



# **Safeguarding Children 2010 Serious Case Review Procedure**

September 2010

## **Bromley Safeguarding Children Board**

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# CONTENTS

<b>CONTEXT</b> .....	1
1 Functions and Role of Bromley Safeguarding Children Board.....	1
2 Managing the Process .....	2
3 The Purpose of Serious Case Reviews (SCRs).....	2
4 Links to Other Processes .....	3
5 When should a Serious Case Review be undertaken?.....	3
6 Scope and Terms of Reference .....	5
7 Flow Chart: BSCB SCR Timescales and Process .....	6
8 Timescale of an SCR .....	7
9 Guidance on preparing Individual Management Reviews.....	9
10 The Overview Report .....	12
11 BSCB SCR Panel action on receiving an overview report .....	13
12 BSCB action on receiving the SCR report .....	13
13 Publication.....	14
14 Accountability and disclosure.....	14
15 Learning lessons locally .....	14
16 Reviewing institutional abuse.....	15
APPENDICES.....	16
TEMPLATE 1: Terms of Reference .....	17
TEMPLATE 2: Individual Management Review .....	20
TEMPLATE 3: Chronology.....	25
TEMPLATE 4: Action Plan.....	26
Information Sheet 1:.....	28
Information Sheet 2.....	29

# CONTEXT

## 1 Functions and Role of Bromley Safeguarding Children Board

- 1.1 Working Together to Safeguard Children 2010, Chapter 8 sets out the main reasons for conducting a serious case Review and explains the reviewing and investigation function of the BSCB. This procedure assists professionals in all agencies to engage with the SCR process. It informs agencies about their role, responsibilities and duty to contribute to serious case review and sets out the BSCB's expectations. This procedure should be read in conjunction with the multi-agency guidance contained within Working Together.
- 1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006<sup>1</sup> requires LSCBs to undertake reviews of serious cases. The regulation states:
- 1. (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
  - 2. A serious case review 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.
- 1.3 Serious Case Reviews should be undertaken in accordance with the procedures and guidance set out in Working Together to Safeguard Children (2010). The same criteria apply to all children, including those with a disability.
- 1.4 The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning. The child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations. Reviews vary in their breadth and complexity but, in all cases, **where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed.** (WT 2010).

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<sup>1</sup> Local Safeguarding Boards Regulations 2006, Statutory Instrument No 2006/90.

## **Referring Cases**

- 1.5 Any professional or agency may refer a case to the BSCB for investigation if they believe that there are important lessons for intra-and/or inter-agency working to be learned from the case. Consequently, the BSCB may request an Individual Agency Management Review to be undertaken and reported to partners.

## **More than One LSCB involved**

- 1.6 Where partner agencies within other LSCB areas knew or had contact with the child, the LSCB for the areas in which the child is or was normally resident takes lead responsibility for conducting the SCR. Other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. Where a child is looked after, the local authority looking after the child has lead responsibility for conducting the SCR.

## **2 Managing the Process**

- 2.1 Bromley Safeguarding Child Board has an Executive Committee, which acts as the SCR Sub Committee, as the need arises. This committee provides advice to the Chair of the BSCB on whether the criteria for conducting an SCR have been met.
- 2.2 When the Chair agrees that an SCR should be undertaken, SCR Sub-Committee convenes a SCR Panel to manage the process and ensure that the SCR is conducted in accordance with the guidance. The committee is responsible for establishing the scope and terms of reference (see Appendix 1) for the review.
- 2.3 In Bromley the Chair of the SCR Panel can be an independent person. It is currently the Independent Chair of the BSCB.
- 2.4 The Chairperson is responsible for notifying Ofsted of the outcome of the decision on whether a SCR is to be undertaken. Other agencies such as health and the police will be responsible for notifying their inspectorates of the decision to conduct a SCR.

## **3 The Purpose of Serious Case Reviews (SCRs)**

- 3.1 The purpose of serious case reviews, as set out by Working Together to Safeguard Children 2010, is to:
- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
  - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
  - improve intra and inter-agency working and better safeguard and promote the welfare of children.

3.2 In all cases and at all stages in the SCR process from the first notification to the final reports, information relating to children, family members and professionals involved in the case should be anonymised before being submitted to any external organisation or body including Ofsted and Department for Education.

#### **4 Links to Other Processes**

4.1 *Investigating how a child died* - this is a matter for Coroners and criminal courts, respectively, to determine as appropriate. Serious case panel should bear in mind any impact the review might have on a criminal case.

4.2 *Child death review procedures* - These can run in conjunction with a serious case review to review whether there are any public health lessons to prevent similar deaths in the future as well as ensuring that families are supported through their bereavement.

4.3 *Disciplinary process* - Serious Case Reviews are not part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a SCR indicating that disciplinary action would be appropriate, such action should be undertaken separately from the SCR process and in line with the agency's disciplinary procedures. Reviews may be conducted concurrently with disciplinary action. In some cases (for example, alleged institutional abuse) it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children. WT 2010

4.4 *Notification of serious incidents*

- *Serious Incident notification (SIN)* - SIN should be completed and submitted to Ofsted and GOL within of Children's Social Care or BSCB being made aware of a potential serious case. Within a month the BSCB should have met to make a decision as to whether or not the case meets the criteria for a serious case review. Ofsted and GOL must be notified of the decision.
- *Serious Untoward Incident (SUIs)* - Within the NHS serious cases involving children are considered as SUIs. The PCT (Commissioning) must be informed via the Designated Nurse of a potential serious case. The PCT must inform NHS London within 24 hours of being notified.

#### **5 When should a Serious Case Review be undertaken?**

5.1 The BSCB will undertake a SCR when:

- a child has died (including death by suspected suicide) **and** abuse or neglect is *known or suspected to be a factor in the death*;
- *a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse*;
- *a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.*

5.2 The BSCB will consider undertaking a SCR when:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

**and** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

5.3 The BSCB Executive Committee, which acts the and Serious Case Review Sub Committee will consider following questions 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:

- Was there clear evidence of a risk of significant harm to a child that was:
  - not recognised by organisations or individuals in contact with the child or perpetrator **or**
  - not shared with others **or**
  - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on 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 the subject of a child protection plan at the time of the incident, or had they previously been 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 LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

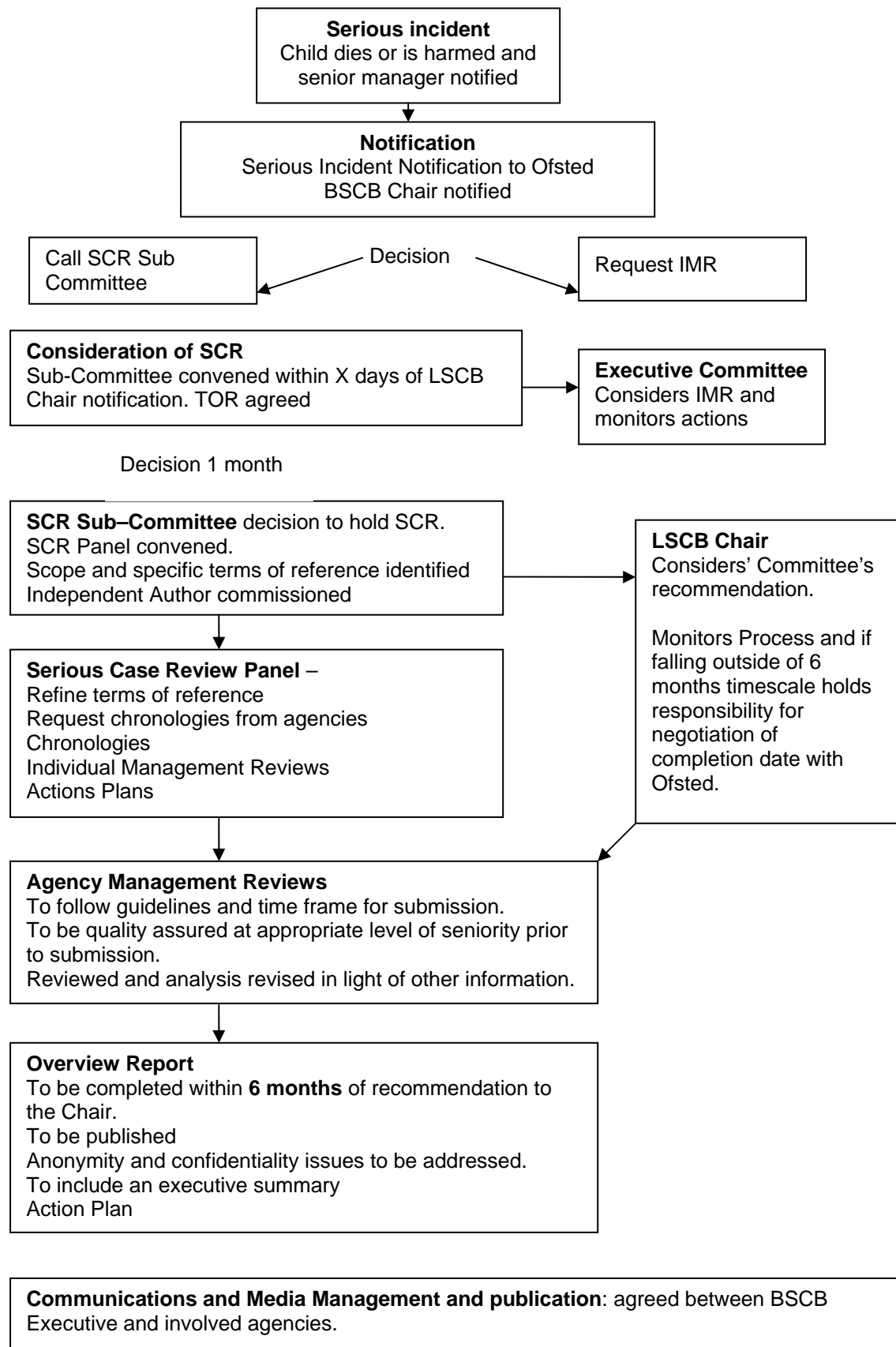
The SCR Sub Committee will make a recommendation to the Chair of the BSCB regarding whether a case should be subject to a SCR. The decision to undertake a SCR will be made by The Chair within one month of this recommendation being made.

## **6 Scope and Terms of Reference**

Working Together 2010 para 8.20 sets out guidance to the SCR Sub Committee and Panel on developing the scope of the review and drawing up clear terms of reference. The BSCB have a standard format for the terms of reference (appendix). It is the responsibility of the BSCB chairperson to ensure that the terms of reference address the key issues in the case and approve them. Other relevant issues to consider include:

- Timescales
- Period of time covering the review
- Relevant background information about the family
- How the family including siblings are involved in the review
- Consideration around religion, race culture diversity and equality
- Immigration status
- Which organisations and professionals need to contribute to the review
- Making the link to and supporting non-statutory organisations
- Involvement of agencies from another LSCB
- Requirement for outside expertise, eg independent legal advice
- Parallel investigations or reviews, eg disciplinary, health processes, prison service
- How the review addresses a coroner's enquiry and criminal investigations or other court proceedings and liaise as appropriate.
- Taking account of research and other SCRs undertaken by the BSCB
- Managing relationship with family, the public and the media throughout.

## 7 Flow Chart: BSCB SCR Timescales and Process



## 8 Timescale of an SCR

SCRs must be completed within 6 months of the decision to conduct a review. The following timescales are to be adhered to unless agreed otherwise with Ofsted. Divergence from the timeline is only acceptable where there have been significant unforeseen complexities or other procedures take priority i.e. criminal proceedings or coroner inquest.

Issue	Timescale	Action required	Person responsible
Notification 1 Incident of serious harm or death		Inform agency lead for safeguarding (initiate of child protection or child death review procedures)	Reporter
Notification 2 Inform BSCB	Within 1 working day of agency lead being informed	Report to Safeguarding Board Manager.	Relevant agency lead
Notification 3 BSCB inform Ofsted and DCSF	Within 2 working Weeks	Notification of serious incident to be submitted to Ofsted and <a href="mailto:scsecretariat@ofsted.gov.uk">scsecretariat@ofsted.gov.uk</a> .	BSCB Manager
Decision 2 on whether to commission a serious case review	Within 1 month of BSCB being informed/notification	Chronologies from agencies involved at time of incident. BSCB serious cases Sub-Committee to be held and Board Chair to have made decision. Agree commissioning of independent consultant and Chair. Initiate media communication plan, if required. Agree terms of reference.	Board agency leads  Board Chair
Notification 4 Serious case review decision to Ofsted	Within 1 working day of Sub Committee.	Inform key organisations. Notify Ofsted of review. Confirm timescales with independent consultant. Terms of Reference sent Ofsted.	Agency leads  Board manager
Management of Process by SCR Panel		SCR Panel manage information submission Advise the BSCB Chair. Review chronology, IMRS and Overview Report.	
Individual management reviews complete	Within 8 weeks of panel	Add to chronology dependent on period being reviewed. Produce analysis. Make organisational recommendations. Ratification by organisation BSCB Lead.	Each organisation must identify a reviewer who has not had any line management involvement with the case.

Issue	Timescale	Action required	Person responsible
Multi agency report commenced	Within 3 months of panel (12 weeks)	SCR Panel meet with independent consultant. Independent consultant receives all reports	Agency leads
Multi agency report draft	Within 4 months of panel (16 weeks)	Working group to meet with independent consultant. Identify gaps.	Agency leads
Final draft	Within 5 months of panel	Independent Consultant and working group to meet with organisation Lead Directors and safeguarding leads to agree report and recommendations.	Agency Leads Organisation Board Leads Organisation Safeguarding Leads
Completed report and action plan	Within 6 months (24 weeks)	Serious cases panel to meet to agree report and recommendations. Agree dissemination of report to organisations directly involved. Transfer recommendations into action plan.	Serious cases panel  BSCB Development Officer
BSCB Executive Committee to receive report.	Within 6 months (24 weeks)	Overview report including Executive Summary and Action Plan to be agreed. Agree dissemination of summary to all agencies.	Executive committee
Submission to Ofsted to London SCB for Review	6 months (24 weeks)	SCR information sent for national evaluation and local review BSCB to submit by post and email SCR paperwork.	BSCB
Action plan progress 1	Within 2 months	Agencies to submit progress to BSCB team.	Agency leads
Progress 2	Within 4 months	Agency leads to submit progress to BSCB team. QA&PM committee to review action plan and report to Executive and Ofsted.	Agency leads  QA&PM chair
Progress 3 And sign off of action plan To Ofsted	Within 12 months	Agency leads submit progress to BSCB team. QA&PM committee to review action plan and report to Executive & Ofsted. Any unresolved issues to be addressed by Agency involved and a report submitted to Executive and Ofsted.	Agency leads  QA&PM chair

## 9 Guidance on preparing Individual Management Reviews

Working Together to Safeguard Children (DCSF 2010) sets out how individual management reviews are to be undertaken. Each agency, whose workers had some contact with the family, will need to produce an individual management review. When an organisation is notified by the LSCB of the requirement to produce an IMR, a senior manager should be allocated the lead for the identification of report author. S/he will need to have the capacity, independence, knowledge and seniority – to be able to challenge credibly. They will need to confirm all the agency records to be included in the review.

The role of the senior manager in the IMR process spans:

- providing support to staff involved;
- giving the message that process is about learning, but being clear where decisions about disciplinary sit;
- confirming which staff are to be interviewed;
- supporting the author and facilitating the process;
- quality assuring the IMR before submission to the SCR Panel – ensuring sign off;
- responding to feedback from the SCR Panel;
- production of an agency action plan in response to recommendations of IMR.

For all individual management reviews the agency should:

- Appoint a senior manager/ independent person who has not had line management responsibility for the workers or team involved to undertake the task of completing the review.
- In the case of schools, the IMR author would be the Lead Officer for Education Safeguarding.
- In the case of the early years and childcare providers the IMR author will be the Early Years Service & Childcare Service Manager.
- In the case of small scale organisations contact should be made with the BSCB who can provide a list of independent authors. Small scale voluntary and community groups may be entitled to further support in commissioning an independent author.
- The BSCB should be contacted for the details of these independent authors.
- Ensure all relevant files are secured and made available to the writer.
- Ensure that the report writer has adequate resources (time, admin, support) to complete the report within the required timescales. Most IMRs will require a minimum of 2 days work.
- Ensure that any staff involved with the family have been given the opportunity to discuss their understanding of what has happened. Support should be offered and remain ongoing, monitored by the line manager.
- Ensure that the report is quality assured by the senior officer in the organisation which has commissioned the report and that they are satisfied with the findings accepted.

- The specified chronology tool and action plan (see appendices) must be used. This should include every case record.
- Each IMR will be graded by Ofsted.
- The main purposes of the agency review is to highlight the contact that the agency had with family members, reflect upon that contact, identify lessons to be learned by the agency and in terms of multi agency working, make recommendations for the agency
- IMRs should be signed and dated by the author and counter-signed by the most senior manager of the agency.
- An analysis of your agency's involvement is required in relation to the review's terms of reference.
- All individual management reviews should be submitted to BSCB within the set timescales.
- Any recommendations identified in the agency's own report should be translated into an action plan immediately. This action plan should be attached to the report. The agency will be informed about any further recommendations identified by the working group or independent author for the multi agency overview report.
- Progress of action plans will be monitored by the BSCB. A lead person within the agency should be nominated to be the contact for the safeguarding board.

Headings for the IMR (Raynes, 2009):

- **Introduction/Summary**  
Summarise the case and suggest areas that need exploring
- **Methodology**  
Explain the process that has been followed to gain the information, such as review of files, interviews with staff involved.
- **Chronology**  
Include as appendix to report. Construct a comprehensive chronology of involvement by the organisation 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. (This chronology should clearly set out when the child was seen and whether the wishes and feelings of the child were sought.)
- **Narrative**  
This is the story that emerges from the chronology to bring the chronology to life. There is no need to comment on practice during this section. Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.  
  
Where an agency has had relevant contact with the alleged perpetrator, the chronology should also cover these actions and should ask whether everything was done which might reasonably have been expected to.

- **Analysis**

This is the author's reflection on the narrative and comments upon the actions taken or not taken. The analysis should address the key points identified in the terms of reference including those set out in the guidance Working Together 2010, but should also identify themes that have emerged from the narrative. The author should consider "why" questions which have been addressed with staff members involved.

- **Lessons to be learned**

List these as clear statements of learning drawing on the analysis. Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? 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 organisations; resources? Are there implications for current policy and practice?

These can be included as bullet points. These should be for the agency to learn.

- **Recommendations**

Keep these short and clear. Avoid recommending "review" or "training" which can be difficult to achieve. Scie (2008) suggest 3 types of recommendations:

1. Issues with clear cut solutions
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 to find solutions

Also consider are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

- **Action Plan (Appendix 3)**

This needs to be 'SMART'. Evidence will be expected to be collected. What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?

Guidance taken from:

Raynes B 2009 *A Guide For Conducting Serious Case Reviews* Reconstruct.  
*Working Together to Safeguarding Children* DCSF, HMSO March 2010

## 10 The Overview Report

The overview report should bring together, and draw overall conclusions from, the information and analysis contained in the individual management reviews, information from the child death review processes, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with management reviews, the precise format depends on the features of the case. This outline is most relevant to abuse or neglect that has taken place in a family setting.

### *Introduction*

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List agencies or types of contributors to review and the nature of their contributions (for example, management review by LA, report through the commissioning PCT from adult mental health service). List the names of the SCR Panel members and the author of overview report.
- List external investigations, if any, that are being conducted (for example the PPO investigation following the death of a child in custody or a mental health inquiry).

### *The 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 organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen, if the child was seen alone and whether the child's wishes and feelings were sought or expressed.
- Consider explicitly any relevant racial, cultural or other equalities issues and whether these are relevant to the behaviours and approach by the organisations and professionals involved.
- Prepare an overview that 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.

### *Analysis*

This part of the overview should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could

improve. The analysis section is also where any examples of good practice should be highlighted. The findings from this SCR should be considered alongside learning from previous SCRs and findings from relevant research.

### *Conclusions and Recommendations*

This part of the report should summarise, in the opinion of the overview author, what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action. Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted.

## **11 BSCB SCR Panel action on receiving an overview report**

On receiving an overview report the BSCB SCR Panel should:

- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- ensure that the overview report is of a high standard and is written in accordance with this guidance;
- commission and agree the content of executive summary for publication;
- translate recommendations into an action plan that should be signed up to at a senior level by each of the organisations that needs to be involved. The plan should set out who will do what, by when, and with what intended outcome. The plan should set out by what means improvements in practice/systems will be monitored and reviewed;
- clarify to whom the report, or any part of it, should be made available;
- make arrangements to provide feedback and debriefing to the child (if surviving) and family members/carers of the subject child as appropriate.

## **12 BSCB action on receiving the SCR report**

BSCB Executive Committee should:

- sign off the final SCR, i.e the individual management reports, the overview report, the executive summary and the action plan;
- provide a copy of the individual management reviews, overview report, executive summary and the multi-agency action plan to Ofsted;
- all personal information relating to children, family members and professionals involved in the case (with the exception of the names of the panel chair, panel members and the overview author) should be anonymised in all the SCR documentation submitted to Ofsted. If the child died in a custodial setting, copies of the SCR should be made

available to the YJB representative on the Panel and copies of the executive summary should be provided to the PPO;

- make arrangements to provide feedback and debriefing to staff and the media as appropriate;
- disseminate the overview report, key findings or the executive summary to involved parties as agreed;
- Receive and act on Ofsted evaluation of the Overview and Executive Summary and action plan establishing a post evaluation action plan where appropriate.
- Implement those actions for which the BSCB has lead responsibility and monitor the timely implementation of the SCR action plan;

### **13 Publication**

Serious Case Review Overview Reports are now required to be published in full, anonymised and redacted as appropriate to protect the identities of children, vulnerable adults etc. The publication of the report is subject to the data protection act. It should only be published after any court proceedings are fully concluded and after Ofsted's evaluation.

The LSCB should ensure that the relevant Ofsted and all other relevant bodies including the Care Quality Commission are appropriately briefed in advance about the publication of the report. Where a child has died in a custodial setting, this briefing should include the YJB. This is to ensure that relevant government departments are fully briefed in advance of the publication of the executive summary.

### **14 Accountability and disclosure**

BSCB will consider carefully who might have an interest in reviews – for example elected and appointed members of authorities, staff, members of the child's family, the public, the media – and what information should be made available to each of these interests. There are difficult interests to balance.

### **15 Learning lessons locally**

Debriefing sessions will be held to deliver key messages across a wide multi-agency audience following serious case reviews.

Quality Assurance and Performance Monitoring Standing Committee will monitor action plans on behalf of BSCB with a report to the BSCB Executive on a quarterly basis.

Quality Assurance and Performance Monitoring Standing Committee will produce annual review of key learning and themes arising from local serious case reviews and relate to any national findings.

## 16 Reviewing institutional abuse

Working Together 2010 sets out expectation when serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply, but reviews are likely to be more complex, on a larger scale, and may require more time. This section should be read in conjunction with the guidance.

It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals.

### **Bibliography**

Working Together to Safeguard Children (March 2010) DCSF

Raynes B 2009 *A Guide For Conducting Serious Case Reviews* Reconstruct

GOL/Ofsted 2007 Serious Incident Notification and Serious Case Reviews: Liaison with Government Office for London (GOL) and Ofsted

NHS London Guidance for SUIs 2009

# Appendices

## TEMPLATE 1 Terms of Reference

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### BROMLEY SAFEGUARDING CHILDREN BOARD SERIOUS CASE REVIEW CHILD TERMS OF REFERENCE

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These terms of reference must be read in conjunction with Appendices related to Working Together 2010 Chapter 8. The quality of an Individual Management Review will be judged in part on its ability to address the points set out below and in Working Together 2010.

#### 1. BACKGROUND

- Current situation
- Siblings
- Parents.
- Previous Agency Involvement

#### 2. SCOPE OF THE REVIEW

The important issues which the review should address in identifying the learning from this specific case. Where necessary LSCB should seek legal advice:

**In addition, the following issues set out in *Chapter 8 of Working Together to Safeguard Children* need to be addressed:**

Terms of reference for Individual Management Reviews (DCSF, 2010)

- Was there clear evidence of a risk of significant harm to a child that was:
  - not recognised by organisations or individuals in contact with the child or perpetrator **or**
  - not shared with others **or**
  - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?

- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on 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 the subject of a child protection plan at the time of the incident, or had they previously been 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 LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

### **3. AGENCIES TO BE INVOLVED IN THE REVIEW**

Individual Management Reviews

Information reports (those agencies with limited involvement)

### **4. COLLATION AND ANALYSIS OF INFORMATION – IMRS**

The agencies identified in Section 2 are required to prepare an Individual agency Management Review (IMR) report that covers their involvement with the child and/or family during the timescales identified within these terms of reference. The report must include:

- a chronology using the template provided.
- a narrative of the agency involvement and
- an analysis of the work identifying any areas of good practice as well as lessons to learn.
- recommendations which are drawn from the lessons to be learned for the agency.
- an action plan, using the template provided which demonstrates how the agency is going to progress any changes to be made in a timely way.

Further guidance on completing IMRS is included in Appendix.

An integrated genogram will be developed and agreed as part of the process.

**5. PERIOD OF TIME COVERED BY THIS REVIEW**

**6. INVOLVEMENT OF FAMILY MEMBER**

The report writer may wish to consider whether it would be constructive to conduct interviews with the young person concerned and family members including:

**7. INDEPENDENCE OF THE REVIEW**

The Serious Case Review Panel will be chaired by .

An independent author is to be appointed to prepare the Overview Report and Executive Summary.

**8. TIMESCALE FOR COMPLETION OF REVIEW**

**9. PARALLEL INVESTIGATIONS**

**10. COMMUNICATION**

Julie Daly, Head of Service Safeguarding and Quality Assurance will manage and co-ordinate the review on behalf of Bromley Safeguarding Children Board.

Contact Details: 0208 313 4610. First Floor, Stockwell Close, Civic Centre, Bromley BR1 3UH.

A strategy for communication with agencies, other authorities and with the media should be developed. A member of the LB Bromley Communications Office will be a member of the SCR Panel.

Communication with agencies involved will be the responsibility and at the direction of the appointed Independent Chair of the Serious Case Review. Communication with the media will be the responsibility and at the direction of the Chair of the Safeguarding Children Board in conjunction with an agreed statement with the Communications Officer within London Borough Bromley Chief Executives Office.

**THESE TERMS OF REFERENCE MAY NEED TO BE REVISITED AS THE REVIEW PROGRESSES AND NEW INFORMATION EMERGES.**

**Date**

**TEMPLATE 2: Individual Management Review**

**BROMLEY SAFEGUARDING CHILDREN BOARD**  
**IMR Guidance & Template**

**INDIVIDUAL MANAGEMENT REVIEW {AGENCY NAME}**

“The aim of management reviews should be 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.”  
Working Together 2010

When completing the IMR please ensure that you refer to any briefing/ guidance and TOR that the SCR panel has given.

Brief factual/contextual summary of the situation leading to the SCR:

NAME OF CHILD(REN) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Death/Date of serious injury \_\_\_\_\_

Name, and contact details of person completing this Individual Management Review:  
Signature:

Name of Lead Officer  
Signature of Lead Officer

Family Details

Name	Date of Birth	Relationship	Ethnic Origin

**Factual Summary of Agency Involvement with family/child during specified time period of SCR**

**1. METHODOLOGY**

**2. CHRONOLOGY OF AGENCY INVOLVEMENT**

*What was your Agency's involvement with this child/children and family?*

Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the child/children and family over the period of time set out in the review's terms of reference.

Would you also please identify the details of the professionals from within your agency who were involved with the family and whether they were interviewed or not for the purposes of this Internal Management Review.

**3. FAMILY TREE**

If your Agency possesses sufficient information, please construct a Family Tree/Genogram and attach it to this report.

**4. ANALYSIS OF INVOLVEMENT**

Consider the events that occurred, the decisions made, and the actions taken or not. It is also important to reflect on where good practice and the strengths of professional support existed. 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. It is helpful to set any analysis in the context of the environmental factors that existed within the system. What was it like for staff working at that time, were there any other factors that may have explained or contributed to events?

Please use the template provided, and if one section does not apply to your agency then identify that this is the case in the appropriate box. Otherwise try to respond to the questions as fully as possible, clarifying the evidence for your views where applicable. Consider specifically:

1. Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

2. When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?

3. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

4. 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?

5. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

6. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

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7. Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

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8. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded? How significant was this to the case?

--

9. Were senior managers or other organisations and professionals involved at points in the case where they should have been?

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10. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

--

11. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

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12. Was there sufficient management accountability for decision making?

*NB: With regard to the specific Terms of Reference which have been drawn up to address the particular issues in this case, it is important that you make further analysis here in respect of these, which are not otherwise covered by the sections above.*

<b>Specific Terms of Reference - No. 1</b>

<b>Specific Terms of Reference - No. 2</b>

**5 LESSONS LEARNED**

**6. RECOMMENDATIONS AND ACTIONS**

**TEMPLATE 3: Chronology**

Date  Format dd.mm.yy  add time of event if significant	Family Contact		Communication		Response and/or outcome	Source of evidence	Comment
	Young Person  <i>Specify if her / his views recorded &amp; if seen alone</i>	Adult  <i>Specify if her /his views recorded</i>	Within Agency  <i>Specify: phone, written, meeting</i>	External to Agency  <i>Specify: phone, written, meeting</i>			

**TEMPLATE 4: Action Plan**

**SERIOUS CASE REVIEW CHILD SINGLE AGENCY ACTION PLAN**

Actions should be SMART - Specific, Measurable, Achievable, Realistic, and Time-bound. SMART tasks and goals are likely to be achieved.

The purpose of a Serious Case Review Action Plan is to:

- identify the actions required by agencies to share lessons learned from the incident, and improve practice, policies and procedures
- identify the form of evidence that confirms the action is undertaken
- track and record the progress of each action
- indicate responsibility for progressing and monitoring the action.

**Glossary**

- Issue – summary of the type of issue covered by the recommendation and action.
- Recommendation - as set out in the Serious Case Review Child overview report.
- Action/Evidence – statement of the actions to be undertaken by the agency/cies, with clear indication of the evidence, e.g. a report/letter.
- Lead – the person who is responsible for taking forward the investigation/monitoring the action.
- Due Date – key milestone in relation to the action and or a completion date.
- Status – progress on the action to included whether it is completed, reasons for any slippage.

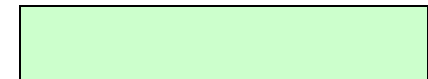
**Status Report Traffic Light**



Red: Significant Issues/slippage



Amber: Issues to be resolved/ some slippage



Green: Completed/ ongoing and no issues

**BROMLEY SCB SERIOUS CASE REVIEW (year) 20-- SINGLE AGENCY (NAME OF AGENCY) ACTION PLAN CHILD ----**

No.	Recommendation	Required Outcome and Evidence	Lead	Due Date	Progress/ Status
<b>AGENCY NAME</b>					

DRAFT

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## Information Sheet 1:

# **BROMLEY SAFEGUARDING CHILDREN BOARD**

## **Serious Case Reviews: Information for Parents**

When a child dies, or is seriously harmed, and abuse or neglect is suspected, the Local Safeguarding Children Board (LSCB) has to undertake a Serious Case Review to see if there are lessons to learn about the way staff have worked with you and your family.

### **What is the Local Safeguarding Children Board (LSCB)?**

The LSCB brings together all the main organisations who work with children and families, to ensure that we work together effectively to keep children safe.

### **What is a Serious Case Review?**

A Serious Case Review looks at how staff and organisations worked together to safeguard you and your brothers and sisters. The Review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is completely separate from any investigation being undertaken by the courts and its aim is not to blame but to learn.

### **Who will carry out the review?**

A panel of professionals from children's services, health services, police and sometimes other organisations such as housing or voluntary agencies that worked with your family will provide reports of the services they gave you and your family. The panel is chaired by a specialist in child protection. The panel will ask an independent author to write an overview report based on the findings of reports from all the agencies to see if there are any lessons to learn about the way professionals have worked with you and your family.

Based on these lessons, the agencies involved in the review will decide what actions they may need to take to change the way they support and protect children and their families.

### **Can I take part?**

Yes you can if you would like to. We will make sure that there is someone who can help you do to this.

### **Who will see the report?**

The government says that the full Overview Report should be available to anyone who wants to read it. We are careful to ensure that only relevant information is released and that the anonymity of family members and individual professionals is preserved.

A summary of the report (called the Executive Summary) which outlines the key findings and recommendations of the review without identifying any personal details will be written. The reports will be published on the Bromley LSCB website only after Ofsted have evaluated the reports and at the conclusion of any court proceedings.

We will give you a copy of this summary.

### **How long will the review take?**

Usually it should take six months from the decision to carry put a review to its completion. This can be longer if there is a lot of information.

# **BROMLEY SAFEGUARDING CHILDREN BOARD**

## **A guide to serious case reviews for staff and managers**

### **1. Introduction**

- 1.1 The death or serious injury of a child is a distressing event for everyone and when this then leads to inquiries being made about the work of professionals who were providing services to the child and family it can lead to staff/professionals feeling very anxious. That is why it is important that all staff involved in the process of a serious case review (SCR) into the death or serious injury of a child have a clear understanding about why the review is happening, what it expects to achieve, what it involves, what is expected of them and what is the timeframe.
- 1.2 Bromley local safeguarding children board's (LSCB) has set up a serious case review panel, (SCRCP) to oversee all the arrangements for case reviews. The panel members are senior representatives from children and families social care, education, health, police, and legal services.
- 1.3 The LSCB recognises that involvement in a SCR case can be a very difficult and stressful experience. It is important that staff involved in the review process are kept informed about the progress of the review and the time scales involved. This will be done through their usual line management arrangements and where possible direct from the LSCB. They should also be offered counselling and other forms of support as necessary by their own agencies. Staff should discuss issues of support within their usual line management arrangements.

### **2. What is a serious case review?**

- 2.1 It is a multi agency review of a case. The principles and framework for the management of SCR are set out in chapter 8 of Working Together to Safeguard Children and also in the London Child Protection Procedures.
- 2.2 Working Together states that a LSCB should always undertake a SCR when a child dies and abuse or neglect is known, or suspected to be, a factor in the child's death. It also adds that a LSCB should always consider whether to complete a SCR in cases where a child has sustained a potentially life-threatening injury or serious and permanent impairment of health and development, suffered serious sexual abuse or been killed by a parent with a mental illness. In addition the LSCB should also consider a SCR if the case gives rise to concerns about multi-agency working – the way in which local professionals and services work together to safeguard children.

### **3. The purpose and function of case reviews**

- 3.1 The overall purpose of a case review is to learn lessons about how we provide services and work together, so that we can continue to improve our safeguarding practice and the way we work with children and their families.

- 3.2 We do this by drawing together all the information about the management of a case; looking at how the events and relationships, both within the family and within the professional network, can be understood and identifying the lessons that can be learned from the case that will inform and improve professional practice in the future. It will also include identifying how these lessons can be acted upon and what is expected to change as a result.
- 3.3 A review is not about looking for blame, but about an open and transparent learning from practice, in order to improve multi-agency working and outcomes for children. Bromley LSCB actively promotes the 'no blame' premise of this work and the lessons learned approach of any review which has the full backing of all senior managers in the accountable agencies.
- 3.4 Bromley LSCB recognise that this learning takes place in a context where some staff involved may be experiencing high levels of distress and anxiety. The objective is to conduct a review that both acknowledges the importance of professional accountability and retains its sensitivity to the needs and feelings of the individuals most directly involved. Support for staff involved is an integral and central part of the process.

#### **4. What does the review involve?**

4.1 There are several stages in this process:

- A SCR panel meeting is held following a referral from any of the agencies to consider if a case meets the criteria.
- The LSCB informs Government Office for London (GOL) and Ofsted that the case will be discussed by the serious case review panel.
- The panel makes their decision against the criteria in "Working Together". If the criteria are met, the panel writes the terms of reference for the review, identifying the particular areas/issues that need to be addressed by the individual management review (IMR) authors when conducting their review of the case and interviews with staff. The terms of reference should be shared with all staff whose work is part of the review, so they understand the focus of the review.
- Case files in all agencies that worked with the family are secured. In cases where work with the family is continuing, copies must be made of the record so that the work can continue.
- All agencies involved identify a professional to undertake a chronology and IMR. This person should be someone who is a child protection specialist and has not had direct involvement in the case. For example in health agencies this will usually be the designated or named nurse.
- The LSCB send the terms of reference to GOL and Ofsted, which includes the agreed timeframe, which at the moment is four months from the point the decision is taken to undertake a review.

- IMR authors complete the chronology on a standard template that identifies all individual contacts with the family and professionals, e.g. phone conversation, visit, correspondence, supervision discussions etc.
- IMR authors then interview relevant staff involved. The IMR author should share the terms of reference with staff whom they are interviewing, which explains the focus of the review. The purpose of the interview is to gain as full a picture as possible of the events that have taken place and the perceptions and views of staff and the context in which decisions and actions were taken. Prior to this the IMR author will have read case files and other relevant documentation and records and will have several areas they want to explore. Staff can also raise areas they wish to bring to the author's attention.
- The IMR author then completes their report and includes all the factual information and then analyses this, offering their opinion based on their overview and additional information such as relevant research. They conclude with recommendations and an action plan
- The IMR authors must then feed back to staff their findings and recommendations. It is important that agencies start to implement the learning from the individual management review immediately it is available.
- An independent person, commissioned by the LSCB, will then undertake an overview report that brings together all the IMRs from all the agencies. They critique the IMRs and analyse the information and make recommendations.
- This report then goes to the strategic leadership board of the LSCB for approval.
- The LSCB then completes an action plan to address the issues raised in the overview report and this plan is monitored by the Quality Assurance sub group of the LSCB.
- The report with action plan is then sent to Ofsted who grade it and to GOL for information.

## **5. Who will do the independent management review (IMR)?**

- 5.1 The arrangements may vary between agencies but it is expected that the person who carries out the review will not have had direct involvement with the case. They should be sufficiently independent of the staff involved to be objective and they should have knowledge and experience of safeguarding work.

## **6. Who can staff talk to about the review and how are staff supported?**

- 6.1 It is very important that staff feel supported during the SCR process. The usual confidentiality rules apply with regard to not discussing the details of a case outside of work. If there is a police investigation there may be further restrictions see (7.1). However, staff are encouraged to discuss the case with their team and manager and other colleagues and professionals involved in the case.
- 6.2 Where there is a death or serious injury to a child staff may wish to express their sympathy to the family. Staff who provided a service to the child/family may wish to hold some form of memorial service if a child has died. It is important that staff feel able, as much as is possible, to communicate with the family as usual. If in any doubt staff should ask their managers to discuss with the LSCB business manager.
- 6.3 Staff should receive support from their line managers and their individual agency throughout the process. Most agencies have support/counselling services available that staff are encouraged to access.
- 6.4 Staff should be kept informed of the progress of the IMR through their managers. On completion of the IMR the author should ensure staff are made aware of its contents and recommendations. We recommend that authors host a feedback meeting with all staff involved in their agency and share in detail the issues addressed and the recommendations made for improving practice. The IMR contains details of different professionals practice and therefore is confidential and can not be shared in this group.
- 6.5 In addition to support provided by individual agencies, Bromley LSCB will host at least two staff support meetings at the beginning and end of the review process and at other times as necessary. This is to ensure staff are fully aware of the terms reference at the beginning and clear about the outcome and recommendations at the end.

## **7. If there is a police investigation am I still allowed to talk about it?**

- 7.1 If there is a police investigation it may mean discussion of the actual incident and/or run up to the incident is not appropriate or permitted. If this is the case please seek advice from the LSCB business manager. It is important to note that a police investigation is a moving process and it may be at one point in time staff are advised not to discuss the case amongst themselves but at a later date this advice might change. It is therefore important to check throughout the process and seek advice from the LSCB business manager.

## **8. Guidance for managers**

- 8.1 Managers should encourage staff to seek support and guidance from line managers. For managers with a case in their team they should encourage team discussion to provide support. This meeting should be an opportunity for staff to talk about how they are feeling and what support they need, it should not be a discussion about who did what, when etc. If this type of discussion is required we recommend it is undertaken by a trained facilitator and guidance should be sought from the LSCB business manager as to the timing of this type of group.

**9. Is the report available to the general public?**

- 9.1 All IMR reports have to be anonymised. The identity of staff is only known by the SCR panel, the IMR authors and the overview authors. These documents are not made public.
- 9.2 At present the overview report is confidential to the SCR panel. The panel can choose how widely it shares it with senior managers in partner agencies to support them improving practice through learning lessons. An executive summary (again anonymised) is produced which is a public document. This will be placed on the LSCB website for a period of time and sent to all staff who were involved.

**10. How does the review relate to disciplinary action?**

- 10.1 The two processes are separate. Each agency has their own disciplinary process. The objective of the review is to improve inter-agency working and to ensure that the agencies, which make up the LSCB, are accountable for the quality of their work in relation to children and families.

**11. Review of other cases**

- 11.1 Bromley has decided that safeguarding practice can be improved by learning from a number of cases where the cases do not meet the criteria for SCR but feel there are important lessons which could be learnt about multi-agency working or practice. In these circumstances a case review or management review will be undertaken. These will in general follow the same process to a SCR but are not subject to inspection by Ofsted.

December 2009