BARNSLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW TOOLKIT

PRACTICE GUIDANCE AND TEMPLATES

SEPTEMBER 2011

CONTENTS

Section		Page Number
1	**INTRODUCTION**	**4**
2	**GENERAL PRINCIPLES**	**5**
2.1	Case Review Methodologies	**5**
3	**PURPOSE OF A SERIOUS CASE REVIEW**	**6**
4	**SETTING UP THE SERIOUS CASE REVIEW**	**7**
4.1	The Criteria for a Serious Case Review	**7**
4.2	Deciding whether to hold a Serious Case Review	**8**
4.3	The preliminary meeting of the Serious Case Review Panel	**8**
4.4	Determining the Scope of a Serious Case Review	**10**
4.5	Children known to more than one SCB	**11**
4.6	Appointing an Independent Chair	**12**
4.7	Serious Case Review Panel Membership	**13**
4.8	Role and Functions of the SCR Panel	**13**
4.9	Selecting the SCR Overview Report author.	**14**
5	**TERMS OF REFERENCE**	**15**
6	**INDIVIDUAL MANAGEMENT REVIEWS**	**15**
6.1	The aim of the IMR	**15**
6.2	Who should complete an IMR?	**16**
6.3	Accessing Agency Records	**17**
6.4	Producing the Chronology	**18**
6.5	Producing the IMR	**18**
6.6	Interviewing staff	**20**
6.7	Agreeing Timescales	**22**
7	**PARALLEL PROCESSES**	**22**
7.1	Working with other Authorities – SCRs across multiple SCB areas	**22**
7.2	Health agencies Serious Untoward Incident Reviews	**23**
7.3	Youth Justice Reviews	**23**
7.4	Coroners involvement/Criminal Court Proceedings/ Domestic Violence Homicide Reviews/Vulnerable Adults Reviews	**23**
7.5	Media Strategy	**24**
7.6	Support for Staff/Disciplinary Processes	**24**

8	**THE SERIOUS CASE REVIEW OVERVIEW REPORT**	**25**
8.1	Introduction	**26**
8.2	The Facts	**26**
8.3	Including the Views of Parents and Relevant Family Members	**26**
8.4	Analysis	**27**
8.5	Conclusions and Recommendations	**29**
9	**LEARNING FROM THE REVIEW**	**29**
9.1	Action Plans	**30**
9.2	Disseminating Lessons Learned	**30**
9.3	Embedding the Learning	**31**
9.4	Learning Lessons Regionally and Nationally	**31**
10	**THE EXECUTIVE SUMMARY**	**31**
11	**ACTION FOLLOWING COMPLETION OF THE REVIEW**	**32**
12	**PUBLICATION OF OVERVIEW REPORT & EXECUTIVE SUMMARY**	**32**
13	**OFSTED EVALUATION OF SERIOUS CASE REVIEWS**	**33**
	Acknowledgements	**34**
	APPENDICES	
A	Checklist for when to hold a Review	**35**
B	Example timeline for a Serious Case Review	**37**
C	Determining the Scope and Terms of Reference	**38**
D	Checklist for the Scoping and Terms of Reference	**40**
E	Example Format for the Chronology	**43**
F	Action Plan Template and Guidance Notes	**44**
G	SMART Recommendations	**45**
H	Template and Guidance for IMRs	**46**
I	Example Quality Checklist for Serious Case Reviews	**54**

1. INTRODUCTION

Barnsley Safeguarding Children Board (BSCB) recognises the importance of Serious Case Reviews (SCRs) in examining the effectiveness of multi agency working and informing and promoting good child protection practice.

These procedures have been developed from the statutory requirements set out in "Working Together to Safeguard Children 2010" and other relevant documents. It is accepted that the process continues to evolve and it the guidance will be revised if necessitated by any significant changes. The guidance has also been informed by a recent Ofsted evaluation of a local SCR.

All agencies and organisations represented on the BSCB are committed to ensuring that any necessary SCR will be undertaken thoroughly, promptly and sensitively. In addition the BSCB is determined that any lessons learned will be acted upon swiftly to ensure that any shortcomings in practice, policies or procedures are addressed.

This guidance should assist participants and those affected by the process to understand their role and responsibilities; be able to contribute positively and act on the Review findings. Its focus is to support an effective SCR through a consistent approach and by providing additional guidance on how to undertake the process and sharing lessons and good practice tools and exemplars. It should be read alongside the statutory guidance in Chapter 8 of Working Together 2010 and the South Yorkshire Child Protection Procedures 2011.

It also provides information about two approaches to case reviews as a useful contextual framework to the carrying out of SCRs;

- The systems approach as outlined in Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews[1] and
- The root cause analysis approach used by the health service[2].

In her final report on a Review of Child Protection, published in May 2011, Professor Eileen Munro recommends a change of approach to SCRs, with learning from the approach taken in sectors such as aviation and healthcare. There should be a stronger focus on understanding the underlying issues that made professionals behave the way they did and what prevented them from being able to properly help and protect children. The current system is too focused on what happened, not why. Munro also recommended that, in the meantime, the Ofsted evaluation of SCRs should cease. The Government's response to the Munro recommendations, published in July 2011, accepted all 15 of the review's main recommendations grouped under 4 major reform themes. However, in relation to SCRs the Government intends to consider this recommendation further during late 2011, and work with the sector to consider evidence and opportunities for using systems review methodologies for SCRs. Consideration will also be given to ending the evaluation of SCRs in their current form.

[1] Learning Together to Safeguard Children: developing a multi-agency a systems approach for case reviews. Sheila Fish, Eileen Munro, Sue Bairstow. Social Care Institute for Excellence. 2008

[2] A Guide to Root Cause Analysis produced by the National Patient Safety Agency - http://www.msnpsa.nhs.uk/rcatoolkit/course/iindex.htm

This guidance currently includes information about the requirements of OFSTED evaluations to ensure that any reviews meet the OFSTED standards and provide the maximum opportunity to ensure that lessons are identified and learned effectively. This section will be revised in due course in the light of the Government's response to the Munro Report should alternative inspection arrangements be instigated

2. GENERAL PRINCIPLES

The following should be regarded as guiding principles in undertaking a SCR:

- **Timely** - Agencies must respond to a decision to undertake a SCR with appropriate urgency and should aim to conclude the review within statutory timescales, i.e. six months from the date of the decision to proceed. The SCB will only agree to an extension for a valid purpose e.g. to interview family members and secure their input. In such circumstances the Board Chair will inform Ofsted of the new completion date and the reason for the extension. .
- **Impartiality** -The SCB is independent of any of its partner agencies. It is crucial that the Review is conducted fairly and impartially. Anyone who has had direct involvement with the child, young person or family should not be responsible for drafting the reports
- **Thoroughness** – It is essential that the case is considered fully and all staff with relevant information have the opportunity to contribute
- **Openness** -The SCB should be open with the family, and others affected by the Review regarding the process and outcomes. The Overview Report will be made available as a public document at the conclusion of the Review and appropriate feedback given to those involved.
- **Confidentiality** – All information gathered throughout the Review process must be treated as highly confidential and only shared or disclosed when appropriate.
- **Cooperation** – The SCB provides a framework to ensure close collaboration between all organisations and agencies involved in Reviews. The cooperation of all member organisations and agencies is essential in this process.
- **Resolution** - At the conclusion of the Review an Action Plan must be produced incorporating the actions that each individual Agency has identified as necessary to ensure that lessons are learnt.

2.1 Case review methodologies

There are a number of case review methodologies which can be used as the basis for undertaking a SCR. Where the criteria for a SCR are met the process set out in Chapter 8 of Working Together 2010 must be followed. However, where the criteria are not met there may still be some learning to be derived from the case. SCBs may wish to undertake a review, e.g. for “near misses” or to “learn from good practice”

The systems approach is based on the presumption that ‘human error is the starting point’. The factors that influence how a member of staff behaves include:

- the tasks they perform;
- the available tools designed to support them;
- the environment in which they operate
- the organisational culture

The systems approach looks for causal explanations in all parts of the system. It examines the interaction between the individual within the wider organisational context to understand why events developed in the way they did. The aim is to make it "harder for people to do something wrong and easier for them to do it right".

The approach identifies the purpose of SCRs as being to get behind what happened in order to understand why it happened, so that the organisations involved can identify and address underlying issues identified. To do this effectively it is important to understand what practitioners thought at the time, what was influencing their assessment of the situation, and what other factors applied, e.g. local priorities, gaps in resources, organisational change etc.

Similarly, the root cause analysis approach attempts to provide "a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it". It recognises that human error is one of a number of contributory factors, others being organisational, strategic and environmental factors.

3. PURPOSE OF A SERIOUS CASE REVIEW

Chapter 8 of "Working Together" defines the purpose of a SCR is to:

- **Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.**
- **Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result, and**
- **Improve intra and inter-agency working and better safeguard and promote the welfare of children.**

SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These matters are for Coroners and criminal courts, respectively, to determine.

The SCR should be conducted so that the process is a learning exercise to understand how agencies work together to safeguard children. The objectives must be for all involved agencies to define:

- What happened
- What were the key decisions in the case
- What were the organisational and individual factors that contributed to the case developing in the way that it did.
- What lessons can be drawn for how agencies work together to safeguard children
- How can these lessons be learnt by all agencies to inform future practice

The focus on multi agency working is important to establish the different involvements of each agency in the case and the family's experience of different services. The aim is to understand why patterns may repeat themselves in different cases/situations and why some professionals might have had difficulties in meeting their statutory safeguarding responsibilities.

A common problem in SCRs is that more time and effort is dedicated to the chronology and the history of the case at the expense of defining clear recommendations to ensure that lessons can be learned and developing a **SMART** Action Plan to facilitate effective actions. (See Appendix G). This latter part of the process is most crucial in ensuring that lessons learnt will result in action and sustained changes.

4. SETTING UP THE SERIOUS CASE REVIEW

4.1 The Criteria for a Serious Case Review

The criteria are set out in Chapter 8 of Working Together – see Appendix A

"When a child dies (including death by suspected 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 of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs 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 SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentence, in a Young Offenders Institution (YOI) a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.*

All child deaths are reviewed in accordance with the child death processes set out in Chapter 7 of Working Together 2010. A SCR may be triggered at any point in the child death review process if a Rapid Response Team or Child Death Overview Panel (CDOP) considers that a case may meet the criteria for a SCR. In the case of a Looked after Child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCBs with an interest or whose local agencies may have had involvement. This CDOP may refer a case to its LSCB Chair if it considers that the criteria for a SCR may be met and a SCR has not been initiated. Flow chart 6 in Chapter 7 of Working Together depicts the interface between the child death review and the SCR processes.

In addition SCBs should **consider** whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

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

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This

includes inter-agency and / or inter-disciplinary working.

The Local Authority must also take steps to ensure that all other children/young people who may be at risk of harm are safeguarded appropriately

4.2 Deciding whether to hold a Serious Case Review
All SCB partner organisations and agencies are responsible for identifying cases which give rise to concern and may meet these criteria. They must also ensure that such incidents are brought to the attention of the SCB without delay.

Each agency should have appropriate arrangements to ensure that serious safeguarding incidents are identified and appropriate notification arrangements are followed e.g. to Ofsted or the Strategic Health Authority. The request to convene a SCR Panel meeting can be made by any partner agency of the SCB to the nominated senior manager in the local authority. The request should demonstrate how the case may meet the criteria for a SCR. The nominated manager will inform the SCB Independent Chair of the request.

Once it is apparent that a SCR may be needed, a preliminary meeting of the SCR panel will be convened. The nominated senior manger will inform all SCB members as follows:

- Details of the case and known family members
- A request that all agency records involving the family should be secured as a matter of priority in accordance with the agency's agreed processes
- An indication that information will need to be gathered for sharing at the preliminary Panel meeting.
- Details of the arrangements for the preliminary Panel meeting if known at that stage.

4.3 The Preliminary meeting of the Serious Case Review Panel.
The remit of the preliminary SCR panel meeting is to share information about agency involvement in the case and determine whether to recommend to the SCB Chair that the criteria for holding a SCR have been met. The Panel may also address whether other options should be considered and recommended.

The Panel will comprise representatives from Specialist Services, Targeted Services, Universal Services, and a Legal Advisor as a minimum, as well as any other partner agency who has provided services to the child / family. Written and verbal information will be received at the Panel meeting. It is good practice for agencies to bring chronologies of their involvement with the family.

The discussion and decisions of the Panel meeting will be minuted. Decision making should be evidence based and explicit. Any disputes should be referred to the SCB Chair who has ultimate responsibility for the decision.

If the Panel feels that important information is missing at this initial meeting it may defer making a recommendation and adjourn to a later date when further information can be available and all the facts established. Such delay is undesirable due to the potential impact on the statutory timetable for completing any SCR (six months from the date of the decision to proceed). All agencies should therefore ensure that they

provide full and comprehensive information about their involvement with and knowledge of the family to the initial Panel meeting.

The Panel should consider each of the following questions which can help in deciding whether a case should be the subject of a SCR. The answer “yes” to any one or more of these questions is likely to indicate that a SCR could yield useful lessons:

- Was there clear evidence of a child having suffered or been likely to suffer significant harm that was;
  - Not recognised by organisations or professionals in contact with the child or perpetrator or;
  - Not shared with others or;
  - Not acted upon appropriately.
- Was the child abused or neglected in an institutional setting (e.g. School, nursery, children’s or family centre, YOI, SCT, immigration removal centre, mother and baby unit in a prison, children’s home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child’s welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the SCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes or that it is in the public interest to undertake a SCR?

Following consideration of all the circumstances and answer to these questions the Panel must determine its recommendation to the SCB Chair as to whether the criteria have been met for conduction a SCR.

Where the Panel determines that the criteria for holding a Serious Case Review **have not been met** there are three basic options for the SCB Chair to consider:

- No further action necessary in accordance with the Panel’s recommendation.

- The commissioning of a single or inter agency review if it appears that there are lessons to be learned for agencies involved.
- A request for an individual agency to undertake an IMR and report back to the SCB where there are concerns about practice at a single agency level.

If it is decided not to recommend initiating a SCR, the full rationale and basis of this decision should be provided to the SCB Chair with reference to the minutes of the Panel meeting.

Where the Panel determines that the criteria **have been met**, it will communicate this to the SCB Chair with a recommendation that a SCR should be initiated.

Responsibility for deciding whether or not to commission a SCR rests with the SCB Chair. The Chair may also decide upon other options irrespective of the Panel's recommendation, as shown above. E.g. If it appears that there are lessons to be learned the Chair may decide that a single or multi-agency review should be undertaken outside of the SCR process or for concerns at a single agency level the SCB may ask the agency to undertake an IMR and report back to the SCB. In very rare cases an individual IMR may unearth additional information which indicates that the criteria for holding a SCR have, in fact, been met. In such circumstances the SCB Chair should be notified to enable them to review their original decision and decide whether a SCR should be commissioned in the light of the new information. .

Next steps
The nominated senior manager will notify the SCB Chair of the Panel's recommendations. If the SCB Chair agrees with the recommendation that the criteria for a SCR **have been met**, they must inform the Director of Children and Young People's Services immediately of the decision to proceed with a SCR.

The Chair/nominated senior manager will also inform the SCB that a SCR is to be held.

Relevant agencies should commission their own Independent Management Reviews (IMRs)

The nominated senior manager should notify the Department for Education and Ofsted about the decision to undertake a SCR. The Primary Care Trust should also inform the SHA of every case that becomes the subject of a SCR.

4.4 Determining the Scope of a Serious Case Review
If the preliminary SCR Panel agrees to recommend to the SCB Chair that the criteria for undertaking a SCR have been met it is also responsible for determining the scope of the SCR and clear terms of reference at the outset. Relevant issues to be considered include:

- What appear to be the most important issues to address in trying to learn from this specific case?
- How can the relevant information best be obtained and analysed?
- Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of professionals or

agencies who will be required to participate in the review?

- The SCB could bring in an outside expert at any stage, to highlight any crucial aspects of the case.
- What time period should the Review cover i.e. how far back should enquiries commence and what is the cut-off point? What family history / background information will help better to understand the recent past and present?
- Which family members and significant others should be included.
- Which organisations, agencies and professionals should contribute to the review (where appropriate, for example, the proprietor of an independent school or playgroup leader)? They maybe asked to submit reports or otherwise contribute.
- How should family members contribute to the review, and who should be responsible for facilitating their involvement?
- Will the case give rise to other parallel investigations of practice (independent health investigations or multi-disciplinary suicide review, a homicide review where a parent has been murdered, a Youth Justice Board Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child/young person has died in a custodial setting). If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions that need to be asked?
- Is there a need to involve organisations, agencies or professionals in other SCB areas and what should be the respective roles and responsibilities for the various SCBs?
- How should the review process take account of a Coroners inquiry, and if relevant any criminal investigations or proceedings relating to the case? Who should liase with the Coroner and /or the Crown Prosecution Service and how is this to be achieved.
- How should the SCR process fit in with the process for other types of review for homicide, mental health or prisons?
- Who will make the link with relevant agencies outside the main statutory remit e.g. the voluntary and community sector?
- When should the Review process start, and by what date should it be completed?
- How should any public, family and media interest be managed before, during and after the review?

Some of these issues may need to be revisited as the Review progresses and new information emerges

4.5 Children known to more than one Safeguarding Children Board
Where partner agencies of more than one SCB have knowledge of, or have had contact with, a child, the SCB for the area in which the child is (or was) normally resident should take lead responsibility for conducting and managing any SCR.

Any other SCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a Looked after Child the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other SCBs with an interest or involvement.

The lead SCB should formally request any IMR required from agencies in another SCB area through that area's SCB and formally notify the other SCB of any recommendations made to agencies within its boundaries at the end of the review to facilitate the learning of local lessons.

4.6 Appointing an Independent Chair for the Serious Case Review Panel
The SCR panel Chair must be an independent person who is not a member of the SCB involved, an employee of any agency involved in the SCR or the Overview Report Author. The SCR panel Chair can be the independent SCB Chair (as they are not from a member agency locally); someone from another SCB not involved in the SCR or from an agency which is not involved in the case. The SCR panel Chair should have relevant skills taking into account the specific issues in the case.

The primary role of the Chair and Panel is to ensure that the experience of the child is kept at the heart of the SCR. The review should ensure that a picture is built up of what life was like for the child and the involvement of agencies should be reviewed in light of this. This should be achieved throughout the IMR process and be reflected in the Overview Report.

The SCR Panel Chair is responsible for;

- Ensuring that the Panel operates effectively so that organisations and agencies collaborate to produce a comprehensive and thorough SCR in a timely fashion which identifies the lessons to be learned from the case and has established a framework to ensure they are learned
- Ensure that IMR authors are supported to meet the agreed standards and requirements and timetable for submission
- Liasing with the SCB chair and nominated senior manager to agree a revised timetable if the statutory timescale is unlikely to be met and ensure arrangements are made for notifying the DfE of any decision to extend the timescale.
- Ensuring that IMRs are quality assured and any gaps and inconsistencies are identified so that necessary amendments can be made to the reports.
- Investigating and attempting to resolve any disputes or issues of non-compliance by participating organisations or agencies.
- Ensuring that the Overview Report author has all the necessary information and acting as a point of contact for the author should questions or points of clarification arise, and directing them to the appropriate agency SCR panel member or IMR report writer.
- Ensuring the draft overview report is considered against the agreed Terms of Reference to ensure that they have been fulfilled.
- Along with SCR panel members, ensuring that the report is comprehensive, well written and meets the requirements of Working Together.

The SCR Panel Chair should also ensure;

- The appropriate professional expertise, level of experience and authority of the panel members
- The availability of expert advice to the Panel if needed
- Clarity of the purpose and the process to be applied throughout, so that everyone understands the task, their role in the process, and the expectations of the Panel - i.e. the IMR authors, Overview Author and senior staff in agencies

- Transparency – to ensure that objectivity and challenge is applied rigorously and consistently to all services throughout the process
- Equality of weight of the views of all SCR panel members – so that appropriate challenge and robust dialogue can take place
- Anonymity and confidentiality – to ensure that final overview reports are entirely and consistently anonymised with no loss of meaning, and that all information remains confidential
- Timeliness – ensure that progress is managed robustly throughout the process to meet statutory deadlines and agreed timescales.
- Independence of the Overview Report author – ensure that the commissioned Overview author is completely independent of all agencies involved in the case, including the professionals and all SCR panel members.

4.7 The Serious Case Review Panel Membership
Once the decision has been made to proceed with a SCR, the nominated senior manager and SCR panel Chair will identify the panel members and convene the first meeting. A core group of agencies will always be involved:

- Children and Young Peoples' Services
- Police
- Health - PCT, commissioning and the local Hospital
- Education - if any child is known to the service

Representatives of other relevant agencies may be invited to participate where they have had contact with the family e.g.

- Adult's social care
- Other Health services e.g. CAMHS
- Probation
- Housing
- Voluntary agencies
- CAFCSS
- Faith and community groups

Panel members need to be clear about their role and function and should be representative of all the relevant key agencies at a sufficiently senior level to be able to comment on their agency's practice; commit any necessary resources to the review and ensure that recommendations can be taken forward. They **must not** have been directly involved in the practice or line management of the case. In addition no Panel member should be involved in preparing their own agency's IMR.

4.8 Role and Functions of the Serious Case Review Panel
The SCR Panel will undertake the following on behalf of the SCB:

- Determine the scope of the review and agree clear terms of reference as recommended by the preliminary SCR panel meeting. (Keep these under review in the light of later information)
- Select the time period over which the events are reviewed. (If necessary the Panel should revise these in the light of additional information)
- Set a timeline for the SCR
- Identity those agencies and professionals that need to undertake IMRs and identify any additional agencies as more information becomes available

- Determine how family members should be invited to contribute to the review, and who will support their involvement
- Ensure that agency staff are supported to participate in the review, e.g. by considering holding a meeting at the start of the process for all staff who may be involved to ensure they understand the SCR process, why one is being held in this case and what is required of them
- Conduct the scrutiny of IMRs, ideally at a draft stage, to identify gaps in knowledge, resolve conflicting information and request additional information to ensure IMRs are of an optimum quality
- Ensure that the child's experience is kept at the heart of the process, specific areas of practice and issues arising in the case are identified and not lost sight of as the review progresses.
- Agree and use effective arrangements for anonymity
- Take into account parallel processes or court processes
- Agree arrangements for working with other SCBs if necessary
- Effectively obtain and use any expert or legal advice required.
- Ensure that any learning is translated into action plans and where appropriate these are immediately implemented
- Ensure that learning already implemented is included in the IMRs and action plans
- Undertake the review within six months, plan for any anticipated delays, ensure extensions are kept to a minimum and that learning is not delayed
- Anticipate and plan for the likelihood of public, family and media interest during and on completion of the SCR.

The SCR panel is responsible for the quality, effectiveness and timeliness of the review, and must quality assure all reports and recommendations to ensure single and multi-agency learning takes place. **The Panel is accountable to the SCB Chair and Board as it is they who are responsible for agreeing and signing off the report. The Panel should project manage the Review to ensure that it is suitably resourced and completed within six months of the original decision to undertake it.**

4.9 Selecting the Serious Case Review Overview Report author

The Overview Report must be prepared by a person, commissioned by the Panel, who is independent of all the local agencies and professionals involved and the SCB(s). They must not be the Chair of the SCB or the SCR panel. Local authorities may establish reciprocal arrangements to provide Overview Report authors to each other.

The Overview author's role is to support the SCR Panel in their analysis of the IMR reports and identification of key issues, gaps or omissions. The Overview Report should capture the Panel's key findings and support the identification of lessons learned in line with the Working Together requirements.

Although the Overview Report author is not a member of the SCR panel they may attend some of the panel meetings to capture the discussion and analysis. This may include:

- Attending any meetings of workers involved.
- Attending any IMR author briefing to ensure that their IMRs support the

production of an effective Overview Report.
- Attending Panel meetings where IMRs are being considered
- Supporting the Panel with the development of analysis, identification of lessons and recommendations.

The Panel may also ask the Overview author to follow up apparent gaps in information where it is not possible to find out through the IMR author. The Overview author may also be responsible for seeking the views of family members as part of the review, sometimes with another Panel member, on advice from key workers in the case.

5 TERMS OF REFERENCE

The quality of the final Overview Report depends on the original terms of reference being comprehensive and effective. It is essential that the SCR Panel agrees comprehensive terms of reference to ensure they incorporate all the issues to provide for a through review and maximise the learning. The SCB Chair should ensure the terms of reference address all the key issues before approving them. Paragraph 8.20 of Working Together lists the key considerations for determining the SCR scope and terms of reference. The following areas warrant particular attention:

- **The timescale for the detailed chronologies - how far back should they go?** Families may have been known to agencies for many years so the review must be specific about the timeframe for the detailed chronology and any previous background information or early events relating to the family. A summary of agency involvement prior to recent years may be sufficient and allow the Panel to concentrate on the detail of recent events.
- **Consideration of the views of the family and extended family.** The Panel must decide which family members are included in the review, when they are to be interviewed and by whom. Panels should decide who will contact family members, the timing and purpose of contact e.g. seeking views, seeking consent to share information, feeding back lessons, agreeing the final report. The final Overview Report should clearly evidence how family's views have influenced lessons learned from the Review
- **Need for Expert advice** The Panel should address the possible need for expert opinion or advice at an early stage e.g. specific knowledge relating to any of the agency areas such as mental health or a particular cultural practice

Although the terms of reference are determined at the outset the Panel should reserve the right to review and amend them if necessary in the light of new information as the Review progresses

6 INDIVIDUAL MANAGEMENT REVIEWS (IMRs)

6.1 The aim of the IMR

An IMR report should detail an individual agency's involvement with the subject child and their family to contribute to and inform the SCR Overview Report. The aim of the IMR is to examine individual and organisational practice openly and critically; to see whether the case indicates that changes could and should be made and, if so, how those changes should be effected.

Each relevant agency identified at the Preliminary Panel meeting should undertake a separate IMR of its involvement with the child / family. This should begin as soon as a decision is taken to proceed with a review and even sooner if a case gives rise to concerns within the individual organisation or agency. During the review, it may become apparent that further IMRs are required from agencies not originally identified at the preliminary Panel meeting.

6.2 Who should complete an IMR?

The SCR Panel will decide which agencies should produce an IMR, based on the extent and nature of their contact with the child / family. The SCR terms of reference will specify which agencies are involved and their expected contribution.

Some of the key agencies represented on SCBs may have designated officers responsible for undertaking IMRs. Where this is not the case agencies should consider assigning this responsibility rather than wait until the need for a SCR arises.

The IMR author should be at a suitably senior level to carry authority and be able to undertake the review competently. They should have sufficient knowledge and expertise to analyse their agency's involvement effectively and make required recommendations for change.

The author should have had no involvement with the case, or have been the immediate line manager of the practitioners involved. (In turn they should be supervised by a manager who also has had no direct responsibilities for the case). Their independence from the case must be explicit, and clearly recorded within the IMR and SCR. The senior commissioning officer within the organisation must ensure that the IMR author is given sufficient time to complete their review with vigour and within agreed timescales as set by the SCR Panel. The findings from the IMR should be formally accepted by this senior officer who will also be responsible for ensuring that recommendations are acted upon.

If it is not possible to identify an appropriate IMR author from within an agency the SCR Panel may consider commissioning an external person to undertake the IMR, maybe through a reciprocal arrangement with a similar organisation in another authority. Organisations with less experience of conducting IMRs, e.g. from the Voluntary sector, may need support and advice from the SCB in producing their IMR. The SCR Panel should ensure this is provided.

Relevant independent professionals should produce reports of their involvement. GP involvement should be included in the PCT IMR. Designated professionals should review and evaluate the practice of all involved health professionals and providers within the PCT area. This may involve reviewing the involvement of individual practitioners and Trusts and advising named professionals and managers who are compiling reports for the review.

Where a child's guardian contributes to a review, the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived as necessary.

6.3 Accessing Agency Records

Once it is known that a case is being considered for a SCR each organisation/agency should secure all their records (including electronic records) relating to the case to guard against loss or interference. The agency records are crucial to producing to a thorough and effective IMR. Where a case is still active, or work is being undertaken with other family members, arrangements should be made for practitioners to have access to records, as necessary.

To produce the necessary detailed chronology on which the IMR will be based the IMR author will need to review **all** of the records held by the agency in relation to the child and other relevant individuals included in the scope of the review. Every contact between the agency, the child and others included in the review should be included in the chronology.

Designated health professionals should ensure that the SCR panel can obtain the information it needs to complete the review. For health organisations each Trust will have a process for requesting access to patient records. This may require a formal written request with the rationale clearly stated. Accessing records for the subject child and any siblings should not be problematic as the reason for the request is directly connected with child protection, and therefore in the children's best interests, supported by the United Nations Convention on the Rights of the Child (1989) and the Children Acts of 1989 and 2004.

Accessing the records of an adult (people over the age of 18) connected to the case requires a different approach. Consent should be actively sought from the adult to share their confidential medical records. Their consent should be informed and involve written permission. Permission is best obtained during a face to face discussion with the adult so that a full explanation can be given as to the purpose of the SCR, why their information may help lessons to be learnt and to answer any questions. A visit, ideally to the person's home, undertaken jointly with another member of the SCR panel is a good way of approaching the issue of consent.

If consent is not given and the panel cannot progress the SCR without the information, the panel should collectively decide to override the adults' right to consent. This can only be done under the terms of the Data Protection Act, e.g. it is justified to prevent crime or is in the public interest. A letter outlining clearly the justification for requesting information without consent should be sent to the Trust or GP concerned. It may be inappropriate to actively seek consent from a suspected perpetrator, in which case consent is immediately overridden using the two criteria mentioned above.

The community services parent held record, known as the "red book", is an important source of information and must be included in the chronology and analysis. The record held by the parent is the property of the NHS Trust. Occasionally the police will seize the "red book" as potential evidence in a prosecution. In this case, it is reasonable for the police to send a good copy of the contents to the Designated Professional coordinating the SCR so they can include relevant information into the health IMR.

The original health records of a dead child can be used as the primary source of information for including in an IMR (providing they are not seized as evidence). For surviving siblings, the records should be requested and frozen. Every page should be

numbered, dated and initialled by the receiving IMR author at the end of any notation. A clear line is drawn under the last entry which is dated and signed by the author. Good copies are then taken of every page (even blank pages) to provide an exact copy for the IMR author to work from. The original is sent back to the health professional who is continuing to work with the family. Electronic records can be printed off. Electronic systems can audit any notes

Both computerised GP print outs and any old '"Lloyd George" records should be reviewed when looking at the primary care element of a SCR. GPs must also be interviewed as for any other health professional involved in the review.

6.4 Producing the chronology
The Panel should notify all agencies of the required format for the chronology at the start of the review, confirming required style for dates and times etc. It is important that contributing agencies provide data in a consistent format to simplify merging it into a multi-agency integrated chronology of all contact with the child / family to inform subsequent analysis. This can be done by each agency populating an excel spreadsheet with the agreed format for dates which can be merged or by using specialised market software. It is important that the required format is agreed and notified early in the process so that everyone uses exactly the same format, including date format, font, font size, use of terms, and how names and any other identifying features of the case will be anonymised. A recommended format for the chronology is included as Appendix E.

A final column can be used for narrative/comments e.g. to highlight key procedures that were not followed at the time or to note any conflicting information from different agencies or between information gleaned from the case file and that which is taken from interviews. The chronology should not be confined to the information taken only from case files and may include interviewees reports of events that were not recorded at the time. All sources of information should be clearly evident within the chronology.

6.5 Producing the IMR
Working Together provides a basic outline format for IMR reports. A suggested template based on this format is included as Appendix H.

An early meeting of the SCR panel and IMR authors will ensure that all contributors to the review have fully understood the terms of reference and are working consistently towards the same objectives. The agenda for this meeting could include:

- Clarifying the reasons for the SCR and ensuring understanding of the process
- Identification of all involved organisations
- Discussion of each of the terms of reference
- Agreement about chronology dates, format and secure methods of sharing information with the SCR panel and overview author
- Agreement about an approach to anonymising names and any other identifying features of the case
- Confirmation of timescales and expected dates of completion of IMRs and completion of overview
- Any contentious issues or disagreements about agency involvement
- Any other local issues
- Consent arrangements

The IMR should examine individual and organisational practice to identify whether changes could and should be made and if so to identify how they will be implemented. It also provides an opportunity to ensure that any learning can be incorporated into the process from the start.

The SCR panel should have a clear process for identifying how appropriate IMR authors will be commissioned, trained and supported during the duration of the SCR including evaluation.

The SCR panel must ensure that IMR authors are well briefed and actively address the Terms of Reference within their report. It is good practice to invite IMR authors to a briefing session prior to commencing the IMR to ensure that the TOR are clear and understood. Good practice might also include inviting IMR authors to present early draft reports to the SCR panel. This provides an opportunity to address any gaps and engage the independent overview report writer in an early dialogue to inform their appraisal and analysis of the IMRs.

The IMR author should use the chronology to identify significant events, aspects of inter-agency working or gaps which require comment or need to be explored further in the report.

The IMR should incorporate findings about practice by the agency's staff, and how they worked with partners, against the terms of reference for the review setting out the analysis of findings for the agency clearly and leading to the identification of appropriate recommendations for the agency. **Where possible it should evidence the use of relevant research.**

On completion of each draft IMR the senior manager from the relevant commissioning agency, (who may be the agency's SCR panel member) should quality assure the report and feedback to the author to enable any amendments to be made and the final version be submitted on time to the SCR panel. **This final version must be signed and dated by the IMR author and countersigned/dated by the senior manager.**

This quality assurance should determine whether the terms of reference have been fully addressed, whether the analysis is appropriate and keeps the child at the centre of the report and pays attention to their racial, cultural, linguistic and religious identity, whether the leaning is identified appropriately and whether the recommendations for the agency are appropriate. This may also include addressing any feedback given by the SCR panel to ensure the final report meets required standards.

Once the IMR is agreed as final it should be submitted to the SCR panel in accordance with agreed timescales. All IMRs must be signed off and approved by both the individual agency and the SCR Panel. A process will be required to respond to any dissension between agencies and how any concerns about the quality of IMR reports will be addressed. In response to the final IMR, each agency should develop an action plan setting out how the recommendations will be taken forward, who by and when. An Action Plan is included at Appendix F.

Recommendations should be written in a SMART (Specific, Measurable, Achievable, Realistic, Timely) manner and address the following;

- What improved outcomes are needed in the agency?
- What specific actions should be taken by whom, and when?
- Is there sufficient resource to achieve the actions?
- How will the agency ensure that the desired outcomes are achieved?
- How will senior management know that the actions taken have made the improvements which were needed?

6.6 Interviewing staff

To explore issues emerging from the review of the case records and the construction of the chronology it is usually necessary to interview staff directly involved in the case. IMR authors will interview staff in their own agency unless the SCR panel decides that the SCR author will undertake the interviews – this may be favoured to provide consistency or eliminate any unintended bias from agency IMR leads.

If there is a criminal investigation and likely criminal trial then it may not be possible to interview some staff members who may be called as witnesses until after the criminal justice process is completed. The principle of completing the review in a timely manner should be pursued and consideration given to which staff members it may be possible to interview ahead of a criminal trial in order that learning is not delayed. It is important that the SCR Panel receives advice on this and plans this carefully with the police Senior Investigating Officer, taking into account the views of the CPS.

The interview is to understand why a practitioner behaved as they did, and their understanding of the case at the time. It is important that they can tell the story of their involvement and the rationale for their practice and they should understand the SCR process and why they are being interviewed. This can be explained if the SCR Panel holds a meeting for all staff involved at the start of the review

More than one member of staff from the agency may need to be interviewed to produce the IMR, including both frontline practitioners and/or managers. In deciding who to interview, the IMR author should consider:

- Who was the lead professional or key worker for the child when key decisions were made or events occurred within the scope of the SCR.
- Who else was closely involved with the child / family at the time of the concerns
- Management involvement in key decisions about the agencies involvement with the child / family, including those relating to the allocation of resources
- The length of time a member of staff was involved with the child or family.

Professionals who have expressed concern about the management of the case should **always** be seen as part of the review.

The IMR author should consider the sequence of staff interviews, taking account of the circumstances of the case. To decide this it may be helpful to refer to the chronology and consider whether to interview frontline staff before managers. IMR authors should prepare well for the interviews and be clear about the specific episodes or issues they would like to discuss. If possible it is useful to share this with the interviewees in advance to enable them to prepare appropriately.

A suggested interview structure is:

- Ensuring the staff member is clear about the SCR process and why they are being interviewed
- Explain that this is an opportunity for the individual to offer an overview of their involvement with the child / family and the working relationship that had developed between them
- Start with asking the practitioner to describe in detail what happened at key periods of their involvement in the case, and any particular episodes which they felt were pivotal in the direction the case took. Keep the questions open ended at this stage
- Follow up with any questions to elaborate on the key episodes
- Summarise and repeat back to ensure accurate understanding of what was said
- Focus on areas central to the case and ask questions which enable the practitioner to explain why they acted in the way they did at the time. This may include contributory factors such as the working environment, management guidance, workload pressures, other agency perspectives etc
- Test out any hypotheses that have emerged by this stage to understand the practitioner's behaviour
- Make sure that time is allocated to talk about good practice in relation to the case
- Summarise the key points at the end of the interview.

For practitioners, consider;

- The strengths and challenges which the work with the child / family presented
- What it felt like working with this child and family
- What life was like for the child (and any siblings)
- The worker's awareness of policy and procedures
- Were child protection and care plans in place and were reviews conducted in a timely manner?
- How well the multi-agency team worked together and how they shared information
- Whether work was child focussed
- The framework within which they were operating to inform their assessment of the family and decisions about risk
- An opportunity for the staff member to consider the contextual factors within which they were working, including the supports which were provided to the member of staff, provision of training, supervision, audit practice etc
- Reflection on critical events and why particular courses of action were taken
- Wider staffing issues within the organisation, for example vacancy levels
- The culture of the organisation or team they were working within and its impact on decision making in individual cases
- Caseloads or other resource issues
- Support from line managers with key decision making and access to resources
- How it felt to work for the organisation at that time
- With hindsight what they think might have made a difference in this case

- What have they learnt about practice since the critical incident in this case?

Managers may additionally be asked;

- How supervision was undertaken
- How work was allocated in the team
- How skills, competence and development needs of staff were assessed
- The support they were receiving from the organisation
- Any resource issues which impacted on the case.

Interviewees should be allowed to comment on the written record of the interview and amend any inaccuracies. Providing they have approved this record their statements can be used as quotes within the report in an anonymised way. It is important that they understand this may happen at the outset of the interview. Some interviewees may wish to bring a supporter or union representative to the interview.

6.7 Agreeing timescales

The most common reason for an "inadequate: OFSTED judgement is a failure to adhere to timescales, particularly production of a late Overview Report because of delayed IMRs. The SCR Panel must be explicit about the need to complete early drafts of the IMRs – regular review meetings early in the process may be helpful in keeping agencies to time. Appendix B sets out an example timeline based on *Working Together* paragraphs 8.22 – 8.27. Within one month of the case coming to their attention the SCB chair is responsible for deciding whether to commission a SCR which must then be completed within a further six months from the decision date.

If the statutory timescales cannot be met a revised timeline should be prepared for the SCB together with reasons for the delay and how learning will be progressed in the meantime. Where there is significant delay to completing a review in full, for example as a result of a criminal prosecution, the SCR Panel may consider producing an interim report outlining the learning identified to date and actions which have been taken to address these ahead of the final report being available.

7. PARALLEL PROCESSES

The Panel and IMR / SCR authors should be take account of any parallel processes that are ongoing at the same time as the SCR and ensure that their impact is managed actively so as not to create avoidable delay.

7.1 Working with other authorities – SCRs across multiple SCB areas

It is possible that, due to family mobility, other authorities may have worked with the child / family at some point in the past, and contributions to the SCR will be required. This makes the review more complicated, but providing the following steps are undertaken, should not hamper or delay the production of the SCR:

- Be absolutely clear about which authority is the lead for the SCR at the start (see paragraph 4.5);
- Be clear about expectations of other SCBs – in some cases a full chronology and IMRs will be required, in others a short summary of involvement will suffice;
- Agree specific approaches to issues at the outset, for example, communication lines, publicity and dissemination strategies, confidentiality, media interest etc;

- Establish a lead liaison officer from other SCBs - if a number of agencies are involved in another SCB area, one lead officer is essential;
- If necessary, hold regular meetings of each of the SCB representatives to review the work and receive progress reports.

7.2 Health Agencies Serious Untoward Incident Reviews
It is common for health agencies to have reported an incident which would normally lead to a Serious Untoward Incident (SUI) review being undertaken about the same family who are the subject of a SCR. This is often the case in adult mental health services or CAMHS. The main point is to agree terms of engagement early on, ensuring that:

- Unless there are very good reasons there should only be one review – the IMR which is being produced for the SCR. The relevant health agency should ensure their Board, the SHA etc are aware that the report will be using IMR not SUI templates and timescales will start from date SCR is decided by the SCB not date of incident.
- If both a SCR and a SUI are being undertaken, terms of reference should be aligned and coherent and early draft reports shared to reduce the risk of different messages and explanations being given for the same incident
- Regular liaison and progress review should be undertaken
- Agreement about publication dates and media strategies is crucial
- Each of these processes has different signing off and approval processes. The chair of the SCR panel should liaise with the lead manager within the health agency to ensure that approval processes for reports are co-ordinated

7.3 Youth Justice Reviews
The Youth Justice Board has an established process for Local Management Review when a serious incident occurs in the community or in a secure children's home. The Prisons and Probation Ombudsman's Fatal Incidents Investigation Team will take the lead when there is a death in other custodial settings such as Secure Treatment Centres and Youth Offending Institutions. Such reviews will be undertaken within the framework of the Child Death Review framework and close liaison with SCBs is recommended in the Youth Justice Board guidance[3]

In both these instances, close liaison is required and lead officers should ensure that the processes fit together in a coherent and sensible way.

7.4 Coroners involvement/ Criminal Court Proceedings/ Domestic Violence Homicide Reviews/ Vulnerable Adult Reviews
These processes may also be taking place in parallel with the SCR. At an early stage the SCR Panel Chair should make contact with the Coroner's office, the Crown Prosecution Service or Police lead to agree any co-ordination needed between the processes such as timing of actions and disclosure of information (in many areas the police representative on the SCR panel will take responsibility for such liaison.

[3] Serious Incidents – Guidance on serious incidence reporting procedures (B319). Youth Justice Board 2007

There should be agreement about when to release specific information, to co-ordinate the timing in relation to court processes – particularly in relation to interviewing staff for the SCR who may also be witnesses in a current police investigation and to ensure there is regular review of this information in response to changing circumstances.

These processes should not delay progress of the SCR unless vital information is awaited which cannot be identified other than through these routes. Court processes will always attract media attention so agreement about media strategies is crucial. The responsibility for conducting Domestic Homicide Reviews lies with the Community Safety Partnership. Formal guidance, setting out the process to be followed and recognising the links to the Safeguarding Children and Safeguarding Adult's Boards has been approved. It is acknowledged that close liaison will be required between the three bodies to ensure that any overlapping processes/duplication is avoided. This is particularly applicable in complex cases e.g. where both an adult and child may have been victims of assault by the same perpetrator.

7.5 Media strategy

It is essential to have an approved media strategy in place. Information may be given to the press before official publication, e.g. from family members or unwitting leaks from one of the participating SCB agencies and the Panel should be prepared for this. Advice about specific media liaison and publicity will come from individual agency departments. The important points to consider are:

- Good communication between media / publicity departments across SCB agencies
- Clear briefings for members of the panel, SCB, appropriate officers within agencies and elected members, so that all concerned parties are fully aware of when to expect media coverage
- Clarity about who will lead the media response and the high level messages.
- Thoughtfulness about the actual wording of reports that will be published – imagine seeing the lines that are written in a newspaper headline or article
- Co-ordination with media releases from any other SCBs or agencies involved.
- Training in working with the media for high profile SCRs.
- A schedule of briefing dates to be circulated to relevant media

7.6 Support for staff / disciplinary processes

SCB agencies will have their own resources and procedures for supporting staff. Staff involved with a case where a child has died or been seriously injured may require emotional support or specific help in dealing with feelings, including guilt, anxiety, defensiveness, isolation, and loss of confidence. The SCR interviews often take place some time after the event of child death or serious injury and may cause a re-emergence of emotional distress. It is important to offer workers support on a personal level and ensure that their feelings do not impact on their professional conduct.

The agency should consider how it can promote the message that the SCR is a learning process, such as by ensuring staff are clear about the purpose of the review, its timescales and how they will be involved. It can be helpful to hold a meeting of all staff involved at the start of the process to confirm this as well as to confirm what support is available to them from the organisation.

In instances where it is clear that staff codes of conduct have been breached, staff may be subject to suspension from duties, or disciplinary investigations and other formal HR processes. Liaison with HR departments will be required to ensure these processes are well managed and fit with the SCR interviews. It may be that disciplinary processes follow the publication of a SCR. It is also possible that early information emerging during the IMR will trigger disciplinary investigations which cannot wait until the end of the process.

8. THE SERIOUS CASE REVIEW OVERVIEW REPORT

Working Together Paragraph 8.40 outlines a clear framework for the Overview Report:

Introduction

- Summarise the circumstances that led to the SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used, including the documents reviewed and whether the information was provided in an interview or through written evidence.
- List agencies and the nature of their contribution to the review e.g. IMR by local authority, report through the PCT as commissioner from adult mental health service.
- List the names and roles / positions / job titles of the SCB chair, SCR panel chair, the overview report author and the job titles and employing organisations of all the SCR panel members.
- List any external investigations that are being conducted, e.g. a PPO investigation following the death of a child in custody or a mental health inquiry.

The facts

- Include an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen alone and whether the child's wishes and feelings were sought or expressed.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

Analysis

This should look at how and why events occurred, decisions were made and actions taken or not taken. In this section reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve. This is also where any examples of good practice (as distinct from that which should be considered standard practice) should be highlighted, and where issues around workforce, environmental factors and family behaviour can be discussed. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the SCB and findings from relevant research.

Conclusions and recommendations
This section should summarise the lessons derived from the case and how they should be translated into recommended actions, with timescales. Recommendations should include those made in individual IMR reports plus any others identified by the panel. The number of recommendations should be limited, focused and specific, and capable of being implemented. Any lessons for national as well as local policy and practice should also be highlighted and information sent to the relevant government department.

8.1 Introduction
In the summary of the circumstances that led to the review it is helpful to refer to any strategy or other meetings where decisions were made, the dates of these meetings and any important points covered.

The independence of the Panel chair, Panel members, IMR authors and overview authors should be stated explicitly, with particular reference to the line management relationships in relation to the case. OFSTED will use this as evidence of independence and it is a significant factor in the evaluation of the SCR.

8.2 The facts
This section should include a narrative that tells the story in a straightforward factual way, using the chronology as a basis. This narrative can be lengthy and it is helpful to describe the detail of key events or episodes, but not translate the full chronology. Short summaries of non eventful periods are recommended. The narrative might include details of the environment at the time, or any specific policy issues if relevant. It can be difficult to differentiate what is included in this section and what comes into the following analysis section - inevitably, the narrative will start to demonstrate the hypothesis about events and highlight the evidence to be used in the analysis section.

8.3 Including the views of parents and relevant family members
There is a presumption that relevant family members will be invited to contribute as fully as possible to the process unless there are clear reasons to exclude or limit their participation. The SCR panel must decide carefully who constitutes relevant family. It may include grandparents or siblings who were closely involved with the child and have a useful contribution about the family's experiences of services. Although this is difficult and painful time for the family, sensitive engagement should be sought. All attempts to engage should be fully recorded in the overview report.

Responsibility for discussing and planning the family participation rests with the SCR panel. The panel should consider how and when the family can contribute and who should facilitate their involvement and give feedback to the family.

Families must always be informed that a SCR is taking place and an explanation given about what to expect, media coverage and that their names will be kept confidential. If the family do not wish to contribute or the panel considers it to be inadvisable the reasons should be fully recorded and included in the overview report. Timing of involvement should be considered carefully, e.g. the opportunity to contribute could be offered after any court processes and the SCR are completed. The boundaries around

which members of the family are involved need to be decided at an early stage. It is important not to make commitments to families that cannot be met.

The views of family members and their experiences of intervention at the time can be invaluable to the learning process. The aim is to get their views about how services were delivered and interagency working. It is accepted that it may be difficult to keep the conversations limited to these areas and emotions may be high. It is helpful to have a designated member of the SCR panel, alongside the SCR author, to be the main point of liaison for the family. Communication with family members should be face to face wherever possible following communication to explain the purpose of the SCR and invite them to contribute.

Involving family members should be undertaken sensitively and requires careful planning to clearly explain the reasons for the review, the process and ensure their views are represented accurately, meaningfully and as they would like to see them within the report. It is good practice to allow any contributing family members to agree how their views are included and to see the report before it is published. Where possible the final Overview Report should clearly evidence how the family's views have been used to influence lessons learned from the Review

If there is a criminal investigation and likely criminal trial then interviewing the family may only occur after the criminal justice process is completed. It is important that the SCR panel receives advice on this and plans this carefully with the police Senior Investigating Officer taking into account the views of the CPS.

8.4 Analysis
This section is central to the process and should link clearly to the evidence provided in the previous sections. The systems approach and root cause analysis both provide useful models to use as a framework for analysis.

The systems approach defines five types of factors which SCR Overview authors may find useful to consider:

- **Human tool operation:** How the individual practitioners concerned with the case interacted with tools such as assessment frameworks, case recording systems, databases etc and what impact this had on the case. Tools are active agents, not passive objects.
- **Human-management system operation**: How did the management systems, including resource issues, supervision, management priorities and compliance with local procedures etc impact on the case.
- **Communication and collaboration in multi-agency working**: How did the joint working of the different agencies impact on the case and did the family understand the differing roles and responsibilities of each agency
- **Family – professional interactions**: How did the relationship between the practitioner and the child and their parents affect the case? How did the family behave towards the practitioner and receive and interpret information from them, and was the relationship a positive or negative one?
- **Human judgement / reasoning**: How were judgements made? What systems were in place to detect and correct any errors of judgement? The systems

approach assumes that such errors are inevitable and the purpose of SCRs therefore is to learn how to minimise human errors in the future.

The Patient Safety Advisory Agency model for root cause analysis divides the factors to consider into categories of human error, and other contributory factors.

- **Human error factors, for example;**
- Skill based errors (slips and lapses) – usually unintended and not typical for the practitioner who tends to recognise their error after the event
- Rule based mistakes – not following procedures for a range of possible reasons e.g., taking shortcuts, issues of non compliance, poor performance etc
- Knowledge based mistakes – these may occur due to inexperience of practitioner

- **Contributory factors, for example;**
- Team / local management – including whether there was clarity of role of the practitioner, support networks, leadership, supervision, culture of the team for example openness versus defensive.
- Communication – was the direction given to the practitioner clearly communicated, were records clear, what was the quality of communication around the case?
- Task – were the policies clear, up to date, fit for purpose, accessible to the practitioner? Was there access to specialist advice or consultation about specific issues?
- Education and training – what training was provided, was supervision of good quality, was the practitioner competent and experienced enough to take on the work associated with this case?
- Equipment – in the health service this applies to the technical equipment available to the practitioner and how effectively it was working. In other agencies this could apply to fitness for purpose of systems, effectiveness of IT systems or possibly additional resources available to the practitioner, e.g. interpreters.
- Work environment – including a wide variety of contextual factors e.g. staffing, skill mix, caseloads, other workload pressures, how much time was available to the practitioner to work on this case, use of temporary staff, context of resource allocation and even wider national issues such as recruitment and retention of social work staff.
- Organisational – what was the impact of the structure, hierarchy, decision making bodies, accountability structures, priorities of the organisation, risk management frameworks, culture of the organisation etc?

Human error and contributory factors can be evaluated to determine the strongest influences in the case direction and thus help to establish the root causes of the outcome.

It is helpful to challenge the analysis by testing / re-testing hypotheses to ensure that judgements made relate closely to factual evidence. It is good practice for SCR authors to employ an independent supervisor or mentor who can challenge the rigour of the analysis and be a second reader of the first draft of the report. The report should include a robust critique of the IMRs and comment on any evident omissions.

The systems approach recommends that the SCR author meets with the practitioners involved in the case at various points during the process to check any inaccuracies and also ensure the interpretation of events is in line with the practitioners' view. The approach argues that these meetings are part of the learning process.

The systems approach guide on the Social Care Institute for Excellence (SCIE) website provides further frameworks and appendices which outline types of contributory factors and are useful in structuring thinking and analysis. http://www.scie.org.uk/children/learningtogether/index.asp

8.5 Conclusions and recommendations

The conclusions should highlight the key lessons learned from the SCR. Some overview report authors may separately itemise the learning for each agency as covered in the various IMRs. The conclusions should be clear about which factors supported good practice and which created, or contributed, to unsafe conditions in which poor practice was more likely to occur.

Recommendations should flow clearly from the analysis/learning identified in the case and be **outcome focused, i.e. concentrate on the end result or desired change in practice or conditions,** not the process required to get there. A limited number of SMART recommendations will be more effective in creating change than a long list without priority areas for action. A good test for the SCB is asking how they would know whether the action has been completed – what is the evidence of changed practice and can this be illustrated in a way which describes how children would be safer as a result?

Overview report authors should maintain independence when drawing up the recommendations, but close liaison with the commissioning authority will produce more productive recommendations that fit with other developments already taking place. The final SCR is agreed by the SCR panel and the SCB. Any disagreement with the views of the overview report author should be set out in the report.

The systems approach defines three different kinds of recommendations:

- Issues with clear solutions that can be addressed locally by all relevant agencies
- Issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers
- Issues that require further research and development to find solutions including those that would need to be addressed at a national level.

9. LEARNING FROM THE REVIEW

The value of SCRs is the learning derived from them and it is vital that as much effort is spent on acting on recommendations as on conducting the actual Review. The following may help to secure maximum benefit from the review process:

- Conduct the review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.

- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant Action Plan to ensure identified changes/improvements are implemented and embedded.
- Seek feedback on review reports from Ofsted who should use reports to inform inspections and performance management.
- Day to day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning.
- Promote a culture of audit and review to gauge the extent to which change is embedded in improved practise.
- Have in place clear, systematic case-recording and record-keeping systems.
- Develop good communication and mutual understanding between different disciplines and different Safeguarding Board members.
- Communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, young people and their families so that attention is not focused disproportionately on tragedies.
- Make sure staff and their representatives understand what can be expected in the event of an event that requires a SCR.

9.1 Action plans

The SCR Action Plan will be developed directly from the recommendations of the Overview report. It will include all the individual IMR recommendations and any overarching cross cutting recommendations for more than one agency. The Action Plan should be realistic and set out clearly the responsible agencies/individuals and specific dates by which actions will be undertaken, as well as the desired outcomes. *Working Together* provides advice on how to ensure maximum benefit from the review process through learning local lessons in paragraph 8.52. A template and locally approved guidance are attached at appendix F.

The Overview Report should be clear about how the Action Plan will be monitored and evaluated. In Barnsley the Quality Assurance and Performance Management Sub-Group is responsible for monitoring the SCR Action Plan through regular review until completion. Individual actions will be signed off as they are completed. Agencies should ensure that this is not a paper exercise. Actions must be meaningful and designed to actually make a difference to practice. The systems approach encourages agencies to create actions that will create environments where it is harder to do something wrong and easier for good practice to flourish.

9.2 Disseminating lessons learned

The Executive Summary can be useful both as a training resource and as the basis for discussion in individual team meetings. It is particularly useful to disseminate the findings amongst staff groups who were involved with the SCR. A meeting should be held with the staff involved to confirm that the review is complete and outline the findings, either on a multi-agency basis or by each agency separately. This helps to quash any myths that may have arisen and also aids understanding and learning.

The SCB may provide a multi-agency briefing which can be very useful in understanding what went wrong between agencies and helping practitioners on the front line understand the whole SCR process. The systems approach recommends that the learning is divided into three groups: environment; systems; skill gaps. Each

of these areas may need a different approach to disseminate the lessons learned – the SCR panel could devise learning and dissemination plans for key groups in each area.

9.3 Embedding the learning

Ensuring that lessons learned are embedded is not easy. There is a danger that the SCR findings, recommendations and action plans have an immediate and short term impact but the learning is not sustained. The Barnsley Serious Case Review Task Group has responsibility for reviewing SCRs from other areas to identify lessons with local resonance and devise locally applicable Action Plans for monitoring by the Quality Assurance Sub-Group. In addition the Quality Assurance Sub-Group's remit to maintain an overview of all multi - agency audit activity includes examining how well actions from previous SCRs have been embedded in changed practice through targeted audits to assess their impact on the organisation and gauge how well the learning has been fully embedded.

9.4 Learning lessons regionally and nationally

Taken together, child death and SCRs are an important source of information to inform national and regional 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. Previously the DCSF commissioned regular national reports, drawing out key findings of SCRs and their implications for policy and practice to assist the process of learning lessons.

10. THE EXECUTIVE SUMMARY

The Executive Summary should convey the full subtleties of the SCR and explain the findings and lessons learned in a meaningful way. It must contain the key messages about the findings, context, contributory factors and explanations of the rationale behind the practitioners' behaviour. The Executive Summary's main purpose is to support the dissemination of the lessons learnt by the review and the implementation of any necessary changes.

Both the Overview Report and Executive Summary should focus on the agencies' learning from the review. However, the Executive Summary should:

- Give minimal information about the family (see suggested format below).
- Summarise what the SCR identified in terms of what went well and what went wrong and the action being taken to rectify any problems.
- Reflect accurately the full Overview Report and not omit any major issues because of political sensitivities or because it is uncomfortable to agencies.
- Be dated so that national expectations at the time can be referenced if needed.

A suggested set of headings for the Executive Summary is:

- Introduction – about the review process
- Case summary - high level summary of what happened and key issues arising from the case (without compromising the anonymity of surviving siblings, other children or family members)
- Findings - the lessons learned
- Future actions for each agency - including any changes that have already been made
- Local features - any context information or recurring themes.

11. ACTION FOLLOWING COMPLETION OF THE REVIEW

Working Together paragraph 8.41 sets out the responsibilities of the SCR Panel in relation to the overview report, and 8.43 – 8.46 gives detailed guidance on the action to be taken by the SCB. The Review should be quality assured by the SCB prior to submission to Ofsted and the DfE. Appendix I is an example quality assurance checklist for SCR Panels and LSCBs.

To receive the Overview Report, Executive Summary, Chronology and Action Plan the SCB should meet promptly, (an extraordinary meeting may be required), to:

- Ensure that contributing organisations, agencies and individuals are satisfied that their information is fully and fairly represented.
- Agree the recommendations and Action Plan which should be SMART and identify responsible agencies/individuals with timescales for actions and the intended outcome. The Plan should include the means by which improvements will be monitored and reviewed.
- Clarify to whom the report, or any part of it, should be made available.
- Make arrangements to provide feedback and debriefing to staff, family members of the subject and the media as appropriate
- Disseminate the report and key findings to those individual organisations/agencies as agreed.
- Provide an anonymised copy of the IMRs, Overview Report, Executive Summary, Integrated Chronology and the individual and multi-agency action plans and chronologies to Ofsted, the DfE and the SHA.

12. PUBLICATION OF THE OVERVIEW REPORT AND EXECUTIVE SUMMARY

On 10 June 2010 the government circulated guidance to SCBs confirming its commitment to publishing SCR Overview Reports in full (together with Executive Summaries). Identifying details should be removed through appropriate redaction and anonymisation to protect the privacy and welfare of vulnerable children and their families. This change applied with immediate effect to all SCRs initiated after 10 June 2010 (although not those initiated prior to that date) and was designed to enable lessons to be learned as widely as possible through greater transparency and accountability.

All references in Chapter 8 of Working Together regarding publication of the Executive Summary should therefore be read as meaning publication of both the Overview Report and Executive Summary. IMRs should not be made publicly available. There is no change to the guidance regarding the content of the Executive Summary which requires that it includes information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed), as a minimum. The Executive Summary should also be suitably anonymised to protect the identity of children and family members (apart from the name of the SCR panel chair, members and the overview author).

It is a statutory requirement to produce and publish Overview Reports and Executive Summaries of SCRs. The SCB should adhere to this guidance and must have clear reasons for any decision to depart from it.

The SCB should not delay in publishing the Overview report once it has been evaluated by Ofsted and any related court proceedings have been concluded. When Ofsted has judged the report at least adequate, any change made to it should be minimal. Change may only be needed to ensure it does not contain any confidential information about the family and the focus is on what the SCR found was good practice and what needed improvement. This is standard practice in any FOI and published report. If Ofsted judged the report to be inadequate it should be redrafted in light of Ofsted's comments.

Overview Reports should be publicly available on the SCB website for a reasonable amount of time to support the dissemination of learning from the review. If a SCB is considering deviating from guidance about publication careful consideration should be given, including securing legal advice on the potential contestability of this decision. This can only be decided locally, on a case by case basis.

Where a SCB identifies concerns about publication of the Report, such as confidentiality issues involving identification of individuals, the SCB, with legal advice, should consider what it is able to publish remembering that the main purpose of SCRs is to identify learning and ensure that this is implemented. Even in the most sensitive cases SCBs should be able to identify and report publicly on the key learning themes. Any proposal by the SCB to limit the content of a published SCR should be discussed with the DfE.

The SCR panel should identify someone to take responsibility for debriefing the family. The SCB should ensure that families are aware of the plans to publish the Reports and may share the contents with families in advance where appropriate. If the publication is likely to attract media attention the SCB should notify the DfE at the earliest opportunity and provide a copy of the press release or a note for a media briefing. This will alert the DfE to the issues that the case raises and what has been done to address them ahead of publication.

Decisions about timing of publication should be made by the SCB in close liaison with other agencies and in line with other processes, particularly the criminal proceedings.

13. OFSTED EVALUATION OF SCRS

This section will be revised in light of any changes to the Ofsted evaluation process. The Munro Report has recommended that Ofsted no longer evaluate SCRs and the Government's final response in relation to alternative inspection arrangements is awaited.

OFSTED evaluation judgements are made on the basis of an evaluation framework that has been developed from *Working Together*. Inspectors follow the requirements set out in Chapter 8 in detail so it is important that these requirements are fully met. Ofsted has published two reports on the outcome of SCR evaluations containing valuable information on emerging themes.

The list below from the first report outlines the main features that Ofsted considers in making their judgements:

- Whether it was appropriate to instigate the review;

- The scope and time period covered by the review;
- The terms of reference and whether the author is suitably independent of the agencies involved;
- Whether the review was completed within the recommended timescales;
- The quality of the individual management review;
- Whether the ethnic, cultural, linguistic and religious needs of the child and family were met by services, and are addressed within the review;
- Whether the family were invited and enabled to contribute to the review process and whether their views have been used to inform the learning.;
- The quality of the review report, including:
    - background information;
    - rigour of analysis and challenge of information in IMRs;
    - joint chronology;
    - appropriate recommendations;
    - reference to research and previous review findings;
    - joint agency action plan with clear targets and timescales;
    - monitoring arrangements by the SCB
- The quality of the executive summary, including whether it is suitably anonymised to protect the family's identity, and whether it is yet published.

Acknowledgements
Publications developed by the London Safeguarding Children Boards, Stoke on Trent Safeguarding Children Board and Doncaster Safeguarding Children Board have all been very useful in the development of this Toolkit, Policies and Procedures.

EQUALITY IMPACT ASSESSMENT
This policy has been equality impact assessed. If on reading this policy/procedure, you feel there are equality and diversity issues, please contact the Safeguarding Board safeguardingchildren@barnsley.gov.uk and, if necessary, the document will be reviewed

This Protocol was ratified in September 2011

Date of Review – September 2013

APPENDIX A: CHECKLIST FOR WHEN TO HOLD A REVIEW

The criteria that a SCB should consider when determining whether to undertake a Serious Case Review are set out in Chapter 8 of W*orking Together 2010*

When should a SCB undertake a Serious Case Review
8.9 When a child dies (including death by suspected 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 of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs 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 SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.

8.10 The death of every child is reviewed in accordance with the child death review processes outlined in Chapter 7 of this guidance. A SCR may be triggered at any point in the child death reviewing process if a rapid response team or Child Death Overview Panel (CDOP) considers a case may meet the criteria for a SCR (see paragraph 7.1). In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other SCBs with an interest or whose local agencies have had involvement as appropriate (see paragraph 7.34). This CDOP may refer a case to its LSCB Chair if it considers the criteria for a SCR may be met and a SCR has not been initiated. Chapter 7, flow chart 6, shows the interface between the child death review and SCR processes.

When should a LSCB <u>consider</u> undertaking a Serious Case Review?
8.11 LSCBs should consider whether to conduct a SCR whenever 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 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.

8.12 The following questions may also help in deciding whether 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:

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

APPENDIX B – EXAMPLE TIMELINE FOR SCR

Action	**Scheduled date**	**Date Completed**
Date SCB notified of serious incident	*Day one*	
SCR Panel to consider whether case meets SCR requirements.	*Week one - two*	
Decision by SCB chair to undertake SCR	*Within one month*	
Initial SCR Panel to agree scope and Terms of Reference	*Within one month*	
Independent overview author commissioned	*Within one month*	
Briefing for IMR authors	*Within one month*	
Submission of chronologies and first draft IMRs	*Month two*	
Second SCR panel to review IMRs and begin identifying analysis and themes for Overview Report	*Month two*	
Involve family	*Month 3-4*	
Submission of final IMRs and single agency action plans	*Month three*	
Third SCR panel and first draft Overview Report	*Months 3-5*	
Determine media strategy	*Month five*	
Fourth SCR panel and final draft	*Month five*	
Complete SCB Action Plan	*Month five-six*	
Produce Overview Report and Executive Summary	*Month six*	
Arrange feedback with family	*Month six*	
Arrange feedback to staff	*Month six*	
SCB Meeting to sign off final SCR (IMRs and single agency action plans, Overview Report and Action Plan, Executive Summary)	*Month six*	
Send ratified final SCR to external bodies	*Month six*	
Deadline for completion	*Six months*	
Actual submission date	*Six months*	
Ofsted evaluation letter received		
Publish Report on SCB website	*Following Ofsted Evaluation*	

APPENDIX C: DETERMINING THE SCOPE AND TERMS OF REFERENCE

Issues to consider in determining the scope of the review are set out in Paragraphs 8.20 and 8.21 of W*orking Together 2010.* Relevant issues are:

- 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 (see paragraph 8.13), 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 – see paragraph 8.33).
- 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?

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.

APPENDIX D: CHECKLIST FOR THE SCOPING AND TERMS OF REFERENCE

The panel should consider the scope of the review process, ***in the light of each case***, and draw up clear terms of reference, in accordance with Appendix C above. It may be useful to consider each of the following, indicating where an issue is not applicable and adding additional considerations where appropriate. Supplementary questions have been included to assist this process.

1. Decision to hold SCR

- *Add date when notification to Ofsted was made*
- *Add date when the chair of SCB (name and independence status)) agreed to commission a SCR. State name and independence status of SCR panel.*
- *Provide detail as to why SCR was necessary using 8.9 or 8.11 as basis*
- *Identify reasons for any delays in deciding to hold SCR*

2. Key Issues: *(really important section)*

- *What specific issues or questions does this case raise?*
- *Are there any unusual factors in this case, what are they?*
- *Are there similarities with previous IMRs or SCRs, If so what are they?*
- *Are there any failings which appear obvious at this stage?*
- *Do there appear to be any gaps in multi - agency working?*
- *Are there any issues which relate to ethnicity, disability, culture or faith which may have a bearing on this review? If not, say so.*
- *Is there any known research which may assist? If so quote it.*
- *Are there other SCRs in region or nationally which are similar?*
- *What good practice was there*

3. Expert Opinion

- *Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals or organisations who will be required to participate in the review?*
- *Might it help the Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?*

4. Time Period over which events should be reviewed

- *Over what time period should events be reviewed, - i.e. how far back should enquiries cover, and what is the cut-off point?*
- *What is the relevance of selecting this time period?(Remember even complex family history can be summarised)*
- *What family history/background information will help better to understand the recent past and present?*

5. Organisations to be involved in this SCR *(would be useful to state which are universal or targeted or specialist services?)*

- *Which organisations and professionals will be asked to contribute to this review and submit reports or otherwise contribute?*
- *What action will the Board take if there is a failure to cooperate with this review?*
- *Who will make the link with relevant interests outside the main statutory organisations – e.g. independent professionals, independent schools, voluntary organisations?*

6. Involvement of Family Members

- *Are there any known factors which may affect the involvement of any family members?*
- *Which family members will be asked to contribute and why?*
- *Are there issues around timing which may affect this dialogue?*
- *Who will be responsible for supporting family members involved?*
- *What resources will be required to facilitate this process?*
- *Which agency and named lead in the agency will take responsibly for coordinating the contacts with the family?*
- *Who will lead in the process necessary in requesting access to adult health records where required?*

7. Other Parallel reviews *(e.g. PPO/ homicide or suicide reviews)*

- *Will the case give rise to other parallel investigations of practice – e.g. independent health investigations or multi-disciplinary suicide reviews, a domestic homicide review, a YJB Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting?*
- *If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions in the most economical way?*
- *What are the arrangements for co-ordinating and liaising with those involved?*
- *What problems may emerge in terms of confidentiality and sharing information and how will these be addressed?*
- *What are the implications of any different or challenging timescales?*

8. Involvement of organisations in other LSCB areas

- *Are there any other organisations involved with this family or any cross boundary issues which may involve other SCBs?*
- *Who will take responsibility for contacting that SCB to negotiate, manage and co-ordinate their involvement in the SCR process?*
- *What should be the respective roles and responsibilities of the different SCBs with an interest*?

9. Coroner's Inquiries/Criminal Investigations

- *Are timescales for Coroners/criminal or civil proceedings known and will revised timescales be likely?*
- *Who will liase with the Coroner's office and/or CPS?*
- *Has the Coroner issued any advice and how will this be addressed in the SCR?*

10. Media Coverage/Enquiries

- *How should any public, family and media interest be managed before, during and after the review?*
- *Be specific, including how reports will be anonymised*
- *Is there a communications/media strategy?*
- *How should any FOI requests relating this case be handled and by whom?*

11. Legal Advice

- *Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review and if yes, give reasons*

12. SCR Review Timescales

- *The review process should start within one month of notification and should, unless extensions are agreed with the DfE, conclude and be forwarded to Ofsted and copied to the DfE within 6 months from that start date.*
- *What are the possibilities that these dates may change and why?*

13. Commissioning of an Independent Author

- *Which Author is being proposed and why? Indicate if they have any specific skills or knowledge.*
- *Specify in what way they are considered 'independent'*
- *Will the SCB require the Author to use a particular format for their report and is a template available?*
- *Specify what is expected of the Author and within what timescales, maybe give some examples of things to consider e.g., dates booked in to present the early findings to the panel, dates for final report to LSCB, a link person for the author and the means by which their work will be facilitated.*
- *Clarify process should Board fail to ratify final report.*

14. Liaison with Ofsted and the DfE

[Name Contact Details] will liaise with the DfE over progress and where any extensions to timescales prove necessary.

APPENDIX E: EXAMPLE FORMAT FOR THE CHRONOLOGY

Date	Start Time	End Time	Source of Information	Subject	Contact/Information	Communication - Within Agency	Communication - External to Agency	Response or Outcome	Comments
01.01.11									

APPENDIX F – ACTION PLAN TEMPLATE AND GUIDANCE NOTES

No	RECOMMENDATION	ACTION	TIMESCALE	STATUS RAG rated	RESPONSIBLE AGENCY & PERSON(S)	PERSON RESPONSIBLE FOR MONITORING	MEASUREMENT(S) OF SUCCESS
1	Detailed objective or recommendation as provided in the original Action Plan **NB** Ensure recommendations are **SMART** when you're drafting the original Action Plan	Must relate **directly** to the recommendation or objective identified.	Final end date when each action will be completed	Type in Red Amber or Green	Name of agency And a senior manager with overall responsibility	Person with responsibility for ensuring that actions happen	These will be audited so must be tangible. **Evidence is required of an improvement in practice directly attributable to the action that can be defined and measured** e.g. improved quality of written reports. Might be an audit / policy document / establishment of a system which can be evidenced etc.
		If there is more than 1 action required then add additional cells so each action is in its own box					

The Barnsley Safeguarding Children Board Quality Assurance Sub - Group has agreed the following definitions for the traffic lights:

Red – Not going to be achieved or not achieved by due date
Amber – Problematic issue but still hope to achieve by due date.
Green – On track to achieve or actually achieved by due date.

APPENDIX G - SMART RECOMMENDATIONS

Recommendations must be SMART to be effective;

S Specific M Measurable A Achievable R Realistic T Timely

It is vital that all actions have a responsible person assigned to them and a realistic timescale for completion.

What outcomes are the actions designed to achieve and how will the organisation evaluate whether they have been achieved.

Recommendations should be, focused, specific and realistic in relation to implementing change.

APPENDIX H: TEMPLATE AND GUIDANCE FOR IMRs

The headings below, taken from Working Together 2010, should guide the preparation of Individual Management Review reports. They provide the basic format although there may be specific areas in individual cases which require further exploration.

Chronology
First a chronology must be prepared of the agency's contact with the family using an agreed template. This is then used as the basis for producing the IMR.

The following comprise the five main components to the report.

1. **Introduction**
   The introduction should name the child and give details about age, ethnicity, relevant family members and the circumstances which precipitated the review. This section should describe the position of the IMR author to explain their independence in relation to the case, the process undertaken in preparing the report and should list the names of those interviewed and other sources of information, e.g. the child's case file.

2. **Narrative**
   Using the chronology as the basis the narrative should describe the sequence of events and critical incidents for the child / family, and the actions taken by the agency in response. This narrative provides the second section of the IMR - the actual chronology should be provided as an appendix.

3. **Analysis of involvement**
   The analysis should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, the analysis should aim to provide an understanding of what happened and why.

   Working Together recommends that the following factors should be considered in the analysis:

   - Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
   - When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken into account when making decisions about the provision of services? Was this information recorded?
   - Did the organisation have policies and procedures in place for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
   - What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
   - Did actions accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and / or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family? Were these explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the SCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations?
- Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

4. **Lessons learned / findings or conclusions**

   This section should provide the conclusions and whether there are lessons learned from the events and analysis in relation to the way the organisation works to safeguard and promote the welfare of children. Instances of good practice should be highlighted, but the main body of this section will outline means of improving practice and policy. This section should include the main messages and implications for systems and processes, and for practice, including for example, management and supervision, multi-agency working, resources, training and development. If there are shortfalls in service which the panel is assured have been addressed since the incident this must be recorded and spelt out if a recommendation is not to be made. Findings should be numbered and relate directly to a recommendation or a reason given as to why a recommendation is not necessary.

5. **Recommendations**

   The recommendations should be **SMART** and outcome focused, so that the responsible senior manager in the agency can draw up an action plan outlining the actions to be taken; by whom, and when, in order to meet specific outcomes. This section should also include how the organisation will evaluate whether the desired outcomes have been achieved.

Other considerations

The five components above comprise the main elements of the IMR and must be included in all reports. Agencies may also provide additional information to set the context for the IMR, e.g. particular management arrangements or frameworks which were in place and relevant or particular circumstances which may have impinged on the events, such as staffing difficulties within the organisation. Set out on the following pages is a basic template for use by IMR Authors

Barnsley Safeguarding Children Board

Individual Management Review on Child X

IMR Author

Title of Executive Director/Chief Executive of the Organisation

Name of Child (ren) subject of SCR: **Child X**
Date of Birth:
Date of Death:

Agency providing the report: IMR Author: Name of Agency

Evaluation statement on behalf of agency:

The IMR conforms to the IMR Report template

The IMR takes into account the specific Terms of Reference for the SCR

The IMR has been checked against Ofsted descriptors

The IMR is:

o Comprehensive

o Well-structured

o Includes good analysis of the information

o Provides explanations for any practice which may be of concern

o Places emphasis on key findings and lessons

o Has sound and SMART recommendations

Signed Date ……..

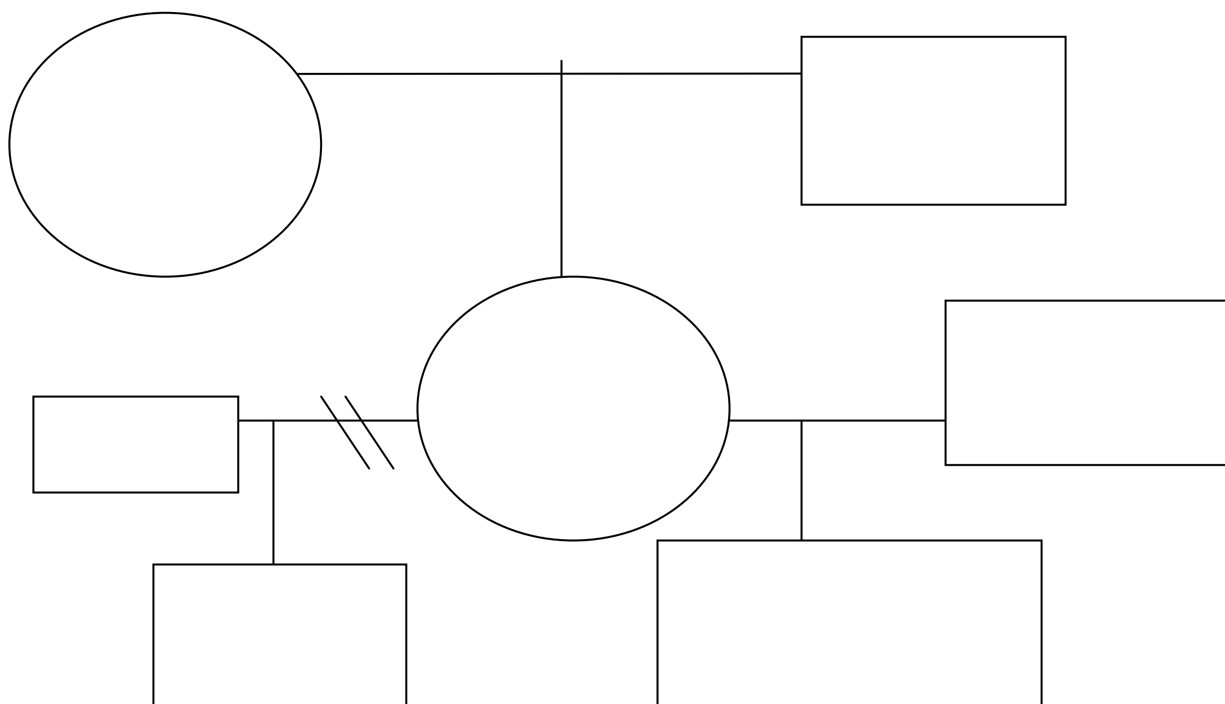
Name:
Role in agency:**.**
IMR Author responsible for writing IMR report.

I have read this report and confirm that I have approved it as my agency's IMR report to the Barnsley Serious Case Review Panel.
Signed
………………………………………Date………………
Name…… ……………………………………………………
Title…… …
On behalf of Name of Agency

CONTENTS	**PAGE**
Genogram	**4**
Introduction	**4**
Terms of Reference	**5**
Methodology	**5**
Summary of agency involvement	**5**
Examples of good practice	**7**
Examples of potential minor improvements to practice	**7**
Analysis of key issues	**7**
What do we learn from this case?	**8**
Key recommendations for action	**9**
Chronology	**Previously supplied in the chronology**
Appendices	**If applicable**

Genogram

This genogram represents the individuals known to the XXXX service. (Ensure it is as comprehensive as necessary. It may be useful to have an agreed chronology for use by all agencies)



Introduction
This individual Management Review (IMR) has been prepared for Barnsley Safeguarding Children Board by (Name) based at(Location) of the (Name of Agency), on behalf of (Name) Services. The author has no line management responsibility for any of the staff referred to in the IMR, which has been prepared in accordance with the guidelines for conducting a Serious Case Review (SCR) set out in Working Together 2010. The period of the Review has been determined by the SCR Panel as (Date) to (Date) and this IMR covers a relevant period within this timeframe.

This IMR will form part of a multi- agency SCR Overview Report in line with the recommendations of Chapter 8: Serious Case Reviews.
It represents an account of services provided by (Name) Services to the key subjects identified on (Date) by the Serious Case Review Panel as:

Subject - Child XX D.O.B. D.O.D

Mother – XX D.O.B

Father - XX D.O.B

Other Siblings D.O.B

Terms of Reference – Individual Management Reviews

In addition to analysing individual and organisational practice, identifying lessons learned and making recommendations to improve future practice, Individual Management Reviews should specifically address the following:

- Did staff in each agency follow relevant interagency and single agency procedures?
- Was the adults' experience of being parented and the likely impact of this on their parenting capacity acknowledged and analysed?
- Did agencies appropriately recognise Child X as a child in need, and possibly a child in need of protection?
- Was the issue of domestic abuse fully addressed and its impact on children's well-being understood?
- Were features of neglect, and their impact fully addressed?
- Make SMART recommendations which indicate the person responsible for implementation, timescales and required outcomes.
- Equality and diversity should be considered to ensure agencies have examined the particular needs of the individuals involved in the case and addressed any areas identified appropriately.

Methodology

This IMR was undertaken through examination of (Details of files etc.) relating to Child X i.e.

- XX
- XX
- XX

All information requested was available for examination.

In addition the author undertook personal interviews with the following staff on (Date) to clarify any areas for further examination and confirm details of their involvement with the family

- (Name)
- (Name)
- (Name)

Summary of agency involvement

Summarise in detail all agency's involvement with the child and family

Equality and Diversity

The local community reflects the make up of the population of Barnsley as a whole i.e. White English culture.

Child XX is of (White English) origin. His (and his family's) religion is (Name if known). He had no particular needs in relation to his ethnicity or religion. (Or list if known)

Examples of good practice
Give examples

Examples of potential minor improvements to practice
Give examples

Analysis of key issues

What do we learn from this case?

Key recommendations for action
In view of the findings from this IMR I recommend:

- List recommendation - ensure they are **SMART**

APPENDIX I: Example Quality Assurance checklist for SCR panels and SCBs

The SCR should be quality assured before submission to Ofsted. The following checklist may be helpful.

Criteria	**Comments** **Achieved / Not Achieved**
The decision to commence the SCR was made in a timely way, in accordance with Working Together.	
Ofsted was notified of the decision to initiate the SCR within a month of the date of the incident coming to attention.	
Any delay in initiating the SCR is explained within the Overview Report.	
The SCR chair is independent of the SCB and all services involved in the case. They have an appropriate level of experience and authority, which is detailed in the overview report.	
Any change of SCR chair during the completion of the review is fully explained in the overview report.	
The SCR panel membership is appropriate in relation to organisations represented, and knowledge and expertise.	
The SCR panel was effective in scrutinising the IMRs, identifying gaps, resolving conflicting information and requesting additional information or revised IMRs if required.	
The SCR chair was effective in project managing the review to completion in a timely and effective way.	
The SCR panel brought the review to completion within 6 months of the date of the decision to proceed or within the timescale agreed with government.	
Terms of Reference	
The SCR panel determined the scope of the review and outlined the terms of reference.	
The time period over which events were to be reviewed was selected and is appropriate.	
If the initial timeframe was later amended the reasons for this are detailed within the overview report.	
The organisations and professionals who were to contribute to the SCR were identified.	
Any additional organisations or professionals identified as the review progressed were fully briefed.	

Family members who were invited contribute to the review were identified and arrangements made to support their engagement. The overview report is clear about how these family members contributions were used to influence the lessons to be learned from the Review, where appropriate.	
The specific areas of practice and issues for the case were identified and kept under review by the SCR panel as the IMRs were completed and scrutinised, and the overview report undertaken.	
The initial terms of reference have been amended to reflect any additional practice issues identified as the review progressed? Learning from these additions has been identified for future SCRs.	
The arrangement for anonymising IMRs was agreed and the format for IMRs issued to organisations / agencies.	
Any parallel process, e.g. domestic homicide, mental health or YJB reviews, criminal investigation, inquest or court processes were taken into account in the planning of the review?	
The areas in which the family was resident during the time period of the review were established and cross boundary arrangements made to engage other SCBs as necessary.	
Any expert or legal advice required was timely, informative and useful, and this advice is reflected in the review.	
Anticipated delays were planned for and extensions agreed with government in advance?	
Potential media interest was planned for and responded to in an effective manner before and during the completion of the SCR.	
Individual Management Reviews	
All organisations/agencies identified suitably independent authors to complete IMRs. The independence of these authors from the case and its line management is explained in the IMRs.	
A briefing was planned and provided for the IMRs authors, all of whom attended. All IMRs are of a similarly high quality	
The timetable set for completion of the IMRs was adhered to. Any unavoidable delays have been addressed by the relevant agency.	
IMRs were submitted from all relevant organisations and professionals. They included a **comprehensive chronology of involvement and a genogram.**	
The SCB chair has been informed of any IMRs not provided in response to requests, and the impact of the absence of any IMRs has	

been assessed and explained within the overview report.	
The IMRs **address all the terms of reference for the review** including any revisions and the requirements in Working Together	
The IMRs identify the records accessed and others consulted or interviewed in the completion of the report.	
All the IMRs evidence the use of appropriate research to inform the review.	
The IMRs are comprehensive, well-structured, analytical, and look openly and critically at practice across the full timeframe of the review, decisions reached and services offered to the child/ren and their family. Rigorous analysis explores all relevant references fully.	
The IMRs identify good practice where appropriate.	
The IMRs reach well founded conclusions, identifying key lessons to be learned and make appropriate recommendations in relation to all issues identified.	
All the IMRs have retained a focus on the child/ren concerned and pay attention to their racial, cultural, linguistic, disability and religious considerations. The IMRs evidence the impact of all such considerations.	
The IMRs are provided in the standard report format provided by the SCR panel, and are fully and appropriately anonymised.	
The IMRs have each been signed off by a Senior Officer within the individual organisations. Evidence of sign off is supplied.	
The IMR recommendations are **SMART** and incorporated into a composite action plan with specific arrangements for its monitoring and evaluation. It is clear that the SCB will know how the recommendations have been implemented and how practice has improved. with specific actions identified to implement each recommendations.	
Each recommendation has: • A specific action designed to implement the recommendation • An identified responsible lead officer • A clear timescale for implementation • A desired outcome in terms of changed practice/improved outcome	
Overview Report	
The independence of the overview report author is described and their background and expertise explained within the Introduction.	
The report focuses on the child's experience and addresses the impact of their racial, cultural, linguistic and religious identity and any disabilities in the family.	

The overview report includes: • A summary of the circumstances leading to the review • The terms of reference • A list of contributors and panel members • A comprehensive genogram, including extended family where appropriate • A summary of the family history • An assessment of the IMRs. • A comprehensive integrated chronology of **all** agency's involvement identifying when the child was seen, if the child was seen alone, and whether their wishes and feelings were sought or expressed. • Details of any engagement with family members and explains how their views have contributed to the review and been used to inform lessons to be learned. • A consideration of any ethnic, cultural or other equalities issues • Analysis of decisions made, action taken, turning points and good practice.	
The report effectively covers all the information provided from the IMRs, analyses and evaluates the information known to agencies critically using the benefit of hindsight, and identifies key lessons to be learnt for individual agencies and the multi agency network. The conclusions are logical and evidence based.	
The report identifies and comments on any omissions identified in the IMRs or chronology.	
The report provides a robust critique from an independent standpoint of the extent to which the IMRs adhered to the terms of reference.	
The report is informed by and references appropriate research.	
The report fulfils the terms of reference, exploring all areas.	
The report is consistent as far as is appropriate with the format contained in Working Together	
The report has a limited number of recommendations related to the review's key findings which are focused, specific and achievable.	
The report is clear about what is expected to change as a result of the recommendations and what the key lessons are for the SCB	
Executive Summary	
The Executive Summary provides an accurate reflection of the key issues arising from the case; information about the review process and SCR panel members; and the recommendations and Action Plan in full.	

The Executive Summary is fully anonymised, written in an accessible and jargon free style	
A comprehensive media strategy is in place for the publication of the Reports.	
Action Plan	
All actions from the IMRs are incorporated into the composite Action Plan. Any overarching cross-cutting recommendations relating to more than one agency are included. The recommendations have been developed into **S**pecific, **M**easurable **A**chievable, **R**ealistic and **T**imely **(SMART**) actions**.**	
The arrangements for monitoring and evaluating the progress of the Action Plan are clearly set out. In Barnsley such monitoring is undertaken by the Quality Assurance and Performance Management Sub-Group of the Safeguarding Board	