

# Bedfordshire Local Safeguarding Children Board

Working together to safeguard children



## Working Draft Serious Case Review Process

(Operational from 01/02/09 & to be reviewed in August 2009)

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### **Glossary**

ESCRP – Executive Serious Case Review Panel  
 SCR – Serious Case Review  
 SCRPG – Serious Case Review Project Group  
 BLSCB – Bedfordshire Local Safeguarding Children Board  
 IMR – Individual Management Review  
 NMR – Near Miss Review  
 IPR – Interagency Practice Review  
 TOR – Terms of Reference  
 DCSF – Department Schools, Children & Families  
 GO East – Government Office East  
 FOI – Freedom of Information  
 DOH – Department of Health  
 SHA – Strategic Health Authority  
 LSCB – Local Safeguarding Children Board  
 FOIA – Freedom of Information Act

**This process is adapted from Essex/Lincolnshire Safeguarding Children Board SCR guidance and aims to ensure a consistent approach to the management of serious case reviews. Appendix 4 has been provided by Diana Madden, Safeguarding Adviser, Government Office for the East of England.**

## 1. Executive Serious Case Review Panel (ESCRP)

### 1.1 Introduction

1.1.1 Bedfordshire Local Safeguarding Children Board (BLSCB) has established an Executive Serious Case Review Panel (ESCRP) as a standing sub group of BLSCB with responsibility for ensuring that BLSCB undertakes Serious Case Reviews (SCR's) in accordance with government guidance set out in Chapter 8 of Working Together to Safeguard Children 2006. The ESCRP will take responsibility for coordinating and monitoring multi agency arrangements for undertaking and publishing SCR's.

1.1.2 These procedures provide comprehensive information on the roles and responsibilities of the ESCRP; it provides details of the framework which BLSCB will apply in ensuring SCR's are conducted in line with government guidance and Ofsted and also includes practice guidance to ensure that consistent standards are applied in the completion and publication of SCR's.

1.1.3 A recent Ofsted report (Dec 2008) evaluating 50 serious case reviews carried out between 1 April 2007 and 31 March 2008 presented these key messages:

Most delays caused by:

- Inability to appoint independent authors
- Internal staffing pressures preventing work being done
- Difficulties in securing the co-operation of relevant agencies
- Complexities of coordinating serious case reviews which cover more than one local area or a number of different agencies
- Inexperience of staff conducting individual management reviews
- Parallel investigations such as coroner's courts and criminal proceedings
- Delays in agreeing final set of recommendations and action plan between agencies.

Reasons for inadequate judgements included:

- Terms of reference unclear
- No agreed format for completion of individual management reviews
- Presentation poor with a complacent approach to the task; absence of basic information Insufficient analysis or critique of practice with a defensive stance rather than open and critical approach to learning lessons
- Key issues not recognised or addressed
- Lack of recommendations that clearly specify how lessons learned will be translated into practice
- Recommendations limited, not relevant to findings, vague and unspecific about time scale for implementation
- Action plans with no clear process for monitoring the implementation or impact of the action plan, in particular no formal role for the LSCB in monitoring and evaluating the impact of the action plan on inter-agency working.

## 1.2 Purpose of the SCR

1.2.1 SCR's are not enquiries into how a child dies or who is culpable; that is a matter for Coroners and Criminal Courts respectively to determine, as appropriate.

1.2.2 The purpose of SCR's is to:

- Establish whether there are lessons to be learned from a 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 hence
- Improve inter-agency working and better safeguarding of children.

## 1.3 Criteria for convening Serious Case Reviews

1.3.1 The same criteria apply to disabled children as to non-disabled children. A case review must always be held when:

- A child dies (including suicide) and abuse or neglect is known or suspected to be a factor.

1.3.2 Additionally a SCR may be held when:

- A child has sustained a serious or life threatening injury or 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.
- A child has suffered serious **Sexual Abuse**
- Their parent has been murdered (including domestic violence situations) and a homicide review is being initiated
- The child has been killed by a parent with mental illness

1.3.3 In cases where a child has not died it may be appropriate to hold a SCR if one or more of the following criteria are met:

- There was a significant risk of harm to a child which was unrecognised by agencies or professionals in contact with the child or alleged perpetrator, or not shared with others or not acted upon properly
- The child was abused in an institutional setting, e.g. school or family centre
- The child dies in a custodial setting
- The child dies whilst absent having run away from home
- The child was being **Looked After** by the local authority at the time of abuse
- Agencies or professionals consider that their concerns were not taken sufficiently seriously or acted upon appropriately by another
- The case indicates that there may be failings in one or more aspect of the local operation of formal child protection procedures which extend beyond the handling of the case
- The child was, or had been, subject to a **Child Protection Plan** or deemed to be at the threshold of risk of **Significant Harm**.
- The case appears to have implications for a range of agencies or professionals

1.3.4 The case suggests that there may be a need for the **Bedfordshire Local Safeguarding Children Board (BLSCB)** to change its protocols or procedures or that

they need to be more effectively promoted, understood or acted upon. Where BLSCB is taking the lead, any other Local Safeguarding Children Board (LSCB) with an interest or involvement in the case will be notified of the decision to hold a review and included in the planning and undertaking of the Review.

1.3.5 Where another LSCB is conducting a review which involves a child or family from the County, BLSCB will cooperate with these reviews.

## **1.4 Ofsted's role and contribution**

1.4.1 From 1 April 2007 regional Government Offices assumed responsibility for on-going monitoring, advice and challenge to local authorities. Ofsted assumed the responsibility for briefing ministers on serious cases, forming a view as to whether a serious case review was necessary, and carrying out an evaluation of the quality of any review undertaken. It also took on the responsibility for maintaining the child protection database on behalf of the DCSF.

1.4.2 Ofsted's authority to evaluate serious case reviews is covered by section 20 of the Children Act 2004. Ofsted carries out this function on behalf of the Secretary of State. The duty of the local authority through the Director of Children's Services is to ensure the establishment of the LSCB and its effective working as set out in paragraph 3.46 of *Working together 2006*. As such, the work of the LSCB, including the evaluation of any SCR, is taken into account in both joint area reviews and annual performance assessments of the local area.

1.4.3 Ofsted requires LSCB's to provide a complete set of papers for evaluation, including the terms of reference, overview report, individual management reports, recommendations and action plan. One of Her Majesty's Inspectors evaluates the review against a set of grade descriptors and in accordance with an evaluation template.

1.4.4 The individual aspects of a serious case review considered in the evaluation include the following.

- whether it was appropriate to instigate the review
- the scope and time period covered by the review
- the terms of reference and whether the author is suitably independent of the agencies involved
- whether the review was completed within recommended timescales
- the quality of the individual management reviews
- whether the ethnic, cultural, linguistic and religious needs of the child and family were met by services, and are addressed within the review
- whether the family were invited and enabled to contribute to the review process
- the quality of the overview report, including:
  - background information
  - rigour of analysis and challenge of information in IMR's
  - joint chronology
  - appropriate recommendations
  - reference to research and previous review findings
  - joint agency action plan with clear targets and timescales
  - monitoring arrangements by the LSCB

- the quality of the executive summary, including whether it is suitably anonymised to protect the family's identity, and whether it is yet published.

1.4.5 The findings of the evaluation and the overall judgement are sent to the chair of the LSCB and the Director of Children's Services, if different. A meeting with the inspector is offered in order that the findings of the evaluation can be further explained and discussed. If the chair and the Director of Children's Services wish, the meeting can also include the Children's Services Adviser from the Regional Government Office who is responsible for supporting and advising the local authority and partners in taking forward the findings of the review.

## 1.5 Summary of ESCR Role and Responsibilities

- The referral form (appendix 1) to be completed by the referring agency and sent to the Chair of ESCR with a copy to the BLSCB Business Manager.
- The ESCR has **1 month** to reach a decision that the case meets the criteria for a SCR and a meeting of the ESCR is convened within **5 working days** of the referral being received.
- When the ESCR decides that the criteria are met, the ESCR will undertake / commission a SCR according to the guidelines set out in Chapter 8 of Working Together to Safeguard Children 2006.
- The ESCR will commission IMR's and draw up clear terms of reference including timescales for the review **within 4 months** and identify who should be on the Serious Case Review Project Group (SCRPG). The SCRPG will undertake the SCR and report back to the ESCR as per the Terms of Reference.
- ESCR will ensure that an Overview Report, with recommendations for action is produced which brings together the information and analysis contained in the IMR's together with reports commissioned from any other relevant parties, using an outline that clearly reflects both guidance in Working Together 2006 and the agreed Terms of Reference.
- ESCR will ensure that all IMR's have been signed off by the Chief Officer or nominated deputy of each organisation and that if necessary, their own legal advice has been sought and considered.
- ESCR will appoint a SCR author who will work directly on and write the Overview Report on behalf of the ESCR.
- ESCR will give adequate consideration to the impact of parallel processes e.g. criminal investigations, disciplinary procedures and advise the LSCB accordingly.
- ESCR will consider the wider issues of accountability and disclosure. The ESCR will identify who might have an interest in SCR's and consider what information should be made available to each of these interested parties. The advice and guidance of the associate members of the ESCR for e.g. Communications staff, Legal Services, Information and Clinical Governance staff will be of value in these discussions.
- ESCR will ensure the timely production of an anonymised Executive Summary.
- ESCR will develop and coordinate a communications strategy to ensure that the lessons learnt from SCR's can be shared and made public.
- Treat all papers relating to the ESCR's work as confidential.
- BLSCB Administrator will mark copies of all Overview Reports as draft until the report is approved and arrange for draft reports to be destroyed.
- ESCR will keep papers locked and secure during the process of a SCR.
- ESCR will retain a single copy of the Overview Report.

- ESCRCP will destroy all other papers.
- ESCRCP will make arrangements for the secure retention of a single copy of their own IMR's and the Overview Report.
- ESCRCP will ensure that all draft copies of the Overview Report are shredded.
- Once the final copy of the SCR and Action Plans has been agreed and signed off by the ESCRCP and Strategic Board and its recommendations accepted then ESCRCP members will be free to destroy all copies of the report as the original will be kept by the BLSCB Administrator.
- BLSCB Administrator will retain copies of all papers associated with a SCR for a period of 7 years.
- BLSCB Administrator will provide access to papers through application to the Chair of BLSCB.

## 1.6 Summary of ESCRCP reporting and notification arrangements

- Director of Children's Services to identify local authority member of ESCRCP who will have responsibility to notify Ofsted and DCSF each time a decision is made to undertake an SCR. This will normally be the BLSCB Business Manager.
- PCT representative on BLSCB to identify member of ESCRCP who will have responsibility to notify Strategic Health Authority (SHA) each time a decision is made to undertake an SCR.
- The BLSCB Business Manager will provide monthly update of SCR's including progress and planned dates for completion to Ofsted and SHA.
- ESCRCP chair and members to ensure that the BLSCB and Chief Executive Officers of relevant organisations are briefed about the work of the ESCRCP on a regular basis.
- ESCRCP to receive IMR's and agree single agency recommendations.
- ESCRCP will negotiate and agree extensions with the Government Office East **serious\_case@goeast.gsi.gov.uk** where a SCR cannot be completed within 4 months.
- ESCRCP will ensure that once the Overview Report is completed and accepted by the BLSCB, the Executive Summary / full report as agreed is circulated to agencies relevant to the case.
- ESCRCP will agree the recommendations of the final overview report and will produce an action plan addressing those recommendations.
- ESCRCP will ensure that the final report (with action plans and IMR's ) is sent to Ofsted and DCSF.
- ESCRCP will monitor the action plans from the Overview Report (IMR actions will be monitored on an exception basis). The Strategic Board will receive a regular report on progress, will include consideration of the strategic and multi agency issues raised by the review in the work programme for the performance management group and will ensure that relevant issues are addressed through the annual business plan.
- Partner agencies will be responsible for monitoring their individual action plans and reporting to the ESCRCP on their progress as requested.

## 1.7 Membership

1.7.1 Members of ESCRCP have a dual role: to represent a professional or organisational view in relation to information brought before the panel **AND** to act collectively in

challenging and supporting partner agencies to ensure that the review reflects well-evidenced and best practice standards.

1.7.2 The expectation is that membership of the group will remain constant and that each representative will commit to a term of 2/3 years in order to provide group stability. In selecting representatives, each agency will:

- Choose a member of staff who is able to represent the organisation's views policies and practice and has been given the mandate to do so.
- Choose a person with sufficient experience and knowledge of the field to inform the debate and the matters under consideration.
- Ensure that representatives have sufficient time allocated to enable the representative to effectively undertake the work of the ESCRP.

## **1.8 Quoracy**

1.8.1 For the ESCRP to be quorate, four members must attend. The meeting can be achieved by telephone conferencing to ensure it is held urgently so that a decision can be made by the BLSCB Chair within one month of the case coming to their attention.

1.8.2 As a matter of principle members of the panel will not combine this role with that of conducting IMR's. This could lead to a conflict of interest and prejudice their independence. Membership is drawn from core members of the BLSCB:

### **1.9 Core Members:**

- BLSCB Independent Chair
- Bedford Borough Assistant Director Children's Social Care
- Bedford Borough Chief Officer Education
- Central Bedfordshire Head of Learning and Schools
- Central Bedfordshire Deputy Director Children Social care
- NHS Bedfordshire Commissioning Services (Designated Doctor and Nurse for Safeguarding Children will provide advice and guidance the Executive Nurse).
- Bedfordshire Community Health Services
- Bedfordshire Police

### **1.10 Officers:**

- Principal Lawyer from either Bedford Borough or Central Bedfordshire and Legal Adviser to BLSCB
- BLSCB Business Manager
- BLSCB Administrator

### **1.11 Role of Legal Advisor**

1.11.1 The role of the Legal Advisor to the ESCRP may include:

- Liaison with other agencies in particular the Police and Crown Prosecution Service to ensure that the SCR process does not conflict with actual or potential prosecutions or appeals
- Analysis of new case law/ statute affecting the SCR process
- Ad hoc advice to the Chair of the ESCRP and to the Overview Report Author

1.11.2 The main focus of legal advice provided to ESCRP is to ensure that the review fulfils its purpose by being widely and appropriately disseminated without exposing BLSCB to unnecessary legal challenge. To achieve this aim:

- IMR's and Overview Reports should be based on clear, logical and lawful Terms of Reference
- Evidence should be clearly sourced. Direct first hand evidence should be given most weight. Where allegations cannot be substantiated by such evidence, it must be clearly identified as unsubstantiated and weighed carefully against other or more reliable evidence
- If allegations are made against individuals in a report those individuals should be given the opportunity to respond before such allegations are included within the final report
- Specific advice should be sought on technical issues e.g. Data Protection, Court rules etc

1.11.3 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 Review. This would normally be done as part of an IMR. If there are concerns of conflicting interests, BLSCB should consider if it is possible for legal advice from a neighbouring authority/independent practitioner to be sought.

## **1.12 Disclosure of Information**

1.12.1 The ESCRP will, as part of the scoping of the SCR make a recommendation to BLSCB on the issue of disclosure of information based on the questions highlighted in this section.

1.12.2 The ESCRP will need to consider what information gathered in the completion of a serious case review will be disclosed and to whom. The focus of those discussions should be to agree what the public interest issues are and how best to facilitate public accountability. In addition the ESCRP will need to consider how lessons about how agencies work together to safeguard children are best disseminated.

1.12.3 The DCSF provides helpful guidance on information sharing (Information Sharing: Practitioners guide) and this resource should be used when considered the disclosure of information contained within a SCR.

1.12.4 The ESCRP should consider all of the stakeholders of the SCR and independently consider the following questions

- Is there a legitimate purpose for the information within the SCR to be shared with the stakeholder?
- Does the information enable a person to be identified? Can the data be anonymised? If the information allows an individual to be identified, the agencies must take reasonable steps to explain what information will be shared, and why, taking into account data protection legislation
- Is the information confidential?
- Has Consent been obtained? Remembering to confirm what constituted consent, whose consent was obtained and when it would not be appropriate to seek consent

- Is there a statutory duty to share information? The most significant test in this area when considering SCR's is the sharing of information under the public interest test. This test is at the heart of the Freedom of Information Act 2000. In forming a judgement on this, ESCRП should consider factors for and against including:
  - Will disclosure further the public's understanding of significant issues
  - Will disclosure promote public accountability and transparency
  - Will disclosure allow the public to understand decisions made by public bodies
  - Will disclosure bring to light information affecting public health and safety
  - Will disclosure affect law enforcement
  - Will disclosure impact on the European Convention of Human Rights
  - Is the information an exemption under the FOIA

1.12.5 It is important to bear in mind that the competing interests are the public interest not private interests. There will often be a private interest in withholding information. Concerns that information may be too complicated for the public to understand is not a good ground for non disclosure. The ESCRП should also consider precedent and cases considered by the Parliamentary commissioner. The default position will be to consider **the need** to know as opposed to **the want** to know.

- What systems and processes will be used to share the information? This means considering only sharing the information which is necessary for the purpose for which it is being shared, sharing it with those who need to know, checking that the information is accurate and up to date, sharing it in a secure way, establishing with the recipient whether they intend to pass it onto other people and ensure that they understand the limits of any consent and finally informing the person the information relates to (and / or the person who shared the information) if they are not aware and it is safe to do so.
- Record the decisions made in a formal way.

1.12.6 It is important for the ESCRП to be aware of Data Protection and Freedom of Information requirements. Under the FOIA any person has the right to make a request for information held by a public authority. While the BLSCB is not a public authority for the purposes of the FOI Act 2000 the organisations forming membership of BLSCB **are** subject to the provision of the Act and should have procedures for dealing with requests. Any organisation receiving a Freedom of Information request concerning a SCR should discuss this with the ESCRП.

1.12.7 The Act recognises that there are grounds for withholding information and provides a number of exemptions from the right to access some of which are subject to a Public Interest test.

1.12.8 Information held and/ or gathered by agencies for the purpose of a SCR may fall within one or more of the following exemptions:-

- Investigations and proceedings conducted by public authorities (e.g. a criminal investigation).
- Court records
- Health and safety (disclosure would be likely to endanger the physical/ mental health/ safety of an individual).
- Personal data -

*Defined in Data Protection Act 1998 as “Data which relates to a living individual who can be identified from those data and any other information in the possession of or likely to come into the possession of the data controller – which includes opinions about the individual and indications about intentions in respect of the individual.”*

- Information provided in confidence (disclosure would constitute a breach of confidence).

1.12.9 Some exemptions are absolute, others are qualified – requiring a balancing exercise to be carried out before a decision is made as to whether to disclose. Agencies should consult their information officer or take legal advice if in any doubt as to whether an exemption applies.

**NB** Requests by an individual *involved with* the SCR, for information concerning them would be dealt with in accordance with the Data Protection Act.

### **1.13 The Criminal Procedure & Investigations Act 1996 and disclosure of information in criminal proceedings.**

1.13.1 This act gives detailed guidance to Police and Prosecutors regarding disclosure of material to the defence in criminal proceedings. There are times when a SCR is being conducted simultaneously with criminal proceedings. On the rare occasion when information comes to light during the SCR process, that may undermine the prosecution case, the prosecutor has a duty to disclose this to the defence.

1.13.2 The Chair of the ESCRP will liaise with the Police Detective Chief Inspector (DCI) with responsibility for child abuse to ascertain whether the timing of any criminal proceedings need to be taken into account for the production of management reviews and the subsequent publication of the overview report. The DCI should consult with other parties about the criminal proceedings such as Coroner, Crown Prosecution Service etc as to their views on timing and disclosure of information.

1.13.3 Once an agreement has been made between the Chair of the ESCRP and Detective Chief Inspector regarding timing and disclosure, this should be reviewed regularly at strategic points in the criminal proceedings and serious case review process e.g. prior to, and following the trial. Authors of management reviews should be made aware that their reviews may be disclosed as evidence, or used in subsequent proceedings.

### **1.14 Timescales**

1.14.1 Given that the primary purpose of SCR's is to contribute to the improvement of inter-agency practice, the ESCRP should ensure that lessons are learned and acted upon as quickly as possible (Working Together, 8.14, 2006).

- Working Together (8.14) states that “within **one month** of a case coming to the attention of the BLSCB Chair who along with the ESCRP will consider the case to make a recommendation on whether the criteria for a SCR are made.

- The SCR should be completed within **a further 4 months**, “unless an alternative timescale is agreed with Ofsted and the DCSF or with the Children’s Services Advisor at Government Office at the outset” (8.15).

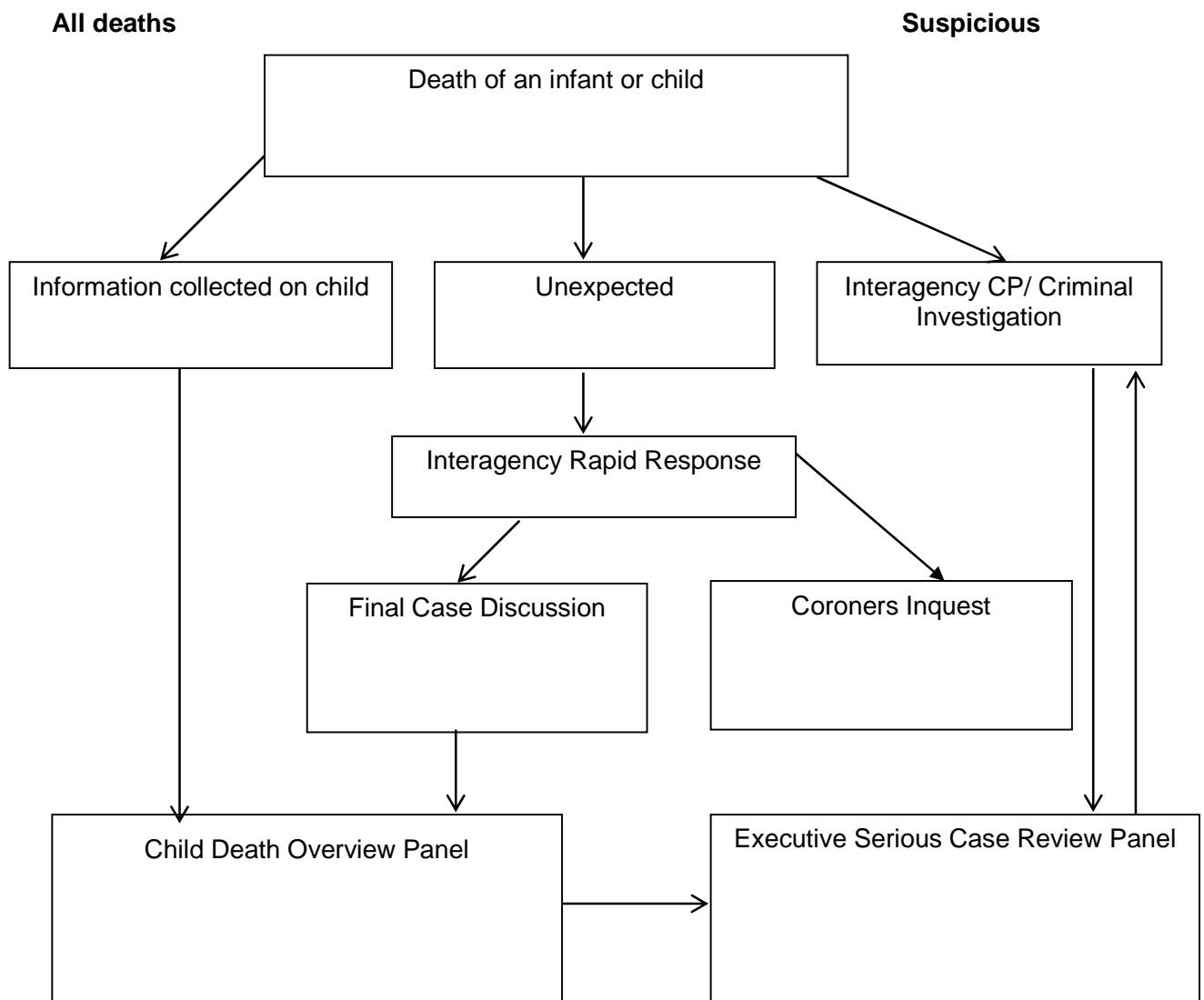
### 1.15 Delay

1.15.1 Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it is clear that a SCR cannot be completed within the 4 month timescale, there should be discussion with Ofsted and with the Children’s Services Advisor at GO East to agree a timescale for completion (8.15).

- SCR’s should not be delayed as a matter of course because of outstanding criminal proceedings, or a pending decision as whether or not to prosecute (8.16).

## 2. Serious Case Review Process

The following table illustrates the interface between the SCR process and the Child Deaths functions of LSCB:



The main aim of these processes is to:

- Identify the cause of death
- Evaluate the circumstances of the death
- Ensure systems offer appropriate support to the families

## 2.1 Referrals

2.1.1 If a representative of any partner organisation of BLSCB feels that a case may meet the criteria for a SCR, they are encouraged to discuss this with their representative on the ESCR or a Senior Manager within their own organisation. This person may then approach the Chair of BLSCB for an informal discussion. This may result in no further action or the need for additional information. Otherwise the next step is for a completed referral form to be sent to the Chair of BLSCB/ESCRP via the BLSCB Business manager [lscb@bedscc.gov.uk](mailto:lscb@bedscc.gov.uk) (see Referral form Appendix 1) the referral should be received within 72 hours of the incident.

## 2.2 First meeting of Executive Serious Case Review Panel

2.2.1 The ESCR have **1 month** from the date of the referral to make a decision as to whether the case meets the criteria for a SCR. For the ESCR to be quorate four members must attend. The ESCR will meet within 5 working days of receiving the referral. This meeting may take place with the use of telephone conferencing if Panel members are unable to meet in person. All ESCR members are to bring initial information relevant to the case to the meeting to ensure adequately informed decision-making. This requires an initial check of their records so that any key concerns may be noted. Following discussion the ESCR may need to have access to further information to assist their decision making in determining whether the case meets the criteria for a SCR.

## 2.3 Agency Notification

2.2.1 Once a SCR has been commissioned, the BLSCB Business Manager will send a copy of the Referral Form and Letter 1 (Appendix 1 & 2) to all core members of the ESCR and to any other agencies where there is any indication that they may have been involved in the case. This requires agencies to seal their files and to confirm if they have had any contact with the child or family and briefly outline their knowledge of the case.

**2.3.2 Letter 1 should be copied to the relevant Chief Officers where there is knowledge to indicate that their agency may have had involvement with the child/family. This includes agencies out of county. It is therefore vital that as soon as the ESCR become aware that other agencies including those out of county have had involvement with the family, the BLSCB Business Manager is made aware.**

## **2.4 Notifying Ofsted / Children's Services Advisor at DCSF (GO East)**

2.4.1 The Designated Person, usually the BLSCB Business Manager on the ESCRP is required to report the decision to commission an SCR to Ofsted and to the Children's Services Advisor at DCSF. The appropriate NHS representative is required to notify the Strategic Health Authority (SHA).

2.4.2 Ofsted's National Business Unit (NBU) – Tel: 08456 40 40 40 – is notified that a SCR is to take place and informs them if there are any immediate reasons why the review may take longer than the prescribed time-scales.

2.4.3 If necessary the following should be informed as appropriate:

- DCSF Children's Safeguarding Unit should be informed immediately of all deaths of looked after children
- DCSF Early Years Unit and Ofsted should be informed if children's day care or childminding is involved.
- DCSF, Ofsted, SHA and DOH should also be informed if a school is involved.

## **2.5 Notifying Families**

2.5.1 Working Together (2006, Chapter 8,) urges LSCB's to consider the degree to which they involve families in SCR's, and who should be responsible to facilitate this. Each case is unique and it is therefore important that careful consideration is given to the best means of notifying families.

2.5.2 Involvement can range from formal notification only, to inviting them to share their views with the Overview Author in writing or through interview. These questions will form part of the discussions when the ESCRP is drawing up the Terms of Reference for the particular SCR.

2.5.3 Normally families (this is usually family members who have played a significant role in the child's life, such as parent(s) and grandparents) should be notified that the SCR is taking place. This is best done by letter either directly to the family members or via their solicitor(s), as seems most appropriate given the particular circumstances. The timing of such notifications is crucial particularly where there are ongoing Police investigations. Under these circumstances, the decision about when to notify needs to take place within the ESCRP, with the Police representative present. Liaison with the family is the responsibility of the Author.

2.5.4 The family should be informed that Working Together requires that the findings of the review are made public. This would usually be through the publication of an executive summary. The family should be reassured that the report will be anonymised and their identity and privacy protected.

2.5.5 The "family" refers primarily to persons with parental responsibility, but those with a legitimate interest in the child may also be involved if the BLSCB believes this to be in the best interests of the child and purposes of the review, and taking into account the views of those with parental responsibility.

## **2.6 Notifying Victims**

2.6.1 Each case is unique and it is therefore important that careful consideration is given to the best means of notifying victims. For example, where the review concerns historical abuse and the child victim is now a young person or adult, a sensitively handled notification can be a positive experience, allowing some sort of “closure”. This can be achieved through them being informed of the process and helped to understand the issues raised.

2.6.2 The Executive Summary could be a useful tool. It may be appropriate, depending on the age and understanding of the child/adult, for this to be done in person, rather than by letter.

## **2.7 Criteria for Serious Case Review not met**

There may be cases where the ESCRCP decides that the criteria are not met and in these circumstances the ESCRCP may consider conducting a review under the following two categories:

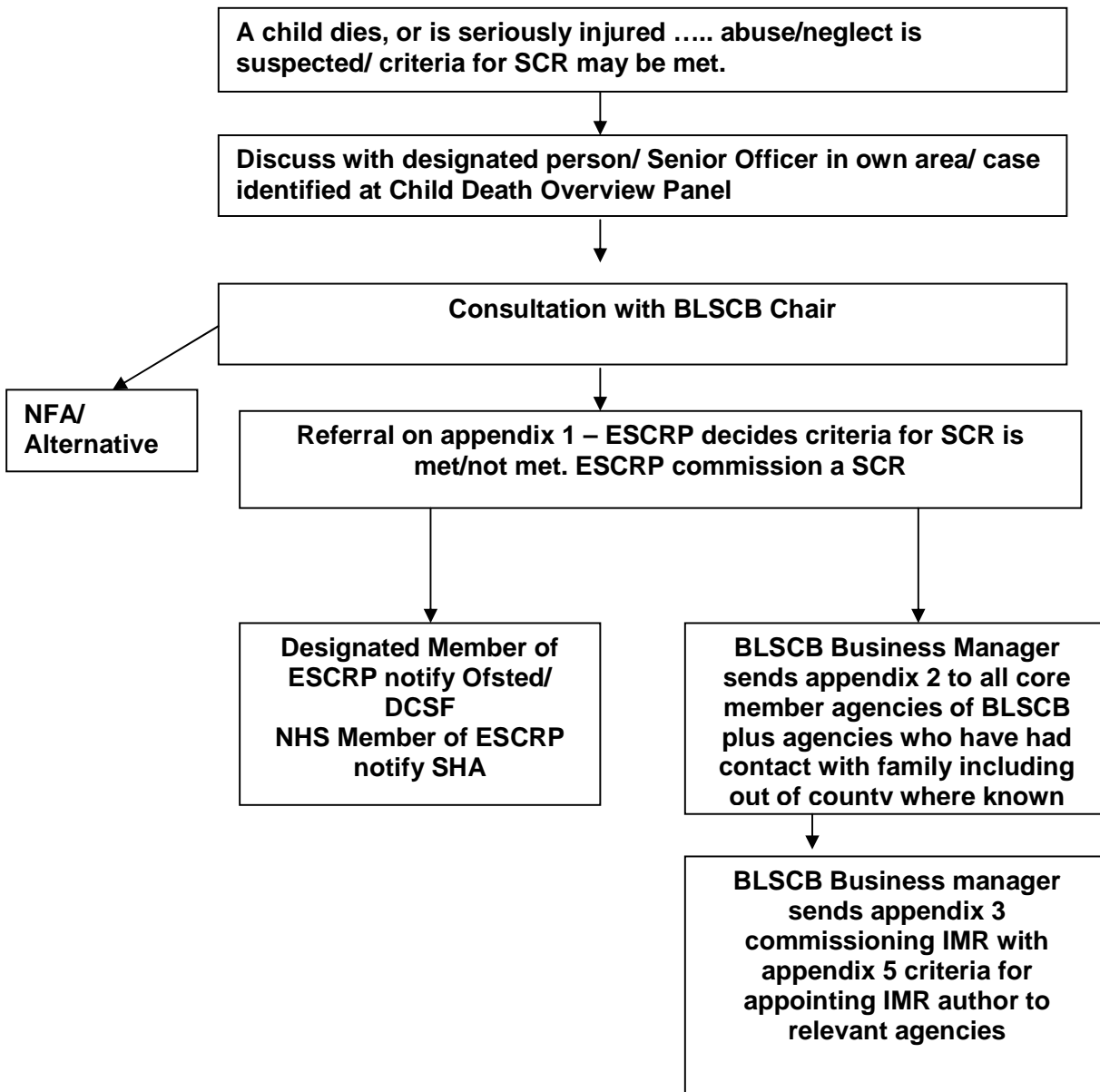
## **2.8 Interagency Practice Reviews (IPR)**

2.8.1 When the ESCRCP decides that a case does not meet the criteria for a SCR as defined in Working Together (2006), the Chair of BLSCB in consultation with the ESCRCP members may decide that an IPR would be the most appropriate way forward. The scope of the IPR will be agreed with the ESCRCP and the work will be carried out by local managers supported by members of the ESCRCP. An independent author will not be appointed to provide a report, but this does not mean that there will be a reduction in rigor 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 BLSCB 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 ESCRCP and the Strategic Board.

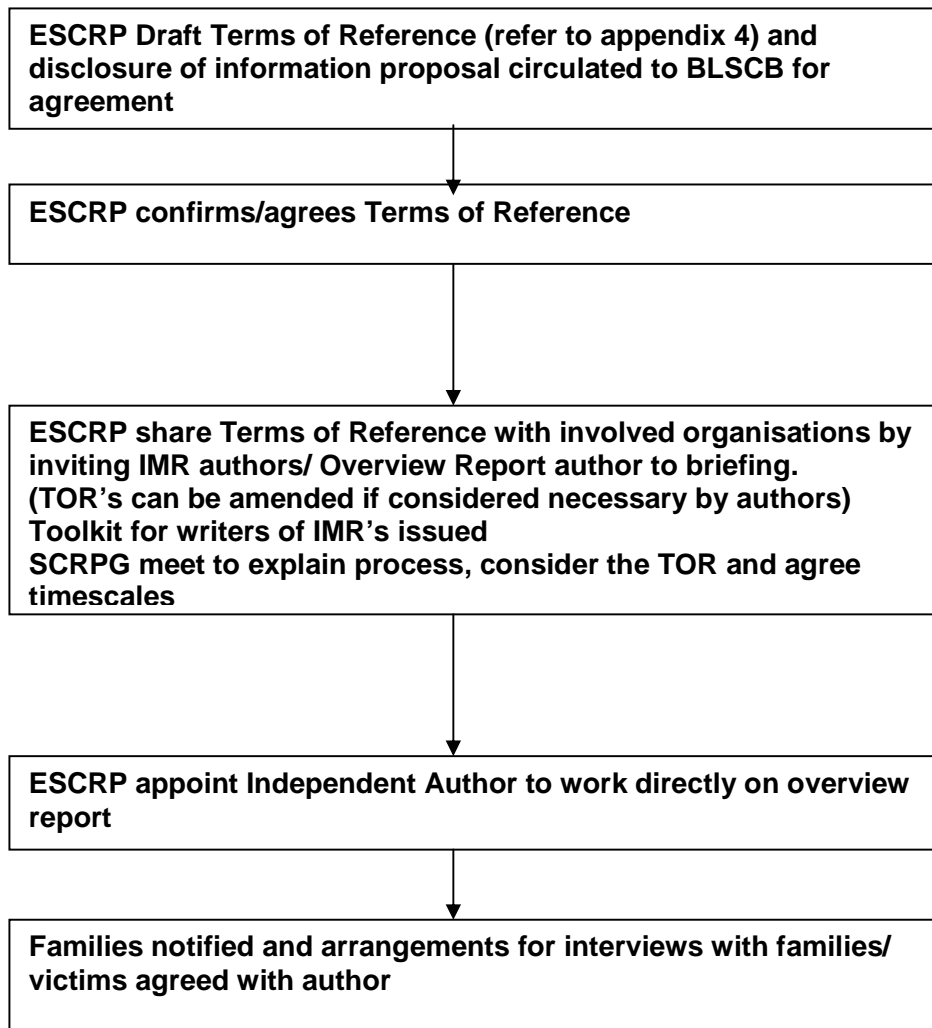
## **2.9 Near Miss Review (NMR)**

2.9.1 Introduces the idea of interagency ‘near miss’ reviews into cases that almost went wrong, a concept already familiar to health colleagues. NMR’s 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 review will be carried out by the managers and practitioners involved and a brief report will be presented to the ESCRCP. Please visit [www.bedfordshirescb.org.uk/publications](http://www.bedfordshirescb.org.uk/publications) for the NMR process.

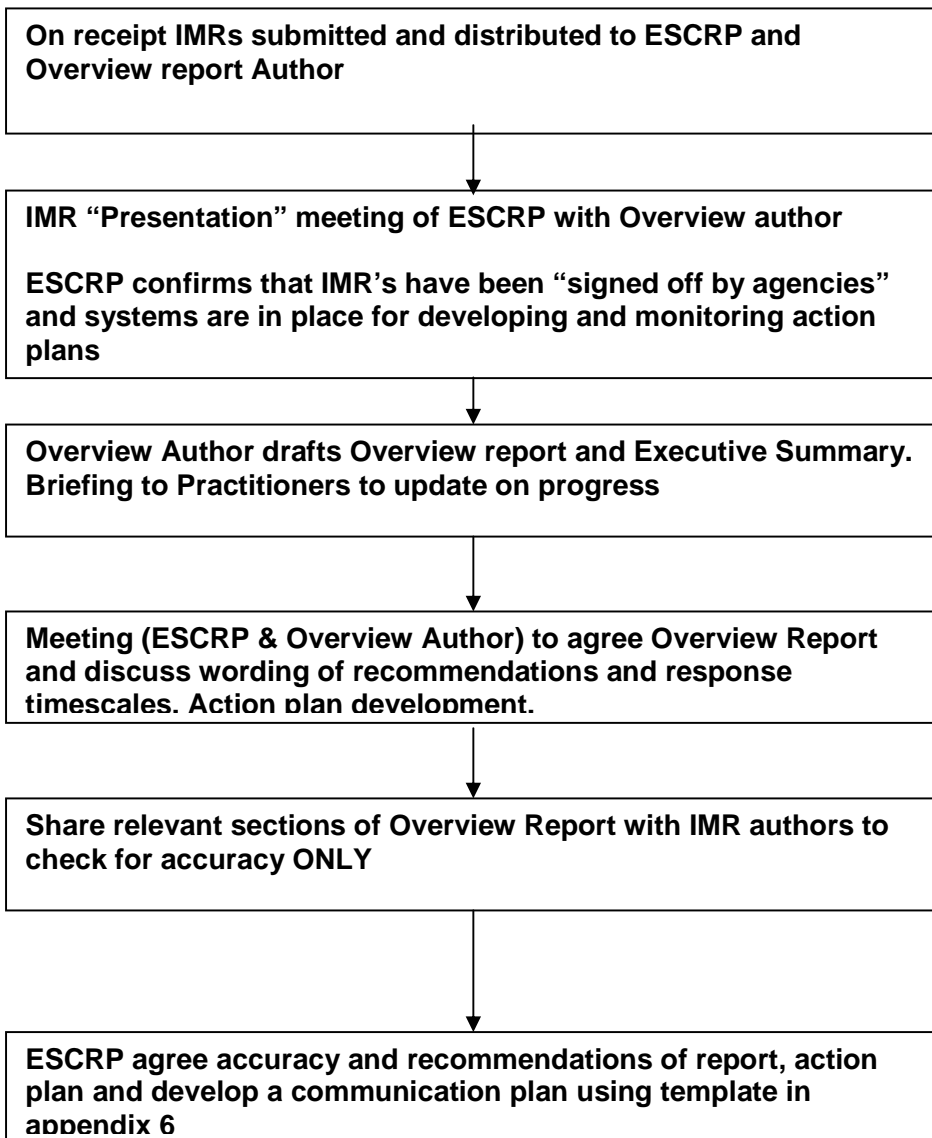
## 1. Referral



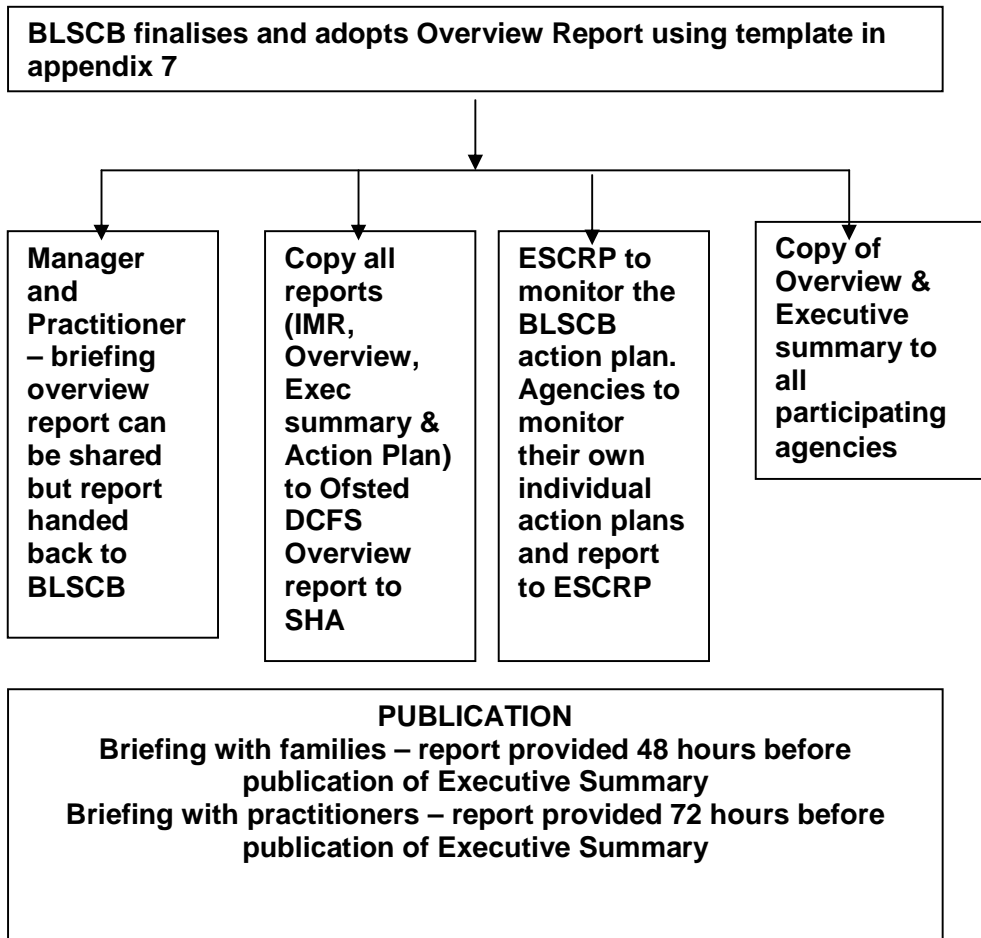
## 2. INSTIGATING A SERIOUS CASE REVIEW



### 3. COMPLETING A SERIOUS CASE REVIEW



#### 4. ROLE OF BLSCB



## **3. Initiating a Serious Case Review**

### **3.1 Agreeing Terms of Reference/ Scoping the SCR**

3.1.1. Better outcomes can be achieved if all the IMR's address the same questions and issues, pertinent to the SCR being undertaken. These are formulated as case-specific Terms of Reference (TOR).

3.1.2 Time spent on this part of the process is crucial and will affect the quality of IMR's and ultimately, lessons arising from the Overview Report. The development of the TOR is time intensive and may take the ESCRП two or three meetings to achieve see appendix 4 page 39 for a draft template.

3.1.3 Initial TOR drawn up following discussion within the ESCRП and need to form part of a consultative process, during which representatives on the ESCRП share them with the relevant officers within their own organisations. As the TOR go through several re-writes, a date on each draft version is vital (use of footer).

3.1.4 The TOR are finalised once they have been discussed at the Overview Report Author's Briefing and maybe amended following further information being collated.

3.1 5 Working Together 2006 (8.12 page 172) provides a checklist of issues that need to be considered when drawing up the Terms of Reference for a SCR.

### **3.2 Author of Overview Report**

3.2.1 There is always a choice to be made about whether to appoint an in-house or independent Overview Author. In both cases "independence" is crucial.

3.2.2 BLSCB recognises the value of using Independent Authors in order to ensure an independent examination of the inter-agency practice issues that arise in each SCR. Whilst this clearly has budget implications, the consequent added value has been acknowledged. It is ultimately the decision of BLSCB chair and the ESCRП to appoint the Overview Report author.

### **3.3 Process for Appointing an Independent Overview Report Author**

3.3.1 The ESCRП has responsibility for identifying suitable candidates. For all externally appointed Authors, a minimum check will include:

- A CV
- An example of an Overview Report recently written by them
- A written reference from a Senior Manager/LSCB Chair in an authority where they have recently written an Overview Report
- A face to face interview with the candidate to confirm that their method of working is congruent with the values and principles laid down in this practice guidance maybe undertaken dependent on timescales and previous knowledge of the Overview Report Writer
- CRB check

3.3.2 For all in house appointed Authors, a minimum check will include:

- A written reference from their line manager expressing support in terms of supervision and time allocation for the individual to undertake the review
- Confirmation that an enhance CRB check has been completed within the last 3 years.

### **3.4 Commissioning a contract with the Overview Report Writer**

3.4.1 Once the appointment is agreed, a contract outlining terms and conditions will be sent to the candidate. The contract to specify the tasks required i.e. Writing of Overview Report and production of Executive Summary and presentation at press conference.

## **4. Completing a Serious Case Review**

### **4.1 Individual Management Reviews (IMR's)**

4.1.1 IMR'S will be commissioned from the organisations involved with the child and family throughout the period of the review agreed as part of the terms of reference.

4.1.2 The ESCRP will provide guidance on what information is required from organisations. Organisations may wish to seek advice from their own legal advisors if they are unclear about information sharing. (i.e. parents information) The aim of IMR's is 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. The ESCRP will provide a briefing to practitioners to explain the SCR process. On receipt of the Appendix 1 & 2 the Chief Officer of the agency will need to identify the author of the IMR.

4.1.3 The author should be a senior member of staff who has not had any direct involvement with the case or team. Agencies can decide to appoint an independent author, which would be at their own expense. Please refer to the IMR Report Writers Toolkit available at [www.bedfordshirelscb.org.uk/publications](http://www.bedfordshirelscb.org.uk/publications)

### **4.2 Sign off of the IMR's**

4.2.1 Upon completion of each management review report, there should be a process for feedback and de-briefing for staff involved, in advance of completion of submission of the IMR. There may also be a need for a follow-up feedback session if the Overview Report raises new issues for the organisation and staff members.

4.2.2 IMR authors must ensure that their reports have been discussed with relevant managers in their own organisation and that the final report is signed off by their Director/Chief Executive Officer (or delegated representative).

**4.2.3 Signed copies of finished reports need to be sent to the BLSCB Administrator by the agreed deadline, so that they can be circulated to the ESCRP.**

**Agencies should ensure that once they have signed off an IMR that they have robust arrangements for developing an action plan and monitoring actions, this**

will enable agencies to report to BLSCB on actions taken once the Overview Report has been accepted.

### 4.3 Presentations of Individual Management Reviews to the ESCR and Overview Author

4.3.1 Once an IMR is completed, it is presented to the ESCR and the completed IMR's will be circulated to all members of the ESCR and the Overview Author by the BLSCB Administrator 1 week before the ESCR meeting.

### 4.4 The Executive Summary

4.4.1 An Executive Summary will be completed which will provide a public document that is short, anonymous, and based on the Overview Report. The ESCR will need to consider the implications of the Freedom of Information Act in deciding what information should be placed in the public domain (refer to section 1.6).

4.4.2 The primary purpose of the Executive Summary is to inform a wider population of the organisations involved, and the public, of the key elements in the SCR, namely:

- **Introduction** - role of BLSCB and ESCR and purpose of the SCR
- **Background/ Case Summary** - anonymised summary of the case and the key themes arising from the case review
- **Case Specific Recommendations/lessons learned** - acknowledge recommendations, action plans and timescales. Identify monitoring and reviewing process
- **Recurring themes** - relationship of the individual case review to previous local and/or national enquiries
- **Implications for future /communication strategy** - professional practice including highlighting good practice and procedural issues and implications for interagency procedures.

4.4.3 The Executive Summary can be used in the following way:

- A demonstration of the way in which BLSCB has exercised its responsibilities in relation to death or injury of child/children.
- A basis for press briefings should the SCR process attract media attention.
- An efficient means of informing Chief Officers and the inter-agency practice community of key learning arising from the review of practice.
- Core information upon which to build more elaborate case specific training materials.

4.4.4 The Executive Summary is completed by the Overview Author. A draft should be circulated to the ESCR for comment before final endorsement by BLSCB.

4.4.5 Copies of all reports should be marked as draft until approved. The publication of the Executive Summary will need to be timed in accordance of any related court proceedings.

### 4.5 Accountability and Disclosure

4.5.1 BLSCB should consider carefully who might have an interest in SCR – 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 BLSCB. The Police Superintendent, as representative on the ESCRP, will need to notify the officer in charge of the criminal investigation of the existence of the Overview Report.

4.5.2 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 ESCRP to consider potential media involvement in line with the BLSCB Media Strategy.

## **4.6 Submission of the SCR and publication of the Executive Summary**

4.6.1 The ESCRP will need to consider a publication strategy to make public the lessons learnt as part of the review. The ESCRP should consider carefully who might have an interest in reviews, for example, elected and appointed members of 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;
- Constraints on public information sharing when criminal proceedings are outstanding, in that providing access to information may not be within the control of the BLSCB.

4.6.2 The key outcomes of a communications strategy will be to:

- To provide information in a clear and consistent way

- To concentrate on the lessons learned and what is and what has been done to address them
- To support the family of the victim and engage them in the launch of the report

4.6.3 When developing a communications strategy, the ESCRP will need to consider the following:

- Key messages
- Key audience
- Types of processes used to make public the lessons learnt, options include, press release, use of website, press conference etc
- Roles and responsibilities of key individuals
- To identify which agency will provide a communication lead including the issuing of press releases on behalf of BLSCB which will be independent from any briefings from other agencies involved in the SCR
- Support offered to families
- Briefing of staff on the contents of the report
- Briefing of the families and those involved in the compilation of the report
- Available resources for publication
- Debriefing arrangements to those involved
- The need for media training

## **4.7 Retention of Papers**

4.7.1 The sensitive nature of information contained within IMR's and the Overview Report must not be underestimated. There is a balance to be kept between sharing information widely in order to increase participation, ownership and learning, and the appropriate management of personal and professional detail.

## **4.8 Finalisation and Adoption of the Overview Report**

4.8.1 The Overview Report and Integrated Chronology need to be formally adopted by the BLSCB. This will be preceded by a formal presentation of the report by the Chair of the ESCRP to the BLSCB in conjunction with the Overview Author.

4.8.2 A central purpose of the adoption meeting is to allow discussion amongst BLSCB members on the case and to secure their commitment to implementing the report's recommendations according to the framework set out in it. .

## **4.9 Ofsted / DCSF /GO East**

Once adopted, the following documents must be sent to the Ofsted / DCFS/GO East:

- IMR's, including the chronology, and recommendations
- The Overview Report
- Integrated Chronology
- Executive Summary
- Agency Action Plans ( agencies other than Local Authority Children's services will need to consent to this)

## 5. Learning from Serious Case Reviews

### 5.1 A strategy for learning and support

**5.1.1 “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.” (Working Together 2006 8.34)**

5.1.2 The focus of SCR’s is on the effectiveness of local services towards children who have suffered very serious or fatal significant harm, and their main messages to agencies concerned have not changed over the 30 years that such inquiries have been undertaken. This is despite the development of a sound legislative framework and the refining of policies and procedures. These developments led the Victoria Climbié report to conclude that the current gap in safeguarding is not a matter of law but of its interpretation. The protection of Victoria required “nothing more than basic good practice being put into operation.”

5.1.3 Basic good practice also requires training, supervision and support. The Bedfordshire serious case reviews highlight training and challenge us to address this appropriately for the thousands of people in our area who share the tough and challenging job of safeguarding children. This document aims to set out a way of helping us to learn from serious case reviews through active multi agency engagement.

5.1.4 It proposes to do this using:

- Case study materials to support learning
- Debriefings for those involved in cases where a serious case review has been undertaken
- Practitioner briefings
- Briefings for managers
- Newsletters- to share learning from reviews
- Focused training (where specific needs are identified).

### 5.2 Case Studies

5.2.1 Case studies will provide a summary of the SCR process and offer an anonymised account of the case. These will list key recommendations, with questions to consider when using the case study. They are aimed to be used in single/inter agency training, practice development groups or other forums. When agreed the case studies should be widely disseminated and briefings offered for those trainers who will be using these on a single agency basis.

5.2.2 The BLSCB may wish to consider evaluating their use by requesting single agency reports on the outcomes of any training provided.

### 5.3 De-briefings for those involved in the SCR

5.3.1 Following adoption/endorsement of the Overview Report and the development of an Action Plan, practitioners directly involved in the case will be invited to a de-briefing meeting.

The purpose is to:

- Give feedback on the Overview Report, Recommendations, Action Plan and messages for learning from these, in advance of dissemination to the wider system
- Where possible, a member of the ESCRP and the Training and Development Commissioning Manager will be present in order to offer further clarification of practice issues arising from the SCR.

5.3.2 For the purposes of the meeting, those attending will be sent a hard copy of the Overview Report in advance. This will be handed back to the BLSCB Administrator at the end of the meeting.

#### **Aims:**

- **Involvement:** to appropriately involve all practitioners dealing directly with the case.
- **Clarification:** this is an opportunity to clarify and discuss the SCR process and its purposes. It is a highly anxious time for practitioners when there may be ongoing work with a family: juggling ongoing operational issues and being open to the perceived scrutiny of the SCR process, being interviewed by the Single Agency Management Review author etc.
- **Participation:** it provides the opportunity to meet other professionals who are in the same boat and also to discuss their often-differing experiences within their agency. For example: support, sealing files, reactions/responses from colleagues.
- **Support:** Some practitioners are well supported through the intense scrutiny of their practice by their own organisation. Others may seek outside, independent support. The briefing would aim to be supportive to practitioners and discuss support available
- **Learning:** To discuss the recommendations and learning from the case and any implications for practice

#### **It is not appropriate to discuss operational issues in this meeting**

#### **The briefing will last no longer than 2 hours and cover the following areas:**

- General issues relating to SCR's (as outlined in Working Together)
- The process of a SCR
- The issues specific to the case review (as outlined in the terms of reference)
- Clarification of any questions or queries that the practitioners may have.

### **5.4 Practitioner Briefings**

These briefings would be available to a wider audience and use the material prepared in the case study (if available)

#### **Aims:**

- **Clarification:** to clarify and discuss the SCR process and its purposes
- **Participation:** to provide the opportunity to meet other professionals to discuss how agencies can best work together to safeguard and promote the welfare of children.

- Learning: To discuss the recommendations and learning from the case and any implications for practice

It is not appropriate to discuss operational issues in this meeting.

The briefing is usually facilitated by a member of the ESCRP; and the Training Development Implementation Sub Group. The briefing will last approximately 2 hours and cover the following areas:

- General issues relating to SCR's (as outlined in Working Together)
- The process of a SCR
- The issues specific to the case review (as outlined in the terms of reference)
- Clarification of any questions or queries that the practitioners may have.

### **5.5 Briefings for managers**

These briefings will use the overview report/case study and aim to offer:

- An opportunity for managers to discuss learning from the case
- Promote shared responsibility for practice development
- Build a culture of learning in organisations

### **5.6 Interface with disciplinary**

The purpose of this report, as distinct from any disciplinary action that an agency may take, needs to be carefully explained to staff. SCR's 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.

**APPENDIX 1 – Referral form to ESCRP for consideration of a Serious Case Review**

**PART 1** (To be completed within 72 hours following identification of an incident occurring by the referring officer following discussion with Senior Manager / Designated Child Protection/Safeguarding Professional or agency member of ESCRP where appropriate).

**1. Referrer**

<b>Name</b>		<b>Agency</b>	
<b>Email</b>		<b>Line Manager</b>	
<b>Phone No</b>		<b>Chief Executive</b>	

*Please fax or email the completed form to:*

**Chair of BLSCB – c/o Sally Stocker Business Manager – 01234 276767  
lscb@bedscc.gov.uk**

**BRIEF RESUME OF FACTS AND FAMILY COMPOSITION**

**2. Child and Family**

Name of Child:	
Date of Birth:	
Date of death (if applicable):	
Date of critical incident:	
Home address:	
Ethnic origin:	
Subject to a Child Protection Plan?	YES/NO
Whereabouts of child at time of critical incident	
Whereabouts of carer at time of critical incident	

Family Composition/Significant Others

Name	Relationship to child	DoB	Address	Legal Status	Ethnic Origin	Was/Is Subject to CP Plan?

**3. Other agencies Involved:**

Name	Agency	Contact Details	Is your agency still involved?

**4. Circumstances that triggered the referral**

a) Death of the Child including death by suicide, “and abuse or neglect is known or suspected to be a factor in the child’s death (Working Together, 8.2).

b) Potentially life-threatening injury (through abuse or neglect), serious sexual abuse, or serious and permanent impairment of health or development (through abuse or neglect) (Working Together 8.2):

c) The parent has been murdered and a homicide review is being initiated (Working Together 8.2).

d) The child has been killed by a parent with a mental illness

OR

e) Concerns about Inter-Agency Working:

Please say what concerns you have about the way agencies worked together in this case, that would indicate the need for a case review (Working Together, 8.2)

**Please outline events and circumstances relevant to the above category.**

## **5. Date of Referral**

## **6. Signed**

**Please summarise the details of the critical incident by addressing the following questions**

- Was there clear evidence of a risk of significant harm to a child, which was:
  - not recognised by organisations or professional in contact with the child or perpetrator *or*
  - not shared with others *or*
  - not acted upon appropriately?
- Was the child killed by a mentally ill parent?
- Was the child abused in an institutional setting (e.g. school, nursery, family centre, Youth Offending Institute (YOI), Children's Home or Armed Forces Training establishment)?
- Did the child die in a custodial setting (YOI or Prison)?
- Was the child abused while being looked after by the local authority?
- 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 upon 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 to a child protection plan or had it been previously 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 BLSCB may need to change its local protocols or procedures, or that protocols and procedures are not adequately being promulgated, understood or acted upon?

(Working Together 8.9)

## CHRONOLOGY OF KEY DATES

Date (& time where appropriate)	Event

**Note: Agencies are reminded of the need to secure their files as soon as they become aware that a Serious Case Review might take place.**

### **PART 2**

(To be completed by the Chair of the LSCB)

**It is [recommended] [not recommended] that this case be subject to a Serious Case Review for the following reasons:-**

**When a case does not meet the criteria for review, other options may be considered:**

	Tick
<b>Interagency Practice Review (IPR)</b>	
<b>Near Miss Review (NMR)</b>	
<b>Bringing practitioners/managers together through an independently facilitated learning day. The aim would be to focus on inter-agency practice processes to effectively support the identified complexities of the case.</b>	
<b>A structured inter-agency audit</b>	
<b>Alternative processes suggested by the nature of the case.</b>	

**The following members of LSCB have been consulted:-**

**Legal advice has/has not been sought**

I recommend that ..... be approached to write the Overview report.

Signed.....Dated.....

**PART 4** (To be completed by the chair of the ESCR)

**The terms of reference and scope of the report agreed by the ESCR is set out below:-**

Signed.....Dated.....

**Appendix 2 - Letter 1 Requesting additional information and to seal files**

Dear Colleague

**(To be sent to ALL BLSCB Core Members plus Chief Officers of agencies who have been involved in service delivery to the family)**

**RE: EXECUTIVE SERIOUS CASE REVIEW PANEL: REQUEST FOR ADDITIONAL INFORMATION**

I am writing to inform you that the Bedfordshire Local Safeguarding Children Board (BLSCB) have commissioned a Serious Case Review under Chapter 8 of Working Together. The attached referral form provides family details.

Under Working Together to Safeguard Children, 2006, Chapter 8, you are required to check your own agency records for past or current involvement with this family and provide us with any information that may assist us in completing a Serious Case Review.

If your agency has not had any involvement with the family, a NIL return is required. Please use the prompts on pages 2 and 3 of the attached referral form. If your agency is aware of any organisation, not represented on the Bedfordshire Local Safeguarding Children Board who has had involvement with the family, please contact me as soon as possible.

If you would like further information on this matter, please contact either your agency representative on the Executive Serious Case Review Panel (ESCRP) ..... or alternatively, you can contact the BLSCB Business Manager Sally Stocker or the BLSCB Secretary Sue Fanthorpe on 01234 276797.

Once all relevant information becomes available, the ESCRP will make a decision on how to proceed. The Panel will agree detailed Terms of Reference for the Serious Case Review which will be drafted and sent to you.

**In the meantime, would you please ensure that any and all files within your organisations relating to this family are sealed and a photocopy made if they will be needed for ongoing work. If agency involvement has been recent you may wish to check with staff if any outstanding records are waiting typing / filing or if any information is stored separately. These records should be included in the case files as soon as possible.**

**Please forward any information you have to Sue Fanthorpe at the above address by..... (Date) in preparation for the ESCRP meeting on .....(date)**

Yours sincerely

**Sally Stocker  
LSCB Business Manager**



- Bedfordshire LSCB is the responsible authority – we are not aware of any other LSCB involvement.
- A case review should always be undertaken when a child dies and abuse or neglect is known or suspected to be a factor in the child's death.

*Working Together* also states that the purpose of such Reviews should be threefold:

- 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;
- to identify clearly what these lessons are, how they will be acted upon, and what is expected to change as a result;
- to improve inter-agency working and to better safeguard children.

### **Scope of Review**

As a minimum, the review should cover the period from **date**.

### **Time Framework**

A document indicating the time framework for this case, as laid down by *Working Together 2006*, is attached. The aim should be to complete the review according to this schedule.

### **Individual Management Review Author**

Will all agencies that have had any involvement in this case please appoint an appropriate author to undertake an IMR. This should be someone of sufficient experience in safeguarding who is independent of the line management of the case and is not reviewing his or her peers.

In nominating this person you are committing them to attend a briefing meeting for all IMR Authors on **day date at time**. They will need adequate time set aside to undertake this work within the very tight timescales required by **Ofsted**.

Please urgently advise Sally Stocker LSCB Business manager tel 01234 276774 or sally.stocker@bedscc.gov.uk as to who will be undertaking the review as Investigating Manager on your behalf **(by Day date)**. If your agency was not involved with the family I would ask you to inform Sally Stocker of this to complete our records.

### **Agency Representation on the Executive Serious Case Review Panel:**

The purpose of the Executive Serious Case Review Panel is to offer expertise and independence rather than representation. Its task is to give an independent overview of how agencies work together. For this review members of the Serious Case Review Project Group (SCRPG) will be as suggested by the ESCRP from:

- list agencies/roles

Please will these agencies also advise Sally Stocker who will be representing them on the SCRPG by \_\_\_\_\_ to enable meetings to be scheduled. Please be aware that membership of the SCRPG involves a significant time commitment. As suggested by the ESCRP, I can confirm that \_\_\_\_\_ will be chairing the SCRPG for this case.

## **Chronologies and Management Reports**

Please submit your Chronology to Sally Stocker by \_\_\_\_\_ and your IMR no later than \_\_\_\_\_. The IMR's should be submitted electronically, but a copy duly signed off by your Chief Executive will also be required. If delays are unavoidable, please alert Sally Stocker as soon as possible.

Please note the need for the Individual Management Report to provide the SCRPG with information about your agency's involvement in this case and to consider learning points that should be reflected in the recommendations made. Staff involved in the case should be interviewed to assist you in completing the Individual Management Report.

## **Serious Case Review Process**

Enclosed is a Serious Case Review Process, giving full details of the process. An electronic version of this will also be sent to you by Sally Stocker. Please will you ensure that this information is passed on to your IMR Author and that information is provided in the required format and according to the guidelines.

If you have any questions or require any help in completing the IMR then please contact \_\_\_\_\_ (Tel \_\_\_\_\_), and they will be pleased to offer guidance on completing the required documents.

## **Password**

The password for this case has been agreed as: \_\_\_\_\_. Please ensure that any confidential documents transmitted electronically are protected using this.

Thank you for your co-operation.  
Yours sincerely

Laura Eades

Chair of Bedfordshire LSCB and Executive Serious Case Review Panel.

## Appendix 3: Letter 2 Commissioning Individual Management Reviews

**To: See Distribution**

**From: Chair of ESCRP**

**Date:**

**Dear Colleague,**

**SERIOUS CASE REVIEW: (Child's Name, DOB and DOD if applicable)**

Bedfordshire Local Safeguarding Children Board has requested that a Serious Case Review under Working Together 2006 takes place concerning the above child/ ren. The aim of the review is to ascertain the facts, analyse them and identify any lessons that need to be learned. Contextual information is important for the Serious Case Review Project Group (SCRPG) to understand the circumstances of the case and make appropriate recommendations for change.

I am writing to you in your capacity as the Chief Executive or Designated Senior Officer to nominate an Individual Management Review Author. Only if the family is known to your organisation will this be necessary.

Please find attached the Terms of Reference for the above Serious Case Review that has been produced by the Executive Serious Case Review Panel in accordance with Working Together to Safeguard Children 2006.

This letter formally commissions an Individual Management Review report from the following organisations:

- Bedford Borough & Central Bedfordshire Council Children's Services
- NHS Bedfordshire
- Bedford Hospital NHS Trust
- Bedfordshire & Luton Partnership Trust
- Bedfordshire Police

**Consider agencies from out of the authority area**

The person you nominate to write your Individual Management Review is invited to a briefing along with the Overview Report Writer on \*\*\*\*\*. This briefing will involve reinforcing general messages on Serious Case Reviews, including format, as well a closer look at the scope of this particular review to ensure that everyone is clear about the remit that they have been given. It will also set out timescales for completion of reports. It is important that your representative attends.

The reports will need to include a chronology of agency involvement with the family. It is a requirement of Working Together 2006 (8.29) that copies of Individual Management Reviews are provided to Ofsted and DCSF with the Overview Report on adoption by the LSCB.

A toolkit for your Individual Management Review writer which includes a template for the report and the chronology will be available at the meeting and can be forwarded electronically.

It is important that the report deadline is met so that they can be circulated to the Executive Serious Case Review Panel in advance of the meeting on \*\*\*\*\*.  
Writers will be expected to attend this meeting to present their reports, and we can organise the timing of presentations when we meet on \*\*\*\*\*.

Please note that the ESCRP reserve the right to remit the IMR if it does not comply with the requirements of Working Together to Safeguard Children or this process.

If you have any questions or queries please contact Sally Stocker LSCB Business Manager 01234 276774 or email sally.stocker@bedscc.gov.uk.

Please confirm the name and contact details of your agency's Individual Management Review author to me by xxxxxxxxxxx

Yours Sincerely

Laura Eades  
LSCB Independent Chair

**Distribution:**  
**Refer to letter 1**  
**cc Chief Officers of all agencies listed**  
**LSCB Officers of all authorities involved**

## Appendix 4: Scoping a Serious Case Review

### Template for Scoping the SCR Process and Identifying Terms of Reference

The panel should consider, *in the light of each case*, the scope of the review process, and draw up clear terms of reference. (WT 8.12) It may be useful for the panel to consider each of the following, indicating where an issue is not applicable and adding additional considerations where appropriate. Supplementary questions have been included to assist this process.

<b>1.</b>	<p><b>Decision to hold SCR</b></p> <ul style="list-style-type: none"> <li>• <i>Add date when notification to Ofsted was made</i></li> <li>• <i>Add date when the Chair of LSCB (name and proof of independence) agreed to hold SCR.</i></li> <li>• <i>State name and independence status of SCR Panel.</i></li> <li>• <i>Provide detail as to why SCR was necessary using 8.5 or 8.6. as basis</i></li> <li>• <i>Identify reasons for any delays in deciding to hold SCR</i></li> </ul>
<b>2.</b>	<p><b>Key Issues:</b> <i>(really important section)</i></p> <ul style="list-style-type: none"> <li>• <i>What specific issues or questions does this case raise?</i></li> <li>• <i>Are there any unusual factors in this case, what are they?</i></li> <li>• <i>Are there similarities with previous IMRs or SCRs, what are they?</i></li> <li>• <i>Are there any failings which appear obvious at this stage?</i></li> <li>• <i>Does there appear to be any gaps in multi –agency working?</i></li> <li>• <i>Are there any issues which relate to ethnicity, disability or faith which may have a bearing on this review? If not, say so.</i></li> <li>• <i>Is there any known research which may assist?</i></li> </ul>
<b>3.</b>	<p><b>Expert Opinion</b></p> <ul style="list-style-type: none"> <li>• <i>Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?</i></li> <li>• <i>Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?</i></li> </ul>
<b>4.</b>	<p><b>Time Period over which events should be reviewed</b></p> <ul style="list-style-type: none"> <li>• <i>Over what time period should events be reviewed, - i.e. how far back should enquiries cover, and what is the cut-off point?</i></li> <li>• <i>What is the relevance of selecting this time period?(Remember even complex family history can be summarised)</i></li> <li>• <i>What family history/background information will help better to understand the recent past and present?</i></li> </ul>
<b>5.</b>	<p><b>Organisations to be involved in this SCR</b> <i>(would be useful to state which are universal/targeted/specialist services?)</i></p> <ul style="list-style-type: none"> <li>• <i>Which organisations and professionals will be asked to contribute to this review and submit reports or otherwise contribute?</i></li> <li>• <i>What action will the Board take if there is a failure to cooperate with this review?</i></li> <li>• <i>Who will make the link with relevant interests outside the main statutory</i></li> </ul>

	<i>organisations – e.g. independent professionals, independent schools, voluntary organisations?</i>
<b>6.</b>	<b>Involvement of Family Members</b> <ul style="list-style-type: none"> <li><i>Are there any known factors which may affect the involvement of any family members?</i></li> <li><i>Which family members will be asked to contribute and why?</i></li> <li><i>Are there issues around timing which may affect this dialogue?</i></li> <li><i>Who will be responsible for supporting family members involved?</i></li> <li><i>What resources will be required to facilitate this process?</i></li> </ul>
<b>7.</b>	<b>Other Parallel reviews (e.g. PPO/ homicide or suicide reviews)</b> <ul style="list-style-type: none"> <li><i>Will the case give rise to other parallel investigations of practice – e.g. independent health investigations or multi-disciplinary suicide reviews, a homicide review where a parent has been murdered, a Youth Justice Board Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting?</i></li> <li><i>If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions that need to be asked, in the most economical way?</i></li> <li><i>What are the arrangements for co-ordinating and liaising with those involved?</i></li> <li><i>What problems may emerge in terms of confidentiality and sharing information and how will these be addressed?</i></li> <li><i>What are the implications of any different or challenging timescales?</i></li> </ul>
<b>8.</b>	<b>Involvement of organisations in other LSCB areas</b> <ul style="list-style-type: none"> <li><i>Are there any other organisations involved with this family or any cross boundary issues which may involve other LSCBs?</i></li> <li><i>Who will take responsibility for contacting that LSCB to negotiate, manage and co-ordinate their involvement in the SCR process?</i></li> <li><i>What should be the respective roles and responsibilities of the different LSCBs with an interest?</i></li> </ul>
<b>9.</b>	<b>Coroner's Inquiries/Criminal Investigations</b> <ul style="list-style-type: none"> <li><i>Are timescales for Coroners/criminal or civil proceedings known and will revised timescales be likely?</i></li> <li><i>Who will liaise with the Coroner's office and/or Crown Prosecution Service?</i></li> <li><i>Has the Coroner issued any advice and how will this be addressed in the SCR?</i></li> </ul>
<b>10.</b>	<b>Media Coverage/Enquiries</b> <ul style="list-style-type: none"> <li><i>How should any public, family and media interest be managed before, during and after the review?</i></li> <li><i>Be specific, including how reports will be anonymised</i></li> <li><i>Is there a communications/media strategy?</i></li> <li><i>How should any FOI requests relating this case be handled and by whom?</i></li> </ul>
<b>11.</b>	<b>Legal Advice</b> <ul style="list-style-type: none"> <li><i>Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review?</i></li> <li><i>If Yes, give reasons</i></li> </ul>
<b>12.</b>	<b>SCR Review Timescales</b> <ul style="list-style-type: none"> <li><i>The review process should start within one month of notification and should,</i></li> </ul>

	<p><i>unless extensions are agreed with Government Office conclude and be forwarded to Ofsted and copied to Government Office within 4 months from that start date.</i></p> <ul style="list-style-type: none"> <li>• <i>What are the possibilities that these dates may change and why?</i></li> </ul>
<b>13.</b>	<p><b>Commissioning of an Independent Overview Author</b></p> <ul style="list-style-type: none"> <li>• <i>Which Author is being proposed and why? Indicate if they have any specific skills or knowledge.</i></li> <li>• <i>Specify in what way they are considered 'independent'</i></li> <li>• <i>Will LSCB require the Author to use a particular format for their report and is a template available?</i></li> <li>• <i>Specify what is expected of the Author and within what timescales, maybe give some examples of things to consider e.g., dates booked in to present the early findings to the panel, dates for final report to LSCB., a link person for the author and the means by which their work will be facilitated.</i></li> <li>• <i>Clarify process should Board fail to ratify final report.</i></li> </ul>
<b>14.</b>	<p><b>Liaison with Government Office</b>  [Name Contact Details] will liase with Government Office over progress and where any extensions to timescales prove necessary.</p>

Some of these issues may need to be revisited as the review progresses and new information emerges. NHS Bedfordshire should always inform its Strategic Health Authority of every case that becomes the subject of a SCR. (WT 8.13)

Safeguarding Advisers

## Appendix 5 – Criteria for appointing IMR Author

### **“Who should conduct Reviews”**

*Each relevant service should undertake a separate management review of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual agency. Relevant independent professionals (including GPs) should contribute reports of their involvement.”* Working Together 2006–8.18.

- a) You must appoint as your Author a person of sufficient seniority to be able to work at all levels within your agency. The Author must be fair in the way that the views of staff are represented. The Author you appoint 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.
- b) The 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 ESCRP.
- c) The Author prepares the report for your agency and is accountable to the Chief Officer for the quality of the report. The report is submitted as an agency report.
- d) The Author acts as the representative for your organisation in its interface with the ESCRP.
- e) The Author should have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the Author will wish to interview staff that are central to the case. Staff who wish to be interviewed should be offered this opportunity by the Author. Such interviews should be allowed.
- f) The Author must ensure that the relevant staff of your agency are informed of the purpose of the Individual Management Review and the process leading to the Serious Case Review. This letter can be copied and circulated as part of this task.
- g) The 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 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 Author.
- h) The Author shall identify and indicate the location of all files relating to (child’s name) and make these files available to the Chairperson of the ESCRP on request.
- i) The compilation of the Individual Management Review report will create a significant extra workload. The Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the Individual Management Review report within the strict time scale. The Author should receive appropriate clerical support throughout. You will appreciate it may be necessary for the Author to be relieved of all their normal duties for the period the Individual Management Review report takes to compile.

## Appendix 6 Overview Report Communications Plan

Key Messages

Key Audience

Types of processes used to make public the lessons learnt. (Press release, use of website, press conference)

Roles and responsibilities of key individuals

Agency leading media management on behalf of LSCB

Support offered to families

Briefing of staff on the contents of the report

Briefing of the families / involved in the compilation of the report

Available resources for publication

Debriefing arrangements to those involved

**Appendix 7 – BLSCB Action Plan on receiving Overview Report**

**Presentation of xxxxxxxx Serious Case Review Overview Report**

**Date of LSCB Meeting xxxxxxxxxxxx**

**Report presented by xxxxxxxxxxxxxx**

- BLSCB is satisfied that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report

- All agencies agree to translate recommendations into an action plan which should be signed up to at a senior level by each of the organisations that need to be involved within 2 months

- Arrangements for dissemination of report

- Acceptance of media strategy

**Signed ..... Date .....**

## **Appendix 8**

### **Protocol for dealing with the publication of Serious Case Reviews.**

It is the principle of the Bedfordshire Local Safeguarding Children Board (BLSCB) that the family involved in the SCR should be informed once the decision has been taken to hold a SCR and that any contact made and wanted by the family should be maintained throughout the process.

1. The Executive Serious Case Review Panel (ESCRP) should consider the implications for the family and address how they are going to inform the family of the outcome. Families should be informed of the outcome of SCR's as soon after the review is completed as possible. They should receive a copy of the Executive Summary and be given the opportunity to comment.
2. Individual organisations considered under the review must take responsibility for feeding back key messages and briefing staff involved in the review about its outcome. The ESCRP should consider who the key managers are and ensure that they receive a copy of the executive summary in order to inform this process.
3. A date for publication should be set at the sign-off meeting.
4. The ESCRP should consider which organisation is going to lead the media management on behalf of the BLSCB; in order to maintain the independence of the Board this may be an independent PR firm hired to oversee the process and whose number could be given out to the press as a point of contact. However, decisions should be made on a case by case basis. A spokesperson, likely to be the independent BLSCB chair, should be nominated.
5. Consideration should also be given as to the method of publication and any connected publicity e.g. should the summary be published only on the website, released to the press etc? In high profile cases is a press conference likely to be needed? Is a high volume of interest anticipated? If so, there needs to be liaison with the lead organisation about how to deal with this.
6. A draft briefing including key messages, implications for agencies, potential questions and responses and a draft press release, if considered appropriate, should be drawn up. This can be finalised outside the meeting but should be completed as soon as possible in order to fit in with the timescale for publication.
7. The briefing and any associated press release need to be clearly identified as having originated from the BLSCB and not from the organisation co-ordinating the media management. It should include a copy of the BLSCB logo.
8. Ten working days before the publication date a copy of the Executive Summary should be sent to all the relevant organisations with a copy of the finalised briefing paper and press release if it has been considered appropriate to complete one. This should carry an embargo until the publication date, but will allow organisations time to liaise with their press officers and compose a response in case they are approached by the media following publication.
9. On the publication date the summary should be publicised in the manner agreed with any necessary support arrangements in place as stated above.

## Appendix 9 Descriptors for the Evaluation of Serious Case Reviews – December 2008

	<b>Outstanding</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Inadequate</b>
<b>Timescales</b>	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.
<b>Scope of the review</b>	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.
<b>Contribution of relevant agencies</b>	The contribution of all relevant agencies is maximised throughout the period of the review.	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 secured.
<b>Independent element</b>	A high level of independence is built into the process including the appointment of an	Independence is built into the process through the appointment of an independent	Independence is built into the process through the appointment of an independent	Insufficient independence is built into the process such as 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.	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.	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.	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.
<b>Involvement of family members</b>	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.
<b>Links to parallel investigations</b>	All other 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.	Other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate effective information sharing processes are in place.	Some parallel investigations such as criminal investigations and coroner's enquiries are identified and the outcomes of these are considered within the review.	Some parallel investigations including criminal investigations and coroner's enquiries have not been considered within the scope of the review and processes for communication are unclear.
<b>Individual management reviews</b>	All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the	Most relevant agencies produce a comprehensive management review of their full involvement with the child and	Most relevant agencies produce individual management reviews of their involvement with the child and	Not all relevant agencies produce a management review of their involvement with the child and family.

	child(ren) 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.	family. 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.	family. Most reviews take into account the individual needs of the child and family and record 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.
<b>Overview report</b>	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	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	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	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

	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.	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	and includes a genogram and a chronology of the family history, circumstances of the child and agency involvement.	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 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.	The report reflects a critical 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.	The report includes 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.	The report lacks rigour in its 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.
<b>Lessons to be learned</b>	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

<b>Action plan</b>	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 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.	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.	action plan for implementation. 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.
<b>Executive summary</b>	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.

