

Serious Case Reviews

AMENDMENT: June 2010

Following the publication of [Tim Loughton's letter to Directors of Children's Services and LSCB Chairs](#) on 10 June 2010, this Chapter was amended in relation to the publication of overview reports for serious case reviews initiated on or after 10 June 2010. These changes are reflected in the following sections:

Paragraph 8.44

Paragraph 8.50

Flow chart 7: Overview of Serious Case Review process

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Reviewing and investigative functions of Local Safeguarding Children Boards

- 8.1 The prime purpose of a **Serious Case Review (SCR)** is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. 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 or being likely to suffer 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, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference 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 necessarily waiting for the SCR to be completed.**
- 8.2 Any professional or agency may refer a case to the Local Safeguarding Children Board (LSCB) if they believe that there are important lessons for intra- and/or interagency working to be learned from the case.
- 8.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 (*The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument no. 2006/90*) requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the processes set out in this chapter. The same criteria apply to all children, including those with a disability (*Safeguarding Disabled Children: Practice guidance (2009). London: Department for Children, Schools and Families.*)
- 8.4 Regulation 5 sets out that:
1. *The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act) are as follows–*
 - 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 Review is one where–*
 - e. *abuse or **neglect** of a child is known or suspected; and*
 - f. *either–*
 - i. *the child has died; or*
 - ii. *the child has been seriously harmed 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.*

The purposes of Serious Case Reviews

- 8.5 The purposes of **SCRs** carried out under this guidance are to:
- establish what lessons are to be learned from the case about the way in which local professionals

and organisations work individually and together to safeguard and promote the welfare of children;

- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

8.6 SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

8.7 Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a SCR indicating that disciplinary action would be appropriate, such action should be undertaken separately from the SCR process and in line with the relevant organisation's disciplinary procedures. SCRs may be conducted at the same time, but should be separate 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.

Safeguarding siblings or other children

8.8 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, **significant harm** and who require safeguarding (for example, siblings or other children in an institution where abuse is alleged). Where there are concerns about the welfare of siblings or other children the guidance in **Chapter 5** should be followed. Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

When should a LSCB undertake a Serious Case Review?

8.9 When a child dies (including death by suspected suicide) **and** abuse or **neglect** is known or suspected to be a factor in the death, the LSCB should **always** conduct a **SCR** into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.

8.10 The death of every child is reviewed in accordance with the child death review processes outlined in **Chapter 7** of this guidance. A SCR may be triggered at any point in the child death reviewing process if a rapid response team or Child Death Overview Panel (CDOP) considers a case may meet the criteria for a SCR (see **paragraph 7.1**). In the case of a **looked after child**, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCBs with an interest or whose local agencies have had involvement as appropriate (see **paragraph 7.34**). This CDOP may refer a case to its LSCB Chair if it considers the criteria for a SCR may be met and a SCR has not been initiated. **Chapter 7, flow chart 6**, shows the interface between the child death review and SCR processes.

When should a LSCB consider undertaking a Serious Case Review?

8.11 LSCBs should consider whether to conduct a **SCR** whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to **sexual abuse**; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004 (*The Home Office is working closely with other government departments to develop a process for undertaking domestic homicide reviews and will ensure that any relevant issues regarding SCRs, or any other statutory reviews, are fully considered and incorporated into that process*); or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

8.12 The following questions may also help in deciding whether a case should be the subject of a SCR. The answer 'yes' to one or more of these questions is likely to indicate that a SCR could yield useful lessons:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
 - not recognised by organisations or professionals in contact with the child or perpetrator; or
 - not shared with others; or
 - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare 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 at the time of the incident, 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?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

Which LSCB should take lead responsibility?

8.13 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 or was normally resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a looked after child, the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other LSCBs with an interest or involvement.

Membership of SCR sub-committees and SCR Panels

- 8.14 Many LSCBs have a standing SCR sub-committee to oversee and quality assure all SCRs undertaken by the LSCB, and to provide advice to the LSCB Chair on whether the criteria for conducting a SCR have been met. A SCR sub-committee should involve representatives from local authority children's social care, health (commissioning Primary Care Trust (PCT) and other partners as relevant), education and the police at a minimum. Members of agencies which have responsibilities for completing Individual Management Reviews (IMRs) may be members of the SCR sub-committee but it should not consist solely of such people.
- 8.15 Following a decision by the LSCB Chair to undertake a SCR, the SCR sub-committee should commission a SCR Panel to manage the process. Where a LSCB does not have a standing SCR sub-committee, a SCR Panel should be convened by the LSCB to advise the LSCB Chair on whether the criteria for undertaking a SCR have been met and, where appropriate, to ensure the SCR is undertaken in accordance with this guidance. In such circumstances the same membership requirements apply to a SCR Panel as set out in paragraph 8.14 for a SCR sub-committee.
- 8.16 The Chair of the SCR sub-committee should be an experienced person and could be the independent Chair of the LSCB, or a member of the LSCB. The Chair of any SCR Panel should not be a member of the LSCB(s) involved in the SCR, an employee of any of the agencies involved in the SCR or the overview report author. The SCR Panel Chair can be the independent LSCB Chair, someone from another LSCB which is not involved in the SCR or from an agency which is not involved in the case.

Instigating a Serious Case Review

Does the case meet the Serious Case Review criteria?

8.17 The LSCB Chair should consider whether a case might meet the criteria for a **SCR**, applying the criteria at **paragraphs 8.9–8.12**. Where the child has died, the LSCB Chair should also use information available from the professionals involved in reviewing the child's death (see **Chapter 7**) to assist in making this

decision. In some cases, it may be valuable to conduct a single IMR rather than a full SCR, for example where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together, or a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a SCR. Methodologies such as those developed by Social Care Institute for Excellence (SCIE) (*Fish S., Munro E. and Bairstow S. (2008) SCIE Report 19: Learning together to safeguard children: developing a multi-agency systems approach for case reviews. London: Social Care Institute for Excellence.*) or root cause analysis used in the health service may be useful here. In such cases, arrangements should be made to share relevant findings with the SCR sub-committee or SCR Panel.

- 8.18 Where the LSCB Chair considers, in a particular case, that the criteria for a SCR may be met, he or she should request that the SCR sub-committee considers whether a SCR should take place. If the SCR sub-committee recommends that a SCR be undertaken, they should also recommend the scope and terms of reference for the review. These recommendations should be forwarded to the Chair of the LSCB, who has ultimate responsibility for deciding whether to conduct a SCR. The LSCB Chair should notify Ofsted of the outcome of this decision as soon as it has been made. Ofsted will then pass this information to the relevant Government Office (GO) and the Department for Children, Schools and Families (DCSF). PCT commissioners should ensure their Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified. The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).
- 8.19 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 LSCB Chair, SCR Panel Chair and the overview report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, the relevant GO and DCSF).

Determining the scope and terms of reference of the review

- 8.20 The SCR sub-committee should consider, in the light of current information known in each case, the scope of the SCR and draw up clear terms of reference. The LSCB Chair should ensure that the terms of reference address the key issues in the case and approve them. The GO Children and Learners Team will be able to assist LSCBs where policy advice on undertaking a SCR is required. Where necessary LSCBs should seek their own legal advice. Relevant issues to consider include the following:
- 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?
 - When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
 - 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 SCR, 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 SCR 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 voluntary organisations?
- Is there a need to involve organisations/professionals working in other LSCB areas (see **paragraph 8.13**), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?
- Who should be appointed as the independent author for the overview report (bearing in mind that this person should not be the Chair of the LSCB, the SCR sub-committee or the SCR Panel – see **paragraph 8.33**).
- Might it help the SCR Panel 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) (*PC 22/2008 Revised Notification and Review Procedures for Serious Further Offences.*) 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 coordinated 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 (SUI) investigation into the provision of healthcare should be coordinated with a SCR.
- How will the SCR terms of reference and processes 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 (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

8.21 Some of these issues may need to be revisited by the SCR Panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the LSCB Chair.

Timescales for initiating and undertaking a Serious Case Review

8.22 Reviews vary widely in their breadth and complexity but, in all cases, where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the **SCR** to be completed. Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the SCR sub-committee, whether a review should take place. An initial decision may need to be revisited if further information comes to light, for example through a criminal investigation or a child death review in accordance with **Chapter 7**. Ofsted and other inspectorates should be notified accordingly as set out in **paragraph 8.18**.

8.23 Serious case reviews should be completed within six months from the date of the decision to proceed. Sometimes the complexity of a case does not become apparent until the SCR is in progress. If it emerges that a SCR cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB should revise its timetable and immediately consult the relevant GO in their capacity to provide advice, support and challenge.

8.24 Where an extension beyond the six month timeframe is necessary, an update on progress and a revised project plan should be produced quickly for the relevant GO to consider. This update should include recommendations for action where these are not dependent on the SCR being concluded until after other proceedings have ended. It should also include actions taken to date and an explanation for the extension to the timescale, including the revised completion date. Where a decision to extend the period for completion is made, this information will be passed to Ofsted by the relevant GO. LSCBs should be proactive in keeping GO Children and Learners Teams fully apprised of timing expectations, of risks of delay and of interdependencies with other parallel or related processes.

8.25 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the SCR Panel 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 finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

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

8.27 The final SCR report, including the executive summary, 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.

Who should be involved in the Serious Case Review?

8.28 The initial scoping of the **SCR** should identify those who should contribute, although it may emerge, as

further information becomes available, that the involvement of others, such as those providing specialist adult services, would be useful. As noted above in **paragraph 8.21**, information of relevance to the review may become available at a later stage through, for example, criminal proceedings or investigations such as those undertaken by the PPO.

- 8.29 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 SCR, and even sooner if a case gives rise to concerns within the individual organisation. Relevant independent professionals should contribute reports of their involvement. Where Cafcass contributes to a review, the prior agreement of the courts should be sought so that the duty of confidentiality which the children's guardian has under the court rules can be waived to the degree necessary.
- 8.30 Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. Where more than one PCT has commissioned services the PCTs will need to agree locally how they will work together. This may involve reviewing the involvement of individual practitioners and NHS trusts, and advising named professionals and managers who are compiling reports for the review. The **designated professionals** should produce an integrated health **chronology** and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the IMR for the PCTs as commissioners. Designated safeguarding health professionals also have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the IMR. If the designated health professional(s) have been clinically involved with the case the PCT should seek advice and help from another PCT designated professional as necessary.
- 8.31 The process of conducting an IMR requires access to records relevant to the child such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the child's own records. In some circumstances the person conducting the IMR may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.
- 8.32 The SCR Panel, on behalf of the LSCB, should commission an overview report that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action. It is crucial that the SCR Panel and the overview report author have access to all relevant documentation and where necessary individual professionals to enable both to undertake effectively their respective SCR functions.
- 8.33 The overview report should be commissioned from a person who is independent of all the local agencies and professionals involved and of the LSCB(s). The overview report author should not be the chair of the LSCB, the SCR sub-committee or the SCR Panel. Those conducting management reviews of individual services should not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.

Individual management reviews – general principles

- 8.34 Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a **chronology** of their involvement with the child and family.
- 8.35 The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about. The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report and when they are satisfied the findings accepted. This senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.
- 8.36 Where a child dies in or whilst under escort to or from a custodial setting such as a YOI or STC, the PPO will conduct a fatal incidents investigation and report on the circumstances surrounding the death of that child. The investigation will examine the child's period in custody and assess the clinical care they received as well as examining relevant factors which led to the child being placed in custody. In such cases a representative of the Youth Justice Board (YJB) should be a member of the SCR Panel to help ensure that relevant youth justice issues are covered. The PPO may be invited to attend SCR Panel meetings for specific, agreed purposes. The SCR terms of reference should set out how the PPO, the SCR Panel and the SCR subcommittee will work together to share relevant information during the process of undertaking the SCR (*The DCSF and PPO are agreeing a memorandum which will set out in more detail how LSCBs and the PPO relate to each other when a fatal incidents investigation is being undertaken by the PPO and a SCR is being undertaken by a LSCB(s) with respect to the same child.*).
- 8.37 The following outline format should guide the preparation of IMRs, to help ensure that the relevant questions are addressed and to ensure that information is provided to LSCBs in a consistent format to help prepare an overview report. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and each SCR should consider carefully the circumstances of individual cases and how best to structure the SCR in the light of the particular circumstances.
- 8.38 Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reasons for this.
- 8.39 On completion of each IMR report there should be a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the executive summary is published. It is important that the SCR process supports an open, just and learning (*The DCSF and PPO are agreeing a memorandum which will set out in more detail how LSCBs and the PPO relate to each other when a fatal incidents investigation is being undertaken by the PPO and a SCR is being undertaken by a LSCB(s) with respect to the same child.*) culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of staff.

Scope and format of individual management reviews

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. (This chronology should clearly set out when the child was seen and whether the wishes and feelings of the child were sought). Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

Where an agency has had relevant contact with the alleged perpetrator, the chronology should also cover these actions and should ask whether everything was done which might reasonably have been expected to manage effectively the risk of harm posed by the alleged perpetrator to the child.

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** something either did or did not happen. Consider specifically the following:

Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or **neglect** and about what to do if they had concerns about a child's welfare?

When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?

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?

Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

Were senior managers or other organisations and professionals involved at points in the case 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?

Were there organisational difficulties being experienced within or between agencies? Were these

due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

Was there sufficient management accountability for decision making?

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? Are there implications for current policy and practice?

Recommendations for action

What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

The Serious Case Review overview report

8.40 The **SCR** overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, information from the child death review processes, where relevant, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with IMRs, the precise format will depend on the features of the case. This outline is most applicable to abuse or **neglect** that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex.

Format of Serious Case Review overview report

Introduction

Summarise the circumstances that led to a SCR being undertaken in this case.

State the terms of reference of the review.

Record the methodology used including the documents reviewed, and whether the information was provided in an interview or through written evidence.

List agencies or types of contributors to review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names of the LSCB Chair, SCR Panel Chair, the author of the overview report and the job titles and employing organisations of all the SCR Panel members.

List parallel processes, if any, that are being conducted (for example, criminal proceedings, PPO investigation following the death of a child in custody or independent investigation of adverse events in mental health services).

The facts

Prepare an anonymised genogram 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, if the child was seen alone and whether the child's wishes and feelings were sought or expressed

Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.

Summarise the relevant information that 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 report 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. It is important that this is objective and open, being clear where systems could improve. The analysis section is also where any examples of good practice should be highlighted. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the LSCB and findings from relevant research.

Conclusions and recommendations

This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales.

Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should usually 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 and the information sent to the relevant government department.

SCR Panel responsibilities for the overview report

8.41 The SCR Panel should:

- ensure that it actively manages the SCR process, seeking legal advice as necessary, so that the findings from other relevant processes such as care or criminal proceedings, an inquest or inquiry/investigation are incorporated into the SCR report;
- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- ensure that the overview report is of a high standard and is written in accordance with this guidance;
- commission and agree the content of the executive summary for publication, ensuring that it accurately represents the full SCR, includes the action plan in full and is fully anonymised apart from including the names of the LSCB Chair, SCR Panel Chair and the overview author and the job titles and the employing organisations of all the SCR Panel members;
- translate recommendations into an action plan that should be signed up to by the senior

manager in each of the organisations which will be involved in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set out the means by which improvements in practice/systems will be monitored and reviewed;

- clarify to whom in which agencies or organisations the executive summary and the action plan of the SCR should be made available to support implementation of the recommendations and the learning of the lessons; and
- make arrangements to provide feedback and debriefing to the child (if surviving) and family members/carers of the subject child as appropriate, following completion of the executive summary.

The executive summary

8.42 In all cases, the SCR overview report and the IMRs should be used to produce an executive summary that should be made public and which accurately reflects the full overview report. The executive summary should include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary should, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members. Executive summaries should be produced according to the following outline format although, as with IMRs and overview reports, the precise format will depend on the features of the case.

Format of Serious Case Review executive summary

Introduction

Summarise the circumstances that led to a SCR being undertaken in this case and the process followed by the review.

List the names of the LSCB Chair, SCR Panel Chair and the author of the overview report, and the job titles and employing organisations of all SCR Panel members.

Note the parallel processes, where relevant, that are being or have been conducted and how they have interrelated with the processes followed by the review (for example, criminal proceedings, PPO investigation following the death of a child in custody, or independent investigation of adverse events in mental health services).

Note the extent to which the family (and the child, where he or she has been seriously harmed) have been involved in the review.

The facts/summary of events

Summarise the key facts of the case and the sequence of events. This should be an accurate précis of circumstances of the child and their family and of the **chronology** of the involvement of the relevant agencies. The narrative should be consistent with the detailed chronology in the full

overview report.

Care should however be taken to ensure that the summary is appropriately anonymised and sensitive to the child and family in respect of information that will be available in the public domain.

Key issues or themes arising from the case

Summarise the key issues or themes arising from the analysis in the overview report, and highlight the key decisions taken in respect of the child and their family and the opportunities for early intervention where they existed. With hindsight could or should different decisions or actions have been taken at the time?

Priorities for learning and change

Describe clearly the conclusions and lessons learned from the review, both for individual agencies and for inter-agency working through the LSCB and the Children's Trust Board, ensuring these are in the context of the issues or themes that arose from the case.

Identify examples of good practice as well as being clear where systems should improve.

Recommendations and action plan

Reproduce the recommendations and action plan from the full SCR.

The action plan should highlight which recommendations are relevant to which agencies, the agency/ies responsible for taking forward specific recommendations, how action will be monitored and by whom. It should also set out the progress that has already been made in implementing or completing recommendations and plans to evaluate the impact of these changes.

LSCB action on receiving the Serious Case Review report

8.43 The **SCR** sub-committee, on behalf of the LSCB, should quality assure the final SCR – that is, the IMR reports, the overview report, the executive summary and the action plan.

8.44 The LSCB should approve the final SCR and:

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, the relevant GO Children and Learners Team, the SHA and DCSF. All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) should be anonymised in all the SCR documentation submitted to Ofsted and the relevant GO. If the child died in a custodial setting, copies of the anonymised SCR should be made available to the YJB and copies of the executive summary should be provided to the PPO;
- make arrangements to provide feedback and debriefing to staff and the media as appropriate;
- disseminate the executive summary and key findings to relevant interested parties;
- **publish only the SCR executive summary once the SCR has been completed***;
- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan;

- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback; and
- formally conclude the review process when the action plan has been implemented and inform the relevant GO of this decision.

*** Following the publication of Tim Loughton's Letter 10 June 2010, there is a new requirement to publish Overview Reports in relation to SCRs initiated after 10 June 2010.**

- 8.45 The LSCB should decide on a case by case basis when to publish the executive summary. This decision should take account of the timing of the conclusion of relevant court cases and statutory processes such as inquests or a PPO investigation. The LSCB, on advice from the SCR Panel and where relevant the CPS, the police or its lawyers, should decide whether new information may become available from these other processes which is likely to have an impact on the lessons to be learned from the SCR. If the findings are not likely to have an impact, then there should be no delay in publishing the SCR executive summary. On the other hand, in some cases it may be best to undertake the IMRs and finalise them and the SCR overview report in the light of this new information or findings before publication of the SCR executive summary. In addition, LSCBs may decide to take account of any points raised in Ofsted's evaluation of the SCR before publishing the SCR executive summary but, depending on local circumstances, it may be necessary for the LSCB to publish it prior to the completion of an evaluation by Ofsted.
- 8.46 All SCRs are evaluated by Ofsted and, in line with the arrangements agreed between inspectorates, the evaluation may involve other inspectorates notably the CQC and HMIC. The evaluation will be shared with the LSCB and, together with the SCR reports as appropriate, with partner inspectorates and Government. Where a SCR has been evaluated as 'inadequate' the LSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The LSCB is then required to submit to Ofsted, within three months, an action plan that addresses the inadequacies of the SCR.

Reviewing institutional abuse

- 8.47 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. SCRs in these circumstances are likely to be more complex, on a larger scale, and may require more time (see **paragraphs 6.10– 6.13**) on investigating complex (organisational or multiple) abuse. Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if children are abused in a residential school, it is important to explore whether and how the school has taken steps to create a safe environment for children, and to respond to specific concerns raised.
- 8.48 There needs to be clarity over the interface between: the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; learning lessons from the SCR to reduce the chance of such events happening again. These three different processes 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.

Accountability and disclosure

- 8.49 LSCBs should consider carefully who might have an interest in SCRs – for example, elected and appointed members of authorities, staff, the child who was seriously harmed and the subject of the SCR, 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; and
- constraints on public information sharing when criminal proceedings are ongoing, in that providing access to information may not be within the control of the LSCB.

8.50 **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 the child (where the SCR was undertaken in respect of a child who was seriously harmed) and family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. The publication of the executive summary needs to be timed in accordance with the conclusion of any related criminal court proceedings. Neither the SCR overview report nor the IMRs should be made publicly available*.**

*** Following the publication of Tim Loughton's Letter 10 June 2010, there is a new requirement to publish Overview Reports in relation to SCRs initiated after 10 June 2010.**

8.51 The LSCB should ensure that the relevant GO Children and Learners Team, Ofsted and all other relevant bodies including the SHA, the CQC, HMIC, HMIP and HMI Probation are appropriately briefed in advance about the publication of the executive summary. Where a child has died in a custodial setting, this briefing should include the YJB and the PPO. The SHA should brief the Department of Health.

Learning lessons locally

8.52 As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, it is essential that the lessons are learned and acted upon. This means that at least as much effort should be spent on implementing the 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 for all those who have been involved in the case;
- consider what type and level of information needs to be disseminated, how and to whom, in the light of a SCR. Be prepared to communicate both examples of good practice and areas where change is required, as well as to integrate this information with that from other serious case or local reviews;
- incorporate the learning into local training programmes; and
- focus recommendations on a small number of key areas, with Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes.

In addition:

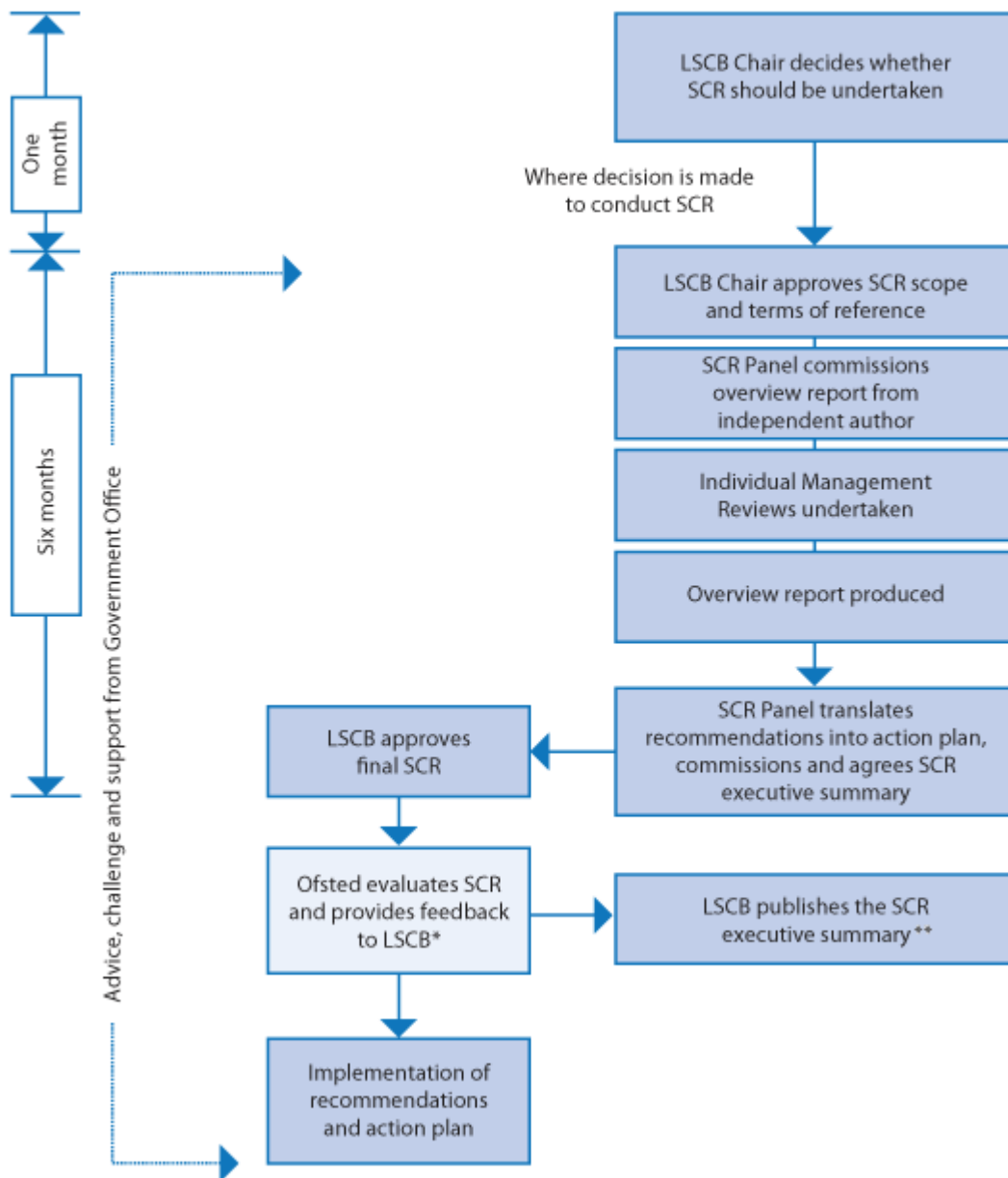
- the LSCB should put in place a means of monitoring and auditing the actions of all agencies against recommendations and intended outcomes; and
- PCTs should seek feedback from SHAs who should use it to inform their performance management role, and the CQC may use the findings of SCRs to inform its processes for regulating NHS and independent sector provider organisations. PCTs will monitor the implementation of the recommendations by provider organisations.

- 8.53 The role of GOs in relation to safeguarding includes giving support and challenge to LSCBs and to Children's Trust Boards in relation to SCR and CDOP activity and implementation. This includes seeking assurance that LSCB and Children's Trust plans are in place and action is being taken to effectively address recommendations.
- 8.54 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; and
 - make sure staff and their representatives understand what can be expected in the event of a child death/SCR.
- 8.55 The SCR sub-committee should provide information to relevant LSCB(s) on the actions taken in response to SCRs which have been completed by the LSCB(s) in the previous year. LSCBs will draw on this information when publishing their annual reports (**paragraph 3.36** sets out LSCB's annual reporting requirements in relation to SCRs). Appropriate care should be taken to ensure confidentiality of personal information and sensitivity to the families whose child is the subject of a SCR. The LSCB annual report should support the driving forward of measures to prevent child deaths and serious harm where abuse and **neglect** have been factors and to safeguard and promote the welfare of children.

Learning lessons nationally

- 8.56 Taken together, child death reviews and SCRs are an important source of information to inform national policy and practice. The 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 regular reports, drawing out key findings of SCRs and their implications for policy and practice to assist the process of learning lessons. In the future relevant findings from the work of the local child death overview teams will be integrated into these reports.

Flow chart 7: Overview of Serious Case Review process



* Where a SCR has been evaluated as 'inadequate' the LSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The LSCB is then required to submit to Ofsted within three months, an action plan that addresses the inadequacies of the SCR.

**** Following the publication of Tim Loughton's Letter 10 June 2010, there is a new requirement to publish Overview Reports in relation to SCRs initiated after 10 June 2010.**