NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CONTENTS

1. CRITERIA

A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;
- A child has been seriously harmed and abuse or neglect is known or suspected;
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected).

The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSCB or LSCBs promptly, and within five working days of becoming aware that the incident has occurred.

For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review (see below) then it will also meet the criteria for a notifiable incident (above). There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

2. AGENCY REFERRAL TO SERIOUS CASE REVIEW SUB GROUP

Where a case is identified where there are issues that potentially meet the criteria for a Serious Case Review the case should be discussed with the manager within the organisation. If in agreement the case potentially meets the criteria the manger should make a referral to the Serious Case review Sub group. Please use the Safeguarding Children's review referral form for consideration by the NEL Serious Case Review Sub Group **(see NEL LSCB Serious Case Review Section on the LSCB Website)**

3. CRITERIA FOR SERIOUS CASE REVIEWS

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

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

- (2) For the purposes of paragraph (1) (e) a serious case is one where:
  a) Abuse or neglect of a child is known or suspected; and
  b) Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

"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 potentially life-threatening injury;
- 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.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB must commission an SCR.

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.

4. DECISIONS WHETHER TO INITIATE A SERIOUS CASE REVIEW

- The NEL LSCB must decide whether an incident notified to them meets the criteria (see Section 1.1, Criteria) for a Serious Case Review. This decision should normally be made within one month of notification of the incident. The final decision on whether to conduct an SCR rests with the LSCB Independent Chair. The Chair may seek peer challenge from another LSCB Chair when considering this decision (and also at other stages in the Serious Case Review process);

- The LSCB must notify Ofsted and the National Panel of Independent Experts of the decision. A decision not to initiate a Serious Case Review may be subject to scrutiny by the national panel and require the provision of further information on request and the LSCB chair may be asked to give evidence in person to the panel;

- The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report;

- The LSCB should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.

5. CONSIDERATION OF CASES THAT DO NOT MEET THE SCR CRITERIA

Where a case does not meet the criteria for review the SCR standing Sub Group will consider whether an alternative form of review should be undertaken where:

- Single agency audits or reviews of cases identify significant practice issues within the service's own safeguarding systems, processes or procedures;
- Complex cases that raise concerns and have implications for more than one agency or service with regard to: Referral, assessment, planning, intervention, decision-making and information sharing;
- Cases in which good or excellent practice has been identified which indicate there would be benefit from a review or in depth scrutiny of factors that would promote good practice and agencies could learn from;
- Cases that have been audited via the multi-agency audit framework and it is felt the case meets any other criteria above and would benefit from review;
- Complex or 'stuck cases' that practitioners or managers are struggling to find a way forward and would benefit from an in depth analysis of factors preventing progress or posing a risk.

Where LSCB member agencies identify a case that does not meet the SCR criteria but may meet the criteria for any of the Learning Lessons style of review listed above use the Safeguarding Children's review referral form for consideration by the NEL Serious Case Review Sub Group.

6. METHODOLOGY FOR LEARNING AND IMPROVEMENT

Working Together 2015 does not prescribe any particular methodology to use in such continuous learning, except that whatever model is used SCRs and other case reviews should be conducted in a way which are consistent with the following 5 principles:

- 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;
- Transparency about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

Whilst Working Together stops short of advocating any specific method the systems methodology as recommended by Professor Munro (**The Munro Review of Child Protection: Final Report: A Child Centred System**) is cited as an example of a model that is consistent with these principles.

Irrespective of the methodology the emphasis must be on the establishment of a local framework for learning and improvement which will achieve the outcomes set out in Learning and Improvement Framework Procedure, Purpose of Local Framework.

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- 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.

7. APPOINTING REVIEWERS

The LSCB will appoint one or more suitable individuals to lead the Serious Case Review. Such individuals should have demonstrated that they are qualified to conduct reviews using the Learning and Improvement Framework Procedure, Principles for a Culture of Continuous Improvement.

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

The LSCB will provide the National Panel of Independent Experts (see Section 1.12, National Panel of Independent Experts on Serious Case Reviews) with the name(s) of the individual(s) appointed to conduct the Serious Case Review and consider carefully any advice which the panel provides about the appointment/s.

Working Together 2015 does not specify the need for an independent chair for the review process: the need for this will depend on the review model selected, the complexity of the case and other local considerations. The approach should be proportionate to the scale and level of complexity of the issues being examined.

8. TIMESCALES FOR SERIOUS CASE REVIEW COMPLETION

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

- Capture points from the case about improvements needed; and
- Take any corrective action identified as required to implement improvements and disseminate learning;
- In addition, the LSCB can require a person or body to comply with a request for information Section 14B of the Children Act 2004. This can only take place where the information is essential to carrying out LSCB statutory functions. Any request for information about individuals must be 'necessary' and 'proportionate' to the reasons for the request. LSCBs should be mindful of the burden of requests and should explain why the information is needed.

9. ENGAGEMENT OF ORGANISATIONS

The LSCB will ensure appropriate representation in the review process of professionals and organisations involved with the child and family.

The LSCB may decide as part of the Serious Case Review to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review. The form in which such written material is provided will depend on the methodology chosen for the review. The standing Serious case Review Sub Group will identify a Serious Case Review Panel will to oversee the management of the review and to report directly back to the standing SCR group. The panel will consist of partner agencies relevant to the specific review.

10. AGREEING IMPROVEMENT ACTION

The LSCB will oversee the process of agreeing with partners what action they need to take in light of the Serious Case Review findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions. The standing SCR Sub are responsible for overseeing the implementation of the SCR action plan in **terms of both progress and impact.**

11. PUBLICATION OF REPORT

In order to provide transparency and to support national sharing of lessons learnt and good practice in writing and publishing such reports, all reviews of cases meeting the Serious Case Review criteria will result in a readily

accessible published report on the LSCB's website. It will remain on the web-site for a minimum of 12 months and thereafter be available on request. Please see **NEL Serious Case Review Report and Publishing Policy**.

The fact that the report will be published must be taken into consideration throughout the process, with reports written in such a way that publication 'will not be likely to harm the welfare of any children or Adults at Risk involved in the case' and consideration given on how best to manage the impact of publication on those affected by the case. The LSCB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders.

The final Serious Case Review report should:

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

The LSCB will publish, either as part of the final Serious Case Review report or in a separate document, information about:

- Actions already taken in response to the review findings;
- The impact these actions have had on improving services; and
- What more will be done.

The LSCB will send copies of all Serious Case Review reports to the National Panel of Independent Experts at least one week before publication. If the LSCB considers that a report should not be published, it should inform the panel which will provide advice. The LSCB will provide all relevant information to the panel on request, to inform its deliberations.

12. NATIONAL PANEL OF INDEPENDENT EXPERTS ON SERIOUS CASE REVIEWS

Working Together to Safeguard Children 2015 introduced a National Panel of Independent Experts to advise and support LSCBs about the initiation and publication of Serious Case Reviews. 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 will report to the relevant Government departments their views of how the system is working. LSCBs should have regard to the panel's advice on:

- Application of the Serious Case Review criteria: whether or not to initiate a Serious Case Review;
- Appointment of reviewers;
- Publication of Serious Case Review reports.

LSCBs should have regard to the 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 reports and invitations to attend meetings.

13. CONSIDERATIONS FOR LOCAL PROCESSES

- Engagement of families, children and service users. There is an increasing body of evidence that the family members, including children, can make a valuable contribution to professional understanding;
- Coordination with parallel review processes (that still require formal IMR's such as Domestic Homicide Reviews);
- Publication in full of the Overview Report;
- Appointment of a 'lead reviewer' rather than an Overview author and independent chair;
- Auditing and monitoring of the 'programme of action' following the findings of the review;
- Using tools which are suitable for inter-agency auditing i.e. those which capture similar data and track evidence in a consistent way.

14. FURTHER INFORMATION

NSPCC Serious Case Reviews Repository

SCIE Serious Case Review Quality Markers