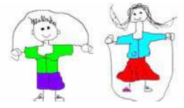
Luton
Safeguarding
Children
Board

LSCB
Bedfordshire

Working Together
to Safeguard Children



Luton & Bedfordshire Local Safeguarding Children Boards

Working together to safeguard children

Toolkit for Individual Management Review Authors (IMR)

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Glossary

LSCB	Luton Safeguarding Children Board
BLSCB	Bedfordshire Local Safeguarding Children Board
SCR	Serious Case Review
ESCRP	Executive Serious Case Review Panel (Beds)
SCRPG	Serious Case Review Project Group (Beds)
SCRP	Serious Care Review Panel (Luton)
IMR	Individual Management Review
IPR	Individual Practice Review
NMR	Near Miss Review
SHA	Strategic Health Authority
DSCF	Department of Children Schools and Families
TOR	Terms of Reference

This toolkit has been developed from Hertfordshire IMR procedures and information from the GO East Offices, Diana Madden.

This toolkit is intended to offer additional guidance to professionals who have been asked to write an Individual Management Review (IMR) as part of the Serious Case Review process. This toolkit should be read alongside Working Together to Safeguard Children (2006) chapter 8, Luton or Bedfordshire Safeguarding Children Board Safeguarding Interagency Procedures and Luton or Bedfordshire Serious Case Review Process, all these can be accessed at www.bedfordshirelscb.org.uk/publications or www.luton.gov.uk/safeguardingchildren

If at any time during the process you need further assistance please do not hesitate to contact the LSCB or BLSCB Business Manager below.

Contact details

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Laura Eades Independent Chair BLSCB
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Catherine Barrett, Business Manager Luton SCB
Geoff Gildersleeve, Independent Chair Luton SCB
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1. Role and responsibilities of the Individual Management Review Author

1.1 The Individual Management Review (IMR) Author must be of sufficient seniority to be able to work at all levels within your agency. The IMR Author must be fair in the way that the views of staff are represented. The IMR Author should be familiar with current child protection practice and is expected to produce an independent and objective report within prescribed timescales in accordance with national guidance.

1.2 The IMR Author will have had no significant involvement in the case under review and should not be the direct line manager of their agency representative on the Serious Case Review Panel (Luton – SCRP) or Executive Serious Case Review Panel (Bedfordshire – ESCRP).

1.3 The IMR Author prepares the report for their agency and is accountable to the Chief Executive for the quality of the report. The report is submitted as an agency report.

1.4 The IMR Author should have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the IMR Author will wish to interview staff that are central to the case. Staffs who wish to be interviewed should be offered this opportunity by the IMR Author. Such interviews should be allowed.

1.5 The IMR Author must ensure that the relevant staffs of their agency are informed of the purpose of the IMR and the process leading to the SCR. The attached Questions and Answers leaflet on page 35 should be given to the interviewee.

1.6 The IMR Author should ensure that all files relating to (child's name) are secured, preferably under lock and key, to ensure information is not lost. The IMR Author should be empowered to demand appropriate security measures are taken. If the case remains open then a full copy of the file should be taken and the original file secured. All files should be made available to the IMR Author.

1.7 The IMR Author shall identify and indicate the location of all files relating to child (ren) and make these files available to the SCRP or ESCRP on request.

1.8 The compilation of the IMR report will create a significant extra workload. The IMR Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the IMR report within the strict time scale. The IMR Author should receive appropriate clerical support throughout. It may be necessary for the IMR Author to be relieved of all their normal duties for the period the IMR report takes to compile.

2. What should I do first?

2.1 Firstly you need to read Luton Safeguarding Children Board (LSCB) or Bedfordshire Local Safeguarding Children Board (BLSCB) Serious Case Review (SCR) process this will help to clarify both the process and the purpose of a SCR. Working Together 2006 (chapter 8) and the LSCB or BLSCB Interagency Safeguarding Procedures and Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1st April 31st March 2008 which can all be downloaded at www.bedfordshirelscb.org.uk/publications.
www.luton.gov.uk/safeguarding

3. What is the purpose of a Serious Case Review?

3.1 The purpose of a SCR 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. Through this process we will identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result. As a consequence, it is expected that the process will help us to improve interagency working and better safeguard and promote the welfare of children. Serious case reviews are not inquiries into how a child died or who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate.

4. When should a Serious Case Review be undertaken?

4.1 A 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. This is irrespective of whether LA children's social care is, or has been, involved with the child or family.

4.2 A LSCB should always consider whether to undertake a serious case review where a child 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, **and** the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children. This includes situations where a parent has been killed in a domestic violence situation, or where a child has been killed by a parent who has a mental illness.

4.3 Any professional may refer such a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case. In addition, the Secretary of State for the Department for Education and Skills has powers to demand an inquiry be held under the Inquiries Act 2005.

4.4 The following questions may help in deciding whether or not a case should be the subject of a serious case review in circumstances other than when a child dies. The answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons.

- Was there clear evidence of a risk of significant harm to a child that was:
  - not recognised by organisations or individuals in contact with the child or
  - perpetrator **or**
  - not shared with others **or**
  - not acted on appropriately?

- Was the child killed by a mentally ill parent?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre, YOI, STC, children's home or Armed Services training establishment)?
- Did the child die in a custodial setting (prison, Young Offenders' Institution or Secure Training Centre)?
- Was the child abused while being looked after by the local authority (LA)?
- Did the child commit suicide, or die while absent having run away from home?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?

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

5. Where the criteria for Serious Case Review are not met.

5.1 There may be cases where the SCRP/ESCRP decides that the criteria above are not met in these circumstances the SCRP/ESCRP may consider conducting a case review under the following two categories:

5.2 Individual Practice Reviews (IPRs)

When the SCRP/ESCRP decides that a case does not meet the criteria for a SCR as defined in Working Together 2006 (page 170 8.5 – 8.9) the Chair of LSCB/SCRP or BLSCB/ESCRP may decide that an Individual Practice Review (IPR) would be the most appropriate way forward. The scope of the IPR will be agreed with the SCRP/ESCRP and the work will be carried out by local managers supported by members of the SCRP/ESCRP. An independent author will not be appointed to provide a report, but this does not mean that here 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 LSCB/BLSCB believes there is significant new learning to be gained or high level public interest issues and in those cases a full SCR will be undertaken. A summary report will be provided to the SCRP/ESCRP and the Strategic Board.

5.3 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 SCRP/ESCRP and will bring together the managers and practitioners involved in the case. A brief report will be presented to the SCRP/ESCRP. For further information please access www.bedfordshirelscb.org.uk/publications for the Near Misses process.

6. The aims of Individual Management Reviews

6.1 As the author of the IMR you will not have any line management responsibility for the case, team or individual worker involved in the case

6.2 IMR's should 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 (Working Together 8.22).

6.3 SCR's are not enquiries into how a child died or who is culpable, the review, including the writing of IMRs, should be conducted in such a way that the process is

a learning exercise. IMR's need to look at the underlying causes e.g capacity of frontline services, quality of management oversight and support and the culture within the team, service and agency.

6.4 It is expected that the IMR Authors will interview relevant staff involved in the case, keep a record of these interviews and ensure both the interviewer and interviewee sign the record of the interview. For further guidance on interviewing please **see page 17 appendix 2**.

7. Content of Individual Management Reviews

7.1 You will be given a template to follow when writing your IMR and it is important to ensure that you adhere to this so that the necessary topics are covered, **see page18 appendix 3**.

7.2 You will also have a copy of the Terms of Reference (TOR) for the case and you should ensure that you address these within your review. These will also contain a timescale detailing from which dates you should start and finish to critically analyse your agency's involvement and it is imperative that these timescales are adhered to.

7.3 Make sure that you include a genogram of the family make up as far as your agency understands it, including grandparents, other significant adults and friends. This pack contains guidance on drawing a genogram, **see page 22 appendix 4.** It is also important to record where agencies missed opportunities to see/ascertain a child's wishes and feelings.

7.4 You will be given a standard format for compiling your chronology, **see page 26 appendix 5**. It is important that you complete this using the format provided as this will assist the LSCB Team when amalgamating all the chronologies. Ensure that the chronologies tell the reader who knew what and when, are explicit as to when the child was seen, what their condition was, and what they said. Missed opportunities to see and speak to the child should also be recorded.

7.5 It is important that the IMR contains an analysis of practice within the case and not just an outline of what happened. You are required to provide a detailed analysis of the actions of individual staff members and an honest self-appraisal on their part as to why they acted in the way they did and communicate this to the reader.

7.6 You will also need to make recommendations on behalf of your agency. Ensure that they are realistic, based on the information contained within your report and that your agency is ready to implement them without delay. Recommendations need to be

S - Specific
M - Measurable
A - Achievable
R - Reasonable
T – Timely

8. Legal advice

8.1 IMR Authors should always consider whether they should obtain advice from their own legal advisors on their draft reports before submitting them. If the content of a report is substantially affected by legal advice it will be helpful to state this. However

ESCRP recognise that legal advice is privileged information and agencies are not under any obligation to disclosure their own legal advice.

8.2 During the course of an IMR the Author may find that legal advice given to the agency is closely associated with significant issues arising from the case. In such circumstances the IMR Author should invite the agency's legal advisers to submit a report to be appended to the IMR report. Any report dealing with legal issues should be prepared by a lawyer with no direct involvement in the case under review; and, with no involvement in the provision of legal advice about that case to the SCRPG.

8.3 Where any in house legal services has had substantial involvement in the case before the event which triggers the SCR, there may be a need to examine that involvement in the SCR. This would normally be done as part of an IMR. If there are concerns of conflicting interests, the BLSCB should consider if it is possible for legal advice from a neighbouring authority to be sought. In the event of Legal Services undertaking an IMR, the Director of Children's Services must give permission for legal professional privileged to be waivered.

9. Gathering information

9.1 Base your report on the standard template and any additional headings agreed which is specific to the case, but do not be constrained by it if you want to include additional information that doesn't seem to fit as long as it is directly relevant to the case.

9.2 Hold internal discussions and interviews and include the results of this in the report. Make sure that any discussions you have with staff are recorded and signed by both yourself and the member of staff.

9.3 Refer to the original files. These should have already been secured by your agency. Photocopies of files should be made where a case remains open – with the photocopies being returned to the case worker, and the originals used for the purpose of the SCR.

9.4 You **MUST** ensure that your review and recommendations are approved and signed off by the appropriate senior manager from your organisation, this should be at Chief Executive / Director level.

9.5 All IMR's are now sent to Ofsted, along with the Overview report for their consideration and evaluation. Because of this, you will find Standards for IMR'S document on **page 36** and the Descriptors for the Evaluation of SCR's on **page 30** this will show you what is being considered when the IMR and Overview Report are being evaluated. All IMRs will be expected to conform to these standards. If an IMR falls short of these, the report will be returned for further work, with guidance as to how it needs to be improved. IMR Authors need to be aware that meeting the tight timescales is imperative.

9.6 Please ensure that all names are anonymised throughout your report with a glossary appended to the report.

10. Writing the report - guidance

- Ensure that the IMR explicitly relates to the TOR.

- Construct a comprehensive chronology (using the template provided) of involvement by the organisation and/or professional(s) in contact with the child over the period of time set out in the review's terms of reference. Summarise decisions reached, the services offered and any other action taken.

- Write reflectively, analytically and evaluative.

- Think about the reader of the report, and 'talk the reader through the process of finding the information and writing the report'. If additional information is needed once the IMRs have been written and submitted to the SCRP/ESCRP, then ensure that the explanation as to why that was done is included and added to the report. Appendices to the report can be added to capture the processes followed.

- Your report should clearly differentiate between recorded fact, opinion and third party information.

- Your analysis should not consist of a rewording of the chronology. It is important to critically analyse your agency's involvement.

- Consider the events that occurred, the decisions made or not made, and the actions taken or not. Where judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.
- It is important that you reach an opinion about what happened in your agency and communicate this to the reader. Make sure that if you are stating your opinion, you clearly state that this is your opinion. Make a judgement of the practice and identify inadequate practice.

- Critically appraise the practice found. Identify poor practice as unacceptable, why these failings in practice took place and what issues contributed to that – for example staffing, training, audit and supervision/management – and suggest their relative importance. Consider alternative courses of action and what would have made a difference to the child.

- Identify and report good practice.

- Remember that the SCR is about a child/children/young person.

- Ensure that you address the issues of ethnicity, linguistic, religion and culture within the IMR.

- Help the reader to understand what life was like for that individual child.

- Help the reader understand
  - i) the child's views, wishes and feelings
  - ii) the child's development and progress
  - iii) the child's relationships and interaction with their carers (some agencies will be in a better position than others to assist with this)

- Recognise that interviews may reveal information that is not in the records.

- Identify the missed opportunities for understanding the child's view.

- Consider the Standards for Individual Management Reviews **on page 36.**

11. Analysis of involvement – guidance

11.1 Within your analysis you will want to consider specifically:

• Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?

• Did the agency have in place policies and procedures for safeguarding children and acting on concerns about their welfare? If these were not followed then provide an analysis of why staff failed to follow basic procedures.

• 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/provided, or relevant enquiries made, in the light of assessments?

• Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing procedures complied with?

• When, and in what way, were the child (ren)'s wishes and feelings ascertained and considered, were there missed opportunities? Was this information recorded? It is likely that every child (ren) subject to a SCR/IMR will have had social exclusion issues.

• Was practice sensitive to the racial, cultural, linguistic, disabilities and religious identity of the child and family? If these issues have not been addressed in the IMR it will be returned for this to be included.

• What was life like for that individual child? The child's development and progress, child's relationship and interaction with their parent/carers.

• Were more senior managers, or other agencies and professionals, involved at points where they should have been?

• Was the work in this case consistent with agency and LSCB/BLSCB policy and procedures for safeguarding children, and wider professional standards?

• Did resource issues impact significantly on the services provided?

12. What do we learn from the case?

12.1 It is important to consider whether there are lessons from this case for the way in which your agency works to safeguard children and promote their welfare? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single and interagency); management and supervision; agency self audit: working in partnership with other agencies; resources, staffing issues and the culture within the team/service/department?

13. Recommendations for action

13.1 Finally, you will need to consider what action should be taken by whom, and by when? What outcomes should these actions bring about and how will your agency evaluate whether they have been achieved? The recommendations must be written in such a way as to inform a meaningful and achievable action plan for your agency.

13.2 Take care to ensure that recommendations include either proposed action or action already taken, who is responsible and the timescales involved.

13.3 The report should then be signed off by your Chief Executive with their name and job title printed underneath. The recommendations should be accepted by the agency and if any actions/recommendations become obvious then they should be implemented without delay and recorded that this has been done in the IMR and in the SCRP/ESCRP/SCRPG minutes.

14. Presenting the Individual Management Review

14.1 Following completion of the IMR you will be invited to a meeting with the SCRP/ESCRP to present your report. Members of the Panel will have received your report and read it prior to the meeting.

14.2 This will be an opportunity for dialogue between you, the SCRP/ESCRP and the Overview Report writer and is an important step in compiling and assessing information.

14.3 IMR Authors will be asked to individually present their reports, highlighting any key themes or findings and discussing any changes already made within the agency.

14.4 There will also be an opportunity for asking questions which may have arisen from the content of the report.

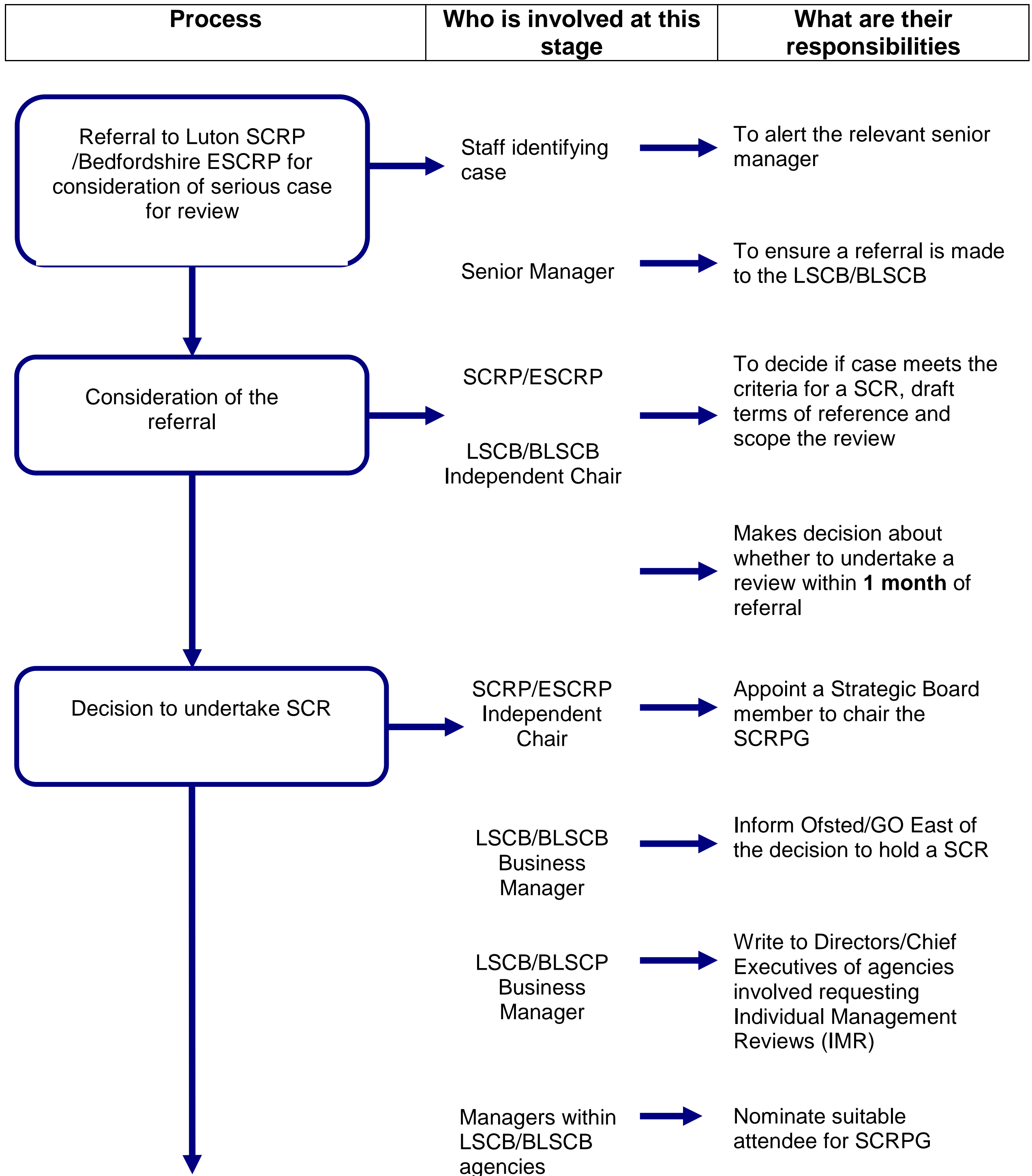
14.5 You may find that the SCRP/ESCRP request further information from your agency, or clarity if there are discrepancies between IMR's. You will be given clear guidance as to what is being asked for and by when it should be returned.

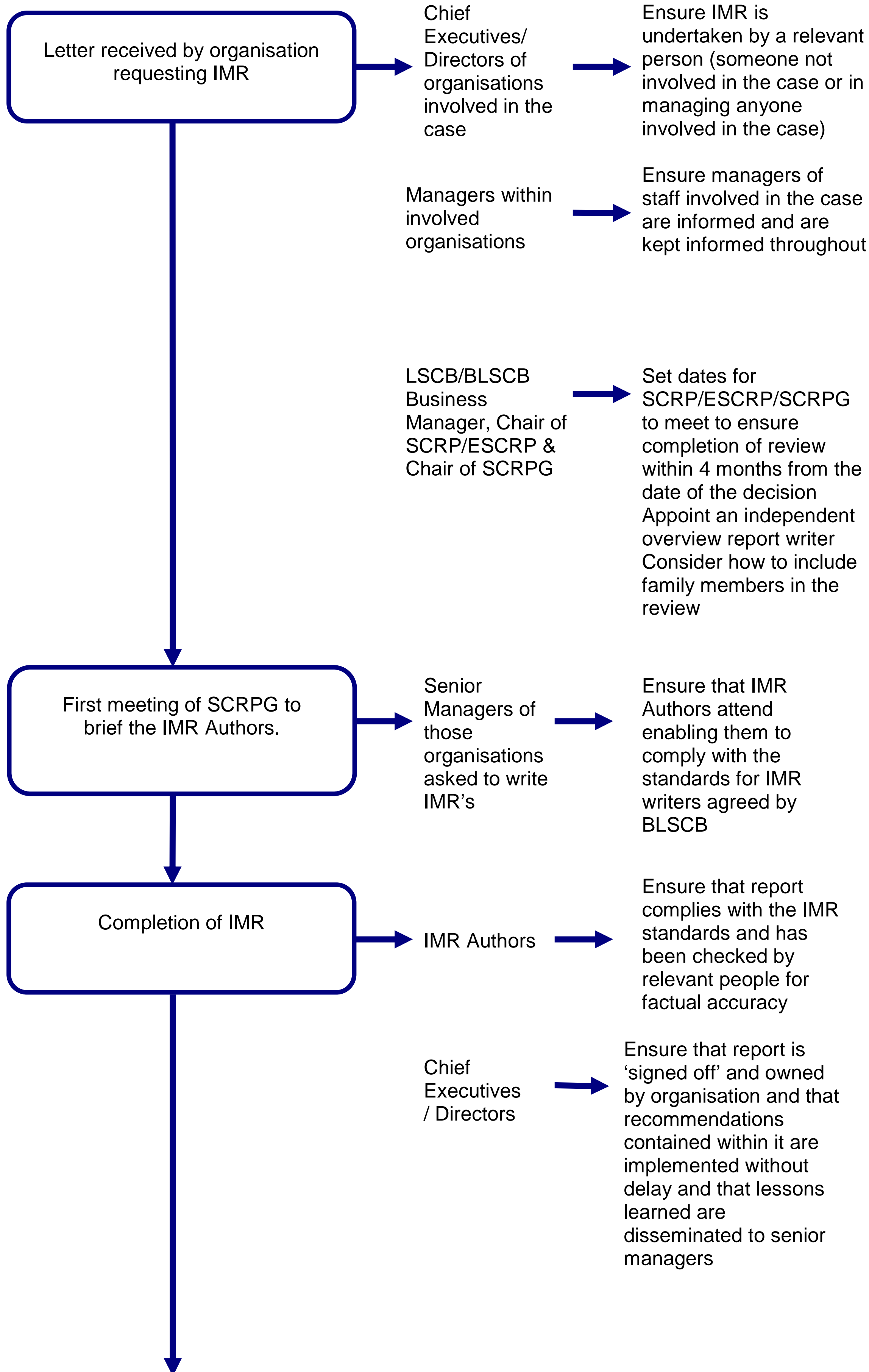
14.6 Information and analysis contained within the IMRs will be drawn together within the Overview Report. This will be written by an independent author who does not belong to any of the agencies involved in the case.

14.7 All recommendations contained within IMRs will be included in the Overview Report as an addendum, and each agency has responsibility for implementing their own recommendations. The SCRP/ESCRP will want to add some multi-agency recommendations and the LSCB/BLSCB will monitor and evaluate the impact of these.

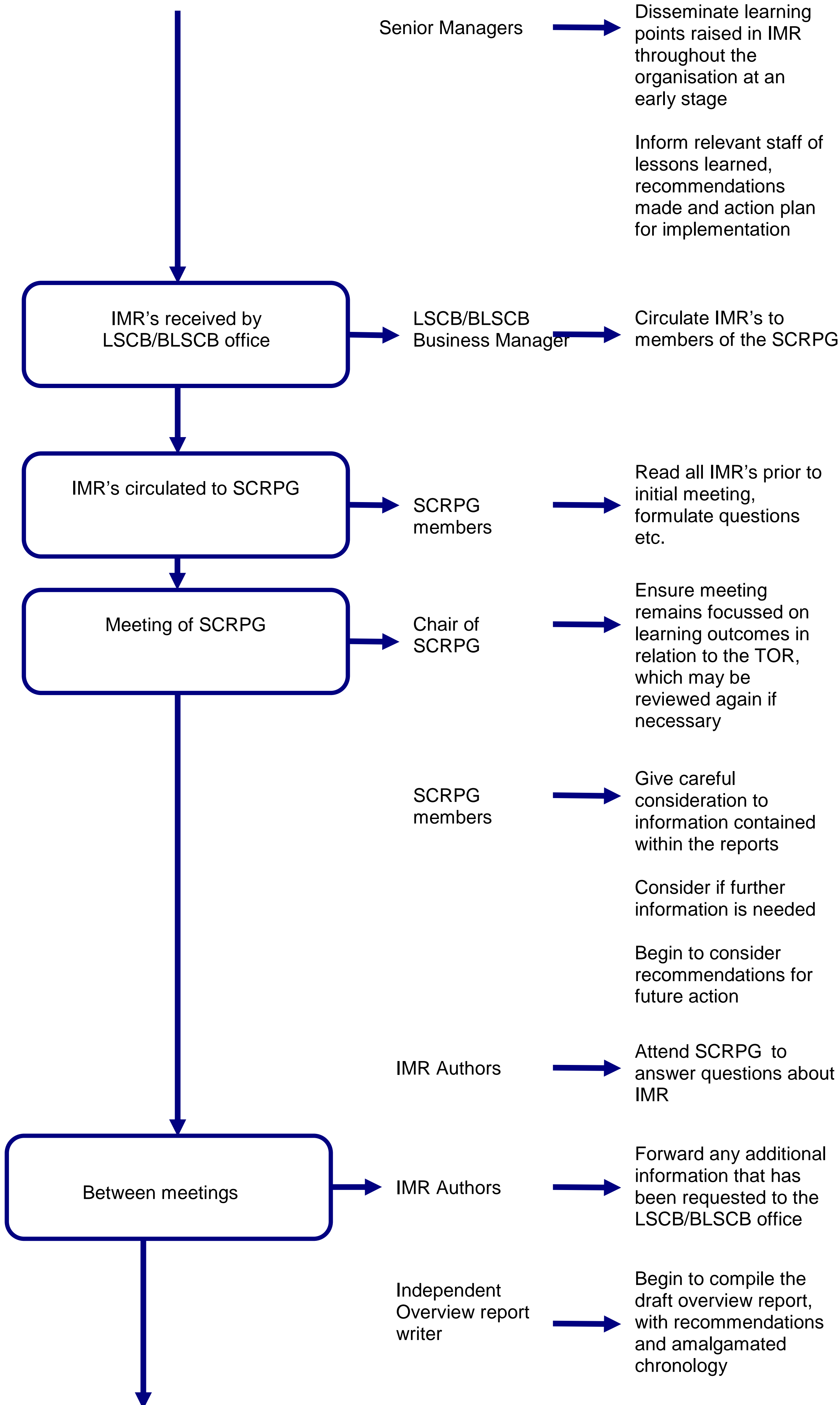
Appendix 1 - Responsibilities of those involved in Serious Case Reviews

Process	Who is involved at this stage	What are their responsibilities

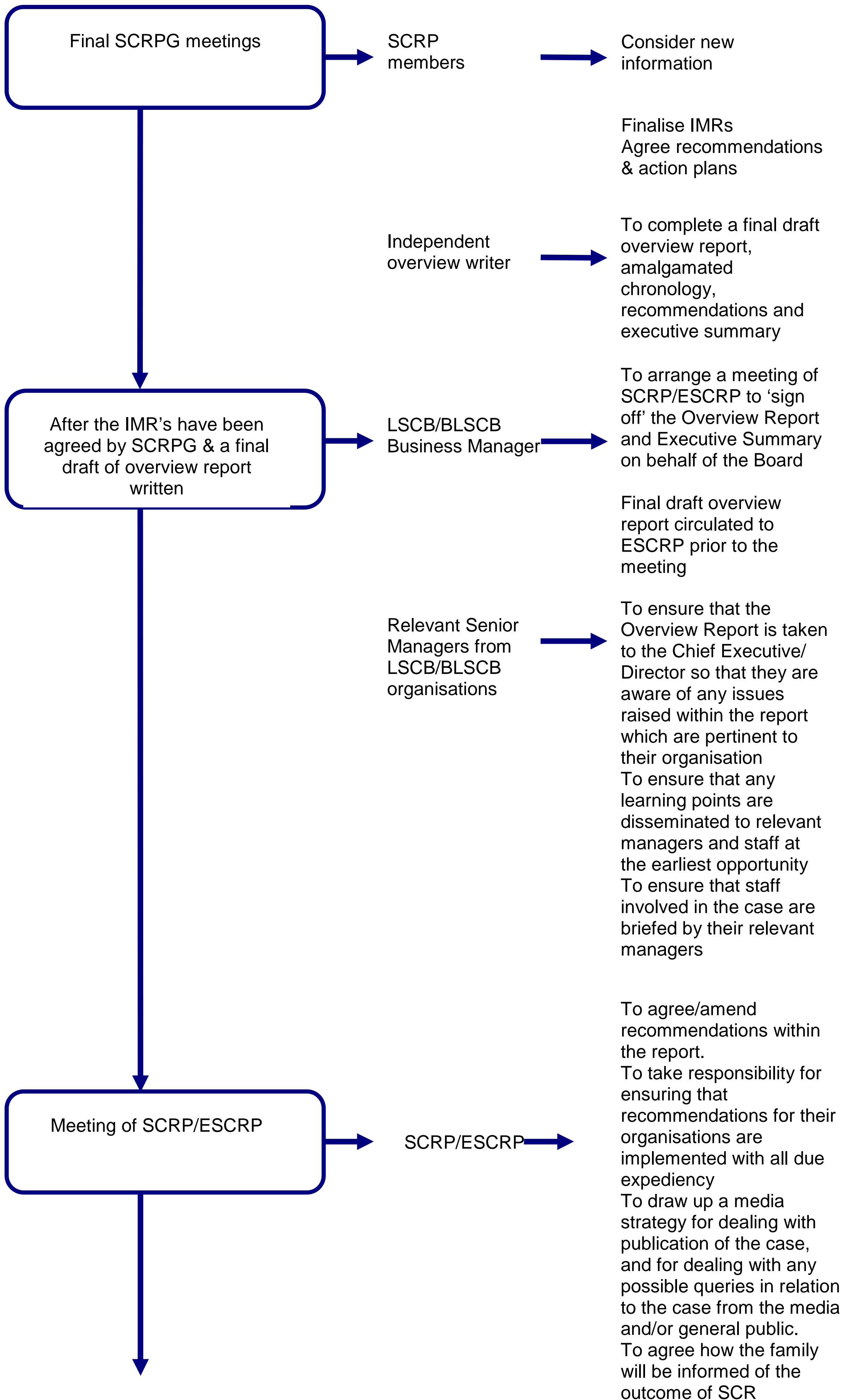


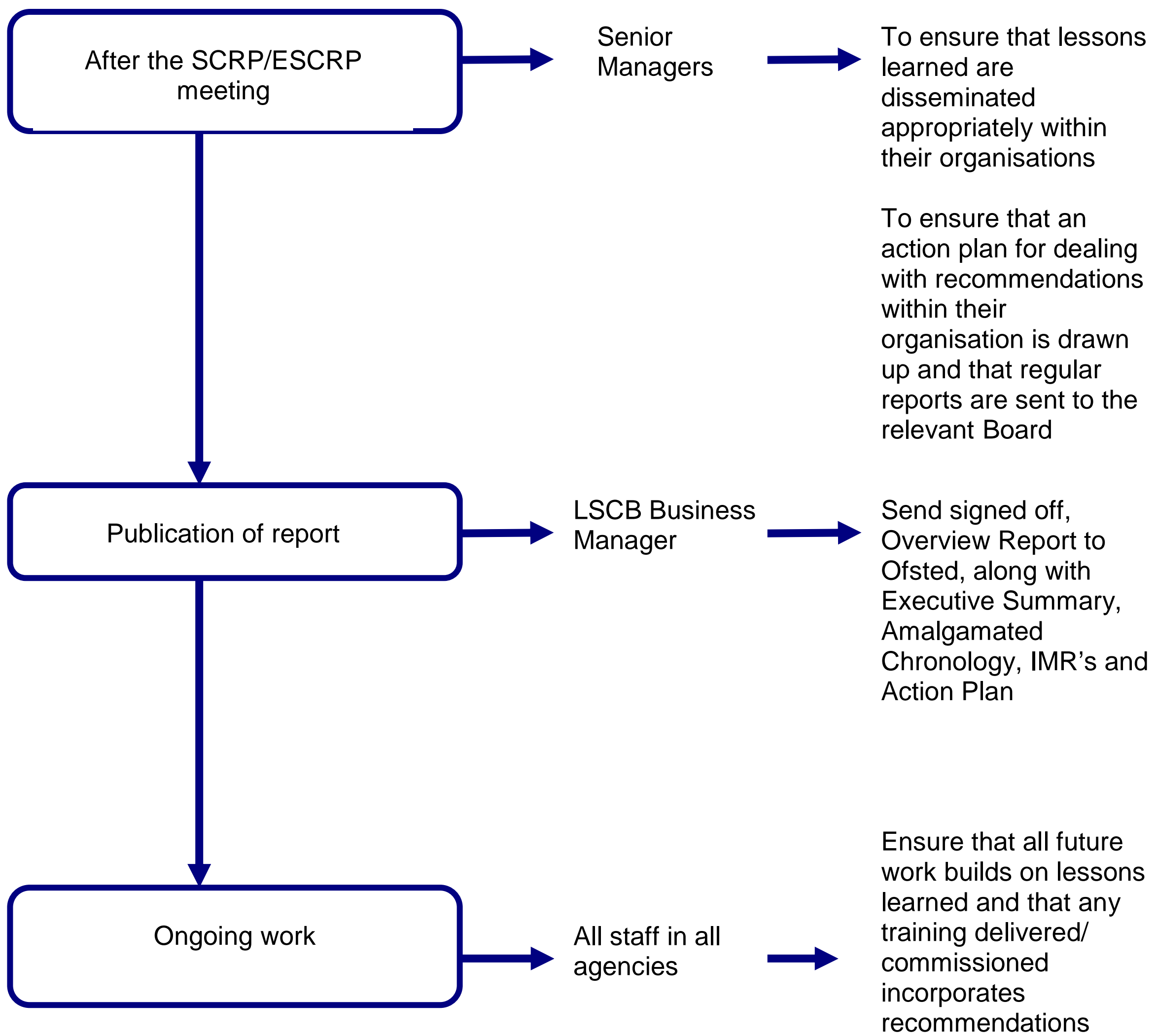


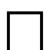
Letter received by organisation requesting IMR
Chief Executives/ Directors of organisations involved in the case
Ensure IMR is undertaken by a relevant person (someone not involved in the case or in managing anyone involved in the case)
Managers within involved organisations
Ensure managers of staff involved in the case are informed and are kept informed throughout
LSCB/BLSCB Business Manager, Chair of SCRP/ESCRP & Chair of SCRPG
Set dates for SCRP/ESCRP/SCRPG to meet to ensure completion of review within 4 months from the date of the decision
Appoint an independent overview report writer
Consider how to include family members in the review
First meeting of SCRPG to brief the IMR Authors.
Senior Managers of those organisations asked to write IMR's
Ensure that IMR Authors attend enabling them to comply with the standards for IMR writers agreed by BLSCB
Completion of IMR
IMR Authors
Ensure that report complies with the IMR standards and has been checked by relevant people for factual accuracy
Chief Executives / Directors
Ensure that report is 'signed off' and owned by organisation and that recommendations contained within it are implemented without delay and that lessons learned are disseminated to senior managers



Senior Managers
Disseminate learning points raised in IMR throughout the organisation at an early stage
Inform relevant staff of lessons learned, recommendations made and action plan for implementation
IMR's received by LSCB/BLSCB office
LSCB/BLSCB Business Manager
Circulate IMR's to members of the SCRPG
IMR's circulated to SCRPG
SCRPG members
Read all IMR's prior to initial meeting, formulate questions etc.
Meeting of SCRPG
Chair of SCRPG
Ensure meeting remains focussed on learning outcomes in relation to the TOR, which may be reviewed again if necessary
SCRPG members
Give careful consideration to information contained within the reports
Consider if further information is needed
Begin to consider recommendations for future action
IMR Authors
Attend SCRPG to answer questions about IMR
Between meetings
IMR Authors
Forward any additional information that has been requested to the LSCB/BLSCB office
Independent Overview report writer
Begin to compile the draft overview report, with recommendations and amalgamated chronology


Final SCRPG meetings
SCRP members
Consider new information
Finalise IMRs
Agree recommendations & action plans
Independent overview writer
To complete a final draft overview report, amalgamated chronology, recommendations and executive summary
After the IMR's have been agreed by SCRPG & a final draft of overview report written
LSCB/BLSCB Business Manager
To arrange a meeting of SCRP/ESCRP to 'sign off' the Overview Report and Executive Summary on behalf of the Board
Final draft overview report circulated to ESCRP prior to the meeting
Relevant Senior Managers from LSCB/BLSCB organisations
To ensure that the Overview Report is taken to the Chief Executive/ Director so that they are aware of any issues raised within the report which are pertinent to their organisation
To ensure that any learning points are disseminated to relevant managers and staff at the earliest opportunity
To ensure that staff involved in the case are briefed by their relevant managers
Meeting of SCRP/ESCRP
SCRP/ESCRP
To agree/amend recommendations within the report.
To take responsibility for ensuring that recommendations for their organisations are implemented with all due expediency
To draw up a media strategy for dealing with publication of the case, and for dealing with any possible queries in relation to the case from the media and/or general public.
To agree how the family will be informed of the outcome of SCR


After the SCRP/ESCRP meeting
Senior Managers
To ensure that lessons learned are disseminated appropriately within their organisations
To ensure that an action plan for dealing with recommendations within their organisation is drawn up and that regular reports are sent to the relevant Board
Publication of report
LSCB Business Manager
Send signed off, Overview Report to Ofsted, along with Executive Summary, Amalgamated Chronology, IMR's and Action Plan
Ongoing work
All staff in all agencies
Ensure that all future work builds on lessons learned and that any training delivered/ commissioned incorporates recommendations



Appendix 2
Interview Format

It is suggested that it may be helpful for Authors to use the following format when conducting interviews in the process of compiling the IMR. DETAILS OF CONTRIBUTOR (to be completed as a preamble to the discussion on the case)

Full name:
Qualifications:
Designation:
Time in post:
Employing Body:
Employing Address:
Home Address:
(where appropriate)
Previous Employment:
Employer Dates Posts held
Description of role in relation to particular case:

MATTERS TO BE COVERED IN INTERVIEWS (to be used in conjunction with the chronology of the case to check facts, to discuss the contributor's specific participation and the time scale of their involvement).

Explore with the contributor:-

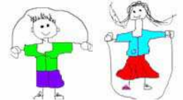
- Their knowledge of the history of the case, the child(ren) and family prior to the individual's involvement;
- Their specific involvement in the case;
- Their knowledge of the agency's policy and procedures in relation to child care and child protection;
- Their knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to CP conferences;
- Methods used to relate to / communicate with other professionals in the case;
- The individual's record keeping;
- The supervision the individual received;
- The individual's feelings about the case, the carer or child and how those feelings were dealt with in supervision;
- The range of training both within and outside the agency in the last two years;
- Whether the agency can learn lessons from the experience;
- Looking back, what the individual would now do differently;
- What lessons the individual can learn from the experience.

Following the interview, it is suggested that the IMR Author writes an interview summary, a copy of which should be handed to the interviewee who, if in agreement, should sign both copies. Where there is disagreement on the content of the summary, this should be identified and noted.

The interview summaries are not required by the ESCRP but are purely to assist in the preparation of the IMR and may be shredded at the end of the process (7 years after completion of the SCR).

Appendix 3

Working Together
to Safeguard Children



Bedfordshire Local Safeguarding Children Board

Working together to safeguard children

Interagency Management Review on Child…………..

This page must be completed by the IIMR Author and Chief Officer/Chief Executive/Director of your agency, prior to submission to the Executive Serious Case Review Panel or Serious Case Review Panel.

Name of Child (ren) subject of SCR:

Date of Birth:

Date of Death:

Agency providing the report:

IMR Author:

Evaluation statement on behalf of agency:

- The IMR conforms to the LSCB 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:
  - Comprehensive
  - Well-structured
  - Includes good analysis of the information
  - Provides explanations for any practice which may be of concern
  - Places emphasis on key findings and lessons
  - 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 Executive Serious Case Review Panel or Serious Case Review Panel.

Signed:……………………………………………………Date……………….

Name……………………………………………………….

Title…………………………………………………………………………..
Chief Officer/Chief Executive/Director responsible for signing off the IMR report.

CONTENTS	PAGE
Genogram	
Introduction	
Summary of agency involvement	
Analysis of key issues	
What do we learn from this case?	
Key recommendations for action	
Chronology	
Appendices	

Terms of Reference: --

Contextual Information

In considering this aspect of the case, the IMR Author needs to decide whether the context in which the case was conducted impacted on decisions made and if so such information need only be included in so far as it is relevant to the actions of the organisations concerned.

In addition to interviews with staff and examination of agency files, the ESCRP will examine contextual information supplied by IMR Authors in order to fully understand the circumstances of the case to make the appropriate recommendations for change. The IMR Author should be able to evidence any assertions made possibly through policies, operational practice at that time, professional / management judgement or research.

Most weight should be given to primary information, although secondary and anecdotal information can be considered, but clearly identified as such and given less weight.

The type of information that would be useful is as follows.

- Volume of work
- Staff turnover, sickness, leave cover and level of permanent/agency staff
- Administrative support

- Organisational change
- Culture in the team, service & department
- Relationships within the team, service & department
- Levels of grievance and capability within the team, service & department
- Unallocated cases
- The social and community context
- Management and Supervision
- Qualitative audits of practice & any relevant practice evidence from audits
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training of the staff involved in the case, with dates, level of training & title of course
- Legal Advice

This is not an exhaustive list and there may be other contextual factors that IMR Authors would wish to include.

Methodology

A bullet point list to identify:

a) Documents seen.
b) Interviews and dates.
c) Information not available/not considered (with reasons).
d) Details of staff involved by name and job title for the benefit of the SCRPG only. **All reports will be completely anonymised, no names of child/ren, families or professionals.**

Genogram

Summary of Facts

Construct a relevant summarised chronology (in narrative form) on child, family and any significant others which could have a bearing on the case and time frame under review. Briefly summarise decisions reached, the services offered and/or provided to the child (ren) and family, and other action taken.
This is not intended to be a repeat of the chronology, but will provide a summary of the information to add a context to the analysis contained within the next section of this report.

Analysis of Involvement

Consider the events that occurred, the decisions made or not made, and the actions taken or not. Where judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider specifically:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
- Did the organisation have in place policies and procedures 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/provided or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection, child in need or care plans in place, and child protection, child in need and/or looked after reviewing processes complied with?
- When, and in what way, were the child (ren)'s wishes and feelings ascertained and taken account of when making decisions? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers, or other organisations and professionals involved at points where they should have been?
- Was the work in this case consistent with each organisation's and the Slab's policy and procedures for safeguarding and promoting the welfare of children, and wider professional standards?

Detailed factual chronology (see page 25)

To include inter-agency contact following the specified format that will be provided electronically.

What Do We Learn From This Case?

Answer the following questions:

- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and interagency); management and supervision; culture within the team. Service, department: working in partnership with other organisations; resources: staffing issues?

Recommendations

These should include:-

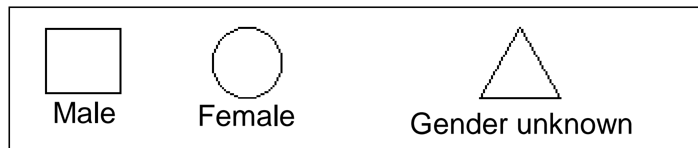
- What changes (if any) could be made to the agency's safeguarding procedures?
- What changes (if any) could be made in inter-agency working in the light of this case?
- What action within the agency should be taken in the light of its findings?
- What areas of good practice are there? Could these be expanded?
- What action should be taken by whom and by when?
- What outcomes for children should these actions bring about?
- How will the agency review/audit whether they have been achieved?

Appendix 4

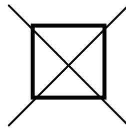
Guidance on drawing a genogram

A genogram is a way of representing a family tree and relationships within the family.

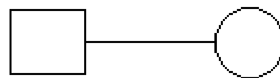
The following symbols are used to represent the gender of family members



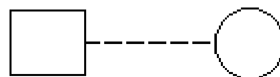
If a family member is deceased, this is indicated by placing a cross through their symbol:



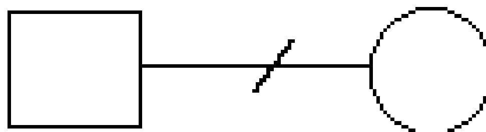
Enduring relationships, such as marriage and cohabitation, are illustrated by a single unbroken line:



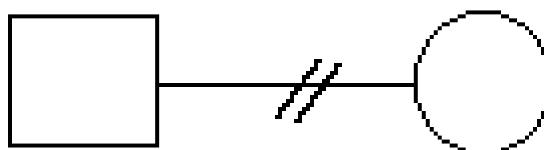
Transitory relationships are illustrated by a single broken line:



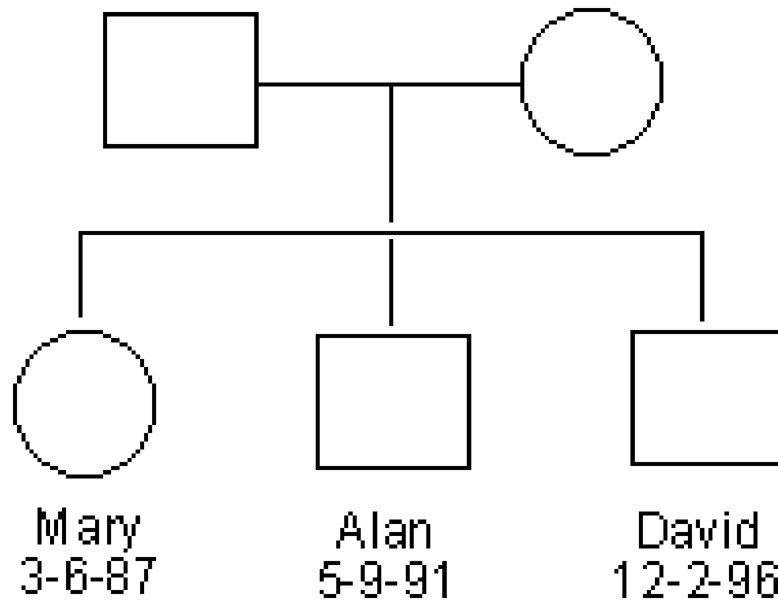
Separation is shown by a single short diagonal line across the relationship line:



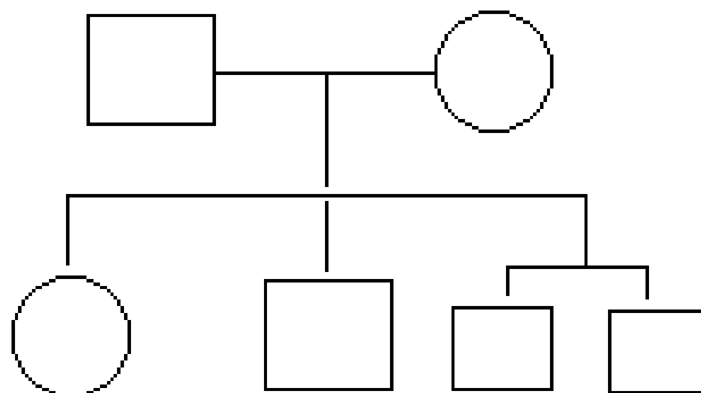
Divorce is shown by two short diagonal lines across the relationship line:



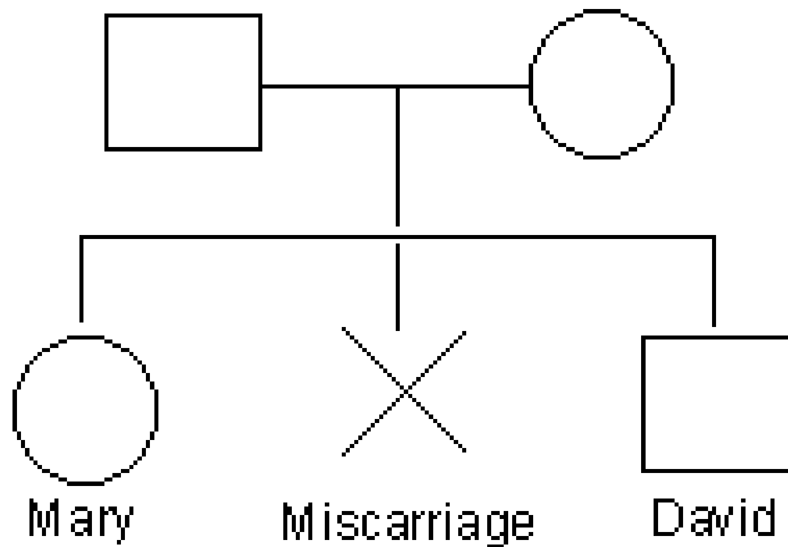
When there are a number of children from the same relationship the eldest child is placed on the furthest left, followed by the second eldest and so on, with the youngest child appearing on the right.



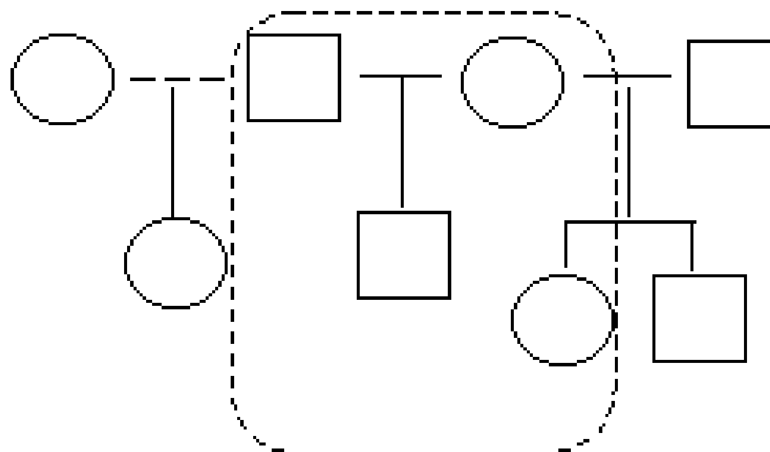
Twins are indicated by two symbols coming from a single 'stalk'



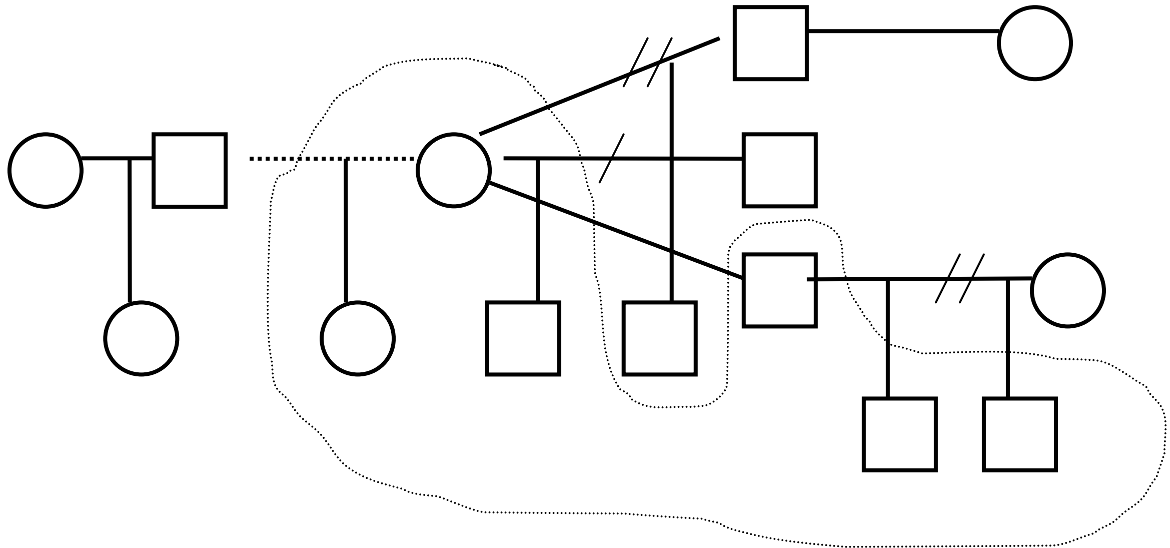
A miscarriage or abortion is indicated by a diagonal cross. In the genogram the miscarriage or abortions should be placed in the diagram in the same order as other children. So for example if a couple had a daughter, Mary, followed by a miscarriage, followed by a son David, their genogram would look like this:



The family members who are part of the same household are indicated by a dotted line which is placed around the household members.



When family relationships are complicated, it is especially important to clearly show family groups.



Make sure that dates of birth and names are clearly written under the symbols.

Using a Genogram

Completing a genogram can fulfil a number of functions:

- identifying intergenerational patterns within families;
- finding out about the family's history and how much of the history individual agencies know.

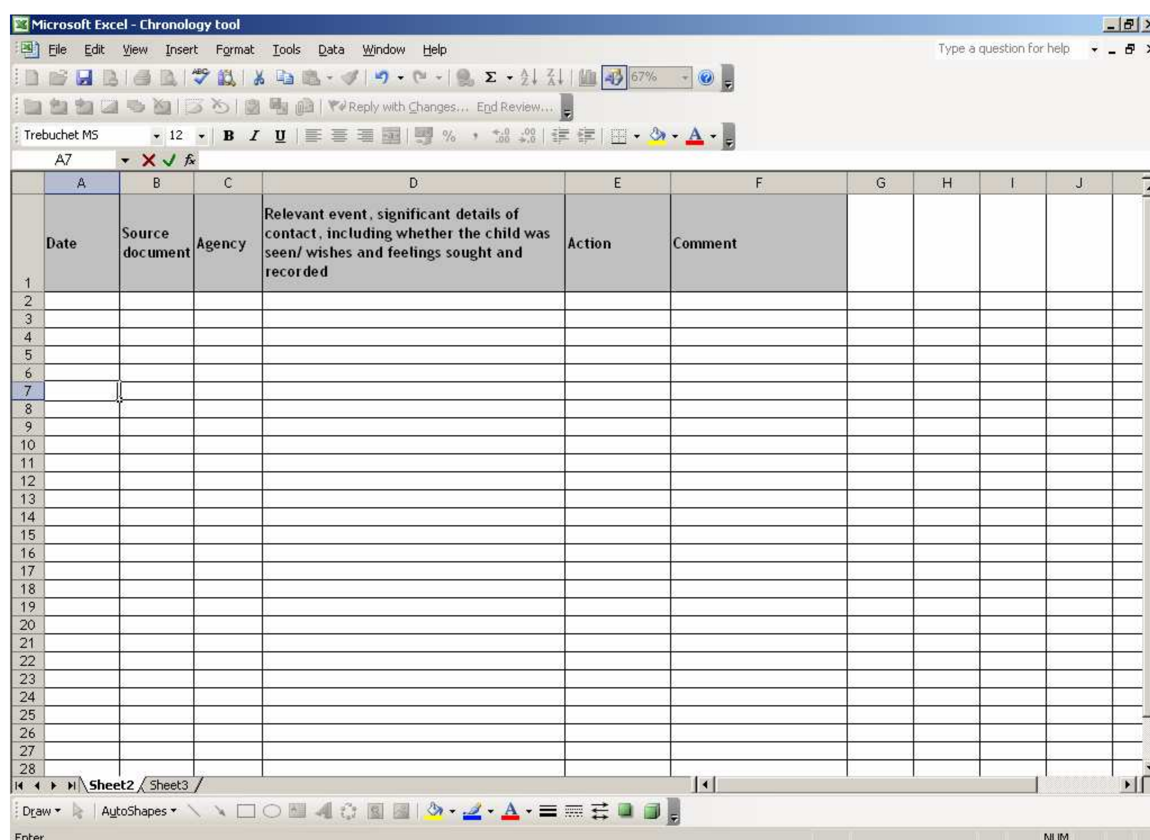
Further information on genograms can be found on page 29 of *Assessing Children in Need and their Families: Practice Guidance* (Department of Health, 2000) www.dh.gov.uk

Appendix 5

Guidance on completing the chronology

The chronology template will be emailed to you from the Bedfordshire Safeguarding Children Board office along with the template for completing the Individual Management Review.

The chronology is in Microsoft Excel format.
When you open the attachment you will find a table which looks like this:

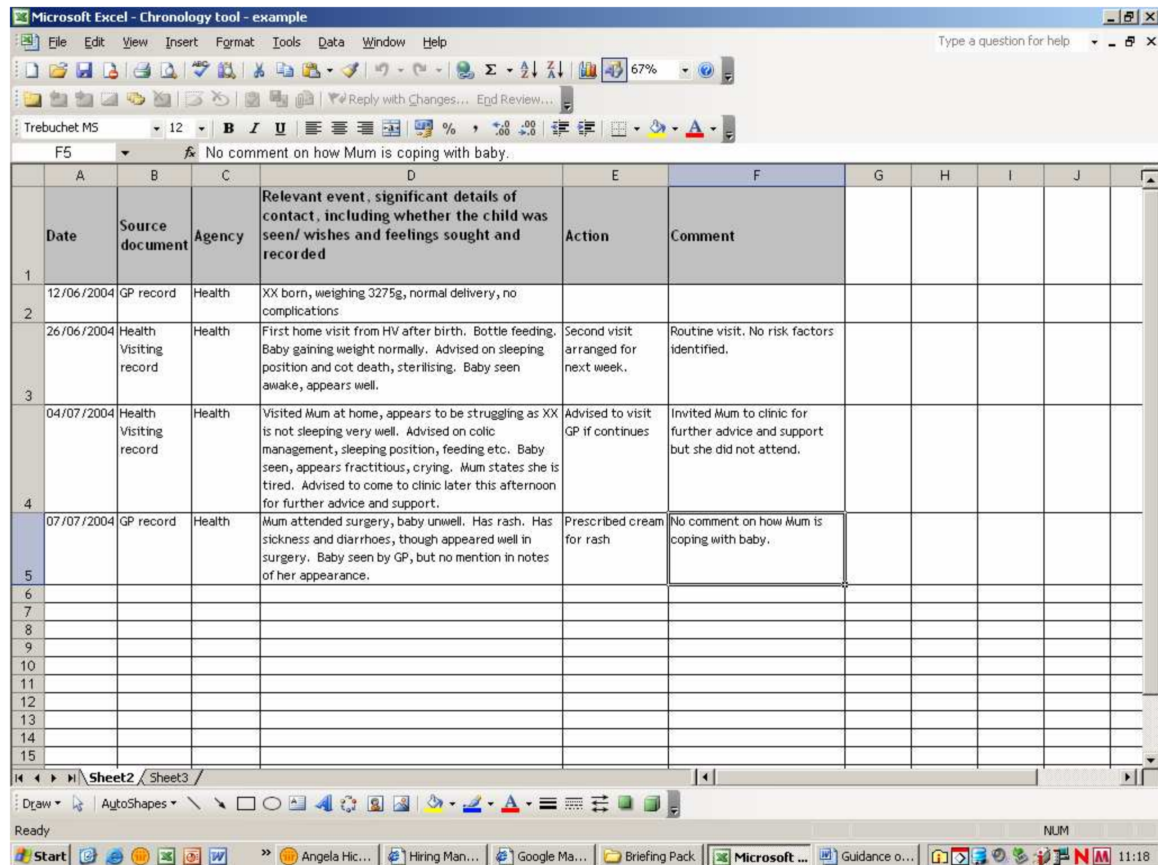


You must complete the date in the format dd/mm/yyyy (e.g. 10/06/2003). This is very important as it makes amalgamating all the chronologies from the various agencies much easier. It will also enable you to sort your entries later so that you don't have to enter everything in chronological order to begin with (see below).

Make sure that each separate event is recorded in a separate row.
If more than one event occurred on the same date, complete each in a separate row and insert the time after the date. Make sure that you **separate the time with a colon hh:mm** (e.g. 17:06) and then, again, the chronologies can be amalgamated and sorted with no problem.

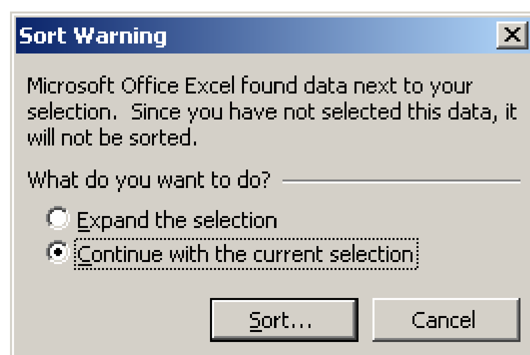
Please do not enter anything else in this column other than the date, and time if necessary otherwise Excel will not recognise the format.

As you fill in each box with information, press the return key when you have finished and the box will expand to accommodate the length of your text.

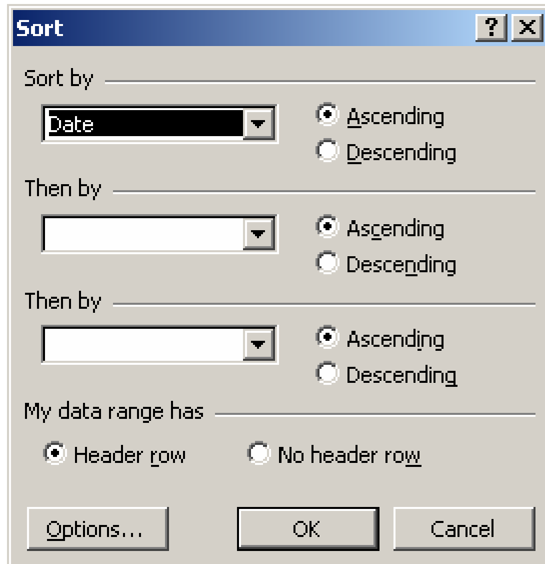


Date	Source document	Agency	Relevant event, significant details of contact, including whether the child was seen/ wishes and feelings sought and recorded	Action	Comment
12/06/2004	GP record	Health	XX born, weighing 3275g, normal delivery, no complications		
26/06/2004	Health Visiting record	Health	First home visit from HV after birth. Bottle feeding. Baby gaining weight normally. Advised on sleeping position and cot death, sterilising. Baby seen awake, appears well.	Second visit arranged for next week.	Routine visit. No risk factors identified.
04/07/2004	Health Visiting record	Health	Visited Mum at home, appears to be struggling as XX is not sleeping very well. Advised on colic management, sleeping position, feeding etc. Baby seen, appears fractitious, crying. Mum states she is tired. Advised to come to clinic later this afternoon for further advice and support.	Advised to visit GP if continues	Invited Mum to clinic for further advice and support but she did not attend.
07/07/2004	GP record	Health	Mum attended surgery, baby unwell. Has rash. Has sickness and diarrhoes, though appeared well in surgery. Baby seen by GP, but no mention in notes of her appearance.	Prescribed cream for rash	No comment on how Mum is coping with baby.

You do not need to enter everything in chronological order – you can sort things when you have finished. In order to do this, highlight the 'date' column, click on the 'data' icon on the toolbar and press 'sort'. You may find a screen pops up which looks like this:



Click 'continue with current selection' and then 'sort'.
You will then be asked:



Click 'ok' and Excel will then sort your entries from the earliest to the most recent. To print, use the mouse to highlight the whole of the area of the report. Click 'file' then 'print area' and 'set print area'. If you then click 'print' you will print the completed chart.
If you have any problems in relation to the completion of this chronology, please contact Sally Stocker on 01234 276774 or at sally.stocker@bedscc.gov.uk or Sue Fanthorpe on 01234 276776 or at sue.fanthorpe@bedscc.gov.uk

Ofsted Descriptors for the Evaluation of Serious Case Reviews (December 2008)

	Outstanding	Good	Satisfactory	Inadequate
Timescales	Requests for extension to the timescale timely and are agreed by Government Office; delays are unavoidable and the review is completed within the agreed timescale.	Requests for extension to the timescale are timely and are agreed by Government Office. Any delays in completion of the review are unavoidable and it is completed broadly in line with an agreed time scale.	All extensions to the timescales are agreed by Government Office. There are delays in the completion of individual management reviews and the overview report, some of which are avoidable.	The timescale for the review is outside the four month guidance and has not been agreed by Government Office. The delay in completion of the review impedes the timely dissemination of the lessons to be learned.
Scope of the review	The decision to conduct a serious case review is appropriate. The scope of the review unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that all relevant questions can be addressed through all the available information and the analysis completed within the agreed time scale. Good contingency arrangements help to ensure timely responses to new information or changes during the process of the review.	The decision to conduct a serious case review is appropriate. The scope of the review unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that nearly all relevant information can be obtained and analysed within the agreed time scale.	The decision to conduct a serious case review is appropriate. The scope of the review is defined and is supported by terms of reference which support the collation and analysis of most of the relevant information available to agencies.	The decision to conduct a serious case review is inappropriate; the criteria set out in WT are not met. The scope of the review is unclear or too limited. It is supported by imprecise terms of reference which fail to ensure that the relevant information can be obtained and analysed.
Contribution of relevant	The contribution of all relevant agencies is maximised	The contribution of all relevant agencies is secured.	The contribution of nearly all relevant agencies is secured.	The contributions of some relevant agencies are not

agencies	throughout the period of the review.			secured.
Independent element	A high level of independence is built into the process including the appointment of an independent author of the overview report and access to expert advice on critical or complex aspects of the case. The independent author is not a member of the serious case review panel. . The serious case review panel include members who hold expert knowledge of the issues relevant to the case. Authors of individual management reviews are independent of line management of the service.	Independence is built into the process through the appointment of an independent author of the overview report. The independent author is not a member of the serious case review panel. The serious case review panel has access to legal advice on critical aspects of the case. Authors of individual management reviews are independent of line management of the service.	Independence is built into the process through the appointment of an independent author of the overview report The independent author is not a member of the serious case review panel. Most individual management review authors are independent of line management of the service. Where this level of independence is not possible, the serious case review panel has demonstrated sufficient transparency and critical analysis of both the individual management reviews and overview report.	Insufficient independence is built into the process such as the appointment of an independent author of the overview report. The serious case review panel does not include an independent member. Authors of individual management reviews are not independent of line management of the service.
Involvement of family members	Arrangements to involve and support relevant family members are comprehensive, appropriate, effective and take into account their ethnic, cultural, linguistic and religious needs.	Clear and appropriate arrangements have been put in place to secure the involvement of relevant family members. Where their involvement was not possible, the reasons are recorded and the members informed of the outcome of the review.	Arrangements have been put in place for relevant family members to contribute information to the review.	The contributions of relevant agencies are not clearly defined and arrangements for the involvement of relevant family members have not been agreed.
Links to parallel investigations	All other parallel investigations including criminal investigations and coroner's	Other parallel investigations including criminal investigations and coroner's	Some parallel investigations such as criminal investigations and coroner's enquiries are	Some parallel investigations including criminal investigations and coroner's

	enquiries are considered and where appropriate, effective information sharing processes or jointly commissioned review arrangements have been agreed.	enquiries are considered and where appropriate effective information sharing processes are in place.	identified and the outcomes of these are considered within the review.	enquiries have not been considered within the scope of the review and processes for communication are unclear.
Individual management reviews	All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the child (ren) and family.	Most relevant agencies produce a comprehensive management review of their full involvement with the child and family.	Most relevant agencies produce individual management reviews of their involvement with the child and family.	Not all relevant agencies produce a management review of their involvement with the child and family.
	The review takes full account of the outcomes for the child (ren) concerned in light of their individual needs and their racial, cultural, linguistic and religious identity.	Any gaps in information are minor and do not impact directly on the outcome for the child (ren) concerned. The review takes into account the individual needs of the child or children and is sensitive to their racial, cultural, linguistic and religious identity.	Most reviews take into account the individual needs of the child and family and record their racial, cultural, linguistic and religious identity.	Some reviews do not take into account the individual needs of the child and family including their racial, cultural, linguistic and religious identity.
	Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.	Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided fully addresses the terms of reference.	Practice is analysed by most agencies openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Gaps in information are identified and explained.	The extent to which practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance is inconsistent across agencies. There are gaps in information which are not fully explained.

	Good practice is highlighted with appropriate consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.	Good practice is highlighted. Nearly all areas for changes in practice are clearly identified and supported with measurable and relevant recommendations for improvement.	Areas for changes in practice are mostly identified and supported with measurable and relevant recommendations for improving practice.	Some areas for changes in practice are identified but are not always supported with measurable and relevant recommendations for improvement.
Overview report	The overview report coherently and accurately brings together the findings of all individual management reviews and other relevant investigations, reviews or enquiries. It summarises the facts of the case succinctly including a clear genogram and a comprehensive and well-organised chronology which maintain a clear focus on the child (ren) concerned throughout.	The overview report accurately brings together the findings of the individual management reviews and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a clear genogram and a comprehensive chronology of events relating to the history of the child and family and agency involvement	The overview report brings together the key findings of all reports from agencies and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a genogram and a chronology of the family history, circumstances of the child and agency involvement.	The overview report does not bring together effectively the findings of the individual management reviews and other relevant investigations, reviews or enquiries. There are some gaps in the genogram and chronology of information relating to the family history, circumstances of the child and agency involvement which impact adversely on the coherence of the report.
	Outcomes for the child (ren) are transparent and well evidenced by the information known to the agencies and professionals concerned about the parents, child and perpetrators, the family history and home circumstances.	Outcomes for the child(ren) are considered against the available information known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances	Reference is made to the most important aspects of the information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child.	Reference is not always made to or effective use made of what information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child.
	The report reflects a robust	The report reflects a critical	The report includes	The report lacks rigour in its

	examination of the facts and provides evidence-based explanations for how and why events occurred and actions or decisions by agencies were or were not taken.	examination of most facts and provides evidence-based explanations for how and why most events occurred and actions or decisions by agencies were or were not taken.	examination of the key facts and provides credible explanations for any gaps in information, how and why events occurred and actions or decisions by agencies were or were not taken.	examination of the facts and explanations on how and why events occurred and actions or decisions by agencies were or were not taken.
	The benefits of hindsight and evidence from research and previous reviews are used comprehensively by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight and research findings are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The use of the benefit of hindsight by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events is not supported by the evidence.
Lessons to be learned	Lessons to be learned, nationally and locally, are clearly identified and supported by specific and achievable recommendations for improving practice in a timely manner.	Lessons to be learned, nationally and locally, are nearly all identified and supported by specific and achievable recommendations for improving practice.	Lessons to be learned, nationally and locally, are identified and supported by relevant recommendations for improvement.	Some lessons to be learned, nationally and locally, are identified but not always supported by specific recommendations for improvement and a relevant action plan for implementation.
Action plan	A comprehensive joint agency action plan is in place, which matches the recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. The plan is outcome focussed and includes actions to disseminate	A joint agency action plan is in place, which matches the recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.	A joint agency action plan is in place, which matches the recommendations of the overview report. Most aspects are supported by targets and lead responsibilities. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.	The joint agency action plan is not robust, and is not SMART. Arrangements for monitoring by the local safeguarding children board are not identified/not robust.

	good practice as well address areas for improvement. Robust arrangements are in place for the local safeguarding children board to monitor progress and evaluate the impact of actions taken.			
Executive summary	An executive summary is completed and includes succinct information about the review process, practice issues and lessons learned from the case and recommendations which have been made. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, including progress on actions required as a result of the review. The executive summary is shared with the family as appropriate.	An executive summary is completed and includes succinct information about the review process, key issues arising from the case and recommendations which have been made. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, and for sharing the executive summary with the family.	An executive summary is completed and includes most relevant information about the review process, key issues arising from the case and recommendations which have been made. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary and for sharing the executive summary with the family.	An executive summary is completed but there are gaps or contradictions in information about the review processor key issues arising from the case and recommendations which have been made. The summary is not suitably anonymised to protect the confidentiality of the child/family members. Arrangements for the publication of the review are not robust. No arrangements have been made to share the executive summary with the family.

Standards for Individual Management Reviews

Agency information

Name of agency	
Date IMR received	
Author of report	
Role of Author	
Explanation as to the independence of the Author from the work undertaken with the child & family in the agency	
Signed off by	

Background Information

Initials of Child	
Date of birth	
Childs ethnic origin (As recorded on notification)	
Date of death/ serious incident	
Contact person	

Content

Family details, including names, dates of birth and addresses	
Full and Clear	
Partial	
Limited/ None	
Genogram/network	
Full and Clear	
Partial	
Limited/ None	
Chronology of Agency Involvement; taken from files, interviews with staff and internal investigations where held.	
Full and Clear	
Partial	
Limited/ None	
Details in the chronology of when the child was seen and his/her views wishes and feelings sought or expressed	
Full and Clear	
Partial	
Limited/ None	
Summary of agency involvement- including quality of the work, supervision and recording and liaison with other staff/agencies	
Full and Clear	
Partial	
Limited/ None	

Does the IMR 'talk' the reader through the process of completing the IMR sufficiently?	
Full and Clear	
Partial	
Limited/ None	

Analysis and recommendations

Analysis and evaluation of decisions made and not made, action taken and not taken, turning points, good practice	
Full and Clear	
Partial	
Limited/ None	
Lessons to be learned; why failure in practice occurred including both the explicit and underlying reasons which contributed to this?	
Full and Clear	
Partial	
Limited/ None	
Recommendation for actions, that are focused, specific and achievable	
Full and Clear	
Partial	
Limited/ None	

Has the report been clearly signed off by an officer of Chief Executive/Director level?	
Comments:	

Is it clear what is expected to change as a result of the recommendations being implemented within the agency? Are any recommendations repeated from previous serious case reviews within the agency?	
Comments:	

Overall judgement on quality of IMR: inadequate/adequate	
Comments:	

Luton
Safeguarding
Children
Board

LSCB
Bedfordshire

Working Together
to Safeguard Children

A guide for professionals involved in a Serious Case Review.

Most commonly asked questions about a Serious Case Review.

(Also known as a Part 8 or Chapter 8 Review)

“What is a Serious Case Review”?

When a child dies or is seriously injured and abuse or neglect is known or suspected to be a factor in the death or serious injury, agencies have to consider whether there are any lessons to be learnt from the tragedy, about the way in which we work together to safeguard and promote the welfare of children and to improve inter-agency working. They are not about how a child died or who is culpable. A serious case review may also occur when a young person commits suicide or where a parent has been killed in a domestic violence situation or where a child has been killed by a parent who has a mental illness.

“Why it is called a Serious Case Review or a Part 8 Case Review?”

The HM Government document “Working Together to Safeguard Children 2006” sets out the guidelines for Local Safeguarding Children Boards to follow in Chapter 8 of the guidance which is why it has always been called a Part 8 or a Chapter 8 Case Review. If you don’t have access to a copy of the document, ask your manager for a copy of Working Together 2006 Chapter 8 or find it at **www.bedfordshirelscb.org.uk/publications** or **www.luton.gov.uk/safeguardingchildren**

“What is the LSCB”?

Local Safeguarding Children’s Boards are a Statutory Body which brings together senior representatives from each of the agencies to agree how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children. There are functions set out in Regulations for e.g.

- Developing and agreeing local safeguarding children policies for inter-agency working
- Recruiting and supervision of people who work with children
- Investigate allegations concerning people who work with children
- Communication and raising awareness
- Monitoring and evaluation
- Participating in planning and commissioning
- Undertaking Serious Case Reviews
- Ensuring that multi-agency child protection training is provided
- Cooperation with neighbouring children services authorities i.e. LA’s and their LSCB partners

“How long will a Serious Case Review take?”

The guidance sets out the time scale, within which the SCR has to be completed, which is 5 months. However sometimes criminal proceedings can delay the process. The manager conducting the review will give you some indication if this is likely to be the case.

“Why were the case files removed?”

This is to guard against loss or interference. You will be given a copy of the file in the event that you are still working with the family or need to refer to the files at a subsequent conference or when giving or preparing a statement.

“What will happen next?”

An Individual Management Review (IMR) will be undertaken by the agency in which you work.

“What is an Individual Management Review as part of the Serious Case Review?”

An IMR is the review a manager or named professionals (for health service staff) from your own agency conducts using the guidance set out in Chapter 8. The aim is to look openly and critically at individual and organisational practice to see whether changes could or should be made. It will also identify good practice. You may be interviewed as part of this process. Your manager and other colleagues may also be involved. Your agency’s IMR Author will meet with IMR Authors from other agencies involved in the SCR, to form what is known as a Serious Case Review Project Group (SCRPG). This group report directly to the Executive Serious Case Review Panel (ESCRP) who agree and sign off the IMR’s and subsequently the Overview report.

“Who will interview me?”

Your agency’s IMR Author may interview you and they will have had no direct line management of the case, team, service or yourself.

“What will the manager be looking for and what will I be asked?”

The IMR Author will first have to construct a chronology of involvement by you and other staff with the child/family, over the period of time under review. They will consider the events that occurred, the professionals involved, the actions taken or not, the decisions taken, whether policies and procedures were followed, whether appropriate services were offered, and whether the child’s wishes, feelings, racial, cultural, linguistic and religious circumstances were taken into consideration. They may also ask you about your qualifications and experience, the training you have received and your supervision arrangements. The IMR Author will take notes of your interview and you will asked to agree that the notes are a true reflection of what was said. This will also give you an opportunity to correct any misunderstandings. These notes will be referred to in the IMR as appropriate.

“Can I have somebody with me when I am interviewed?”

Yes. A friend, colleague, or line manager can be present. Their role is to support you, not to represent you. If you wish to have someone accompany you, then it would be advisable to inform the IMR Author ahead of time.

“What other form of support will I be able to have?”

This can be a stressful time for you and your may like to talk to somebody about your feelings and about what has happened. The IMR Author who is undertaking the IMR should tell you about the support arrangements in your agency, but if they don’t tell you, please ask.

“Is everybody interviewed?”

Usually everybody is interviewed, but it will depend on a number of factors, e.g. what are their involvement and the nature of their involvement.

“What happens next?”

A “multi-agency chronology” and an “Overview Report” will be prepared.

“What is a multi-agency chronology?”

This details contact with the child/family by all agency staff combined into one sequential chronology. It provides a complete picture of all the professionals’ involvement with the child and family and usually “tells the story”. This multi-agency chronology is included in the “Overview Report.”

“What is an Overview Report?”

When all the IMRs have been received, an overview report is commissioned by the LSCB which brings together and analyses the findings of the various IMRs from agencies and others and which makes recommendations for future action.

“Is this process part of the Disciplinary procedure?”

No.

“Will disciplinary action be taken against me?”

If the outcome of your agency IMR finds that policies and procedures were not followed or there were other shortcomings identified, there may be the possibility that action will be taken. In these circumstances you should refer to your agency’s disciplinary procedure and seek advice from your Line Manager, Union and/or Human Resources representative.

“When will I know the outcome?”

Once the LSCB has accepted the final Overview report, the IMR Author from your agency will contact you to give you feedback.

“Can I see the final report?”

Once the LSCB have approved the Overview report, an Executive Summary will be prepared and you will be given a copy. This report will include all the conclusions and the recommendations for the agency and the LSCB.

“Will anybody else see the report?”

The Executive Summary will be a public document. Publication will be timed in accordance with the conclusion of any related court proceedings.

“Will I be named in the report?”

No, nobody will be identified by name. You will be given an identifying number e.g. SW1 for social worker 1. This is also to protect the confidentiality of the relevant family.

“Will I be able to disagree with the IMR Author’s findings?”

Not, normally. If you disagree with the notes of the interview you have been sent, it is in your interest, to send your comments to the IMR Author in writing.

“Can I tell anyone about this?”

No, this is a confidential process. You can discuss your feelings, but not the circumstances of the case with the person offering your support and you can also discuss it with your line manager and the IMR Author involved in the process. It is particularly important information does not leak into the public domain, if criminal proceedings are outstanding, in that access to the contents of information may not be within the control of the LSCB.

“Is this a Public Inquiry?”

No, only the government can set up a Public Inquiry.

“Who owns the report and what is its legal status?”

The Overview report is owned by the LSCB and its’ constituent agencies. The document “Working Together to Safeguard Children 2006” is issued under Section 7 of the Local Authority Social Services Act, under the guidance of the Secretary of State. As such, it does not have the full force of statute, but

should be complied with unless local circumstances indicate exceptional reasons which justify a variation.

"Does the family know?"

The family will be made aware of the Serious Case Review being undertaken depending on the circumstances of the individual case. Families will be given the opportunity to have their say as part of the process and will be given a copy of the Executive summary as appropriate.

"Are there other types of serious case reviews?"

Yes if the LSCB is concerned about the way a case was managed on a multi-agency basis, but it doesn't meet the criteria set out in Working Together 2006 for a Serious Case Review, an Individual Practice Review (IPR) or a Near Miss Review (NMR) can be undertaken instead.

"What is the difference?"

Ofsted is not informed with an IPR or NMR and staff may not be interviewed unless there is a need to clarify certain information or check out information not recorded in records. Your manager will tell you exactly what the arrangements will be.