

PART 8

SERIOUS CASE REVIEWS

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SERIOUS CASE REVIEWS

Summary

1. This established process of learning lessons from the review of serious cases is now reinforced within the statutory regulations. It is clearly intended to apply to all children. Serious case reviews correspond with parallel arrangements governing inter-agency working in the wake of all child deaths and provide an important mechanism for generating better-informed practice across agencies.
2. The **purpose** of reviews however is neither to apportion blame nor to establish culpability. Those are matters for coroners and for criminal courts. It is rather to:
 - establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - identify what the lessons are, how they can be acted upon, and what is expected to change as a result, and
 - improve inter-agency working in consequence

Criteria

3. The Safeguarding Children Board should **always undertake a serious case review** when a child dies (including death by suicide) and abuse and neglect is known or suspected to be a factor. This is irrespective of the child or family being previously known to children's social care (social services).
4. Particular consideration should be given to circumstances in which a child has been killed by a parent with a mental illness.
5. Additionally, the Board should consider whether to undertake a serious case review where:
 - a child sustains a potentially life-threatening injury or serious and permanent impairment of health or development through abuse or neglect, or
 - a child has been subjected to particularly serious sexual abuse
 - a child's parent has been murdered, and a homicide review is being initiated

And

- the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children
6. **A number of indicators can also usefully assist the Board** in establishing whether the criteria for a case review are met.
- clear evidence of risk of significant harm that was not acted upon, or not recognised, or shared with others
 - a child abused in an institutional setting (eg school, early years setting, children’s unit or armed service training establishment)
 - a young person dieing in a custodial setting
 - a child abused while being looked after by the local authority
 - a child who dies while absent, having run away from where they live
 - apparent failings in aspects of the operation of local safeguarding children procedures, beyond the handling of the individual case
 - abuse of a child subject to a child protection plan, or who had previously been the subject of a child protection plan (or on the child protection register)

Responsibilities

7. When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local agencies should consider immediately whether there are other children in the child/family’s immediate network who may be at risk of significant harm and whose welfare needs to be safeguarded.
8. NB: Separate guidance exists for the management of Sudden Unexplained Death in Infancy (SUDI). **(See Part 11).**
9. In all circumstances, the need to safeguard and promote the welfare of any individual child should be referred to children’s social care via the First Response Service.
10. Lead responsibility for implementing and conducting a serious case review rests with the **Safeguarding Children Board in whose area the child is/was normally resident.**
11. Boards in other local authority areas however, who may have or have had an interest the case (e.g. looked after children), should be included as partners in jointly-planning and conducting the review.

12. Any professional may refer a case to the Board where they believe that the criteria for a serious case review may apply. They may consult their agency's representative on the Board as appropriate, but all notifications should be addressed in writing to the Chairperson of the Safeguarding Children Board (via Children and Lifelong Learning Headquarters).
13. The Safeguarding Children Board Manager has responsibility for coordinating the necessary arrangements in considering the implementation of this procedure and for advising the Chairperson and the appropriate regulatory body respectively.
14. The Chief Executive of each contributing agency should ensure that an appropriate management review is reported to the Board within timescales.
15. The Secretary of State for the Department for Education and skills otherwise has powers to demand an inquiry to be held under the Inquiries Act 2005.

Instigating a Serious Case Review

16. The Board will receive notifications from individual professionals, including those involved in reviewing a child's death. The Board Manager will then arrange to convene a serious case review panel to consider the circumstances of the case and to make recommendations to the Chairperson of the Board within one month of receipt of the written notification about whether the criteria are met.
17. The panel should comprise of senior professionals who are independent of local line management arrangements for the case in question. It should include at least a representative of the local authority children's social care division, the health service, education and the police. Written and verbal information may be received at this stage.
18. In some cases, the serious case review panel may recommend an individual management review takes place by a single agency or a smaller-scale audit of a case that otherwise may not fully meet the criteria for a serious case review.

Determining the Scope of the Review

19. The review panel, in making recommendations to the Chairperson of the Board, should endeavour to identify, given the context of the case in question:
 - whether the criteria are met (see paragraphs 3-6)

- the most important aspects that the review should address in learning lessons
- how necessary aspects of independence might be brought to bear, particularly in terms of overseeing the review, compiling the inter-agency overview report and in analysing any particular matters of individual agency involvement
- the historical timescale and specific aspects of focus, particularly in complex longitudinal family or organisational networks
- which organisations should be contributing, particularly those who are not primary members of the Safeguarding Children Board, and how these links might be made
- how family members should be involved and who should be responsible for supporting or facilitating their involvement
- any parallel enquiries that may need to take place, e.g. homicide review, Youth Justice Board serious incident review, MAPPA serious case review – and whether any jointly-commissioned processes would be appropriate, together with resource implications
- any cross-border implications affecting other Safeguarding Children Boards
- whether the review process should be taking account of a parallel coroner's enquiry, or indeed any criminal investigation
- anticipating any media interest and the need for the Board obtaining legal advice

Timescales

Within one month:

20. Decision made by Chairperson of Board about invoking this procedure upon the recommendation of a serious case review panel.

Within three and a half months:

21. Serious case review panel reports its findings and makes recommendations to Staffordshire Safeguarding Children Board.

Within four months:

22. Inter-Agency overview report submitted to the Department for Education and Skills, via the regulatory body, together with an action plan in taking forward the recommendations and in reinforcing the lessons learned.

23. Any changes or extensions to this timescale should be agreed in advance with the regulatory body. In more **complex circumstances** for instance surrounding an institution, where there may be multiple victims and/or persons believed responsible, more time may be required. Terms of reference for the review in these circumstances need to be carefully constructed.
24. There may need to be clarity about the interface between the review process and the necessary strands of an investigation. Immediate consideration has to be given to ensuring that all children are safe and agreements reached between those individuals leading the enquiries.

Individual Management Reviews

25. Once it is known that a case is being considered for a serious case review, each agency should secure records relating to the case to guard against loss or interference.
26. Each contributing agency should make arrangements to undertake an individual management review of its involvement with the child and family as soon as the decision to review is confirmed. This should be conducted by an appropriate senior manager who has had no direct line management responsibility for the case in question.
27. Relevant independent professionals, e.g. GPs, should also contribute reports of their involvement. Designated professionals have an important role to play in providing advice and guidance in balancing disclosure with confidentiality, and in evaluating the overall influence of a range of health professionals and providers in safeguarding children's welfare.
28. Where a children's guardian contributes to a review, leave of the court should be obtained in waiving the guardian's duty of confidentiality to an appropriate degree.
29. Paragraphs 8.26 and 8.27 of Working Together (2006) highlight the scope and analysis of involvement that should be contained in a management review. The analysis should be based on a factual chronology of significant contacts by the agency with the child and family concerned.
30. Experience shows that where circumstances allow, the interviewing of staff that have provided direct access and services brings a more rounded appreciation of agency involvement to the review. Care should be taken to distinguish reviews from disciplinary processes. Information, however, arising from a review may be used to inform other processes, including disciplinary action.

Safeguarding Children Board Overview

31. The inter-agency overview report should be commissioned from a person who is independent of all the agencies/professionals involved. It should bring together and draw overall conclusions from the information and analysis contained in the individual management reviews, from child death review processes, together with reports commissioned from any other relevant interests.

32. Paragraph 8.28 of Working Together (2006) illustrates an outline format for the overview, including the introduction, the facts, an analysis and conclusions and recommendations.

33. Upon receipt of the overview, the Safeguarding Children Board should:

- ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the overview
- translate recommendations into an action plan which should be endorsed at a senior level by each of the agencies involved. The plan should set out individual actions by named individuals and to agreed timescales
- clarify to whom the report, or any part of it, should be made available
- disseminate key findings to interested parties, including contributing staff, family members and the media as appropriate
- submit a copy of the overview together with the action plan and individual managements reports to the DfES by the relevant regulatory body (the Commission for Social Care Inspection and/or its successor body)
- consider carefully who might have additional interest in reviews e.g. elected members, wider public, and how intricate balances between accountability and confidentiality are to be maintained

Learning Lessons

34. In receiving the inter-agency overview and in reviewing the action plan, the Safeguarding Children Board should:

- as far as possible, engender an environment of shared learning, rather than of a trial or ordeal for professional staff
- establish what information is to be disseminated, by what means and to whom
- celebrate examples of good practice as well as identify areas for development or change

- focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes
- put in place a means of reviewing actions and outcomes against recommendations and intended outcomes
- seek feedback on review reports from the regulatory body