Guidance Governing the Conduct of

SERIOUS CASE REVIEWS
(Part One)

Newcastle Safeguarding Children Board

May 2010

With thanks to:
Darlington, Durham, Hartlepool,
Middlesbrough,Redcar & Cleveland
and Stockton-on-Tees LSCBs

Newcastle
Safeguarding
Children Board

C O N T E N T S

SCR Guidance Part Two - Templates

The example documents listed below are included in Part Two of the Guidance. They can be localised to meet the needs of individual LSCBs, apart from the Job Descriptions and Person Specifications. Part Two of the guidance can be obtained from your NSCB Coordinator.

Reference	Document Title
1	SCR Flowcharts: Consideration, Process and Overview
2	SCR Leaflet for Professionals
3	SCR Consideration Request Form
4	Letter of Agreement for the Independent Author
5	SCR Panel Chair Job Description and Person Specification
6	SCR Independent Author Job Description and Person Specification
7	SCR Individual Management Review Author Job Description and Person Specification
8	Colour Code for Organisations 2009
9	SCR Sub Committee Notes Pro Forma
10	SCR Stage Recording Record
11	SCR Terms of Reference Checklist
12	SCR Genogram
13	SCR Abbreviations List
14	SCR OFSTED Notification of Serious Child Care Incidents
15	SCR Chronology
16	SCR Initiating letter
17	SCR Coroners letter
18	SCR Management Review Report Format
19	SCR Interviewee Format Guidance
20	SCR Consent form Sept
21	SCR Unable to contact you (parent) letter
22	Example of SCR Leaflet to Parents
23	SCR Media Contacts
24	SCR Overview Report Format
25	SCR Action Plan
26	SCR Exec Summary
27	SCR Ofsted evaluation template
28	SCR Ofsted Judgements and Descriptors

Local Safeguarding Children Boards

Local Safeguarding Children Boards are the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. They must be pro-active and also undertake a co-ordinating and monitoring role. Crucially they are regularly assessed by the relevant inspectorates, which monitor and evaluate their effectiveness in terms of the contribution they make to the welfare of children.

One of the most important functions of Local Safeguarding Children Board is to undertake reviews of serious cases and to advise the local authority and its Board partners on lessons to be learned (Regulation 5(e)).

This guidance document based on Working Together to Safeguard Children 2010 (Chapter 8), has been prepared to help all partners understand their role and the process involved when the need for a Serious Case Review is identified. The shaded sections are local additions to Working Together 2009.

1 Reviewing and Investigative Functions of Local Safeguarding Children Boards

1.1 The prime purpose of a serious case review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented at all stages of the process, including the conclusions and recommendations. Reviews vary in their breadth and complexity but in all cases, where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed.

1.2 Any professional or agency may refer a case to the Local Safeguarding Children Board (LSCB) if they believe that there are important lessons for intra and/or inter-agency working to be learned from the case. The SCR Sub Committee does not have to be chaired by an Independent Serious Case Review Panel Chair.

1.3 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.

2. The Purposes of Serious Case Reviews

2.1 The purposes of SCRs carried out under this guidance are to:

2.1.1 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

2.1.2 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

2.1.3 Improve intra and inter-agency working and so better safeguard and promote the welfare of children.

2.2 SCRs 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.

2.3 Nor are SCRs part of any disciplinary enquiry or process relating to individual practitioners. Where information emerges in the course of a SCR indicating that disciplinary action should be initiated under established procedures, the relevant processes should be undertaken separately to the SCR process. Alternatively, some SCRs 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.

Safeguarding Siblings or Other Children

2.4 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 Chapter 5 of Working Together 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.

When Should A LSCB Undertake A Serious Case Review?

2.5 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 SCR 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. These SCRs should included situation where a child has been killed by a parent, care or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR 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. Local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (e.g. siblings, or other children in an institution where abuse is alleged).

2.6 LSCBs should consider whether a SCR should be conducted where a child has been seriously harmed in the following situations:

2.6.1 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

2.6.2 A child has been subjected to serious sexual abuse; or

2.6.3 A parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or

2.6.4 A child has been seriously harmed following a violent assault perpetrated by another child or an adult; **and**

2.6.5 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.

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

2.7.1 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?

2.7.2 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)?

2.7.3 Was the child abused or neglected while being looked after by the local authority (LA)?

2.7.4 Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?

2.7.5 Did the child suffer harm during an unauthorised absence from an institution or having run away from home or other care setting?

2.7.6 Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?

2.7.8 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?

2.7.9 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 register?

2.7.10 Does the case appear to have implications for a range of agencies and/or professionals?

2.7.11 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?

2.7.12 Are there any indications that the circumstances of the case may have national implications for systems or processes or, that it is in the public interest to undertake a SCR?

Which LSCB Should Take Lead Responsibility?

2.8 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. 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. Where a partner agency from another LSCB is requested to undertake an IMR, 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 IMR and the Lead LSCBs Serious Case Review when concluded. In addition 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.

Institutional Abuse and Multiple Abuse

2.9 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. SCRs in these circumstances are likely to be more complex, on a larger scale, and may require more time (see paragraphs 6.7 – 6.10 in Working Together (2006) on investigating complex (organisational or multiple) abuse. 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".

2.10. 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 SCR 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.

2.11 At the conclusion of the Complex Abuse Investigation process the case will be considered for referral to the Serious Case Review Sub Committee Panel. 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 Panel and the reasons for it will be recorded in the Panel minutes.

2.12 If the SCR 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.

3 Membership of SCR Sub Committees and SCR Panels

3.1. The LSCB may have a standing SCR sub committee to oversee the quality assurance of all SCRs undertaken by the LSCB and to provide advice to the LSCB Chair on whether the criteria for conducting a SCR have been met. The Sub committee will involve representatives from Local Authority Children's Social Care, Health (commissioning Primary Care Trust and other partners as relevant), Education and Police at a minimum. Members of agencies who have responsibility for completing Individual Management Reviews (IMRs) may be members of the SCR sub committee but it should not consist solely of such people.

3.2. The Chair of the SCR sub committee should be an experienced person and could be the Independent Chair of the LSCB, or a member of the LSCB. This is not the same for the Chair of the Serious Case Review Panel. The Chair of the SCR panel should not be a member of the LSCB(s) involved in the SCR, an employee of any of the agencies involved in the SCR or the overview report author.

3.3. The Serious Case Review Panel Chair can however be the LSCB Independent Chair, someone from another LSCB, which is not involved in the SCR, or from an agency, which is not involved in the case.

3.4. If the SCR 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 Chair must be engaged for future meetings and to oversee the process.

3.5. If the criteria are not met and the SCR 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 SCR, 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 SCR. 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 SCR Sub Committee, Panel and the LSCB.

3.6. Where the criteria are met and the Chair of the LSCB agrees a Serious Case Review the NSCB Coordinator will commission an Independent Person to chair this Serious Case Review Panel together with an independent author for the overview report. The Serious Case Review Panel Chair will ensure that the panel operates effectively and independently of the member organisations. 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

3.7. 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 SCR 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.

3.8. The Serious Case Review Panel will meet all relevant timescales in the Working Together Guidance (2010) as set out elsewhere in this Guidance and will ensure that its membership and that of the Serious Case Review Panel, whether permanent or temporary is appropriate to the conduct of the review.

3.9. The Board also delegates to the Serious Case Review Committee responsibility for monitoring the implementation of the Multi Agency Action Plan on behalf of the Board to whom regular progress reports will be presented.

3.10. Responsibility to keep under review the contents of this Guidance is delegated to the NSCB Coordinator and to report to the Board with any proposals for improvement or change.

4 Serious Case Review Procedure

Responsibility Of Independent Chair

4.1. The Independent Chair of the Serious Case Review Panel will: -

4.1.1 Have sufficient skills, experience and knowledge as per agreed Job Description and Person Specification

4.1.2 Take overall responsibility for the conduct of the Serious Case Review

4.1.3 Ensure Members of the Panel 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.
- Planning how often and when the Panel should meet.
- Setting a timescale for single agency password protected first draft and final Management Review reports, to be made available to the Chair.
- Setting a timescale for reports to be circulated to the Panel members, prior to meetings.
- Clarity about what to include in chronologies e.g. every agency recording or selected recording and if the latter, the basis for selection.
- Management and administrative arrangements.

4.1.4 Report regularly to the Board on the activity of the Panel and on the progress of any Action Plans;

4.1.5 Maintain communication with the Chair of the Board and NSCB Coordinator and make recommendations regarding process and timescale in relation to the review.

Responsibility Of Members Of The Serious Case Review Panel

4.2. Individual Panel members are responsible for:

4.2.1. 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.

4.2.2. Ensuring that the IM report has been quality assured and signed off by the IMR Senior Officer for their agency

Responsibility Of Independent Overview Author

4.3. The Independent Author will: -

4.3.1 Have sufficient skills, experience and knowledge as per agreed Job Description and Person Specification

4.3.2 Chair the Serious Case Review Writers' Group meetings if an Independent Chair is not present

4.3.3 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.

4.3.4 Analyse the chronologies and reports to identify good practice, omissions, missed opportunities and key areas of learning.

4.3.5 Request additional information from the IMRAs if required.

4.3.6 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

4.3.7 Produce and present a Power Point presentation that summarises the SCR for LSCB members and inter agency briefings.

4.3.8 Maintain communication regarding process with the Chair of the Serious Case Review Panel and NSCB Coordinator to ensure that timescales, quality standards and criteria as required by Ofsted and the LSCB are met.

Responsibility of Individual Agencies Contributing to the Single Agency Review Process.

4.4. Individual agencies will: -

4.4.1 Appoint a skilled experience person who meets the requirements of the IMR specification to undertake the tasks outlined in the job description and procedural guidance as specified. This includes attending meetings of the Serious Case Review Writing Group.

4.4.2 Panel members must ensure that the IMRAs are provided with the appropriate support and resources to undertake the IMR

4.4.3 Appoint a Senior Manager who will read the final draft of the Single Agency Review and approve it for submission to the Independent Overview Author. The Senior Manager will be responsible for signing off the final version of the Single Agency Review on behalf of the agency.

Responsibility Of NSCB Coordinator

4.5. The NSCB Coordinator will: -

4.5.1 Take overall responsibility for the co-ordination and business planning processes.

4.5.2 Act as an advisor in respect of the Serious Case Review.

4.5.3 Identify the availability of Independent Chairs and Authors.

4.5.4 Commission independent persons as appropriate.

4.5.5 Draft all correspondence and initial documentation in accordance with this guidance.

4.5.6 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

4.5.7 Attend both the Serious Case Review Sub Committee, Panel and Writers Group

4.5.8 Liaise with Government Office, Ofsted, the Coroner and other statutory bodies as appropriate.

4.5.9 Confirm and co-ordinate the personnel from the agencies who will be involved in the process e.g., Panel Members, Individual Management Review Authors.

4.5.10 Act as a point of contact.

4.5.11 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.

Responsibility Of Professionals in the SCR Process

4.6 Any professional who becomes aware of a case, which they believe fits the criteria for a serious case review or management review should discuss their concerns with their manager or senior officer and s/he will discuss them with your NSCB agency representative. If following this discussion it is agreed to make a referral for consideration, contact will be made with the NSCB Coordinator who will explain the next steps. Having made the referral it will be considered by the serious case review sub committee who will make a recommendation to the Chair of the NSCB as to whether the information, having been thoroughly considered, meets the criteria laid down in Working Together to Safeguard Children (DCSF 2010) for a Serious Case Review.

4.7 Anyone who has contributed the review at any stage will receive feedback to enable them to reflect on it in order to learn and implement the lessons learned. Managers may take further actions as required. Feedback to professionals is part of the agency's

responsibilities following a Review, and would not be shared or discussed with the SCR Panel or Writers Group, other than to confirm that it had taken place

4.8 Summary of Professionals Responsibility

- ✓ Maintain up to date case records with chronologies
- ✓ Share concerns and refer as appropriate
- ✓ Support and provide information for reviews
- ✓ Take on board learning from case reviews
- ✓ Implement practice as appropriate.
- ✓ SAFEGUARD AND PROTECT CHILDREN & YOUNG PEOPLE

5 What does a Serious Case Review Involve?

5.1 A Serious Case Review is a process that requires a number of separate written reports and action plans; Overview, Executive Summary and an action plan to be produced as set out below in order to learn and implement lessons.

Does The Case Meet The Serious Case Review Criteria?

5.2 The LSCB Chair should consider whether a case might meet the criteria for a SCR. Where the child has died, the LSCB Chair should also use information available from the professionals involved in reviewing the child's death (see Chapter 7 of Working Together (2009)) to assist in making this decision. In some cases, it may be valuable to conduct a single IMR rather than a full SCR, for example where there are lessons to be learned about the way in which 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 SCR. Methodologies such as those developed by SCIE[4] or root cause analysis used in the health service may be useful here. In such cases, arrangements should be made to share relevant findings with the SCR sub-committee or SCR Panel.

5.3 Where the LSCB Chair considers, in a particular case, that the criteria for a SCR may be met, he or she should request that the SCR sub-committee considers whether a SCR should take place. If the SCR sub-committee recommends that a SCR be undertaken, they should also recommend the scope and terms of reference for the review. These recommendations should be forwarded to the Chair of the LSCB, who has ultimate responsibility for deciding whether to conduct a SCR. 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 relevant Government Office (GO) and the Department for Education. 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) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).

5.4 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the final SCR report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, SCR Panel Chair and the overview report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, the relevant GO and Department for Education).

Determining The Scope And Terms Of Reference Of The Review

5.5 The SCR sub-committee should consider, in the light of current information known in each case, the scope of the SCR 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. The GO Children and Learners Team will be able to assist LSCBs where policy advice on undertaking a SCR is required. Where necessary LSCBs should seek their own legal advice.

5.6 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 SCR 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 SCR, 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 SCR 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 SCR?
- 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 SCR sub-committee or the SCR Panel).
- Might it help the SCR 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 SCR.
- How will the SCR 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 SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

5.6 Some of these issues may need to be revisited by the SCR 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

Timescales For Initiating And Undertaking A Serious Case Review

5.7 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 SCR 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 SCR 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 Chapter 7 of Working Together (2010). Ofsted and other inspectorates should be notified accordingly

5.8 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 SCR is in progress. If it emerges that a SCR 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 GO in their capacity to provide advice, support and challenge.

5.9 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 GO to consider. This update should include recommendations for action where these are not dependent on the SCR 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 GO. LSCBs should be proactive in keeping GO Children and Learners Teams fully appraised of timing expectations, of risks of delay and of interdependencies with other parallel or related processes

5.10 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the SCR 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 SCR 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 IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

5.11 SCRs 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 SCR 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.

5.12 The final SCR 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.

Who Should Be Involved In The Serious Case Review?

5.13 The initial scoping of the SCR should identify those who should contribute, although it may emerge, as further information becomes available, that the involvement of others, such as those providing specialist adult services, would be useful. As noted above information of relevance to the review may become available at a later stage through, for example, criminal proceedings or investigations such as those undertaken by the PPO.

5.14 Each relevant service should undertake an IMR of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a SCR, and even sooner if a case gives rise to concerns within the individual organisation. Relevant independent professionals should contribute reports of their involvement. 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.

5.15 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. 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 IMR 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 IMR. 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.

5.16 The process of conducting an IMR 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 IMR 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.

5.17 The SCR Panel, on behalf of the LSCB, should commission an overview report that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action. It is crucial that the SCR 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 SCR functions.

5.18 The overview report should be commissioned from 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 SCR sub-committee or the SCR 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.

Individual Management Reviews

5.19 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.

5.20 Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having promptly secured their case records, should begin quickly to draw up a chronology of their involvement with the child and family. In some cases the police may require the original records from agencies but a copy will be retained for the purpose of the review.

5.21 The aim of IMRs 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. The IMR reports should be quality assured by the senior officer in the organisation that has commissioned the report. This senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on

5.22 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 SCR Panel to help ensure that relevant youth justice issues are covered. The PPO may be invited to attend SCR Panel meetings for specific, agreed purposes. The SCR terms of reference should set out how the PPO, the SCR Panel and the SCR sub-committee will work together to share relevant information during the process of undertaking the SCR

5.23 The first draft of the IMR should be completed within 10 weeks of the decision to initiate a Serious Case Review.

5.24 Those conducting IMRs will not have been directly concerned with the child or family, or be the immediate line manager of the practitioner(s) involved.

5.25 Each report author should have sufficient skills, experience and knowledge to prepare the IMR (as per agreed Job Description and Person Specification).

5.26 All relevant records will be read and a list of staff to be interviewed will be drawn up by the IMRA Staff will be supported throughout this process. Notes will be taken during the interview of the questions asked and the responses received. A copy will be given to the interviewee who will have the opportunity to verify them. The agency will arrange for an appropriate debriefing to be provided to any staff involved in the IMR its completion. The interviewer may use the Interviewee Guide provided by the NSCB as an aide. Where it is not possible to interview a relevant person, e.g. they have left the organisation, an adequate explanation for the rationale why it has not taken place must be recorded in the IMR.

5.27 If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order for the IMR Author to understand and record the reasons for this.

5.28 The purpose of the IMR 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.

5.29 The authors will meet with the Independent Author as the SCR Writers group, to review the single agency chronologies that the LSCB Unit will have combined into one multi agency chronology, in order to identify the key issues and any early lessons to be learnt.

5.30 On completion of each IMR 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. This senior officer will be responsible for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on. At this stage it will be submitted to the Independent Author via the NSCB Coordinator for consideration at the Writers Group meeting.

5.31 There should be a process of feedback and debriefing for the 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 executive summary is published. It is important that the SCR process supports an open, just and

learning culture and is not perceived as a disciplinary-type hearing, which may intimidate and undermine the confidence of staff.

5.32 The recommendations contained within the IMR will be translated into a Single Agency Action Plan with details of action, expected outcomes and timescales for the actions to be implanted for considerations and approval by the Authorising Manager prior to submission to the Serious Case Review Panel. This should not prevent early lessons from being implemented by the individual services or organisations that have contributed to the review. The Authorising Manager will accept responsibility for implementing the IMR Action Plan, which will be monitored within single agencies and alongside the multi agency action plan by the Serious Case Review Sub Committee on behalf of the Board to show progress.

Overview Report

5.33 5.53 The SCR overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, 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 although, as with IMRs, the precise format will depend on the features of the case. The outline is most applicable to abuse or neglect that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex. .

5.34 The report will be completed within the timescales outlined in the SCR Process Flowchart and Working Together. If additional time is required the Chair of the Serious Case Review Panel will advise the Chair of the LSCB that an extension may be required to complete the task. The Chair of the LSCB will determine whether an extension request will be made to Government Office.

5.35 Recommendations included in the Overview Report should include a reference to the IMR Action Plans but should not simply be a rewriting of these. The Overview Recommendations should stem from 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).

5.36 Once satisfied with the report the Independent Author will present it to the Serious Case Review Panel.

SCR Panel Responsibilities For The Overview Report

5.37 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.

5.38 When undertaking this task the members contributing role should take precedence over their role as a representative of their organisation

5.39 The SCR 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.

5.40 The SCR Panel will also:

- ensure that it actively manages the SCR process, seeking legal advice as necessary, so that the findings from other relevant processes such as care or criminal proceedings, an inquest or inquiry/investigation are incorporated into the SCR report;
- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- ensure that the overview report is of a high standard and is written in accordance with this guidance;
- commission and agree the content of the executive summary for publication, ensuring that it accurately represents the full SCR, includes the action plan in full and is fully anonymised apart from including the names of the SCR Panel Chair and the overview author and the job titles and the employing organisations of all the SCR Panel members;
- translate recommendations into an action plan that should be signed up to by the senior manager in each of the organisations that will be involved in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set out the means by which improvements in practice/systems will be monitored and reviewed;
- clarify to whom in which agencies or organisations the executive summary and the action plan of the SCR should be made available to support implementation of the recommendations and the learning of the lessons; and
- make arrangements to provide feedback and debriefing to the child (if surviving) and family members/carers of the subject child as appropriate, following completion of the executive summary.

5.41 Once agreed by the Board the Overview Report, Executive Report, Combined Chronology and the Multi Agency Action Plan together with all IMRs including the single agency chronologies and action plans will be submitted to OFSTED, the DCSF, GONE and the Strategic Health Authority.

Executive Summary

5.42 The Independent Author will draft an Executive Summary in the agreed format, for presentation to the Panel and LSCB. The SCR overview report and the IMRs should be used by the Independent Author to produce the executive summary, which accurately reflects the full overview report.

5.43 The Executive Summary will become a public document following receipt of the final evaluation from Ofsted. It will include, as a minimum: -

- Information about the review process
- Key issues arising from the case and
- The recommendations and the inter agency action plan (including any actions that have been completed)

5.44 The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998.

5.45 The executive summary should, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members.

5.46 The Executive Summary will be published as previously stated following a satisfactory evaluation from Ofsted and at the conclusion of any related court cases and statutory process such as inquests or PPO investigation (criminal or coroners proceedings).

5.47 Any delay in publishing the 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.

5.48 The Serious Case Review Panel will make recommendations to the Board as to how the Executive Summary shall be made public in accordance with local and national agreements e.g. in some cases a press conference may be appropriate whilst in others a report to a public committee may suffice. See also section 8 “Disclosure of Information”.

Multi Agency Action Plan

5.49 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 SCR Panel members will then complete the multi agency action plan to show how the recommendations will be implemented as detailed below.

5.50 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.

5.51 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.

5.52 It will be regularly monitored by the Serious Case Review Committee on behalf of the Board to show progress. The Action Plan will be updated to show progress and will be submitted to the Board on a regular basis until all the objectives have been achieved. The Board will then sign off the completed Multi Agency Action Plan and GONE will be informed.

5.53 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.

LSCB Action On Receiving The Serious Case Review Report

5.54 The SCR sub-committee, on behalf of the LSCB, should quality assure the final SCR – that is, the IMR reports, the overview report, the executive summary and the action plan before it is presented to the LSCB for approval.

5.55 The LSCB should approve the final SCR and:

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, the relevant GO Children and Learners Team, the SHA and DCSF. *All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) should be anonymised in all the SCR documentation submitted to Ofsted and the relevant GO.* If the child died in a custodial setting, copies of the anonymised SCR should be made

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

- make arrangements to provide feedback and debriefing to staff and the media as appropriate;
- disseminate the executive summary and key findings to relevant interested parties;
- publish only the SCR executive summary once the SCR has been completed;
- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan;
- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback; and
- formally conclude the review process when the action plan has been implemented and inform the relevant GO of this decision.

Parallel Processes

5.56 Criminal investigations, Serious Incident investigations, Coroners and legal proceedings or similar may run concurrently with the review. The Serious Case Review Panel will identify such processes and will ensure that the timing of the publication of the Executive Summary is sensitive to the timing of their outcomes, court process and any external or media interest.

5.57 Disciplinary action may be considered from the outset or at any point in the review process by a single agency. The inquiries undertaken as part of the Single Agency Review process may help to inform any decision about disciplinary action. The Serious Case Review Panel will be informed of any disciplinary proceedings but it will not be involved or kept informed of their content or outcomes.

5.58 Child protection inquiries or practice changes may be identified as being necessary at any point in the review process and may be made immediately either because of their urgency or because they are straightforward to implement without waiting for the finalisation of the Action Plan.

Feedback

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

5.60 As referred to above the IMR Author or an agreed alternative Officer will provide feedback 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.

5.61 At the end of all the formal processes, when the Serious Case Review has ended, feedback will be given to a multi agency group of staff in order to ensure the lessons learned are shared; staff have the opportunity to discuss the findings to support their understanding and to improve practice.

5.62 The Executive Summary will be a public document, (Section 8 Disclosure of Information) and will be available to all staff. The Overview Report will contain some confidential information and will therefore only have limited circulation to avoid a potential breach of the data protection legislations or the European Convention of Human Rights.

6 Relations with the Police and Coroner and Criminal Proceedings

6.1. 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.

6.2. 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

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

6.4. If publication of the Executive Summary is to be delayed this will not prevent early lessons from being implemented by the individual services or organisations, which have contributed to the review.

7 Relations with the Media

7.1. The Local Safeguarding Children Board (the Board) is a partnership in which the Council and several key partners work together with the common aim of safeguarding and promoting the welfare of children.

7.2. As a multi-agency partnership, the Board represents a particular challenge in terms of media relations. The media traditionally likes to be able to access a single point of contact for dealing with reactive enquiries. This will be via the NSCB Chair or his / her nominated representative

7.3. 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.

7.4. 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.

7.5. 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

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

Public And Media Relations Guiding Principles

7.7 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 (2009)": -

- 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. sub judice rules, data protection legislation, any relevant exemptions under the Freedom of Information Act 2000

7.8 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 SCR 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 were an approach from the press about a case subject to review is received, LSCB's will confirm that the SCR is taking place and will advise of planned publication (as outlined above) and suggest press / media monitoring of the website.
- The timing of SCR publication should be delayed until the LSCB receives confirmation of the results of the evaluation by Ofsted.
- SCR's Executive Summaries are published on LSCB websites for 6 months prior to being removed.
- LSCBs support the co-ordination of the timing of SCR publications across the region, by providing regular updates on timing and delays in order to support other LSCB's in the process of effectively managing publication.

Key Contacts

7.9 Key contacts have been identified within all partner agencies; they will act as the point of contact for all public relations and media activity in relation to Serious Case Reviews. This is necessary to share information and agree a planned or rapid response to matters relating to Serious Case Reviews.

7.10 Current list of key partner contacts can be found in appendices. It is the responsibility of each Board partner to keep the LSCB aware of any changes. The NSCB Coordinator will maintain this list, circulate it and regularly check it for accuracy. This will happen a minimum of every 12 months.

Media Enquiries

7.11 The NSCB Coordinator in liaison with the local authority press office 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.

7.12 The local authority press office in liaison with the NSCB Coordinator 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 at 7.7 and 7.8.

7.13 Any media enquiries relating to services or individuals associated with the Serious Case Review from partner agencies should still be the subject of discussion with the LSCB Chair to ensure that consistent and clear messages are provided in a co-ordinated response.

7.14 This will be undertaken in consultation with: -

- The Chair of the Board, or through that person's nominated contact where the Chair is not an officer of the local authority and
- The local authority Director of Children's Services where s/he is not also the Chair of the Board

7.15 All partner agencies involved in a particular case will have prior warning/sight of any media press release or statement.

7.16 The NSCB Coordinator will be kept informed of all actions undertaken and will be sent a copy of all communication prior to release to the media for inclusion in the audit trail.

7.17 Where it is found that there is a likelihood of media attention the LSCB Chair / Business Manager in liaison with the local authority press office will initiate a dialogue with key media contacts to determine which matters, if any, will be handled collectively by the Board, which will be handled by individual Board partners and will consider and advise upon the release of information into the public domain in line with guiding principles.

7.18 The Key partners will if it is decided necessary:

- Draft a holding statement for the Board (and agree it with the Chair of the Board), and co-ordinate draft statements prepared by each agency; which will be signed off by all partners in advance of its release.
- Put in place agreed media monitoring arrangements, and co-ordinate media activity by the relevant agencies;
- Draft a communication strategy for the case;
- Convene further meetings of the Case Media Leads Group as necessary (and liaise directly outside those meetings as necessary) and
- Brief the Chair of the Board, the Chair of the Serious Case Review Panel and the Director of Children's Services on an ongoing basis.
- Agree and thereafter monitor and amend the overall communication strategy for the case;

- Identify any tensions between the agencies (which might, for example arise because of different reporting systems), and where these are not readily resolved, escalate as appropriate and manage around them;
- Consider the timing and content of any joint press statements; giving advanced warning whenever possible
- Agree approval processes for media contact and messages
- Consider whether and if so when to hold a press conference;
- Consider the need for any related communication activity in support of the release of the Serious Case Review Executive Summary, and any associated Action Plans and
- Ultimately, hold a suitable debrief, identifying lessons learnt, and report back to the Local Safeguarding Children's Board

7.19 Each agencies Media Lead will: -

- Liaise internally within the partner organisation to ensure they are suitably briefed in relation to their organisations involvement with the case (including for example being briefed on any Single Agency Reports available);
- Draft a holding statement for that agency and share it with the lead agency key contact and LSCB Chair;
- Respond to any media enquiries relevant to their organisation (or refer on others as appropriate) and promptly advise the other agency leads;
- Collate their own agency's needs and information for integration into the collective communication strategy including: -
    i. Identification of key audiences;
    ii. Identification of key dates;
    iii. Deadlines and processes;
    iv. Identification of key messages and Q&As;
    v. Identification of spokespeople & media train as necessary
- Liaise as appropriate with key liaison contacts for family members if this has not already been actioned by the LSCB Chair, to ensure that family members do not learn distressing news for the first time through the media and
- Liaise as appropriate with their contacts in regulatory bodies, Government departments etc.

Reporting and Monitoring Arrangements

7.20 Regular updates are provided to the Board as part of the Serious Case Review process and will include reference as appropriate to the media / communication strategy for the case.

Requests Made Under The Freedom Of Information Act 2000

7.21 Any requests for information received from the press or media will be handled in accordance with section 9 Freedom of Information.

8 Disclosure of Information

8.1. The overall aim of the Local Safeguarding Children Board (the Board) is for maximum transparency in relation to the outcome of Serious Case Reviews. This however needs to be balanced against the Board's overriding duty to protect the confidentiality of individuals in accordance with both common law e.g. public interest immunity, statute e.g. data protection legislation and the European Convention of Human Rights as well as the need to retain the integrity of the review process itself.

8.2. LSCBs should consider carefully who might have an interest in reviews for example elected and pointed members of authorities, staff members of the child's family, the public, the media – and what information should be available to each of these interests.

8.3. When determining what information to publish and to whom (as set out below) the Board must balance the difficult interests including: -

- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
- The accountability of public services and the importance of maintaining public confidence in the process of internal review
- The need to secure full and open participation from the different agencies and professionals involved
- Its responsibility to provide relevant information to those with a legitimate interest and
- Constraints on public information sharing when criminal or coronial proceedings are ongoing, in the providing access to information may not be within the control of the LSCB

Publishing the Executive Summary

8.4. The LSCB should decide on a case-by-case basis when to publish the executive summary. This decision should take account of the timing of the conclusion of relevant court cases, statutory processes such as inquests or a PPO investigation and local agreements.

8.5. The LSCB, on advice from the SCR Panel and where relevant the CPS, the police or its lawyers, should decide whether new information may become available from these other processes which is likely to have an impact on the lessons to be learnt from the SCR. If the findings are not likely to have an impact, then there should be no delay in publishing the SCR executive summary. On the other hand, in some cases it may be best to undertake the IMRs and finalise them and the SCR overview report in the light of this new information or findings before publication of the SCR executive summary.

8.6. In addition, LSCBs may decide to take account of any points raised in Ofsted's evaluation of the SCR before publishing the SCR executive summary but, depending on local circumstances, it may be necessary for the LSCB to publish it prior to the completion of an evaluation by Ofsted.

8.7. All SCRs are evaluated by Ofsted and, in line with the arrangements agreed between inspectorates; the evaluation may involve other inspectorates notably the CQC and HMIC. The evaluation will be shared with the LCSB and, together with the published executive summary, with partner inspectorates and government. Where a SCR has been evaluated as 'inadequate' the LSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The LSCB is then required to submit to Ofsted, within three months, an action plan that addresses the inadequacies of the SCR.

8.8. The Executive Summary in line with the regional LSCBs agreement: -

- Will be published on the Board's website for six months
- Its contents will be suitably anonymised in order to protect the confidentiality of children, relevant family members and others to comply with the Data Protection Act 1989 (apart from the names of the SCR Panel Chair, Members and the Overview Author);
- Its publication will be timed to coincide with the outcome of any related court proceedings (including sentencing but not including any appeal that may be lodged).

8.9. The Executive Summary will include as a minimum: -

- Information about the review process
- Key issues arising from the case and

- The recommendations and
- The full action plan including any recommendations including any actions that have been completed

Overview Report

8.10. By its very nature the Overview Report will contain some confidential details about family members and others who are named and information by which individuals, although not named, can be identified.

8.11. Neither the SCR Overview Report nor the IMRs should be made publicly available.

8.12. Provided the recommendations in the Overview Report do not contain confidential details about individuals or information by which individuals can be identified, they will be published as part of the Executive Summary.

Single Agency Reports

8.13. By their very nature these reports will contain some confidential details about family members and others who are named in the report and information by which individuals, although not named, can be identified. Disclosure by the Board or the organisation concerned may be in breach of the data protection legislation or the European Convention of Human Rights.

8.14. As with the Overview Report IMRs should not be made publicly available.

8.15. If an organisation that has contributed to a Serious Case Review proposes to publish an Action Plan in response to the recommendations in its IMR (Single Agency Report), it will first notify the Chair of the Board that the Action Plan is to be published and will discuss with the Chair their reasons and timing of the proposed publication. The Chair will disseminate that information to the other members of the Board.

8.16. A report will be submitted to the next meeting of the Board by the representative of the organisation setting out details of what has been published, when it was published and to whom.

Multi Agency Action Plan

8.17. The Multi Agency Action Plan will be published as part of the Executive Summary

Dissemination of Information

8.18. It is acknowledged by the Board that various groups of people will have a legitimate interest in Serious Case Reviews and their outcome. LSCBs should consider carefully who might have an interest in SCRs – for example elected and appointed members of authorities, staff, the child who was seriously harmed and the subject of the SCR, members of the child's family, the public, the media – and what information The publication of an Executive Summary of an Overview Report will address as far as possible public interest issues of accountability and transparency without compromising the confidentiality of the review itself.

8.19. Prior to the dissemination of the information the LSCB should ensure that the relevant Government Office Children and Learners Team, Ofsted and all other relevant bodies including SHA, the CQC, Her HMIC and HMIP are appropriately briefed in advance about the publication of the executive summary. 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.

8.20. 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 of the Executive Summary, and the date of its publication.** The final version of the executive summary should be suitably anonymised and sent by email to SCR.SIN@ofsted.gov.uk. This is to be effective from 1 March 2010.

8.21. Ofsted advise that this in response to "The Protection of Children in England: A Progress Report"; Lord Laming recommendations 47 & 48. They have agreed to:

- 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 executive summary, 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 authorities and primary care trusts.

9 Freedom of Information Requests

9.1. The Local Safeguarding Children Board (the Board) is a partnership in which the Local Authority (the Council) and several key public authority partners work together with the common aim of safeguarding and promoting the welfare of children.

9.2. 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

9.3. This general right of access to information held by public authorities is subject to a number of exemptions. Personal information does not have to be disclosed if its disclosure would breach the data protection principles. Information provided in confidence may be withheld if its release would constitute an actionable breach. There is also an exemption relating to information the disclosure of which would be prejudicial to the effective conduct of public affairs, although this is subject to the public interest test (see below).

9.4. 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 Single Agency Report or Reports, the Overview Report, the Executive Summary or the Multi Agency Action Plan.

9.5. Requests may be received from: -

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

9.6. 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.

9.7. Although some exemptions are absolute, in most cases where a public authority seeks to rely on one or more of the exemptions in order to withhold information, it must also apply the public interest test i.e. it must decide whether it would serve the interests of the public better to withhold or disclose the information. The courts have often distinguished between matters, which are in the public interest, and matters, which merely interest the public.

9.8. Where a public authority seeks to rely on one or more of the exemptions in order to withhold information it must issue a Refusal Notice within the same timeframe (20 working days) specifying the exemption and why it applies. This time limit may be extended if the public authority needs more time to consider the public interest test.

9.9. The Board will publish the recommendations of the Serious Case Review within the Executive Summary. Requests for the disclosure of any other documents or information will be dealt with as set out below.

Responding To Freedom of Information Requests

9.10. Every request for information, which is not, the subject of section 9 of this Protocol, must be considered on its merits. There can be no blanket ban on the disclosure of certain types of documents e.g. Single Agency Reports or Overview Reports. The Freedom of Information Act 2000 does not allow this. Nothing in this Protocol can override the legislation.

9.11. 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.

9.12. 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.

9.13. 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.

Information Commissioner

9.14. If a request for information under the Freedom of Information Act 2000 (the Act) is refused then the complainant has a right of appeal to the Information Commissioner. The Commissioner's role is to decide whether a request for information made to a public authority has been dealt with in accordance with the requirements of the Act.

10 Learning Lessons

10.1. As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, they will be of little value unless the lessons are indeed learned and acted upon as quickly as possible. This means that at least as much effort should be spent on implementing the recommendations as on conducting the review. Reviews will be conducted in such a way that the process is a learning exercise rather than a trial or ordeal.

10.2. Recommendations in the Single Agency Review Reports, the Overview Report and the Multi Agency Action Plan will focus on a small number of key areas with specific and achievable proposals for change and intended outcomes.

10.3. On completion of the Serious Case Review, the Board, in order to assist in gaining maxim benefit will: -

- Consider what type and level of information needs to be disseminated, how and to whom, in the light of a SCR. Be prepared to communicate both examples of good practice and areas where change is required, as well as to integrate this information with that from other serious case or local reviews;
- Incorporate the learning into local training programmes
- Put in place a means of monitoring and auditing the actions of all agencies against recommendations and intended outcomes;

10.4 The LSCB will utilise feedback on SCR reports and the implementation of the findings from Ofsted and regional Government Offices respectively. The role of GOs in relation to safeguarding includes giving support and challenge to LSCBs and to Children's Trusts in relation to SCR and Child Death Overview Panel activity and implementation; and.

10.5 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 SCRs 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.

10.6 All SCRs 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 executive summary, with partner inspectorates and monitoring organisations to ensure that the lessons learned are implemented.

10.7 In addition if a SCR 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 3 months of receipt of the letter, an action plan that addresses the inadequacies of the review.

10.8 Day to day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning:

- Establish a culture of audit and review. Make sure that tragedies are not the only reason inter agency work is reviewed.
- Have in place clear systematic case recording and record keeping systems
- Develop good communication and mutual understanding between different disciplines and different LSCB members
- Communicate with the local community and media to raise awareness of the positive and helping work of statutory services with children, so that attention is not focused disproportionately on tragedies
- Make sure staff and their representatives understand what can be expected in the event of a child death / SCR.

10.9 The SCR sub-committee should provide information to relevant LSCB(s) on the actions taken in response to SCRs, which have been completed by the LSCB(s) in the previous year. LSCBs will draw on this information when publishing their annual reports. Appropriate care should be taken to ensure confidentiality of personal information and sensitivity to the families whose child is the subject of a SCR. The LSCB annual report should support the driving forward of measures to prevent child deaths and serious harm where abuse and neglect have been factors and to safeguard and promote the welfare of children.

Learning Lessons Nationally

10.10 Taken together, child death and SCRs are an important source of information to inform national policy and practice. The DCSF is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF commissions regular reports, drawing out key findings of SCRs 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.

11 Document Management and Security

11.1. 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.

11.2. 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.

11.3. One master copy of each agency's Single Agency Report (IMR) including the Action Plan will be retained with the Overview Report, Executive Summary and Multi Agency Action Plan.

11.4. 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 NSCB Coordinator and subject to restricted access to authorised persons only. These master copies will be retained by the Administrator in secure conditions throughout the period of the review process.

11.5. Access requests from authorised persons, which are agreed, will be recorded.

11.6. Hard copies of the Overview Report will be limited in number and stored securely. Each copy will be numbered, and a signing-out procedure used when a copy is issued. When hard copies are provided they will be in bound form.

11.7. Authorised persons wishing to access hard copies of the Overview Report will sign for the copy, leaving contact details to ensure swift retrieval if required. During the period that the hard copy is signed out, the person receiving it is responsible at all times for its security and confidentiality.

11.8. External requests for electronic or hard copies of the Executive Summary will be responded to by the NSCB Coordinator in consultation with the LSCB Chair. All such requests and the reasons given for making them will be recorded.

11.9. 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 local authority and all other hard copies destroyed. These documents will be retained for the period set down for the retention of children's records.