Serious Case Review Process

July 2016

1. Criteria

The Hillingdon LSCB must undertake reviews of serious cases in specified circumstance. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the Hillingdon LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

A Serious Case Review must always be initiated when:

- Abuse or neglect of a child is known or suspected;

  AND EITHER;

i. The child has died; OR

ii. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Thus cases meeting **either** of these criteria must always trigger a Serious Case Review. Additionally, even if these criteria are not met a Serious Case Review should always be carried out when:

a) A child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre, a secure children's home or where the child was detained under the Mental Health Act 2005.

2. Referral of a Case to the Serious Case Review Panel

A referral to the Serious Case Review Panel can be made by any Hillingdon LSCB partner with the agreement of their Board representative. Partner organisations making a referral for a Serious Case Review have a responsibility to quality assure the referral prior to sending it through to the Hillingdon LSCB and to compare it to the criteria for a Serious Case Review in Working Together 2015. If the case meets the criteria for a Serious Case Review the referral should be made to the Hillingdon LSCB Business Manager using the agreed form.

- The Hillingdon LSCB can commission an alternative review from relevant organisations involved. In cases, the Project Plan and the Learning and action plan arising from these should be forwarded to the Hillingdon LSCB for information/monitoring.
- All cases where a child has died or suffered a potentially life threatening injury, serious sexual abuse or sustained serious and permanent impairment of health or development, and abuse or neglect are known or suspected should be notified to Ofsted using the serious incident notification electronic link. All these cases should also be considered by the Hillingdon LSCB with a referral made by an agreed organisation.
- Referrals should be made on agreed referral form (see SCR Referral Form) and sent to the Board Manager through the Business Office by secure e-mail
- Referrals from Child Death Overview Panel (CDOP) should be made by the CDOP Chair and sent to the Chair of Hillingdon LSCB through the Business Office by secure e-mail.
- Where the case appears to meet the criteria for a Serious Case Review, prior to consideration at the Serious Case Review Panel, information will be gathered from each organisation involved with the child and their family to enable an informed decision to be made. This will be undertaken using the Information Gathering Form (see SCR Request for Information Pro-Forma) which will be sent to the Hillingdon LSCB organisational representative by secure e-mail. There will be occasions where full information gathering is not required but this decision should be made by the Serious Case Review Panel.

3. Decisions whether to initiate a Serious Case Review

- The Serious Case Review Panel will normally consider the case within a month of receipt of the referral. The Chair of the panel will make a recommendation to the Hillingdon LSCB Independent Chair who will make a final decision within 14 days of receipt of the recommendation.
- Where the decision is that a Serious Case Review will be commissioned, the Hillingdon LSCB Board members will be notified.
- Ofsted and The Department for Education will also be informed of the decision within 14 days. The Hillingdon LSCB Independent Chair will inform the National Serious Case Review Panel and Serious Case Review decisions on all cases notified to Ofsted as well as any cases referred for a Serious Case Review.
- Where a Serious Case Review has been agreed, the names of the reviewers appointed to undertake the review should be sent to the national panel with the decision. If a Serious Case Review has not been agreed the Serious Incident Notification (if available, if not, brief case information) and the explanation for why the case does not meet the Serious Case Review criteria should be sent.

If the Serious Case Review criteria are not met, the Hillingdon LSCB may still decide to commission an alternative form of case review.

4. Principles of Serious Case Reviews

All Serious Case Reviews will:

- Be led by an appropriately trained Independent Chair/Reviewer.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within.
- Be proportionate according to the scale and level of complexity of the issues being examined and transparent about the way the decisions are made and data is collected and analysed.
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened.
- Include involvement of family members where possible and appropriate.
- Be inclusive of all organisations involved with the child and their family and ensure information is gathered from frontline practitioners involved in the case.

- Include individual organisational information from Internal Management Reviews/Reports/Chronologies and contribution to panels.
- Make use of relevant research and case evidence to inform the findings of the review.
- Identify what actions are required to develop practice.
- Ensure that the report is written for publication, where possible without redaction.
- Lead to sustained improvements in practice and have a positive impact on the outcomes for children and families.

5. Methodology for Learning & Improvement

Working Together 2015 does not prescribe any particular methodology to use in such continuous learning, except that whatever model is used it must be consistent with the above principles.

Examples of Models

- **SCIE Learning Together (LT) -** Learning Together has been piloted and evaluated during the Working Together consultation period and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved.
- **Root Cause Analysis (RCA)** - Root Cause Analysis has been used within health agencies as the method to learn from significant incidents. Root Cause Analysis sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.
- **Child Practice Reviews (The Welsh Model)** - The Welsh Model replaced the Serious Case Review system as the statutory guidance in Wales on 1st January 2013. This process consists of several inter-related parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an extended review which involves an additional level of scrutiny of the work of the statutory agencies.

- **Significant Incident Learning Process (SILP)** - Significant Incident Learning Process was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.
- **Appreciative Enquiry (AI)** - Appreciative Enquiry is rooted in action research and organisational development, is a strengths based, collaborative approach for creating learning change. Serious Case Reviews conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective Serious Case Reviews hindsight wisdom to design practice improvements.

Irrespective of the methodology the emphasis must be on the establishment of a local framework for learning and improvement which will achieve the outcomes set out on Learning and Improvement Framework Procedure, Purpose of Local Framework, and undertaking a review which is proportionate to the scale and level of complexity of the issues being examined.

Learning and actions for improvement indentified from the process will be disseminated through the locally agreed Learning and Improvement Framework detailed in Learning and Improvement Framework Procedure.

6. Commissioning the Review

- The Serious Case Review will be commissioned through the Serious Case Review Panel. This will include agreeing:

  - The scope and Terms of Reference of the review using the appropriate form.
  - An Independent Reviewer/Chair/Author who is suitably qualified/experienced to lead the review and organisation representatives for the Serious Case Review Panel.
  - Which organisations are required to contribute chronologies and the timescale for this?

- Consideration of the requirement for agencies to submit Individual Management Reviews (IMRs)/Reports and the timescales for these.
- SCRSP/SIRSG members who are senior representatives of organisations involved with the child and their family, or required to support the panel with additional information/advice.
- The level of involvement by practitioners involved in the case.

- The model for the Serious Case Review should be considered and agreed at this point, along with the identification of IMR/Report Authors and their involvement in the process.
- The impact and timing of any parallel processes on the review must be acknowledged at this stage. Police advice must be sought in relation to the potential impact of the Serious Case Review and talking to practitioners/managers involved in the case where there is a criminal investigation or the potential for one. Liaison with the Coroner must be undertaken throughout the Serious Case Review when there is potential for an inquest.
- Where other LSCB areas have been involved in the provision or services to the family, liaison between LSCB Managers will be undertaken to commission chronologies, reports and panel representatives as required. In some circumstances (for example, where there is significant involvement of 2 or more LSCB's, consideration should be given to undertaking a joint Serious Case Review).
- A briefing session will be held to support partner organisations involved within the review to share information on the case, the Terms of Reference, the process of the Serious Case Review (including timescales) and how practitioners will be engaged within the process.
- The Hillingdon LSCB will provide the National Panel of Independent Experts with the name(s) of the individual(s) appointed to conduct the Serious Case Review and consider carefully any advice which the panel provides about the appointment(s).

7. Information Sharing/Consent

- Clarity on the legislative framework for sharing to make a decision about whether a case meets the criteria for a Serious Case Review and to undertake the Serious Case Review will be included in the initial request for information from agencies. Working Together 2015 sets out a requirement for persons and bodies to comply with a request for information, any such request will be necessary and proportionate.
- Once a Serious Case Review has been agreed, consideration of the legislative framework to share information within the process will be undertaken by the Serious Case Review Panel.
- Agreement on the involvement of the family is to include:

  - At what point the parents/families will be informed of the Serious Case Review (specific family members will be indentified and agreement about who will be identified, when and by whom).
  - Issues in relation to consent and public interest including the impact of criminal, coronial and care proceedings on the ability to liaise with the family.
  - Inclusion of their views on the findings of the review.
  - The impact of publication of the Serious Case Review Report.
  - Feedback to inform them of the progress of the Serious Case Review.

- The agreements must be clearly recorded within the Terms of Reference.

8. Timescales for Serious Case Review completion

The Hillingdon LSCB will aim for completion of the Serious Case Review within six months of initiation. If this is not possible (e.g. because of potential prejudice to related court proceedings), every effort should be made while the Serious Case Review is in progress to:

- Capture points from the case about improvements needed, and
- Take any corrective action identified as required.

9. Serious Case Review Process

- **Chronologies** - will be requested from all organisations involved with the child and their family using the agreed template.
- **IMRs/Reports** - (on the agreed template). A decision on the use of IMR's or similar report submission will be made on a case by case basis; and be dependent on the review method identified. In some cases they may not be used at all, in others they may be requested from organisations with relevant and significant involvement with the child and their family. If an organisation had only minimal involvement with the family and this wasn't connected to the Terms of Reference for the review, consideration will be given to the requirements for them to complete a background report or just a chronology.

    - The first panel will be used to develop a narrative of the case, ensuring a common understanding of the sequence of events and key practice issues. IMR authors and Panel members will be invited to this meeting.

- **Quality Assurance** - Quality Assurance of the IMRs/Information Reports will be undertaken using an agreed process that ensures they include adequate information and reflect the Terms of Reference. This will include consideration of the organisation action plans. Agencies should take responsibility for quality assuring reports prior to submission.

    - The second panel (and subsequent panels if required) will be used to analyse the case based on the narrative and key practice issues. All panel members should be invited to attend, along with IMR authors if appropriate.
- **Subsequent Panels** - will be required to identify key learning from the review, as well as ensuring information on the context of the case, good practice, research and changes in practice are identified and included within the Serious Case Review report.

10. Reports and Publication

In order to provide transparency and to support national sharing of lessons learnt and good practice in writing and publishing such reports, all reviews of cases meeting the Serious Case Review criteria will result in a readily accessible published report on the Hillingdon LSCB's website. It will normally remain on the website for a minimum of 12 months and thereafter be available on request.

The fact that the report will be published must be taken into consideration throughout the process, with reports written is such a way that publication will not be likely to harm the welfare of any children or Vulnerable Adults involved in the case and consideration given on how best to manage the impact of publication on those affected by the case. The Hillingdon LSCB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders.

The final Serious Case Review report will:

- Be fully anonymised to ensure the child and any siblings are not identifiable.
- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence.
- Be written in plain English and in a way that can be easily understood by professionals and the public alike.
- Be suitable for publication without needing to be amended or redacted.

Quality assurance of the Serious Case Review Report will be undertaken by the Serious Case Review panel with sign-off from the Board. Key Learning should be indentified within the Serious Case Review Panel to enable the formulation of appropriate recommendations and an action plan.

The Serious Case Review Panel will be responsible for agreeing the Serious Case Review recommendations and Strategic Action Plan, along with the Serious Case Review Report prior to presentation to the Board.

The Board will be responsible for the ratifying of all Serious Case Review documentation prior to submission to the Department for Education.

Publication will be carefully planned depending on any parallel processes (criminal and coronial) and family contributions and the national Serious Case Review Panel will be consulted for advice and guidance.

The Hillingdon LSCB will publish, either as part of the final Serious Case Review report or in a separate document, information about:

- Actions already taken in response to the review findings
- The impact these actions have had on improving services
- What more will be done

The Hillingdon LSCB will send copies of all Serious Case Review reports to the National Panel of Independent Experts at least one week before publication. If the Hillingdon LSCB considers that a report should not be published, it should inform the panel which will provide advice. The Hillingdon LSCB will provide all relevant information to the panel on request, to inform its deliberations.

A **media strategy** will be developed to support publication and the management of any media queries.

11. National Panel of Independent Experts on Serious Case Reviews

Working Together to Safeguard Children 2013 introduced a National Panel of Independent Experts to advise and support LSCB's about the initiation and publication of Serious Case Reviews. The panel will report to the relevant Government departments their views of how the system is working. LSCB's should give regard to the panel's advice on:

- Application of the Serious Case Review criteria: whether or not to initiate a Serious Case Review
- Appointment of reviewers
- Publication of Serious Case Review reports

LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of reports and invitations to attend meetings.