



Serious Case Reviews and Lessons Learned Reviews – a guide for practitioners.

Introduction

One of the statutory functions of Local Safeguarding Children Boards (LSCBs) is to undertake reviews of serious cases where a child has died and abuse or neglect are suspected to be a factor. This is irrespective of whether the child has been known to Children's Care. The LSCB must advise the Children's Services Authority and Board Partners on lessons to be learned. These reviews are called serious case reviews or Chapter 8 reviews. They have also been referred to as Part 8 Reviews.

In Medway, we have also chosen to review cases that do not meet the criteria for a serious case review as laid down in Working Together 2006 but where there are nonetheless lessons to be learned about multi-agency working to safeguard children and promote their welfare. These reviews are called "lessons learned reviews".

This guide for practitioners aims to help explain the difference between the two types of review and help practitioners prepare should they have to provide information for such reviews.

DEFINITION OF A SERIOUS CASE REVIEW

(Taken from Working Together to Safeguard Children 2006 Chapter 8)

When a child dies, and abuse or neglect are known or suspected to be a factor in the death, LSCBs should undertake a Serious Case Review to ascertain whether there are any lessons to be learned about the ways in which organisations work together to safeguard and promote the welfare of children. This will involve an examination of the involvement with the child and family of organisations and professionals.

Additionally, LSCBs should always consider whether a Serious Case Review should be conducted:

- where a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect, or
- has been subjected to particularly serious sexual abuse, or
- their parent has been murdered and a homicide review is being initiated, or

- the child has been killed by a parent with a mental illness, or
- the case gives rise to concerns about inter-agency working to protect children from harm.

The Serious Case Review Panel is established to undertake Case Reviews on behalf of the Local Safeguarding Children Board.

The purpose of a Case Review is not to blame individual practitioners or agencies and they are not inquiries into how a child died or who is culpable. These are matters for the Coroners or Criminal Courts to decide.

Their purpose is to:

- “Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence,
- To improve inter-agency working and better safeguard and promote the welfare of children.”

(Working Together 8.3)

When a Case Does Not Meet the Criteria

Where a case does not meet the criteria for review, other options may be considered including the following:

- A “lessons learned” review by the Quality Assurance and Case Review subgroup
- A Single Agency Management Review.
- Bringing practitioners/managers together through an independently facilitated learning day. The aim would be to focus on inter-agency practice processes to effectively support the identified complexities of the case
- A structured inter-agency Audit
- Alternative processes suggested by the nature of the case.

DEFINITION OF A LESSONS LEARNED REVIEW

A Lessons Learned review is held when the threshold criteria for convening a SCR are not met (eg a child has not died or suffered significant injury; or a child has died but due to natural causes or an accident but where there are or have been perhaps concerns relating to multi-agency working with the family) but where an incident has occurred and there are concerns about multi-agency working to safeguard children and promote their welfare. For example where a child has died of natural causes, but multi-agency working has been found to be a cause for concern.

Process

Lessons Learned Reviews follow the same procedural process as Serious Case Reviews using the guidance as detailed below, with the exception that Lessons Learned Reviews are not published or sent to the Strategic Health Authority or OfSTED .

The MSCB has produced a SCR Procedures and Practice Guidance Manual, which can be found at: <http://tinyurl.com/2u6p6j>. This includes flowcharts of the process that is followed.

1 Referral for Review

Any professional (in consultation with the designated CP professional in their organization) may refer a case, which they believe meets the above criteria to the chair of the LSCB. In addition, the Secretary of State for the Department for Education and Skills has powers to demand an inquiry to be held under the Inquiries Act 2005. The referral is sent to the Chair of the MSCB Quality Assurance and Case Review (QACR) subgroup who discusses its contents with a multi-agency forum made up of members of the QACR group. This multi-agency forum is called a Serious Case Review Panel (SCRCP).

2 The Serious Case Review Panel

The core members of the SCRCP are from health, Police and the LA. This group will make a recommendation about whether or not the case referred meets the criteria for a SCR to the Independent Chair of the MSCB. It is the responsibility of the MSCB Independent Chair to decide whether or not a SCR should be undertaken.

If the case is accepted for a SCR or a LL review, the process is similar although when SCRs are undertaken, OfSted (formerly CSCI) must always be notified and kept informed of developments.

All agencies that have had contact with the family (including relevant Independent professionals such as GPs and voluntary and private organisations) will be informed by the MSCB Chair and asked to secure their records immediately.

The Serious Case Review Panel should meet and consider the scope of the review process. For example:

- The most important issues to address in this case
- Who should contribute to the review
- What information is required
- Who should be appointed to write the Overview report
- Whether an outside expert should be co-opted onto the panel at any stage to shed light on crucial aspects of the case
- Timescales

3 Individual Management Reports (IMR)

Individual agencies who have been involved with the child and their family will be asked to provide an Individual management report (IMR) which will include a chronology of their involvement, a review of all case files, interviews with practitioners and any other relevant information. These reports should be written by a senior member of staff who has not had any previous involvement with the child or family and counter signed by an officer able to represent the agency as a whole and therefore accept responsibility for the contents of the report.

4 The Overview Report

The IMRs will be presented to the SCR Panel and an Overview report will be written, which brings together and draws overall conclusions from the information and analysis contained in the individual management reviews and any other relevant reports.

The Overview Reports will include;

- An analysis of the standard of practice
- Any lessons that can be learnt about how to improve practice
- Recommendations for individual agencies from the Individual Management Reviews
- Recommendations to be implemented through the LSCB action plan.

What happens next?

“Reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as on conducting the review.”

(Working Together 2006 para 8.34)

One of the criticisms of the Joint Area Review (JAR) undertaken in 2006 was that recommendations and action plans developed following serious case reviews were not implemented, monitored, reviewed and audited. This meant that little changed and that practice issues were not effectively challenged. Medway is not alone. The focus of Serious Case Reviews is on the effectiveness of local services towards children who have suffered very serious or fatal significant harm, and their main messages to agencies concerned nationally have not changed over the 30 years that such inquiries have been undertaken.

As a response, MSCB have reviewed all of the SCRs undertaken in recent years and have ensured that all of the recommendations made have been implemented by all agencies. It has also introduced lessons learned reviews to consider other cases where multi-agency working can be enhanced and

outcomes for children improved through review and evaluation. The MSCB has also put in place an audit system to ensure that all SCR and LL action plans are implemented and embedded.

Delivering a change in practice is a challenge and requires a commitment from local agencies to drive forward a change in culture and an agreed, specific programme plan.

Basic good practice also requires training, supervision and support. The Serious Case Reviews undertaken in Medway highlight the need for training and challenge us to address this appropriately for the thousands of people in our area who share the tough and challenging job of safeguarding children.

The MSCB are working to develop ways of helping us to learn from serious case reviews through active multi agency engagement.

It proposes to do this using:

- Case study materials to support learning
- Debriefings for those involved in cases where a serious case review has been undertaken
- Practitioner briefings
- Briefings for managers
- Newsletters- to share learning from reviews
- Focused training (where specific needs are identified)

Further information can be found in the SCR procedures and Practice Guidance Manual at: <http://tinyurl.com/2u6p6j>

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July 2007