

Section 8 – Serious Case Review

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Introduction

8.1.1 Regulation 5 requires LSCBs to undertake reviews of serious cases set out in Chapter 8 Working Together to Safeguard Children (2006). They should be undertaken in accordance with the procedures set out in this Chapter. The same criteria apply to disabled children as to non-disabled children.

8.1.2 When a child dies and abuse or neglect are known or suspected to be a factor in the death, local agencies must consider immediately whether there are other children at risk of harm who need safeguarding (e.g. siblings, other children in an institution where abuse is alleged). Thereafter, agencies will consider whether there are any lessons to be learned from the tragedy about the ways in which they work together to safeguard children. When a child dies (including suicide) and abuse or neglect is known or suspected to be a factor in the case Durham LSCB will always conduct a review into the involvement with the child and family of organisations and professionals. Additionally, Durham LSCB will always consider whether a review should be conducted where a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development, or has been subjected to particularly serious sexual abuse; and the case gives rise to concerns about inter-agency working to protect children.

8.1.3 The 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. A positive answer to several of these questions is likely to indicate that a Review could yield useful lessons:

- Was there clear evidence of a risk of significant harm to a child which was:
 - not recognised by agencies or professionals in contact with the child or perpetrator? *or*
 - not shared with others? *or*
 - not acted upon appropriately?
- Was the child abused in an institutional setting (e.g. school, nursery and family centre YOI, Secure Training Centre, Children's Home or Armed Forces training establishment)?
- Did the child die in a custodial setting (e.g. prison, YOI or Secure Training Centre)?
- Did the child commit suicide, or die while absent having run away from home?
- Was the child abused whilst being looked after by the Local Authority?
- Does one or more agencies or professionals consider that concerns were not taken sufficiently seriously or acted upon appropriately by another agency?

- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding procedures which go beyond the handling of this case?
- Was the child the subject of a Child Protection Plan or had previously been subject of a Child Protection Plan?
- 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 upon?

Purpose

8.2.1 The purpose of the Serious Case Review carried out under this guidance is to:

- establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children.
- identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
- to improve inter-agency working and better safeguarding and promote the welfare of children.
- whether the circumstances of the case indicate a need to revise or update existing procedures, policies, practice or protocols.
- whether any other remedial action is necessary.

8.2.2 The Serious Case Review is not an enquiry into how a child died or who is culpable, this is a matter for the Coroner and Criminal Courts to determine as appropriate.

General Principles

8.2.2 When carrying out a Review under these procedures, the LSCB and its constituent agencies will be guided by the following principles:

Urgency

Agencies should take action immediately and follow this through as quickly as possible.

Impartiality

Those conducting the Reviews should not have been directly concerned with the child or family.

➤ **Thoroughness**

Consideration of all important factors.

➤ **Openness**

No suspicion of concealment of information.

➤ **Confidentiality**

To respect individual's rights.

➤ **Co-operation**

All agencies collaborate under the auspices of the LSCB.

➤ **Resolution**

The sharing of individual Management Reviews should be undertaken at the earliest opportunity to ensure a consistent, full and timely understanding of the issues for all agencies for resolution.

8.3.2 Where more than one LSCB has knowledge of a child, the LSCB for the area in which the child is/was normally resident should take lead responsibility for conducting the review. Any other LSCB that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the review. In the cases of Looked After children, the responsible Authority should exercise lead responsibility for conducting any review, again involving other LSCBs with an interest or involvement.

Criteria for Convening a Serious Case Review

8.4.1A Serious Case Review should always be conducted when a child dies in suspicious circumstances (including suicide) and abuse or neglect are known or suspected to have been a factor in the child's death. This is irrespective of the involvement of Safeguarding & Specialist Services.

8.4.2The LSCB should also consider whether or not to undertake a Serious Case Review when:

- a child sustains a potentially life threatening injury, or serious and permanent impairment of health and development through abuse and neglect;
- a child has been subjected to particularly serious sexual abuse;
- the child has been killed by a parent with a mental illness where a parent has been killed in a domestic abuse situation;
- a parent has been killed in a domestic abuse situation;

and the case gives rise to concerns about inter-agency working to protect children from harm.

8.4.3Any agency or a professional may refer such a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case. Agencies or professionals will need to bring their concern to the attention of their LSCB representative who will in turn inform the LSCB Business Manager. (See [Appendix 4](#) for LSCB members contact details).

8.5 Immediate Action by All Agencies

8.5.1 Immediately upon receipt of this information the LSCB Business Manager will notify the LSCB Chair – in some circumstances the need for a Serious Case Review will be self evident whereas in other circumstances it will be necessary to convene a meeting of the Serious Case Review Panel in order to determine whether or not the criteria are met for convening a Serious Case Review. The Secretary of State for the DCSF has powers to demand an inquiry be held under the Inquiries Act.

Serious Case Review Panel

Membership

8.6.1 A Serious Case Review Panel is a standing Panel Chaired by the LSCB Business Manager with the following representatives:

- Designated Nurse Child Protection;
- Designated Paediatrician;
- Detective Chief Inspector, Vulnerability Unit;
- Strategic Manager, Children & Young People's Service;
- Manager, National Probation Service

8.6.2 The purpose of the Serious Case Review Panel is to consider whether or not on the available evidence it would be appropriate to initiate a Serious Case Review or to consider an alternative response and to duly make recommendations to the LSCB Chair. This should be convened with urgency.

8.6.3 In order to safeguard objectivity and impartiality, wherever possible, these members should not be people who are involved in the management of the case or have had prior involvement, and on occasion it may be necessary to amend the membership. Members should attend the meeting with sufficient information about their agency's involvement with the family in order to enable the Panel to make a recommendation based upon information gathered which will be forwarded to the LSCB Chair.

8.6.4 If the criteria are not met, consideration will be given to the value of exploring other methods for learning lessons if it appears there are concerns regarding the management of the case.

Decision to Conduct a Serious Case Review

8.6.5 The LSCB Chair has ultimate responsibility for deciding whether or not to conduct a serious case review, and must do so within one month following a recommendation from a Serious Case Review Panel. Immediately following the making of this decision, the Local Authority should inform Ofsted. This information will be passed to DCSF and Government Office North East by Ofsted. If the decision is made to hold a Serious Case Review, the Panel must meet within five working days of the notification.

8.6.6 In addition to informing Ofsted, the LSCB Chair will:

- notify Ofsted
- notify all Chief Officers of partner organisations that a Serious Case Review is to be held and will formally request that all records are secured.
- consult with Police and Corporate & Legal Services in the event of the need for information to be given to the public or media.
- convene a meeting of the Serious Case Review Panel.
- consider any alternative/additional action that may need to be taken.

8.7.3 The LSCB Business Manager in consultation with the LSCB Chair will secure the services of an independent person to Chair the Serious Case Review Panel and in consultation with designated LSCB representatives secure representation on the Serious Case Review Panel.

Scope of a Case Review

8.8.1 On the basis of the information available the Serious Case Review Panel will draw up clear Terms of Reference for the Serious Case Review. Some of these issues may need to be revisited as the review progresses and new information emerges.

8.8.2 Relevant issues include:

- What appear to be the most important issues to address in trying to learn from the specific case?
- How can the information best be obtained and analysed?
- Who should be appointed as the independent author of the Overview Report?
- Are there any features of the case which indicate that any part of the review process should involve a party independent of the professionals/organisations who will be required to participate in the review? Might it be helpful to bring in an outside expert at any stage?
- Over what period of time should events be reviewed, i.e. how far back is the cut off point? Is there any relevant family history/background which could assist in understanding the circumstances?
- Which organisations and professionals should contribute to the review, including reports from, for example, the proprietor of an independent school, playgroup leader?
- How should family members be invited to contribute to the Review and who should facilitate their contribution?
- Will the case give rise to other parallel lines of investigations of practice, for example independent health investigations, multi-disciplinary suicide reviews where a parent has been murdered, Child Death Reviews, YJB Serious Incident Review, and Prisons & Probation Ombudsman Investigation where a child has died in a custodial setting?
- If so how can a co-ordinated or jointly commissioned Review process best address all the relevant questions which need to be asked in the most economical way?
- Is there a need to involve agencies, professionals in other LSCB areas and, if so, what should be the respective roles and responsibilities of the different LSCBs with an interest?
- How should the Review process take account of a Coroner's Inquiry and (if relevant) any criminal investigation or proceedings related to the case?

Arrangements need to be made to how best liaise with the Coroner and/or the Crown Prosecution Service.

- How should the serious case review fit in with the processes for other types of reviews, e.g. homicide, mental health or prisons?
- Who will make the link with relevant interest outside the main statutory agencies, e.g. independent professionals, independent schools, voluntary organisations?
- When should the Review process start and by what date should it be completed?
- How should any public, family or media interest be managed before, during and after the Review?
- Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

8.8.3 In the event of a decision not to undertake a Serious Case Review the Serious Case Review Panel members should continue to consider any material changes to the facts of the case and notify the Chair of the LSCB if there is a need to review this decision.

Timescales of a Serious Case Review

8.8.4 Once a decision has been made to proceed to a Serious Case Review this should be completed within a further four months following the LSCB Chair's decision to initiate unless an alternative timescale has been agreed with Government Office North East at the onset. The timescales for actions will be agreed at the Serious Case Review Panel.

8.8.5 The complexity of the case may not become apparent until the Serious Case Review process is underway. Where criminal proceedings are underway or under consideration the Chair of the Serious Case Review Panel should discuss with the relevant criminal justice agencies how the Review process should take account of such proceedings.

8.8.6 This may include the timing, the interviews of relevant personnel and who should contribute at what stage. In some cases it may not be possible to complete a Review until after criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented. As soon as it becomes apparent that the Serious Case Review cannot be completed within four months there should be a discussion with Government Office North East to negotiate a timescale for completion.

Agency Responsibilities

- 8.8.7 Each relevant service should undertake a separate Management Review, to be undertaken by someone who has not had direct involvement with the child or family or the immediate line manager. This should commence as soon as the decision to undertake a review has been made, and even sooner if the case gives rise to concerns within individual organisations. Once it is known that a Serious Case Review is being considered each organisation should have ensured that case records are secured promptly to guard against loss or interference.
- 8.8.8 In preparation for a Serious Case Review the agency's senior officer should:
- arrange for all case records relating to individuals with a link to the child or family to be located and secured;
 - ascertain records of child protection training in the last three years for members of staff involved;
 - where there is current involvement, make arrangements for access by providing a working copy of records to the reviewer;
 - appoint a suitably qualified senior member of staff to carry out the agency Management Review and assure appropriate administrative and secretarial support, having first established wherever possible that the individuals have not had previous involvement in the management of or practice in relation to the particular case;
 - ensure that the person carrying out the Management Review is familiar with the local guidance:
 - ensure that the person carrying out the Review has been provided with copies of the Serious Case Review Best Practice Guidance.

Management Review Process

- 8.8.9 Management Review officers need to be identified as soon as the agencies are notified of the intention to hold a Serious Case Review.
- 8.8.10 A briefing meeting will be offered to identified Management Review officers carried out by the LSCB Business Manager to:
- share information regarding background;
 - clarify roles and responsibilities;
 - clarify Terms of Reference/scope and timescale;
 - review chronology and report format;
 - clarify interview format and process.
- 8.8.11 The following is provided as a checklist for staff undertaking Management Reviews, who should also refer to the Serious Case Review Best Practice Guidance:
1. Identify key staff to be interviewed.
 2. Advise Service Managers of this process and the need to release staff and the time involved.
 3. Obtain all relevant records.
 4. Arrange a briefing for all staff who are to be involved and consult with senior managers about issues to be addressed.
 5. The briefing of staff will address:
 - remit for Review;
 - format and recording arrangements for interviews;
 - consider those staff to be interviewed;
 - preparation for interviews and time needed;
 - release from usual duties to prepare and participate;
 - support needs;
 - purpose of interview and expectations of interviewee;

- access to record of individual interviews;
- access to chronology;
- the arrangement for access to relevant information from the reports;
- possible outcomes/debriefing arrangements;
- confidentiality.

6. Arrange interviews and confirm in writing including interview format, profile of interviewee format, Terms of Reference and purpose of Review.

7. Collect and read all the relevant documentation which gives the context for the professional handling of the case.

8. Interview staff, record all interviews and send transcripts to interviewees as soon as possible to identify issues of factual accuracy and any other amendments they consider appropriate.

9. Produce agency's Management Review report.

10. Report to be agreed by senior managers of each agency and discuss with staff involved as appropriate.

11. Debriefing meeting with staff involved on completion of the Management Review process in advance of completion of the Overview Report.

12. Develop action-planning process to implement recommendations.

8.8.12 The format for Management review is included in the LSCB Serious Case Review Best Practice Guidance.

8.8.13 Management Reviews are to be completed and endorsed by the senior officer and sent to the LSCB Business Manager according to the timescales agreed at the Serious Case Review Panel. (The first Panel meeting following the decision of the Chair to carry out a Serious Case Review).

8.8.14 On completion of each Management Review, feedback and debriefing for all staff involved should take place by agency in advance of the completion of the Overview Report.

8.8.15 The LSCB Admin Co-ordinator will complete the composite chronology and this will be circulated according to the timescales agreed at the Serious Case Review Panel.

8.9 The Second Serious Case Review Panel Meeting

8.9.1 This will be held according to the timescales agreed at the Serious Case Review Panel.

8.9.2 Purpose is to:

- review individual Management Reviews and the composite chronology to identify any discrepancies;
- identify key issues and themes;
- formulate conclusions and recommendations.

Draft LSCB Overview Report

- 8.9.3 The draft LSCB Overview Report should be completed according to the timescales agreed at the Serious Case Review Panel. Overview Reports should be produced according to the outlined format, although the precise format would depend upon the features of the case. The report should be anonymised in order to protect the individuals concerned.
- 8.9.4 The format for the report recommended is in the LSCB Serious Case Review Best Practice Guidance and may vary depending on the features of the case.
- 8.9.5 The Serious Case Review Panel should meet according to the timescales agreed at the Serious Case Review Panel to agree the draft Overview Report including the Executive Summary.
- 8.9.6 The draft Overview Report should then be circulated to an extra-ordinary meeting of the LSCB, according to the timescales agreed at the Serious Case Review Panel. The draft Overview Report should be circulated ten working days in advance of the meeting.
- 8.9.7 On receiving the draft Overview Report the LSCB should:
- ensure that the contributing agencies are satisfied that their information is fairly and fully represented in the Overview Report;
 - discuss and agree conclusions, recommendations and timescales for individual agency action plans;
 - clarify to whom the Report or parts of it should be made available;
 - disseminate Report or key findings to interested parties as agreed;
 - make arrangements to provide feedback and debriefing to:
 - staff;
 - family members of the subject child;
 - media as appropriate;
 - members of the Serious Case Review Panel.
 - provide a copy of the Overview Report, Executive Summary, inter-agency and single-agency action plans and individual Management Reviews to OFSTED and DCSF;
- 8.9.8 This stage needs to take account of confidentiality and balance accountability of public services and maintaining public confidence.

- 8.9.9 The executive summary will be made public at the conclusion of criminal proceedings, it may not be possible to complete or publish a report prior to criminal or Coroner's proceedings have concluded. Strategic Health Authority and OFSTED need to be briefed in advance regarding publication, so that they can work jointly to ensure that the Department of Health and DCSF respectively are fully briefed in advance of the publication of the Executive Summary. This will be undertaken by Ofsted in conjunction with Government Office North East.
- 8.9.10 Action Plans must be forwarded by each agency to the LSCB Business Manager, within the timescales agreed at the LSCB extra-ordinary meeting, these are appended to the final report, which will be submitted to OfSTED.
- 8.9.11 Conclusions and recommendations should be shared with relevant agencies and staff within eight weeks of the LSCB extra-ordinary meeting.

Review of Recommendations

- 8.9.12 Action Plans are monitored by the LSCB Serious Case Review Group in accordance with the Performance Management Framework.

8.10 Timescales Chart

Timescale (when applicable)	Action	Person Respo nsible
Immediately	Agency who first becomes aware of Serious Case Review criteria being met or concerns around child's death or serious injuries notifies the LSCB Business Manager	Senior Officer in identifying agency
Immediately	LSCB Business Manager informs LSCB Chair	LSCB Business Manager
Immediately	Once known that a Serious Case Review is being considered, SCR Panel members should ensure that individual agencies secure records and draw up a chronology of involvement	SCR Panel
	<p>Serious Case Review Panel meets, Chaired by the LSCB Business Manager to consider whether or not on the available evidence it would be appropriate to initiate a Serious Case Review or to consider an alternative response and to duly make recommendations to the LSCB Chair.</p> <p>If a Serious Case Review is to take place the Serious Case Review Panel is identified.</p> <p>The Panel should comprise representatives from the three main operational agencies and three from agencies not operationally involved.</p>	SCR Panel
Chair makes a decision within one month unless alternative timescales are agreed with OFSTED from the outset.	The Serious Case Review Panel's recommendation will be forwarded to the LSCB Chair, who makes a decision as to whether to hold a Serious Case Review.	LSCB Chair
Immediate	All relevant files and documents are secured by each agency.	Individual Agency Heads
Immediate	OFSTED informed of Serious Case Review. This will be passed to DCSF and GONE by Ofsted.	LSCB Chair
Immediate	Secure the services of an independent person to Chair the Serious Case Review Panel and write the Overview Report.	LSCB Chair & Business Manager

Timescale	Action	Person Responsible
<p>Within 5 working days of the notification.</p> <p>The Review should be concluded within 4 months of this meeting</p>	<p>The Serious Case Review Panel meets to consider the Scope of Review and Terms of Reference and agree timescales.</p>	<p>SCR Panel</p>
	<p>Agency Heads appoint Management Review officers and each service will undertake a separate Management Review to commence as soon as a decision to undertake a review has been made.</p>	<p>Individual Agency Heads</p>
	<p>LSCB Business Manager holds briefing meeting for Management Review officers to:</p> <ul style="list-style-type: none"> ➤ share information regarding background ➤ clarify role/responsibility ➤ clarify Terms of Reference, scope and timescale ➤ review chronology and report format ➤ clarify interview format and process 	<p>LSCB Business Manager</p>
	<p>Management Reviews are completed and endorsed by the senior officer and sent to LSCB Business Manager</p>	<p>Management Review officers</p>
	<p>On completion of each management review feedback and debriefing for all staff involved should take place by agency in advance of the completion of the Overview report</p>	<p>Agencies</p>
	<p>Integrated chronology compiled. Chronology and Management Reviews circulated to Serious Case Review Panel.</p>	<p>LSCB Admin Co-ordinator</p>
	<p>Second meeting of the Serious Case Review Panel. Purpose is to:</p> <ul style="list-style-type: none"> ➤ review individual Management Review reports and integrated chronologies and identify discrepancies; ➤ identify key issues and themes; ➤ formulate conclusions and areas for recommendations. <p>There may be more meetings as the Serious Case Review Panel feels appropriate to complete the Overview Report.</p>	<p>Serious Case Review Panel</p>

	A draft Overview Report to be completed. Any variance to this timescale to this timescale requires agreement from GONE and should be pursued only when the complexity of the case makes it appropriate.	Report writer with support from LSCB Admin Co-ordinator
	A meeting of the Serious Case Review Panel to agree the draft Overview Report.	SCR Panel
	Draft Overview Report circulated to LSCB.	LSCB Admin Co-ordinator
	<p>Extra-ordinary meeting of the LSCB to:</p> <ul style="list-style-type: none"> ➤ discuss and agree conclusions and recommendations; ➤ arrange for Action Plans to be completed and endorsed and adopted at senior level by the agencies involved; ➤ agree timescales; ➤ ensure that the contributing agencies are satisfied that their information is fairly and fully represented in the Overview Report; ➤ clarify to whom the Report or parts of it should be made available; ➤ disseminate Report or key findings to interested parties as agreed; ➤ make arrangements to provide feedback and debriefing to: <ul style="list-style-type: none"> - staff; - family members of the subject child; - media as appropriate; - members of the Serious Case Review. ➤ provide a copy of the Overview Report, Executive Summary, inter-agency and single-agency action plans and individual Management Reviews to OFSTED and DCSF. 	All LSCB members
	Action Plans to be forwarded to the LSCB Business Manager to be appended to the final report and submitted to OfSTED.	Officers identified by extra-ordinary LSCB
	<p>Overview Report, Management Reviews and Action Plans to be forwarded to OFSTED and DCSF.</p> <p>Strategic Health Authority, Ofsted and DCSF need to be briefed in advance of the publication of Executive Summary.</p>	LSCB Business Manager & LSCB Admin Co-ordinator
	Conclusions and recommendations shared with relevant agency/staff.	LSCB members