East of England Region Children's Sector Led Improvement

Local Commissioning of Serious Case Reviews

Support for Independent Chairs of Safeguarding Children Boards and Serious Case Review/Serious Incident Notification Panels/Sub Groups

August 2015

Table of Contents

1 INTRODUCTION AND CONTEXT

Working Together (DfE 2015) outlines the responsibilities of the LSCB independent chair to make the final decision regarding whether or not a serious incident reaches the threshold for a Serious Case Review (SCR).

This document, commissioned by the East of England Children's Sector Led Improvement Board, aims to support the LSCB independent chair and other partners to make sound judgements when a serious incident is notified. The overall aim being to ensure there is a robust and consistent process to guide decision making in line with the criteria found in Working Together (DfE 2015) (Chapter 4) and provide some clarity around the commissioning process. It is not intended to replace local arrangements but to support LSCB's in providing some tools to assist with the process. The recently published ADCS (2015) on the role of serious case reviews provides complementary guidance. See http://www.virtualstaffcollege.co.uk/useful-stuff/featured-reading/research/serious-case-reviews/

In recognising the changing landscape for SCR activity there is a need to ensure that Boards have a clear view about the key influences, which need to be taken into account including;

- Munro Review and its impact on revised statutory guidance
- Positioning of Inspection and Regulation (not solely Ofsted)
- Emergence and views of National ‘expert‘ Panel
- Recent responses and actions of the Department for Education (DfE)
- Continued high media profile
- Guidance from the Association of Independent Chairs
- The need for proportionality

Boards must also be aware of their accountabilities to families directly concerned with the case when commissioning reviews and where called upon to do so, should be capable of both explaining and justifying the reason the review is, or is not, being commissioned.

The guidance makes no recommendations about the choice of methodology of review as the basis upon which SCRs or other Learning Reviews may be commissioned is contained within statutory guidance.

All reviews commissioned by LSCBs should have a focus on learning and the capacity to influence development and improvement of practice, both at a systems level as well as an individual level.

2 ROLES AND RESPONSIBILITIES IN SERIOUS CASE REVIEWS

The following people have roles to play, they may not all be involved in every review. Before you start it may be helpful to identify who are the key stakeholders and participants that need to be involved and at what stage.

Referrer	The professional who thinks that a Serious Case Review may be warranted, makes a referral to their own safeguarding lead.
Their agency safeguarding lead	Decides whether the referral warrants a Serious Case Review and, if so, makes a referral to the LSCB safeguarding manager.
LSCB safeguarding manager	Receives the serious incident notification and contacts the LSCB independent chair and chair of the SCR sub group (if not LSCB chair). This person then may co-ordinate any review process, and sits on the Panel.
LSCB Independent chair	Decides whether a review is warranted. If so instructs the SCR sub-committee/panel to start the review process.
SCR sub-committee or equivalent depending on structure of LSCB	This is a group of managers responsible for commissioning Serious Case Reviews, quality assuring the reviews and ensuring that lessons are learned.
LSCB business support	Serious Case Reviews are administratively heavy. This person takes minutes at the SCR panel meetings, helps the safeguarding manager co-ordinate meetings and puts together the joint chronology.
SCR panel members	These are senior managers from local agencies independent of the case. Their role is to assist the process by adding their professional and local knowledge, assisting the lead reviewer/s through debate and discussion and quality assuring their report.
Review Team	As an alternative to an SCR panel, it is becoming more common to have a review team made up of the key senior professionals who had no operational involvement in the case who will oversee and contribute to the review and support lead reviewer/s in their work.
Independent chair of the SCR panel	Once commissioned there should be an independent person to chair the SCR panel/review team. This person must be independent of the case but can also be independent of the area. Their roles are to co-ordinate the SCR panel or review team, chair meetings and manage the process. They could also be one of the lead reviewers.
Agency report authors	These are managers from local agencies independent of the case. They produce a chronology and a report of their agency's involvement in the case usually to a template provided by the SCR panel.

Senior managers	Their responsibility is to “sign off” the agency reports confirming that they are happy with its quality and recommendations. They should normally be representative member of LSCB, unless the agency is not represented in which case it should be the Director of that agency.
Independent author (lead reviewer or reviewers)	This person, or people, independent of the case and the area leads the investigation, analyses the agency reports/chronologies, interviews staff and family members, facilitates practitioner events i(f being held) and sees any other interested parties, ending with production of a review report fit for publication.
Staff who knew the child	Attend meetings with the lead reviewer/s (and agency report authors) to discuss their involvement, answer “why” questions, consider the learning and advise on potential recommendations. This may be through individual conversations or as part of a case group/ practitioner event or a mixture of both.
Managers of staff who knew the child	Attend meetings with the lead reviewer/s (and agency report authors) as requested to discuss the context within which their staff were working, answer “why” questions, consider the learning and advice on potential recommendations.
Family members	It is good practice to invite family members to be invited to give their view on services provided and support they were or were not given. The review team and lead reviewer/chari should consider the best way that this can be done in order to ensure their participation.
The perpetrators of the abuse	Depending on the case it may also be very helpful to invite perpetrators to participate. Review team with the lead reviewer/chair will need to agree how and best way to do this. If criminal proceedings are taking place this need to be carefully agreed with the SIO (senior investigating officer) and CPS.
Communications officer	Manages contact with the Media and liaises with media officers in other agencies to ensure a joined up approach.
Legal department	Advises on any legal matters considered beyond the understanding of panel members.
National Panel of independent experts	The role of the panel is to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel also reports to the Government their views of how the SCR system is working. The panel’s remit includes advising LSCBs about: a) application of the SCR criteria; b) appointment of reviewers; and c) publication of SCR reports

The LSCB Board members	Must agree a final ‘sign off’ – usually via a extraordinary whole Board meeting which lead reviewer/s attend. It is crucial that senior leaders understand learning and consider findings in order that any improvements can be made.

3 CRITERIA FOR COMMISSIONING A SERIOUS CASE REVIEW

Working Together (DfE 2015) requires a Serious Case Review to be undertaken for every case where abuse or neglect is known or suspected[1] and either:

- a child dies; or
- a child is seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

This includes cases where a child died by suspected suicide. Where a case is being considered where the child was seriously harmed unless there is definitive evidence that there are no concerns about interagency working, the LSCB must commission an SCR.

Seriously harmed includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

a. a potentially life-threatening injury;
b. a serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

LSCB independent chairs must consider not so much the act itself or any physical repercussions arising from that act but the psychological harm suffered by victims. Serious harm therefore does not relate solely to the incident itself, (which could be of a serious or less serious nature) but rather to the effect on the child or the likely effect on other children of similar incidents. To assist in this decision the following questions could be asked:

- Was the child seriously assaulted and has this led to the possibility of enduring psychological harm?
- Is the child recovering from any injuries?
- Should a medical expert be called in to give a view?
- Should the LSCB independent chair call for legal advice?
- Should the LSCB independent chair ask for a peer review from a fellow independent chair?

Appendix 1 contains a checklist for Independent chairs.

[1] The threshold for 'suspect' should be consistent with s47 Children Act 1989 "reasonable cause to suspect". The following question should be asked: given what we now know should this incident have led to a child protection investigation? If "yes" and the child has been seriously harmed then a Serious Case Review should take place.

NOTIFICATION OF A SERIOUS INCIDENT

Any agency, Child Death Overview Panel (CDOP) or other authority or LSCB can make a referral for a case to be considered for a serious or other case review, but referrals must be supported by their senior officers. Each LSCB will have its own local protocol for how this information is received. LSCBs if they do not have one may consider adapting the serious incident notification form developed by Bedford Borough LSCB to ensure there is clarity about what information should be provided. http://www.bedford.gov.uk/health_and_social_care/children__young_people/safeguarding_children_board/professionals/learning_and_improvement_scr.aspx

Some reviews involve children who have lived in a number of areas and so more than one LSCB will be involved. In this case the LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for an SCR and should lead on the review but liaise with the LSCBs who were involved in the past. Liaison could be done through the relevant safeguarding managers and at least one representative from other relevant LSCBs should sit on the SCR panel.

Incidents and circumstances that must be notified by the Local Authority to the LSCB;

1. when a child has died (including death by suicide) and abuse or neglect is known or suspected
2. when a child has been seriously harmed and abuse or neglect is known or suspected;
3. when a looked after child has died (including cases where abuse or neglect is not known or suspected); or
4. when a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected).

In addition, even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

In the following cases agencies should give serious consideration to notifying the circumstances to the LSCB. If in doubt discuss the circumstances with the LSCB business manager who will take advice from the independent chair.

1. There was clear evidence of a risk of significant harm to a child that was:
    a. not recognised by organisations or individuals in contact with the child or perpetrator or
    b. not shared with others or
    c. not acted on appropriately
2. A child died while absent from or having run away from home or other care setting

3. One or more professional considers that their concerns were not taken sufficiently seriously, or acted on appropriately, by another
4. The case indicates 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 the specific case
5. The child concerned was the subject of a child protection plan, or had previously been the subject of a plan or on the child protection register
6. The case suggests that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not adequately understood or acted on
7. There are indications that the circumstances of the case may have national implications for systems or processes or there are significant public interest or community issues.

Contact details and notification forms for notifying incidents to Ofsted are available on Ofsted's website https://www.gov.uk/government/organisations/ofsted

This referral must state clearly why they believe the incident warrants a serious incident or may reach threshold for a serious or other case review.

Following the notification to the LSCB, the safeguarding manager undertakes an initial fact finding process with partners including asking them to collate an agency chronology. This is shared with the Serious Case Review sub-committee[2] who consider the issue and (if in agreement that the incident warrants a Serious Case Review) makes a recommendation to the LSCB independent chair. All agency representatives should give a clear rationale for their view and this should be recorded in order that the LSCB independent chair can make an informed decision. A flowchart to assist in this process devised by Essex LSCB can be found in appendix 2.

If in doubt the LSCB independent chair could seek legal or medical advice and a peer review from fellow independent chairs. If the decision is made to not proceed then the LSCB independent chair will write a letter to the referrer and their agency's safeguarding lead (copy to SCR sub-committee) with full explanations for the reason; this letter should also be sent to the National Panel of independent experts where their decision will be subject to scrutiny. The LSCB should provide sufficient information to them to inform its deliberations and the LSCB independent chair should be prepared to attend in person to give evidence. In cases where an LSCB is challenged by the National Panel of independent experts to change its original decision, the LSCB should inform Ofsted, DfE and the National Panel of independent experts of the final outcome.

[2] This is a group of managers responsible for commissioning Serious Case Reviews, quality assuring the reviews and ensuring that lessons are learned.

If the decision is to go ahead with the Serious Case Review then the LSCB independent chair will instruct the SCR sub-committee (or equivalent) to recruit a SCR panel who will decide upon the methodology for the review, assist the lead reviewer/s and quality assure the process. The SCR sub-committee may also appoint a fully independent[3] chair of the SCR panel if they think the review warrants further independence.

The LSCB having received a notification from the LA should report any incident that meets the above criteria to Ofsted, DfE and the national panel of independent experts within five working days of the chair's decision. The LSCB should once commissioned, provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR.

LSCBs should have regard to their panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.

At all points in this process professionals should be aware that any other involved children may be at risk and they should seek assurances that these children are safe.

The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to:

- capture points from the case about improvements needed; and
- take corrective action to implement improvements and disseminate learning.

LSCBs should also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements, which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together but must be fully accountable to the Board with clear commitment from partner agencies for time and resources.

The following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;

[3] "Fully independent" means someone who has no links with the case and who is not employed by any local agencies.

- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB's annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

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

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

PROPORTIONALITY

Working Together (DfE 2015) states that 'the approach to reviews should be proportionate according to the scale and level of complexity of the issues being examined" (Chapter 4, paragraph 10). The National Panel of independent experts is asking for reviews to be more succinct and focused. The decision about proportionality needs to be made early in the process as it will fundamentally affect the terms of reference and scope but be subject to review and iteration as the process develops. The decision whether to ask for individual management reviews needs to be taken carefully, these are resource intensive and it may be that there are more proportionate ways of getting the story behind the case by for example bringing key practitioners together.

SCOPING THE REVIEW AND CHOOSING METHODOLOGY

Working Together (DfE 2015) gives LSCB's permission to be innovative in the range and type of reviews commissioned. The Scoping Checklist on page 13 will help you determine what type of methodology will bring out the most learning.

Chairs will need to decide which is most likely to suit each particular review based on the individual circumstances of the case.

To assist in deciding upon the best approach LSCB independent chairs could consider:

- How serious is the harm caused in terms of the context, nature and impact of the incidence or events, including the potential accountability of agencies or professionals in contributing to the outcome – for example, was the child known to a number of professionals or agencies, was the abuse allegedly perpetrated by one of them, or potentially linked to a professional failure to protect, including a failure to consider the child's needs as meeting agencies criteria for help and support - is there likely to be professional culpability or even wilful neglect?
- What public interest is there currently, or likely to be in the outcome?
- Are there any other reviews or proceedings being undertaken in relation to the case, such as Independent Police Complaints Commission (IPCC) or mental health review, domestic homicide review or formal complaint, and is there a need to dovetail these processes to reduce duplication?
- Are there any legal requirements, for example judicial review?

There are a number of individuals and organisations offering approaches to Serious Case Reviews and a list of potential independent authors/chairs can be found on the Association of LSCB chairs website http://www.lscbchairs.org.uk/

The following types of review are common and few independent authors, chairs and organisations stick rigidly to one methodology. Thorough examination of agency chronologies can help determine which type of review is most suitable.

Traditional SCR with (Individual Management Review) IMRs and chronologies	This is a paper-based approach. It lacks the opportunity to answer "why" questions as there is a limited amount of involvement from practitioners.
SCR with agency reports and a series of interviews	This has the advantages of a paper-based approach but uses the term "agency reports" as opposed to IMRs to differentiate the approach. An agency report is less prescribed (and shorter) than a traditional IMR. The addition of conversations with practitioners and family members allows for much more context to be included.
Internal review of one agency or organisation	This can be a very thorough investigation but it does not involve a large number of agencies. The lead reviewer/s should still be answerable to a SCR panel to offer advice, guidance and quality assurance.
Systems SCR	This relies less on written reports and more on conversations with practitioners and family members. It looks for systemic issues both within and between agencies.
Partnership review	This is where two agencies are involved, but no others.
Thematic review	Useful for where there has been a history of concerns around a theme such as neglect, or there are a number of victims, e.g. cohort of young people subject to CSE.

Practitioner case event	Where the key practitioners who have been involved in the case come together with the lead reviewers to look at what was happening at the time and understand more about why things happened as they did. Some additional guidance for LSCBs on holding one of these can be found on page 21-22
Audit of cases	This is suitable when a single issue has been identified.

Whatever level is chosen the methodology used should:

- Reflect a culture of continuous learning and improvement;
- Be led by individuals who are independent of the case and agencies;
- Fully involve professionals and managers who should be able to contribute without fear of being blamed for actions they took in good faith;
- have a clear and realistic timeframe (historical information can be summarised)
- Invite families including children to contribute;
- Invite perpetrators to contribute;
- Invite (where appropriate) friends of the young person to contribute;
- Produce publishable, anonymised, reports with no redactions.

SCOPING CHECKLIST OF QUESTIONS

(Adapted from Social Care Institute for Excellence (SCIE) Learning Together scoping document)

Safeguarding Board:	
What is the Board wanting to look at: Particular case/Practice theme/agency or multi agency issue? Other agendas: • Trying out a new method of learning • Building internal capacity in the mentoring option • Extent of organisational sign up – is this something the Board supports? What about others? What about independent providers?	
Does the SCR involve more than one Board-Is it a joint review or is there a lead LSCB?	
Board preference Is the Board wanting to: • Use a specific model or methodology? • Try out something new?	

• Stick with the traditional way of doing things?	
Purpose of the Review What do the Board think they want to learn more about (this might be posed as a research question)	
What Budget is available?	
What time period will be reviewed?	
When do you want the Review to start?	
What else is happening? • Any disciplinary proceedings on-going for staff? • Any parallel proceedings? • Any known conflict between agencies/staff related to this case? • Any vulnerabilities or concerns?	
Are you asking for IMRs/agency chronologies? Do you have a template?	
Informing and involving family members (This needs to be discussed in more depth once lead reviewers have been commissioned.) How are family going to be informed about the SCR?	
Who will provide support to the Review? Who will be the main senior manager contact? Who will provide admin support to the review? How will documents and files etc. be assessed?	
Accountability/Quality Assurance and Governance	

What process is in place to address the above?	
Final Report Are you clear in what format and style, tone, length you want this to be? What is the process for sign off?	
Who will lead on the Project Plan for the Review? What are the key dates, meetings, milestones? Do you have a contingency plan? Have you got a communications/media plan?	

4 GOVERNANCE

COMMISSIONING AUTHORS (LEAD REVIEWERS)

The identification of lead reviewer/s will to a degree depend on local knowledge and contacts. However, it is crucial that there is good governance in the contracting process to ensure that should difficulties arise there is a process for escalation and management.

The association of LSCB chairs holds a list of authors http://www.lscbchairs.org.uk/; there are a number of other providers.

Every LSCB should ensure that the commissioning of lead reviewers is supported by a comprehensive contract. It is always worth speaking to any previous LSCB who have worked with a reviewer before.

The key things to include are:

- timeframe-how long do the reviewers think it will take , what is a realistic end date for completion, it is always good to establish this at the start and have a project plan to aid the process
- number of days
- key milestones
- contingency plans if reviewers are ill or there is some other delay such as court /criminal proceedings
- any limitations
- process for quality assurance and sign off
- what to do if there is disagreement between the LSCB and the lead reviewer/s
- clarity about copyright and ownership of report
- expectations about final report style format and structure
- if executive summary is required
- family contact
- media involvement and expectations about any contact with the press
- how confidentiality will be maintained, do they have secure email etc., do they have insurance?

AGENCY INVOLVEMENT AND COMMITMENT

All agencies involved in a SCR must ensure that they support the lead reviewer/s by giving them all the assistance, information and support they need in a timely manner. Agencies can be involved in a number of ways:

- Allocating senior managers to the SCR panel/review team
- Identifying managers to write agency reports
- Allowing staff and first line managers time to attend meetings about the review
- Allowing staff time to interact with the lead reviewer/s and agency report author in order to clarify details
- Ensuring staff involved have adequate support throughout the process
- Providing written reports for inclusion in the overview report regarding changes that have been implemented since the incident
- Allocating resources to ensure proper implementation of practice improvement and development
- Allocating sufficient administrative support to the review to minute panel/review meetings and coordinate interviews, practitioner events etc.

Any professional involved in a Serious Case Review needs to be told by their own agency that the review is a high priority and they may need to be given relief from their general duties to ensure they can participate wholly and to schedule their time accordingly.

Each LSCB should have an escalation strategy based upon the following process in the event that an agency is not meeting its obligations:

1. Lead reviewer/s agree deadlines and quality issues with staff and authors, (if unsuccessful)
2. Issue passed to the independent chair of the SCR panel to agree deadlines and quality issues with staff and authors, (if unsuccessful)
3. Independent chair of the SCR panel contacts senior managers in the relevant agency (if unsuccessful)
4. Issue is passed to the LSCB independent chair to discuss at Board level.

All agencies do not need to provide the same level of report and the requests for information should be proportionate to the involvement of the agency. In some cases a review of their own files, a chronology and confirmation that the agency has no record of note could be acceptable. The review does not need to have the same key questions asked of each agency; questions can be targeted so they are relevant for different professionals. Agency reports should be ‘signed off’ by a senior manager.

OWNERSHIP

Whilst the review report is the property of the commissioning agency – the LSCB, it is signed by the author (lead reviewers), and as such is recognised as being their work and intellectual property. The Board has responsibility for assuring the quality of the report and should not agree a report that is below the quality required. The Board is however not responsible for the author’s views. In the event that there is disagreement between the author and the Board (not related to quality) both parties

could add addendums to the report explaining their differences. In practice there is rarely a significant disagreement between the LSCB and the author though individual senior agency managers can put pressure on an author to change the report: in this instance the SCR panel should take a view. Authors are more likely to be amenable to a change of tone rather than a change of direction.

There could be a clear statement that sets out that the LSCB as commissioner of the review is responsible for the actions resulting from it. Whilst the content will have been broadly agreed between the Board and the author prior to publication, the latter has a professional responsibility as an independent person to set out any limitations to their findings or hindrance to their work. This could form the basis of the relationship between the lead reviewer/s and the LSCB as the review progresses, and should inform any disagreements between the LSCB and the author.

It will be the LSCB independent chair that will ultimately determine whether the review is meeting the quality standard required and who will be accountable for the outcomes of the review. This will need to inform the contract and the governance arrangements for the review. The lead reviewer/s must be enabled to pursue wherever the learning takes them and not to be prevented from exploring areas that are relevant to the review, but uncomfortable for the agencies involved. The lead reviewer/s should be able to discuss with the LSCB independent chair any issues that arise and to seek resolution of any problems or disagreements if the SCR panel has not resolved these.

Similarly, the LSCB independent chair may determine that the lead reviewer/s is stepping beyond the limits of the terms of reference in a way that is not helpful, and may, at worse, decide to terminate the contract and to re-commission the review. The LSCB independent chair may also determine that the initial scope of the review is too broad and may scale back the Serious Case Review to a more focussed and local review, or vice-versa. The arbiter in these circumstances is unclear, but is likely to be either the National Panel of independent experts, or the LSCB independent chair may seek advice from the National Association of LSCB Chairs.

5 TERMS OF REFERENCE

Each Serious Case Review should have terms of reference (TOR). These will need to explain the rationale for the methodology being used, including the limitations of the methodology and the way in which it will enable learning to be captured. Terms of reference should be subject to change and their suitability and relevance could be considered at each SCR panel meeting. It is advisable not to prescribe too detailed TOR until the lead reviewer/s have been appointed, as they may want to influence this and add value and expertise to the process.

They could include, (as a minimum):

- Purpose of the review – including reference to the specific incident or circumstances and the child or children who are subject to the review
- The following statement
    - Serious Case Reviews should be conducted in a way which:
        - recognises the complex circumstances in which professionals work together to safeguard children;
        - seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
        - seeks to understand practice from the viewpoint of the individuals and organisation involved at the time rather than using hindsight;
        - is transparent about the way data is collected and analysed; and
        - makes use of relevant research and case evidence to inform the findings.
- A list of contributors to the review
- Discussion about family and friends of the child who will be invited to contribute
- Key questions to be examined (See below) what it is that the LSCB want to learn more about
- How good practice will be acknowledged and celebrated
- Consideration of other processes, their likely impact and the interface between them, for example is there also a Domestic Homicide Review, how will these processes work together and is there an agreement about having one report?
- Consideration of the involvement of other geographical areas
- Timescale of the review and a timeframe of the period to be considered including a statement that any historical information considered relevant should be included
- Brief biographies of all independent people involved
- How learning will be disseminated and change will happen and be monitored
- Governance arrangements for the review including, as appropriate, SCR Panel, SCR sub-committee and LSCB
- The publication of the review and how accessible it will be to the public

Key questions are crucial to a review and it is helpful to define what your overall aim or research question is. Questions could be produced continuously starting from the point of commission of the review leading to an initial set of questions produced by

the end of the first Panel meeting. The list should include “why” questions and the lead reviewer/s (author) and Panel could be encouraged to adapt, delete and add to the questions as the review progresses providing always that there is an explanation included in the report for the reasons for change. A systems review will uncover other findings as it goes along and new questions may be posed.

DIVERSITY AND CULTURAL ISSUES

The commissioning of the Serious Case Review should include a requirement that all agency reports address cultural and diversity issues. This can often be difficult for agency report authors and the lead reviewer/s as professionals across agencies still often refrain from giving adequate attention to these issues in their own work. This lack should be commented upon though the lead reviewer/s should, at least, speculate upon the cultural issues for the child and may be able, with due contact with the child and family, describe these issues in detail.

There are times when diversity issues should be at the forefront of a report: instances of child sexual exploitation involving only one ethnic group, or the bullying of a child with disabilities for example. In such cases diversity questions should form part of the specific questions for the review to address.

PARALLEL PROCESSES

It is usual for there to be parallel processes when a Serious Case Review is being undertaken: these could be criminal prosecution, IPCC, domestic homicide or mental health review. ACPO/CPS (2014 SCR & Criminal Proceedings guidance) outlines how to manage parallel proceedings and this should guide any SCR panel's approach.

Criminal prosecution	Establish a relationship (as a minimum) between the police senior investigating officer and the lead reviewer/s. Liaise regularly. The main issue is the lead reviewer/s should not focus questions upon the event itself (this is primarily the crime that is being investigated) as this may interfere with the due process of law. Rather the lead reviewer/s concentrates upon the events leading up to the event itself and the services that were (or weren’t) provided and ways in which those services could be improved. The criminal prosecution is usually underway at the beginning of the SCR process. This means that there is material that the lead reviewer/s could make use of: video interviews and statements of victims and perpetrators. Recent reviews have used material from the trial. The use of this material does give context to the report and relieves the victim or family the necessity to retell their story. Official guidance (published 2014) can be found at http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf
IPCC	This is a similar process to a Serious Case Review but focused only upon police actions. The two authors should liaise throughout and share information. Material from one report can be quoted in the other.
Domestic homicide	In the case of murders of adults and children a domestic homicide review and a Serious Case Review will be called. One panel should be

	set up comprising members from both adults' and children's services. Two reports will need to be produced; they could be the same and written by one author, different reports with a different slant written by one author or different reports written by two authors.
Mental health	In the case of a child being murdered by an adult with a mental health problem a mental health review will be called. One panel should be set up comprising members from both adults' and children's services. Two reports will need to be produced; they could be the same and written by one author, different reports with a different slant written by one author or different reports written by two authors.

STAFF AND FAMILY INVOLVEMENT

The principle and benefits of involving family and practitioners in SCRs is well documented. SCR panels under the guidance of the lead reviewer/s should at the earliest stage consider how and who should be involved and any risks involved in doing so.

The protection of children should be paramount consideration. The process for how families and staff are alerted to the SCR must be agreed and appropriate methods of communicating identified. This may involve a number of stages depending on methodology and scope. There must be sufficient support identified for both staff and family and named senior staff charged with leading on the process for their agency.

There is often a huge emotional impact on staff who are deeply affected by a Serious Case Review: Their contribution to the review is crucial as they can often explain why things were or were not done, the context within which they were working, management and resource issues. The SCR panel, and lead reviewer/s should determine the most appropriate forum for seeing staff and this will depend on the methodology chosen, emotional impact, parallel proceedings and timeframe. Either way all staff should be given the opportunity to meet with the lead reviewer/s alone if they wish before or after they attend group discussion. Consideration will also be needed to ensure they are involved in hearing the outcome of key findings to reflect upon whether these will develop and improve practice.

If as part of the review the lead reviewer/s are intending to hold a practitioner event it is crucial that the SCR review team/panel ensure that this is planned and facilitated well. There are some key things that need to be considered in pre event preparation.

PRACTITIONER EVENT CHECKLIST

Issue for discussion	**Commentary**	**Action/ resolution agreed**
Identifying the right practitioners to attend	Really helpful for review team/panel to draw up clear list of who and why they want to involve certain professionals	

Communication, support and briefing pre and post the practitioner event	Key role of review/panel members to ensure this happens and their role in it	
Managing who else should be there, who will facilitate, what happens if managers or uninvited people turn up	Unexpected people always turn up, really important that chair/lead reviewers manage this with the agency leads. What if the LSCB chair wants to come or another senior manager, legal advisor what is your view on this? Who from the review team/panel should attend? If they are also senior managers to staff at the event how will this impact on participation.	
Setting the right tone	Need to agree how conflict, emotions will be handled and agree prior to the event who will be on hand to provide support on the day	
Confidence in the facilitators	Have you checked if the lead reviewer/s have done it before, these are not easy events and must be done by confident and experienced facilitators	
Venue	This makes all the difference, it must be a facility that is conducive to the event, has break out space, refreshments food and warmth	
Pre event administration and recording the event itself	Organising an event takes quite a lot of time, have you agreed who will do this? Often there are chronologies, or other information to be copied and adapted for the event. Have you agreed how the information on the day will be captured and fed back	

	to review team and participants?	
Clarity about purpose and timing	The lead reviewers must be clear at what stage in the review they want to hold the event and what they see as the primary purpose of it. This is should be agreed and scoped out with the review team and chair.	
How case and child will be referred to ensure that the event brings the child/ren into the room	Helpful if this is discussed prior to the event. Are there any limitations regarding confidentiality? How can you make sure that it is child focused?	
De brief process	Need to ensure that at the end of the day this happens, ensure you have enough time, they can be very emotional events	
What if key people are missing?	There are always people who cannot attend, have left/moved on. It is possible to try and seek their views via other means prior to the event and bring this into the room on their behalf.	

It is rare but occasionally staff members involved in a Serious Case Review are also subject to disciplinary proceedings caused by the same event that led to the review being called. In this case the two procedures can run concurrently but there should be close liaison between the staff member's manager and the lead reviewer/s.

INVOLVEMENT OF THE YOUNG PERSON

Wherever possible young people should be supported to participate in the review to ensure their voice is heard. Depending on their age and capacity they should be appropriately informed of the process and timetable and continually offered the opportunity to have their views heard.

FAMILY INVOLVEMENT

Professionals should be aware that Serious Case Reviews (or any published reviews) could be traumatic for children who have survived abuse or neglect, other children within their family and family members. They can also be cathartic,

demonstrating the importance with which local professionals; senior managers and the State itself place upon the devastating effect of their child being abused.

Parents and people with parental responsibility should be involved in reviews though there may be debate in situations when a young adult who had been abused does not want them to be involved. The Panel will need to balance the wishes of the young person with the family's right to know and the possibility that the family may be able to offer further insight that will assist the review. If nothing else they must be informed of the publication date of the report and any Press activity. The panel, review team, independent chair and lead reviewer need to make informed judgements on whom to involve.

Further family members and significant others should be invited to participate. This should be with the young person's permission (or if the child is too young the permission of parents and people with parental responsibility). In cases where permission has not been given but the Panel believe that the extended family or significant others have something of value to offer the lack of permission can be over-ridden.

Involvement may involve members of the public wider than family. These could be:

- the child as appropriate
- their brothers and sisters
- friends of the child
- parents/foster carers
- others with parental responsibility
- grandparents
- uncles and aunts
- friends of the family
- any member of the public who made a referral regarding the incident
- the perpetrator of the abuse

It is rarely appropriate to have only one meeting as family members need to have the process explained to them, be invited to add their lines of enquiry and have findings fed back to them. These meetings can be shared between Board business managers, review team members and lead reviewer/s. Family members frequently add a further dimension to reviews; they talk about "how" services were delivered as well as "what" services were delivered.

Perpetrators of abuse and neglect can offer insight into their actions and can discuss issues of prevention.

6 THE FINAL REPORT

FINDINGS AND RECOMMENDATIONS

The purpose of these reviews is to identify improvements, which are needed, and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of death, serious injury or harm to children.

Recommendations need to be short, punchy and unambiguous. Social Care Institute for Excellence (SCIE) suggest that there are three different kinds of recommendations:

1. Issues with clear cut solutions that can be addressed locally and by all relevant agencies
2. Issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers.
3. Issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level.

Authors should be careful about recommending “review” and “training” as these are easy to state but time consuming to apply. When people fail to do something that they probably know they should be doing – more training is unlike to improve matters. All panel members, not just the lead reviewer/s, should suggest recommendations, ideally few in number.

ACTION / IMPROVEMENT PLANS

The LSCB should consider the findings and recommendations, take responsibility for them and use them to assist with the development of their action plan. Depending on the type of review commissioned the style and format for action will vary. It is not the job of the lead reviewer/s to do this on their behalf.

The following headings could be used to turn recommendations/findings into action plans but a tick box approach to evidence action may not bring about any significant change so should be used cautiously.

- Finding (what did the review find) what questions does this pose for the LSCB?
- Objective (what is being recommended?)
- Actions (what needs to be done)
- Date (by when)
- Lead (who is responsible)
- Outcomes (these should be expressed in terms of impact not process.) So an outcome for training on record keeping, for example, is not “90 staff will have attended training” but “record keeping will better reflect the voice of the child” and we can evidence that is had made a difference because a recent audit of 50 cases shows a marked improvement.

There needs to be some way of collating what difference any of the learning has made to local practice, this will need to be evidenced.

The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

SIGN OFF FROM THE BOARD

The SCR Panel should work with the lead reviewer/s to get the report fit to go to the Board before a presentation is made to the Full Board. The presentation could be (at least) a discussion of the findings of the review. The discussion could be formal or informal but could include:

- The reason for the review
- The methodology chosen
- A description of what happened
- An analysis relating to the key questions and some appraisal of the standard of practice
- Broad recommendations and findings

A small group of Board members or the SCR sub-committee should then be tasked with agreeing the final wording of the report based upon the views of the Full Board.

7 MEDIA STRATEGY

Handling the media well (usually local newspapers but sometimes national press, radio and TV) is crucial in assuring the public about how well lessons are being learned, practice improved and reducing the 'witch hunt' mentality that can ensue from Serious Case Reviews. There should be a joined up approach between all LSCB partner agency's communication officers; it is often helpful if the Local Authority take responsibility for coordinating any media strategy.

Media contact should be considered throughout the review process and should be based upon balancing the likely public interest in the case and the needs of surviving family members. The DfE expect all SCR's to be published without redaction and any decision not to will need to be communicated to them. There are times when it may be best to publish a review without notification to the Press if it is of little public interest but could be damaging to family members.

Where press coverage is likely the LSCB should:

- ensure that the communications officer in the Local Authority contacts the local Press (and National Media if the case is likely to be of national interest) – and keeps them updated of events;
- be helpful and clear, acknowledge concerns, be sympathetic to families whose children have died or been injured and be clear that there is already, or will be a robust review, but explain why you cannot compromise the confidentiality of children and give a time scale for when more details will be released;
- ensure that everyone understands how press releases will be made and that no statements should be made outside of the agreed strategy;
- be proactive – develop a media strategy as soon as a review is commissioned and have a clear and succinct statement ready (which will change as the review progresses) that is agreed by all agencies;
- delegate someone (possibly the SCR panel chair) to lead on advising the communications officer regarding progress;
- not leak any details, likely findings or recommendations until the review process is complete and all people involved can agree a joint approach to the Media;
- ensure that all Press enquiries should be passed to the SCR panel chair (or anyone else nominated to deal with the Press) who should follow these guidelines when responding;
- communicate the findings to all chief executives in all local agencies and advises them of the next steps;
- prepare a joint press statement involving (at least) the SCR panel chair, lead reviewer/s, LSCB independent chair, Director of Children Services (DCS), Head of Service for safeguarding children and other agencies communications officer;
- consider inviting local newspaper representatives (as well as National Media if appropriate) to a specially convened Media briefing event; this should be tightly managed and should involve as few people as possible (all of whom

should have received training on dealing with the Media). These could be the LSCB independent chair, DCS and the lead reviewer/s and senior managers of any relevant agencies. It is likely that the public want to see independence (of the review) but a local agency commitment to change and this joint approach provides that;
- ensure that a liaison officer is allocated to the family, this could be already in place via the police, or could be the LSCB safeguarding business manager. The family need to know what will be said and when and they need to be advised about how to handle any enquiries that they may get from the Media. The family should be able to make the same use of any support available to local agencies as any professional, i.e. reference made to the communications officer or person responsible for liaising with the Media.

Communication with local press should not just be related to Serious Case Reviews. It is equally important to:

- Have in place a clear communication strategy for the Board which includes your relationship with the media as a matter of course;
- Nurture your relationship with the local press, providing them with updates on local safeguarding initiatives so that you have named people to relate to and a more sympathetic ear when things go wrong – use the Local Authorities press office to make sure that you have regular meetings with the press as the LSCB independent chair;
- Keep your LSCB website up to date as this is the front facing part of the Board;
- Have in place an agreement with all member agencies that all statements to the press regarding safeguarding work – not just case reviews - are routed through the LSCB independent chair and nominated press officer. This could include any single agency issues that relate to the protection of children. A united approach is crucial. Best practice is to have a small media communications group made up of press officers from each of the key agencies, who are proactively targeting the local press and who will then act as the working group for any Serious Case Review communication, and who will ensure that there are no ‘leaks’.

PUBLICATION

The LSCB must prepare for publication at the very start of the review. The final published report, which should be written in plain English and be suitable for publication without needing to be amended or redacted, should provide enough detail so that the public reader can understand what happened, (or didn’t happen) and why, together with what has been learned and how this has already developed and improved practice and systems, or how it will in the future. It should be written in such a way that publication would not be likely to harm the welfare of any children or vulnerable adults involved in the case.

The LSCB chair will also be expected to write a formal response to the SCR report and this should be published alongside the report where possible and sent to the DfE and National Panel

Lead reviewers may also be asked to produce a shorter learning summary to support dissemination and feedback to practitioners and the wider professional network. The report should be readily accessible on the LSCB's website for a minimum of 12 months and thereafter should be made available on request.

In exceptional circumstances where there is deemed to be a significant risk of further harm to a child or their family the LSCB may decide not to publish a SCR. Any decision would need to fully discussed with the DfE, anonymous publication is also an option in exceptional cases, with the agreement of the National Panel. They will ask for 'evidence' from experts who know the case to support whatever your reasons are for not wanting to publish locally.

8 LEARNING AND IMPROVEMENT FRAMEWORK

LSCBs should maintain a local learning and improvement framework, which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

SCRs play an important part in the Learning and Improvement framework for the Board and well-functioning LSCBs are able to evidence that all staff are aware of the outcomes of local reviews and take account of these in their practice.

The learning from SCRs takes place in three ways:

1. During the review process – a good review will ensure that those involved are given the opportunity to consider events in a safe way and to learn from them through reflection with the reviewer/s, either on an individual or group basis. The lead reviewer/s will usually evidence this in the report itself. Systems methodologies usually feature whole system learning events so that the focus throughout is on learning and agreeing solutions. However, as a minimum, professionals who have been involved in the life of the child need also to be involved in reflecting on practice and contributing to the review. This should be evidenced in the report itself, and also via feedback questionnaires to those staff when the review is finished; where reviews are critical of practice, the review draft should have been shared with the staff concerned and their thoughts and responses considered in the way in which the report is written. The Board should be able to evidence this feedback loop.

2. Through dissemination of the SCR report after the review – this should be planned at the outset, and as a minimum should include information sessions for staff across all member agencies. This could include e-learning and/or face-to-face sessions, including all member agencies confirming that the SCR has been discussed in service and team meetings. Narrative is a powerful element of learning and case studies could be created from each SCR that then inform the training and development programme for the Board.

3. Through the implementation of recommendations and findings – professionals should know what underpins changes to their practice so that they can understand and internalise such changes: this is very powerfully demonstrated in systems learning approaches where professionals are given the opportunity for reflection and to frame change positively. To replicate this learning more widely, the implementation of recommendations could therefore be explained to all staff via the training programme and the communications strategy of the Board. The LSCB website could clearly link outcomes from Serious Case Reviews to changes in training or procedures so that this is an overt message to staff, and Board members could identify opportunities for professionals to meet to discuss learning and to provide feedback to the Board about how the implementation of recommendations affects their daily practice.

The Board will also need to assure learning through:

- Feedback from training and information sessions
- Single and multi-agency audit of cases reflecting the themes identified in SCRs and other reviews;
- Development of practice forums or discussion sets or circles where specific SCR related issues are reflected on in relation to current practice and systems, and
- Critical or vital signs and exception reports relating to the performance data for the Board

The following 'Learning and Improvement Framework' could be included at the introduction to any Serious Case Review report. These are that Serious Case Reviews:

- Are necessary to ensure transparency of practice and decision-making and to promote continuous and accountable[4] learning across the professional network that provides support and help to vulnerable children in our society
- Will demonstrate compassion, humanity, and be fearless in pursuit of learning
- Will always use an evidence based approach that is objective, fair, and based on equalities principles
- Will always seek to reflect the voice of families
- Will follow a systems approach – in acknowledging that individuals do not work alone, but operate within broader systems and an organisational, political and personal context which impacts on their practice and that learning needs to understand and address this in understanding why things happen
- Will reflect the multi-agency context and responsibility for safeguarding children
- Will be proportionate to the individual circumstances that prompt the review
- Will result in reports written in order to be published in line with the first principle, whilst respecting confidentiality and demonstrating sensitivity about the impact of this on families and professionals
- Will result in development of practice as well as practitioner and organisational development

Improvements to practice should be implemented as soon as they are recognised.

[4] Accountability in a review is to the public, families, victims, professionals and ultimately to government and can be cathartic and positive in laying to rest public and family concerns

9 APPENDIX 1 CHECKLIST FOR LSCB INDEPENDENT CHAIRS

Commissioning Serious Case Reviews – Checklist for LSCB independent chairs

Issue / criteria		Comments
1	In relation to the incident referred: Has a child or children died?	
2	Is there evidence or suspicion of abuse or neglect? - Are there any factors present that would indicate risks to the child concerned or increased vulnerability? If so, what are they?	
If these answers are YES then you must commission an SCR If question 1 is no, but question 2 is YES, then you need to consider 3:		
3	Is the harm 'serious' that is, it has/had an enduring and/or significant impact on the child and their past/ current or future life chances?	
If the answer is YES then you must commission an SCR If you are unsure you must consult with a peer independent chair: Date: Peer Chair: Decision and rationale: If the decision is to proceed with an SCR, the following checklist will assist you in commissioning a proportionate review		
4	On a scale of 1 – 5, with 5 being high, a) What is the likelihood of there being potential professional culpability in terms of actual harm or failure to safeguard? b) What is the level of public interest in the case now, or likely to be in the future when these events are in the public domain?	
If the answer to the above are scores of 4 or 5 you should consider a hybrid or investigative methodology Scores of 3 and below will lend themselves well to systems learning or root cause analysis types of approaches		
5	What methodology is likely to be most helpful in identifying learning? Who will be most important to engage in the review?	

Issue / criteria		Comments
6	What governance will be in place – will there be an SCR Panel? If so, who will Chair it? Who will quality assure the process?	
7	Are there any other review or legal processes in place that might impact on this review? Is so, what and how?	
8	What qualities and experience should the lead reviewer/s have for this case? Is there a need for expert advice in addition to this?	
9	What finance is available/ identified for the review?	
10	What is the time scale for review completion?	
11	What is the media strategy: who will lead this? (see checklist for media) Engagement of key agencies – who, when, how? Pre-meeting with local press? Joint statement to be agreed? Press briefing?	
See also suggested checklist for review scope and remit		Chair's signature: Date:

10 APPENDIX 2 GUIDELINES FOR DECISION MAKING

1.

Incident leading to referral

The referral must clearly state why - in line with statutory guidance - a review is thought to be necessary and that the referral is fully supported by the agency concerned.

NB: A short period of reflection is advised before submitting a referral to ensure that it is appropriate.

2.

LSCB Manager and Director/Lead for Safeguarding to undertake initial review and circulate to SCR Sub Committee for comment

3.

Comments collated by LSCB

Advise Board Independent Chair who will agree whether appropriate for SCR Consideration Panel

3(i) **If Yes:**

- **All agencies requested to provide written information held on family**
- **Proceed to consideration panel**

(Timescale – 14 days)

3(ii) **If No:**

- **Letter to Referrer with full explanation of reason(s)**
- **Confirmation to SCR Sub Committee**

4.

Convene Consideration Panel and appoint Panel Chair, who should be independent of the services directly concerned with the case

Collated multi-agency information will be shared before the meeting

5.

At the consideration meeting the Panel Chair will make clear the purpose of the meeting and ensure that an overview of the case is outlined to all Panel Members based on the information available at that time

6.

The Board's legal adviser will remind Panel Members of the options available to them in considering the circumstances of the case, based on national guidelines and may comment on how they are likely to apply to the case

7.

Panel Chair will require all agencies present to give information known to them about the case and those directly involved. The Panel Chair will seek to ensure that information is clear and unambiguous.

Panel Chair will ensure that key information is carefully logged for future reference

8.

Panel Chair will ensure that the information given by agencies is discussed, questioned where necessary, and clearly understood by the Panel members

9.

Based on the information available related to the incident and the case, the Panel Chair will ask Members to explain whether or not they consider that learning may arise from further consideration of the case and whether it should be subject to review - clearly giving a rationale in support of their view (which must be recorded)

Members will be asked to vote based on the following:-

- **(i) The rationale for their view of whether the criteria set out in Working Together for review are met**
- **(ii) Proportionality – the type of review undertaken and the learning expected based on the principles set out in Working Together**

*The rationale referred to here will be based on agencies' consideration of the circumstances of the case and **NOT** concerns about reviewing processes*

10.

In the event that the Panel considers that further learning could be derived it will then consider the nature of the review that may be appropriate, i.e. SCR or alternate review, also taking into account the advice of the Board's legal adviser. The Panel should also comment on any key issues it believes to be essential in setting out terms of reference for the review.

It is important that the Panel separate consideration of the need for review from the actual review process given that they are two entirely different considerations

11.

Panel Chair will promptly write to Independent Chair confirming the Panel's recommendation regarding the need for SCR or other review. This letter will make clear the key considerations and rationale of the Panel in reaching its conclusion and highlight any significant areas of disagreement if necessary. This recommendation must be clear and unambiguous to the Chair stating the reasoning behind the decision.

12.

Independent Chair will promptly consider the recommendations of the Panel and seek clarification or additional information, if considered necessary. It should be clear that the Independent Chair will not automatically accept recommendations from the Panel and will reserve the right to challenge if considered necessary or appropriate. The basis of any challenge from the Independent Chair will be made clear

The options open to the Independent Chair at this point are to accept or reject the recommendations of the Panel or to defer a decision pending receipt of further information. The Independent Chair will reserve the right to review this decision in light of any further information which may become available

13.

The Independent Chair will make a decision and confirm in writing to the Panel Chair and the Chair of the standing SCR Sub Committee.

14.

If SCR or other review to be commissioned the Independent Chair will request that a review panel be convened and a Lead Reviewer be appointed.

15.

Terms of reference and methodology to be discussed and agreed with the Lead Reviewer by the LSCB Manager/Lead for Safeguarding and then signed off by the Panel taking into account key issues arising from the consideration panel discussions

The terms of reference will need to make clear explicitly which organisations/agencies are expected to co-operate with the review and also the basis upon which they are required to contribute information to the review process

11 APPENDIX 3 CASE STUDIES

The following case studies can be used as a discussion tool for decision making at SCR panels against the criteria in Working Together (DfE 2015) (chapter 4).

CASE STUDY 1

A young woman (aged 22) had been in care to the local authority. Her baby died three days after a premature birth. She said she had fallen over. She had been in a relationship with a man and there was one instance of physical domestic abuse between them. No charges were brought by the police against the mother or the man.

The LSCB decided that there was a suspicion that the man may have kicked her in the stomach causing the premature birth and so a Serious Case Review was commissioned. A panel was set up, a joint chronology produced and an author was invited to audit files and interview the young woman and staff.

It transpired that it was not possible to write a report as there was no relevant information.

CASE STUDY 2

An employee at a school was sentenced to imprisonment for sexual activity with a minor (a pupil at the school). Initial investigations showed that the family had no contact with agencies beyond the normal universal services and the employee had not come to the attention of any agencies beforehand.

The LSCB decided that a Serious Case Review was warranted because the girl had been seriously harmed and there were lessons to be learned. A panel was set up and lead reviewer/s commissioned. Agency files were checked and, as no other information was available the review consisted of interviews with school pupils, the perpetrator and professionals and a short report was drafted detailing how practice would be improved and developed.

CASE STUDY 3

A baby died after co-sleeping with his grandmother (who had been drinking) on a sofa. The baby's mother had a low level of learning difficulties and had accessed services from Health professionals and a Children's centre.

The LSCB decided that a Serious Case Review was warranted because the baby had died and the mother and grandmother had been charged by the police with neglect. A panel was set up, a joint chronology was created and the lead reviewer/s carried out four group conversations with staff, accessed case records and files and produced a long and detailed report.

CASE STUDY 4

A young woman who had been in care was sexually abused by at least 20 men over a period of 6 years when she was aged 12-18.

The LSCB decided that she had been seriously harmed and there were lessons to be learnt regarding how professionals worked together. A panel was set up, all agencies produced agency reports, perpetrators, the young woman and staff members were seen as well as case files and a long and detailed report was produced.

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