



Notification of a Serious Case Review Process

THIS DOCUMENT SETS OUT WHAT HAPPENS WHEN CHILDREN DIE OR ARE SERIOUSLY HARMED AS A RESULT OF ABUSE OR NEGLECT ACROSS CAMBRIDGESHIRE AND PETERBOROUGH

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1. Introduction:

Partners of the Cambridgeshire and Peterborough Safeguarding Children Board (CPSCB) have a responsibility to ensure, as far as possible, the safety of children and young people within the context of the services they provide. Serious Case Reviews (SCR), when they do occur, can cause pain and suffering to those directly involved, have the potential to generate media interest and undermine public confidence in the system.

It is therefore essential that the CPSCB has in place an established system for dealing with Serious Case Reviews.

The aim of this guidance is to clarify the framework by which partner organisations can make referrals for consideration of Serious Case Reviews to the attention of CPSCB, and outline the investigative process.

It is hoped that the framework outlined in this guidance will enable CPSCB to develop an overview of referrals in order to highlight deficiencies in provision that might not be obvious if incidents are considered in isolation. It also affords an opportunity to identify good practice operationally or in policy at a local or national level. Through this guidance, the CPSCB aims to ensure that there is a rigorous system of scrutiny in place at local level. Common themes and emerging trends identified by examining all referrals can be used to inform future policy, guidance and training.

2. Immediate Response - Referral:

Working Together 2015 is clear that *“Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children”*¹.

When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding (for example, siblings or other children in an institution where abuse is alleged).

While entirely respecting this guidance, the Board would expect professionals to have discussed the circumstances of such a case with either their designated professional for

¹ [Working Together 2015](#) (Chapter 4 Para 1)

safeguarding or their agency's representative on the Board if they are not the named person before making the referral.

This should not be a replacement for making a safeguarding referral to Children's Social Care.

When satisfied there is evidence that the threshold for a Serious Case Review may be met, the matter should be referred urgently to the CPSCB Business Unit using the **Serious Case Review Referral form** which can be found on the [SCR page of the CPSCB Website](#) and emailed to GCSxSeriousCaseReview@cambridgeshire.gcsx.gov.uk, who will immediately share the referral with the Independent Chair of the Serious Case Review Sub-Committee.

Please ensure that section 1 of the form is fully completed.

If you are submitting the form electronically, you are strongly advised to password protect the document as e-mail is not a secure route unless both sender and recipient have a secure email address e.g. those that contain a GCSx or NHS.net suffix. Please adhere to your agencies policy about the safe transmission of information that references patient identifiable information.

Following notification of the case by the Business unit, members of the Serious Case Review Sub-Committee will be expected to complete and return the relevant section on the referral form with initial information on the child and family from their own agency.

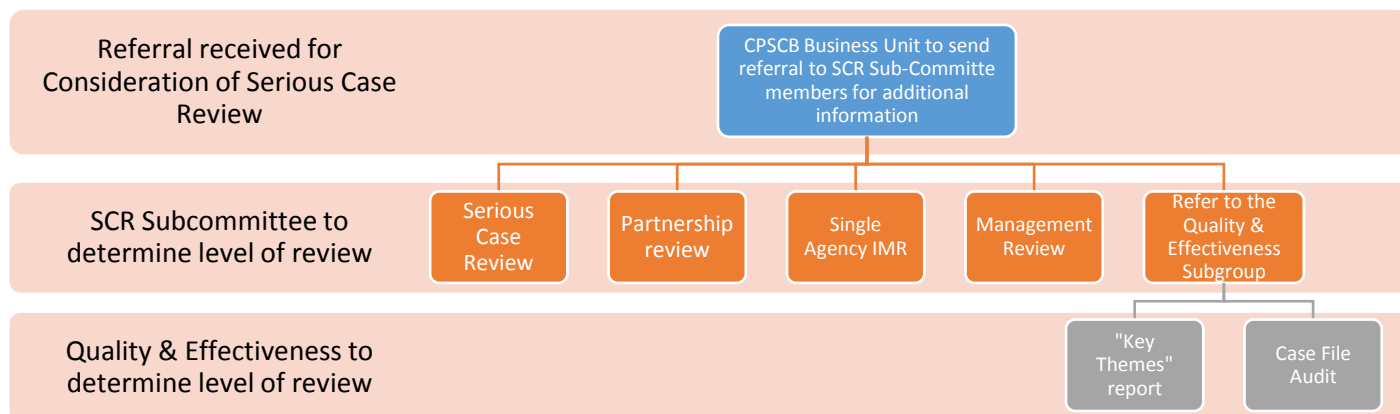
It is a procedural requirement and good practice that the Chair of CPSCB decides within one month of this referral whether or not a Serious Case Review is to be instigated.

Given this timescale, it is essential that the Serious Case Review Sub-Committee meet within three weeks of notification that the threshold for a Serious Case Review may be met to consider the available information.

Once a date is agreed, invitations should be sent to all members of the Serious Case Review Sub-Committee advising them of the meeting and requesting that they come prepared with at least basic information about their agency's involvement with the child and his/her family.

It should be emphasised that the Serious Case Review Sub-Committee can only make an appropriate decision if it has adequate information and therefore it is important that members attend well prepared. **If they are unable to attend for any reason then a deputy should be nominated to share information or, at the discretion of the Chair, a written report can be submitted.**

3. Framework for the reporting of a case notification to PSCB:



4. The Criteria leading to consideration for a Serious Case Review (SCR):

The PSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006² set out the 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:

- A) Abuse or Neglect of a child is known or suspected; **AND**
- B) 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:

1. Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide), irrespective of whether local authority children's social care is, or has been, involved with the child or family; OR

² <http://www.legislation.gov.uk/uksi/2006/90/made>

2. Abuse or Neglect of a child is known or suspected AND 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. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.

Additionally, even if these criteria are not met a Serious Case Review should always be carried out when:

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

The LSCB should also consider a review when there are concerns about the way in which local professionals and services worked together with respect to a child:

4. Who sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
5. Who has been seriously harmed as a result of being subjected to sexual abuse; or
6. Whose parent has been murdered and a homicide review is being initiated under the Domestic Violence, Crime and Victims Act 2004; or
7. Who has been killed by a parent with a mental illness; or
8. * Who has been seriously harmed following a violent assault perpetrated by another child or an adult;

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

The following questions may also help in deciding whether a case should be the subject of a serious case review. The answer 'yes' to one or more of these questions is likely to indicate that a serious case review could yield useful lessons:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
 - not recognised by organisations or professionals in contact with the child or perpetrator or
 - not shared with others or
 - not acted on appropriately?

- Was the child abused or neglected in an institutional setting (for example, School, Nursery, Children's or Family Centre, Young Offender Institution (YOI), Secure Training Centre, Immigration Removal Centre, Mother and Baby unit in a prison, Children's Home or Armed Services Training Establishment)?
- Was the child abused or neglected 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 children 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 PSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- 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 serious case review?

5. Criteria for a Serious Case Review met:

If the Chair of the Board agrees that the threshold is met and authorises the commencement of a Serious Case Review then the Board has 6 months from the date of the decision to proceed to complete the task and submit the Overview Report, Executive Summary and Action Plan to Ofsted for evaluation.

The LSCB must notify [Ofsted](#) and the [National Panel of Independent Experts](#) of the decision. A decision not to initiate a Serious Case Review may be subject to scrutiny by the national panel and require the provision of further information on request and the PSCB chair may be asked to give evidence in person to the panel.

In the event of the Chairs authorisation of a Serious Case Review, a number of actions need to take place simultaneously and within three working days of that decision.

Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference.

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 following 5 principles:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations; involved at the time rather than using hindsight;
- Transparency about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

Whilst Working Together stops short of advocating any specific method the systems methodology as recommended by Professor Munro ([The Munro Review of Child Protection: Final Report: A Child Centred System](#)) is cited as an example of a model that is consistent with these principles.

6. Some Examples of Models which may be considered:

Significant Incident Learning Process (SILP) 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';

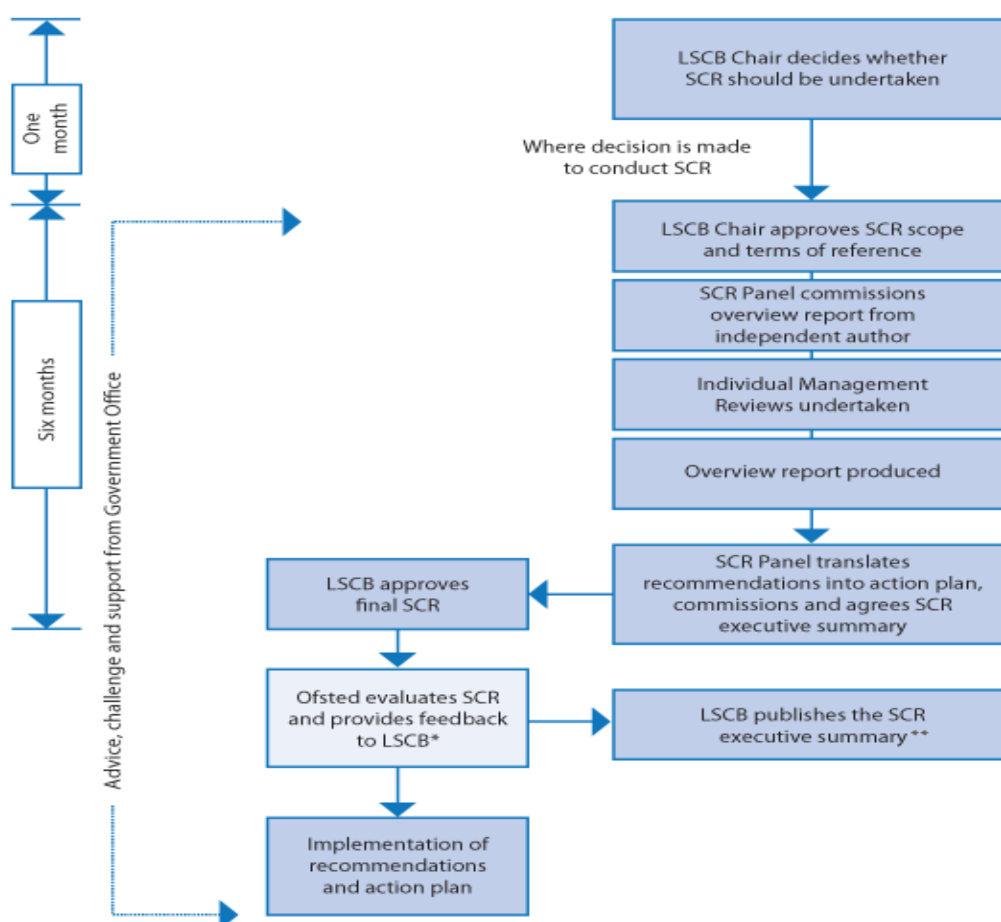
SCIE Learning Together* (LT) had been piloted and evaluated during the Working Together consultation period and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved;

Root Cause Analysis (RCA) has been used within health agencies as the method to learn from significant incidents. RCA 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;

Serious case Reviews are not limited to systems methodology; there may be cases which require the inclusion of issues from outside a strictly defined systems model.

7. The Serious Case Review Panel:

Once a decision has been made by the Serious Case Review Sub-Committee to conduct a serious case review and this decision has been endorsed by the Chair of the PSCB. A Serious Case Review Panel (SCRP) is set up with representatives from relevant agencies involved in the case, who may already be represented on the Serious Case Review Sub-Committee or have been selected specially due to their expert knowledge. The panel will scope the Terms of Reference and the methodology to be used for the SCR which will determine the Overview Process below.



8. Action by Agencies following decision of an SCR:

A letter of notification will be sent to Chief Officers of the agencies involved and copied to members of the Serious Case Review Panel formally requesting Individual Management Reviews (IMR) and informing them of the Terms of Reference and timescale of the review.

Chief Officers should nominate an officer to complete the IMR ensuring this officer has had no involvement with the child/family or case in question and inform the PSCB Business Manager of who has been identified.

As IMRs are usually expected to be completed in about one month it is important that an IMR authors' briefing should be held very early in the process and normally within one week of the Chairs decision. Authors should be advised to spend the first week collating information for the chronology and then they will be given guidance on completing the [IMR template](#) at the briefing meeting. Senior officers should also be advised the priority that this work must take.

The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about. IMR Authors should differentiate between information and opinion. When expressing an opinion authors should explain how they arrived at that view and provide supporting evidence with examples. The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report and when they are satisfied the findings accepted. This senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.

When completed the IMR **must** be signed off by the contributing agency's Director or Chief Executive. The Action Plan developed by the agency should form part of the IMR and should address each recommendation from the IMR. There should be no delay in implementing the Action plan.

The CPSCB will require evidence of the agency actions and will audit the impact of specific recommendations on a planned basis. Ongoing reviews will take place with reports to CPSCB.

Reports which are not clearly signed off will be returned.

On completion of each IMR report there should be a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the Serious Case Review Overview report has been completed but before it is published. It is important that the Serious Case Review process supports an open, just and learning culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of staff.

A nil return should be returned from those agencies who have no contribution to make to the SCR.

9. Notifying Families:

It is important that consideration is given to the best means of notifying families that a serious case review is being undertaken. Generally best practice would be to share and explain a notification letter with a family through personal delivery by a professional from the lead agency.

The timings of such notifications are crucial, particularly where there are current Police investigations. Where there are pending criminal proceedings involving the parents and or family members the decision about how and when to notify the family needs to take place within the Serious Case Review Panel with the Police representative present.

Where appropriate the family will be invited to contribute to the review and a decision will be made at the scoping meeting who is best placed to meet with the family for this purpose.

10. Notifying Victims:

The Serious Case Review Panel will need to consider the best means of notifying victims of a serious case review. For example where a review concerns historical abuse and the child victim is now an adult; a sensitively handled notification can be a positive experience, allowing some sort of closure. A personal approach to talk through the written information is likely to be best practice.

11. Cases not meeting the criteria for a Serious Case Review:

If the Serious Case Review Sub-Committee decides that the criteria for a Serious Case Review is not met but considers there are issues about inter agency practice then one or more of the following may be agreed as a way forward;

A Partnership case review:

Undertaking such a review allows the PSCB greater flexibility than under the Serious Case Review process. Although there may be occasions where the process will mirror a Serious Case Review. A Partnership Case Review may be completed more speedily and can be more focused on specific issues as identified by the Serious Case Review Panel during the initial discussion. It may also provide a good opportunity to involve practitioners and managers more directly in cases where the CPSCB has identified there are useful lessons to be learnt about practice. A summary report with recommendations will be prepared for consideration by the Serious Case Review Panel.

Management Review:

A facilitated learning day for practitioners and managers to focus on specific inter agency practice issues

Such an event would involve a facilitator identified by the Serious Case Review Panel (who may or may not be independent) meeting with a group of practitioners and or managers who have been involved in a case. The event would provide the opportunity to consider the inter agency working in the case, identifying practice issues and any barriers to achieving best outcomes. Recommendations from the event would be considered by the Serious Case Review Panel.

A Single Agency Individual Management Review:

In some cases it may be valuable to conduct a single agency Individual Management Review rather than a full Serious Case Review (or Inter-agency Case Audit), for example where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together

An inter-agency case audit:

If the case does not meet the criteria for an Serious Case Review, the Serious Case Review Subcommittee may recommend the CPSCB Quality & Effectiveness Subgroup to carry out an Inter-agency case audit where a particular issue seems to have been significant in the harm or neglect of a child, or they may have been a number of cases with a common theme. The CPSCB Quality & Effectiveness Subgroup may commission an independent auditor to complete the work or build the issue into any inter agency audits already planned.

A Key Themes Report:

A Key Themes Report will usually be produced when several Notifications are considered together to highlight a number of common/overlapping issues. The forum for discussion of such a report would be the CPSCB Quality & Effectiveness Subgroup who would then be tasked with compiling a summary report that would inform their schedule of audits.

12. Monitoring of Recommendations:

Monitoring of Serious Case Review, Partnership Case Review, Management Review & Single Agency IMR recommendations and Action plans will be the responsibility of the Serious Case Review Sub-committee

Recommendations/Action plans from Case Audits and Key Themes Report will be the responsibility of the Quality & Effectiveness subgroup

Recommendations/Action plans from Case Reviews will be further audited by the Quality & Effectiveness group to see whether this has been sustained and have made an impact.

13. Publication of Reports:

The PSCB Business Manager/Business Support Officer will ensure that the Overview Report and if applicable the Executive Summary is published to the CPSCB website at the required time for agreed Serious Case Reviews. Where necessary, the CPSCB Business Manager and Independent Chair will also coordinate the media strategy.

Key themes and messages from all reviews and audits will be included in the CPSCB's quarterly newsletter which is also published on the CPSCB website