



Serious Case and Lessons Learned Review

Procedures and Practice Guidance

THE WORK OF THE SERIOUS CASE REVIEW PANEL

This document is based upon Working Together to Safeguard Children 2006 and should be read in conjunction with the Kent and Medway Safeguarding Children Procedures Module 14.3

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INTRODUCTION

One of the key functions of Local Safeguarding Children Boards is to undertake reviews of serious cases and advise the Children's Services Authority and Board Partners on lessons to be learned. This obligation is imposed by Regulation 5 of the Local Safeguarding Children Board Regulations 2005 and Working Together (2006).

These procedures and practice guidance summarise:

- The purpose of Serious Case and Lessons Learned Reviews and the criteria for conducting them
- The process for initiating Serious Case Reviews and subsequent conduct
- Actions consequently required of each member agency and of the MSCB

These were ratified by the Medway Safeguarding Children Board on 17/06/08 and will be reviewed in **24 months** from this date.

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PART ONE: CONTEXT

DEFINITION OF A SERIOUS CASE REVIEW

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

- 1.1.1 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.
- 1.1.2 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.
- 1.1.3 The Serious Case Review Panel is established to undertake Case Reviews on behalf of the Medway Safeguarding Children Board.

PURPOSE OF A SERIOUS CASE REVIEW

- 1.2.1 The purpose of a Case Review 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 SHOULD MSCB UNDERTAKE A SERIOUS CASE REVIEW?

- 1.3.1 MSCB should always undertake 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. This is irrespective of whether Medway Council Children's Social Services is or has been involved with the child or family.
- 1.3.2 MSCB should also consider conducting a review when there are concerns about the way in which local professionals and services worked together with respect to a child:
- Who sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
 - Who has been subjected to particularly serious sexual abuse; or
 - Whose parent has been murdered and a homicide review is being initiated; or
 - Who has been killed by a parent with a mental illness
 - The case gives rise to concerns about inter-agency working to protect children from harm.
- 1.3.3 Where more than one LSCB has knowledge of a child, the LSCB for the area in which the child is / was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the review. Please refer to Appendix X.
- 1.3.4 In the case of looked after children, the local authority which has responsibility for the child should take lead responsibility for conducting the review, again involving other LSCBs with an interest or involvement.
- 1.3.5 Any professional may refer such a case to the MSCB if it is believed that there are important lessons for inter-agency working to be learned from the case.
- 1.3.6 In addition, the Secretary of State for the Department for Children, Schools and Families has powers to demand an inquiry be held under the Inquiries Act 2005.
- 1.3.7 In cases where the criteria of 1.32 (above) are satisfied the following questions taken from Working Together to Safeguard Children (para 8.9) may help in deciding whether or not a case should be the subject of a serious case review. In circumstances other than when a child dies, the answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons:

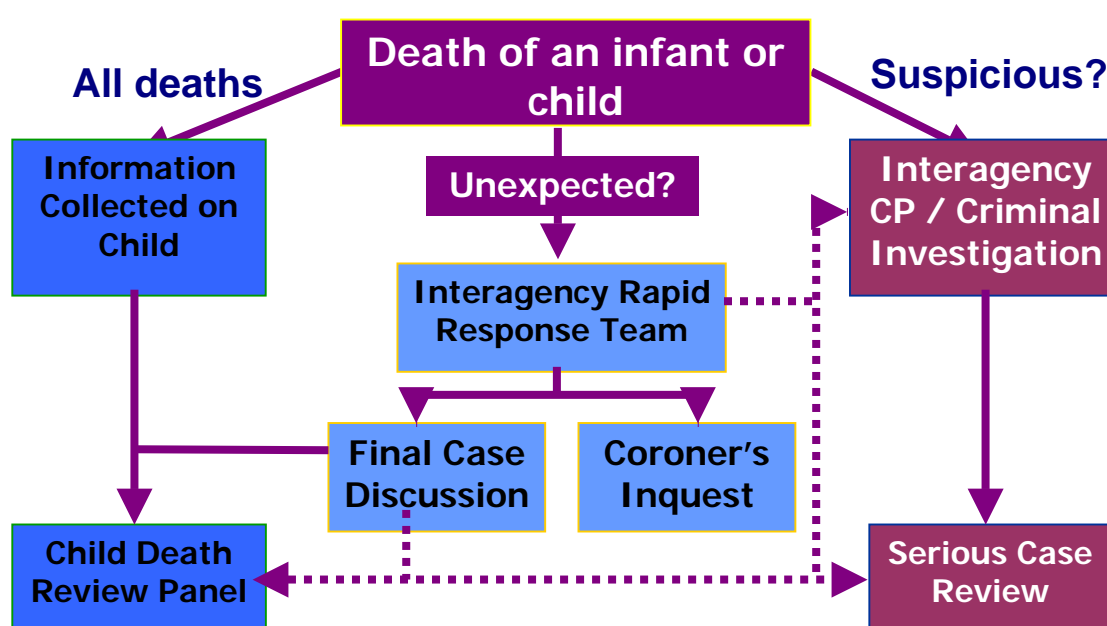
- Was there clear evidence of a risk of significant harm to a child, which was:
 - o not recognised by organisations or individuals in contact with the child or perpetrator; or
 - o not shared with others; or
 - o not acted upon appropriately?
- Was the child killed by a mentally ill parent?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre, Young Offender Institution, Secure Training Centre, children's home or armed services training establishment)?
- Did the child die in a custodial (prison, Young Offender Institution or Secure Training Centre) setting?
- Was the child abused while being looked after by the local authority?
- Did the child commit suicide or die while absent having run away from home?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?
- Was the child subject of a child protection plan or had it been previously the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the MSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately disseminated, understood or acted upon?

LESSONS LEARNED REVIEWS

- 1.4.1 Lessons Learned Reviews are undertaken on cases which do not meet the threshold for Serious Case Reviews but where there are nonetheless lessons to be learned about case management and multi-agency working. These reviews follow the same format, timescales and principles of statutory SCRs with the exception that they are not reported to Ofsted, the SHA and the DCSF.
- 1.4.2 For the purposes of this practice guidance, all references to the Serious Case Review Panel (SCRCP) should also include the Lessons Learned Review Panel.

CHILD DEATH REVIEWS

- 1.5.1 Working Together to Safeguard Children 2006, Chapter 7 sets out the procedures to be followed when a child dies in each LSCB area. It describes two inter-related processes for reviewing child deaths (either of which can trigger a Serious Case Review).
- 1.5.2 In Medway, unexpected child deaths will be reviewed through the same Panel as reviews referrals for Serious Case or Lessons Learned Review. The links with the Child Death Review Panel are shown below:



SERIOUS CASE REVIEW PANEL: MEMBERSHIP

- 1.6.1 Members of the Serious Case Review Panel (SCRCP) have a dual role; to represent a professional or organisational view in relation to information brought before the Panel *AND* to act collectively in representing well-evidenced, best practice standards.
- 1.6.2 The expectation is that membership of the group will remain constant and that each representative will commit to a term of 2/3 years in order to provide group stability and continuity.

Co-opted Members

Members will be co-opted to the SCRP if their specialist skills are needed for a given Case Review.

SERIOUS CASE REVIEW PANEL (SCRP): ROLES AND RESPONSIBILITIES

1.7.1 GENERAL

1. To decide whether or not a case meets the criteria for holding a Case Review as set out in Working Together 2006 (8.9) and make recommendation to the MSCB Chair/delegated person, who has ultimate responsibility for the decision.
2. Where the criteria are met, to undertake a Case Review according to Working Together guidelines (Working Together, 2006, Chapter 8).
3. Where the criteria are not met, the SCRP will act as a resource for the discussion of complex cases. For example, where a child has not died, but has sustained serious injury, and concerns are highlighted over inter-agency/single agency practice, the SCRP may make recommendations for appropriate alternative action – for example a Lessons Learned Review.
4. Determine the scope of each Case Review and commission Individual Management Reviews using this guidance developed from Working Together 2006, and draw up clear Terms of Reference including time scales.
5. Give adequate consideration to the impact of parallel processes, for example, criminal investigation or disciplinary procedures.
6. Ensure that the identified Chief Executive Officer in each organisation signs off Individual Management Reviews.
7. To consider the wider issues of accountability and disclosure. To identify who might have an interest in Case Reviews (for example, Chief Officers, Elected Members, staff, and members of the child's family, the public, and the media) and consider what information should be made available to each of these interested parties. The advice and guidance of the associate members of the SCRP from Press & PR and the Legal Section of the Council will be of value in resolving these issues.
8. Ensure that an Overview Report, with recommendations for action, is produced which brings together the information and analysis contained in Individual Management Reviews, together with reports commissioned from

any other relevant parties, using an outline that clearly reflects both guidance in Working Together 2006 and the agreed Terms of Reference.

9. Ensure the timely production of an anonymised Executive Summary and, when appropriate, commission training materials.

REPORTING

10. Director of Children's Services or nominated person to notify the Ofsted and the PCT to notify the Strategic Health Authority each time a decision is made to undertake a Case Review. (See Appendix IX).
11. Ensure that the Medway Children Safeguarding Board and Chief Executive Officers of organisations are briefed about the work of the Serious Cases Review Panel on a regular basis, receive reports on individual cases and agree recommendations.
12. Contact Ofsted to agree an extension where the SCR cannot be completed within 4 months.
13. Ensure that once a Case Review is completed the Executive Summary and MSCB Action Plan are circulated to agencies relevant to the case.
14. Send report (with action plan and IMR reports) to Ofsted, the Government Office South East and the DCSF.
15. Liaise with the QACR Subgroup regarding the monitoring of action plans.
16. Liaise with the Training subgroup regarding the development of case studies and training arising from recommendations.

ROLE OF THE LEGAL ADVISER

1.8.1 Legal advice to the SCRCP may cover:

- Liaison with other agencies in particular the Police and Crown Prosecution Service to ensure that the Case Review process does not conflict with actual or potential prosecutions.
- Analysis of new case law/statute affecting the review process.
- Ad hoc advice to the Chair/Vice chair of the SCRCP and to the Overview Report Author.

1.8.2 The main focus of any legal advice provided to the SCRP should be to ensure that the review could fulfil its purpose by being widely and appropriately disseminated within involved organisations without exposing the SCRP to unnecessary legal challenge. To achieve this aim;

- Individual Management Reviews (IMR's) and Overview Reports should be based on clear, logical and lawful Terms of Reference.
- Evidence should be clearly sourced. Direct first-hand evidence should be given most weight. Where allegations cannot be substantiated by such evidence, this does not mean that they should be entirely omitted. However, they should be clearly identified as unsubstantiated and weighed carefully against other more reliable evidence.
- If allegations are made against individuals who are identified in a report (either by name or by necessary implication) those individuals should be given the opportunity to respond before such allegations are included in the final report.
- Specific advice should be sought on technical issues e.g. Data Protection Act, Court Rules etc.

1.8.3 Where any in-house legal service has had substantial involvement in the case before the event, which triggers the Case Review, there may be a need to examine that involvement as part of the Case Review. This could be done by the Principal Solicitor as a Legal Services Management Review and submitted with other Individual Management Reviews. If it is felt that there may be a conflict of interest or that the objectivity of the Individual Management Review is affected it would be possible for that Review to be undertaken by the Legal Services department of a neighbouring authority.

THE IMPACT OF THE FREEDOM OF INFORMATION ACT 2000 (FOIA)

1.9.1 Under the FOIA any person has the right to make a request for information held by a public authority.

1.9.2 The organisations forming membership of the MSCB are subject to the provision of the Act and should have procedures for dealing with requests. Any organisation receiving a Freedom of Information request concerning a Serious Case Review should discuss this with the MSCB.

1.9.3 The Act recognises that there are grounds for withholding information and provides a number of exemptions from the right to access some of which are subject to a Public Interest test.

1.9.4 Information held and/ or gathered by agencies for the purpose of a Case Review may fall within one or more of the following exemptions:

- Investigations and proceedings conducted by public authorities (e.g. a criminal investigation).
- Court records
- Health and safety (disclosure would be likely to endanger the physical/ mental health/ safety of an individual).
- Personal data *
- Information provided in confidence (disclosure would constitute a breach of confidence).

1.9.5 Some exemptions are absolute, others are qualified – requiring a balancing exercise to be carried out before a decision is made as to whether to disclose. Agencies should consult their information officer or take legal advice if in any doubt as to whether an exemption applies.

NB Requests by an individual *involved with* the Case Review, for information concerning themselves would be dealt with in accordance with the Data Protection Act.

Defined in Data Protection Act 1998 as "Data which relates to a living individual who can be identified from those data and any other information in the possession of or likely to come into the possession of the data controller – which includes opinions about the individual and indications about intentions in respect of the individual."

THE CRIMINAL PROCEDURE & INVESTIGATIONS ACT 1996

1.10.1 This Act gives detailed guidance to Police and Prosecutors regarding disclosure of material to the defence in criminal proceedings.

1.10.2 There are times when a Serious Case Review is being conducted simultaneously with criminal proceedings. On the rare occasion when information comes to light during the Serious Case Review process, that may undermine the prosecution case, the prosecutor has a duty to disclose this to the defence.

1.10.3 In such circumstances, this should be referred to the Crown Prosecution Service via the Police representative on the Panel.

TIMESCALES

1.11.1 Given that the primary purpose of Case Reviews is to contribute to the improvement of inter-agency practice, the SCRCP should ensure that lessons are learned and acted upon as quickly as possible (Working Together, 8.14, 2006).

- The referral should be sent to the Chair of the MSCB, via the MSCB support team, within 72 hours if a case may meet the SCR criteria.
- Working Together (8.14) states that “within one month of a case coming to the attention of the LSCB Chair, the decision should have been made by the LSCB chair, following recommendation from the Review Panel, on whether a review should take place”. Within Medway the MSCB chair delegates this decision to the chair of the SCRCP.
- The Case Review should be completed within a further 4 months, “unless an alternative timescale is agreed with the OFSTED at the outset” (8.15).

1.11.2 Delay

Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it is clear that a Case Review cannot be completed within the 4 month timescale, there should be discussion with the OFSTED to agree a timescale for completion (8.15).

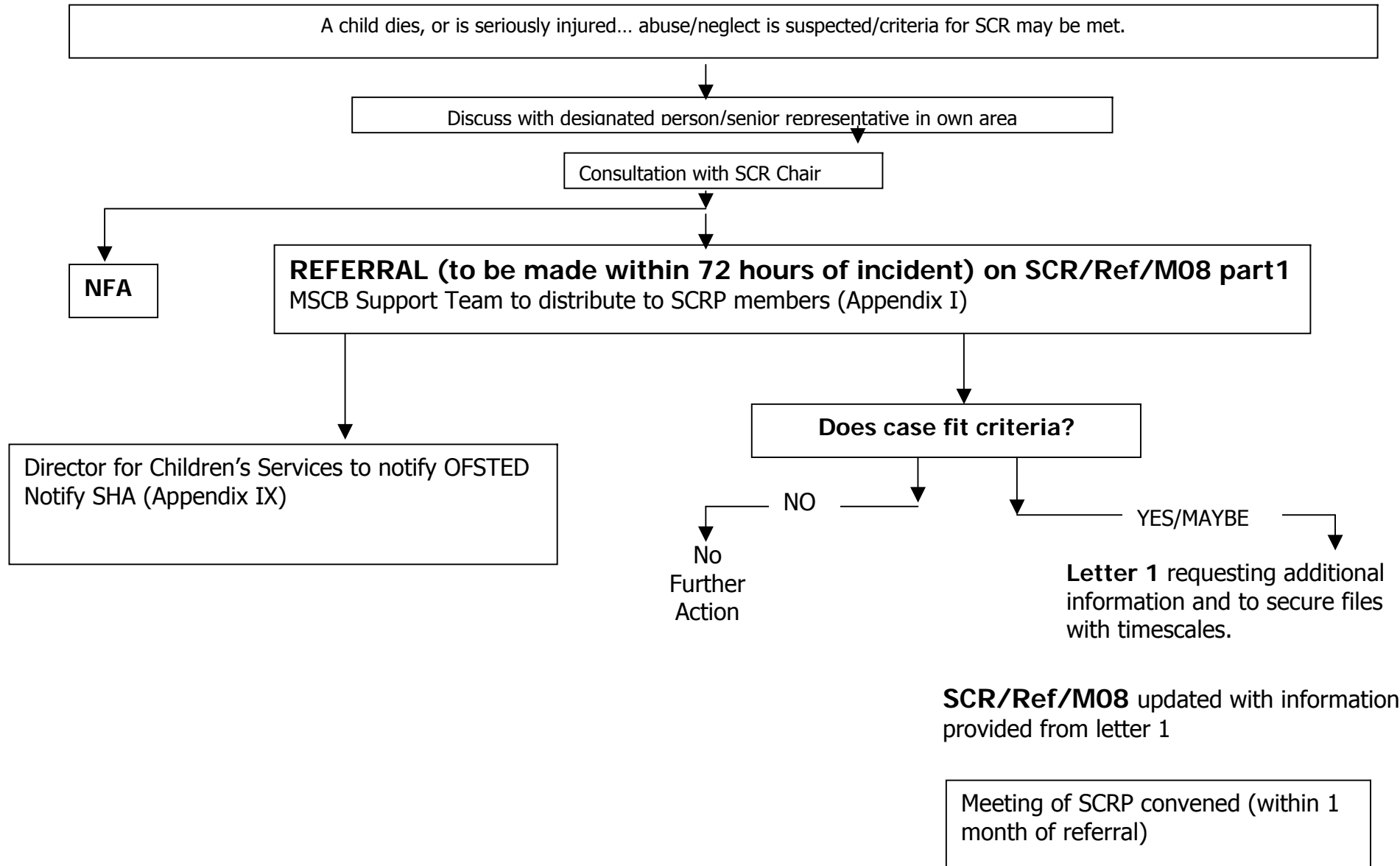
- Case Reviews should not be delayed as a matter of course because of outstanding criminal proceedings, or a pending decision as whether or not to prosecute (8.16).

Please refer to timescale chart appended at Appendix XIII

PART TWO: THE PROCESS

The following section gives details of the complex processes involved in Serious Case and Lessons Learned Reviews. The flow charts should be read in conjunction with the text, which gives full details.

1. REFERRAL



2. DECISION MAKING

Meeting of SCRP (standing group) to make recommendation to chair, terms of reference and scope, identify author, confirm panel members. Complete SCR/Ref/M08 Referral Form Parts 2 to 4 (Appendix I)

↓
Consultation regarding terms of reference

↓
Recommendation to Chair of LSCB – using completed Parts 1 & 2 of Referral form SCR/Ref/M08

↓
Chair's Decision – to be recorded on Part 3 of Referral Form and signed at Part 4

Alternative Action

No Further Action

Proceed to Case Review

↓
Lessons Learned Review

↓
Single Agency Management Review

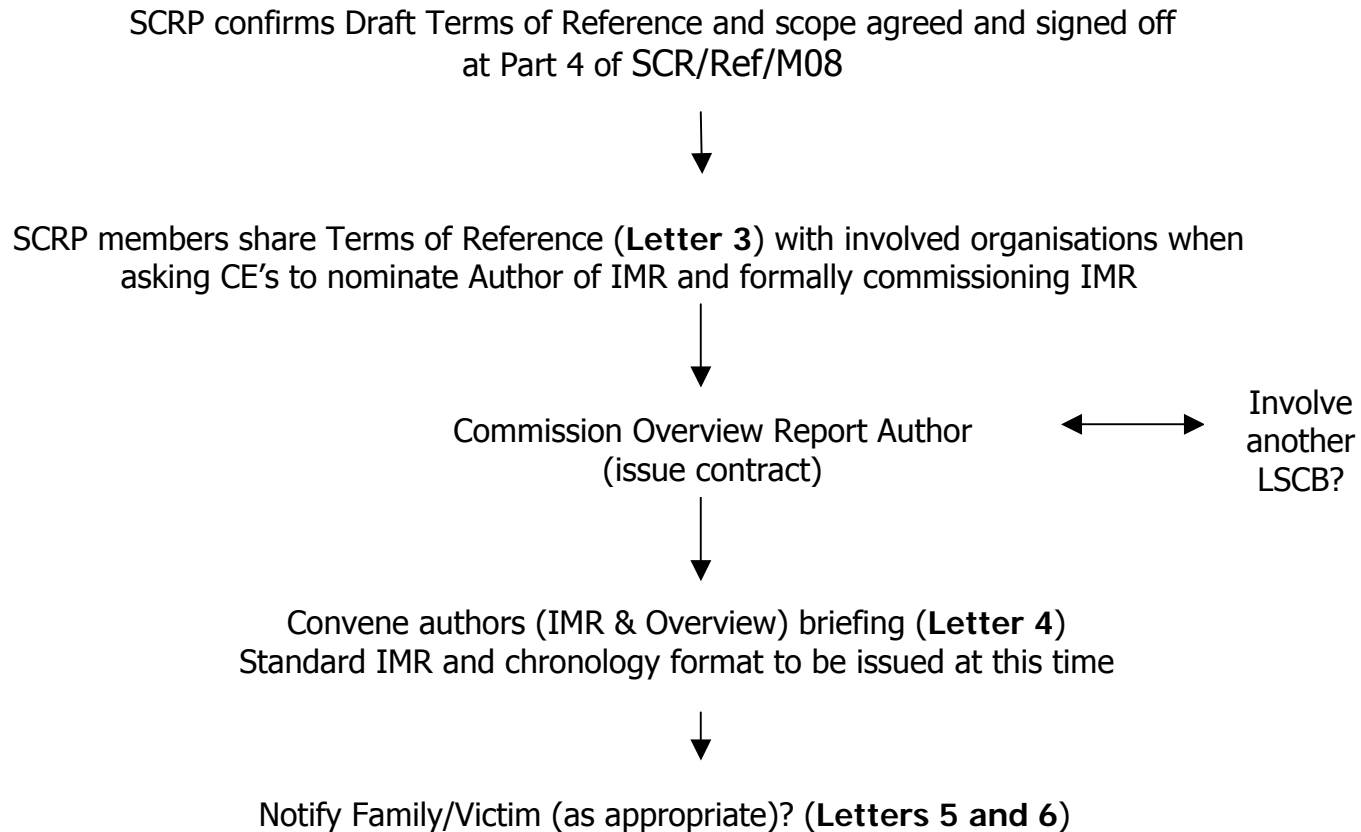
↓
Inter-agency Training & Development initiative

↓
Notify organisations of decision and that files may be released.
Letter 2

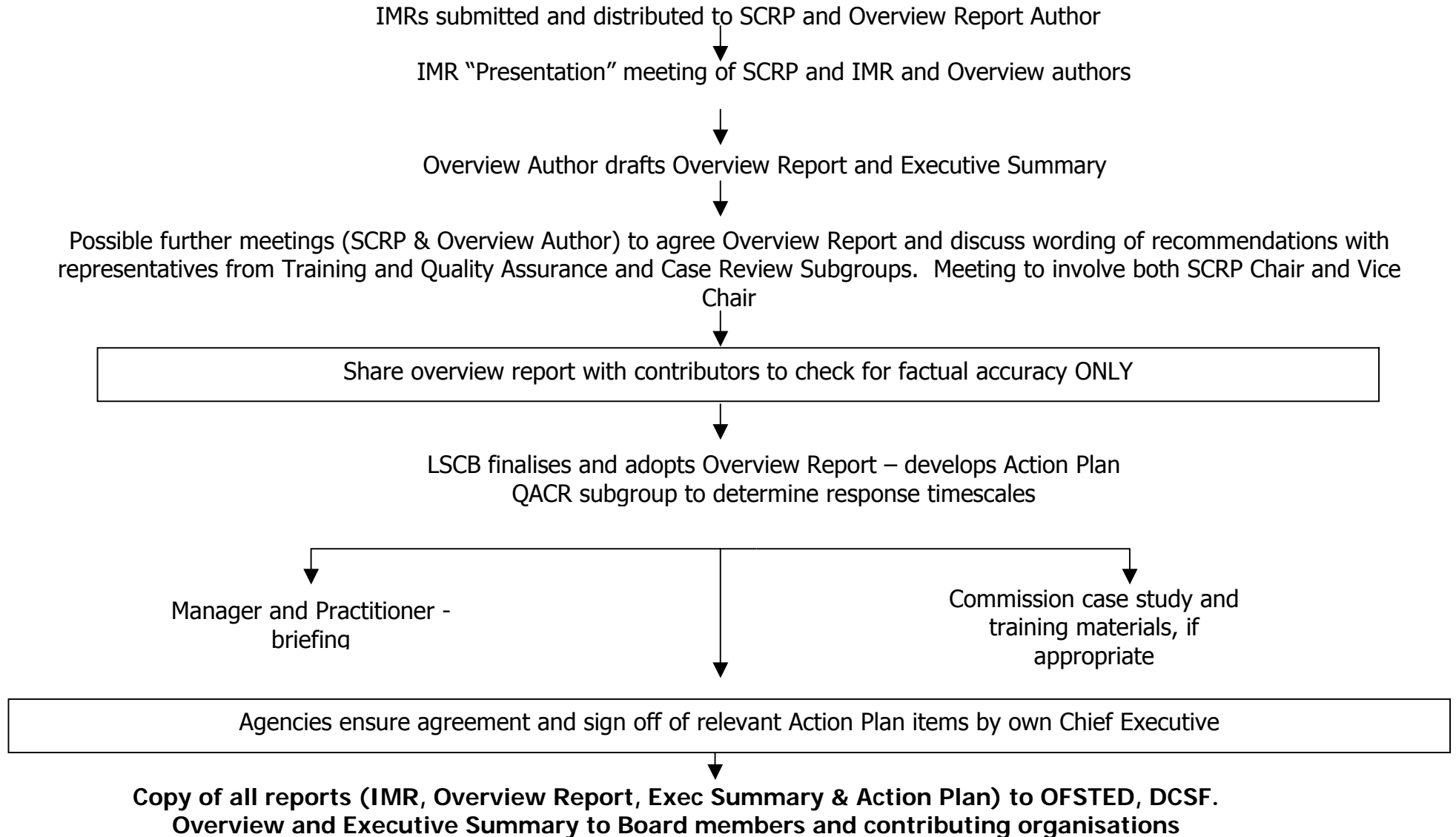
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Notification to Chief Executives (Letter 3) of all relevant organisations asking them to

- Identify IMR authors
- Commission IMR

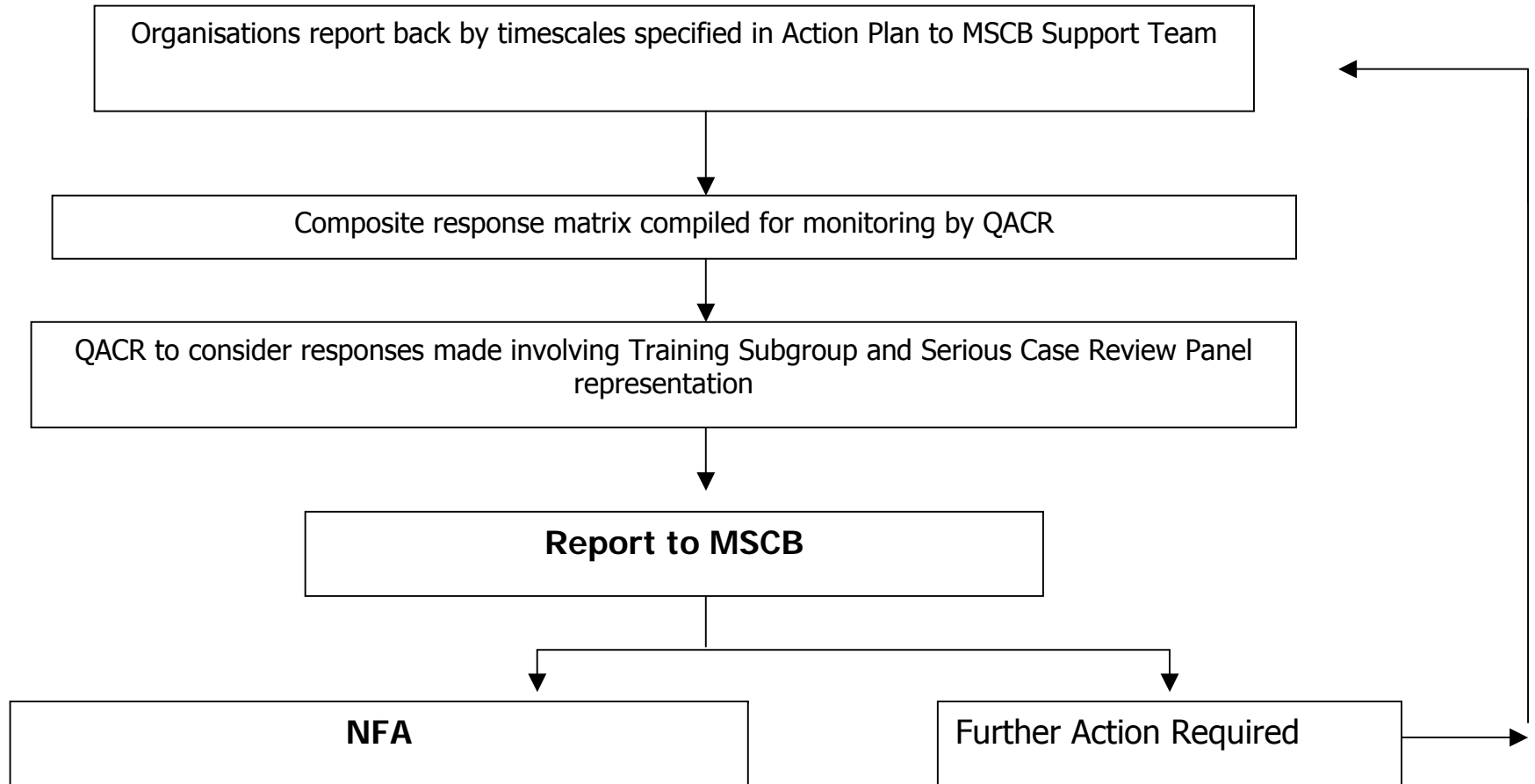
3. INITIATING A CASE REVIEW



4.COMPLETING A CASE REVIEW



5. MONITORING



SECTION 1. REFERRAL – INSTIGATING A REVIEW

- 2.1.1 Any professional or agency working within the local Child Protection network can refer a case to the MSCB for a Serious Case Review, whether or not their particular agency has had any involvement with the child/family. If a representative of any partner organisation of the Medway Safeguarding Children Board feels that a case may meet the criteria for a Serious Case Review, they are encouraged to discuss this with the designated person/senior representative within their own organisation. This person may then approach the SCR Chair via the MSCB support team for an informal discussion. This may result in no further action or the need for additional information. Otherwise the next step is for a completed referral form to be sent to the Chair of MSCB (see Referral form SCR/Ref/M08 at Appendix I).
- 2.1.2 On receipt of formal referral, and if deemed appropriate, then a meeting of the SCR will be convened by the vice chair of the SCR panel. If, from the information provided on the referral form, there is an indication that other agencies are/have been involved in the case, then the MSCB will write to them, asking for information that would help the SCR to decide whether/not the criteria are met.
- 2.1.3 During the referral process, in order to facilitate efficient exchange of information, each member of the SCR will act as a single point of contact (SPOC) within their own organisation. When relevant, they will also take responsibility for presenting the referral to the Serious Cases Review Panel on behalf of their own organisation.
- 2.14 Notification
- a) **Agency Notification**
- i) Once a case has been referred for consideration to conduct a Case Review, Chief Officers in agencies known or thought to be involved will be asked to provide brief details of their knowledge of the case (Part 1 of Referral Form number SCR/Ref/M08).
 - ii) The letter of notification should include an instruction to agencies to seal files relating to the child and family (see Working Together, 2006) (Letter 1).
 - iii) This letter of notification should be copied to Chief Officers of the LSCB partner organisations.

b) Notifying OFSTED

The Director of Children's Services or nominated person is required to report all decisions to Ofsted and the PCT is required to notify the Strategic Health Authority (SHA).

SECTION 2. DECISION MAKING

- 2.2.1 There are several steps in reaching a decision as to whether or not a Case Review should be commissioned.
1. The SCRP meet to consider whether or not the specified criteria (see below) are met. All members should give priority to this meeting. At least three partner organisations must be represented, and views should be sought in advance from those members who are unable to attend.
 2. The meeting is chaired by the Chair/vice chair of the SCRP,
 3. The Chair of the meeting will ensure that the referral is discussed fully and that all views are heard. The decision will be based on the majority view. Dissent will be minuted. The chair will have the casting vote where necessary
 4. The Chair of the MSCB is informed of the recommendation in writing.
 5. The Chair of MSCB has ultimate responsibility for deciding whether or not to conduct a Case Review.
 6. Once this decision has been made, the OFSTED and SHA will be informed (Working Together 8.11) and organisations asked to nominate their IMR author.

The Criteria for Undertaking a Case Review

- 2.2.2 The criteria for undertaking SCR's is laid out in Working Together 2006 and are included on Part 1 of the SCR Referral Form SCR/Ref/M08. Please also see Section 1 Instigating a review Page 20.

Notifying Families

- 2.2.3 Working Together (2006) para 8.12 urges LSCBs to consider the degree to which they involve families in Case Reviews, and who should be responsible to facilitate this.
- 2.2.4 Each case is unique and it is therefore important that the SCRP carefully considers the best means of notifying families and how support may be offered to them – eg through the use of advocacy services.
- 2.2.5 Involvement can range from formal notification only, to inviting them to share their views with the Overview Author in writing or through interview. These questions will form part of the discussions when the

SCRP is drawing up the Terms of Reference for the particular Case Review.

2.2.6 Normally families (this is usually family members who have played a significant role in the child's life, such as parent(s) and grandparents) should be notified that the Case Review is taking place. This may be done by letter either directly to the family members or via their solicitor(s), although it is important to consider other forms of communication as seems most appropriate given the particular circumstances. The timing of such notifications is crucial particularly where there are ongoing Police investigations. Under these circumstances, the decision about when to notify needs to take place within the SCR, with the Police representative present. Please see section 3 page 29 for more information about involving families in reviews.

Notifying Victims

2.2.7 Each case is unique and it is therefore important that the SCR carefully considers the best means of notifying victims and how support may be offered to them – eg through the use of advocacy and support services.

2.2.8 For example, where the review concerns historical abuse and the child victim is now a young person or adult, a sensitively handled notification can be a positive experience, allowing some sort of "closure". This can be achieved through them being informed of the process and helped to understand the issues raised.

2.2.9 The Executive Summary could be a useful tool. It may be appropriate, depending on the age and understanding of the child/adult, for this to be done in person, rather than by letter.

When a Case Does Not Meet the Criteria

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

- A Lessons Learned Review
- 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
- Alternative processes suggested by the nature of the case.

Organisations, OFSTED and the SHA to be informed of this decision using the information on SCR/Ref/M08. (Letter 2)

SECTION 3 - INITIATING A CASE REVIEW

Agreeing a workable Terms Of Reference

- 2.3.1 Better outcomes can be achieved if all the Individual Management Reviews address the same questions and issues, pertinent to the Case Review being undertaken. These are formulated as case-specific Terms of Reference.
- 2.3.2 Time spent on this part of the process is crucial and will affect the quality of Individual Management Reviews and ultimately, lessons arising from the Overview Report. The development of Terms of Reference is time intensive and may take the SCRP two or three scoping meetings to achieve.
- 2.3.3 Initial Terms of Reference drawn up following discussion within the SCRP need to form part of a consultative process, during which representatives on the SCRP share them with the relevant officers within their own organisations.
- 2.3.4 Terms of Reference may go through several re-writes, a date on each draft version is vital (use of footer).
- 2.3.5 The Terms of Reference are finalised once they have been discussed at the Overview Report Author's Briefing.
- 2.3.6 Working Together (8.12) provides a checklist of issues that need to be considered when drawing up the Terms of Reference for a Case Review:
- 2.3.7 Checklist of Issues
- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
 - Who should be appointed as the independent author for the overview report?
 - Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review? Might it help the SCRP to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
 - Over what time period should events be reviewed? How far back should enquiries cover, and what is the cut-off point? What family

history/background information will help better to understand the recent past and present?

- Which organisations and professionals should contribute to the review, and who else (e.g. proprietor of the independent school, playgroup leader) should be asked to submit reports or otherwise contribute?
- How should family members be invited to contribute to the review and who should be responsible for facilitating their involvement? (Please see page 29)
- Will the case give rise to other parallel investigations of practice, for example, independent health investigations or multi disciplinary suicide reviews, a homicide review where a parent has been murdered, YJB serious incident review and a prison and probation ombudsman investigation where a child has died in a custodial setting and, if so, how should review processes fit?
- If there are parallel investigations of practice, how can a co-ordinated or jointly commissioned review process best address all the relevant questions that need to be asked, in the most economical way?
- Is there a need to involve organisations/professionals in other LSCB areas and what should be their respective roles and responsibilities?
- How should the review process take account of a Coroner's enquiry, and (if relevant) any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Crown Prosecution Service?
- How should the SCR process fit with the process for other types of review? Eg: homicide or mental health.
- Who will make the link with relevant interests outside the main statutory agencies, e.g. independent professionals, independent schools, voluntary organisations?
- When should the review process start and by what date should it be completed?
- How should any public, family and media interest be handled, before, during and after the review?
- Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

For a sample terms of reference, please see Appendix II

2.3.8 Following the scoping meeting, the SCRP Chair will, in conjunction with the MSCB Manager:

- i) Draft a record of the meeting including decisions, agreed actions and timetable. This will be circulated to members of the Overview Panel and the Chair of the MSCB for information.
- ii) Formulate and agree the final Terms of Reference for the Overview Report
- iii) Write to relevant agency Chief Officers informing them of proposed actions and timetables and asking them to identify who will draft their agency management reviews. It is the responsibility of Chief Officers to ensure that the authors of the agency report are aware of the MSCB expectations in respect of report style & content and timetable. (see page 36)
- iv) Consider whether a Briefing meeting with authors of Agency Reviews should be held
- v) Contact specialist consultants where necessary and negotiate their involvement
- vi) If required, co-opt other members of the MSCB to the Overview Panel and brief them and their Chief Officer on the process and role of the co-opted members

2.3.9 All other Panel members will carry out appropriate actions agreed at the Scoping Meeting.

2.3.10 Panel members should be constant throughout the time of the review and should attend all the Overview review meetings.

INVOLVING FAMILIES

2.3.11 Working Together to Safeguard Children 2006 advises that LSCBs should:

- Consider how family members might contribute to the review, and who should be responsible for facilitating their involvement?
- Make arrangements to provide feedback and debriefing to staff, family members of the subject child and the media as appropriate
- Carefully consider who might have an interest in reviews, including members of the child's family, and what information should be available to each of these interests
- To anticipate requests for information and plan in advance how they should be met.

2.3.12 When planning and conducting a Serious Case Review, the Panel will always consider the degree to which family members can be involved in the process. Engagement with, and feedback to the family, should be an integral part of the process wherever possible.

2.3.13 There will be a presumption that family members will be invited to contribute as fully as possible to the Serious Case or Lessons Learned Review process unless there are reasons to exclude or limit their participation. The degree to which family members are involved will be considered at the first and reviewed at all subsequent meetings of the Serious Case or Lessons Learned Review Panel.

2.3.14 Where it is not advisable or achievable the reasons should be explicitly recorded in the overview report.

Defining the Family:

2.3.15 The 'family' of a child subject to a Serious Case or Lessons Learned Review should be identified. Members should not necessarily be limited to those with Parental Responsibility or blood relatives. The family may for example include foster parents, step parents and other members of a wider family group.

2.3.16 It may be possible / necessary to involve some family members and exclude others.

Suggested Checklist of Limiting Factors

2.3.17 The following should be considered at the first meeting of the Panel to assist the decision making process on whether family members should be involved:

- Where there is criminal investigation or prosecution, and a family member may be responsible for abuse, that person should not be consulted or give information directly to the Panel until the investigation/prosecution is concluded as their involvement may prejudice the investigation/prosecution. If a family member is a witness in an ongoing enquiry, or may be called by the prosecution or defence at a trial, they should not be involved.
- Additionally, exclusion should apply to anyone who there is reason to believe may have allegiance to a suspect or perpetrator and may be tempted to disclose to them information gleaned from the process prior to the finalising of an investigation or trial. Any involvement of a perpetrator or witness in a Serious Case Review that does occur must be reported to the Police/CPS. It is recordable and potentially disclosable.

- Where involvement is likely to complicate any Children Act proceedings and/or put children at risk.
- Where a family member has made a claim or intimated that a claim will be made against one or more agencies in respect of the events that are the subject of the review, or where the family may have a potential claim against one or more of the agencies. In such cases, the Panel will consider any advice received from the insurers or legal advisers of the relevant agencies when deciding on the involvement of family members.
- There may be particular reasons, which will make it exceptionally difficult for family members to respond positively to involvement in the Review due to anger, or distress, which may impede professional exploration of the issues.
- It is an expectation that professional will share information freely although it is recognised it may present difficulties and in these cases a risk assessment should be undertaken
- Preserving confidentiality will become more difficult as the range of those included is widened.

2.3.18 The Overview Panel must consider, and keep under review, the degree to which family members should be involved. It will be important to balance the human rights of family members against the overall objective of identifying ways in which Safeguarding procedures and practice can be improved to benefit all children and their families in Medway.

Options on How to Involve the Family

2.3.19 The following options will apply. Each option could include the stages above. There are legal implications for each of the levels of involvement, but the last four options give rise to the greatest risk of litigation, either from the family, the child or professionals identifiable from the Review report. Update/progress reports to agencies insurers and the CPS at stages throughout the process is strongly recommended and mandatory when options 7 – 8 below are being considered.

- 1 Provide support to the family from agencies as appropriate/requested from the start
- 2 Tell the family that the agencies will investigate what has happened
- 3 Inform the family that a Serious Case Review is to be undertaken and explain the purpose and process

- 4 Return to the family at intervals to inform them of progress
- 5 Request information from the family on their perspective of what has happened
- 6 Provide opportunity for the family to contribute written or verbal views to the review
- 7 Share content of executive summary with the family
- 8 Partial report to be shared with the family – see above on disclosure of contents of report.

2.3.20 When information is provided to a family member, the person or agency providing the information will advise the family member that the information is confidential and should not be shared with third parties.

2.3.21 At the conclusion of a Serious Case or Lessons Learned Review, the Overview Panel should always consider what ongoing support family members may need and seek to provide appropriate services from relevant agencies/organisations.

2.3.22 This involvement of family members in the Serious Case Review process will be kept under review by the QACR Subgroup.

THE OVERVIEW AUTHOR

Commissioning an Independent Overview Author

2.3.23 There is always a choice to be made about whether to appoint an in-house or independent Overview Author (see Bullock and Sinclair, pages 38 & 39). In both cases “independence” is crucial.

2.3.24 Medway Safeguarding Children Board has developed the use of Independent Authors in order to ensure an additional level of independent examination of the inter-agency practice issues that arise in each Serious Case Review. Whilst this clearly has budget implications, the consequent added value has been acknowledged.

2.3.25 Where Lessons Learned Reviews are to be undertaken, a senior member of the Serious Case Review Panel whose agency has had little or no involvement with the case will undertake to compile the final overview Report

Process for Commissioning an Independent Overview Author

2.3.26 The MSCB is developing a register of suitably experienced and qualified people who could be appointed to undertake the role of Independent Overview Author for a Serious Case Review.

2.3.27 These people will need to meet the Person Specification detailed below. They must consent on being entered onto the register of Independent Overview Authors. The MSCB Manager and the Chair of the QACR subgroup will review the register on a regular basis, ensuring that those individuals on the list wish to remain on it.

Person Specification

- i. Minimum of 5 years post-qualifying experience in Child Protection
- ii. Senior management experience in a relevant agency or organisation
- iii. Previous experience of writing SCR Overview Reports and complex reports (examples will need to be seen)
- iv. Considerable experience of chairing multi-agency meetings
- v. Knowledge of current legislation and guidance relating to children
- vi. Excellent interpersonal skills
- vii. Excellent verbal and non-verbal communication skills
- viii. Ability to develop SMART recommendations based upon the analysis of available information
- ix. Ability to work to agreed deadlines
- x. Experience of dealing with the media

2.3.28 In addition, Independent Overview Authors will be asked to provide:

- A written reference from a Senior Manager/MSCB Chair in an authority where they have recently written an Overview Report
- Evidence that their method of working is congruent with the values and principles laid down in this practice guidance (a copy will be provided)
- Enhanced CRB check

2.3.29 In some instances an interview by some representatives of the Serious Case Review Panel may be helpful.

Commissioning Contract

2.3.30 Once the appointment is agreed, a contract outlining terms and conditions will be sent to the candidate. The contract to specify the tasks required i.e. writing of Overview Report and production of Executive Summary.

ROLES AND RESPONSIBILITIES OF THE INDEPENDENT OVERVIEW AUTHOR

2.3.31 The Overview Author will:-

- Be independent of the key agencies that have undertaken the internal management reviews as far as practicable.
- Abide by the terms of reference including making arrangements to seek the view of the parents/carer if agreed
- To arrange a plan of meetings.
- To compile, using the agreed formats :-
 - i. Composite Chronology
 - ii. The Overview Report - See Appendix VII
 - iii. Executive Summary See Appendix VIII
 - iv. Draft Action Plan
- To ensure that the child is known by "his/her" or by an anonymous first name and that the officers involved are appropriately anonymised e.g. Health Visitor 1 in the final version of the Overview Report.
- To ensure the Overview Report & Executive Summary are based on fact and are open, honest and transparent with no suggestion of malice either in the report or in its dissemination. The purpose of the report is to learn lessons and to identify how those lessons can be acted upon.
- To ensure clear, robust, meaningful SMART recommendations are made that will effect service change.
- To send to authors of the internal management reports the draft overview report for comment in respect of accuracy.

- If any additional enquiries arise these to be answered through the author of the Agency Individual Management Reports or other appropriate Officer. The Chair or Panel would not usually be expected to interview officers.
- If further concerns for example, relating to child protection issues arise during the course of the Overview Panels work, The Overview Author will immediately inform the Board, Police & Children's Social Care. The Overview Panel must not investigate.

2.3.32 The final report will be forwarded to the Chair of MSCB who will consider the report and discuss any amendment or clarification required with the Chair of the Overview Panel.

Working Co-operatively with the Overview Author

2.3.33 It is crucial to enable the Overview Author to engage with the local system and processes so they can make sense of the information that is presented to them in the reports from the Individual Management Review Authors. However, it is vital that they also feel able to maintain their independence.

Meetings

2.3.34 Currently Overview Authors are invited to attend the following meetings:

- Briefing for Authors
- Serious Case Review Panel/Lessons Learned Review Panel where reports are presented
- Subsequent meetings of the Serious Cases Review Panel/Lessons Learned Review Panel where draft versions of the Overview Report (usually two) are discussed.

Involvement with Families

2.3.35 There can also be some involvement with families if the latter choose to make representation to the Serious Cases Review Panel via the Overview Author.

INDIVIDUAL MANAGEMENT REVIEWS (IMRs)

2.3.36 Each organisation that is identified as having had involvement with the child (or children) in question is required to undertake an Individual Management Review. The aim of IMR's is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about

2.3.37 Once completed the IMR needs to be signed off by the relevant Director/Chief Executive (or delegated representative) in the organisation.

2.3.38 The aim of IMRs should be to:

- Establish a factual chronology of the action which has been taken within the agency;
- Analyse the involvement of the agency;
- Consider what lessons may be learned from the case about the way in which the agency works to safeguard children and promote their welfare;
- 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 and
- To improve inter-agency working and better safeguard children.

2.3.39 The questions to consider are:

i) What Was Our Involvement with this Child and Family?

Construct a comprehensive chronology of involvement by the agency using the format provided and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference. Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

ii) What do we learn From This Case?

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

iii) Recommendations for Action

What action should be taken by whom, and by when? What outcomes should these actions bring about, and how will the agency review whether they have been achieved? It would also be useful to include any information pertaining to any actions which have already been implemented regarding, for example, any disciplinary processes integrated or changes in single agency policy responses to circumstances.

Please refer to Appendix IV for the standard MSCB format for IMRs which must be followed.

BRIEFING FOR AUTHORS OF INDIVIDUAL MANAGEMENT REVIEWS AND THE OVERVIEW REPORT

2.3.40 The aim of the Authors Briefing is to reach agreement about how best to achieve a well-integrated and coherent Case Review. In reaching such agreements it is important:

- To explain the process, what is expected & when.
- To ensure that authors understand the Terms of Reference for the Case Review. Some fine-tuning may be necessary. It is crucial that the Terms of Reference are meaningful and workable for authors.
- To agree the headings for both the Individual Management and Overview reports using the Terms of Reference and the format guidance in Working Together 2006.
- To ensure that comments made and conclusions reached within all reports are evidenced.
- To raise awareness about the possible need to seek legal advice in the preparation of author's reports.
- To stress the importance of meeting agreed deadlines for the submission of their reports to the SCR Panel.
- To ensure that single agency authors understand the purpose and value of individual presentation of their report to the SCRP.

2.3.41 Additional benefits of the Authors Briefing are:

- All authors meet each other in a supportive, informal environment.
- A face-to-face meeting ensures everyone hears the same message. Confusions/questions/queries can be dealt with on the spot.
- It offers a chance to dispel myths and anxieties about the Case Review process.
- It enables a timetable to be set for the sequential presentation of reports to the SCRP on an agreed day.

TASKS OF INDIVIDUAL MANAGEMENT REVIEW AUTHORS

2.3.42 This is intended as a checklist and is not necessarily sequential.

- i) Identify key staff to be interviewed.
- ii) Advise Senior Managers of this process, the need to release staff and time involved.
- iii) Obtain all relevant records. (Staff may need to be provided with exact photocopies if these are working files.)
- iv) Arrange a briefing for all staff that are to be involved and consult with senior managers about issues to be addressed. (See list in v below and "Communicating with staff" below)
- v) A briefing with staff will address:
 - remit for review;
 - format and recording arrangements for interviews;
 - preparation for interviews and time needed;
 - location (e.g. not at normal place of work);
 - release from usual duties to prepare and participate;
 - support needs;
 - purpose of interview and expectations of interviewee;
 - access to record of individual interviews;
 - access to chronology;
 - the arrangements for access to relevant information from the reports;
 - possible outcomes/debriefing arrangements;
 - confidentiality.
- vi) Arrange interviews and confirm in writing including interview format, profile of interviewee format, terms of reference and

purpose of review. For a suggested interview format, please refer to Appendix VI

- vii) Collect and read all the relevant documentation which gives the context for the professional handling of the case including procedures, guidelines etc.
- viii) Compile a chronology using the MSCB template (please refer to Appendix IV), provided by the MSCB Administrator. Using the template will make it easier to prepare a Composite Chronology and corroborate information provided by each organisation under the headings provided.
- ix) A genogram and pen picture of each child or children will also be required. If this is not done the matter will be referred back to the agency to ask them to comply.
- x) Conduct and record interviews and send report/transcripts to interviewees as soon as possible to identify issues of factual accuracy and any other amendments they consider appropriate. Template will be provided by the MSCB Administrator.
- xi) To produce an agency's review report. The MSCB template must be used. This helps to help ensure that the relevant questions are addressed, and to provide information to MSCB in a consistent format to help with preparing an overview report. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues which need to be explored and the Overview Panel should consider carefully the circumstances of individual cases and how best to structure the review in the light of those particular circumstances.
- xii) Report to be agreed by senior managers of each agency and discussed with staff involved as appropriate.
- xiii) Debriefing meeting with staff involved on completion of the Serious Case Review.

Legal Advice

2.3.43 Authors of Individual Management Reviews should always consider whether they should obtain advice from their own legal advisors on their draft reports before submitting them. Legal advice need never be accepted without challenge. If the content of a report is substantially affected by legal advice this should be stated so that, if necessary the SCRP can consider obtaining a second opinion.

2.3.44 During the course of an individual agency review, the IMR Author may find that legal advice given to the agency is closely associated with significant issues arising from the case. In such circumstances the IMR Author should invite the agency's legal advisers to submit a report to be annexed to the IMR report. Any report dealing with legal issues should be prepared by a lawyer with no direct involvement in the case under review; and, with no involvement in the provision of legal advice about that case to the Serious Case Review Panel.

Sign off

2.3.45 IMR authors must ensure that their reports have been discussed with relevant managers in their own organisation and that the final report is signed off by their Director/Chief Executive Officer (or delegated representative).

2.3.46 Signed copies of finished reports need to be sent to the MSCB Administrator by the agreed deadline, so that they can be circulated to the SCRP.

COMMUNICATING WITH STAFF

2.3.47 It is the responsibility of Individual agencies to inform the staff involved in the early stages of the serious case review process of the terms of reference/parameters of the review.

2.3.48 Individual staff and their managers likely to be involved in the review will be informed by their agency senior managers and should be offered support and advice on the process of the review. Senior Managers will need to take account of the impact of the Serious Case Review process on staff.

2.3.49 Depending on case characteristics some members of staff may require independent counselling support to assist them in coping with the personal impact of the situation.

2.3.50 They should be informed of the need for confidentiality throughout the review period.

2.3.51 Where the review process exceeds the Working Together 2006 recommended timescales affected staff should be kept updated by their managers on the progress of the review

2.3.52 Upon completion of the single agency management review report each agency will need to ensure that staff involved receive feedback and

debriefing in advance of the completion of the overview report of the MSCB.

2.3.53 The findings of the overview report together with what are considered by senior agency managers as relevant extracts of the report (the full report, wherever possible) should be made available to involved and directly affected agency staff prior to the report being presented to the full MSCB meeting.

2.3.54 Neither copies of single agency reports nor the overview report may be given to individual staff members for them to retain.

2.3.55 Case reviews are not a part of any disciplinary enquiry or process, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases (e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard other children.

SECTION 4: COMPLETING A CASE REVIEW

Presentation of Individual Management Reviews to the Serious Case/Lessons Learned Review Panel and Overview Author

- 2.4.1 Once Individual Management Reviews are completed, they are presented to the SCRP in the following way:
- 2.4.2 Completed reports will be circulated to all members of the Serious Case Review Panel and the Overview Author by the MSCB Administrator at least 1 week before the meeting.
- 2.4.3 Key Features of the Presentation Meeting are:
- Individual Management Review authors will present their reports to the SCRP and Overview Author sequentially throughout the day (or two days in very complex cases)
 - Authors are invited to identify the key findings of their work.
 - The meeting provides the Overview Author and the SCRP with an opportunity to engage in a dialogue with Single Agency Management Review Authors in order to “make sense” of issues central to the Case Review
 - It also provides the opportunity to deal with omissions, questions, and queries arising from the different reports or between different reports/chronologies.
 - It is the first point at which key inter-agency practice issues begin to emerge.

WRITING THE OVERVIEW REPORT

- 2.4.4 The core information upon which the Overview Report is based arises from Individual Management Reviews and the discussion of emerging practice issues within the SCRP. The Overview Report is expected to identify any significant discrepancies between those reports or perspectives (in fact or analysis) and seeks to reconcile them through discussion with authors and the SCRP.
- 2.4.5 The Overview Report will be produced using the headings agreed at the Authors briefing session and in line with the standard format provided (Please refer to Appendix VII)- a combination of the format recommended in Working Together 2006 and case-specific issues from the agreed Terms of Reference.

PROCESS OF COMPILING AN OVERVIEW REPORT

2.4.6 The Independent Overview author, on receipt of the IMRs will identify any discrepancies between agency reports as they are received. This will be brought to the attention to the MSCB Manager in order that issues can be addressed without delay.

2.4.7 The Overview Panel will, in conjunction with the Overview Author:

- Establish a factual integrated chronology of the action which has been taken within the agency;
- Consider the agency reviewing officers' reports. Each agency involved will determine what further action is required within their own agency and this will be included in their report and shared with the SCRP;
- Identify the key issues against the format for the overview report.
- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- Analyse how and why events occurred, decisions were made, actions were taken or not. Any examples of good practice should be also be highlighted.
- Translate recommendations into a draft action plan to be considered by the Medway Safeguarding Children Board which must be agreed to at a senior level by each of the organisations that need to be involved. The plan will set out who will do what, by when, and with what intended outcome. Please see below for further details.
- Agree the executive summary of the overview report compiled by the chair, which will provide a summarised and anonymised version of the report for publication on the MSCB website;

2.4.8 When the Overview Author has produced the first draft report, this will normally be presented to the SCRP for discussion and comment. This discussion aims to enable the Overview Author to place his/her analysis in the current context of inter-agency work, thus increasing the likelihood of helpful recommendations for action. The final Overview Report however, should reflect the independent view of the author.

2.4.9 Several drafts may be produced and discussed before the report is finalised for endorsement by the Medway Safeguarding Children Board.

Making Recommendations

2.4.10 SCR Recommendations should be SMART:

Specific	Setting out exactly what should be done.
Measurable	Setting out the result which is to be achieved (how much, how many, how well).
Achievable	The recommendation can be implemented and the individual to whom it is addressed is able and has the authority and resources to do this.
Realistic	Implementing the recommendation is possible in the 'real world' and not just in theory, bearing in mind any existing constraints.
Timed	There is a timescale in which the recommendation is to be implemented.

2.4.11 SMART recommendations should not include multiple tasks. Where there are several aspects to a recommendation these should be separately numbered (1a, 1b, 1c etc). Individual monitoring criteria should be attached to each part.

Responsibilities

2.4.12 Each recommendation made should be addressed to a specific person who has the authority via the management structure to ensure that the required work is carried out. In most cases this will not be the person who will actually do the work; responsibility for this should be allocated internally by agencies during the development of their action plans (see below).

2.4.13 The person to whom the recommendation is addressed will however be held ultimately accountable for work that does/does not take place. When adopting the report it is therefore important that Board members highlight if the wrong person has been selected to attach responsibility to or if they believe what has been requested is unachievable.

The Overview report must be dated and signed by the author

ACTION PLANNING AND IMPLEMENTATION

2.4.14 A good Action Plan will include:

- SMART recommendations

- Confirmation that the recommendation has been agreed at the appropriate level in the agency
- Clear and precise action to be taken in order to implement the recommendation
- Who is responsible for ensuring that each Action happens
- The timescale for completion of each action point
- With what intended outcome
- By what means improvements in practice/systems will be monitored and reviewed
- Signing Off arrangements – whether the action has been taken and completed
- The MSCB Action Plan template below will be used in the Individual Management and overview reports

RECOMMENDATION	ACTION What are we going to do?	BY WHOM Who is going to do it?	OUTCOME What do we intend to achieve?	MONITORING What has been achieved?	ASSESSMENT How is your agency meeting these recommendations? (Traffic light here)

2.4.15 On receiving an Overview Report, the MSCB should:

- Clarify to whom the report, or any part of it, should be made available;
- Disseminate the report or key findings to interested parties as agreed. Make arrangements to provide feedback and de-briefing to staff, family members of the subject child and the media, as appropriate;
- Agree any urgent action arising from the serious case review which requires immediate action;
- In the case of a serious case review, provide a copy of the overview report, action plan and individual management reports to Ofsted and the DCSF.

Audit and Monitoring

2.4.16 Monitoring of the action plan produced from the overview report and agreed by the MSCB will be undertaken by the QACR Subgroup reporting back to MSCB.

2.4.17 Any areas of inter-agency activity identified as of particular concern may also be referred for consideration by the performance monitoring subgroup as a potential area for future audit and research.

THE EXECUTIVE SUMMARY

2.4.18 The Executive Summary is short, anonymous, and based on the Overview Report. This is a public document (Working Together 8.33).

2.4.19 Its primary purpose is to inform a wider population of the organisations involved and family members of the key elements in the Case Review, namely:

- The purpose and scope of the Case Review
- An outline of the Review Process, including the organisations involved in providing information.
- A brief outline of the circumstances that led to a Case Review.
- A succinct account of inter-agency practice issues identified
- Intended actions

2.4.20 The Executive Summary can be used in the following way:

- A demonstration of the way in which the MSCB has exercised its responsibilities in relation to death or injury of child/children.
- A basis for press briefings should the Case Review process attract media attention.
- An efficient means of informing Chief Officers and the inter-agency practice community of key learning arising from the review of practice.
- Core information upon which to build more elaborate case specific training materials.

2.4.21 The DSCF biennial analysis of serious case reviews 2003-2005 (DCSF 2008) recommend the following items should be included in Executive Summaries to achieve a greater depth of learning:

- Anonymised name or initials of the child, and age at the time of the incident;
- The serious case review process – brief outline of the purpose and scope of the review and terms of reference;
- Reasons for conducting the review and what SCR criteria were met (or if the criteria were not met the reason for conducting the review);
- Brief case summary to include details of incident, kind of maltreatment, who was believed to be responsible for the abuse;

- Family background (including anonymised details of members of the household in which the child was living, or otherwise relevant persons with ages if possible). Potentially identifying details need to be restricted to the Overview Report.
- Context of ages involved and resourcing (eg staff absence/vacancies etc);
- Key recommendations indicating the resource implications (time/human resources, services) or action plan;
- Key themes and lessons learnt

2.4.22 The Executive Summary is completed by the overview author. A draft should be circulated to the SCRP for comment before final endorsement by the MSCB Management Group. Copies of all reports should be marked as draft until the report is approved by the MSCB.

RETENTION OF PAPERS

2.4.23 The sensitive nature of information contained within Individual Management Reviews and the Overview Report must not be underestimated. There is a balance to be kept between sharing information widely in order to increase participation, ownership and learning, and the appropriate management of personal and professional detail.

2.4.24 The following practice will, in most instances, minimise the chances of inappropriate disclosure.

1. SCRP Members will:

- Treat all papers relating to the SCRP's work as confidential
- Keep papers locked and secure during the process of a Case Review.
- Retain a single copy of the Overview Report.
- Will destroy all other papers.

2. Each MSCB partner organisation will:

- Make arrangements for the secure retention of a single copy of their own Individual Management Reviews and the Overview Report
- Ensuring that all draft copies of the Overview Report are returned to the MSCB for shredding.

3. The MSCB Administrator responsible for the SCRP will:

- Retain copies of all papers associated with a Serious Case Review for a period of 10 years.

- Provide access to papers through application to the Chair of the LSCB.
- Mark copies of all Overview Reports as draft until the report is approved and arrange for draft reports to be returned to the MSCB and destroyed.
- Retain a copy of the final overview report and action plan

FINALISATION AND ADOPTION OF THE OVERVIEW REPORT & TRANSLATING THE OVERVIEW RECOMMENDATIONS INTO A WORKABLE ACTION PLAN

2.4.25 The Overview Report and Integrated Chronology need to be formally adopted by the Medway Safeguarding Children Board. This will be preceded by a formal presentation of the report by the Chair of the SCR to the Board.

Action Plan

2.4.26 A central purpose of the adoption meeting is to secure MSCB ownership of an achievable action plan, based on the Overview Report recommendations. QACR subgroup to agree timescales to attach to the agreed action plan.

2.4.27 Once the MSCB has adopted the report and its recommendations; it is sent to all those involved for implementation.

2.4.28 Once agreed, the action plan will form part of the current MSCB Business Plan and be subject to regular review.

OFSTED and DCSF

2.4.29 Once adopted, the following documents must be sent to the OFSTED and DCSF.

- Individual Management Reviews, including the chronology, and recommendations
- The Overview Report
- Integrated Chronology
- MSCB Action Plan
- Executive Summary

The Role of MSCB members

2.4.30 When Board members receive their copy of the SCR they are responsible for:

- Reading the information and gaining from their own perspective an understanding of: the key facts of the case, the key themes and findings, the roles individual agencies played in the case and the implications of the case for inter-agency practice. They should come to the Board meeting prepared to discuss this.
- Communicating about the SCR and its recommendations in their organisation prior to Board meeting to ensure they are aware of potential issues from an operational level which may make implementation difficult. N.B. The SCR is a confidential document and at this stage has not yet been endorsed by the Board therefore members should use their discretion in doing this – copies of the **draft** Report should not be made and electronic versions not made available to others. (Once the Report has been adopted and a finalised version distributed, agency representatives may share the Report as outlined in the guidance provided).
- At the Board meeting, adopting the Report and recommendations. They should do this on the basis that they have read and understood the recommendations, **the guidance on their implementation, the timescales set for this** and the implications of this for the agencies they represent.

2.4.31 By adopting the recommendations members are committing their organisations to their implementation. Therefore should they foresee any reasons that would prevent the implementation of the recommendations in the manner requested they should raise these. If these matters are not resolvable at the meeting it may require further work to be undertaken on the Report prior to achieving final Board sign off, in which case it would need to come back to a future meeting. Alternatively the Board could agree to adopt the report subject to further work being undertaken and then receiving a report on this.

2.4.32 In situations where Board members do not feel able to sign off recommendations as they are presented to them it is their responsibility to suggest what changes are required.

2.4.33 Following the adoption of the Report, Board member agency Chief Executives will be sent a finalised copy of it. An accompanying letter from the MSCB Chair will formally advise them of the key facts of the case, of the Report's recommendations, and will request their implementation. Those representing the agencies on the Board (when this is not the Chief Executive) and others such as staff in designated posts will also receive copies. **Board representatives are responsible for tracking the progress of recommendation implementation within their agencies and for ensuring reports are provided back to the Board when requested.**

2.4.34 (Copies of the Report will also be sent to other agencies who had a role in the case who may not be Board members such as agencies from other areas).

2.4.35 In addition to other monitoring activity approximately two years following the adoption of each report the Board will request relevant agencies to provide an overview of whether the desired outcomes of the recommendations have been achieved (see detail below). Board Members will be responsible for reporting this information from their agencies and for contributing to the evaluation of the Report's overall impact.

2.4.36 NB: Reports containing recommendations for agencies who are not Board Members:

Recommendations may be made for organisations (such as community / faith organisations) which are not specifically represented on the MSCB. In this case the SCR Panel and MSCB Manager must consult with them about the recommendations and obtain their views and sign off in the same way as they would with Board members. This should be done prior to the Board meeting where the report is signed off.

SECTION 5. MONITORING THE IMPLEMENTATION OF RECOMMENDATIONS FROM A CASE REVIEW

Agreed Actions Arising from the Overview Report:

2.5.1 The MSCB Quality Assurance and Case Review Subgroup, which meets every 6 weeks, will be responsible for monitoring the implementation of actions arising from the Overview Report. Recommendations form part of the MSCB Business Plan. The MSCB will be updated on progress on a regular basis.

Agreed Actions Arising from the Single Agency Management Reviews:

2.5.2 6 months from the date that the Overview Report is adopted/endorsed by the MSCB, the relevant MSCB representatives whose organisations have produced Individual Management Reviews will give an update to the MSCB QACR subgroup on the implementation of those single agency recommendations, in particular, highlighting progress, difficulties and delays.

Training Subgroup:

2.5.3 There is an explicit link to the Training Subgroup to ensure that learning and action points from Case Reviews inform plans for future training, key manager's/practitioner's seminars and other staff development.

PART THREE: LEARNING FROM SERIOUS CASE REVIEWS

LEARNING FROM SERIOUS CASE AND LESSONS LEARNED REVIEWS- A STRATEGY FOR LEARNING AND SUPPORT

"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)

Learning Lessons Nationally

3.1.1 Taken together, child death and serious case reviews should be an important source of information to inform national policy and practice. The DCSF is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF will commission overview reports at least every two years, drawing out key findings of serious case reviews and their implications for policy and practice. It is considering how best to disseminate the findings from the work of the local child death overview teams.

Learning Lessons Locally

3.1.2 The focus of Serious Case and Lessons Learned 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 have not changed over the 30 years that such inquiries have been undertaken. This is despite the development of a sound legislative framework and the refining of policies and procedures. These developments led the Victoria Climbié report to conclude that the current gap in safeguarding is not a matter of law but of its interpretation. The protection of Victoria required "nothing more than basic good practice being put into operation".

3.1.3 To maximise the benefit from the review process, it is suggested that:

- As far as possible, the review should be conducted in such a way that the process is a learning exercise in itself, rather than a trial or ordeal;
- Consider what information needs to be disseminated, how, and to whom, in the light of a review. Be prepared to communicate both examples of good practice and areas where change is required;
- Focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes; primary care trusts (PCTs) should seek feedback from

the strategic health authority, who should use it to inform their performance management role;

- The MSCB should put in place a means of auditing action against recommendations and intended outcomes;
- Seek feedback on review reports from Ofsted, who should use reports to inform inspections and performance management.

3.1.4 Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- Establish a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed;
- Have in place clear, systematic case recording and record keeping systems;
- Develop good communication and mutual understanding between different disciplines and different MSCB members;
- Communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies;
- Make sure staff and their representatives understand what can be expected in the event of a child death / case review.

3.1.5 The lessons to be learned from Serious Case and/or Lessons Learned Reviews are to be collated annually by the MSCB Manager and the results of this exercise are to be reported to the MSCB and disseminated to partner agencies.

3.1.6 The progress of the agreed MSCB Action Plan will be monitored by the MSCB through the QACR Subgroup, who will report quarterly to the MSCB on progress against actions. The update of Action Plans will be undertaken quarterly by the MSCB Manager.

3.1.7 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.

3.1.8 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. This document aims to set out a way of helping us to learn from serious case reviews through active multi agency engagement.

3.1.9 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)

Case Studies

3.1.10 Case studies will provide a summary of the SCR process and offer an anonymised account of the case. These will list key recommendations, with questions to consider when using the case study. They are aimed to be used in single/inter agency training, practice development groups or other fora. When agreed the case studies should be widely disseminated and briefings offered for those trainers who will be using these on a single agency basis

3.1.11 The MSCB may wish to consider evaluating their use by requesting single agency reports on the outcomes of any training provided.

De-briefings for those specifically involved in cases where a SCR has taken place:

3.1.12 Following adoption/endorsement of the Overview Report and the development of an Action Plan, practitioners directly involved in the case will be invited to a de-briefing meeting.

3.1.13 The purpose is to:

- Give feedback on the Overview Report, Recommendations, Action Plan and messages for learning from these, in advance of dissemination to the wider system
- Where possible, a member of the SCR panel and a member of the Training subgroup will be present in order to offer further clarification of practice issues arising from the Case Review.

3.1.14 For the purposes of the meeting, those attending will be sent a hard copy of the Overview Report in advance. This will be handed back to the MSCB Officer at the end of the meeting.

Aims:

- Involvement: to appropriately involve all practitioners dealing directly with the case.
- Clarification: this is an opportunity to clarify and discuss the Case Review process and its purposes. It is a highly anxious time for practitioners when there may be ongoing work with a family:

juggling ongoing operational issues and being open to the perceived scrutiny of a Case Review process, being interviewed by the Single Agency Management Review author etc.

- **Participation:** it provides the opportunity to meet other professionals who are in the same boat and also to discuss their often-differing experiences within their agency. For example: support, sealing files, reactions/responses from colleagues.
- **Support:** Some practitioners are well supported through the intense scrutiny of their practice by their own organisation. Others may seek outside, independent support. The briefing would aim to be supportive to practitioners and discuss support available
- **Learning:** To discuss the recommendations and learning from the case and any implications for practice

It is not appropriate to discuss operational issues in this meeting

The briefing will last approximately 2 hours and cover the following areas:

- General issues relating to SCR's (as outlined in Working Together)
- The process of a SCR
- The issues specific to the case review (as outlined in the terms of reference)
- Clarification of any questions or queries that the practitioners may have.

Practitioner Briefings about the outcomes of SCRs

3.1.15 These briefings would be available to a wider audience and use the material prepared in the case study (if available)

Aims:

- **Clarification:** to clarify and discuss the Case Review process and its purposes
- **Participation:** to provide the opportunity to meet other professionals to discuss how agencies can best work together to safeguard and promote the welfare of children.
- **Learning:** To discuss the recommendations and learning from the case and any implications for practice

It is not appropriate to discuss operational issues in this meeting

3.1.16 The briefing is usually facilitated by a member of the SCR panel; and the Training subgroup. The briefing will last approximately 2 hours and cover the following areas:

- General issues relating to SCR's (as outlined in Working Together)
- The process of a SCR
- The issues specific to the case review (as outlined in the terms of reference)
- Clarification of any questions or queried that the practitioners may have.

Briefings for managers

3.1.17 These briefings will use the overview report/case study and aim to offer:

- **An opportunity for managers to discuss learning from the case**
- **Promote shared responsibility for practice development**
- **Build a culture of learning in organisation**

Appendix I



**SCR/REF/M08
REFERRAL FORM CONSIDERATION FOR A SERIOUS CASE REVIEW**

Section 1

Section 1 to be completed within 72 hours of incident by referring officer following discussion with line manager/designated Child Protection professional, where appropriate. Please refer to Working Together 2006 and Kent & Medway Safeguarding Children Procedures, Module 14: email: mscb@medway.gov.uk.

1.1 Referrer Details

Name	
Position	
Agency	
Contact Details	
Line Manager	
Is your Line Manager aware of the referral?	Yes <input type="checkbox"/> No <input type="checkbox"/>

1.2 Child Details

<u>Name</u>	
Date of Birth (dd/mm/yyyy)	
Date of Death (if appl.) (dd/mm/yyyy)	
Home Address	
Ethnic Origin	
Religion	
Does the child have any special needs or a disability? If yes, please specify:	Yes <input type="checkbox"/> No <input type="checkbox"/>

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Educational Establishment	
Does the Child have any Special Educational Needs? If yes, please specify:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the child subject to a Child Protection Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>

1.3 Family Details/Significant Others

<u>Name</u>								
<u>Relationship to the child</u>								
Date of Birth (dd/mm/yyyy)								
Address								
Legal Status/ Criminal Proceedings								
Ethnic Origin								
Religion								
Do any of the above (including parents) have special needs or a disability? If yes, please specify:	Yes <input type="checkbox"/>		No <input type="checkbox"/>					
Have any of the above been or are currently subject to a Child Protection Plan? If yes, please specify:	Yes <input type="checkbox"/>		No <input type="checkbox"/>					

1.4 Other Agencies Involved

Agency			
Officer			
Position			
Contact Details			
Are they still involved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

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1.5 Circumstances Triggering Referral

	Please tick
Death of Child and abuse or neglect is known or suspected to be a factor in the child's death	
Potentially life threatening injury, serious sexual abuse, or serious and permanent impairment of health or development [through abuse or neglect]	
The parent has been murdered and a homicide review is being initiated	
The child has been killed by a parent with a mental illness	
Concerns about inter-agency working	

1.6 Events & Circumstances Relevant to Referral Category

Where was the child at the time?	
Who was the carer for the child at the time?	
What was the legal status of the child at the time?	

1.7 Details of the Incident or Concern that Lead to Referral

(See guidance at the end of this form)

1.8 Chronology of Key Events

Date (& time where appropriate)	Event										
Signed											
Date (dd/mm/yyyy)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>										

1.9 Other Matters of relevance

[Please include any matters which the Panel should be aware of when making a recommendation]

Appendix I

Section 2

(To be completed by MSCB Screening Panel Chair)

2.1 Screening Panel Meeting

A screening panel meeting was held on									
---------------------------------------	--	--	--	--	--	--	--	--	--

2.2 Recommendation

A Serious Case Review is:	Recommended <input type="checkbox"/>	Not Recommended <input type="checkbox"/>
Please state the reasons of the panel for this decision:		

Where a Serious Case Review is not recommended please complete Section 2.3

2.3 Other Reviews Options

	Please tick
A Lessons Learned Review	
A Multi-Agency Review	
A Single Agency Management Review	
A Multi-Agency Training Event	
Alternative Process Suggested by the Nature of the Case	
No Action	

The following members of the Serious Case Review Panel have been consulted:	
Has legal advice been Sought?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Signed	
Date (dd/mm/yyyy)	

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Section 3

(To be completed by MSCB Chair)

3.1 Decision

My decision is that the case should be subject to the following:

	Please tick
A Serious Case Review	
A Lessons Learned Review	
A Multi-Agency Review	
A Single Agency Management Review	
A Multi-Agency Training Event	
Alternative Process Suggested by the Nature of the Case	
No Action	

3.2 Issues

The following issues are of particular significance:	
--	--

3.3 Overview Report

I recommend that _____ be approached to write the overview report.									
Signed									
Date (dd/mm/yyyy)									

Appendix I

Section 4

(To be completed by the Chair of the Serious Case Review Panel)

4.1 Scope of Review

The Serious Case Review Panel met on:									
The terms of reference and scope of the review is set out:									
Signed									
Date (dd/mm/yyyy)									

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Section 5 - Guidance for completing this form

5.1 General

<p>The objective of this form is to convey as much information that is readily available at the time of completion. If information is unavailable <u>do not delay</u> in making this referral. Additional facts can be made later.</p>	
<p>Advice and support in completing this form can be found at MSCB offices contactable as follows:</p>	<p>e-mail: mscb@medway.gov.uk Website: www.mscb.org.uk Tel: 01634 336329 Fax: 01634 331484</p>

5.2 Completing the critical incident summary (see Section 1.7)

- Were there any historic, retrospective concerns or clear evidence of a risk of significant harm to a child within the previous 4 weeks, which was:
 - not recognised by organisations or professional in contact with the child or perpetrator *or*
 - not shared with others *or*
 - not acted upon appropriately?
- Was the child killed by a mentally ill parent?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre, YOI, STC, Children's Home or Armed Forces Training establishment)?
- Did the child die in a custodial setting (YOI, Prison or STC)?
- Was the child abused while being looked after by the local authority?
- Did the child commit suicide, or die, while absent having run away from home?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of this case?
- Was the child subject to a child protection plan or had it been previously the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or

Appendix I

professionals?

- Does the case suggest that the MSCB may need to change its local protocols or procedures, or that protocols and procedures are not adequately being promulgated, understood or acted upon?

Appendix II



SCOPING DOCUMENT

Serious Case/Lessons Learned Review

Name of Child:
Date of Birth:
Date of death:
Date of critical incident:
Home address:
Educational Establishment
Ethnic origin:

Family Composition/Significant Others

Name	Relationship to child	DoB	Address	Ethnic Origin

Background information

(should be taken from the SCR/Ref/M08 form)

Terms of Reference

Individual Management Reports should address the following issues (these are examples and not an exhaustive list – each case will be unique):

1. Establishing the facts of the case.
2. This should include a focus on:

The Child

- Child development needs: health, education, family and social relationships
- The nature of any injuries up to and including the incident under review.
- Significant events

The Mother

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- Her recent and previous ante and post natal care (in respect of her children***** and any other pregnancies)
- Her physical, emotional and mental health
- What is known of her wider family and social context, including parenting capacity and environmental factors

The Siblings

- Child development needs: health, education, family and social relationships

The Father

- His physical, emotional and mental health
- What is known of his wider family and social context, including his parenting capacity and environmental factors?

The Framework for the Assessment of Children in Need provides a systematic basis for collecting and analysing information.

3. Information gathering, assessment of need and decision making by the agencies involved, from the time that ***** and ***** were deemed by ... to be Children in Need
4. Whether Child Protection Procedures were followed.
5. The inter-agency information sharing and decision-making up to and including the Child Protection Conference on *****.
6. Any cross border issues.
7. Are any of the agencies aware of any resource issues that may have affected their ability to respond appropriately to this family?
8. Any other information that appears relevant to the review.
9. Authors are invited to make comment on the learning that this case might have generated that needs to be reflected in the newly endorsed MSCB Unexplained Deaths Protocol

Formats of Reports and Chronology

The required report format and chronology can be found in MSCB's Serious Case Review Procedures and Practice Guidance (which can be downloaded at www.mscb.org.uk in appendices 4 and 5 is to be used by all report writers and preferably emailed as an excel document to MSCB Administrator Steve Dickens to collate. All report authors must complete a genogram of the family.

Chair MSCB Case Review Panel

Appendix III

CRITERIA FOR APPOINTING AN INDIVIDUAL MANAGEMENT REVIEW (IMR) AUTHOR

"Who should conduct Reviews?"

Each relevant service should undertake a separate management review of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual agency. Relevant independent professionals (including GPs) should contribute reports of their involvement.¹

- a) You must appoint as your Author a person of sufficient seniority to be able to work at all levels within your agency. The Author must be fair in the way that the views of staff are represented. The Author you appoint 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.
- b) The Author will have had no significant involvement in the case under review and should not be the direct line manager of their agency representative on the SCR. P.
- c) The Author prepares the report for your agency and is accountable to the Chief Officer for the quality of the report. The report is submitted as an agency report.
- d) The Author acts as the representative for your organisation in its interface with the SCR. P.
- e) The Author should have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the Author will wish to interview staff who are central to the case. Staff who wish to be interviewed should be offered this opportunity by the Author. Such interviews should be allowed.
- f) The Author must ensure that the relevant staff of your agency are informed of the purpose of the Individual Management Review and the process leading to the Serious Case Review. This letter can be copied and circulated as part of this task.
- g) The Author should ensure that all files relating to (child's name) are secured, preferably under lock and key, to ensure information is not lost. The Author should be empowered to demand appropriate security measures are taken. If the case remains open then a full copy

¹ Taken from Working Together 2006 – Section 8.18.

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of the file should be taken and the original file secured. All files should be made available to the Author.

- h) The Author shall identify and indicate the location of all files relating to (child's name) and make these files available to the Chairperson of the SCR on request.
- i) The compilation of the Individual Management Review report will create a significant extra workload. It is important that agencies support members of their staff who are required to contribute to SCRs. The Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the Individual Management Review report within the **strict time scale**. The Author should receive appropriate clerical support throughout. You will appreciate it may be necessary for the Author to be relieved of all their normal duties for the period the Individual Management Review report takes to compile.

Appropriate extracts of the IMR should be shared with workers involved with the case to ensure the report is factually correct prior to submission.

Your report on (child's name) must be submitted by (date).

Meeting dates for the Serious Case Review Panel have already been set and senior managers from all agencies are represented. If your Individual Management Review report is not received within the prescribed timescale, the work of the panel cannot proceed. This will result in the MSCB having to specify to the Commission for Social Care Inspection why the report has been delayed further.

Appendix IV

TEMPLATE FOR INDIVIDUAL MANAGEMENT REVIEW (IMR)



STRICTLY CONFIDENTIAL

SERIOUS CASE/LESSONS LEARNED REVIEW – (NAME OF CHILD)

INDIVIDUAL MANAGEMENT REVIEW REPORT OF

(name of agency)

**PREPARED FOR THE
MSCB SERIOUS CASE REVIEW PANEL**

AUTHOR: Name:

Post:

Address:

Tel No.:

Date

Appendix IV

1 INTRODUCTION

1.1 Reason for the review

1.2 Terms of reference

1.3 Contextual Information

In considering this aspect of the case, the Report writer needs to decide whether the context in which the case was conducted impacted on decisions made and if so such information need only be included in so far as it is relevant to the actions of the organisations concerned.

In addition to interviews with staff and examination of agency files, the Panel will examine contextual information supplied by IMR authors in order to fully understand the circumstances of the case to make the appropriate recommendations for change.

The type of information that would be useful is as follows.

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organisational change
- Unallocated cases
- The social and community context
- Management and Supervision
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal Advice

This is not an exhaustive list and there may be other contextual factors that Reviewing Officers would wish to include.

1.4 Methodology

To Include:

- a) How the agency carried out the review.
- b) Details of documents seen.
- c) List of interviews and dates.
- d) Details of information not available/not considered (with reasons).
- e) Details of how agency staff were kept informed of the purpose and process of the Individual Agency Review.
- f) Details of staff involved by name and job title for the benefit of the Panel only. The overview report will be completely anonymised.
- g) Were you given sufficient time to complete the task?

Appendix IV

2 FAMILY INFORMATION

2.1 Family Composition and genogram

2.2 Summary of family background and circumstances

To include:

- a) Relevant chronological history (in narrative form) on child, family and any significant others which could have a bearing on the case under review e.g.:
 - data on present and past relationships;
 - marriages;
 - children and home circumstances;
 - adult's own childhood;
 - existence and definition of violence within family;
 - existence of and definitions of violence towards people outside of family;
 - relationships with extended family and the local community.
- b) Further amplification of relevant facts in terms of contextual information
- c) Other relevant information to be appended:-
 - Child Protection Conference Minutes
 - Planning or Review Meeting Minutes
 - Criminal antecedents
 - Growth Assessment Charts
- d) Details of the agencies internal child protection procedures. Copy to be attached.

3 ANALYSIS OF INVOLVEMENT

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

- How did agencies work together? Please comment as necessary.
- What problems were experienced in the preparation of the report?
- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had concerns about a child?
- Did the agency have in place policies and procedures for safeguarding children and acting on concerns about their welfare.
- Were the internal child protection procedures appropriate?
- Were the decisions and actions taken in line with policies and procedures within the agency?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

Appendix IV

- Were actions in accordance with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child/ren)'s wishes and feelings ascertained and considered? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers, or other agencies and professionals, involved at points where they should have been?
- Was the work in this case consistent with agency and MSCB policy and procedures for safeguarding children and wider professional standards?

4 RECOMMENDATIONS

Recommendations in IMRs should pertain to your agency, as well as to inter agency practice. These must be SMART (Specific, Measurable, Achievable, Realistic and Timely) and should include:-

- a) What changes (if any) could be made to your agency's child protection procedures?
- b) What changes (if any) could be made in inter-agency working in the light of this case?
- c) What action within the agency should be taken in the light of its findings?
- d) What areas of good practice are there? Could these be expanded?
- e) What action should be taken by whom and by when?
- f) What outcomes should these actions bring about?
- g) How will the agency review whether they have been achieved?

Signatures required on completed report.

Author of IMR

Head of Agency

Date

Date

Appendix V

Chronology Contents

<u>Date</u>	<u>Time</u>	<u>Child/Family Member</u>	<u>Professional Eg Health Visitor/Social Worker</u>	<u>Significant Events/Incidents and if child seen</u>	<u>Agency</u>	<u>Management Review Officer's Comments Including good practice</u>

Appendix VI

Interview Format

It is suggested that it may be helpful for Authors to use the following format when conducting interviews in the process of compiling the IMR.

DETAILS OF CONTRIBUTOR (to be completed as a preamble to the discussion on the case)

Full name:

Qualifications:

Designation:

Time in post:

Employing Body:

Employing Address:

Home Address:

(where appropriate)

Previous Employment:

Employer Dates Posts held

Description of role in relation to particular case:

MATTERS TO BE COVERED IN INTERVIEWS (to be used in conjunction with the chronology of the case to check facts, to discuss the contributor's specific participation and the time scale of their involvement). Explore with the contributor:-

- their knowledge of the history of the case, the child(ren) and family prior to the individual's involvement;
- their specific involvement in the case;
- their knowledge of the agency's policy and procedures in relation to child care and child protection;
- their knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to CP conferences;
- the methods used to relate to and communicate with other professionals in the case;
- the individual's record keeping;
- the supervision the individual received;
- the individual's feelings about the case, the carer or child and how those feelings were dealt with in supervision;
- the range of training both within and outside the agency in the last two years;
- whether the agency can learn lessons from the experience;
- looking back, what the individual would now do differently;
- what lessons the individual can learn from the experience.

Appendix VI

Following the interview, it is suggested that the Author write an interview summary, a copy of which should be handed to the interviewee who, if in agreement, should sign both copies. Where there is disagreement on the content of the summary, this should be identified and noted.

The interview summaries are not required by the Panel but are purely to assist in the preparation of the IMR and may be shredded at the end of the process if desired.

Appendix VI

Guidance notes for completion of Detailed Factual Chronology (appendix 5) as part of the Individual Management Review (appendix 4)

The purpose of using the supplied Excel spreadsheet to compile a detailed chronology is to enable a summary of key events in each agency's involvement with a child so that the Overview Author may consider these either separately or merge the documents in order to compare other agencies' activities on one 'timeline'.

It is therefore very important that the author of the IMR, is cited on the definitions of the table headings and ensures that the document is written in this format so that all IMR formats are the same. The decision as to what is relevant or appropriate is a decision for the author but completion of the form should compliment guidance found on the Standard Format for Completion of IMR's (Appendix IV)

Electronic blank copies of the spreadsheet are available for completion from the MSCB Administrator

Date / Time: This should be completed in the format **dd/mm/yy**. In cases where only the month and year are known but no specific day, please enter '01' as the day.

Agency: This should be the agency responsible for the record which is being reported, e.g. in the case of a police IMR, the author would write 'Police'. The IMR author should be consistent in the way this is written throughout the report, i.e. not change to other terms or cases, such as 'POLICE' or 'CIAU'. If there are more than one IMR from the same agency (e.g. different facets of 'Health') then this will be picked up by the Author of the Overview report and appropriate titles given to reflect the difference.

Significant Events: This section should include a very brief overview of all the significant events in the IMR agency's involvement with the child or family. It will include the following as a guide:

- Initial referrals and subsequent referrals received
- Visits of note
- Key decisions made about care plans / agency action.
- Noted changes in family structure / context
- Occasions where other agencies were requested
- Noted variations in the presentation of the child or family
- Concerns noted by the agency
- How the Child presented, to include any relevant information about noted child demeanour, injuries or illnesses.
- The child's view if applicable.

Appendix VI

It will also include anything else that the author considers as significant, often unique to each agency e.g. housing move, arrests, school reports etc.

Response: What agency decisions about care plans, investigations etc. were made and what actions were taken on or immediately after the reported event. Were referrals made to another agency?

Appendix VII

TEMPLATE FOR SERIOUS CASE/LESSONS LEARNED REVIEW OVERVIEW REPORT



STRICTLY CONFIDENTIAL

SERIOUS CASE/LESSONS LEARNED REVIEW – (NAME OF CHILD) OVERVIEW REPORT

**PREPARED FOR THE
MEDWAY SAFEGUARDING CHILDREN BOARD**

AUTHOR: Name:

Post:

Address:

Tel No.:

Date

Appendix VII

1 Introduction

- Summarise the circumstances that led to a review being undertaken in this case
- State Terms of Reference of the Case Review
- List contributors to the review and the nature of their contributions (e.g. management review by LA, report from adult mental health service).
- List SCRP members and author of overview report

2 Facts

- Prepare a genogram showing membership of family, extended family, and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant agencies, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen and the child's views and wishes sought or expressed.
- Prepare an overview which summarises what relevant information was known to the agencies and professionals involved, about the parents/carers, any perpetrator, and the home circumstances of the children.

3 Analysis

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

4 Conclusions and Recommendations

This part of the report should summarise what, in the opinion of the review panel, are the lessons to be drawn from the case and how those lessons should be translated into recommendations for action. Recommendations should include, but not be limited to, the recommendations made in individual agency reports. Recommendations should be few in number, focused and specific, and capable of being implemented.

The SCRP to be involved in discussion with the report writer on the wording of recommendations, the rationale and desired outcomes. This discussion to involve representatives from the Training and QACR subgroups and the Chair and Vice Chair of the QACR subgroup. Recommendations will be made using SMART principles (see NSPCC (2004) Safeguarding Through Audit framework for further details)

If there are lessons for national, as well as local, policy and practice these should also be highlighted.

Recommendations from Single Agency Management Review Reports

These should be included as an appendix to the Overview Report. These must have been discussed with relevant managers in their own organisation

Appendix VII

and that the final recommendations are endorsed by the relevant Director/Chief Executive Officer (or delegated representative) of the agency.

The Overview report must be dated and signed by the author

Author of Report

Date _____

Appendix VIII

TEMPLATE FOR EXECUTIVE SUMMARY



STRICTLY CONFIDENTIAL

SERIOUS CASE/LESSONS LEARNED REVIEW – (NAME OF CHILD)

EXECUTIVE SUMMARY

**PREPARED FOR THE
MEDWAY SAFEGUARDING CHILDREN BOARD**

AUTHOR: Name:

Post:

Address:

Tel No.:

Date

Appendix VIII

Introduction

- Anonymised name or initials of the child, and age at the time of the incident;
- Family background (including anonymised details of members of the household in which the child was living, or otherwise relevant persons with ages if possible). Potentially identifying details need to be restricted to the Overview Report.
- Review process – brief outline of the purpose and scope of the review and terms of reference;
- Reasons for conducting the review and what SCR criteria were met (or if the criteria were not met the reason for conducting the review);

Summary of case

- details of incident, kind of maltreatment, who was believed to be responsible for the abuse/incident;
- Context of ages involved and resourcing (eg staff absence/vacancies etc);
- Key themes and lessons learnt

Conclusions and Recommendations

- Key recommendations indicating the resource implications (time/human resources, services) or action plan;

Notification of serious childcare incident

Please use this form to record the details of any serious childcare incident that must be notified to the Secretary of State. The completed form should be returned **by post** to Ofsted’s National Business Unit, Royal Exchange Buildings, St Ann’s Square, Manchester, M2 7LA. However, in urgent situations, particularly if there is significant media interest, telephone us on 08456 404040 and then complete and return this form.

1. Notifier details

Local authority		Name	
Role		Telephone number	
Date notified (dd/mm/yyyy)		Linked cases	

2. Reason for notification (more than one box may be ticked)

Serious case review confirmed	Death or serious injury to a child where a child protection issue is likely to be of major public concern. (<i>Working together to safeguard children</i> , Chapter 8.)	<input type="checkbox"/>
Serious case review possible but not yet confirmed	Death or serious injury to a child where a child protection issue is likely to be of major public concern. (<i>Working together to safeguard children</i> , Chapter 8.)	<input type="checkbox"/>
Death of a looked-after child	Children Act 1989 Schedule 2 paragraph 20(1)(a) National Minimum Standards for Children’s Homes, Standard 20; Children’s Home Regulations 2002, Regulation 30, Schedule 5; Fostering Services Regulations 2002, Regulation 43, Schedule 8.	<input type="checkbox"/>
Death or serious harm to a child in a children’s home	Children’s Home Regulation 19 (2) (a) and (c) National Minimum Standards for Children’s Homes; Children’s Home Regulations 2002 Schedule 5; Fostering Services Regulations 2002, Schedule 8	<input type="checkbox"/>
Serious harm to a child	As above	<input type="checkbox"/>
Conduct of a member of staff	(Please provide details on a separate sheet)	<input type="checkbox"/>

3. Child details

Child’s last name(s)		Child’s forename(s)	
Other names used		Child’s date of birth (dd/mm/yyyy)	
Age (if no DOB known)		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Parents’ names		Siblings’ names and ages	

Family note to identify key family relationships, e.g. step parents, cohabitees, including information about who is resident with the child:

Ethnicity We collect this data for monitoring purposes only.						
(a) White		(b) Mixed		(c) Asian or Asian British		
<input type="checkbox"/>	British	<input type="checkbox"/>	Asian and White	<input type="checkbox"/>	Indian	
<input type="checkbox"/>	Irish	<input type="checkbox"/>	Black African and White	<input type="checkbox"/>	Pakistani	
<input type="checkbox"/>	Any other White background	<input type="checkbox"/>	Black Caribbean and White	<input type="checkbox"/>	Bangladeshi	
		<input type="checkbox"/>	Any other mixed background	<input type="checkbox"/>	Chinese	
				<input type="checkbox"/>	Any other Asian background	
(d) Black or Black British		(e) Other ethnic groups		(f) Not declared		
<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Any other ethnic group (please specify):	<input type="checkbox"/>	Not declared	
<input type="checkbox"/>	African					
<input type="checkbox"/>	Any other Black background					

Is the child on the Child Protection Register?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Has been
Category of registration									
<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	Emotional abuse	<input type="checkbox"/>	Neglect		

Are any siblings on the Child Protection Register?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Has been
Category of registration									
<input type="checkbox"/>	Physical abuse	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	Emotional abuse	<input type="checkbox"/>	Neglect		

Legal status					
<input type="checkbox"/>	Adoption	<input type="checkbox"/>	Emergency Protection Order	<input type="checkbox"/>	Police Protection Order
<input type="checkbox"/>	Supervision Order	<input type="checkbox"/>	Care Order	<input type="checkbox"/>	Ward of Court
<input type="checkbox"/>	Section 20 Accommodation	<input type="checkbox"/>	Residence Order	<input type="checkbox"/>	None
<input type="checkbox"/>	Other (please specify)				

Does the child have a disability that affects any of the following?						<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Please tick those that apply.									
<input type="checkbox"/>	Mobility	<input type="checkbox"/>	Hand function	<input type="checkbox"/>	Personal care	<input type="checkbox"/>	Incontinence		
<input type="checkbox"/>	Communication	<input type="checkbox"/>	Learning	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Vision		
<input type="checkbox"/>	Behaviour	<input type="checkbox"/>	Consciousness						

4. Incident details

Local authority where incident took		Responsible local	
-------------------------------------	--	-------------------	--

place		authority	
Date of incident (dd/mm/yyyy)			

Type of incident	
<input type="checkbox"/> Serious injury	<input type="checkbox"/> Death (include date of death) (dd/mm/yyyy)

Residence/placement at time of incident		
<input type="checkbox"/> Living at home	<input type="checkbox"/> Living with relatives	<input type="checkbox"/> With foster carers (short term)
<input type="checkbox"/> With foster carers (long term)	<input type="checkbox"/> With foster carers (short break)	<input type="checkbox"/> Residential children's home
<input type="checkbox"/> Residential children's home (short break)	<input type="checkbox"/> Lodgings	
<input type="checkbox"/> Residential school	<input type="checkbox"/> Semi-independence unit	<input type="checkbox"/> Mother and baby unit
<input type="checkbox"/> Hospital	<input type="checkbox"/> Residential family unit	<input type="checkbox"/> Not yet known
<input type="checkbox"/> Other (please specify)		

Name of institution (if accommodated)	
---------------------------------------	--

Institution sector			
<input type="checkbox"/> Local authority	<input type="checkbox"/> Voluntary	<input type="checkbox"/> Private	<input type="checkbox"/> Not known

Cause of incident		
<input type="checkbox"/> Natural causes	<input type="checkbox"/> Non-accidental injury	<input type="checkbox"/> Self-harm
<input type="checkbox"/> Not yet known	<input type="checkbox"/> Non-accidental death	<input type="checkbox"/> Road traffic accident (RTA)
<input type="checkbox"/> Suicide	<input type="checkbox"/> Accidental death	<input type="checkbox"/> Sudden Infant Death Syndrome
<input type="checkbox"/> Neglect	<input type="checkbox"/> Accidental injury	<input type="checkbox"/> Drug/solvent misuse
<input type="checkbox"/> Other (please specify)		

Case outline <i>(please attach additional information if necessary)</i>

Characteristics of case		
<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Parental mental health	<input type="checkbox"/> Fabricated illness	<input type="checkbox"/> Shaken baby syndrome
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Parent in care	<input type="checkbox"/> More than one child abused
<input type="checkbox"/> Child of teenage pregnancy	<input type="checkbox"/> Parent is care leaver	<input type="checkbox"/> Serious illness
<input type="checkbox"/> Emotional abuse	<input type="checkbox"/> Recent neglect	<input type="checkbox"/> Long-standing neglect
<input type="checkbox"/> Physical abuse		

Is this case linked to a complex abuse investigation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

Name(s) of alleged abuser(s)			
Name(s) of person(s) charged and relationship to child			
Have criminal proceedings been instigated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Possible
Has there been a conviction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Media interest			
<input type="checkbox"/> National	<input type="checkbox"/> Local	<input type="checkbox"/> None	<input type="checkbox"/> Not known

Appendix X

PROTOCOL FOR THE MANAGEMENT OF SERIOUS CASE REVIEWS (where more than one Authority is responsible/involved)

INTRODUCTION

1. Serious Case Reviews are by their nature complex processes, bringing together information and analysis from a number of different agencies and distilling from these lessons for future practice. In circumstances where it is clear that a Serious Case Review (SCR) will involve agencies in another local authority area, the MSCB is committed to ensuring careful planning and management of the review process. This will minimise the potential for confusion and discord and ensure that lessons can be learned to improve practice.
2. When the MSCB takes the decision to conduct a SCR where there are serious concerns in respect of a child living in one local authority and that child has spent significant time in the other local authority or received services from that local authority , we agree to the following sequence of events.
3. The Chair of the LSCB commissioning the Review will inform the Chair of the other LSCB and the Chairs will agree whether the SCR will be conducted as:
 - a. A single LSCB review with limited input from the other LSCB OR
 - b. A joint SCR where members of each SCR Panel work together as an expanded panel.
4. This decision will depend on the complexity of the case and the degree of involvement of each partnership. Should the Chairs be unable to agree, the matter will be referred to Chief Executives and/or OFSTED for a final decision.

WHEN A SINGLE LSCB SERIOUS CASE REVIEW WITH LIMITED INPUT FROM THE OTHER LSCB HAS BEEN AGREED

5. In the event of a SCR commencing under the auspices of a single partnership (see a. above), the two Chairs will remain in close contact. Should it become apparent that there are significant issues emerging for the partnership that is not managing the process, the Terms of Reference will be reviewed and the option to move to a more joint arrangement will be agreed.

Appendix X

WHEN A JOINT SERIOUS CASE REVIEW HAS BEEN AGREED

Set up Arrangements

6. In view of the possible differences in process between local authorities the arrangements for a joint SCR should be clearly specified. Written Terms of Reference must be agreed and presented to each LSCB. The Terms of Reference should include the following:
 - Membership of the joint SCR Panel. Membership will ordinarily reflect the respective interests of the two local authorities and will include those with specialist knowledge relevant to the case.
 - Which agencies will be asked for single management reports
 - The scope of the Review – see Appendix 2
 - Timescales
 - Process to be followed
 - Format of reports and chronology – Appendices 4 and 5
 - What information will be made available to any court proceedings

7. The following arrangements should also be agreed at this point.
 - Administrative support to the process
 - How the Overview writer will be identified and how the SCR Panels will work with them.
 - Joint agreement about the legal framework for the review. Each LSCB is likely to seek its own legal advice and a joint position must be negotiated.
 - Arrangements for an initial meeting to consider media implications and how to deal with them.
 - Sharing of costs.

Matters to be agreed by both areas towards the end of the process:

8. By this stage the joint SCR Panel will have a good understanding of the central issues of the case and be in a position to make careful arrangements to ensure that the following events take place:
 - Opportunity for the joint SCR Panel to consider and agree the factual accuracy of the Overview Report
 - Opportunity for both the LSCBs to discuss findings and recommendations with the Overview Writer
 - Drafting of the Executive Summary – to be jointly agreed by both the LSCB's.
 - (Joint?) Briefings for Chief Officers
 - Media Strategy agreed by both LSCBs at joint meeting with Press Officers, LSCB Chairs (and Chief Officers if necessary). Meeting to be noted.
 - Debriefings for staff

Appendix X

- Arrangements to inform OFSTED

Debriefing

9. Following a Serious Cases Review the Chairs will arrange to meet with others who have been involved in the process to address any outstanding issues.

SCOPING A SERIOUS CASE REVIEW WHERE MORE THAN ONE LSCB IS INVOLVED

The following matters to be jointly considered and agreed by the Chairs and SCR Panels of LSCB s in the event of a joint Serious Case Review. In the event of a review lead by one partnership with limited input from the other the Chairs of both partnerships should have the opportunity to contribute to the scoping of the Review and its Terms of Reference.

- i. What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
- ii. Are there features of the case, which indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/ agencies who will be required to participate in the review? Would it help the review panel to bring in an outside expert at any stage, to shed light on particular aspects of the case?
- iii. Over what time period should events be reviewed, i.e. how far back should enquiries cover, and what is the cut-off point? What family history/ background information will help better to understand the recent past and present which the review should try and capture?
- iv. Which agencies and professionals should contribute to the review, and are there any other individuals or organisations (e.g., proprietor of independent school, housing officer, playgroup leader) who should be asked to submit reports or contribute in a different way?
- v. Should any members of staff be interviewed?
- vi. Should family members be invited to contribute to the review, and if so how can this be facilitated?
- vii. Will the case give rise to other parallel investigations of practice, for example, a mental health homicide or suicide enquiry, and if so, how

Appendix X

can a co-ordinated review process best address all the relevant questions which need to be asked, in the most economical way?

- viii. Are there implications in respect of disciplinary proceedings, is an HR perspective required and are there implications for staff being interviewed?
- ix. How should the review process take account of a Coroner's enquiry, and (if relevant) any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Crown Prosecution Service?
- x. Who will make the link with relevant interests outside the main statutory agencies, i.e. independent professionals, independent schools, voluntary organisations?
- xi. When should the review process start and by what date should it be completed?
- xii. How should any media interest be handled, before, during and after the review? In cases where there is likely to be media interest it is particularly important to have a strong media strategy in place that is understood and agreed by both the LSCB's and the respective Press Offices. A meeting of the Chairs and Press Officers and legal representatives to be arranged at an early stage in the review and then towards the conclusion of the review – or at any other point where it seems sensible to do so, e.g.: the conclusion of a trial, a coroner's inquest etc.
- xiii. How should any public or family interest be dealt with?
- xiv. Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

Some of these issues may need to be revisited as the review progresses and new information emerges.

Appendix XI

CONFIDENTIAL – Letter 1 (requesting additional information and to secure files)

Dear Colleague [**Member of the QACR Subgroup**]

REFERRAL TO THE SERIOUS CASE REVIEW PANEL (SCRP): REQUEST FOR ADDITIONAL INFORMATION

You will see from the attached form (SCR1/2006 Part 1) that a referral has been made to the Serious Cases Review Panel about:

.....(Name, DOB, Address of Child)

Would you please check your own agency records for past or current involvement with this family and provide us with any information that may assist us in deciding whether/not the criteria for holding a case review are met and record this in the appropriate sections of the Referral Form SCR1/2006.

Just to remind you, the criteria are laid down in Working Together To Safeguard Children 2006, Chapter 8. In helping us to make the decision, we would welcome any information you have using the prompts on pages 2 and 3 of the attached referral form.

You do have a representative of your agency on the Serious Cases Review Panel. Their contact details are outlined below, if you would like to discuss the matter with them. Alternatively, you can contact me on...

It is the intention of the SCRCP to proceed in a measured way in relation to this referral. Once relevant information becomes available, the SCRCP will make a decision on how to proceed. If it is decided to proceed to review detailed Terms of Reference will be drafted and sent to you. If it is decided not to proceed we will inform you.

In the meantime, would you please ensure that any and all files within your organisations relating to this family are stored securely for audit (and if necessary, copied to enable agency work to continue if required)

Please forward any information you have to by..... (Date) in preparation for the SCRCP meeting on(date)

Yours sincerely

Chair, SCRCP

Suggested Distribution:

Appendix XI

CONFIDENTIAL – Letter (Notifying organisations of NFA))

Dear Colleague

REFERRAL TO THE SERIOUS CASES REVIEW PANEL (SCRP): INFORMATION

Further to our letter dated regarding a referral to the Serious Cases Review Panel about:

.....(Name of child)

This referral has now been considered by the Serious Case Review Panel and, following recommendations made to the MSCB Chair, a decision has been made not to proceed with a Serious Case Review.

All files relating to this family may now be released.

The Serious Case Review Panel has proposed the following alternative action in relation to this case. (Delete and add details as appropriate)

- Lessons Learned Review
- Single Agency Management Review
- Inter agency training and development initiative
- Internal Audit
- Discussion at Medway Safeguarding Children Board Practitioner Forum

Thank you for your assistance with this matter.

Yours sincerely

Chair, SCRП

Suggested Distribution:

Appendix XI

Sample: Letter Commissioning Individual Management Reviews– Letter 3

To: see distribution
From: Chair, SCRP
Date:

Dear Colleague,

SERIOUS CASE REVIEW: (child's name, address, DOB and DOD if applicable)

Following the **Circumstances of child**, The MSCB has requested that a Serious Case/Lessons Learned Review under Working Together 2006 take place concerning the above child. The aim of the review is to ascertain the facts, analyse them and identify any lessons that need to be learned. Contextual information is important for the panel to understand the circumstances of the case and make appropriate recommendations for change.

I am therefore writing to formally request that your organisation conduct an Individual Management Review using the guidance published by the MSCB which can be found at www.mscb.org.uk and which constitutes part of the Kent and Medway Safeguarding Procedures. This requires that you investigate (or appoint a person to investigate) any involvement by your service as identified in the scope (including the interviewing of any relevant caseworker, and reading the case file).

This report is required by **Date** and should be sent to the MSCB Administrator Steve Dickens. There will be then a meeting of the Investigating Officers from all agencies with the **Serious Case Review/Lessons Learned Panel** on **Date** where an overview report will be produced including a summary, SMART learning outcomes for practitioners/agencies and a report to the MSCB, which will include a draft action plan.

If your organisation has not had any involvement with the family, I would be grateful if you could confirm this in writing.

Individual Management Reviews are required in respect of the involvement of:

- Agency - Section
- Agency Section

Appendix XI

Cont...

~2~

I enclose the scope of the review. Report authors must follow the format laid down in the Serious Case Review guidance and answer the specific questions contained within the scoping document attached, the chronology must be completed in the given format.

As you can appreciate this matter is highly confidential and of a sensitive nature.

Thank you for your co-operation.

Yours sincerely,

Jim Leivers
Chair
Medway Safeguarding Children Board

CC : Board Member

Distribution:

To Chief Executives of involved organisations with copy to Board member.

For Information:

Members of Serious Cases Review Panel

Appendix XI

Sample: Letter of Invitation to Authors Briefing – Letter 4

STRICTLY CONFIDENTIAL

**MEDWAY SAFEGUARDING CHILDREN BOARD
SERIOUS CASE REVIEW: BRIEFING FOR AUTHORS (IMR AND
OVERVIEW AUTHORS)**

Dear Colleague

SUBJECT: Name, DOB & DOD (if applicable)

The purpose of this letter is to invite you as a nominated author (IMR or Overview) to a briefing on *****

Include Part 1 of Referral form that will now contain information from all involved agencies – requested in letter 1.

The (*designation of professional*) referred this case to the Serious Case Review Panel on *****. The group met on*****. It was their view that the conditions outlined in paragraph 8.2 of Working Together 2006 had been met and that a Case Review should take place:

"A LSCB should always consider whether to undertake a serious case review 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, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children. This includes situations where a parent has been killed in a domestic violence situation or where a child has been killed by a parent who has a mental illness."

The group recommended to the Chair of LSCB that a Case Review should be undertaken. This recommendation received written endorsement from the Chair of MSCB on *****.

Appendix XI

Sample: Letter of Notification to Parents – Letter 5

Date: *****

STRICTLY CONFIDENTIAL

Dear *****

RE: MEDWAY SAFEGUARDING CHILDREN BOARD: SERIOUS CASE REVIEW

First of all I would like to offer my sincere condolences on the death of (child's name).

The purpose of this letter is to inform you that because of ***** death, and the circumstances surrounding it, Medway Safeguarding Children Board (MSCB) will carry out a review. The Government requires us to do this.

The purpose of the review is:

- To establish whether there are lessons to be learned about the way in which local professionals or organisations, work together to safeguard and promote the welfare of children
- To identify clearly what those lessons are, how they will be acted upon and what changes might be necessary
- To improve inter agency working and better safeguard children.

The process for the review can be found in a document called Working Together to Safeguard Children - A Guide to Inter Agency Working to Safeguard and Promote the Welfare of Children, Chapter 8, Department of Health 2006. I enclose a copy of the relevant chapter of Working Together, for your information, or for you to share with your solicitor, if you wish.

This may seem very complicated to you, at such a distressing time, but I do want to emphasise that this Case Review will not influence any ongoing police investigations, or the work that is happening at the moment between your family and professionals such as your social worker and health visitor. This is a separate process, involving senior managers from all the agencies that make up the MSCB (Health, Police, Children and Young People's Services, Probation).

As part of the information gathering process for all of this, we want to give you the opportunity, if you wish to make any comments or observations to the MSCB's Serious Case Review Panel, this can either be done in writing or through speaking to ***** in her capacity as Independent Author for the Overview Report.

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Please do not hesitate to contact ***** (her phone number and address are at the top of the letter) if you want to make some comments or observations to the Case Review if you would like anything in this letter to be explained to you in more detail, or if you would like to know more about who is on the LSCB and who is involved in this Case Review.

If you feel you need some support with this process, you may wish to contact

You may want to take independent legal advice before making any decisions about all of this. If your solicitor has any queries he or she is welcome to contact the Legal Adviser to the Serious Case Review Panel, (contact details)

Yours sincerely

Independent Chair, Medway Safeguarding Children Board

Copy To:

Members of the Serious Case Review Panel
Overview Author
OFSTED and DCSF
Individual Management Review Authors

Appendix XI

Sample: Letter of Notification to Victims – Letter 6

Dear X

(eg) I am writing to inform you that after X was convicted last year, the Medway Children Safeguarding Board decided to review the circumstances that led to you, and others, being cared for by that family.

Whenever children have been seriously harmed, Local Children Safeguarding Boards (LSCB) have a duty to look at their situation and ask the question, "Is there any way in which this might have been prevented?" They need to look at how professionals worked together. Having thoroughly reviewed records, the LSCB then makes recommendations to organisations that have responsibilities for children about how they can improve the way they work together.

This process, which is called a Serious Case Review, is managed by a group of very experienced people from Health, the Local Authority, Housing, Police and Probation. Such a group has been working for several months and is just completing its work. The LSCB will produce an anonymous Executive Summary of its findings. If you would like a copy of the summary please let me know.

Yours sincerely

SCRIP Chair

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Appendix XI

Sample: Letter of Invitation to a Practitioners De-Briefing - Letter 7

To: distribution list
From: MSCB Manager
Date:

Dear Colleague

SERIOUS CASE REVIEW: (child's name): PRACTITIONERS DE-BRIEFING

As you will be aware a serious case review was held on the above child. This review has now been concluded and the executive summary of that is available for dissemination.

We recognise that is important to share the Overview Report and its findings with all those directly involved in the case, and would therefore like to invite you to a de-briefing on the afternoon of **(date, time & venue)**

Please complete the attached reply slip to indicate whether/not you are able to attend. If there is someone you think should be invited but who is not on the list below, please contact MSCB Administrator (contact details)

LSCB

Distribution:

For Attendance; Practitioners

For Information

Members of SCRP

Single Agency Management Review Authors

OFSTED

Overview Author

Key people in relevant agencies

✂
Please return to: MSCB Administrator, Contact Details

NAME:

WORKPLACE:

I am *able/unable to attend the meeting on date, time and venue.

Appendix XII

Bibliography

- Children Act 1989, Children Act 2004
- The Local Safeguarding Children Board Regulations 2005
- Freedom of Information Act 2000
- Working Together. (2006) Department for Education & Skills, 2006 – Serious Case Reviews Chapter 8.
- Framework For the Assessment of Children In Need and their Families, DoH, 2000
- What To Do If You're Worried a Child is Being Abused, DoH, HO, DFES, 2003
- Learning From Case Reviews, Roger Bullock and Ruth Sinclair, Department of Health, 2002
- Department of Health Safeguarding Standards, Standard 1
- Learning How to Make Children Safer, UEA/National Assembly for Wales, 2002
- Unexplained Child Deaths Protocol (ref)
- DCSF (2008) "Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005" Research Report DCSF-RR023
- DCSF (2008) "Improving Safeguarding Practice" Study of Serious Case Reviews 2001-3 Research Report DCSF-RR022

Appendix XIII

Timescale

This process related to SCR and should not be confused with statutory notification requirements and the related process (please refer to paragraph 2.14 on p23). It **does not** relate to cases where there are ongoing s47 child protection investigations or enquiries.

Timescale	Action	Person responsible
Immediate (Day 1)	Agency who first becomes aware of review criteria being met notifies MSCB Chair or Board Manager.	Senior officer in identifying agency
Immediate (Day 1)	MSCB Chair informs the Chief Executive, Children's Services Officer, Heads of appropriate agencies	MSCB Chair & Board Manager
Immediate (Day 1)	If relevant, MSCB Chair liaises with relevant agency heads and the Local Authority Legal Adviser regarding media response and public relations issues through Medway Council's Press Officer.	MSCB Chair
Before day 5	<p>Core SCR Panel meets</p> <p>A decision is made as to:</p> <ul style="list-style-type: none"> • whether a SCR or LLR is to be held, the scope and timescale for the review; • the timescale for commencing the individual management reviews and the timescale for the composite review; consideration to be given to possible delay if criminal or civil proceedings are likely; • consideration to be given to any other type of enquiry i.e. an internal investigation . <p>If a Serious Case or Lessons Learned Review is to take place the Overview Review Panel is identified.</p>	MSCB Chair
Immediate Before day 5	All relevant files and documents are secured by each agency	Individual Agency Heads
Immediate Before day 5	Ofsted informed of Serious Case Review	DCS
<p>Within 5 working days of decision to undertake a Serious Case Review</p> <p>Before day 9</p>	Agency Leads appoint Management Review Officers	Individual Agency Heads

Appendix XIII

Timescale	Action	Person responsible
<p>Within 5 working days of decision to undertake a SCR.</p> <p>Before day 9</p>	<p>First meeting of SCR Overview Panel:</p> <ul style="list-style-type: none"> • To share information or hear update of the case under review. • To plan the review and agree parameters of review. • To allocate tasks. • To agree timescale of review. National guidance versus complexity of individual case. • To consider implications of any legal proceedings. • To outline a strategy re publication of SCR. • To agree a media strategy. • To consider appointment of an independent person to write the composite report. • Dependent on the complexities of the situation consideration could be given to the appointment of an independent chairperson. 	<p>MSCB Chair</p> <p>All members of the SCR Group</p>
<p>Within 10 working days of decision to undertake a SCR</p> <p>Before day 15</p>	<p>Briefing meeting for Individual Management Review Officers.</p> <ul style="list-style-type: none"> • To share information about the background and current situation. • To clarify roles, responsibilities and tasks of Individual Management Review Officer. • To share information about the management of the case review, terms of reference and timescales. • To discuss Individual Management Review, chronology and report format. • To discuss interview format and interviewing process. • To define the parameters and guidelines applicable throughout the period covered by the Review. <p>If there is likely to be any deviation from the identified timescales this should be brought to the attention of the Chair of the Review Panel who will inform the Chairperson of the MSCB who will take any action necessary</p>	<p>Chair of Overview Panel</p> <p>MSCB Manager</p>
<p>Within 25 working days of SCR being established</p> <p>Before day 25</p>	<p>Individual Management Review Reports completed and Single Agency Chronologies compiled and delivered to MSCB Manager.</p>	<p>Individual Management Review Officers</p>
<p>Within 35 working days of SCR being established</p> <p>Before day 35</p>	<p>Composite Chronology compiled</p>	<p>MSCB Manager & MSCB Administrator</p>
<p>Within 35 working days of SCR being established.</p> <p>Before day 35</p>	<p>Composite chronology and Single Agency reports circulated to SCR Overview Panel.</p>	<p>MSCB Manager & MSCB Administrator</p>

Appendix XIII

Timescale	Action	Person responsible
<p>Within 40 working days of SCR being established</p> <p>Before day 40</p> <p>There may be as many meetings as the SCR Panel feels appropriate to complete the final report.</p>	<p>Second meeting of Overview SCR Panel</p> <ul style="list-style-type: none"> • To review Individual Management Review Reports and composite chronology and identify discrepancies. • To identify who will compile the Composite Review Report. • To identify key issues and themes. • To formulate conclusions and areas for recommendations 	<p>MSCB Manager & MSCB Administrator</p>
<p>Within 30 working days of second meeting of SCR Panel</p> <p>Before day 65</p>	<p>A Draft Composite Review Report to be completed. Any variance to this timescale requires agreement from the Ofsted and should be pursued only when the complexity of the case makes it appropriate.</p>	<p>Report writer as identified using principles attached.</p> <p>MSCB Administrator.</p>
<p>Within 5 working days of the draft Composite Report being circulated to Review Group members</p> <p>Before day 70</p>	<p>A meeting of the Serious Case Review Group to agree the Draft Composite Report</p>	<p>Chair of SCR Panel</p>
<p>10 days before MSCB meets.</p> <p>Before day 75</p>	<p>Draft Composite Review Report circulated to MSCB</p>	<p>MSCB Manager & MSCB Administrator</p>
<p>At 17 working weeks from the decision to carry out a Serious Case Review.</p> <p>At day 85</p>	<p>Extraordinary meeting of Medway Safeguarding Children Board (if required) to:-</p> <ul style="list-style-type: none"> • Consider draft Composite Report. • Discuss & agree conclusion & recommendations and ratify report. • Decide priorities for action. • Request action plans for implementation of recommendations for MSCB and from each agency involved including timescales. • Decide on feedback strategy for all agencies and staff. 	<p>All MSCB Board members</p>
<p>Within 1 working week of extraordinary meeting of MSCB.</p> <p>Before day 90</p>	<p>Action Plans to be forwarded to the chairperson of the Review Group to be appended to the final report and submitted to Ofsted.</p>	<p>Officers identified by extraordinary MSCB</p>

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Timescale	Action	Person responsible
Within 1 working week of extraordinary meeting MSCB Before day 90	One copy of Composite Report, Individual Management Review Reports and Action Plans to be forwarded to OfSTED.	MSCB Manager & MSCB Administrator
Within 8 weeks of extraordinary meeting of MSCB Before day 125	Conclusions and recommendations shared with relevant agency/staff.	MSCB Board Members
Subsequent MSCB meetings	To review progress of MSCB and Single Agency Action Plans.	MSCB Chairperson and MSCB Manager