Framework for conducting

Serious Case Reviews

Calderdale Safeguarding Children Board

January 2015

Contents

1.0 INTRODUCTION

Calderdale Safeguarding Children Board CSCB) consists of the Safeguarding Board, Business Group and various Sub Groups. The statutory organisations within Calderdale are required to co-operate with Calderdale Council in the establishment and operation of the CSCB and will have shared responsibility for the effective discharge of its functions.

The Board has an Independent Chair, who provides leadership for the Board and ensures that it operates effectively. A team of staff support the work of the Board and its sub-groups. http://www.calderdale-scb.org.uk/

Local Safeguarding Children Boards are required to undertake serious case reviews as set out in Chapter 4 of *Working Together to Safeguard Children 2013, which states that:*

Each local framework should support the work of the LSCB and their partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.

Local Safeguarding Children Boards may use any learning model for undertaking a Serious Case Review providing it is consistent with the principles set out in *Working Together to Safeguard Children 2013*

This document sets out the process for undertaking a Serious Case Review and options for the serious case review Panel to consider dependent on the circumstances and context of the individual case

Each serious case review will be conducted for the purpose of learning and improvement as outlined in the CSCB Learning and Improvement Framework and recommendations for improvement will be monitored as part of the process.
Calderdale Safeguarding Children Board recognise that effective practice, systems, and governance across all organisations and partnership

arrangements need to be able to demonstrate and evidence that learning results in change and improvement, and that CSCB has a lead role in demonstrating this

2.0 PURPOSE OF CONDUCTING A SERIOUS CASE REVIEW

Working Together to Safeguard Children 2013 (s11 p65) states that "*professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. These processes should be transparent, with findings of reviews shared publicly."*

2.1 Criteria for a Serious Case Review

Regulation 5 of the LSCB Regulations 2006 requires LSCBs to undertake reviews of serious cases where:

> 5.2 a) Abuse or neglect of a child is known or suspected; and
> 5.2 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 the above 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, a 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 Health Act 2005. Regulation 5.2 b) (i) includes cases where a child died by suspected suicide.

The final decision on whether to conduct the SCR rests with the LSCB Chair. If a SCR is not required because the criteria in regulation 5.2 are not met, the LSCB may still decide to commission a SCR or they may choose to commission/undertake an alternative form of case review. (Page 68 WT2013)

2.2 The role of the National Panel of Independent Experts

The National Panel of Experts are an independent Panel who help ensure that lessons are learned when a child dies or is seriously harmed and there are signs of abuse or neglect. The Panel will advise and challenge LSCBs to initiate and publish high quality serious case reviews in order that nationally, lessons can be learned to drive up the quality of child protection services and avoid mistakes being repeated. For more information see Chapter 4 of Working Together to Safeguard Children 2013.
https://www.gov.uk/government/publications/serious-case-review-Panel-first-

annual-report (link to 1st Annual Report July 2014)

http://www.sequeli.com/docs/DfE%20Commissioning%20materials%20for%20LSCBs.pdf (LSCB commissioning materials February 2014)

3.0 PRINCIPLES FOR CONDUCTING A SERIOUS CASE REVIEW

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent of the case** under review and of the organisations whose actions are being reviewed;
- **Professionals must 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 sensitively. This is important for ensuring that the child is at the centre of the process;
- **Final reports of SCRs must be published**, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through **regular monitoring** and follow up so that the findings from these reviews make a **real impact on improving outcomes for children.**

(Page 66 Working Together 2013)

SCRs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

(Page 67 Working Together 2013)

3.1 Notification of a serious incident

Child Death Reviews - Since 1 April 2008 Local Safeguarding Children Boards have been required to review the deaths of all children in their area. The regulations are outlined in Working Together to Safeguard Children: Chapter 5. The purpose of the child death review process is to collect and analyse information about the death of each child who normally resides in Calderdale with a view to identifying any matters of concern affecting the health, safety, or welfare of children, or any wider public health concerns. Data is collected from all known agencies that may hold information on each child.

Notification of Serious Incident – when there is a death or serious injury to a child and abuse or neglect is known or suspected; agencies will notify the Business and Quality Assurance Manager of CSCB Safeguarding Children Board

The Business and Quality Assurance Manager will notify the CSCB Independent Chair and Calderdale Metropolitan Borough Council Safeguarding & Quality Assurance Service Manager

The Safeguarding & Quality Assurance Service Manager in consultation with the Business and Quality Assurance Manager will consider notifying Ofsted of the incident if it complies with the Serious Childcare Incident Notifications: Local authorities are obliged to notify Ofsted of serious incidents involving children and young people under the age of 18 years of the following types of incidents.

- Are serious enough that they may lead to a Serious Case Review (including “where a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect; or
- Involve a child death and will automatically lead to a Serious Case Review (“when 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
- Should be brought to the attention of Ofsted and the Government because of concern about professional practice or implications for Government policy; or
- Raise issues about a council’s professional practice that may need to be considered further in the context of performance assessment; or
- Have attracted or are likely to attract media attention.

Where the criteria above is met, the Business and Quality Assurance Manager will notify the Department for Education via e-mail: mailbox.cpod@education.gsi.gov.uk

The Business and Quality Assurance Manager will notify the Chair of the CSCB Case Review Sub group, the Independent Chair of CSCB and the Designated Nurse, who will inform the Calderdale Clinical Commissioning Group and NHS England.

The notifications will normally be done within five working days of notification of the incident or death.

3.2 Where an incident appears to meet the Serious Case Review criteria;

- The CSCB Secretariat will write to all Board Members on behalf of the CSCB Independent Chair to inform of the incident or death and the possibility of a serious case review. Agencies will be asked to secure all files relating to the case immediately and provide a brief report of agency involvement with the child or their family within two weeks of the notification of incident or death.

- A Serious Case Review Committee meeting will be arranged for three weeks after the date of the notification of incident or death to ensure the decision can be considered by the Independent Chair before the National Panel of Experts and Ofsted are notified within one month of the date of notification of death (Working Together 2013).

- The CSCB Secretariat will collate the information received from agencies and send to Serious Case Review (SCR) Committee members at least three working days before the SCR Committee meeting.

- SCR Committee members will be members of the Case Review Sub Group plus any additional partners who can bring clarity or further information to inform the decision making. The SCR Committee Chair will be the Chair of the SCR Panel.

3.3 Recommendation and Decision Making

The SCR Committee will consider the information presented by each agency, against the criteria for conducting a SCR (See Section 2 above: Criteria). The committee will make a **recommendation** which will be fully minuted and saved as evidence, as are all meetings which are part of the SCR process.

At the meeting, the SCR Committee will either:

- Agree that the information provided meets the criteria for a serious case review and notify the Independent Chair of the CSCB within one working day. They will provide the Independent Chair with full information in writing of their recommendation; evidencing how the case meets the criteria, together with the minutes of the Committee meeting

OR

- In cases where there is additional complexity or questions about undertaking a serious case review, the Panel may invite the Independent Chair of CSCB to a meeting or the Chair of the SCR Committee may speak to the Independent Chair of the CSCB independently before a decision is made.

- Where there is not sufficient information available, or the discovery through disclosure that there may be other information that may impact on the consideration. In such circumstances if may still be possible to reach a conclusion subject to the request for and / or the receipt of further information or it may be necessary to suspend the Committee and re convene.

OR

- Agree that the criteria for a SCR has not been met and notify the Independent Chair of CSCB, outlining how the information provided does not meet the criteria and provide the minutes of the Committee to enable the Independent Chair to agree or challenge the decision. The Committee may consider that an alternative form of review should be undertaken. If there are lessons evident from the information for a single agency, a request should be sent from the Committee to the relevant agency to address these. Where the criteria are not met, then the CSCB should still consider conducting a review of the case to learn lessons from practice, including instances of good practice. This should be progressed as per the Learning and Improvement Framework

Where a serious incident does not meet the above criteria and a child has died, the Child Death Overview Panel (CDOP) will assume responsibility and the CDOP process will be followed as per Chapter of Working Together 2013.

3.4 Decision

The role of the Independent Chair in the SCR process is significant. It is the responsibility of the Independent Chair to make the ultimate decision about whether the CSCB should commission a SCR, or a different process for learning lessons.

The Independent Chair will determine in the light of the Working Together 2013 criteria and the evidence and recommendation and make a **decision** as to whether or not the criterion for a Serious Case review is met.

The Independent Chair will consider the recommendation and evidence submitted by the SCR Committee within five working days, he/she will make such further enquiries and meet as necessary with members of the Committee so as to fully understand and consider the recommendation

It is common practice and an expectation of Chairs who are members of the Association of LSCB Chairs, that having made a decision on the basis of the advice of the local Committee, that a Peer review is undertaken with another LSCB Chair.

In the event that a Committee member or members dissent from the majority recommendation this will be recorded and the Independent Chair can undertake to meet with this person/persons in order to consider their position and point of view.

The Independent Chair will provide the Chairs of the Case Review Sub Group, the SCR Committee and the CSCB Business and Quality Assurance Manager with his/her reasons and rationale for the decision. This will be in writing together with the signed and dated agreement. See Appendix 5

In the event of a decision to proceed with an SCR the Independent Chair may outline any guidance, requests or considerations that he/she would expect a future SCR Panel to consider in undertaking the review in relation to Terms of Reference, methodology, special circumstances, concurrent proceedings, process management, quality assurance and publication

In the event of a decision not to proceed the Independent Chair will, as required, make available to the Case Review Sub Group and the National Panel of Experts such evidence that will help explain the decision and the rationale for any other form of review decided upon.

4.0 ESTABLISHING A SERIOUS CASE REVIEW PANEL

A Serious Case Review Panel will be established to actively manage the SCR process on behalf of the LSCB, reporting to the LSCB through the Independent Chair. The Panel will be made up of senior representatives from local agencies and as a minimum will include four separate agencies. Representative must have no direct line management responsibility for the case. Where an agency is subject to the review, it may be necessary to consider their attendance at the SCR Panel. The Panel may also request representatives from other agencies as necessary dependent on the case. Where appropriate representatives may be co-opted onto the Panel. In addition, the Panel may seek specialist advice as necessary at the discretion of the Chair of the Panel

The Panel is responsible for:

- Establishing a clear timescale from the outset of the review process to ensure that the review can be completed within agreed timescales
- Considering and finalising the key issues set out in the terms of reference to be considered as part of the review
- Establishing a process for involving family members in the review process
- Seeking and quality assuring the IMRs/agency information reports
- Seeking legal and other specialist advice as necessary, and ensuring that the findings from other relevant processes (such as care or criminal proceedings, a coronial inquest or other types of inquiry/investigation) are incorporated into the SCR findings.
- Informing the Coroner that a Serious Case Review is being undertaken. This would be undertaken by the Independent Chair of the LSCB, as the commissioner of the SCR
- Commissioning alongside the Independent Reviewer and CSCB Independent Chair an overview report that brings together and provides

an analysis of who did what and the underlying reasons that led individuals and organisations to act as they did, that demonstrates an understanding of practice from the viewpoint of the individuals and organisation involved at the time; a report which ensures that contributing organisations and individuals are satisfied that their information is fully and fairly represented and which is fully anonymised to protect the identity of the children, families and staff.

- Ensuring that recommendations from the review are translated into an action plan (to be agreed by the Board) and establishing responsible officers, timeframes, intended outcomes and how success will be measured
- Making arrangements to provide feedback and debriefing to children, families and staff affected by the review, prior to publication.
- The Panel Chair should ensure that Panel members and those commissioned to provide IMR's are appropriately briefed and trained.

4.1 Panel Chair

The SCR Panel along with the CSCB Business and Quality Assurance Manager will identify a Chair of the SCR Panel. The Chair may be a Board Member who is independent of the case or an external Independent Chair – the SCR Panel will make an informed decision about who to employ to lead the SCR Process. The final decision on the appointment rests with the CSCB Independent Chair to ensure independence as well as quality assurance. The SCR Panel Chair will be suitably experienced and will not have management responsibility for operational working in any agency involved in the SCR.

4.2 Serious Case Reviewer / Author

- The CSCB will appoint one or more suitable individuals who are independent of all local agencies, the CSCB and the case under review. They must be able to demonstrate that they are qualified to conduct reviews using the approach set out in Working Together 2013. They will be commissioned in consultation and agreement with the Panel and will be appointed following the initial planning of the process.

- The LSCB Business and Quality Assurance Manager will provide the National Panel of Experts with the name(s) of the individual(s) appointed to conduct the SCR; and in accordance with Working Together 2013 will consider carefully any advice from the National Panel of Experts about appointment of reviewers.

- The SCR reviewer / author will be expected to provide a report which includes a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence. Their report should be written in plain English so it can be understood easily by professionals and the public alike. Their report must be suitable for publication without needing to be amended or redacted, for example it will not contain personal data which needs to be protected. Further details about the expectations of the SCR should be agreed before the

review commences, and where foreseeable written in the Terms of Reference. Agreement should also be reached between the Panel and Author (s) around proportionality. At each Panel thereafter the views of the Author (s) and Panel should be discussed if there is to be any divergence from the initial Terms of Reference and an agreement reached.

4.3 Methodology

The Chair of the SCR Panel; the Independent Chair and Business and Quality Assurance Manager of CSCB will make a decision about the type of methodology to apply to the undertaking of the review depending on the presenting facts. See Appendix 1.

The approach should be proportionate according to the scale, level and complexity of the issues being examined (Chapter 4 paragraph 9, Working Together 2013). It is important to recognise complexity, understanding who, what and why people acted as they did at the time (Chapter 4, paragraph 10, Working Together 2013).

Fairness, impartiality, thoroughness, accountability and transparency need to be weighed against the need to carry out a review which is proportionate. The following are likely to be relevant factors:

- The seriousness of the incident and complexity of the issues
- Any public interest in the outcome
- Any other reviews or investigations being conducted (in order to avoid unnecessary duplication and ensuring the SCR process is compliant with other legal concurrent processes)
- Any legal requirement such as Article 2 ECHR and any possibility of challenge by judicial review
- The likely effectiveness of the methodology for the purpose intended

The decision taken, and its rationale, should be carefully recorded in the terms of reference and in the published report. The advantages and disadvantages (including any of the compromises above) of the chosen methodology should be explained.

The CSCB Business and Quality Assurance Manager will advise board members that a serious case review is to be undertaken and request agencies to compile a more detailed and comprehensive chronology of all their involvement with the child and family, listing every contact, conversation and/or activity relating to the child and family subject to review. The request will specify a timescale to be considered for the purposes of the review.

The CSCB Business and Quality Assurance Manager will inform the National Panel of Experts of the decision of CSCB to undertake a SCR. (mailbox.SCRPANEL@education.gsi.gov.uk) The Safeguarding and Quality Assurance Manager will notify Ofsted and the Business and Quality Assurance Manager will update the Department of Education.

Working Together 2013 states that ‘LSCB’s 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'.

The SCR Panel will ensure:

A) the process for any extension or variation on timescales re agreement and reporting are considered and agreed by the SCR Panel Chair, Business and Quality Assurance Manager and CSCB Independent Chair
B) There is a balance between quality/thoroughness and timely completion of review

4.4 Terms of Reference

The Panel will identify key issues to be considered to inform the terms of reference for this review:

Suggested content for the terms of reference (note this is not exhaustive or prescriptive)	
1	Purpose of the review e.g. 'to improve services and prevent similar deaths or serious injury' or to examine a specific incident, for example: whether it could have been foreseen that the discharge of a child from A&E on a precise date would have put them at risk?
2	Scope of the review – including time periods and family members to be included in the review
3	Issues to be examined and their context – specific terms of reference
4	Methodology to be used, including reasons after formal consideration by the Panel of each type of methodology and proportionality available.
5	A statement that good practice will be acknowledged
6	Reference to disclosure, criminal proceedings or any other matters causing delay
7	Confidentiality and anonymity arrangements
8	Ethos of the review including a commitment to family involvement and adherence to the Equality Act 2010
9	Arrangements for feedback on progress to the commissioners – including timetable
10	A statement that a report and executive summary will be written, with recommendations if appropriate
11	A statement that the report will be published and disseminated, this being the responsibility of the commissioners

The terms of reference will include reference to:

- Key agencies to contribute to the review either through IMR's or full detailed chronologies with analysis
- Key issues to be considered as part of the review process
- How there will be a balance between establishing fact, the relationship between cause and effect and the forming of evidence based judgements
- Key agencies/practitioners to be included in the Learning Event/s or structured conversations
- The constitution of the review team (i.e. those who will assist in facilitating the learning event) if a Learning Event is required
- Key agencies to be represented on the SCR Panel
- The timescale for the review
- The process for involving family members
- The process for ensuring the SCR takes account of parallel processes
- Determining what policies and procedures were in place and whether these were followed, including equality and diversity
- The basis and quality of advice provided where taken in the handling and management of case and the forming of professional judgements
- The resources and staffing/caseload levels in partner agencies at the time
- A major part of the process is about scrutiny and analysis, in addition to
  a) challenge
  b) agencies working together to confirm learning and resolve any differences

Each agency is expected to:

a) Identify and act on learning without waiting for completion of the review.
b) Act on any identified issue or concern relating to error and professional performance/conduct without waiting for completion of the review

5.0 COMPLETING THE SERIOUS CASE REVIEW

The main objectives for the SCR Panel and the Lead Reviewer are to:

- Collate and analyse the detailed information and findings from information received from the agencies and practitioners and families involved, including any the Individual Management Reviews, chronologies, practitioner learning events, interviews with family members, front line practitioners etc. In the light of this the aims are to: -
- Confirm/agree any further Terms of Reference and time period for the SCR

- Identify if any further information is needed or other reports need commissioning
- Scrutinise and analyse to confirm learning and resolve any differences

The terms of reference should be subject to regular review of the TOR and additions made where appropriate. Terms of reference will not be amended unless there were particular and unusual circumstances and would need LSCB/Board approval.

A suggested Agenda for the SCR Panel first meeting should include:

1. Introductions
2. Brief outline of case to be reviewed
3. Presentation/Analysis of the Individual Management Reviews (if included)
4. Review Terms of Reference and scope of review
5. Involvement of family / other parties
6. Consideration of any parallel investigations or proceedings in this case
7. Agree any further steps/actions
8. Agree date for circulation of 1st draft of the Overview Report
9. Date of next meeting (minimum of 5 working days following circulation of the Draft Report)

NB: Members should have available copies or links to local Child Protection procedures and Working Together 2013.

The reviewer will work with the SCR Panel in accordance with the terms of reference.

In the first Panel meeting; analysis, discussion, and scrutiny of the SCR information will inform the process, and to enable the SCR Reviewer / Author to complete a first draft within the timescales agreed within the terms of reference. A deadline will be agreed for completion and submission to the Panel.

A typical SCR Panel meeting agenda :

1. Introductions/Apologies
2. Minutes of previous meeting
3. Matters arising from meeting
4. Draft Overview Report
5. Introduction
6. The Facts
7. Analysis
8. Confirm/Develop Recommendations
9. Identify any outstanding actions / tasks
10. Agree process for Panel approval of Final Draft
11. Date for presentation to CSCB

6.0 THE OVERVIEW REPORT

The overview report should bring together the relevant information and analysis contained in the individual agency reports, together with any reports commissioned from other parties. The following format is suggested, although details may need to be changed depending on the nature of the case.

1. Introduction

- Summary of circumstances leading to the SCR.
- Terms of reference.
- List of contributors to the SCR, Panel members and author(s) of the overview report

2. The Facts

3. Genogram showing family membership, including extended family and index child's household

4. Acknowledgement of and reference to any issues relating to disability or ethnic/religious diversity. Summary of chronology of involvement with the child and family by all relevant professionals, paying particular attention to occasions when the child was seen and the child's views or wishes sought or expressed.
5. Summary of the relevant information known to the agencies involved about the parents/carers, and the home circumstances of the children
6. Analysis - A consideration of how and why events occurred, judgements and decisions made and actions taken or not. There may be comment as to whether, in the Author's view, different decisions or actions may have led to an alternative course of events. The analysis section may also be able to highlight examples of good practice. The analysis should be structured so as to reflect the terms of reference of the SCR.

The analysis should include:-

- the treatment of and assessment of agency learning and actions resulting from the earlier part of the review process.
- Whether the death / serious incident was predictable and avoidable including:
- What is the evidence for this and rationale?
- How is this demonstrated agency by agency in a proportionate way?

7. Conclusions and Recommendations - This should include a summary of the findings of the review, lessons to be learned from the case, and the Panel's recommendations for action. Recommendations should include, but not be limited to, the recommendations made in the individual agency reports. Recommendations should be few in number, focused and specific, and capable of being implemented.

7.0 LEARNING

When things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. The outcomes from a Serious Case Review should include:

- Establishing whether there are lessons to be learned about how individuals and agencies work together to safeguard children
- Identification of what those lessons are, how they are to be acted upon, what is expected to change as a result and how changes will be brought about.
- Highlighting examples of good practice which can be adopted across agencies as part of the learning process.

7.1 Learning relating to Families

- The Chair of the SCR Panel and the LSCB Chair should write to the family as soon as possible to advise that a serious case review is being undertaken.

- As the review progresses, the Panel should consider which family members may be able to provide valuable feedback on the services they received. The Panel will need to seek advice from the police about approaching family members if there are likely to be criminal proceedings.

- When family members have been identified, it is good practice to provide a letter to the family through a staff member that they feel comfortable with (i.e. a police family liaison officer). This enables the member of staff to talk through the review process and enable family members to make an informed decision about whether to participate.

- Should family members wish to contribute to the review, they would usually meet with representatives of the Panel (author and Chair if available) to discuss the services they received. Notes of these meetings should be written up and the family should have the opportunity to review these notes before they are circulated to the Panel.

- The feedback from the family should be reflected throughout the overview report.

8.0 OVERVIEW REPORT

Working Together 2013 states that an overview report will be published and readily accessible on the CSCB website for a minimum of 12 months and will be available on request thereafter. The report will be written taking into

consideration full publication and therefore will not contain information that would be likely to harm the welfare of any children or vulnerable adults involved in the case. The CSCB should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. In some cases the welfare of children or vulnerable adults may preclude publication of the overview report in which case the CSCB's decision in this respect will be referred to the National Panel of Experts for advice. In these circumstances the CSCB will consider options of redacting the overview report or producing a separate Lessons Learned Report, to meet its obligations for public accountability and the dissemination of learning.

The CSCB Independent Chair has to make the final decision about whether to publish the SCR report, based on the premise that all SCRs should be published, unless there are very compelling reasons not to.

The overview report will:

- 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
- be suitable for publication without needing to be amended or redacted
- comply with the Data Protection Act 1998
- comply with any other restrictions on publication of information, such as court orders

Recommendations and Action Plans:

- The CSCB will publish as part of the overview 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;
- Recommendations for further action
- and what more will be done

Recommendations need to be SMART (specific, measurable, realistic, achievable and timely) so that they are more likely to be implemented and audited. It is therefore valuable to focus on framing and negotiating recommendations as part of the SCR process.

8.1 CSCB Independent Chair and SCR Panel Chair

The overview report, recommendations and action plans will be sent to all Board Members and the Independent Chair who will take responsibility for ensuring that the overview report complies with the above before approving and accepting the report. An Aide Memoir for Board Members can be found in Appendix >>>) The Independent Chair and the CSCB will give

consideration to any concerns about the feasibility of publishing the report and raise such concerns with the National Panel of Experts.

8.2 Legal Consultation

- the Panel will seek legal advice throughout the process as necessary, which may be independent of the Local Authority if appropriate.
- the overview report will be sent to a CSCB legal advisor prior to CSCB approval to ensure it complies with Data Protection Act 1998 and any other restrictions on publication of information

8.3 Parallel processes

The timing of publication will take into account any other processes which may impact; such as criminal investigations and court proceedings. Consultation will take place with the appropriate agencies to agree supremacy of investigations, or which processes can run in parallel, to ensure investigations or processes are not compromised.

8.4 Overview Report to CSCB Safeguarding Children Board

Following agreement of the draft overview report and action plans by the SCR Panel, the report and plan will be presented to the CSCB by the Chair of the Panel and the lead reviewer. Subject to any agreed amendments, the CSCB may approve the report for publication. The CSCB may not agree the report and instead require further work to be done to satisfy itself that the above objectives for a SCR have been met. In this instance the CSCB has the authorisation to reinstate the SCR Panel to complete the areas the CSCB has raised issues and command further work to be done to answer questions raised by the CSCB and fulfil any actions the CSCB requires it to undertake. The SCR Panel will meet at the earliest opportunity to agree and complete actions and at such a point the SCR Panel decides the report is ready to be received by the full CSCB, the report will be presented and the cycle followed until the report is agreed by the CSCB. This process is key in executing a high quality, thorough and transparent report but the CSCB and Panel must ensure that a timely manner is kept to and the National Panel of Experts are informed at each stage of this process / delay.

8.5 National Panel of Experts

The Independent Chair of CSCB will send the overview report to the National Panel of Experts at least one week before publication. If the CSCB and Independent Chair consider the SCR report should not be published, it should inform the Panel which will provide advice to the Chair and CSCB.

8.6 Publication

The Independent Chair of CSCB will ensure the final overview report is discussed at a media strategy meeting where required. The media representatives from all relevant agencies and members of the Panel will

agree with CSCB Independent Chair a strategy for publication; including whether a media conference is necessary. This will include a statement from the CSCB Independent Chair about the most appropriate time for publication and will ensure liaison with appropriate media representatives from other board agencies.

8.7 Sharing the Report prior to publication

Family members – the Panel will agree appropriate arrangements to be made to share the report with family members prior to publication. This will wherever possible be the same Panel members who involved the family members in contributing to the report.

Staff – agency representatives on the Panel will advise on the most appropriate way to share the report with practitioners who were involved in the case. This can be done via Panel members sharing with their own agency staff or via a briefing involving all agency staff.

9.0 IMPLEMENTING THE LEARNING

The following section to be read in conjunction with the CSCB Learning and Improvement Framework which details how the learning will be implemented and provides the basis for improving services and reducing the risk of future harm to children.

Each agency will be responsible for ensuring any agency learning/recommendation for their service identified in the overview report or, where relevant their agency IMR, is implemented. The action plan will contain an identified agency lead and agreed dates for completion. The Case Review Sub Group will regularly monitor the action plans, the timescales and will require evidence of implementation from agencies.

The Case Review sub group also has the option to interview Board Members and their organisations in challenge events to ensure evidence provided was robust and that impact was positive outcomes for children and their families.

Where appropriate; policies, procedures, protocols and practice guidance will be updated and/or developed.

The Case Review Sub Group will widely disseminate the learning from the SCR with partner agencies; through newsletters; via the CSCB Sub Groups; via briefings and through single agency and multi agency training courses as appropriate in accordance with the CSCB Learning and Improvement Framework.

The Case Review Sub Group will maintain an up to date register of progress against all recommendations and will compile evidence provided by the agencies to demonstrate that the lessons have led to improvements in outcomes for children

Agencies should submit progress reports to the Case Review Sub Group. Completed action plans should be submitted and signed off by the Case Review Sub Group.

Where there are recommendations that have a focus on multi agency working, this will be subject to clear planning, identifying responsible officers, timeframes, and intended outcomes and how success will be measured.

10.0 DATA PROTECTION

Should the CSCB be approached to share information regarding the SCR such as IMRs, chronologies or Overview Reports, legal advice should be sought immediately by a legal professional who can advice the CSCB with matters regarding Freedom of Information requests, Data Protection Law and provide legal advice and guidance to the CSCB.

Appendix 1 SCR Methodologies

The following provide further information on methods for undertaking serious case reviews which adhere to the principles set out in Working Together to Safeguard Children 2013 and which may inform the approach taken by CSCB.

There are two distinct methodologies for conducting Serious Case Reviews: Systems approach and Investigative approach. There are tensions between using the two different methodologies which are outlined in the table below.

'The crux of a systems approach… is that it examines human performance in its context and recognises that people's competence in carrying out tasks to a high standard is influenced by the whole system around them' Munro, 2012

Systems approach	**Investigative approach**
Timeliness	Completeness
Local Ownership	Objectivity
Psychological Safety for staff	Auditability
Collaborative inquiry	Externally conducted
Learning in the investigation process	Learning in the Outcome
Focus on making change happen	Focus on producing better reports
Learning facilitators	Investigators

The following are different types of Review

- **SCIE Learning Together** (LT) is a systems approach and has been piloted and evaluated and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved. http://www.scie.org.uk/publications/guides/guide24/.

- **Significant Incident Learning Process (SILP)** is also a systems approach and was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

- **Traditional Model** is an investigative approach using Independent Management Reviews or IMRs (described in Appendix 2)

- **Root Cause Analysis** (RCA) techniques to understand the underlying causes of incidents rather than identifying individual failure. RCA is a class of problem solving methods aimed at identifying the root causes

of problems, or events rather than merely addressing the obvious symptoms. Based on human error theory, (Reason 1990) the RCA model has been adapted for use in health and social care settings.

- **Child Practice Reviews** replaced the Serious Case Review system as the statutory guidance in Wales on 01.01.13, this process consists of several inter-related parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an extended review which involves an additional level of scrutiny of the work of the statutory agencies. http://wales.gov.uk/docs/dhss/publications/121221guidanceen.pdf

Using a hybrid methodology:

The tensions listed above are not irreconcilable. Some methodologies can be combined. For example some Root Cause Analysis tools may be used in addition to investigative approached as part of a 'how and why' analysis. Each review will have its own characteristics and may be placed anywhere on the 'systems-investigative' continuum, allowing a proportionate review tailored to the individual circumstances.

Appendix 2 Individual management Reviews (IMRs)

If IMRs are requested, agencies will use their chronology to inform an Individual Management Review (IMR) of their involvement with the child and/or their family.

A Chronology is a list, in date order, of all the significant events in a child or young person's life summarising the knowledge and information held by agencies involved with the child and family, recorded as brief 'headlines' to provide an immediate, visual overview and which supports the whole case record about a child or young person. It is not: the detailed case recording; a diary / list of dates; an assessment; or an end in itself.

The aim of IMRs is to look openly and critically at the systems which influence individual and organisational practice to see if improvement should be made and, if so, to identify how those changes can be brought about. In situations where there is considerable involvement of health agencies it may be beneficial to commission an IMR from a commissioning body i.e. CCG or NHS England.

If IMRs are not being requested guidance will be provided in respect of the type of chronology to be provided which will include analysis of the information and agency learning. Please see above

IMR Authors

The Individual Management Review (IMR) Author must be of sufficient seniority to be able to work at all levels within the agency. The IMR Author must be fair in the way that the views of staff are represented. The IMR Author should be familiar with current child protection practice and is expected to produce an independent and objective report within prescribed timescales in accordance with national guidance.

The IMR Author will have had no significant involvement in the case under review and should not be in a line management relationship with their agency representative on the Serious Case Review Panel.

The IMR Author prepares the report for their agency and is accountable to the Chief Officer for the quality of the report. The report is submitted as an agency report.

The IMR Author should have unrestricted rights of enquiry and access to staff, paper and electronic records and files. It is envisaged that the IMR Author will wish to interview staff that are central to the case. Staff who wish to be interviewed should be offered this opportunity by the IMR Author. Such interviews should be allowed.

The IMR Author must ensure that the relevant agency staff are informed of the purpose of the IMR and the process leading to the SCR.

The IMR Author should ensure that all files relating to the child are secured, preferably under lock and key, to ensure information is not altered or lost. The IMR Author should be empowered to demand appropriate security measures are taken. If the case remains open then a full copy of the file should be taken and the original file secured. All files should be made available to the IMR Author. The IMR Author may need to take advice on the working of the agency's electronic records to ensure that he or she has a good understanding of when and how records have been created.

The IMR Author shall identify and indicate the location of all files relating to child (ren) and make any document contained in these files available on request.

The compilation of the IMR report will create a significant extra workload. The IMR Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the IMR report within the strict time scale. The IMR Author should receive appropriate clerical support throughout. It may be necessary for the IMR Author to be relieved of some or all their normal duties for the period the IMR report takes to compile.

At the beginning of the SCR process, the CSCB unit will provide a training and briefing session to authors and managers who have responsibility for signing off IMRs. The training and briefing session will outline the requirements of the IMR and how this fits with the broader SCR process. It will provide information about the terms of reference to be considered as part of the review and how to provide robust analysis of agency involvement.

At the briefing session, authors will receive a template and guidance notes for completing the IMR. The IMR should follow the headings of the template and use the guidance notes to assist them with completing relevant sections. IMRs which do not follow the template or are not completed as per the guidance will not be accepted, and the authors will be asked to resubmit.

If IMRs are <u>not</u> being requested agencies will be provided with guidance about completing chronologies, analysis and agency learning and who should undertake this within the organisation and advising of the need for senior management sign off. Briefing sessions will be arranged to clarify the process.

Calderdale use ChronoLator, a tool to combine multi-agency chronologies into a single collective table of events. Further assistance with completing the IMR/Chronologies can be sought from the CSCB Unit and named professionals within individual agencies

Interviewing Staff

If there is a criminal investigation and likely criminal trial then it may not be possible to interview some staff members who may be called as witnesses until after the criminal justice process is completed. The principle of

completing the review in a timely manner should be pursued and consideration given to which staff members it may be possible to interview and what areas it may be possible to speak to them ahead of a criminal trial in order that learning is not delayed. It is important that the SCR Panel receives advice on this and plans this carefully with the Senior Investigating Officer from the police taking into account the views of the CPS.

The information from chronologies is largely drawn from agency records. IMR / chronology authors may wish to interview staff as part of the process in exploring issues. Interviewees should be given the opportunity to comment on the transcript or record of the interview.

Staff may be expected to further contribute to learning by participating in a practice learning event/or events undertaken by the SCR Panel to check assumptions about why decisions were made and understand more fully the context from a practitioners' viewpoint.

Depending on the agreed method practitioners and managers may also be required to participate in structured conversations with the review team to ensure their experience is captured in the review.

The purpose of learning events or structured conversations is to facilitate a broad discussion between SCR Reviewer / author, front-line practitioners and their first-line managers, and representatives of the SCR Panel. The discussion will follow the key themes identified from the agency reports.

The Learning Event(s)/ structured conversations should explore:

- How agency systems influenced practice, for example work environment, case loads, opportunity for reflective supervision
- How agency systems support communication and collaboration in responding to incidents; undertaking assessments and on-going work with families
- How professional and family interactions influenced practice
- How professional judgement/reasoning influenced practice
- If any patterns of practice create unsafe conditions in which poor practice is more likely

The event(s)/structured conversations should encourage a transparent, systematic and rigorous process for analysis

The event(s) should be a learning exercise in itself and promote the culture of learning. If the decision is to undertake a multi-agency learning event it may be necessary to consider the number in attendance – e.g. is the number manageable to make the event productive or does there need to be specific events for certain agencies which will enhance the learning.

Information from the practitioner learning events or structured conversations will be made available to the participants to check the review team has represented their views accurately and effectively and ensure their full participation in the process

It is anticipated that any serious practice concerns about an agency, practitioner/s will have already become evident through the Agency Reports (IMRs) or other means of agency information gathering and as such it will be expected that the agency will follow their normal practice in respect of any disciplinary procedures necessary.

Providing an Overview of the Family

The IMR should paint a picture of what was known about the child (ren) subject to the review and how they interacted with and were affected by family members and other significant adults.

Given that this information may come from a combination of agency records and interviews with staff working directly with the family, it is important to be clear about the source of the information, particularly when information is the expressed opinion of staff or the author.

The IMR template is provided for authors to identify what agencies knew about:

- The child (ren) subject to review. This should include any information about this child's expressed wishes/feelings; ethnicity, religion, disability; neighbourhood and community; health, wellbeing and overall presentation/ demeanour; and behaviour towards his carers and others and

- Significant adults in the child (ren)'s life, including social history (with a focus on information/events that may impact parenting capacity); ethnicity, religion, disability; neighbourhood and community; health, wellbeing and overall presentation/demeanour; and behaviour towards the child and others. It is recognised that social history will include information outside the scope of the review in terms of timescales.

Providing a Narrative of Agency Involvement with the Family

- The IMR should provide a clear narrative of the agency's involvement with the child, family and/or other significant adults for the period under consideration for the review (which is identified in the terms of reference). This should bring out key events from the chronology.

- Authors should provide sufficient detail about key events that will require further analysis, particularly those judged to be significant to understanding the way that the case developed and was handled. This can include a specific assessment/intervention; or a service provided over an extended period of time. It is important to note that this can include good or problematic practice.

- It is important that readers of the report, who are likely to be from outside of the organisation, are able to gain a clear understanding of the services that were provided to the family, what they were trying to

achieve, and what legislative/policy framework they are provided within. It is also important that authors are clear about how the services provided fit in within the agency's broader organisational structure.

Providing a Robust Analysis of Agency Involvement with the Family

- The IMR will need to provide rigorous critical analysis of the systems that influence practice. The terms of reference, which will be provided by the SCR overview Panel, are to be addressed in full.

- Authors should consider the events that occurred, the decisions made, and the actions taken or not taken. It is important that the author portray an understanding of what happened (or did not happen) and why. As such, it may be necessary to provide some contextual information about pressures on agencies, staff workload, sickness/leave, supervision and access to support.

- It is recognised that authors will need to consider past practice. If an author feels that there was practice that could be seen to be problematic, but is unlikely to recur given policies/procedures and/or working practices have been changed, this will need to be explained and evidenced (i.e. by reference to revised procedures).

Management Sign off of Reports

- IMRs will not be made available to the public (but may be subject to legal requests for disclosure ref LSCB position statement/section), but will inform the overview report and, as such, should be carefully vetted by the submitting agency to ensure it is an accurate, objective depiction of their involvement.

- The IMR will need to be signed off by someone in the organisation with sufficient authority in the organisation to take responsibility for the consequences of publishing information contained within the report; and for implementing recommendations.

- This senior manager will need to ensure that appropriate approval processes are in place to quality assure IMRs. It is crucial that information in the report is accurate; that the analysis of services provided is objective; and that recommendations are fit for purpose. As such, the senior officer should consider the IMR carefully against the terms of reference for the review and the guidance notes provided by the CSCB.

- It is recommended that the senior officer meet with the IMR author and/or relevant heads of service/professionals with responsibilities for safeguarding to quality assure the report.

- IMRs must reflect the terms of reference

- If the method of review does not include IMRs the above process for signing off the agency information, analysis and agency learning should still go through the process cited above.

  The submitted IMR may be the basis for later challenge of and by the agency within the SCR Panel scrutiny and Quality Assurance process and/or as a result of the work of the reviewer, and therefore all information should be robust and accurate.

Appendix 3 Aide Memoir for Board Members when considering a SCR Overview Report to be agreed and accepted

As a Board and Board Member we need to be clear about and sure that:

Our case review process has been open, thorough, objective and independent in order that we have;

1. Identified fact and supported agencies involved to identify learning, acknowledge areas for improvement and taken action

2. Identified fact and as a Board identified learning and acknowledged areas for improvement and taken action

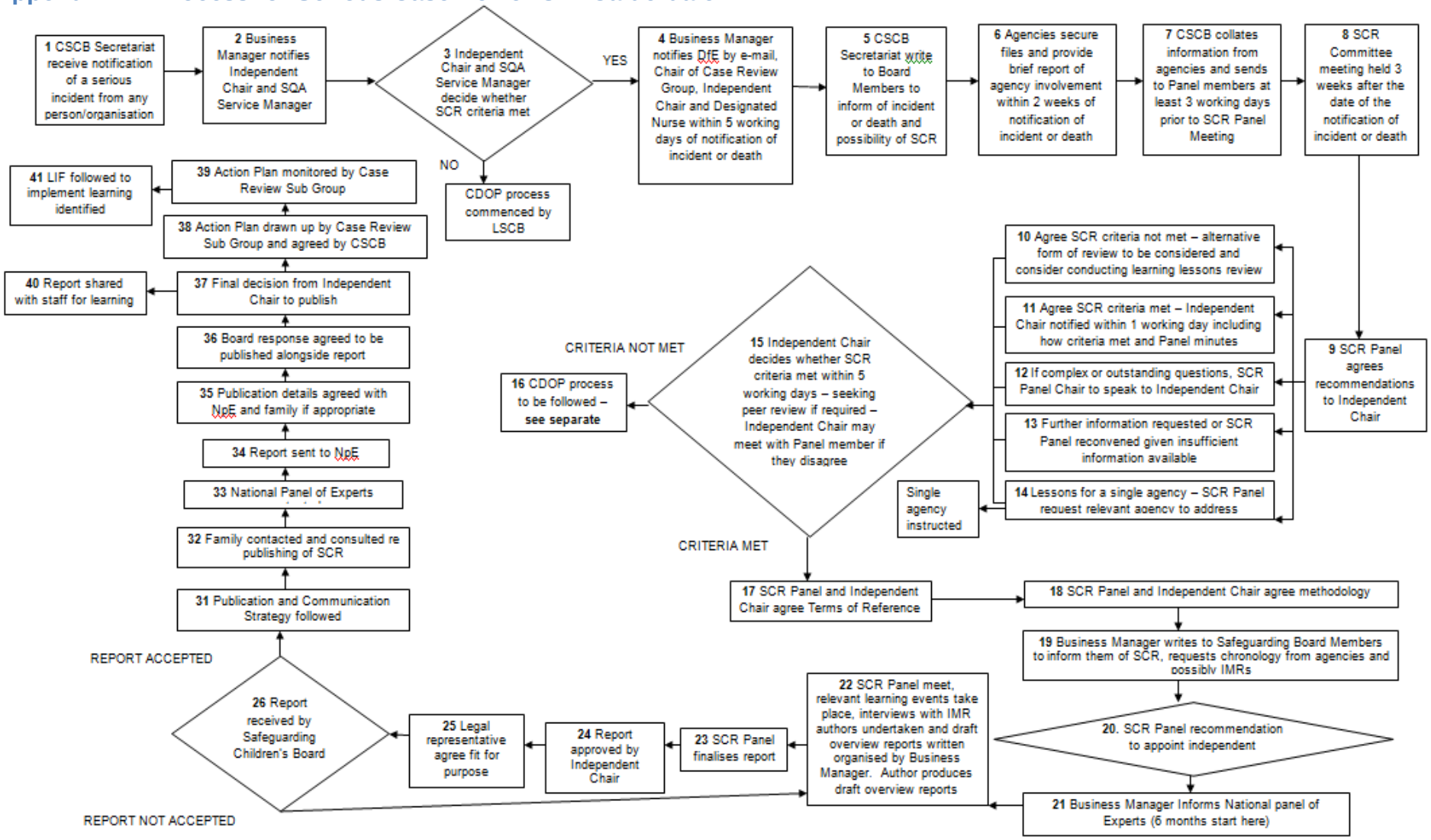
3. That family members have been consulted and where appropriate have been able to contribute

4. That findings and recommendations are coherent, concise and achievable

5. That the agencies involved and the Board are prepared to accept and act on, and if appropriate add to the recommendations identified in the Overview Report

6. That as a Board we are in a position to manage/monitor and where appropriate implement the above, and have a clear timetable and resources to do this.

Appendix 4: Process for Serious Case Reviews in Calderdale



Appendix 5: SCR Decision Making Proforma

CHILD/YOUNG PERSON'S DETAILS

Family Name:		**Given Name:**		**Also known as:**	
Dob or expected date of delivery:		**Date of Death / Incident**:		Male ☐	Female ☐
Home Address (include Postcode):					
Childs Status:	Looked After Child	CP Registration	Child in Need	Not known to Children's Social Care	

INFORMATION TO BE PRESENTED TO LSCB CHAIR FOLLOWING SCR SUB GROUP MEETING (*This should be clear and evidence based taking into account all of the information available and cover anticipated questions that may be asked by the Chair or National SCR Panel).*

(The LSCB for the area in which the child is normally resident should 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). *Please note this form will need to be updated following each meeting at which a case is discussed, updated information is presented to the LSCB Chair and when recording his / her determination of the information to ensure there is a composite record for audit purposes.*

Date of SCR Sub Group Meeting:		**Has a Serious Incident Notification been sent to Ofsted by Children's Social Care? ***	**Yes / No**
SCR Sub Group Recommendation to Chair:			

DATE CHAIR'S DECISION TO BE MADE BY:		*** DATE SCR NATIONAL PANEL TO BE ADVISED BY:**	

LSCB CHAIR PEER REVIEW

Date of advice/support/challenge:	**Source of advice/support/challenge:**
Nature of Peer Advice/Support/Challenge:	

LSCB CHAIR DECISION

Has Criteria for SCR Been	**Yes**	**No**	**Inconclusive**	

Met?				

N.B. Once the LSCB Chair has made a decision on whether or not to initiate an SCR, National SCR Panel should be informed by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk

If LSCB Chair has decided to initiate an SCR, the National SCR Panel and Ofsted should be advised. They should also be provided with the names of the reviewers Panel Chair / Reviewer & Author / Reviewer.

If the LSCB Chair has decided not to initiate an SCR, the National SCR panel must be advised of the decision within 14 days and provided with a copy of the Local Authority's Serious Incident Notification and an explanation why the LSCB Chair has decided the case does not meet the SCR criteria – it is therefore important that the rationale behind the decision making is clear and well recorded.

Chairs rationale on which his / her decision is based. This information will be used in the email to the National Panel :

Alternative Learning Proposed	**Yes**	**No**	**Methodology Type**	

LSCB Chair:	**Signed:**		**Date:**
Date SCR Sub Group Advised of Decision:		**Date National Panel Advised of Decision:**	
Date Ofsted advised of decision if applicable:		**Date DfE advised of decision if applicable:**	