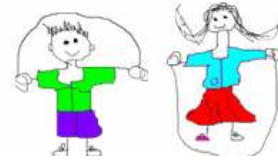




*Working Together
to Safeguard Children*



Bedfordshire Local Safeguarding Children Board

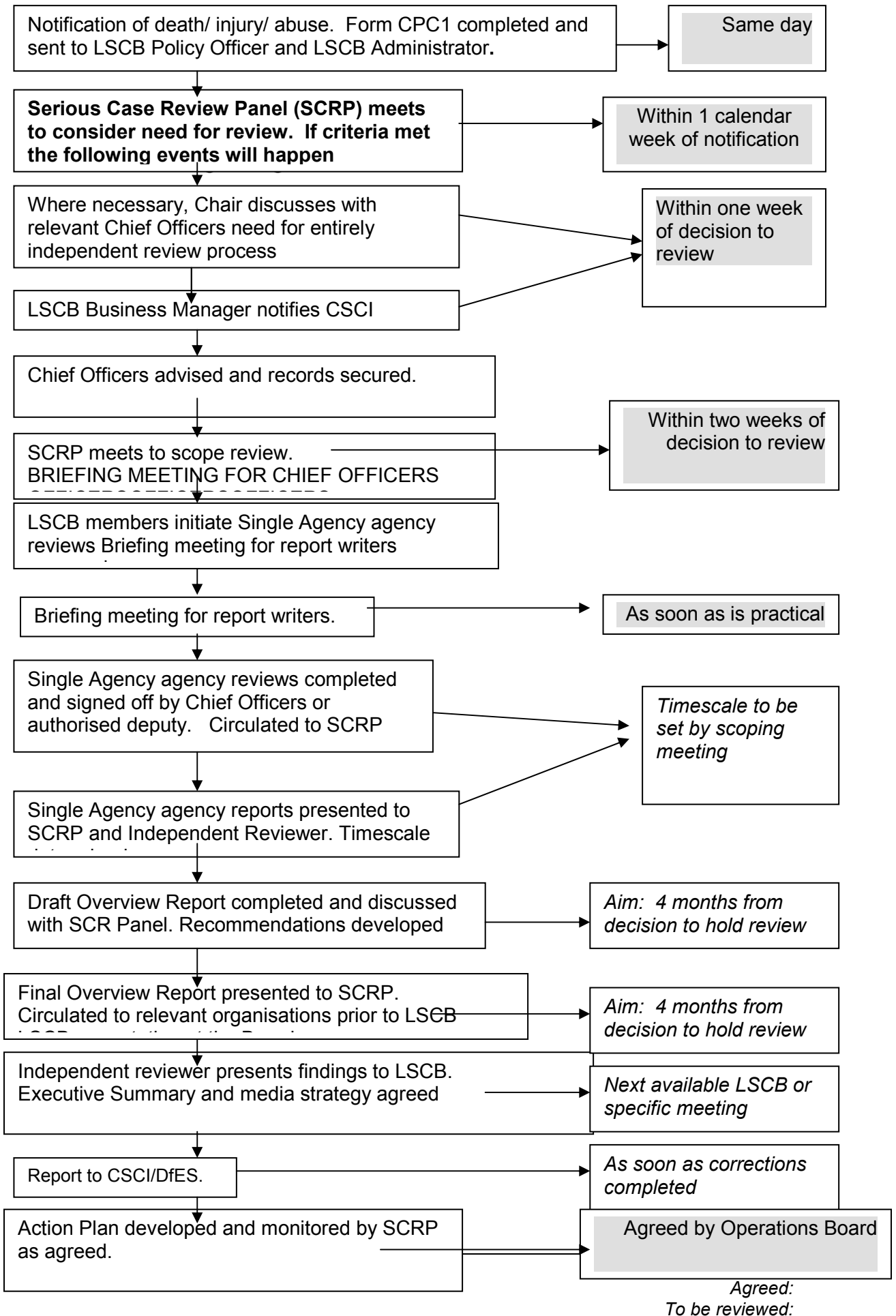
Serious Cases Review Process

Draft: 9

Date agreed by LSCB: February 2007

Date to be reviewed: ?

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Agreed:
To be reviewed:

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BEDFORDSHIRE LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEWS

1 INTRODUCTION

The purpose of serious case reviews carried out under Working Together (2006) is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- as a consequence, to improve inter-agency working and better safeguard children.

Serious case reviews are not enquiries into how a child died or who is culpable; that is a matter for determination by Coroners and Criminal Courts respectively.

The Serious Case Review Panel is established to undertake Case Reviews on behalf of the Bedfordshire Local Safeguarding Children Board in accordance with government guidance set out in Working Together to Safeguard Children (2006). The Independent chair of Bedfordshire's LSCB also chairs the Serious Case Review Panel.

The Serious Case Review Panel does the following:

- Undertakes Serious Case Reviews in accordance with government guidance
- Reviews cases referred by members of the LSCB
- Makes recommendations to the LSCB to ensure that lessons from Case Reviews result in improved practice
- Monitors timescale
- Develops and monitors action plans arising from a case review
- Acts as a reference point for staff within their agency/organisation/professional community
- Advises the LSCB of any major new initiatives within this area of responsibility
- Will develop the Child Death Team (to be operational by April 2008)
- Reports to the Strategic Board

2 SERIOUS CASE REVIEW PANEL MEMBERSHIP

The core membership of the Serious Cases Review Panel, in addition to the Chair, consists of:

- The Designated Doctor
- The Designated Nurse
- Senior Social Care Manager
- Senior Education Officer
- Police Superintendent
- Legal Advisor

Representatives from other agencies for example will be identified to join the Panel as appropriate to each case.

Members of the Panel have a dual role; to represent a profession or organisation in discussions about serious case reviews and to act collectively to promote best practice standards.

In selecting representatives each agency shall:

- Choose a member of staff who is able to represent the organisation, their policies and practice appropriately.
- Choose a professional with sufficient experience and knowledge to inform the debate about cases under consideration
- Choose a member of staff of sufficiently seniority to ensure that recommendations rising from Serious Case Reviews are acted upon within individual organisations.

As a matter of principle members of the panel will not combine this role with that of conducting the Single Agency Management Reviews. If a member of the Panel is asked to undertake an Single Agency Management Review or they have had personal involvement with the case under consideration, they will withdraw from the panel for that case and may nominate another member of staff from their organisation to sit on the Serious Case Review Panel.

3 CRITERIA FOR A SERIOUS CASE REVIEW

The LSCB should always undertake a serious case review when:

- A child dies (including death by suicide)
and
- Abuse or neglect is known or suspected to be a factor in the child's death.

The LSCB should consider whether to undertake a serious case review where a child:

- The case gives rise to concerns about inter-agency working to protect children from harm

AND one or more of the following apply:

- Has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect or Has been subjected to particularly serious sexual abuse, or
- Their parent has been murdered and a homicide review is being initiated, or
- A parent has been killed in a domestic violence situation.

Additionally when a child dies, and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children at risk of harm who need safeguarding (e.g. siblings, other children in an institution where abuse is alleged).

The following questions may help in deciding whether or not a case should be the subject to a serious case review in circumstances other than when the child dies – a

“yes” answer to several of these questions is likely to indicate that a review will yield useful lessons:

- Was there clear evidence of a risk of significant harm to a child, which was
 - Not recognised by agencies or professionals in contact with the child or perpetrator
- or
- Not shared with others or
- Not acted upon appropriately?

- Was the child/children abused in an institutional setting, (e.g. school, nursery, family centre, children’s home, young offenders institution secure training centre or armed services training establishment)?

- Did the child abused in a custodial (prison, young offenders institution or secure training centre) setting?

- Was the child abused while being looked after by the local authority?

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

- Does the case indicate that there may be failings in one or more aspects of the local operation of the formal child protection procedures, which go beyond the handling of this case?

- Was the child’s subject to a child protection plan or had it been previously 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 were not adequately understood or acted upon?

Any agency or professional may refer a case to the LSCB Chair if the above criteria are met and it is believed that there are important lessons for inter-agency working to be learned from the case. (*Referral form pro forma G in appendices*)

In addition, the Secretary of State can ask the Children’s Commissioner to hold an inquiry, using powers under the Inquiries Act 2005.

4 DECISION MAKING:

Having considered the available information, the Bedfordshire LSCB will decide to take one of the following actions:

- Instigate a serious cases review (see 5)
- Instigate an Interagency management review (see 12.1)
- Instigate a ‘near miss’ review (see 13)
- Agree no further action and discuss the reasons for this with the referrer.

5 INSTIGATING A SERIOUS CASE REVIEW

The LSCB should first decide whether or not a case should be the subject of a serious case review, applying the criteria above.

5.1 Notifying CSCI, DfES and the SHA

Local Authorities should always inform the local region of the Commission for Social Care Inspection of every case that becomes the subject of a serious case review or when there has been a death of or serious incident involving a looked after child or a child in regulated provision. CSCI holds a national child protection database that can also be accessed by DfES for reporting and analysis purposes

5.2 Working across different Safeguarding Boards

Where more than one LSCB has knowledge of a child the LSCB for the area in which the child is/was normally resident should take lead responsibility for conducting the review. Any other LSCB's that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the review. In the case of looked after children, the responsible authority should exercise lead responsibility for conducting the review, again involving other LSCB's with an interest or involvement. Bedfordshire has a cross border protocol agreed with Luton and Cambridgeshire (Appendix A)

5.3 Setting up the Review

The Serious Cases Review Panel chaired by the independent chair of the LSCB is committed to meeting at short notice to consider the need for, and to manage the conduct of serious case reviews. The Chair will consult with the members of the Review Panel within 2 working days about the need to conduct a Case Review. The Review Panel may decide to seek more information before making a decision and may contact relevant organisations. (*pro forma letter 2 in appendices*) A decision to conduct a case review must be made within 28 days.

The Review Panel decision should be forwarded as a recommendation to the chair of the LSCB who has ultimate responsibility for deciding whether or not to conduct a serious case review.

In exceptional circumstances, for example, in the event of major public concern, it may be decided by the LSCB Chair in consultation with Chief Officers of the main agencies involved in the case, that a wholly independent review is required. In these circumstances, the independent review will become the Serious Case Review and members of the Serious Case Review Panel may be required to support the process

If the chair of the LSCB and the SCRCP agree that a serious case review is required, arrangements will be made to:

- Ensure any immediate action necessary to safeguard other children in the household has been taken
- Secure the files and all records held.
- Inform Chief Officers by letter (*pro forma letter H in appendices*) asking them to secure files and appoint a member of their staff to complete their Single Agency management review)

The Chair of the Serious Cases Review Panel will ensure that Chief Officers (or their authorised deputies i.e., representatives on the LSCB) are notified **within 24 hours** of the decision to proceed with a Serious Case Review.

The Serious Case Review Panel may also decide to advise the family or other victims of abuse of their decision to conduct a case review. (*pro forma letters I & J in appendices*)

5.4 Securing Records

The Chief Officer (or member of the LSCB Strategic Board) of the individual organisations should make arrangements to secure all case records immediately to guard against loss or interference. Work to draw up a chronology of involvement with the child and family should begin.

Chief Officers will need to identify a member of staff who will be able to undertake the Single Agency Management Review. Staff asked to conduct a management review should not have been directly involved with the child or family, or be the immediate manager of the practitioner(s) involved.

The report writer may need to interview staff involved with the child and their family. If this is deemed necessary the report authors are advised to keep a written record of the interview and to share this with the interviewee. It is not necessary to submit the records of these interviews with their final report.

Given that the primary purpose of Case Reviews is to contribute to the improvement of interagency practice, the SCRP should ensure that lessons should be learned and acted upon as quickly as possible.

- Within one month of a case coming to the attention of the LSCB Chair, there should be a meeting of the SCRP to consider whether the criteria for conducting a case review are met
- Reviews should be completed within a further 4 months, unless an alternative timescale is agreed with Commission for Social Care Inspection at the outset. Sometimes the complexity of a case does not become apparent until the review is in progress. (*Working Together 2006*)

In practice it can be difficult to complete a thorough Case Review within the timescale established and it is not unusual for revised timescales to be required.

Case Reviews should not be delayed as a matter of course because of outstanding criminal proceedings or a pending decision as to whether or not to prosecute. In some cases it may not be possible to publish a review until after Coroners or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented.

5.5 Scoping the Serious Case Review

In deciding how to conduct the Serious Case Review the SCRCP will give consideration to the following factors;

- What are the most important issues to address in learning from this specific case? How can the relevant information best be obtained and analysed?
- Who should be appointed as the Independent author for the Overview report?
- Are there features of the case which indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/agencies who will be required to participate in the review? Might it help the review panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, i.e. how far back should Single Agency Management Reviews cover, and what is the cut-off point? What family history/ background information will help to better understand the recent past and present?
- Which agencies and professionals should contribute to the Review, (including where appropriate for example the proprietor of an independent school or a playgroup leader) and be asked to submit reports or otherwise contribute?
- How should family members contribute to the review and who should be responsible for facilitating their involvement?
- Does the case give rise to other parallel investigations of practice, for example independent health investigations for multi disciplinary suicide review, a homicide review when a parent has been murdered, a Youth Justice Board Serious Incident Review and a Prison Ombudsman investigation when a child has died in a custodial setting? If so, would a co-ordinated or jointly commissioned review process be the most economical method of addressing all the relevant questions that need to be asked?
- Is there a need to involve organisations/ professionals in other LSCB areas and what should be the respective roles and responsibilities of the different LSCB's with an interest?
- How should the review process take account of a Coroner's inquiry and any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Police/Crown Prosecution Service?
- Who will make the link with relevant interests outside the main statutory organisations for example independent professionals, independent schools and voluntary organisations?

- When should the review process start and by what date should it be completed?
- How should any public, family and media interest be handled, before, during and after the review?
- Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

Some of the above issues may need to be revisited as the review progresses and new information emerges.

The Scoping meeting will also:

- Convene a briefing meeting for the authors of the single agency management reviews (SAMRs), agreeing who will chair the meeting and who from the SCRP will be present.
- Set the date by which reports must be with the administrator to the SCRP.
- A date for the presentation of the Single Agency Management Review Reports to the SCRP
- Consider the process for appointing an independent Report Writer for the Overview Report and Executive Summary. Agree who will negotiate the contractual arrangements (see REF)
- Make the timescales clear and agree action to be taken in the event of delay
- End date for submission of overview report to LSCB and subsequently to CSCI (this may require an extraordinary LSCB meeting)

The terms of reference for the case review will be sent out to Chief Officers in a letter. (*pro forma letter K in the appendices*)

5.6 Practitioner meeting

The primary aim of this meeting is to appropriately involve all practitioners who have been involved or who are dealing with the case.

The meeting will provide an opportunity to:

- Clarify the case review process and its purpose. This can be a highly anxious time for practitioners who may be continuing to work with the family whilst also participating in the Single Agency management review process.
- Participate and share with other professionals in a similar position their experiences.

6 SINGLE AGENCY MANAGEMENT REVIEWS

Each agency who has been involved or who has knowledge of the child and their immediate family will be asked to undertake an Single Agency Management Review for their agency. The aim of the review should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and if so to identify how those changes will be brought about.

Each Single Agency Management Report should be completed within the timescale set at the scoping meeting (between 4 and 6 weeks). The Single Agency Management Report should be countersigned by the respective Chief Officer before being sent to the LSCB administrator for distribution to members of the Serious Case Review Panel.

The Single Agency Review should contain a comprehensive chronology of the involvement by the agency, on the template provided. A genogram and pen picture of the child should also be included. The report should detail the actions of the professionals in contact with the child and their family over the period of time as set out in the terms of reference. The report writer should include decisions reached, the services offered and or provided to the child and their family, and other actions taken.

The outline format at APPENDIX should guide the preparation of management reviews and help ensure that the relevant questions are addressed. Providing information to the LSCB in a consistent format will help in the preparation of the overview report. Each case may give rise to specific questions and issues which need to be explored – these will have been identified at the scoping meeting and will need consideration in addition to those matters identified in the general format above.

Single Agency management Review authors must ensure that the report has been discussed with the relevant managers in their own organisation and that the final report is signed off by their Director/Chief Executive Officer. They may also need to consider seeking legal advice on their draft report.

6.1 Interface with disciplinary action

The purpose of this report, as distinct from any disciplinary action that an agency may take, needs to be carefully explained to staff. Serious case reviews are not part of any disciplinary process, but information that emerges in the course of reviews may indicate that disciplinary action should be considered under the established procedures. Alternatively reviews may be conducted concurrently with disciplinary action, as in some cases, for example institutional abuse, disciplinary action may be needed to safeguard the welfare of other children

6.2 Briefing Meeting for Single Agency Management Reviewers

This will be held as soon as practicable after the scoping meeting once the individual reviewers have been identified. The meeting provides an opportunity for discussion about the expectations of the LSCB, the required format for the report and chronology. A face to face meeting ensures that everyone hears the same message, confusion, questions and queries can be dealt with on the spot. It also offers the chance to dispel myths and anxieties about the case review process. It enables a timetable to be established for the sequential presentation of the reports to the SCR Panel. The dates for submission of their reports and the meeting the SCR Panel and the Independent Reviewer will be agreed.

The SCR panel will send a letter confirming the format for the Single Agency management review to Chief Officers. (*pro forma letter 8 in appendices*) and reminding them of the need to develop an action plan based on the findings which will be reviewed by the LSCB.

7 SCRP REVIEW MEETINGS

Receiving the Single Agency Management Reviews

Each Single Agency Management Reviewer will be invited to talk through their report with the SCRCP and Independent Reviewer. This will allow discussion, questions to be raised and clarification of any aspect of a report. It will also allow an opportunity for discussion of individual organisation's recommendations.

The timescale for the completion of the Overview Report and Executive Summary will be agreed from this meeting with the Independent Overview Report writer.

8 THE INDEPENDENT REVIEWER

The LSCB should commission an overview report which brings together and analyses the findings of the various reports from organisations and which makes recommendations for future action. The overview report should be commissioned from a person who is independent of all the organisations and professionals involved.

There are however, budgetary restraints to consider in the choice between an in house or independent report writer. If an in house author is agreed then it is not appropriate for this person to be a current member of the Serious Case Review Panel, or for them to have had any involvement with the child or family or be the line manager of any of the practitioners involved.

8.1 Process for appointing an Independent Reviewer

The Chair of the Serious Case Review Panel in conjunction with the Business Manager and/or the Training Manager for the LSCB will have responsibility for identifying suitable candidates and taking them through an approval process that will include:

- Providing a Curriculum Vitae
- Holding an enhanced CRB clearance
- Providing references from another LSCB for whom the candidate has completed an Overview Report.

In some cases an interview by members of the Serious Case Review Panel may be appropriate.

8.2 Commissioning contract for Independent Reviewer

(this will need to be drafted)

Once an appointment is agreed a contract will be drawn up between the candidate and the LSCB stipulating the conditions for the work and agreeing costs and timescales. The contract will also include:

- Expectations in respect of the recommendations, ie that they will be drawn up with the SCRCP and be tight, relevant and measurable
- Criteria for the Executive Summary and timing of its publication
- How improvements in practice will be reflected in the report
- Involvement with family members
- Distribution of sensitive information
- Any additional work to be commissioned (eg: training materials)
- Arrangements if timescale likely to be delayed or costs likely to increase

The Independent Reviewer will be invited to attend the following meetings:

- Briefing for Single Agency Management Report writers
- Serious Case Review meetings where reports are presented.
- Subsequent meetings of the Serious Case Review Panel where draft versions of the Overview Report are discussed.
- Presentation of report to the LSCB
- and, possibly, to a practitioner debriefing meeting

9 OVERVIEW REPORT

The overview report should bring together and draw overall conclusions from the information and analysis contained in the Single Agency Management Reviews, together with any specialist reports commissioned from other sources. Overview reports should be produced according to the outline attached at **APPENDIX** although, as with single agency management reviews, the precise format will depend on the features of the case. This outline, recommended within Working Together 2006, will be most relevant to abuse or neglect which has taken place in a family setting.

It is likely that there will be additional ‘themes’ or issues identified at the scoping stage which will need to be considered within the report.

Recommendations from the Single Agency Management Reviews should be included in an appendix to the Overview Report.

The Overview Report, including the Executive Summary (see below) and the integrated chronology are required to be formally endorsed by the Local Safeguarding Children Board with all of the single agency management reports. The LSCB will clarify to whom the report, or any part of it, should be made available.

On receiving the overview report, the Chair and members of the SCR Panel will need to ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the overview report. This will include sending Chief Officers of the relevant agencies a copy of the report prior to the LSCB.

The SCR panel will agree a final draft of the Overview report for endorsement by the LSCB and will oversee the preparation of an Executive Summary and associated media strategy.

9.1 Presentation Of Findings To LSCB

The Independent Reviewer will be invited to share the Overview report findings at a combined meeting of the LSCB Strategic and Operational Boards. The Executive Summary and the associated media strategy will also be discussed

9.2 CSCI, DfES and SHA

When the Overview report has been endorsed by the LSCB, the Serious Case Review Panel should ensure that the following documents are sent to CSCI

- Single Agency Management Reviews, including the chronology and recommendations
- The Overview Report
- The Integrated Chronology

- The LSCB Action plan

No information should be made public before the DFES and SHA have received these reports and had the opportunity to brief the Department of Education and Skills and the Department of Health.

9.3 Executive Summary

The Overview Report must contain an Executive Summary. The Executive Summary becomes a public document the primary purpose of which is to inform a wider population of the key elements in the Case Review, namely,

- A brief outline of the review process, including the organisations involved in providing information
- A brief outline of the circumstances that led to the Serious Case Review
- key issues arising from the case
- Recommendation which have been made

Prior to publication the content will need to be made anonymous, in order to protect the confidentiality of family members and others.

Publication of the Executive Summary will need to be timed in accordance with the conclusion of any related court proceedings.

9.4 Media Strategy

A media Strategy must be developed in conjunction with the Executive Summary

10 ACTION PLAN

A central purpose of the Serious Case Review is to secure LSCB ownership of an achievable action plan based on the Overview Report recommendations. The action plan should set out who should do what, by when and with what intended outcome. The plan should set out by what means improvements in practice/systems will be monitored and reviewed.

The Action Plan will be developed by the SCRCP and will include details of the dissemination strategy and the monitoring arrangements.

Once agreed the action plan will contribute to the current LSCB Work Programme and should influence the APA and other agency self assessments where the 'staying safe' outcome is considered

10.1 Monitoring The Action Plans

The Action Plans generated by the single agency and overview reports are the means by which practice is improved and monitoring their implementation is an essential part of the process.

Individual agencies are responsible for implementing the actions arising from their own agency reports and will also have responsibilities arising from the overview report.

The LSCB may have actions arising from the Overview Report (eg development of procedures, training programme etc.).

The SCRCP will take responsibility for drafting the Action Plan associated with the Overview Report and take to the Operations Board for implementation.

Within six months from that meeting the SCRCP will seek an update from

- Individual organisations on their single agency action plan,
- Individual agencies on actions identified within the overview report, and
- the Operations Board on actions relating to LSCB activity

The SCRCP will report to the LSCB within 9 months on progress.

11 REVIEWING INSTITUTIONAL ABUSE

When serious abuse takes place in an institution or multiple abusers are involved the same principles of review apply but these reviews are likely to be more complex, on a larger scale and take longer to complete. Term of reference will need to be drawn up carefully for example if a child had been abused in a school, it would be important to explore what steps had been taken by the school to create a safe environment for children and to respond to the specific concerns raised.

There needs to be clarity in the interface between the different processes of:

- Investigation (including criminal investigations)
- Case Management (including help for abused children)
- Immediate measures (to ensure that other children are safe) and
- Review (learning lessons to reduce risk of reoccurrence)

The different processes should inform each other. Any proposals for review should be agreed with those leading on any criminal investigation, to make sure that they do not prejudice criminal proceedings.

12 WHERE THE CRITERIA FOR SERIOUS CASE REVIEW ARE NOT MET

There may be cases where the Serious Case Review Panel decides that the criteria above is not met, in these circumstances the Panel may considering conducting a case review under the following two categories:

12.1 Interagency Management Reviews (IMRs)

When the SCR Panel decides that a case does not meet the criteria for a Serious Case Review as defined in Working Together (2006), the Chair of the LSCB in consultation with the Serious Case Review Panel may decided that an inter agency management review would be the most appropriate way forward. The scope of the inter agency

management review will be agreed with the Serious Case Review Panel and the work will be carried out by local managers supported by members of the Serious Case Review Panel. An independent author will not be appointed to provide a report, but this does not mean that there will be a reduction in rigorousness of approach. There will however be greater flexibility to construct a process that will maximise learning for agencies and staff. The exceptions to this process would be where the Chair of the LSCB believes there is significant new learning to be gained or high level public interest issues and in those cases a full serious case review will be undertaken. A summary report will be provided to the Serious Case Review Panel and the Operations Board.

12.2 Terms of Reference for the Interagency Management Review

The Serious Case Review Panel will develop draft Terms of Reference focussing on:

- 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?
- Might it help to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
- Over what time period should events be reviewed, i.e. how far back should enquiries cover. What family history/ background information will better help to understand the case?
- Which agencies and professionals should contribute to the review
- Whether family members should be invited to contribute to the review, and if so how?
- Is there a need to involve agencies/ professionals in other LSCB/ACPC areas and what should be their respective role?
- Timescale for completing the Interagency Management Review.

Arrangements for conducting the Inter agency management review and the terms of reference will be circulated to the SCRP

The Inter agency Management Review group will produce a brief report of no more than 12 sides of A4, summarising:

- Basic facts of the case
- Analysis of the interagency working
- Key themes
- Recommendations to improve practice.

The Interagency Management Review Group will be invited to meet with the SCRP to discuss the findings and agree what should be presented to the LSCB for endorsement and action.

12.3 Interagency 'Near Miss' Reviews (NMRs)

Near Miss Reviews are increasingly being seen as providing a speedy and helpful way of improving single or inter - agency practice through looking at what nearly went wrong. The NMR will be facilitated by a member of the SCRIP and will bring together the managers and practitioners involved in the case. A brief report will be presented to the Serious Case Review Panel.

13 CONFIDENTIALITY AND STORAGE

All copies of the overview report will be individually numbered and a record kept of who is responsible for each copy. The report will contain the names of family members, but not the professionals involved. Copies of the report will be collected from LSCB members, after the consultation and endorsement process, unless the LSCB Chair decides differently.

The executive summary, incorporating the action plan, and timetable agreed by the LSCB, will be sent to all members of the LSCB and all Chief Officers involved. It will also be made available to the public via the LSCB website¹.

An archive of all reports and documentation collected during the case review will be maintained securely by the LSCB administrator. Access to the archive can be obtained via the LSCB administrator with the agreement of the LSCB Chair.

If the overview report is to be used in any other circumstances, e.g. training, the LSCB Chair must ensure any necessary amendment to ensure confidentiality. A report amended in this way must have an identifier in the footer.

14 ACCOUNTABILITY AND DISCLOSURE

LSCBs should consider carefully who might have an interest in serious case reviews – e.g.: elected and appointed members of local authorities, health trusts, police authorities; staff, members of the child's family, the public, the media – and what information should be made available to each of these interests. There are difficult interests to balance, among them:

- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others.
- The accountability of public services and the importance of maintaining public confidence in the process of internal review.
- The need to secure full and open participation from the different agencies and professionals involved.
- The responsibility to provide relevant information to those with a legitimate interest, and

- Constraints on sharing information when criminal proceedings are outstanding, in that providing access to information may not be within the control of the LSCB. The Police Superintendent, as representative on the Serious Case Review Panel, will need to notify the officer in charge of the criminal investigation of the existence of the overview report.

It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for de-briefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. It will be the responsibility of the SCRCP to consider potential media involvement in line with the LSCB Media Strategy.

15 LEARNING LESSONS LOCALLY

Serious Case Reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- As far as possible, the serious case review should be conducted in such a way that the process is a learning exercise in itself, rather than a trial or ordeal.
- Consider what information needs to be disseminated, how and to whom, in the light of a review. Be prepared to communicate examples of both good practice and areas where change is required.
- Focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes.
- The LSCB should put in place a means of auditing action against recommendations and intended outcomes.
- Seek feedback on review reports from the CSCI who should use reports to inform inspections and performance management.
- Agree how the action plan will be implemented and monitored.

15.1 Dissemination Strategy

The Serious Case Review Panel must determine how the Overview Report and key findings are disseminated to professionals, the media and if appropriate the family. (See [general dissemination policy at APPENDIX](#))

The details of the dissemination strategy to be included in the Action Plan

The dissemination strategy will include as a minimum

- *A de-briefing meeting for practitioners involved in the case, facilitated by the Chair of the LSCB and possibly involving the Independent Reviewer*
- *Incorporation of lessons into training*
- *Discussion of findings within sub-groups*

- *Presentation of findings to senior management meetings in individual agencies.*

15.2 De-briefing meeting

Following the endorsement of the overview report by the LSCB and the development of an action plan, the practitioners directly involved with the case may be invited to a de briefing meeting. (*pro forma letter 10 in appendices*) The meeting will provide an opportunity to give feedback on the Overview Report, the findings and recommendations, the action plan formulated and the learning.

The meeting will be managed by the chair of the SCR Panel And the Independent Reviewer may be invited to attend

Protocol for the management of Serious Case Reviews between Bedfordshire LSCB and other Local Safeguarding Children Boards

INTRODUCTION

- 1 Serious Case Reviews are by their nature complex processes, bringing together information and analysis from a number of different agencies and distilling from these lessons for future practice. In circumstances where it is clear that a Serious Case Review (SCR) will involve agencies in more than one county, Bedfordshire LSCB is committed to ensuring careful planning and management of the review process. This will minimise the potential for confusion and discord and ensure that lessons can be learned to improve practice.
- 2 When Bedfordshire LSCB takes the decision to conduct a SCR into the death of a child or where there are serious concerns in respect of child living in Bedfordshire and that child has spent significant time in the another County or received services from that County, we agree to the following sequence of events.
- 3 The Chair of the LSCB commissioning the Review will inform the Chair of the other LSCB and the respective Chairs will agree whether the SCR will be conducted as:
 - a. A single LSCB review with limited input from the other LSCB
 - b. A joint SCR where members of each SCR Panel work together as an expanded panel.
- 4 This decision will depend on the complexity of the case and the degree of involvement of each partnership. Should the Chairs be unable to agree, the matter will be referred to Chief Executives and/or CSCI for a final decision.

WHEN A SINGLE LSCB SERIOUS CASE REVIEW WITH LIMITED INPUT FROM THE OTHER LSCB/ACPC HAS BEEN AGREED

- 5 In the event of a SCR commencing under the auspices of a single partnership (see a. above), the two Chairs will remain in close contact. Should it become apparent that there are significant issues emerging for the partnership that is not managing the process, the Terms of Reference will be reviewed and the option to move to a more joint arrangement will be agreed?

WHEN A JOINT SERIOUS CASE REVIEW HAS BEEN AGREED

Set up Arrangements

- 6 In view of the likely differences in process between Bedfordshire LSCB and other LSCB's the arrangements for a SCR should be clearly specified, with written Terms of Reference agreed and presented to each LSCB. The Terms of Reference should include the following:

- The membership of the joint SCR Panel, drawn from both LSCB's and including those with specialist knowledge relevant to the case.
- The agencies who will be asked for single agency management reports
- The scope of the Review – see Appendix One
- Timescales
- Process to be followed
- Format of reports and chronology

7 The following arrangements should also be agreed at this point.

- Administrative support to the process
- How the Independent Reviewer will be identified and how the SCR Panels will work with them.
- Joint agreement about the legal framework for the review. Each LSCB/ACPC is likely to seek its own legal advice and a joint position will need to be negotiated.
- Arrangements for an initial meeting to consider media implications and how to manage this process.

Matters to be agreed by both LSCB's towards the end of the process:

8 By this stage the joint SCR Panel will have a good understanding of the central issues of the case and should be in a position to make careful arrangements to ensure that the following events take place:

- Opportunity for the joint SCR Panel to consider and agree the factual accuracy of the Overview Report
- Opportunity for both LSCB's to discuss findings and recommendations with the Independent Reviewer
- Drafting of the Executive Summary – to be jointly agreed by both LSCB's.
- Agree a joint briefing for Chief Officers from each county.
- Agree a Media Strategy at a joint meeting with Press Officers, LSCB Chairs and relevant Chief Officers.
- Debriefings for staff
- Arrangements to inform CSCI

Debriefing

9 Following a Serious Cases Review the Chairs will arrange to meet with the professionals who have been involved in the process to address any outstanding issues.

BEDFORDSHIRE LOCAL SAFEGUARDING CHILDREN BOARD
Serious Case Review Chronology

Agency:

Name of person completing chronology:

PLEASE complete the chronology as a single long list, not as a series of separate pages.

PLEASE include enough detail for the reader to know what happened. It is not helpful simply to put something like 'Meeting with X'. The reader needs to know what went on at the meeting (what was discussed and what decided, for example). Without such information, no judgement is possible.

PLEASE include single complete dates in the DATE column. Do not include periods (from – to -), or incomplete dates (must be day, month and year). For periods, use either the start date or the end date, whichever would be more useful, and indicate the period in the body of the text. If an exact date is not known, guesstimate and note in the text 'exact date not known'. Do not include time of day in this column; put it in the text.

PLEASE DO NOT use 'ditto' signs of any kind to indicate 'same as above' since your rows will not be kept together when all the chronologies are integrated.

DATE	<i>CONTACT WITH CHILD (inc direct contact, medical information, reports, observations)</i>	CONTACT WITH PARENTS/CARERS and other family members	INTER/INTRA-AGENCY COMMUNICATION Internal / interagency phone calls/letters etc	SOURCE OF RECORD	STAFF INVOLVED List initials of those involved and provide a separate ID list	COMMENT Opportunity for author to clarify or explain information or to raise queries.

Information leaflet for practitioners
 Information leaflet for families

Barbara Trevanion
 Chair of LSCB
 August 2006