

Section 8 – Serious Case Review

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INTRODUCTION

- 8.1 These procedures should be read in consultation with the Sub Regional Guidance “Multi-Agency Guidance Governing the Conduct of Serious Case Reviews” endorsed by Durham LSCB April 2010.**
- 8.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the procedures set out in this chapter. The same criteria apply to all children, including those with a disability. It sets out that:
- (1) The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act are as follows:
 - (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 review is one where:
 - (a) abuse of neglect 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 the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
- 8.3 It is essential, to maximise the quality of learning, that the child’s daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the Serious Case Review, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the Serious Case Review as well as the ways in which the information is presented 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 Serious Case Review to be completed.**

SAFEGUARDING SIBLINGS OR OTHER CHILDREN

- 8.4 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor in the death, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, significant harm and who required safeguarding (for example, siblings or other children in an institution where abuse is alleged). Where there are concerns about the welfare of siblings or other children the guidance in [Section 5](#) of these procedures should be followed. Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

PURPOSE OF SERIOUS CASE REVIEWS

8.5 The purpose of Serious Case Reviews carried out under this procedure are to:

- Establish whether there are lessons 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 they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working and so better safeguard and promote the welfare of children.

8.6 Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate. Nor are Serious Case Reviews part of any disciplinary enquiry or process relating to individual practitioners. Where information emerges in the course of a Serious Case Reviews indicating that disciplinary action should be initiated under established procedures, the relevant processes should be undertaken separately to the Serious Case Review process. Alternatively, some Serious Case Reviews may be conducted concurrently with (but separate from) 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.

CRITERIA FOR CONVENING A SERIOUS CASE REVIEW

8.7 When a child dies (including death by suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a Serious Case Review into the involvement with the child and family of organisations and professionals. This is irrespective of whether Local Authority Children's Social Care is, or has been involved with the child or family.

8.8 These Serious Case Reviews should include situations where 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. In addition, a Serious Case Review should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC), or where the child was detained under the Mental Health Act 2005.

8.9 LSCBs should **consider** whether a Serious Case Review should be conducted where a child has been seriously harmed in the following situations:

- 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 serious 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.**

8.10 The following questions may help in deciding whether or not a case should be the subject of a Serious Case Review. The answer 'yes' to one or more of these questions is likely to indicate that a Serious Case Review could yield useful lessons.

- 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 (e.g. school, nursery, children or family centre, Youth Offending Institution, Secure Training Centre, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the Local Authority (LA)?
- 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 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, or had they previously been the subject of a plan or on the child protection list?
- 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 Serious Case Review?

WHICH LSCB SHOULD TAKE LEAD RESPONSIBILITY?

8.11 Where partner agencies of more than one LSCB have known about or had contact with the child, the LSCB for the area in which the child is / was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the review.

Looked After Children

8.12 In the case of a looked after child, the Local Authority looking after the child should exercise lead responsibility for conducting any review, again involving other LSCBs with an interest or involvement.

8.13 Where a partner agency from another LSCB is requested to undertake an Individual Management Review, that agency should as a matter of good practice notify their LSCB of the request. They should subsequently share with their LSCB any areas for concern, good practice and lessons to be learned from both the Individual Management Review and the Lead LSCB Serious Case Review when concluded. In addition the Lead LSCBs Chair should clarify in writing to the Chair of any other LSCBs that have or have had an interest or involvement in the case to determine the agencies and level of involvement required. At the conclusion of the review and prior to the publication of the Executive Summary liaison should take place with the LSCB Chair(s) regarding any potential media interest that may arise.

CASES REFERRED TO THE LSCB

8.14 Any 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. Cases are to be referred using the template for the purpose.

CONSIDERATION OF THE NEED FOR A SERIOUS CASE REVIEW FOLLOWING A COMPLEX ABUSE INVESTIGATION

- 8.15 At the conclusion of the Complex Abuse Investigation process the case will be considered for referral to the Serious Case Review Sub-Committee. If it is agreed that a referral should be made, they will consider the facts as they are then known and decide whether to recommend to the Chair of the Board that a Serious Case Review should be conducted. The decision of the Sub-Committee and the reasons for it will be recorded in the Sub-Committee minutes.
- 8.16 If the Serious Case Review Sub-Committee recommends that a Serious Case Review should be conducted and that recommendation is approved by the Chair of the Board the same principles will apply as to any other Serious Case Review but reviews will be more complex, on a larger scale and may require more time to complete.
- 8.17 Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if children are abused in a residential school, it is important to explore whether and how the school has taken steps to create a safe environment for children, and to respond to specific concerns raised. The investigation of institutional abuse and multiple abuse will be dealt with using the specific Home Office Guidelines "Complex Child Abuse Investigations: Inter Agency Issues". (Refer to Section 9 Complex & Organised abuse).
- 8.18 There needs to be clarity over the interface between: the different processes of investigation (including criminal investigations); case management, including help for abused children and immediate measures to ensure that other children are safe; learning lessons from the Serious Case Review to reduce the chance of such events happening again. These three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

DELEGATED RESPONSIBILITIES OF THE SERIOUS CASE REVIEW SUB-COMMITTEE AND SERIOUS CASE REVIEW PANEL

- 8.19 The Board delegates to the Serious Case Review Sub-Committee and Panel its responsibility for conducting Serious Case Reviews although the Board must agree the final reports. This delegation includes managing and overseeing the entire Serious Case Review process. The Serious Case Review Sub-Committee decision is forwarded as a recommendation to the Chair of the LSCB, who has ultimate responsibility for deciding whether or not to conduct a Serious Case review. Delegation of the process continues through to the completion of the review following approval by the Serious Case Review Panel and Sub-Committee for ratification by the Board.

INITIATING A SERIOUS CASE REVIEW - THE ROLE OF THE SERIOUS CASE REVIEW SUB-COMMITTEE

8.20 Where the LSCB Chair considers, in a particular case, that the criteria for a Serious Case Review may be met, he or she will request that the Serious Case Review Sub-Committee considers whether a Serious Case Review should take place.

8.21 Where the child has died, the LSCB Chair should also use information available from the professionals involved in reviewing the child's death (see [Section 7](#) - Child Death Reviews) to assist in making this decision.

8.22 The Serious Case Review Sub-Committee will consider, in the light of current information known in each case, the scope of the Serious Case Review and draw up clear terms of reference. The LSCB Chair should ensure that the terms of reference address the key issues in the case and approve them.

8.23 The Serious Case Review Sub-Committee, on behalf of the LSCB, should quality assure the final Serious Case Review – that is, the Individual Management Review reports, the Overview Report, the Executive Summary and the action plan before it is presented to the LSCB for approval.

Chair of the Serious Case Review Sub-Committee

8.24 The Chair of the Serious Case Review Sub-Committee should be an experienced person and could be the Independent Chair of the LSCB, or a member of the LSCB.

Membership of the Serious Case Review Sub-Committee

8.25 The Serious Case Review Sub-Committee should involve representatives from the following agencies at a minimum:

- Safeguarding and Specialist Services
- Commissioning Primary Health Trust and other health partners as relevant
- Education
- Police

8.26 Agencies who have responsibility for completing Individual Management Reviews may be members of the Sub-Committee but it should not consist solely of such people.

8.27 Members should attend the Sub-Committee with sufficient information about their agency's involvement with the family in order to enable the Committee to make a recommendation based upon information gathered which will be forwarded to the LSCB Chair. Members should have sufficient expertise to provide opinion about the level and appropriateness of the services provided by their agency.

DETERMINING THE SCOPE AND TERMS OF REFERENCE OF THE REVIEW

8.28 Relevant issues to consider include the following:

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed including, for instance, information on the mental health of relevant adults?
- When should the Serious Case Review start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the Executive Summary?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the Serious Case Review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the Serious Case Review including, where appropriate, for example, the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?
- Is there a need to involve organisations/professionals working in other LSCB areas, and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed Serious Case Review?
- Who should be appointed as the independent author for the Overview Report (bearing in mind that this person should not be the Chair of the LSCB, the Serious Case Review Sub-Committee or the Serious Case Review Panel)?

- Might it help the Serious Case Review Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO) or MAPPA Serious Case Review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated with a Serious Case Review.
- How will the Serious Case Review Terms of Reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (including the biennial overview reports of Serious Case Reviews) and from Serious Case Reviews which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the Serious Case Review? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the Serious Case Review?

8.29 Some of these issues may need to be revisited by the Serious Case Review Panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the LSCB Chair.

8.30 The initial scoping of the Serious Case Review should identify who should contribute , although it may emerge as further information becomes available that the involvement of others would be useful e.g. those providing specialist adult services. Information of relevance to the review may also become available at a later stage through, for example Criminal Proceedings or other investigations.

OTHER DECISIONS

8.31 If the criteria are not met and the Serious Case Review Sub-Committee agree there are lessons to be learned they can agree an appropriate process for this to take place. In some cases, this may be a single Individual Management Review (IMR) rather than a full Serious Case Review, for example where there are lessons to be learned about the way staff worked within one agency rather than about how agencies worked together, or a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a full Serious Case Review. Here methodologies such as that developed by SCIE (2008) may be useful. In such cases arrangements should be made to share relevant findings with the Serious Case Review Sub-Committee, Panel and the LSCB.

NOTIFICATION OF THE DECISION

8.32 The following actions should be undertaken:

- The LSCB Chair should notify Ofsted of the outcome of this decision as soon as it has been made. Ofsted will then pass this information to the Department for Education (DfE).
- PCT commissioners should ensure their Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified.
- The Police should also notify Her Majesty's Inspectorate of Constabulary (HMIC)
- The National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).
- The Chair of the LSCB will notify all Chief Officers requesting that all relevant records are secured.

ANONYMITY

8.33 In all cases and at all stages in the Serious Case Review process from the first notification to Ofsted of a serious incident to the completion of the final Serious Case Review report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, Serious Case Review Panel Chair and the Overview Report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, and DfE).

THE ROLE OF THE SERIOUS CASE REVIEW PANEL

- 8.34 If the Serious Case Review Sub-Committee considers the criteria for a Serious Case Review has been met and the LSCB Chair confirms their decision, an Independent Serious Case Review Panel will be convened and an Independent Chair must be engaged for future meetings and to oversee the process. The Serious Case Review Panel Chair will ensure that the panel operates effectively and independently of the member organisations.
- 8.35 At the first meeting of the Serious Case Review Panel the Independent Chair will reaffirm with the members, the Scope of the Review, Terms of Reference and any other processes as included within this guidance
- 8.36 The Serious Case Review Panel, on behalf of the LSCB, should commission an overview report that brings together and analyses the findings of the various Individual Management Reviews from organisations and others, and that makes recommendations for future action. It is crucial that the Serious Case Review Panel and the overview report author have access to all relevant documentation and where necessary individual professionals to enable both to undertake effectively their respective Serious Case Review functions.
- 8.37 Where a child dies in or whilst under escort to or from a custodial setting such as a YOI or STC, the PPO will conduct a fatal incidents investigation and report on the circumstances surrounding the death of that child. The investigation will examine the child's period in custody and assess the clinical care they received as well as examining relevant factors that led to the child being placed in custody. In such cases a representative of the Youth Justice Board (YJB) should be a member of the Serious Case Review Panel to help ensure that relevant youth justice issues.
- 8.38 The PPO may be invited to attend Serious Case Review Panel meetings for specific, agreed purposes. The Serious Case Review Terms of Reference should set out how the PPO, the Serious Case Review Panel and the Serious Case Review Sub-Committee will work together to share relevant information during the process of undertaking the Serious Case Review.
- 8.39 The Overview Report should be commissioned to a person who is independent of all the local agencies and professionals involved and of the LSCB(s). The Overview Report author should not be the Chair of the LSCB, the Serious Case Review Sub-Committee or the Serious Case Review Panel. Those conducting Management Reviews of individual services should not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.
- 8.40 On receiving the Overview Report the Chair of the Serious Case Review Panel will arrange to meet with Panel and Sub Committee Members to quality assure the reports and action plans against national criteria e.g. Working Together and Ofsted descriptors.
- 8.41 When undertaking this task the members contributing role should take precedence over their role as a representative of their organisation.

8.42 The Serious Case Review Panel will consider the recommendations included in the multi-agency action plan to determine that the action and outcome is **SMART**, robust, viable and has an appropriate lead officer and timescale against each action.

5.27 The Serious Case Review Panel will also:

- ensure that it actively manages the Serious Case Review process;
- 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, Executive Summary and action plans are of a high standard and are written in accordance with this the Serious Case Review Sub-Regional Guidance;
- ensuring reports are fully anonymised apart from the names of the LSCB Chair, Serious Case Review Panel Chair and the overview author;
- translate recommendations into an action plan that should be signed up to by the Senior Managers in each of the organisations which will be involved in implementing the action plan. The plan should set out:
 - who will do what;
 - by when;
 - the intended outcome;
 - how success will be measured;
 - the process for monitor and review.
- agree dissemination to support implementation of the recommendations and the learning of the lessons;
- make arrangements to provide feedback and debriefing to the child (if surviving), and family members.

Serious Case Review Panel Chair

8.43 The Chair of the Serious Case Review Panel should meet the requirements as detailed in the Sub-Regional Guidance. The Chair will not be a member of the LSCB(s) involved in the Serious Case Review, an employee of any of the agencies involved in the Serious Case Review or the Overview Report author.

8.44 The Chair will undertake the responsibilities detailed in the Sub-Regional Serious Case Review Guidance.

Serious Case Review Panel Membership

8.45 The Serious Case Review Panel should involve representatives from the following agencies at a minimum:

- Safeguarding and Specialist Services
- Commissioning Primary Health Trust and other health partners as relevant
- Education
- Police

8.46 Agencies who have responsibility for completing Individual Management Reviews may be members of the Sub-Committee but it should not consist solely of such people.

INDIVIDUAL MANAGEMENT REVIEWS

8.47 The initial scoping of the Serious Case Review should identify those agencies that should contribute to the Serious Case Review process, although it may emerge as further information becomes available, that the involvement of others is necessary.

8.48 Every service or organisation that has had contact with the family in question will undertake a separate management review, known as an Individual Management Review (IMR), of its involvement with the child and family. A written report of each review will be produced in the agreed format. **This should begin as soon as a decision is taken to proceed with a Serious Case Review, and even sooner if the case gives rise to concerns within the individual organisation,**

8.49 Where Cafcass contributes to a review, the prior agreement of the courts should be sought so that the duty of confidentiality, which the children's guardian has under the court rules, can be waived to the degree necessary.

Aim of the Individual Management Review

8.50 The aim of Individual Management Reviews should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about.

Timing

8.51 The first draft of the Individual Management Review should be completed within 10 weeks of the decision to initiate a Serious Case Review.

Responsibility of Agencies and the Individual Management Review Authors

8.52 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.

8.53 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 skilled experience person who meets the requirements of the Individual Management Review specification to undertake the tasks outlined in the job description and person specification. This includes attending meetings of the Serious Case Review Writing Group;
- 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 and has or is available to attend the Individual Management Review training which will be arranged at the onset of the Serious Case Review.

Quality Assurance

8.54 On completion of each Individual Management Review a senior officer (the Authorising Manager) will on behalf of the service or organisation concerned quality assure and agree the content of the report, its findings and its recommendations. Senior officers may find it helpful to use the checklist provided within the Best Practice Guidance. The senior officer will be responsible for ensuring that the recommendations of the Individual Management Review, and where appropriate the Overview Report, are acted on.

8.55 The Individual Management Review will be considered at the writers group. Both the independent author and the independent panel chair who chairs the writers group will need to be satisfied that the Individual Management Review meets the expected standards.

Production of an Integrated Health Chronology and Overview

8.56 Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. Where more than one PCT has commissioned services the PCTs will need to agree locally how they will work together. This may involve reviewing the involvement of individual practitioners and NHS Trusts, and advising named professionals and managers who are compiling reports for the review.

8.57 The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the Individual Management Review for the PCTs as commissioners. Designated safeguarding health professionals also have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the Individual Management Review.

8.58 If the designated health professional(s) have been clinically involved with the case the PCT should seek advice and help from another PCT designated professional as necessary.

Individual Management Review Recommendations and Action Plans

8.59 The recommendations contained within the IMR will be translated into a single-agency Action Plan with details of action, expected outcome, timescales and lead officer. These will be approved by the authorising officer within the agency prior to submission to the Serious Case Review Panel.

8.60 The Authorising Manager will accept responsibility for implementing the Individual Management Review Action Plan, which will be monitored within single agencies.

Feedback and Debriefing

8.61 The agency will arrange for an appropriate feedback and debriefing to be provided to any staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the Overview Report and Executive Summary is published.

INFORMATION SHARING FOR THE PURPOSE OF CONDUCTING A SERIOUS CASE REVIEW

- 8.62 The process of conducting a Serious Case Review requires access to records relevant to the child such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the child's own records. In some circumstances the person conducting the Individual Management Review may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case-by-case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.
- 8.63 All relevant records will be read and a list of staff to be interviewed will be drawn up by the Individual Management Review Author Staff should be supported by their agencies throughout this process.
- 8.64 Where staff or others are interviewed by those preparing Individual Management Reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed to find the reason for this. Where it is not possible to interview a relevant person, an adequate explanation for the rationale why it has not taken place must be recorded in the Individual Management Review.
- 8.65 The purpose of the Individual Management Review is to examine practice, not to invoke disciplinary action. If issues arise which may lead to disciplinary action this will be reported to the appropriate person within the agency.**

SERIOUS CASE REVIEW WRITERS GROUP

- 8.66 This is chaired by the Independent Panel Chair. The Independent Author may Chair this meeting if the Independent Panel Chair is not available.
- 8.67 The authors will initially meet with the Independent Author as the Serious Case Review Writers Group, to review the single agency chronologies that the LSCB will have combined into one multi agency chronology, in order to identify the key issues and any early lessons to be learnt. This should be undertaken as soon as possible as it will form the basis for discussion and identification of key areas.

INDEPENDENT AUTHOR

8.68 The Independent Author is responsible for:

- maintaining timely communication with the Individual Management Review Authors, their own agency staff, senior managers, legal advisers, and others identified within their agency as needing to know about the progress of the review.
- ensuring that the Individual Management Review has been quality assured and signed off by the Individual Management Review Senior Officer for their agency

8.69 The Independent Author will:

- have sufficient skills, experience and knowledge as per agreed Job Description and Person Specification;
- chair the Serious Case Review Writers' Group meetings if an Independent Chair is not present;
- provide the scrutiny and quality assurance of the Writers Group, clarifying and challenging where necessary to ensure lessons to be learned are identified and that recommendations are **SMART** prior to the draft reports being subject to further scrutiny by the Serious Case Review Panel;
- analyse the chronologies and reports to identify good practice, omissions, missed opportunities and key areas of learning;
- request additional information from the Individual Management Review Authors if required. Write the Serious Case Review Overview and Executive Summary Reports and an outline Inter agency Action Plan, as set out in the statutory regulation and local guidance prior to it being submitted to the Serious Case Review Panel;
- produce and present a Powerpoint presentation that summarises the Serious Case Review for LSCB members and inter agency briefings.
- Maintain communication regarding process with the Chair of the Serious Case Review Panel and LSCB Business Manager to ensure that timescales, quality standards and criteria as required by Ofsted and the LSCB are met.

RESPONSIBILITY OF LSCB BUSINESS MANAGER

8.70 The LSCB Business Manager will:

- take overall responsibility for the co-ordination and business planning processes.
- act as an advisor in respect of the Serious Case Review.
- identify the availability of Independent Chairs and Authors.
- commission independent persons as appropriate.
- draft all correspondence and initial documentation in accordance with this guidance.
- in liaison with the Serious Case Review Chair make appropriate contacts with the family to ensure they have the opportunity to contribute to the review.
- attend both the Serious Case Review Sub-Committee, Panel and Writers Group.
- liaise with Government, Ofsted, the Coroner and other statutory bodies as appropriate.
- confirm and co-ordinate the personnel from the agencies who will be involved in the process e.g., Panel Members, Individual Management Review Authors.
- act as a point of contact and advice.
- ensure the Independent Chair, Author and the Members of the Sub-Committee, Panel and Writers' Group are clear about what they are required to do, what they should expect from each other and the agreed process. This includes:
 - setting a timescale for completion in liaison with the LSCB Chair.
 - liaising with the Panel Chair and Author to plan how often and when the Panel and Writers Group should meet.
 - undertake briefings as appropriate.

OVERVIEW REPORT

8.71 The Serious Case Review 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, where relevant, reports commissioned from any other relevant interests and the authors own deliberations. Overview Reports should be produced in the agreed format.

8.72 Recommendations included in the Overview Report should include a reference to the Individual Management Review Action Plans but should not simply be a rewriting of these. The Overview Recommendations should stem directly from the lessons raised within the body of the report. They 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. **All recommendations should be SMART (Specific, Measurable, Achievable, Realistic, Timely).**

MULTI-AGENCY ACTION PLAN

8.73 On completion of the Overview Report the Independent Author will put the recommendations from that Report for one more of the services or organisations concerned into a draft Multi-Agency Action Plan. The Serious Case Review Panel members will then complete the multi-agency action plan to show how the recommendations will be implemented as detailed below.

8.74 The plan will set out:

- who will do what, by when and with what intended outcome; *and*
- by what means improvements in practice/systems will be monitored and reviewed by the Board.

8.75 The Multi-Agency Action Plan will be submitted to the Serious Case Review Panel for robustness of it being SMART, acceptance or agreement as to how to improve upon it.

EXECUTIVE SUMMARY

8.76 The Independent Author will draft an Executive Summary in the agreed format, for presentation to the Panel and LSCB. The Serious Case Review Overview Report and the Individual Management Reviews should be used by the Independent Author to produce the Executive Summary, which accurately reflects the full Overview Report.

8.77 The Executive Summary should include:

- information about the review process;
- key issues arising from the case; *and*
- the recommendations and the multi-agency action plan (including any actions that have been completed).

8.78 The Executive Summary should include the names of the LSCB Chair, Serious Case Review Panel Chair, the Overview Report Author, and the job titles and employing organisations.

8.79 The draft Overview Report and Executive Summary and action plans 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 10 working days in advance of the meeting.

LSCB ACTION ON RECEIVING THE SERIOUS CASE REVIEW REPORT

8.80 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;
- disseminate Report or key findings to interested parties as agreed;
- make arrangements to provide feedback and debriefing to:
 - family members of the subject child;
 - media as appropriate;
- provide a an embargoed copy of the Individual Management Reviews, Overview Report, Executive Summary and the individual and multi-agency action plans and chronologies to Ofsted, the SHA and DfE. All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and Serious Case Review Panel Chairs and the Overview Report Author) should be anonymised in all the SCR documentation submitted to Ofsted and other relevant parties. If the child died in a custodial setting, copies of the Overview report and Executive Summary should be made available to the YJB and copies of the and PPO;
- clarify partner agencies arrangements to provide feedback and debriefing to staff
- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the Serious Case Review action plan;
- on receipt of the evaluation letter from Ofsted, The LSCB will inform partner agencies of the content and take any actions as required by Ofsted.
- formally conclude the review process when the action plan has been implemented and inform the relevant parties.

PUBLICATION OF REPORTS

- 8.81 The LSCB is required to publish both the Overview Report and the Executive Summary. Publication of these reports will be in line with the arrangements set out in the Serious Case Review Sub-Regional Guidance.
- 8.82 Serious Case Reviews contain personal information and it is vitally important that published Serious Case Reviews are appropriately redacted and anonymised to protect the privacy and welfare of vulnerable children and their families. There is an important balance to be struck between transparency and openness so that lessons can be learned, and the protection and welfare of individuals.
- 8.83 Overview Reports should be published together with the Executive Summary unless there is compelling reasons relating to the welfare of any children directly concerned in the case for this not to happen.
- 8.84 Both the Overview and the Executive Summary should be anonymised and should not contain identifiable details. This means that Overview Reports are prepared in a suitable manner for publication or redacted appropriately before publication.
- 8.85 The Individual Management Reports are not public documents.
- 8.86 Prior to publication of the information the LSCB should ensure Ofsted and all other relevant bodies including DfE, SHA, the CQC, Her HMIC and HMIP are appropriately briefed in advance about the publication. Where a child has died in a custodial setting, this briefing should include the YJB. The Strategic Health Authority (SHA) should brief the Department of Health.
- 8.87 Any delay in publishing the Overview Report and Executive Summary pending the outcome of related criminal or coroners proceedings or for any other reason should not prevent early lessons from being implemented by the individual service or organisations that have contributed to the review.**

TIMESCALES OF A SERIOUS CASE REVIEW

- 8.88 Reviews vary widely in their breadth and complexity but, in all cases, **where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the Serious Case Review to be completed.** Within one month of a case coming to the attention of the LSCB Chair, he or she should decide, following a recommendation from the Serious Case Review Sub-Committee, whether a review should take place. An initial decision may need to be revisited if further information comes to light, for example through a criminal investigation or a Child Death Review in accordance with Section 7 of these procedures and other inspectorates should be notified accordingly.

- 8.89 Serious Case Reviews should be completed within six months from the date of the decision to proceed. Sometimes the complexity of a case does not become apparent until the Serious Case Review is in progress. If it emerges that a Serious Case Review cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB should revise its timetable and immediately consult the relevant persons in their capacity to provide advice, support and challenge.
- 8.90 Where an extension beyond the six month timeframe is necessary, an update on progress and a revised project plan should be produced quickly for the relevant parties to consider. This update should include recommendations for action where these are not dependent on the Serious Case Review being concluded until after other proceedings have ended. It should also include actions taken to date and an explanation for the extension to the timescale, including the revised completion date. Where a decision to extend the period for completion is made, this information will be passed to Ofsted by the relevant parties. LSCBs should be proactive in keeping relevant parties fully appraised of timing expectations, of risks of delay and of interdependencies with other parallel or related processes.
- 8.91 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the Serious Case Review Panel should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the Serious Case Review is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage? Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to finalise the Individual Management Reviews and the Overview Report or to finalise and publish the Serious Case review until after coronial or criminal proceedings have been concluded and a satisfactory judgement received from Ofsted, but this should not prevent early lessons learned from being acted upon.
- 8.92 Serious Case Reviews should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The LSCB Chair should make these decisions on a case by case basis based on advice from the Chair of the Serious Case Review Panel and having consulted with the Local Authority where there are pending family cases. The LSCB Chair may also need to seek legal advice to assist in deciding how to proceed.
- 8.93 The final Serious Case Review report, including the Executive Summary, should take full account of salient new information, which becomes available during the course of these proceedings and the facts, conclusions and recommendations should be revised accordingly.
- 8.94 Feedback to professionals is part of the agency's responsibilities following a Review, and would not be shared or discussed with the Serious Case Review Panel or Writers Group, other than to confirm that it had taken place.

MONITORING OF ACTION PLANS

8.95 All agencies should ensure they have appropriate quality assurance process in place to continue to monitor compliance with practice issues raised in the course of the Serious Case Review. They should also report to the Board when there are concerns and when they have undertaken any related audits.

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

FEEDBACK

8.97 It is the agencies' responsibility to ensure that lessons learned from Serious Case Reviews are shared, understood and acted upon.

8.98 Feed back should be provided to anyone who has contributed to the review to enable them to reflect on it in order to learn and implement the lessons from the reports findings. Managers may take further actions as required.

8.99 PCTs (NHS Commissioners) should seek feedback from SHAs and use the lessons learned to inform their performance management role. The Care Quality Commission may also use the findings of Serious Case Reviews to inform its processes for regulating NHS and independent health sector provider organisations. PCTs will monitor the implementation of the recommendations by provider health organisations.

RELATIONS WITH THE POLICE, CORONER AND CRIMINAL PROCEEDINGS

8.100 Serious Case Reviews should not be delayed as a matter of course because of outstanding coroner or criminal proceedings or an outstanding decision on whether or not to prosecute.

8.101 If coroner or criminal proceedings follow the death or serious injury of a child the Chair of the Serious Case Review Panel will liaise with the Coroner, Police and Crown Prosecution Service to agree how the Serious Case Review will take account of those proceedings, e.g.:

- The timing of the review;
- The way in which the review is conducted;
- The potential contamination of witnesses;
- Who should contribute to the review and at what stage, including family members.

8.102 The Serious Case Review Panel will also consider whether publication of the Overview Report and Executive Summary should be delayed until the outcome of any coroner or criminal proceedings (including sentencing but not including any appeal).

MEDIA

- 8.103 The overall aim of the Board is to achieve maximum transparency and openness in relation to the outcome of Serious Case Reviews so that lessons can be learned and acted upon as quickly as possible. This however needs to be balanced against the Board's overriding duty to protect the confidentiality of individuals in accordance with both common law and statute.
- 8.104 The Board acknowledges the importance of establishing clear and coherent lines of communication between the Board partners in the conduct of their relations with the public both directly and through the media. This includes effective interaction and the promotion of better understanding of the work and the role of the Board.
- 8.105 The Board will ensure that all relations with the media are handled effectively, and that a fair, co-ordinated and balanced coverage of the work of the Board is maintained. It will ensure that the correct agencies are involved in relevant enquiries, and that individual agencies deal with any service specific enquiries.

Responsibility

- 8.106 Whilst all partner agencies have responsibility for safeguarding and promoting the welfare of children as part of their LSCB responsibilities for co-ordinating the work of their agencies, lead responsibility lies with the Chair of the LSCB. S/he is accountable to the Director of Children & Young People's Service and any media communication must be made in agreement with the Director.

Public & Media Relations Guiding Principles

- 8.107 All public and media relations activity will be guided by the following principles as set out in the Government Guidance "Working Together to Safeguard Children (2010)":
- The paramount need to safeguard children;
 - The need to maintain public confidence in the Local Authority and its Board partners and to enhance the public's understanding of individual partner's responsibility for safeguarding and promoting the welfare of children; *and*
 - The need to properly balance any legitimate public interest against any relevant constraints e.g. subjudice rules, data protection legislation, any relevant exemptions under the Freedom of Information Act 2000
- 8.108 All public and media relations activity will also be governed by the North East Regional Safeguarding Network Protocol in relation to the publication of Serious Case Reviews. This specifies:
- that each LSCB supports the principle of taking a responsive approach to the publication of Serious Case Review Executive Summaries.
 - publication would consist of placing the Executive Summaries on the LSCB website – unless the merit of a particular case leads the LSCB to consider that a more pro-active approach to managing the media is necessary.

- that where an approach from the press about a case subject to review is received, LSCB's will confirm that the Serious Case Review is taking place and will advise of planned publication (as outlined above) and suggest press/media monitoring of the website.
- the timing of Serious Case Review publication should be delayed until the LSCB receives confirmation of the results of the evaluation by Ofsted and other proceedings that may inform the SCR have concluded.
- Serious Case Review's Executive Summaries are published on the LSCB website for a period of six months.

Media Enquiries

- 8.109 The LSCB will inform all LSCB Key Media Contacts via email of the Serious Case Review to raise their awareness and ensure that any enquiries are directed to the LSCB Chair or nominated representative.
- 8.110 The LSCB will take lead responsibility for responding to media enquiries relating to Serious Case Reviews and will liaise as appropriate with other key media contacts, if the case warrants it having regard to the Guiding Principles.
- 8.111 Any media enquiries relating to services or individuals associated with the Serious Case Review from partner agencies should be still be the subject of discussion with the LSCB Chair to ensure that consistent and clear messages are provided in a co-ordinated response.
- 8.112 All partner agencies involved in a particular case will have prior warning/sight of any media press release or statement.

Requests made under The Freedom of Information Act 2000

- 8.113 The Local Safeguarding Children Board is a partnership in which the Local Authority and several key public authority partners work together with the common aim of safeguarding and promoting the welfare of children.
- 8.114 The Freedom of Information Act 2000 provides the public with a general right of access to information held by public authorities. Public authorities include local government, the police, the NHS and state schools. Local Safeguarding Children Boards are exempt from this Act however the individual agencies are required to comply
- 8.115 From time to time requests may be directed to the Chair of the Board or to individual partner organisations for the disclosure of information relating to the conduct of Serious Case Reviews e.g. for a copy of a Individual Management Reviews, the Overview Report, the Executive Summary or the Multi-Agency Action Plan.

8.116 Requests may be received from:

- The press or media;
- Members of the public;
- Members of the Council;
- Representatives of any partner organisation.

8.117 There are strict time limits for responding to such Freedom of Information (FOI) requests. Any information that the public authority is required to release must be disclosed to the applicant within 20 working days of the receipt of the request.

Responding to Freedom of Information Requests

8.118 Every request for information, which is not, the subject of section 9 must be considered. There can be no blanket ban on the disclosure of certain types of documents e.g. Individual Management Reviews or Overview Reports. The Freedom of Information Act 2000 does not allow this.

8.119 Although a Serious Case Review is commissioned and “owned” by the members of the Board working in partnership with each other, a response to a Freedom of information request must come from the organisation to which the request is made.

8.120 If a partner organisation receives a Freedom of Information request, which relates to a Serious Case Review commissioned by the Board it will draft a response based on the advice of its own Freedom Information Officer or legal adviser.

8.121 The request and the response will be copied to the Chair and all members of the Board for their information prior to it being sent to the requester.

EVALUATION BY OFSTED

8.122 All Serious Case Reviews are evaluated by Ofsted and where appropriate, the evaluation may involve other inspectorates notably, the CQC and HMIC. The evaluation will be shared with the LSCB and, together with the published Overview Report and Executive Summary, with partner inspectorates and monitoring organisations to ensure that the lessons learned are implemented.

8.123 In addition if a Serious Case Review has been evaluated as 'inadequate' the LSCB should convene a panel, to be chaired by an independent person to reconsider the review. The LSCB is then required to submit to Ofsted with three months of receipt of the letter, an action plan that addresses the inadequacies of the review.

8.124 In order to assist the process, Ofsted have requested that within one month of receipt of evaluation letters that are issued by them to LSCBs, that they are sent the final version and the date of its publication. The final version of the Executive Summary should be suitably anonymised and sent by secure e-mail.

8.125 Ofsted will:

- Update the Care Quality Commission, HMI Constabulary and HMI Probation when a Local Safeguarding Children Board (LSCB) notifies them of a decision to instigate a serious case review;
- Share copies of the relevant Individual Management Review(s), Overview Report, single agency and multi-agency action plans, Executive Summary and their evaluation letter with the three inspectorates as required; *and*
- Upon receipt of the final Report and confirmation of publication by the LSCB, send a copy electronically to the three inspectorates (as required), the Association of Chief Police Officers, Strategic Health Authority and Primary Care Trust.

LEARNING LESSONS NATIONALLY

8.126 Taken together, child death and Serious Case Reviews are an important source of information to inform national policy and practice. The DfE is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DfE commissions regular reports, drawing out key findings of Serious Case Reviews and their implications for policy and practice to assist the process of learning lessons. In the future relevant findings from the work of the local child death overview teams will be integrated into these reports.

DOCUMENT MANAGEMENT AND SECURITY

- 8.127 Serious Case Review documentation must be treated as highly sensitive, confidential, and stored securely by all agencies. All electronic information must be shared in accordance with IT protocols and sent by secure email or use of password protection for agencies that do not have access to secure e mail.
- 8.128 Secure sharing, retention and storage of Single Agency Reports and accompanying documents, such as records of staff interviews, is the responsibility of the originating agency and may be used as part of parallel or subsequent processes such as disciplinary or insurance activity.
- 8.129 One master copy of each agency's Individual Management Review including the Action Plan will be retained with the Overview Report, Executive Summary and Multi-Agency Action Plan.
- 8.130 During the review process, secure sharing, retention and storage of master copies of the Single Agency Reports, the Overview Report, the Executive Summary, the Multi-Agency Action Plan and any relevant accompanying documents, will be the responsibility of the LSCB and subject to restricted access to authorised persons only. These master copies will be retained by the Admin Co-ordinator in secure conditions throughout the period of the review process.

- 8.131 Hard copies of the Overview Report will be limited in number and stored securely.
- 8.132 External requests for electronic or hard copies of the Executive Summary will be responded to in consultation with the LSCB Chair. All such requests and the reasons given for making them will be recorded.
- 8.133 After the satisfactory conclusion of the Serious Case Review process and auditing of the Action Plan, as approved by LSCB and Ofsted, the master copies of all documents will be stored securely by the LSCB. These documents will be retained for the period set down for the retention of children's records.

TIMESCALES CHART

Timescale (when applicable)	Action	Person Responsible
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 using the Referral template	Senior Officer in identifying agency
Immediately	LSCB Business Manager informs LSCB Chair	LSCB Business Manager
Immediately	If information suggests that the criteria for a Serious Case review may be met Members of the SCR Sub-Committee are notified and a SCR Sub-Committee convened. Once known that a Serious Case Review is being considered, SCR Sub-Committee members should ensure that individual agencies secure records, deal with issues pertaining to consent and draw up a chronology of involvement	SCR Sub-Committee
Immediate	All relevant files and documents are secured by each agency. Each agency starts the process of putting together a chronology	Individual Agency Heads
	Serious Case Review Sub-Committee meets, chaired by the LSCB Business Manager or other Board member 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. If a Serious Case Review is recommended to take place the Serious Case Review Panel is identified and arrangement made to appoint an independent chair and an independent Overview Report Author.	SCR Sub-Committee

Timescale (when applicable)	Action	Person Responsible
Chair makes a decision within one month of a case coming to their attention.	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
Immediately Following confirmation that a SCR will take place	Ofsted informed of Serious Case Review. This will be passed to DfE, Ofsted and other relevant parties	LSCB Chair
Immediately Following confirmation that a SCR will take place	Relevant agencies will be formally advised of the decision and will be requested to appoint a Individual management review author who is both experienced and trained to undertake the an Individual Management Review	
Within 10 weeks of the decision to hold a SCR	The Individual Management Review authors will complete the first draft	
Within 6 months of the LSCB Chair's decision to proceed.	SCR completed, agreed by the LSCB and submitted to Ofsted and other relevant parties.	