) within which the abuse is alleged.

4.2 Where there are concerns about the welfare of siblings or other children, the Pan-Hampshire/4LSCB Child Protection Procedures must be followed, including those covering organised and complex abuse if relevant.

5. When to undertake a SCR[1]

5.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed[2] and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

5.2 Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) **must always** trigger an SCR.[3]

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[1] Paragraphs 5.1-55.5 are taken from Chapter 4 Working Together to Safeguard Children 2015

[2] Working Together 2015 paragraphs 4:17 includes a definition of seriously harmed (see 5.4)

[3] The National Panel of Independent Experts on SCRs has issued the following guidance for LSCBs on SCR initiation decisions:

1) **Serious Incident occurs where**
   a) a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of heath or development through abuse of neglect
   OR
   b) a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.
2) **LSCB Chair considers whether and how to proceed with an SCR**
   If the child has died the criteria for an SCR will most likely be met
   Questions to consider include:
   If the child has not died; are there concerns about how agencies or professionals worked together to protect the child?
   What is the scope of the review and who needs to be involved?
   Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

5.3 In addition, even if one of these criteria are not met an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Capacity Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

5.4 Working Together 2015 provides a definition of seriously harmed as:
'"Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;
- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.' [4]

5.4 Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chairperson. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review (e.g. a learning review).

5.5 LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee the implementation of actions resulting from these reviews and reflect on progress in its annual report.

6. Deciding which LSCB should take lead responsibility

6.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them meets the criteria for an SCR.

6.2 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is / was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in the case should be included as partners in jointly planning, undertaking the review and the recommendations for learning and improvement. PSCB does not have the power to instruct other LSCBs to carry out any action (and vice versa), but should ensure the responsibilities are clearly communicated to another LSCB. Where another LSCB does not agree with an action or fails to carry it out, the SCR Committee Chairperson should seek clarification of the reasons why and if necessary escalate the issues to the PSCB Independent Chairperson.

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[4] Working Together 2015, paragraph 4.17

6.3 In the case of looked after children, the local authority with statutory responsibility for looking after the child should take lead responsibility for conducting the review, again involving other LSCBs with an interest or involvement.

7. Referring cases for consideration

7.1 Each agency must have arrangements for identifying cases where the agency considers that criteria for a SCR may be met. It is important that any practitioner or professional is able to discuss a case with their agency safeguarding children lead if they think a SCR may be required.

7.2 Any agency may refer a case to the PSCB that appears to meet the criteria. The agency safeguarding lead should notify the PSCB Business unit of a referral and confirm this in writing within 48 hours using the referral form (see Appendix B). The relevant agency Chief Officer must be notified of the referral by their agency safeguarding lead.

7.3 The PSCB Business unit will request agency reports using a proforma once the case has been confirmed as a referral. This should enable the reports to be available at the next available SCR Committee.

7.4 PSCB Chairperson has ultimate responsibility for deciding whether to conduct a serious case review.

7.5 Cases may be referred by the Child Death Overview Processes. The Rapid Response arrangements or the Chairperson of the Child Death Overview Panel (CDOP) may refer a case to the PSCB that appears to meet the criteria and which (s)he considers is likely to have important lessons for inter-agency working. A professional involved in the Child Death Overview processes can refer at any stage as in 7.1 above.

7.6 In addition, the Secretary of State for the Department for Education has powers to demand an inquiry be held under the *Inquiries Act 2005*.

8. SCR Committee

8.1 The PSCB has a standing Serious Case Review Committee and has several functions and tasks delegated to it by the PSCB. In summary, the SCR Committee will coordinate the following inter-related activity to ensure the local Learning and Improvement Framework is effectively implemented:

- Procedures are up to date and compliant with Working Together 2015 to be ‘best prepared’ to respond to any referral regarding a serious incident which may or may not fall within the criteria for a Serious Case Review.
- Making recommendations to the PSCB Independent Chairperson as to:
    - whether a Serious Case Review should be carried out and the methodology to be used, or
    - whether a Serious Case Review should not be carried out but another type of learning review should be undertaken and the methodology to be used, or
    - whether other action should be taken by the LSCB in line with the Learning & Improvement Framework.
- Commissioning Serious Case Reviews or other types of learning reviews on behalf of the PSCB.

- Monitoring partner agency and the PSCB's action plans following the publication of a Serious Case Review or other types of learning reviews.
- Using the learning from own and other LSCB Serious Case Reviews and national research on Serious Case Reviews to inform policy, practice and the PSCB multi agency training programme.

8.2 The standing SCR Committee will meet or be convened separately (to the monthly meetings) once a referral for a possible SCR has been made to the PSCB and the PSCB Chairperson is satisfied that the PSCB must make a decision based on the available information. As a minimum, the SCR Committee will have nominated senior representatives from:

- Children's Social Care, Portsmouth City Council (PCC)
- Health Commissioning & Partners (as a minimum this may be representation by either the Designated Doctor or Designated Nurse, CCG)
- Education Services, PCC
- Hampshire Police

In addition, LA Child Protection Adviser is also member of SCR Committee.

8.3 The PCC LA Legal Adviser (for Children's Services) and the PSCB Business Manager should attend or be available to the Committee for advice. The PSCB Administrator will provide dedicated admin support to the Committee.

8.4 When the SCR Committee is convened specifically to make a decision to recommend to the PSCB Independent Chairperson on the criteria for an SCR, partner agency representatives may be co-opted to provide knowledge of their agency's contact with a child and his or her family or to provide expert advice.

8.5 The PSCB SCR Committee should be chaired by an experienced person who could be a member of the PSCB. The PSCB Chairperson in consultation with the standing SCR Committee Chairperson may consider that an Independent Chairperson should be appointed to chair a particular SCR Committee. This may be considered when the PSCB requires an additional level of independence (e.g. due to a conflict of interest, specialist expertise is required, complex issues).

8.6 To be quorate, 100% of members must be present when a decision is required under Chapter 4 of Working Together to Safeguard Children. In exceptional circumstances, where a member is not able to attend, the SCR Committee Chairperson may proceed with the meeting and reach a decision on the basis that further delay would not be consistent with the PSCB Learning & Improvement Framework.

8.7 The PSCB Business unit will notify the SCR Committee members that they are to be convened for the purposes of deciding whether to recommend that a SCR should be undertaken.

8.8 Once it is known that a case is being considered for review, each organisation should immediately secure its records relating to the case to guard against loss or interference.

9. Deciding whether to initiate a SCR

9.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be

made within one month of notification of the incident. The final decision rests with the respective LSCB Chairperson.

9.2 The LSCB Chairperson may seek peer challenge from another LSCB Chairperson when considering this decision and also at other stages in the SCR process.

9.3 In considering whether a case meets the criteria for a serious case review the PSCB Chairperson should receive a written briefing from the SCR Committee Chairperson. This should include the reasons for the SCR Committee's view on whether the criteria has been met or not, plus an outline of the methodology for a SCR or other case review. Where the child has died, the PSCB Chairperson should also use information available from the professionals involved in reviewing the child's death to assist in making this decision (i.e. CDOP/Rapid response multi agency meetings minutes and standard reports).

9.4 The LSCB Chairperson will inform the Director of Children's Services whether a SCR should be initiated or not. The decision will also be communicated to the SCR Committee via the LSCB Business unit and subsequent arrangements made for the SCR or case review to begin.

9.5 The PSCB Business unit should let Ofsted and the National Panel of Independent Experts on SCRs (National Panel) know of the decision (see Appendix D). If an LSCB decides not to initiate an SCR, their decision may be subject to scrutiny by the National Panel. The LSCB should provide information to the Panel on request to inform its deliberations and the respective LSCB Chairperson should be prepared to attend in person to give evidence to the Panel.

9.6 Following a decision by the PSCB Chairperson to undertake a SCR, the SCR Committee should make arrangements to manage and quality assure the process on a case by case basis. This role may be undertaken by the standing SCR Committee or by a separate SCR 'Panel' appointed by the SCR Committee. The expectation would be for the lead reviewer to report on a regular basis to the SCR Committee or 'Panel' on the progress of the review, emerging learning, timescales for completion, costs and the arrangements for the Final SCR Report and presentation to PSCB.

10. Timescales for initiating and undertaking a SCR

10.1 Within one month of a case coming to the attention of the PSCB Chairperson, he or she should decide, following a recommendation from the standing SCR Committee, whether to initiate a Serious Case Review.

10.2 A LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

10.3 In some cases, criminal proceedings may follow the death or serious injury of a child. The SCR Committee Chairperson should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the SCR is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage? Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to complete and publish the Final SCR Report until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

10.4 SCRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The PSCB Chairperson should make these decisions on a case by case basis based on advice from the SCR Panel Chairperson and having consulted with the local authority (where there are pending family cases). The PSCB Chairperson may also need to seek legal advice to assist in deciding how to proceed.

10.5 The Final SCR Report should take full account of salient, new information which becomes available during the course of these proceedings and the facts, conclusions and recommendations should be revised accordingly.

11. Notifications

11.1 Once the PSCB Chairperson has decided to carry out a SCR, a letter of notification will be sent by the PSCB Chairperson to Chief Executive Officers of the agencies involved. This will be undertaken by the PSCB Business unit.

11.2 The PSCB Chairperson should notify Ofsted and the National Panel of Independent Experts on SCRs (National Panel) whether or not a serious case review will be initiated as soon as the decision is made. Other agencies that are inspected should make their own notifications as required. CCG commissioners should ensure their Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified. The National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation). In addition the DfE Early Years Unit and Ofsted should be informed if children's day care or childminding is involved and the DfE should also be informed if a school is involved. Other agencies must inform their relevant regulatory bodies as appropriate.

11.3 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the Final SCR Report, information relating to children, family members and professionals involved in the case (with the exception of the PSCB Chairperson, SCR Panel Chairperson and Lead Reviewer) should be anonymised before being submitted to any external organisation or body (including Ofsted, the National Panel and any Government Departments).

12. Notifying and Engaging the Family

12.1 It is important that consideration is given to the best means of notifying families that a SCR is being undertaken. Effective communication at an early stage may be vital in gaining cooperation from family members during the SCR process (e.g. interviews). The use of interpreters or translation services should be used where English is not the first language of the family members. Every effort should be made to personally deliver and explain a notification letter to the family. This should be done by the Chairperson or a member of the SCR Committee. Good practice would be to also involve a practitioner known and trusted by the family. A letter should not be sent 'cold' to family members unless every reasonable attempt to arrange a face-to-face interview has been exhausted. In such situations the wording of the letter should be carefully thought through.

12.2 Where a child has survived and is the subject of a SCR, (s)he must be informed (given their age and understanding) that a SCR is being initiated and the process explained in a suitable way. Where the child is too young to be informed, arrangements should be made for relevant communications to be archived for such a time when it may be appropriate to inform the child retrospectively.

12.3 The timings of such notifications are crucial, particularly when there are current Police investigations. When there are pending criminal proceedings involving the parents and

or family members, the decision about how and when to notify the family needs to taken by the SCR Committee with the Police representative present.

12.4 When appropriate the family will be invited to share their views with the Serious Case Lead Reviewer.

13. Determining the methodology for a SCR

13.1 If the SCR Committee advises that a SCR should take place, they must also recommend the methodology for the review. The methodology used and the way an SCR should be conducted must be consistent with the principles for learning and improvement set out in Chapter 4 Working Together 2015 paragraphs 9-11. LSCBs may use any learning model which is consistent with those principles in this guidance, including the systems methodology recommended by Professor Munro[5].

13.2 The initial scoping of the SCR should take into account the current information known in each case and must identify those who should contribute. As further information becomes available other contributors may be needed.

13.4 As part of the LSCB's ongoing Learning & Improvement Framework the PSCB may have specific questions that should be answered as part of the SCR. These may link to previous findings through monitoring and evaluation (e.g. through multi agency case audits, learning reviews). It is important not to view the SCR process in isolation and separate from other PSCB activities for learning and improvement.

13.5 For relevant issues to be considered see Appendix C.

14. Appointing Reviewers

14.1 The PSCB should appoint one (or in some cases two) suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using methodologies consistent with Chapter 4 Working Together 2013. The lead reviewer should be independent of the PSCB and the organisations involved in the case.

14.2 The PSCB Chairperson in conjunction with the SCR Committee Chairperson will identify suitable candidates, dependent on the needs of each case review. Candidates will be asked to supply:

- a Curriculum Vitae; and
- a referee who will be a Senior Manager or PSCB Chairperson in an area where they have previously been lead reviewer on a SCR or written a SCR Final Report or complex report in a related field.

14.3 Once a SCR Lead Reviewer has been identified a commissioning letter and contract outlining terms and conditions for the case review will be drawn up by the PSCB Business Manager. The contract will include details of the time allocated, costs agreed, timescales for completion and the format the Final SCR Report.

14.4 The Lead Reviewer is likely to be commissioned to produce the Final SCR Report. However, this needs to be confirmed on a case by case basis.

[5] Department for Education The Munro Review of Child Protection: Final Report: A Child Centred System, (May 2011)

14.5 The PSCB Business manager should provide the National Panel of Independent Experts with the name(s) of the individual(s) they appoint to conduct the SCR. LSCBs should consider carefully any advice from the Panel about the appointment of reviewers.

15. Publishing Reports

15.1 All reviews of cases meeting the SCR criteria must result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to compromise the welfare of any children or vulnerable adults involved in the case.

15.2 Final SCR Reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

15.3 The Final SCR Report should enable professionals from all relevant sectors to understand fully what happened in each case, the context in which the events occurred and to learn and apply the lessons. The Final SCR Report should bring together the facts, analyse the findings and may make recommendations for future action dependent on the methodology used.

15.4 LSCBs should publish, either as part of the Final SCR Report or in a separate document, information about actions which have already been taken in response to the emerging review findings, the impact these actions have had on improving services, and what more will be done.

15.5 When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on any siblings, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders.

15.6 LSCBs should send copies of all SCR reports to the National Panel of Independent Experts at least one week before publication. If an LSCB considers that an SCR report should not be published, it should inform the Panel which will provide advice to the LSCB. The LSCB should provide all relevant information to the Panel on request, to inform its deliberations.

16. LSCB action on receiving the Final SCR Report

16.1 The SCR Committee, on behalf of the PSCB, should quality assure the Final SCR Report.

16.2 The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings.

16.3 The PSCB (main Board) should approve the Final SCR Report and:

- Make arrangements to provide feedback and debriefing to family members as appropriate;
- Make arrangements to provide feedback and debriefing to staff as appropriate;
- Make arrangements to provide a briefing to the media as appropriate;
- Disseminate the Final SCR Report to relevant interested parties;
- Publish the Final SCR Report once the SCR has been completed
- Implement those actions for which the PSCB has lead responsibility and monitor the timely implementation of the actions resulting from the SCR;
- Formally conclude the review process when all the actions have been implemented.

16.4 Prior to publication the PSCB and partner agencies should anticipate the likely response from the media and plan in advance how to manage it constructively. A lead agency may take responsibility for de-briefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals.

17. Audit and monitoring

17.1 Monitoring of the actions produced from the Final SCR Report will be undertaken by the standing SCR Committee reporting back to PSCB on a regular basis. Upon completion, the SCR Committee will advise the Board that all actions are complete so the Board can sign off the SCR process.

17.2 Any areas of inter-agency activity identified as of particular concern may also be referred for consideration to the PSCB Monitoring, Evaluation & Scrutiny Committee as a potential area for monitoring and review.

18. Reviewing Institutional Abuse

18.1 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. But, reviews are likely to be more complex, on a larger scale, and may require more time. The scope of the SCR and the methodology needs to be carefully considered to explore the issues relevant to the specific case.

18.2 If, for example, children had been abused in a residential school, it would be important to explore whether and how the school had taken steps to create a safe environment for children, and to respond to specific concerns raised.

18.3 There needs to be clarity over the interface between the different stages of investigation (including criminal investigations); case-management, including help for abused children and immediate measures to ensure that other children are safe, and review (i.e. learning lessons from the case to reduce the chance of such events happening again). The three different stages should inform each other. Any proposals for review should be agreed with those leading criminal investigations to make sure that they do not prejudice possible criminal proceedings.

19. Supporting Staff

19.1 The death or serious injury of a child is likely to be a traumatic event for practitioners involved (including unpaid staff such as volunteers), particularly if they were involved in service delivery to the child or to the child's family.

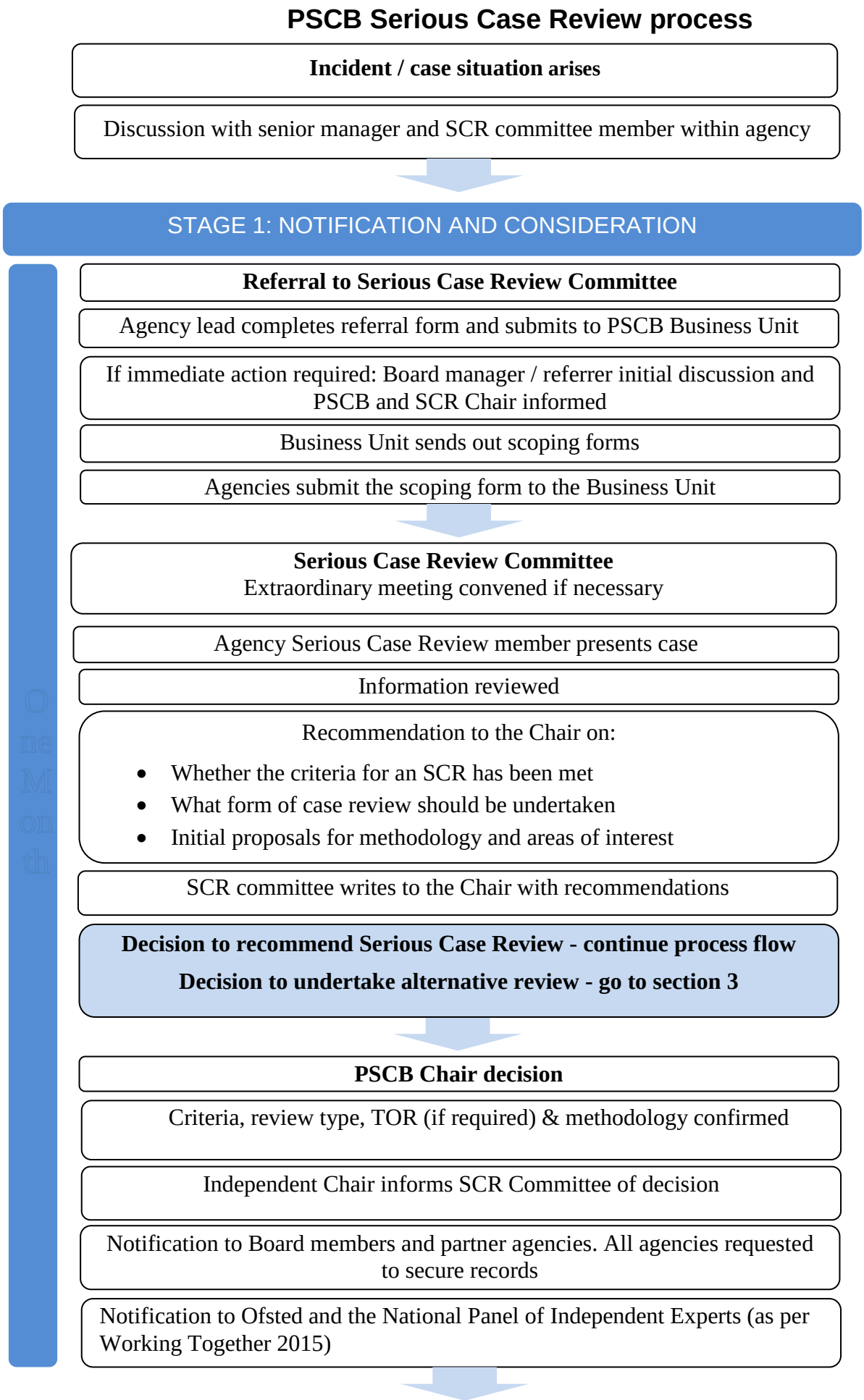
19.2 Managers have a duty of care to employees and volunteers and should ensure that whether they are interviewed or not in relation to a case where there is a SCR all staff involved are offered support through the SCR process. This might be by the provision of support from the employer (such as one-to-one or group sessions) or by giving advice about sources of independent support.

19.3 Managers should advise staff about access to support through the employing agency (e.g. many organisations have employee welfare services for example which may be able to assist).

19.4 In addition, or as an alternative, staff may also wish to consult their Trade Union or professional association about sources of support. Managers should not prevent or discourage this.

Appendix A:

Serious case review process



STAGE 2: Review

Five Months

Review Commissioned

SCR Review Panel established

Review Panel confirms TOR (if required), methodology, oversight arrangements

Independent Reviewer appointed. National Panel notified

Family involvement considered

Board members and relevant partner agencies informed

Review undertaken

Information gathered (e.g. chronologies, agency reports, practitioner interviews and meetings - dependant on methodology)

Oversight of the review process by SCR committee (delegated to a review panel)

Engagement with family and practitioners (dependent on methodology)

Independent Reviewer submits report to PSCB

Outcomes

Extraordinary or tabled PSCB meeting to agree final SCR report

Final report produced with findings

Multi and single agency action plans produced

Outcomes shared with the family

Copy of the report sent to National Panel at least one week prior to publication

Communication and media strategy agreed

SCR publication

STAGE 3: LEARNING & IMPROVEMENT

as outlined in the Learning & Improvement Framework

Embedding learning

Partner agencies progress action plans

Key messages are communicated as outlined in the Communications Strategy

Implications of key messages on PSCB work plans considered at the PSCB Committee Chairs group

Key messages fed into multi and single agency training

Evaluation

SCR committee oversees progress against action plans

Further reviews of practice

Evaluation of training

Appendix B

SCR or Case Review Referral Form

REQUEST FOR CONSIDERATION OF A CASE (serious case review or otherwise)

1. Child's Details			
Child's First Name		Surname	
Other Names Known			
Date of birth		Date of death (as appropriate)	
Ethnicity		Religion	
Address			
Previous address (if known)			
Parent/Carer			
Name of sibling/s and their date of birth/s			

2. Referral Details	
Date of referral to LSCB	
Your name	
Your role	
Organisation	
Address	
Tel. No.	
Email	
Date of notification	
Any linked cases:	

3. Agencies known to be involved with the case (please tick)			
Childrens Services			
Police			
School / Nursery			
Health Services			
Education			
GP Surgery			
Others (please specify)			

6. Case Outline
Please give a summary of the circumstances of this case *(Please continue on a separate sheet if necessary)*

7. Serious Case Review Criteria
Please explain why you feel this case should be considered for a Serious Case Review. The headings below reflect the criteria for a SCR as set out in Working Together (2015):

A child has died or has been seriously harmed

Abuse or neglect of a child is known or suspected

There is a cause for concern as to the way the authority, Board partners or other persons have worked together to safeguard the child

(Please continue on a separate sheet if necessary)

PLEASE RETURN THIS COMPLETED FORM TO:

Portsmouth Safeguarding Children Board: pscb@southampton.gov.uk**.** Please password protect this document or send securely to aileen.blakely@portsmouthcc.gcsx.gov.uk and title your email "Confidential SCR referral".

For Office Use:	
Date case discussed by LSCB SCR Committee	
Recommendation to be made by Serious Case Working Group to Chair of LSCB	
This case fits the criteria within Working Together 2015 and should be considered for a Serious Case Review	
This case does not meet the criteria within Working Together and should not be considered for a Serious Case Review	
This case does not fit the criteria within Working Together for a full Serious Case Review, however we recommend a review, detail below:	
Chair of Serious Case Review Committee: Signed……..	Date……

Appendix C

Key Questions for considering scope and methodology of SCR

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the SCR report?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point?
- What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the serious case review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the serious case review including, where appropriate, for example, the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or third sector organisations? Is there a need to involve organisations/ professionals working in other LSCB areas and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the PSCB need to obtain independent legal advice about any aspect of the proposed serious case review?
- What experience, knowledge and skills are required from the person who will be appointed as the Lead Reviewer?
- Might it help the SCR Committee to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO). Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO) or MAPPA serious case review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated with a serious case review.

- How will the scope of the serious case review fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (e.g. national) and from serious case reviews which have been undertaken by the PSCB?
- How should any family, public and media interest be managed before, during and after the serious case review? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the serious case review?

Appendix D

National panel of independent experts on serious case reviews

26 June 2013

The government announced in Working Together to Safeguard Children in March 2013, that a national panel of independent experts would be established to give Local Safeguarding Children's Boards (LSCBs) access to expert advice from an independent source to help them make the right decisions about conducting and publishing serious case reviews (SCRs).

The panel members are Peter Wanless, Nicholas Dann, Elizabeth Clarke and Jenni Russell. The panel is independent of Government and will provide advice to LSCBs drawing on their own individual areas of expertise.

It will be fully operational from 1 July 2013 and will advise and challenge Local Safeguarding Children Boards (LSCBs) to initiate and publish high-quality SCRs. This is so that lessons can be learned locally and nationally to drive up the quality of child protection services and avoid mistakes being repeated.

The panel will initially advise LSCBs on:

- any decision made by an LSCB not to initiate an SCR following a serious incident which meets certain agreed criteria
- any case where an LSCB has concerns about publication of an SCR report

LSCBs should inform the panel about their SCR initiation and publication decisions. Full information on how the panel will operate and when to contact the panel are set out in the national panel of independent experts on serious case reviews instructions for LSCBs.

The panel has its own dedicated secretariat which will initially be hosted in the Department for Education. These arrangements will be subject to review.

A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat using the contact address on this page.

Panel Members (as at June 2013):

- Peter Wanless is Chief Executive of the NSPCC
- Nicholas Dann is Head of International Development at the Air Accidents Investigation Branch (AAIB)
- Elizabeth Clarke is a practising barrister who has specialised in family law
- Jenni Russell is a columnist for the Sunday Times, the Evening Standard and the Guardian

Panel meetings are expected to be held bi-monthly (January, March, May, July, September & November) monthly:

Contact details

Serious case review panel
Email: **Mailbox.SCRPANEL@education.gsi.gov.uk**

Appendix E

National panel of independent experts on Serious Case Review
Information for LSCBs and Chairs on how the panel will operate

1. Scope of the panel

The role of the panel is set out in *Working Together to Safeguard Children* (2015). The panel's remit will include advising LSCB and Chairs about: application of the SCR criteria; appointment of reviewers; and publication of SCR reports.

The panel will initially advise LSCB Chair's on:

i) any decision made by an LSCB Chair not to initiate an SCR following a serious incident; and

ii) any SCR which an LSCB Chair has indicated it does not plan to publish.

2. Serious Case Review criteria

- Serious Case Review: for every case where abuse or neglect is known or suspected and either:
    - A child dies; or
    - A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

3. Publication of reports

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs.

From the start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.[6]

4. Which cases should the LSCB Chair inform the panel about?

The LSCB Chair should inform the panel about their SCR decisions on cases which:

(a) have been, or should be notified to Ofsted and the Department by the local authority because abuse or neglect is known or suspected and either (i) a child has **died** or (ii) a child has suffered a potentially **life-threatening** injury, **serious sexual abuse** or **sustained serious and permanent impairment** of health or development; or

(b) which come to the attention of the LSCB Chair through another source and, in the LSCB Chair view meets the criteria in (ai) or (aii) above.

The LSCB Chair does not need to inform the panel about other categories of incident which may come to their attention but which clearly fall outside the criteria for an SCR, such as

[6] *Working Together to Safeguard Children* March 2015

accidental deaths or deaths of looked after children where there are no suspicions of abuse or neglect.

The Department is planning to review the processes for notification of serious incidents over the coming year.

5. What information should the LSCB Chair provide to the panel?

Initiation

In cases where the LSCB Chair has **decided to initiate** an SCR, the Chair should give the panel:

• the name(s) of the reviewer(s) appointed to conduct the SCR.

In cases where the **LSCB Chair has decided NOT to initiate an SCR**, the Chair should:

• let the panel know within 14 days and provide a copy of the local authority's Serious Incident Notification if available (if this is not available, please provide brief anonymised details of the case covering the nature of the incident; ages of the children involved; their relationship with any alleged perpetrator(s); agency involvement with the family; and any criminal investigation;

• provide an explanation why the case does not meet the SCR criteria.

Publication

In cases where the **LSCB Chair has concerns about publication of an SCR report**, the Chair should refer their concerns to the panel. This could be done at any time in the course of conducting an SCR.

The LSCB Chair should provide the panel with the following information:

• what the LSCB has done to ensure that the SCR will be written with publication in mind. How has the reviewer been briefed?

• where is the potential difficulty coming from? For example, is it from agencies contributing to the review, from family members, or are there general concerns about media activity?

• how has the LSCB balanced these interests with the public interest in understanding the issues raised by the case and with the importance of ensuring that lessons are learnt to improve services to children and families?

• are there are any legal restrictions on releasing certain information in the report?

• what consideration has been given to amending the style and content of the report to make it fit for publication?

• what expert advice has the LSCB drawn on when considering publication of the report? For example has there been advice from lawyers or medical or communications professionals?

• how is the LSCB managing media interest in the case?

6. How will confidentiality of the information be preserved?

Panel members have agreed and signed up to terms and conditions which include confidentiality clauses. Members have agreed that personal, sensitive or otherwise confidential information will only be used in furtherance of the panel's objectives.

Information that will be shared with panel members will be sent through secure email links and encryption.

The panel would not be subject to the Freedom of Information Act 2000 because it is not a public authority as defined at section 3 of the Freedom of Information Act 2000.

7. How to contact the panel

A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat: Mailbox.SCRPANEL@education.gsi.gov.uk

The flowcharts which follow set out the process for contacting the panel.

8. What is the turnaround time?

The dates of future panel meetings will be communicated to LSCB Chairs. The panel will inform LSCBs Chairs of the panel's advice within a week of each panel meeting. This will be communicated by a letter to LSCB Chairs.

9. Attendance at panel meetings by LSCB Chairs

On some occasions, the panel may ask the LSCB Chair to attend a panel meeting if they would like to discuss the case further. This will be on a case by case basis. Costs of attendance by the LSCB Chair can be reimbursed by prior arrangement with the secretariat. The LSCB Chair may bring others to the meeting on request but costs of attendance by other individuals will not be reimbursed.

Appendix F

Flowchart 1: SCR initiation decisions

Serious Incident occurs where:
a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of heath or development through abuse of neglect.
OR
a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.

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LSCB Chair considers whether and how to proceed with an SCR
If the child has died the criteria for an SCR will most likely be met
Questions to consider include:
If the child has not died; are there concerns about how agencies or professionals worked together to protect the child
What is the scope of the review and who needs to be involved?
Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

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Once an LSCB Chair has made a decision on whether or not to initiate an SCR, the LSCB Chair should inform the panel by emailing the secretariat at:
Mailbox.SCRPANEL@education.gsi.gov.uk

↙ ↘

YES
If an LSCB Chair has decided to initiate an SCR, the LSCB Chair should let the panel and Ofsted know of their decision.

Appointing reviewers

LSCB Chairs should also let the panel know:

• name(s) of the reviewer(s) appointed to conduct the SCR.

This will be for information. The panel has no formal role in vetting reviewers.

NO
If an LSCB Chair has decided not to initiate an SCR, the LSCB Chair should let the panel know their decision within 14 days, providing a copy of the local authority's Serious Incident Notification and an explanation why the LSCB Chair has decided the case does not meet the SCR criteria

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Panel meetings
The panel expects to meet every 2 months to review the details of cases mitted. The panel may request a meeting or further information from the LSCB Chair before being in a position to advise about a case. If so the panel will contact the Chair direct.

Appendix G

Flowchart 2: SCR report publication decisions