



SERIOUS CASE REVIEWS January 2008

1. Introduction

- 1.1 Regulation 5(1) (e) of the LSCB Regulation 2006 (S1 2006 No 90) requires LSCBs to instigate a serious case review (SCR) in specified circumstances.
- 1.2 Chapter 8 of *Working Together to Safeguard Children* defines the circumstances in which a LSCB should initiate a SCR and describes how it is to be conducted.
- 1.3 Chapter 8 is issued under s16 of the Children Act 2004, which states that Children's Services Authorities and each of the statutory partners must, in exercising their functions relating to a LSCB, have regard to any guidance given to them for the purpose by the Secretary of State. This means that they must take the guidance into account and, if they decide to depart from it, have clear reasons for doing so.
- 1.4 The following sections summarise, with respect to a SCR:
- Its purpose and the criteria for conducting it
 - The process for its initiation and subsequent conduct and
 - Actions consequently required of each member agency

2. Purpose

- 2.1 The purpose of a SCR is to:
- Establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
 - Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence
 - Improve inter-agency working and better safeguard and promote the welfare of children
- 2.1 SCRs are **not** inquiries into how a child died or who is culpable. These are matters for Coroners and criminal courts respectively.

3. Criteria for convening SCRs

- 3.1 When a child dies (including suicide) and abuse or neglect are known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding e.g. siblings, others in an institution where abuse is alleged.
- 3.2 Thereafter, in such circumstances the LSCB should always conduct a SCR (regardless of whether Children's Social Care was involved with the family).

3.3 The LSCB should also consider the justification for a SCR when:

- A child sustains a potentially life-threatening injury or serious and permanent impairment of health or development
- Has been subjected to **particularly** serious sexual abuse or
- Her/his parent has been murdered and a homicide review is being initiated
- The child has been killed by a parent with a mental illness **and**
- The case gives rise to concerns about inter-agency working to protect children

3.3 In cases not satisfying the specific criteria above, it is appropriate to hold a SCR if several of the following criteria are met:

- There was clear evidence of a risk of significant harm to a child unrecognised by organisations or individuals in contact with the child or perpetrator, **or** not shared with others **or** not acted upon properly
- The child was abused in an institutional setting e.g. school, nursery, family centre YOI, STC, Children's Home or Armed Services training establishment
- The child was abused while being looked after by the local authority
- The child committed suicide or died whilst absent having run away from home
- One or more agency or professional considers its concerns were not taken sufficiently seriously, or acted upon appropriately by another
- The case indicates that there may be failings in one or more aspect of the local operation of formal safeguarding procedures which extend beyond the handling of the case
- The child was or had been the subject of a child protection plan or on the child protection register
- The case appears to have implications for a range of agencies or professionals
- The case suggests that there may be a need for the LSCB to change its protocols or procedures, or that they need to be more effectively promoted, understood or acted upon

3.4 When BSCB takes the decision to conduct a SCR and other authorities are involved, the Chair of BSCB will inform the Chair of any other relevant LSCB. Together, they will agree whether the SCR will be conducted as:

- A) A single LSCB review with limited input from the other LSCB **or**
- B) A joint SCR where members of each SCR Panel work together as an expanded panel

3.5 This decision will depend on the complexity of the case and the degree of involvement of each partnership. Should the Chairs be unable to agree, the matter will be referred to Chief Executives and/or CSCI for a final decision.

4. Instigating a SCR

4.1 Any professional or agency that concludes a case review may be required must immediately notify the Chair of the Strategic and Serious Case Review (SSCR) Sub Committee to recommend whether or not the case should be subject of a SCR, applying the criteria in (insert relevant paragraph numbers).

4.2 The recommendation of the SSCR Sub Committee must be forwarded to the Chair of the BSCB, who has ultimate responsibility for deciding whether or not to conduct a serious case review.

4.3 In conducting a Serious Case Review, the SSCR Sub Committee must at the very least consist of representatives of:

- Children's Services (both Social Care and Education)
- Health
- Police

4.4 Members of the SSCR Sub Committee have a dual role; to represent professional or organisational views in relation to information brought before the Committee **and** to act collectively in representing well-evidenced, best practice standards.

4.5 The SSCR Sub Committee must therefore also consider co-opting additional representatives to ensure that each review is informed and directed by those relevant fields associated with each case.

4.6 In selecting representatives each agency shall:

- Choose a member of staff who is able to represent the organisation's views, policies and practice appropriately, and has an explicit mandate to do so.
- Choose a person with sufficient experience and knowledge of the field to inform the debate and the matters under consideration.
- Choose an individual of sufficient seniority to ensure that recommendations arising from the serious case review are appropriately addressed within individual agencies.

5. Individual Management and Partnership Reviews not meeting the criteria for a serious case review

5.1 In some cases, it may be valuable to conduct individual management reviews of individual cases which give rise to concern but do not meet the criteria for a full serious case review. In such cases arrangements should be made to share findings with the SSCR Sub Committee.

5.2 Partnership Reviews are smaller scale multi-agency reviews, undertaken when a case suggests that the BSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on. In such cases arrangements should also be made to share findings with the SSCR Sub Committee.

6. Notification of Serious Case Reviews

6.1 The Local Authority should inform the National Business Unit of the Office for Standards in Education, Children's Services and Skills (Ofsted) of every case that becomes the subject of a serious case review. This information will be passed to the DCSF by Ofsted.

6.2 The Chair of the Strategic and Serious Case Review Sub-Committee will confirm for the BSCB that the NBU has been notified.

6.3 NB. The Children's Services Adviser in the local Government Office can provide advice and support in carrying out serious case reviews.

6.4 The PCT, via The Head of Child Family and Specialist Services should inform the Strategic Health Authority (SHA) of every case that becomes the subject of a serious case review.

7. Determining the Scope of a Serious Case Review

7.1 The SSCR Sub Committee should consider, in the light of each case, the scope of the review and draw up clear terms of reference. Relevant issues include:

- What appear to be the most important issues to address in trying to learn from this specific case – how can the relevant information best be obtained and analysed?
- Who should be appointed as the independent chair for the overview report?
- Are there features of the case, which indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review? Might it help the review panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, i.e. how far back should enquiries cover, and what is the cut-off point? What family history/background information will help better to understand the recent past and present?
- Which organisations and professionals should contribute to the review?
- Where appropriate, e.g. proprietor of independent school or playgroup leader could be asked to submit reports or otherwise contribute.
- How should family members contribute to the review, and who should be responsible for facilitating their involvement?
- Will the case give rise to other parallel investigations of practice, e.g. independent health investigations or multi-disciplinary suicide review, a homicide review where a parent has been murdered, YJB serious incident review or a Prisons and Probation Ombudsman investigation where a child has died in a custodial setting – and if so, how can a co-ordinated review process best address all the relevant questions which need to be asked, in the most economical way?
- Is there a need to involve organisations/professionals in other LSCB areas, and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- How should the serious case review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the serious case review process fit in with the processes for other types of reviews e.g. for homicide, mental health or prisons?
- Who will make the link with relevant interests outside the main statutory organisations e.g. independent professionals, independent schools, and voluntary organisations?
- When should the review process start and by what date should it be completed?
- How should any public, family and media interest be handled, before, during, and after the review?
- Does the BSCB need to obtain independent legal advice about any aspect of the proposed review?

7.2 Some of these issues may need to be re-visited as the review progresses and new information emerges.

8. Timing

8.1 Reviews will vary widely in breadth and complexity. In all cases, lessons should be learned and acted upon as quickly as possible.

- 8.2 Within one month of a case coming to the attention of the BSCB Chair, the decision should be made by her/him on whether a review should take place, following a recommendation from the SSCR Sub Committee.
- 8.3 Individual organisations should rapidly secure case records (see below) and begin work to draw up a chronology of involvement with the child and family.
- 8.4 Reviews should be completed within a further four months, unless an alternative timescale is agreed with Ofsted.
- 8.5 Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges a review cannot be completed within four months of the Chair's decision to initiate it, the Children's Services Advisor should be approached to agree a timescale for completion
- 8.6 In some cases, criminal proceedings may follow the death or serious injury of a child. Those co-ordinating the review should discuss with the relevant criminal justice agencies how the review process should take account of such proceedings, e.g. how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), and who should contribute at what stage?
- 8.7 Serious case reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute.
- 8.8 In some cases it may not be possible to complete or to publish a review until after Coroner's or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented.

9. Who should conduct Serious Case Reviews?

- 9.1 Initial scoping of the review should identify contributors, though it may emerge, as information becomes available, that the involvement of others would be useful (in particular, information of relevance to the review may become available through criminal proceedings).
- 9.2 Each relevant service should designate an appropriate professional to undertake a separate management review of its involvement with the child and family (see below). This should begin as soon as a decision is taken to proceed with a review, and sooner if a case gives rise to concerns within the individual organisation.
- 9.3 Relevant independent professionals (including GPs) should contribute reports of their involvement.
- 9.4 Designated professionals should review and evaluate the practice of all involved health professionals and providers within the PCT area. This may involve reviewing the involvement of individual practitioners and Trusts and also advising named professionals and managers who are compiling reports for the review.
- 9.5 Designated professionals have an important role in providing guidance on how to balance confidentiality and disclosure issues.
- 9.6 Where a children's guardian contributes to the review, prior agreement of the court should be sought so her/his duty of confidentiality under court rules can be waived to the degree necessary.

10. Individual Management Reviews

- 10.1 Following notification by the SSCR Sub Committee, each organisation should identify or commission an appropriate manager to undertake the IMR.
- 10.2 Those conducting IMRs should not have been directly concerned with the child or family, or with the immediate line manager of the practitioner/s involved.
- 10.3 Once it is known that a case is being considered for review, a senior manager in each organisation should secure records relating to the case to guard against loss or interference.
- 10.4 Where operational staff require access to information contained on the file for ongoing work, the above senior manager should make the necessary arrangements e.g. providing staff with photocopied extracts whilst retaining the original records.
- 10.5 The aim of the IMR should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.
- 10.6 The findings from the IMR reports should be accepted by the senior officer, in the organisations who has commissioned the IMR, and who will be responsible for ensuring that recommendations are acted upon.
- 10.7 On completion of each management review report, there should be a process for relevant feedback and debriefing for staff involved, in advance of completion of the overview report by the BSCB.
- 10.8 There may also be a need for a follow-up feedback session if the BSCB overview report raises new issues for the organisation and staff members.
- 10.9 SCRs are not a part of any disciplinary enquiry or process, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures.
- 10.10 Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases e.g. alleged institutional abuse, disciplinary action may be needed urgently to safeguard and promote the welfare of other children.
- 10.11 Where a child dies in a custodial setting, the Prisons and probations Ombudsman investigates and reports on the circumstances surrounding the death of that child. The investigation examines the child's period in custody and assesses the clinical care they received. The report is normally made available to assist any serious case review process.
- 10.12 The outline format (appendix A) should guide the preparation of management reviews, to help ensure that the relevant questions are addressed, and to provide information to the BSCB in a consistent format to help with preparing an overview report.
- 10.13 The questions posed do not comprise a comprehensive check-list relevant to all situations. Each case may give rise to specific questions or issues which need to be explored, and each review should consider carefully the circumstances of individual cases and how best to structure a review in the light of those particular circumstances.

10.14 Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.

11. Overview Report

11.1 The BSCB should commission an overview report which brings together and analyses the findings of the various reports from organisations and others, and which makes recommendations for future action.

11.2 should be commissioned from a person who is independent of all the bodies/agencies/professionals involved.

11.3 This report should bring together, and draw overall conclusions from the information and analysis contained in the individual management reviews, together with reports commissioned from any other relevant interests.

11.4 Overview reports should be produced according to the outline format (appendix B). As with management review reports, the precise format will depend upon the features of the case. This outline will be most relevant to abuse or neglect which has taken place in a family setting.

Format for 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. Briefly summarise decisions reached, the services offered and/or provided to the child (ren) and family, and other action taken.

Analysis of involvement

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

1. Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
2. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
3. 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?
4. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
5. Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
6. When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making revisions about children's services? Was this information recorded?
7. Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
8. Were more senior managers or other organisations and professionals involved at points where they should have been?
9. Was the work in this case consistent with each organisation's and the BSCBs policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

What do we learn from this case?

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

Recommendations for action

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

Format for BSCB overview report

Introduction

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

The facts

- Prepare a 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 and the child's wishes and feelings sought or expressed.
- Prepare an overview that summarises what relevant information was known to the agencies and professionals involved about the parents/ carers, any perpetrator and the home circumstances of the children.

Analysis

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

Conclusions and recommendations

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