Enfield Safeguarding Children Board

Procedure for Serious Case Reviews / Management Reviews

… because safeguarding children is everyone's responsibility

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Contents

1. Introduction

1.1 Statutory guidance on serious case reviews (SCRs) is given in Chapter 4 Working Together to Safeguard Children (2013). This states:

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

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

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

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

(b) either — (i) the child has died; or (ii) the child has been seriously harmed 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.

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

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

2. When should a LSCB consider undertaking a serious case review?

2.1 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; 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.

2.2 Any professional may refer such a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case.

2.3 For further guidance refer to chapter 4 Working Together (2013) and appendix 2 which sets out key tasks for the LSCB and SCR panel.

3. Process

3.1 The Serious Case Review (SCR) Sub-Committee reports to and is directly accountable to Enfield Safeguarding Children Board (ESCB).

3.2 The SCR Sub-Committee will decide the level of the case reviews whether they are serious case reviews (SCRs) or management reviews (MRs). MRs are carried out in cases which give rise to concern but that do not meet the criteria for a full serious case review.

3.3 SCRs involve the reporting of the case to government and the commissioning of an independent consultant to conduct the review and write an overview report. MRs on the other hand are carried out locally, 'in-house'.

3.4 The Chair of the ESCB and the Head of Safeguarding and Quality Assurance Service will ensure that the procedures are adhered to, including notifying SCRs to OFSTED using the Notification of Serious Child Care Incident form (Appendix 1). Notification of the decision of the Panel must be made to OFSTED and the Independent Panel of Experts.

3.5 As part of the process it is likely that professionals (and occasionally family members, including the child, if appropriate) may be interviewed as part of the process. This will be agreed by the SCR Panel when scoping the report.

3.6 The overview report should be commissioned from a person who is independent of all the agencies/professionals involved. Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved. A list of independent consultants who complete serious case reviews is held by the Head of SQAS.

3.7 Enfield's Procurement Procedures must be adhered to when commissioning an independent consultant. This will include:

- obtaining three quotes under the Tendering Process
- issuing and signing of a council contract between the report writer and Head of SQAS
- securing a purchase order for the task
- agreeing a fixed fee for the piece of work within agreed timescales

See *Guidance Note 7 on the Procurement of Consultants and other Professional Services (available on Enfield Eye or Head of SQAS).*

3.8 The SCR Sub-Committee should convene a Serious Case Review panel.

3.9 Serious Case Review Panel will consist of:

- a review panel chair – Head of Safeguarding Children and Quality Assurance Service*;
- an administrator provided by the LSCB;
- the Designated Doctor and Nurse,
- a senior member of the Police,
- an Education representative;
- Senior professionals from other agencies who have a relevant contribution to an individual review.
- The LSCB Business Manager

** this will be decided on a case by case basis and will be chaired by the Head of Safeguarding Children and Quality Assurance Service only if there has been very little involvement with Children's Services.*

3.10 Each panel member will be responsible for ensuring their agency completes individual management review including chronology. This may require a panel member to actively support the person in their agency with responsibility for completing the report.

3.11 The panel will work to the terms of reference agreed by the SCR Sub-Committee. These may be subject to change during the process.

4. Timescale

4.1 As soon as it has been established that a serious incident has occurred, notification must be sent to OFSTED by the Chair of the LSCB

4.2 The decision about whether a serious case review is required must be made within one month of the case coming to the attention of the ESCB Chair.

4.3 The LA child protection adviser (Head of SQAS) must, within one working day of the decision that a SCR is required, complete the following tasks:

- Confirm that arrangements have been made (where necessary via a strategy meeting) to ensure the safety of other children or family members;
- Check the LA children's social care client index to establish if the adult/s or child/ren are known;
- Check with the police and designated doctor and nurse for any relevant information;
- Secure the LA children's social care files;
- Inform the Director of Children's Services;
- Identify the agencies which have been involved with the child and alert them, via a letter from ESCB Chair to their chief executive, to their obligation to undertake an internal management review as a contribution to the overall serious case review; this to be supported by the ESCB Business Manager.
- Confirm to OFSTED and the National Panel of Experts that the incident is a SCR

4.4 The serious case review must be completed within 6 months of the notification to OFSTED, unless an alternative timescale is agreed OFSTED.

4.5 On completion of the serious case review the Quality Assurance and Serious Case Review sub committee will determine the most appropriate method on debriefing agencies/services involved and to ensure lessons are learned.

Please note the Child Death Process will also run concurrently.

5. Components of a Serious Case Review

5.1 Executive Summary

In Enfield these are completed so that the contents can be shared with the family. They give a brief overview of the incident, which gave rise to the review, terms of reference, summary of the incident, key themes and lessons learnt, and recommendations. It should also include the names of the LSCB Chair, SCR Panel Chair, Overview Report Author, and the job titles and employing organisations of all the SCR Panel members.

5.2 Overview Report

The overview report should contain:

5.2.1 Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the systems 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 CCG as commissioner from adult mental health service). List the names and

roles/positions/job titles 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 external investigations, if any, that are being conducted.

5.2.2 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.

5.2.3 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. This part of the process needs to follow a systems methodology as set out in Working Together 2014 as part of a learning and improvement framework.

5.2.4 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.

5.3 Signing Off the Report

5.3.1 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. The LSCB should approve the final SCR.

5.3.2 The SCR Panel will formulate the integrated action plan from the recommendations in the SCR Report. These recommendations should be specific, measurable, achievable, relevant and timely (SMART).

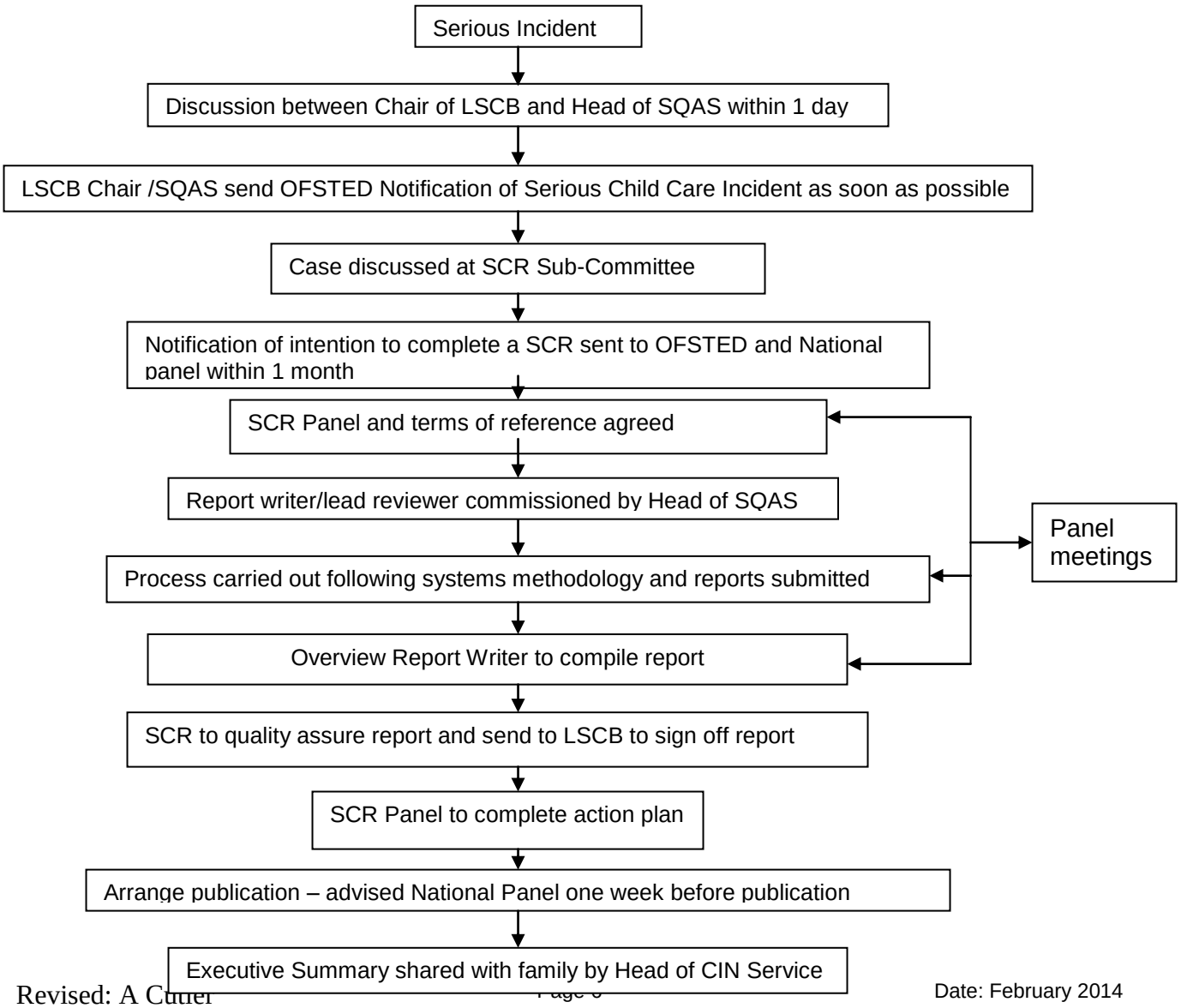
5.3.3 Arrangements must be made for the SCR to be published and available on the website. The National Panel must be advised of publication one week before publication is due.

5.4 Lessons Learnt

5.4.1 The SCR Panel will ensure that arrangements are put in place for IMR report writers and participants to give feedback and disseminate lessons learnt to each of their agency.

5.4.2 The LSCB will make arrangements for a multi-agency learning event to take place.

6. Process for Serious Case Reviews



Appendices

Appendix 1 Proforma for Notification to OFSTED

This can be accessed via the OFSTED website at:
http://www.ofsted.gov.uk/resources/notification-of-serious-childcare-incident

Appendix 2 Working Together SCR Checklist

Serious case review process as set out in Working Together 2013

Serious Case Review checklist

Decisions whether to initiate an SCR

The LSCB for the area in which the child is normally resident must decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the 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.

The LSCB should let Ofsted and the national panel of independent experts know their decision.

If the LSCB decides not to initiate an SCR, their decision may be subject to scrutiny by the national panel. The LSCB should provide information to the panel on request to inform its deliberations and the LSCB Chair should be prepared to attend in person to give evidence to the panel.

Appointing reviewers

The LSCB should 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. The lead reviewer should be independent of the LSCB and the organisations involved in the case. 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.

Engagement of organisations

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

Timescale for SCR completion

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

Agreeing improvement action

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

Publication of reports

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

Final SCR reports should:

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

LSCBs 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.

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

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

Appendix 3 Chronology

Child's full name: DOB:
Language/s spoken at home: Ethnic origin: Religion:
Legal status of child:
Dates of any period subject to child protection plan:
Dates covered by chronology:

Date	**Family Contact**		**Communication**		**Response for Outcome**	**Source of Evidence**	**Comment**
	Child Specify if views recorded & if seen alone	**Adult** Specify if views recorded	**Within Agency** Specify phone, written or meeting	**External to Agency** Specify phone, written or meeting			

Appendix 4 Enfield Process for SCR

Local SCR Process for Enfield Serious Case Reviews

All local processes also follow the guidelines including deadlines as set out in Working Together 2013.

1) Notification of case to the SCR panel by concerned agency:

Concerned Manager contacts the SCR Panel lead for their agency who passes to ESCB Business Manager to put on agenda for discussion at Panel.

Written report – why it meets the criteria for an SCR. Consideration should be made of any other review process as part of this (see attached form)

2) If it may meet the SCR criteria:

- Call an extraordinary meeting of the panel with all relevant agencies represented
- Prior to the meeting, all agencies to consider their position and provide a report or chronology as directed by the Panel Chair. This should not be a full chronology but rather form the basis of a discussion to consider any issues of interagency practice which would help the panel come to a decision.
- Case discussion takes place – each agency setting out involvement and concerns about practice
- Agencies make a recommendation to the Chair
- Chair makes a decision based on the discussions and information from the agencies
- National Panel of Experts and OFSTED informed of decision.

3) If SCR agreed

- Chair writes to all Board members to advise that and SCR will take place.
- Agencies to confirm their involvement in producing an IMR and a representative to sit on the case panel.
- Chair also to contact other LSCBs who are involved, requesting contact details of agencies involved.

4) Case panel of all appropriate agencies to meet – agree TOR and scope of the SCR

- Author/lead reviewer agreed

5) Set up contract with author and where required the chair of the case panel

6) Set up further case panel meeting to discuss process including IMRS and any actions in line with systems methodology for the review. Process and actions follow this meeting, following systems methodology. ESCB Business manager to work with Lead Reviewer as required

7) Case panel discusses the outcomes of the process

8) Subsequent panel meeting - draft overview report discussed

9) Overview report goes to full SCR panel for sign off – ideally author presents this

10) Publication agreed – National Panel of Experts to be advised one week before publication

10) Action plans followed up and monitored via m ain SCR panel

11)Process for the dissemination of learning agreed and put in place

Roles:

- Agencies are responsible for reporting processes with their lead body or regulatory body – this does not fall to the LSCB

LSCB – inform Ofsted of SCR and monitor progress against deadlines

Form for referral of case to SCR Panel

Meeting: SCR

Enfield Safeguarding Children Board Referral of case for consideration under SCR processes

Child and adult names, dates of birth and address	**Date**:

Summary:

Request/Recommendations to the LSCB. **Please state how the case meets the criteria for an SCR using the criteria in Working Together 2013**

Name of SCR Panel Member of the referring agency: **Telephone:** **Email:**