



Serious Case Review (SCR)

Procedures and Guidance

This guidance should be read in conjunction with

Chapter 8 of "Working together to Safeguard Children"
(Dec 2009)

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Sub-group: Serious Case Review Commissioning Group (SCRCG)
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1 Statutory Background

- 1.1 The Warrington Safeguarding Children Board (WSCB) is constituted and established to conform to its statutory obligations under the Children Act 2004 and any subsequent revisions or extensions.
- 1.2 Local Safeguarding Children Boards Regulations (2006)¹ define the functions and objectives of the WSCB. Regulation 5 requires the Board to undertake reviews of serious cases. These are to be undertaken in accordance with the procedures set out in Chapter 8 of 'Working Together to Safeguard Children (2009)²'.
- 1.3 Throughout this document, references to the relevant paragraphs of 'Working Together' will be given in brackets, thus (8.1). This guidance has been reviewed to reflect the recommendations included in Lord Laming's report³.

2 Purpose (8.6)

- 2.1 The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard children. An SCR carried out under the guidance of 'Working Together' will:
 - a) 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
 - b) identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result
 - c) as a consequence, improve the inter-agency working and better safeguard and promote the welfare of children
- 2.2 Serious Case Reviews are not inquiries into how a child died or who is culpable. These are matters for the Coroners or Criminal Courts to decide.

3 Criteria (8.10)

- 3.1 When a child dies (including by suicide), and abuse or neglect are known or suspected to be a factor, the LSCB must conduct a serious case review into the involvement of organisations and professionals with the child and family. This is irrespective of whether local authority safeguarding services is or has been involved.

¹ Statutory Instrument 2006 No90 – the Local Safeguarding Children Board Regulations

² This document has been written with reference to the revision to Chapter 8 published in Dec 2009

³ 'The Protection of Children in England: A Progress Report'.

- 3.2 When a child receives potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained impairment of health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children, the LSCB must consider whether to undertake a serious case review.

Deciding to hold a serious case review (8.12)

The answer 'yes' to several of these questions indicates that a review should be held:

- Was there clear evidence of a risk of significant harm to a child that was:
 - not recognised by organisations or individuals in with contact with the - child or perpetrator, or
 - not shared with others, or
 - not acted on appropriately
- Was the child abused in an institutional setting (e.g school, nursery, family centre, Youth Offender's Institution, children's home, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed services training establishment)?
- Was the child abused while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan, or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that these are not being adequately promulgated, understood or acted upon?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

- 3.3 Any professional may refer a case to the chair of the LSCB if they believe that there are important lessons for inter-agency working (8.3). In addition, the Secretary of State for the DCSF can instruct the LSCB to hold a review.

4 Instigating a Serious Case Review in Warrington

- 4.1 The WSCB must first determine whether a case should be subject to a SCR in line with the criteria (8.10-8.12). The final decision to instigate a serious case review is made by the Independent Chair of the WSCB, on the recommendation of the Serious Case Review Commissioning Sub-group (8.14). The decision will be made within twenty working days (one month) of the case being brought to the Chair's attention (8.22).
- 4.2 If a review is to take place, the local authority must inform OFSTED. The NHS Warrington PCT will be responsible for informing the Strategic Health Authority that an SCR is underway.
- 4.3 The SCR will be completed within six months of the chair's decision that a review should be completed, unless an alternative timescale is agreed with OFSTED at the outset, or unless it becomes clear - once the review is in progress - that six months will not be long enough, in which case a revised completion date must be agreed with Government Office North West (8.24).
- 4.4 Any criminal proceedings following the death or serious injury of a child must not prevent early lessons being learned and implemented. The WSCB Chair will liaise with the relevant criminal justice agencies to ensure that the review can be undertaken promptly in a way that does not compromise criminal proceedings (8.25).

5 Considering a Serious Case Review – whether to proceed

- 5.1 Any requests to consider an SCR should be directed to the WSCB Independent Chair. Once a request is received, the Chair will make a decision within 20 working days about whether to proceed to a full SCR.
- 5.2 The Serious Case Review Commissioning Group (SCRCG) will play a key role in supporting the WSCB Chair to make this decision. As part of the WSCB governance framework, the SCRCG is chaired by a member of the main board. Its terms of reference⁴ detail its role in assessing whether criteria for a serious case review are met and providing advice to the WSCB Chair in this respect.
- 5.3 Whenever there is a need to consider whether a case should be subject to a serious case review, the chair will ask the SCRCG to:

⁴ See SCRCG Terms of Reference, available at www.safeguardingwarringtonchildren.gov.uk

- a) meet within 5 working days of a request to consider an SCR being received by the WSCB Chair.
 - b) review the immediately available information relating to the case
 - c) advise the WSCB Chair whether they consider the criteria for an SCR are met, referring to Chapter 7 and paragraphs 8.10-8.12 of 'Working Together' to inform this advice
 - d) provide an initial scope for any review recommended
 - e) set out the Terms of Reference against which a Serious Case Review Panel can be established under an independent chair (8.20)
 - f) indicate the timetable for completion for the Review
 - g) complete its deliberations within 10 working days, providing a recommendation about whether to proceed, to the WSCB Chair
- 5.4 In addition, the WSCB Chair may seek guidance from GONW and Ofsted to inform the final decision about whether to progress to SCR within 20 working days of the original request being received.
- 5.5 The WSCB Chair will keep the Executive Director for Children and Young People's Services informed throughout this processes.
- 5.6 If the decision to hold a Serious Case Review is made, the Serious Case Review Commissioning Group will:
- a) establish an SCR Panel made up of those best able to contribute to a review of the case against the initial scope laid down
 - b) commission an independent chair for the SCR Panel
- 5.7 Where the SCRCG recommend that a review is not warranted, the panel may still make recommendations in relation to single agency management reviews in terms of lessons that may be learned.
- 5.8 The SCRCG will take no part in the case review, but will retain a commissioning responsibility in respect of any independent chair appointed. The ultimate responsibility for ensuring the prompt and appropriate completion of the SCR sits with the WSCB Chair
- 6 Commissioning an Independent Chair and Overview Report Author**
- 6.1 All Serious Case Reviews in Warrington will be chaired by a person independent of the work of the Board or its sub-groups, and wholly unconnected with the case under consideration. A specific appointment will be made for each review undertaken.
- 6.2 The SCRCG will oversee the appointment. The advice of GONW Safeguarding Adviser will be sought to identify appropriately qualified candidates to consider.

6.3 An independent author will be appointed to compile the SCR Overview Report, drawing together the material compiled in agency individual management reviews (IMRs) (8.14-8.16). This appointment will be made by the Independent Chair of the WSCB.

6.4 Remuneration rates will be determined specifically for each case and will be decided with reference to guidance provided by GONW.

7 Establishing the Terms of Reference for a Serious Case Review

7.1 The SCRCG will set the initial terms of reference for any serious case review proposed in Warrington. Once underway, the Serious Case Review Panel, under an independent chair, may need to refine these terms in the light of information determined during the review process. However, the terms of reference must always remain compliant with guidance offered in 'Working Together' and should:

- a) make reference to the need to consider issues of race, culture, religion, language, identity.
- b) address in specific detail the issue of keeping families informed of the review process and engaging in the review process, stating a minimum expectation in relation to contact with families
- c) take into account action by agencies to safeguard and protect the subject child (and any other relevant children) beyond the "trigger incident".
- d) identify whether there are particular issues for individual agencies to consider within their management reviews.

8 Role of the Serious Case Review Panel

8.1 An ad hoc Serious Case Review Panel will be established specifically to conduct SCRs in Warrington. The WSCB will appoint an independent chair for the SCR Panel. The Panel will function separately from the SCRCG, which will remain as a standing panel of the WSCB.

8.2 The WSCB Business Manager, acting as SCR Co-ordinator, will support the SCR Panel and its chair throughout its operation.

8.3 The SCR Panel will :

- a) receive outline terms of reference from the SCRCG, drawn up as part of the process to confirm that the serious case review criteria were met.
- b) revise or amend the terms of references, if necessary, as the process of review gets underway. (8.12)
- c) complete its review within six months of its establishment, unless an extended timetable is agreed with Ofsted (8..22)

- d) direct agencies to identify Individual Management Review (IMR) authors
- e) identify an independent overview author
- f) monitor closely the progress of on going SCR's
- g) receive the final overview report and executive summary of SCR's
- h) report to the full WSCB, securing its endorsement of the SCR report
- i) monitor the multi-agency action plan to ensure actions are completed
- j) ensure the appropriate publication of findings from SCR's
- k) ensure that lessons are learned in order to best safeguard and promote the well being of children and young people in the authority

9 Involving the Police

- 9.1 When the WSCB Chair has decided that a serious case review is necessary, and when terms of reference have been decided, the Assistant Chief Constable, Territorial Policing, must be notified in writing, requesting the provision of police resources to undertake the review. Correspondence should be sent to the Cheshire Constabulary Police HQ, Clemonds Hey, Oakmere Road, Winsford, CW7 2UA.
- 9.2 The Assistant Chief Constable will notify the Detective Chief Inspector, Strategic Public Protection Unit, who will co-ordinate the police involvement in the review. The investigating officer will be the Detective Chief Inspector, Major Crime Review Team.

10 Individual Management Reviews (IMR)

- 10.1 Each relevant service must undertake a separate management review of its involvement with the child and family (8.34). These must begin as soon as a decision is taken to proceed with a review, or sooner if a case gives rise to concerns within the individual organisation.
- 10.2 Those conducting individual reviews must not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved. Subject to this condition, the Designated Professionals within PCT areas should review and evaluate the practice of all health professionals and providers involved.
- 10.3 Once it is known that a case is being considered for review, individual organisations must promptly secure, mark and date case records relating to the case to guard against loss or interference, and begin work quickly to draw up a chronology of involvement with the child and family (8.39).

- 10.4 The aim of an IMR is to look openly and critically at prevailing practice to see whether the case indicates that changes could be made to improve outcomes for children (8.34).
- 10.5 Individual Management Reviews (IMRs) carried out as part of the SCR must be completed within the prescribed timescales.
- 10.6 Chapter 8 of 'Working Together to Safeguard Children 2009' (8.34-8.39) contains detailed guidance on conducting IMRs. Warrington Safeguarding Children Board has adopted the common template format for IMRs developed by LSCB across the North West. A copy of the pro-forma, together with appropriate additional guidance, is provided to support these procedures, and will form the basis of the information sessions held for IMR authors when a serious case review is called. Please note, that if the case is complex, involving abuse in an institutional setting it may be appropriate to generate an alternative IMR template designed to meet the specific demands of such a case.
- 10.7 There will be a minimum of 2 meetings (more may be necessary) involving the IMR and overview authors in the course of completion of the Serious Case Review. These meetings are facilitated by the WSCB Business Manager acting as SCR Co-ordinator. These meetings will:
- a) Address any difficulties being experienced in completing the reports
 - b) Consider if more time is needed to carry out the review and why
 - c) Review, if necessary, the terms of reference for the SCR
 - d) Share knowledge and findings to date to enhance knowledge and learning from the case
 - e) Ensure compliance with the IMR protocols from all relevant agencies
- 10.8 The Serious Case Review Commissioning Group will monitor the progress of SCR's and receive reports from the above meetings relating to the specific SCR's.
- 10.9 IMRs are not part of any disciplinary processes but information that emerges as part of the enquiry may indicate that disciplinary action ought to be considered under established procedures.

11 Contributions of Independent professionals

- 11.1 Relevant independent professionals (including GPs) must contribute reports of their involvement with the child and family. Where a children's guardian contributes to a review, the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived to the degree necessary.

12 WSCB Overview Report: Learning from SCR

- 12.1 The Serious Case Review Panel, on behalf of the WSCB, will commission an overview report that brings together and analyses the findings of the various reports from organisations and others (management reviews, reviews by independent persons or bodies, contributions from family members, any other source) (8.40).
- 12.2 The overview report will be commissioned from a person who is independent of all agencies/ professionals involved (8.32) and will make recommendations for future actions.

WSCB Overview Report – outline format (8.40)

Introduction:

- Summary of background circumstances
- Terms of Reference
- Record the methodology used
- List of contributors, including any external investigators
- Names of the SCR Panel members, independent chair and author of overview report

The Facts:

- Genogram
- Integrated chronology – noting specifically each time the child was seen by a professional
- Consider explicitly relevant ethnic/cultural issues
- Summary overview

Analysis:

- How and why events occurred
- Decisions made and actions taken, and the reasons for this
- ‘Application of Hindsight’ – might different actions have led to a different course of events?
- Highlight good practice

Conclusions and recommendations:

- The lessons to be drawn from the case
- Recommendations for action
- Any national implications identified

- 12.3 ‘Working Together’ emphasises the importance of focusing recommendations on a small number of key areas, with specific and achievable proposals for change, which clearly indicated the outcomes intended by the actions to be taken (8.52).

12.4 Recommendations should be:

- Specific:** *clearly defined and emanating from the reports*
Measurable: *so that delivery can be proved*
Achievable: *within an agreed timescale*
Relevant: *link to the findings of the report and the time/resources available*
Timely: *set within specific time frames for achieving outcomes*

13 The Executive Summary (8.42)

13.1 The SCR Panel will ensure that an Executive Summary is produced which accurately reflects the full overview report. The summary will include:

- Information about the review process
- Key issues arising from the case
- The recommendations
- The Action Plan
- Name of the WSCB Chair, SCR Panel Chair and the overview author
- Job titles and employing organisation of all SCR Panel members

13.2 The summary will be anonymised to protect the identity of children, relevant family members and others.

14 WSCB action on receiving the SCR report (8.43)

14.1 The SCR Panel will assure the quality of the final Serious Case Review: the IMRs, overview report, executive summary and action plan.

14.2 The WSCB Chair will be responsible for ensuring that the Board are kept informed about the progress of the SCR, and that the report is presented to the full Board to be signed off. The Board must:

- a) Ensure that each contributing agency is satisfied that their information is fairly reflected in the overview report.
- b) Agree a detailed action plan and ensure its endorsement at senior level within agencies responsible for its delivery.
- c) Disseminate the Executive Summary and key findings as appropriate (see 8.49).
- d) Publish the Executive Summary once the SCR is completed.

- e) Make arrangements to debrief staff, family members and the media.
- f) Submit the overview report, action plan and IMRs to Ofsted, Government Office Children and Learners Team, the SHA and the DCSF. In the case of a death in custody, copies will also be submitted to the Youth Justice Board.
- g) Comply with GONW scrutiny of the delivery of the action plan.
- h) Formally conclude the process when the relevant action plan has been implemented, and inform GONW of this decision.

15 Learning lessons locally (8.52)

- 15.1 The SCR Panel will at all times be aware that the purpose of any SCR is to learn lessons to improve inter-agency working. This will include communicating examples of good practice demonstrated during the review. Learning will be incorporated into local training programmes.
- 15.2 A small number of focused recommendations arising from the report is anticipated which will provide a positive platform for pursuing proposed changes and improving outcomes. This will be further supported by a culture of routine audit and review of cases from across the inter-agency spectrum.
- 15.3 Upon completion of the SCR, it will fall to the SCRCG to review the process and develop any amendments to procedures or protocols in place in Warrington, in line with the 'key tasks' for the group identified under its terms of reference.

Government Office Safeguarding Advisers 'Checklist' for SCR (Dec 2008)

1 Decision to hold SCR

- a) Add date when notification to Ofsted was made
- b) Add date when the Chair of LSCB agreed to hold SCR.
- c) Provide detail as why SCR was necessary using 8.5 or 8.6. as basis
- d) Identify reasons for any delays
- e) State name and independence status of SCR Panel.
- f) Identify reasons for any delays in deciding to hold SCR

2 Key Issues: (really important section)

- a) What specific issues or questions does this case raise?
- b) Are there any unusual factors in this case, what are they?
- c) Are there similarities with previous IMRs or SCRs, what are they?
- d) Are there any failings which appear obvious at this stage?
- e) Do there appear to be any gaps in multi –agency working?
- f) Are there any issues which relate to ethnicity, disability or faith which may have a bearing on this review? If not, say so.
- g) Is there any known research which may assist?
- h) Are there other SCRs in the region or nationally which are similar?

3 Commissioning of an Independent Author

- a) What specific knowledge is needed?
- b) What specific skills are needed?
- c) Which Author is being proposed and why?
- d) Specify in what way they are considered 'independent'
- e) Will LSCB require the Author to use a particular format for their report and is a template available?
- f) Specify what is expected of the Author and within what timescale. Perhaps give some examples of things to consider such as: dates booked in to present the early findings to the panel, dates for final report to LSCB. Whether the author will chair the panel?

4 Expert Opinion

- a) 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?
- b) May it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?

5 Time Period over which events should be reviewed

- a) Over what time period should events be reviewed, - i.e. how far back should enquiries cover, and what is the cut-off point?
- b) What is the relevance of selecting this time period?(Remember even complex family history can be summarised)
- c) What family history/background information will help better to understand the recent past and present?

6 Organisations to be involved in this SCR (would be useful to state which are universal/targeted/specialist services?)

- a) Which organisations and professionals will be asked to contribute to this review and submit reports or otherwise contribute?
- b) What action will the Board take if there is a failure to cooperate with this review?
- c) Who will make the link with relevant interests outside the main statutory organisations – e.g. independent professionals, independent schools, voluntary organisations?

7 Involvement of Family Members

- a) Are there any known factors which may affect the involvement of any family members?
- b) Which family members will be asked to contribute and why?
- c) Are there issues around timing which may affect this dialogue?
- d) Who will be responsible for supporting family members involved?
- e) What resources will be required to facilitate this process?

8 Other Parallel reviews (e.g. PPO/ homicide or suicide reviews)

- a) 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 YJB Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting?
- b) 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?
- c) What are the arrangements for co-ordinating and liaising with those involved?
- d) What problems may emerge in terms of confidentiality and sharing information and how will these be addressed?
What are the implications of any different or challenging timescales?

9 Involvement of organisations in other LSCB areas

- a) Are there any other organisations involved with this family or any cross

boundary issues which may involve other LSCBs?

- b) Who will take responsibility for contacting that LSCB to negotiate, manage and co-ordinate their involvement in the SCR process?
- c) What should be the respective roles and responsibilities of the different LSCBs with an interest?

10 Coroner's Inquiries/Criminal Investigations

- a) Are timescales for Coroners/criminal or civil proceedings known and will revised timescales be likely?
- b) Who will liaise with the Coroner's office and/or CPS?
- c) Has the Coroner issued any advice and how will this be addressed in the SCR?

11 Media Coverage/Enquiries

- a) How should any public, family and media interest be managed before, during and after the review?
- b) Be specific, including how reports will be anonymised
- c) Is there a communications/media strategy?
- d) How should any FOI requests relating to this case be handled and by whom?

12 Legal Advice

Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review – if 'yes', give reasons

13 SCR Review Timescales

- a) The review process should start within one month of notification and should, unless extensions are agreed with GO, conclude and be forwarded to Ofsted and copied to GO within 4* months from that start date.
- b) What are the possibilities that these dates may change and why?

14 Liaison with Ofsted and GO

- a) [Name Contact Details] will liaise with xxxxxx in GO over progress and where any extensions to timescales prove necessary.

*This has now changed to 6 months with the revised version of 'Working Together' 2009

Guidance for completing Individual Management Reviews (IMR)

Below are some helpful questions to assist in the drawing up of an Individual Management Review (8.39):

What was our involvement with this child and family?

Construct a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference. (This chronology should clearly set out when the child was seen and whether the wishes and feelings of the child were sought). Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

Where an agency has had relevant contact with the alleged perpetrator, the chronology should also cover these actions and should ask whether everything was done which might reasonably have been expected to manage effectively the risk of harm posed by the alleged perpetrator to the child.

Analysis of involvement

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

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protections and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

What do we learn from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single- and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?

Recommendations for action

What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

WSCB - Serious Case Review Process

