Swindon Local Safeguarding Children Board

SERIOUS CASE REVIEW PROCESS

1. Introduction

This guidance reflects the requirements of Chapter 4 together 2013 and regulation 5 of the Local Safeguarding Children Board (LSCB) Regulations.

Undertaking Serious Case Reviews is part of the reviewing and investigative functions of LSCBs. The prime purpose of a SCR is for agencies and individuals to learn lessons and to improve the way in which they work individually and collectively to safeguard and promote the welfare of children.

Regulation 5 of the Local Safeguarding Children boards Regulations 2006 requires LSCB's to undertake reviews of serious cases.

A serious case is one where

a) abuse or neglect is known or suspected *and*
b) 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 and their Board partner or other relevant persons have worked together to safeguard the child

Principles

Principles in undertaking reviews [ii]

The approach taken should be proportionate according to the scale and complexity of the issues being examined

- Reviews of serious cases shall be led by individuals who are independent of the case under review and of the organisation whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Families, including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and seriously.

2. When will the LSCB undertake a Serious Case Review?

2.1 Swindon LSCB will always undertake a Serious Case Review when:

i. a child dies (including death by suicide) **and** abuse or neglect is known or suspected to be a factor in the child's death *or*
ii. a child dies in custody, in police custody, on remand following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home or where a child was detained under the Mental Capacity Act 2005 Regulations (2)(b)(ii).

iii. when a case is being considered under Regulation S(2)(b)(ii), unless it is clear there are no concerns about inter-agency working, the LSCB must commission an SCR. The final decision on whether to commission an SCR rests with the LSCB Chair. If an SCR is not required because the criteria in Regulation S(2)(b)(ii) are not met, the LSCB may still decide to commission an SCR or an alternative form of care review.

2.2 Swindon LSCB will always consider whether to undertake a Serious Case Review (SCR) when:

- a child has suffered a potentially life-threatening injury or serious and permanent impairment of health and development through abuse and neglect; or
- a parent has been murdered and a homicide review is being initiated 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 interagency working to protect children from harm.

2.3 Swindon LSCB will also undertake reviews on cases which do not meet the SCR criteria, but which can provide useful insights into the way organisations are working together to safeguard and promote the welfare of children, including those where there has been good practice.

3. Membership of Serious Case Review Sub-group and Panels

3.1 Swindon LSCB has a standing Serious Case Review sub-group to oversee and quality-assure all SCRs undertaken by the LSCB and to advise the LSCB Chair as to whether the criteria for conducting an SCR have been met.

3.2 The membership of the SCR sub-group is:

- Head of Safeguarding
- Detective Inspector Public Protection Unit
- Designated Doctor for Safeguarding
- Schools Safeguarding Lead
- NSPCC
- Named Nurse for Safeguarding SBC
- Early Years Safeguarding Lead
- Early Support Manager Integrated Teams
- Manager, Safeguarding & Quality Assurance Team SBC
- Safeguarding Lead South Western Ambulance Service
- LSCB Business Manager

3.4 Following a decision by the LSCB Chair to undertake an SCR, the SCR sub-group will commission an SCR Panel to manage the process. Wherever possible, panel members should be independent of any direct involvement in the case being reviewed and can include outside experts as appropriate to the content of the case.

4. The National Panel

The National Panels remit will include advising LSCB about

- Application of SCR criteria
- Appointment of reviewers
- Publication of SCR reports

The Panel will initially advise LSCBs on:

i. any decision made by an LSCB not to initiate an SCR following a serious case incident; and
ii. any SCR which an LSCB has indicated it does not plan to publish

5. Action on Notification of a Suspected SCR

5.1 Where more than one LSCB has knowledge of a child, the LSCB for the area which the child is/was normally resident should decide whether an SCR should be conducted. This decision should normally be made within one month. Any other LSCB that has an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the review.

5.2 The LSCB Business Manager will co-ordinate a meeting of the SCR sub- group within 5 working days of a notification being received. They will consider information from each individual agency and made a recommendation about the appropriateness of a Serious Case Review. The sub-group may decide that further information is needed in order for a decision to be made and they will then reconvene to consider the matter again.

5.3 On being notified of a sub-group meeting each member must ensure that they:

- Establish if the child is known to their agency
- Secure or copy the case records, including computer records, for the children and/or adults
- If the child has died, ensure that all involved managers and staff are aware of the child's death, and provide agency support as required.

5.4 The SCR sub-group will make a recommendation to the Chair of the LSCB as to whether an SCR should be undertaken. The independent Chair of the LSCB will be briefed on the outcome of the meeting by the Chair of the Serious Case Review sub-group.

5.5 The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

5.6 The sub-group should identify who will make up the case review Panel.

6. Decision to undertake a review

6.1 Once the LSCB has made a decision on whether or not to initiate an SCR, the LSCB should inform:

- The National Panel by emailing the secretariat at

SCRPanel@education.gsi.gov.uk

- Ofsted, using Ofsted's Notification of a Serious Childcare Incident Form
- The Care Quality Commission
- The Clinical Commissioning group
- NHS England local office
- Individual members of the Panel should inform their own organisations as appropriate
- Crown Prosecution Service if there are criminal proceedings.

6.2 If the decision is made to **initiate a SCR** then the LSCB should also let the National Panel know the name of the reviewer(s) appointed and why they have been chosen, the type of review to be conducted.

6.3 If the decision is **not to initiate an SCR** the LSCB should let the National Panel know of their decision providing a copy of the local authority's Serious Incident Notification and an explanation why the LSCB has decided that the case does not meet the SCR criteria.

6.4 The LSCB Chair, in consultation with the SCR sub-group Chair will decide whether to initiate a local case review and how this will be undertaken.

6.5 The LSCB Business Manager will send a notification letter to all LSCB members, and any private or voluntary sector service known to be involved. The letter will request them to:

- Establish if the child or adults involved are known to any service within their agency
- Inform the chief executive or senior officer of the agency, if not already informed by a representative of the SCR Panel
- Establish whether or not there are outstanding criminal care proceedings which may affect the timeframe for the review
- Secure the case records for the children and/or adults.

6.6 The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance and the Swindon LSCB model for conducting reviews. The lead reviewer should be independent of the LSCB and the organisations involved in the case.

6.7 The LSCB should provide the National Panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert Panel about appointment of reviewers.

6.8 The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations with the child and family. The priority should 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.

6.9 The LSCB Business Manager will establish a case review panel meeting within 28 days of a decision.

6.10 The LSCB Business Manager will notify the Coroner and the Chair of the Child Death Overview Panel in the case of a child death.

6.11 The LSCB Business Manager will notify the Local Authority Press Office.

6.12 The Children's Services Director and the LSCB Business Manager will consider any alternative/additional action that may need to be undertaken.

7. Timescales

7.1 The LSCB should aim for the completion of an SCR within six month 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 the points from the case about improvements needed, and
ii. take corrective action

7.2 If it becomes clear that the review cannot be completed within 6 months of the Chair's decision to initiate it then the National Panel should be notified.

7.3 In some cases criminal proceedings may follow the death or serious injury of a child. The Chair of the Serious Case Review 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. Useful work to understand and learn from the case can often proceed without the risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to finalise and publish until after coronial or criminal proceedings have been concluded, but this should not prevent any findings being acted upon.

7.4 The final serious case review 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.

8. The style scope and terms of reference of an SCR

8.1 The preferred model for Swindon LSCB SCRs is the learning systems model[i]. The key principles in this approach are:

i. **To avoid hindsight bias** - to understand what it was like at the time.
ii. **To provide adequate explanations** - to appraise and explain decisions, actions, inactions in the professional handling of the case. To see performance as the result of interactions between the context and what the individual brings to it.

iii. **Move from the individual instance to the general significance -** provide a "window on the system" that illuminates what bolsters and what hinders the reliability of the multi-agency child protection system functioning.

iv. **Produce findings and questions for the Board to consider.**

8.2 If the serious case review sub-committee advises that a serious case review should take place they should also recommend the scope and terms of reference for the review.

8.3 Relevant issues to consider include:

- What appear to be the initial issues which need to be addressed by what is known of the case at the early stage?
- Over what period of time should the child's life be reviewed?
- What should be the nature of involvement of the family, siblings
- Where the review does not involve a child death what should be the involvement of the child who is the subject of the review?
- Any specific considerations around ethnicity, religion, diversity or equality issues that may rate special consideration
- Which organisation and professional should be asked to be involved in the review group and which will be part of the practitioners group?
- Who should be appointed as the independent author of the overview report?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed serious case review?
- Will the case give rise to other parallel investigations of practice, for example domestic homicide review, Fatal Incidents investigation – where the child has died in a custodial setting, or MAPPA case review? If there is a parallel review how can the two reviews be co-ordinated?
- How should any media or public interest be managed before, during and after the serious case review?

The LSCB chair should ensure that the terms of reference address key issues in the case and approve them.

9. The Case Review Group

9.1 Following the decision to undertake a serious case review the serious case sub-committee should commission a serious case review group to manage the process.

9.2 Review group members should be senior officers within an agency

9.3 The first review group meeting should take place within 28 days of the decision to undertake a SCR

9.4 For the first review group meeting a merged chronology should be available for the group.

9.4 Involvement of family members:
Careful consideration should be given by the SCR review panel on the best way to gain the views of the family on the services provided. Where this is by a meeting with the family this should usually be conducted by the lead reviewer

9.5 The SCR review panel should ensure that it:

- Actively manages the SCR process seeking legal advice as necessary
- Ensure that contributing organisations and individuals are satisfied that their information is fully represented in the overview report
- Agree the final content of the report and the findings presented to the LSCB.

10. Approval and distribution of Overview report/Executive summary

10.1 The SCR review group/or subcommittee, on behalf of LSCB should quality-assure the final SCR.

10.2 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 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 harm the welfare of any children or vulnerable adults involved in the case.

10.3 The LSCB should approve the final SCR report. The final SCR report 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.

10.3 The LSCB should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

10.4 When compiling and preparing to publish the report, the LSCB should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. The LSCB 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.

10.5 The LSCB 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.

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i Working together 2013

ii Learning Review Model. Swindon LSCB.gov.uk

FLOW CHART SUMMARY OF SCR PROCESS (<u>to be completed</u>)