Serious Case Review (SCR) & Learning Review Procedure and Guidance

June 2017

Contents

1. Introduction

1.1 A function of the Brighton & Hove LSCB is to conduct a Serious Case Review (SCR) after a child has died or is seriously harmed[1] as a result of abuse or neglect within the Local Authority area. This document sets out the arrangements that are in place to respond to Serious Case Reviews (SCRs) and Learning Reviews and what happens once a referral is made to the Brighton & Hove LSCB Chairperson under Chapter 4 of Working Together to Safeguard Children (2015).

1.2 A flowchart (see Appendix A) shows the key processes involved.

1.3 Any partner agency may refer a case to the Brighton & Hove LSCB if they believe that there are important lessons for multi-agency working to be learned from the case.

2. Engagement of organisations

2.1 The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of any review to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review, together with relevant information about family members.

2.2 The LSCB notes the guidance issued by the President of the Family Division on Judicial Cooperation with Serious Case Reviews, which advises that the judiciary do not need to participate in the Serious Case Review Process. We understand that the judiciary takes this stance, not to evade scrutiny or accountability, but in order to protect its independence and the independence of individual judges. However the LSCB will share our final reports, and the Findings from these reviews, with the President of the Family Division in the understanding that he will disseminate these to the wider judiciary.

3. Purpose of Case Reviews

3.1 The purpose of a serious case review, or any other type of case review within the Brighton & Hove LSCB Learning & Improvement Framework, is to identify improvements which are needed and to consolidate good practice. We must translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

3.2 The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of any review. This perspective should inform the scope of the review as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and findings. Reviews vary in their breadth and

[1] Seriously harmed" includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following: a potentially life-threatening injury; serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development. This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. Working Together 2015

complexity but, in all cases, where possible lessons should be acted upon quickly without necessarily waiting for the review to be completed.

3.3 The focus on multi-agency working in reviews is important to establish the different narratives that each agency may have had about the case, and the family's experience of different services. The purpose should be to understand why differing narratives occur, particularly where there is a pattern which repeats itself in a number of cases or situations. The review can support the development of an understanding of why some professionals might have had difficulties meeting their statutory safeguarding responsibilities.

3.4 Reviews are not inquiries into how a child died or was seriously harmed, or who is culpable; that is a matter for coroners and criminal courts respectively to determine, as appropriate.

3.5 Reviews are also not part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of a review indicating that disciplinary action should be initiated under established procedures, the relevant processes should be undertaken separately from the review process. Alternatively, some reviews may be conducted concurrently with (but separately from) disciplinary action. In some cases (for example, alleged institutional abuse) it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children.

4. Safeguarding siblings or other children

4.1 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, local organisations should immediately ascertain whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding e.g. siblings or other children in a family network, institution or social network (including social media) within which abuse is alleged.

4.2 Where there are concerns about the welfare of siblings or other children, the Pan-Sussex Child Protection Procedures must be followed, including those covering organised and complex abuse if relevant.

5. When to undertake a SCR[2]

5.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(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.

[2] Paragraphs 5.1-55.5 are taken from Chapter 4 Working Together to Safeguard Children 2015

5.2 Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) **must always** trigger an SCR.[3]

5.3 In addition, even if one of these criteria are not met an SCR **should always** be carried out when 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 Capacity Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

5.4 Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission a SCR or they may choose to commission an alternative form of review.

5.5 LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee the implementation of actions resulting from these reviews and reflect on progress in its annual report. In Brighton & Hove we call these reviews Learning Reviews. We also have the opportunity to commission the Monitoring & Evaluation Subcommittee to undertake multi-agency audits on behalf of the Case Review Subcommittee.

6. Deciding which LSCB should take lead responsibility

6.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them meets the criteria for an SCR.

6.2 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is / was normally resident should take lead responsibility for conducting any review. Any other LSCBs that have an interest or involvement in the case should be invited to be included as partners in jointly planning, undertaking the review and the recommendations for learning and improvement. Brighton & Hove LSCB does not have the power to instruct other LSCBs to carry out any action (and vice versa), but should ensure the responsibilities are clearly communicated to another LSCB. Where another LSCB does not agree with an action or fails to carry it out, the Case Review Subcommittee Chairperson should seek clarification of the reasons why and if necessary escalate the issues to the LSCB Independent Chairperson.

6.3 In the case of looked after children, the local authority with statutory responsibility for looking after the child should take lead responsibility for conducting the review, again involving other LSCBs with an interest or involvement.

7. Referring cases for consideration

[3] The National Panel of Independent Experts on SCRs has issued the following guidance for LSCBs on SCR initiation decisions:

1) **Serious Incident occurs where**
   a) a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of heath or development through abuse of neglect
   OR
   b) a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.
2) **LSCB Chair considers whether and how to proceed with an SCR**
   If the child has died the criteria for an SCR will most likely be met

7.1 Each agency must have arrangements for identifying cases where the agency considers that criteria for a SCR may be met. It is important that any practitioner or professional is able to discuss a case with their agency safeguarding children lead if they think a SCR may be required.

7.2 Any agency may refer a case to the LSCB that appears to meet the criteria. The agency safeguarding lead should notify the BHCC Head of Safeguarding/CP Adviser of a referral and confirm this in writing within 48 hours using the referral form (see Appendix B). The relevant agency Chief Officer must be notified of the referral by their agency safeguarding lead.

7.3 The LSCB Business Manager will request agency information to enable the reports to be available at the next available Case Review Subcommittee so that the group can make an informed recommendation to the Chairperson as to whether a SCR or Learning Review should be commissioned, or if no further action should be taken.

7.4 The Brighton & Hove LSCB Chairperson has ultimate responsibility for deciding whether to conduct a review.

7.5 Cases may be referred by the Child Death Overview Panel. The Chairperson of the Child Death Overview Panel (CDOP) may refer a case to the LSCB that appears to meet the criteria and which he or she considers is likely to have important lessons for inter-agency working. A professional involved in the Child Death Overview Panel can at any stage as in 7.1 above.

7.6 In addition, the Secretary of State for the Department for Education has powers to demand an inquiry be held under the *Inquiries Act 2005*.

8. Case Review Sub Committee

8.1 The Brighton & Hove LSCB has a standing Case Review Subcommittee. The Subcommittee has several functions and tasks delegated to it by the Brighton & Hove LSCB. In summary, the Case Review Subcommittee will coordinate the following inter-related activity to ensure the local Learning and Improvement Framework is effectively implemented:

- Procedures are up to date and compliant with Working Together 2015 to be 'best prepared' to respond to any referral regarding a serious incident which may or may not fall within the criteria for a Serious Case Review.
- Making recommendations to the LSCB Independent Chairperson as to:
    - whether a Serious Case Review should be carried out and the methodology to be used, or
    - whether a Serious Case Review should not be carried out but another type of learning review should be undertaken and the methodology to be used, or
    - whether other action should be taken by the LSCB in line with the Learning & Improvement Framework.
- Commissioning Serious Case Reviews or other types of Learning Reviews on behalf of the LSCB.
- Monitoring partner agency and the LSCB's action plans following the publication of a Serious Case Review or completion of another type of Learning Review.

- Using the learning from own and other LSCB Serious Case Reviews and national learning on Serious Case Reviews to inform policy, practice and the LSCB learning and development programme.

8.2 The standing Case Review Subcommittee meets monthly. As a minimum, the Case Review Subcommittee will have nominated senior representatives from:

- Children's Social Work, BHCC
- Health Commissioning & Partners (represented by either the Designated Doctor and/or Designated Nurse)
- Education Services, BHCC
- Sussex Police
- Kent, Surrey & Sussex CRC
- Public Health
- Lay Member

In addition, BHCC Head of Safeguarding/CP Adviser is also member of SCR Subcommittee.

8.3 The BHCC Legal Adviser and the LSCB Business Manager should attend or be available to the Subcommittee for advice. The LSCB Administrator will provide dedicated admin support to the Subcommittee.

8.4 If the Subcommittee is to make a decision to recommend to the LSCB Independent Chairperson on the criteria for an SCR, partner agency representatives may be co-opted to provide knowledge of their agency's contact with a child and his or her family or to provide expert advice.

8.5 The standing Subcommittee should be chaired by an experienced person who could be a member of the Brighton & Hove LSCB. The LSCB Chairperson in consultation with the Subcommittee Chairperson may consider that an Independent Chairperson should be appointed to chair a particular Case Review Subcommittee. This may be considered when the Brighton & Hove LSCB requires an additional level of independence (e.g. due to a conflict of interest, specialist expertise is required, complex issues).

8.6 The minimum requirement for the Subcommittee to be quorate is three representatives from Children's Social Care, Health Commissioning & Partners, Police and Education. In exceptional circumstances, where a member is not able to attend, the Subcommittee Chairperson may proceed with the meeting and reach a decision on the basis that further delay would not be consistent with the Learning & Improvement Framework.

8.7 The Brighton & Hove LSCB Business Manager will notify the Subcommittee members that they are to be convened for the purposes of deciding whether to recommend that a SCR should be undertaken.

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

9. Deciding whether to initiate a SCR

9.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be

made within one month of notification of the incident. The final decision rests with the LSCB Chairperson.

9.2 The Chairperson may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

9.3 In considering whether a case meets the criteria for a serious case review the Brighton & Hove LSCB Chairperson should receive a written briefing from the Case Review Subcommittee Chairperson. This should include the reasons for the Subcommittee's view on whether the criteria has been met or not, plus an outline of the methodology for a SCR or other Learning Review. Where the child has died, the Brighton & Hove LSCB Chairperson should also use information available from the professionals involved in reviewing the child's death to assist in making this decision (i.e. CDOP minutes and standard reports).

9.4 The LSCB Chairperson will inform the BHCC Head of Safeguarding/CP Adviser whether a SCR should be initiated or not. This will then be communicated to the Case Review Subcommittee via the LSCB Business Manager and subsequent arrangements made for the SCR or Learning Review to begin.

9.5 The LSCB should let Ofsted and the National Panel of Independent Experts on SCRs (National Panel) know their decision (see Appendix D). If the LSCB decides not to initiate an SCR, their decision may be subject to scrutiny by the national panel. The LSCB should provide information to the panel on request to inform its deliberations and the LSCB Chair should be prepared to attend in person to give evidence to the panel.

9.6 Following a decision by the Brighton & Hove LSCB Chairperson to undertake a SCR, the Case Review Subcommittee should make arrangements to manage and quality assure the process on a case by case basis. This role may be undertaken by the standing Case Review Subcommittee or by a separate SCR 'Panel'. The expectation would be for the lead reviewer to report on a regular basis to the Case Review Subcommittee or 'Panel' on the progress of the review, emerging learning, timescales for completion, costs and the arrangements for the Final SCR Report and presentation to LSCB.

10. Timescales for initiating and undertaking a review

10.1 Within one month of a case coming to the attention of the Brighton & Hove LSCB Chairperson, he or she should decide, following a recommendation from the standing Case Review Sub Committee, whether to initiate a Serious Case Review or Learning Review.

10.2 The LSCB should aim for completion of a review within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the review is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

10.3 In some cases, criminal proceedings may follow the death or serious injury of a child. The Case Review Subcommittee Chairperson should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the review is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage? Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings.

10.4 Where a child has died it may well be the case that their death will be the subject of an inquest conducted by the coroner. The function of the inquest will be to establish the circumstances and cause of the death. Consideration will need to be given on a case by

case basis as to the degree to which any Serious Case Review needs to be informed by the inquest, and vice versa, and this will have implications for the timescales of any review.

10.5 In the event that a Serious Case Review is being conducted in relation to a case which is also the subject of a coroner's inquest, the Legal Adviser to the LSCB will ensure that the coroner is made aware of the intention to conduct a Serious Case Review. The coroner will wish to know the likely timescale of the review, and terms of reference.

10.6 The Legal Adviser to the LSCB will consider at an early stage the degree to which it will be necessary in the circumstances of the case for the SCR team to have access to information which may emerge from the enquiries of the coroner, and the subsequent inquest. The coroner will also wish to consider the extent to which it will be necessary to receive relevant information from the review, or even whether or not the inquest can proceed prior to the review concluding. These are issues which should be considered with the benefit of legal advice by the lead reviewers, Subcommittee and Chairperson, and then raised with the coroner on behalf of the LSCB at the first pre inquest review hearing.

10.7 Staff involved in the review should be informed that there is legal precedent for the coroner asking to see the material obtained by the review team, and that therefore it is possible that information shared with the Review Team during the review process will be shared with the coroner, who can then decide to disclose any part of the information obtained in the inquest with any interested party to the inquest, including the family. Where agencies participating in the review are also made interested parties to the inquest, it will be possible for staff to seek their own legal advice about this, and if necessary their agency can make its own representations to the coroner. Where possible family members should be met with and made aware of reviews findings prior to receiving any review documents via the coroner's court.

10.8 In the event that there are proceedings which have been or are being conducted in the family court at the time of the review, the allocated local authority lawyer will be requested to consider whether there is any relevant information pertinent to the terms of the review obtained within the family proceedings. If this is the case the Legal Adviser to the LSCB should be informed and consideration given as to whether or not an application to the family court is needed for disclosure of the identified material to the review team.

10.9 Reviews should not be delayed as a matter of course because of outstanding family, civil or administrative court cases or coroners proceedings. The LSCB Chairperson will make decisions as to the timing of the review on a case by case basis, based on advice from the Case Review Subcommittee Chairperson, having consulted with the local authority or the police where there are any dual court processes, e.g. pending criminal, civil proceedings, and where necessary having obtained legal advice.

10.10 The final Review Report should take full account of salient, new information which becomes available during the course of these any civil or criminal proceedings, and the facts, conclusions and recommendations should be revised accordingly.

11. Notifications

11.1 Once the Brighton & Hove LSCB Chairperson has decided to carry out a SCR, a letter of notification will be sent by the LSCB Chairperson to Chief Executive Officers of the agencies involved. This will be undertaken by the LSCB Business Manager.

11.2 The Brighton & Hove LSCB Chairperson should notify the Ofsted and the National Panel of Independent Experts on SCRs (National Panel) whether or not a serious case review will be initiated as soon as the decision is made. It is good practice for other agencies to notify their respective regulators. CCG commissioners should ensure the Care Quality Commission (CQC) are notified. The Police should also notify Her Majesty's Inspectorate of Constabulary (HMIC), and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation). In addition to Ofsted and the DfE, the DfE Early Years Unit and Ofsted should be informed if children's day care or childminding is involved; and the DfE should also be informed if a school is involved. Other agencies must inform the relevant regulatory bodies as appropriate.

11.3 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the Final SCR Report, information relating to children, family members and professionals involved in the case (with the exception of the B&H LSCB Chairperson, SCR Panel Chairperson and Lead Reviewer) should be anonymised before being submitted to any external organisation or body (including Ofsted, the National Panel and any Government Departments).

11.4 If the Brighton & Hove LSCB Chairperson has decided to carry out a Learning Review the Case Review Subcommittee will notify the relevant agencies during the determining a methodology stage – see page 10

12. Notifying and Engaging the Family

12.1 It is important that consideration is given to the best means of notifying families that a review is being undertaken. Effective communication at an early stage may be vital in gaining cooperation from family members during the review process (e.g. interviews). The use of interpreters or translation services should be used where English is not the first language of the family members. Generally best practice would be to personally deliver and explain a notification letter with a family by a professional already involved with the family or the lead reviewers for a review. It is not good practice for a letter to be sent 'cold' to family members unless every reasonable attempt to arrange a face-to-face interview has been exhausted. In such situations the wording of the letter should be carefully thought through.

12.2 Where a child has survived and is the subject of a review, they must be informed (given their age and understanding) that a review is being initiated and the process explained in a suitable way. Where the child is too young to be informed, arrangements should be made for relevant communications to be archived for such a time when it may be appropriate to inform the child retrospectively.

12.3 The timings of such notifications are crucial, particularly when there are current Police investigations. When there are pending criminal proceedings involving the parents and or family members, the decision about how and when to notify the family needs to taken by the Review Team on the case review, there must be a Police representative present.

12.4 When appropriate the family will be invited to share their views with the Lead Reviewer.

12.5 If the review team identify relevant third parties whom it is considered can offer an important perspective on the case (such as friends or key members of the network of the family), consideration will be given to inviting them to participate in the review by meeting with the lead reviewers. The means of notifying them of the request should be the subject of careful consideration, informed by their circumstances.

13. Determining the methodology for a review

13.1 If the Case Review Subcommittee advises that a review should take place, they must also recommend the methodology for the review. The methodology used and the way a review should be conducted must be consistent with the principles for learning and improvement set out in Chapter 4 Working Together 2015.

13.2 See the Brighton & Hove LSCB Learning & Improvement Framework for examples of the methodology models for consideration.

13.3 The initial scoping of the review should take into account the current information known in each case and must identify those who should contribute. As further information becomes available other contributors may be needed.

13.4 As part of the LSCB's ongoing Learning & Improvement Framework, the LSCB may have specific questions that should be answered as part of the review. These may link to previous lessons learnt through monitoring and evaluation (e.g. through multi agency case audits). It is important not to view the review process as a separate from other LSCB activities.

13.5 For relevant issues to be considered see Appendix C.

14. Appointing Reviewers

14.1 The LSCB should appoint one (or in some cases two) suitable individuals to lead the review who have demonstrated that they are qualified to conduct reviews using methodologies consistent with Chapter 4 Working Together 2015. In a Serious Case Review the lead reviewer should be independent of the LSCB and the organisations involved in the case.

14.2 For a Serious Case Review the LSCB Business Manager should provide the national panel of independent experts and the Department for Education with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

14.3 The Brighton & Hove LSCB Chairperson in conjunction with the Case Review Subcommittee Chairperson will identify suitable candidates, dependent on the needs of each case review. Candidates will be asked to supply:

- a Curriculum Vitae; and
- a referee who will be a Senior Manager or LSCB Chairperson in an authority where they have previously been lead reviewer on a SCR or written a SCR Final Report or complex reporting a related field.

14.4 Once a Lead Reviewer has been identified a commissioning letter and contract outlining terms and conditions for the case review will be drawn up by the LSCB Business Manager. The contract will include details of the time allocated, costs agreed, timescales for completion and the format of the Final Report.

14.5 The Lead Reviewer is likely to be commissioned to produce the Final SCR Report. However, this needs to be confirmed on a case by case basis.

15. Publishing Reports

15.1 All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration and shared with all involved in the review process, including family and professionals. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

15.2 All reviews of cases that **do not** met the SCR criteria will not result in a report which is published. A synopsis of learning will be drafted and this will be readily accessible on the LSCB's website and proactively distributed to staff, including the in the LSCB Safeguarding Newsletter.

15.3 Final Review Reports should:

- 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 ; and
- be suitable for publication without needing to be amended or redacted.

15.4 The Final Report should enable professionals from all relevant sectors to understand fully what happened in each case, the context in which the events occurred and to learn and apply the lessons. The Final Report should bring together the facts, analyse the findings and may make recommendations for future action dependent on the methodology used.

15.5 Brighton & Hove LSCB should publish, either as part of the Final Report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

15.6 When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case, including the impact upon staff.

15.7 LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders which restrict published material about the family. Where a report has been provided to the coroner's inquest prior to publication it should be noted that the inquest is held in public, and therefore there will be scope for reporting of the report in so far as it is made public during the inquest.

15.8 LSCBs should send copies of all SCR reports to the national panel of independent experts at least one week before publication. If an LSCB considers that an SCR report should not be published, it should inform the panel which will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations.

16. LSCB action on receiving the Final Report

16.1 The Case Review Subcommittee, on behalf of the Brighton & Hove LSCB, should quality assure the Final Report.

16.2 The LSCB should oversee the process of agreeing with partners what action they need to take in light of the reviews findings.

16.3 The Brighton & Hove LSCB should approve the Final Report and:

- Make arrangements to provide feedback and debriefing to family members as appropriate;
- Make arrangements to provide feedback and debriefing to staff as appropriate;
- Make arrangements to provide a briefing to the media as appropriate;
- Disseminate the Final Report to relevant interested parties;
- If an SCR, publish the Final SCR Report once the SCR has been completed
- Implement those actions for which the B&H LSCB has lead responsibility and monitor the timely implementation of the actions resulting from the review;
- Formally conclude the review process when all the actions have been implemented.

16.4 In an SCR, prior to publication the Brighton & Hove LSCB and partner agencies should anticipate the likely response from the media and plan in advance how to manage it constructively. 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.

17. Audit and monitoring

17.1 Monitoring of the actions produced from the Final Report will be undertaken by the standing Case Review Subcommittee reporting back to LSCB on a regular basis. Upon completion, the Case Review Subcommittee will advise the Board that all actions are complete.

17.2 Any areas of inter-agency activity identified as of particular concern may also be referred for consideration to the Brighton & Hove LSCB Monitoring & Evaluation Subcommittee as a potential area for monitoring and review.

18. Reviewing Institutional Abuse

18.1 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply but reviews are likely to be more complex, on a larger scale, and may require more time. The scope of the SCR and the methodology needs to be carefully considered to explore the issues relevant to the specific case.

18.2 If, for example, children had been abused in a residential school, it would be important to explore whether and how the school had taken steps to create a safe environment for children, and to respond to specific concerns raised.

18.3 There needs to be clarity over the interface between the different processes of investigation (including criminal investigations); case-management, including help for abused children and immediate measures to ensure that other children are safe; and review (i.e. learning lessons from the case to reduce the chance of such events

happening again). The three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

19. Supporting Staff

19.1 The death or serious injury of a child may be a traumatic event for involved staff (including unpaid staff such as volunteers), particularly if they were involved in service delivery to the child or to the child's family.

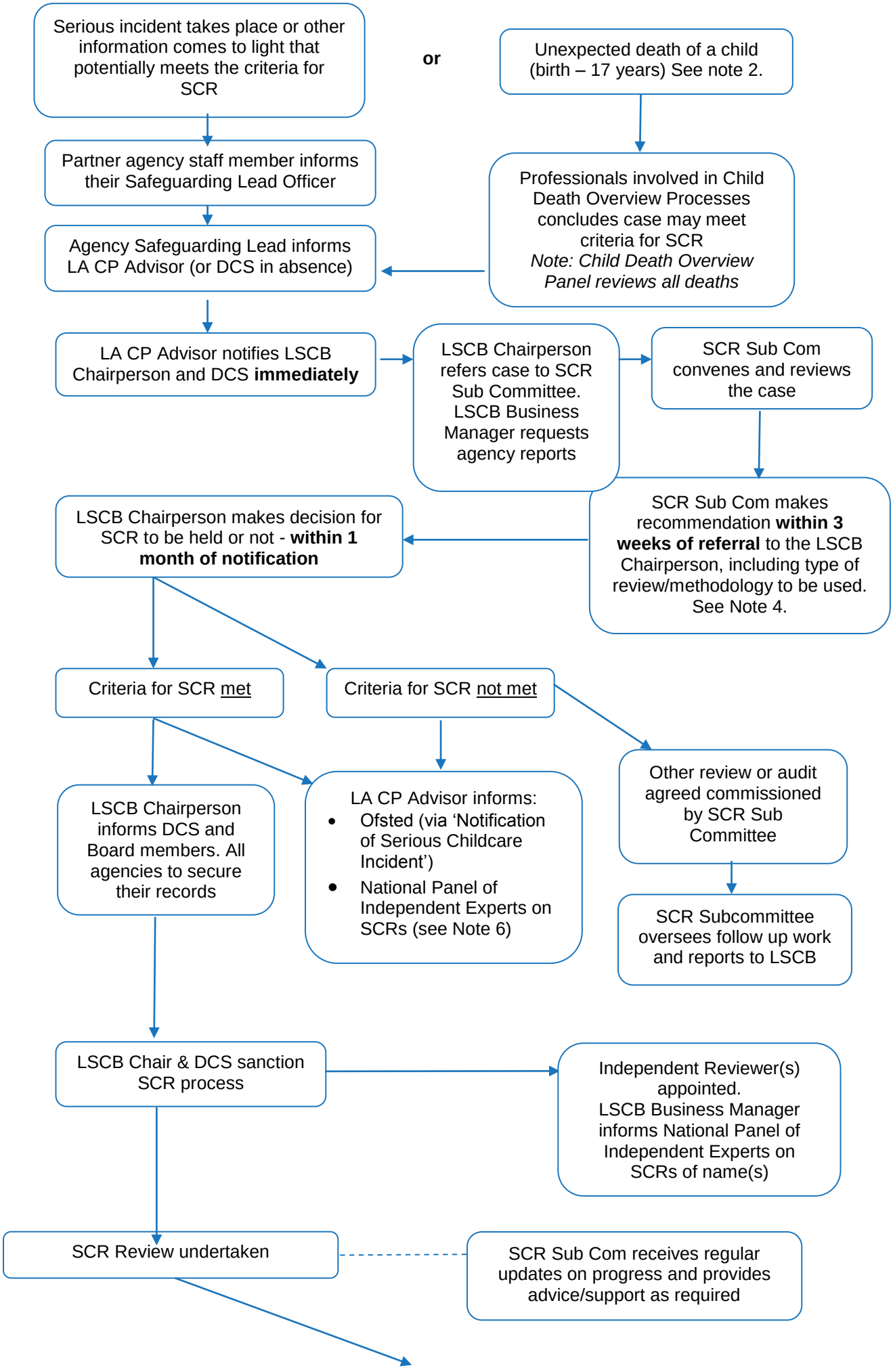
19.2 Managers have a duty of care to employees and volunteers and should ensure that whether they are interviewed or not in relation to a case where there is a LSCB Review, staff involved is supported through the process. This might be by the provision of support from the employer or by giving advice about sources of independent support.

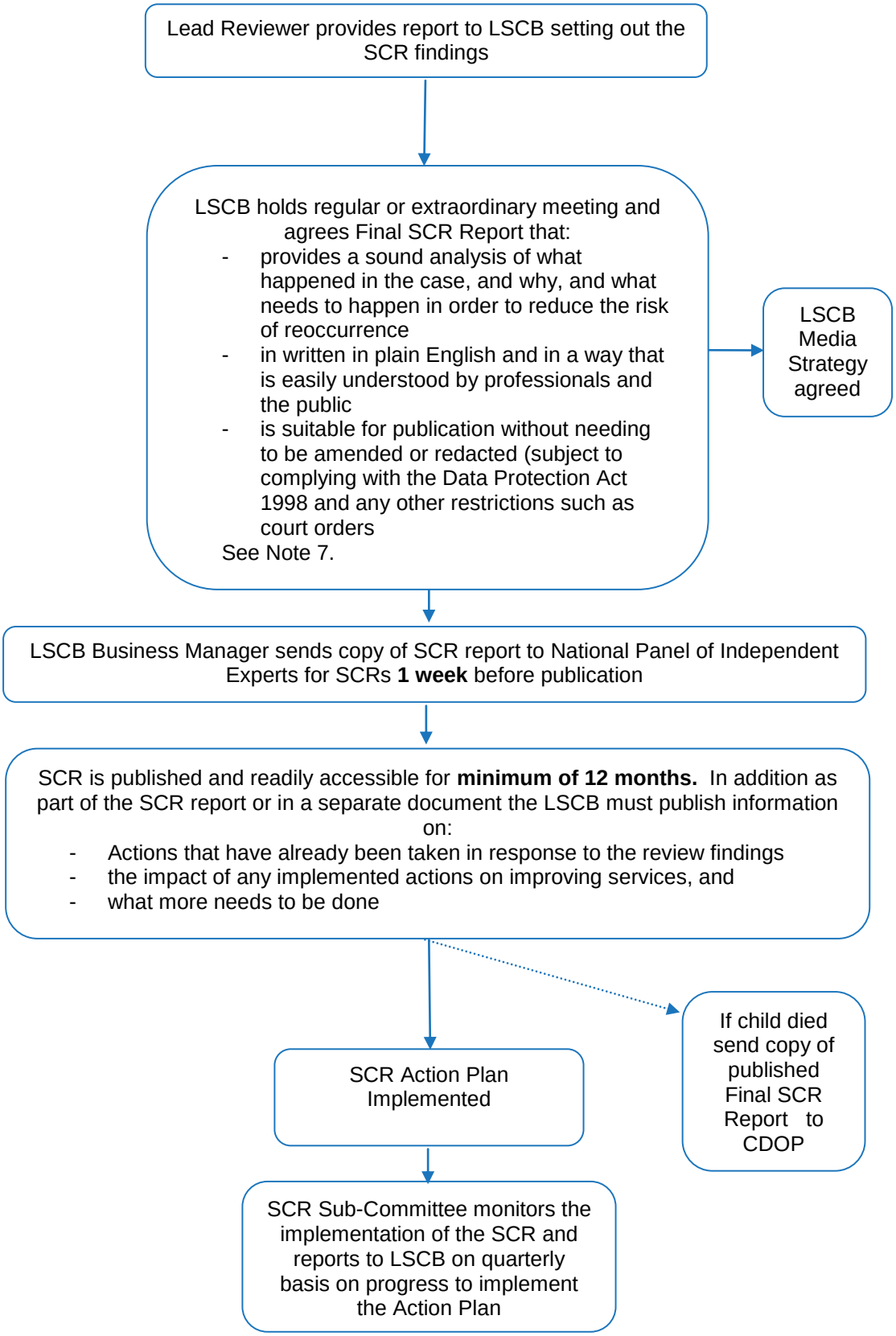
19.3 Managers should advise staff about access to support through the employing agency (e.g. many organisations have employee welfare services for example which may be able to assist).

19.4 In addition, or as an alternative, staff may also wish to consult their Trades Union or professional association about sources of support. Managers should not prevent or discourage this.

19.5 The LSCB has produced support guidance for staff involved in SCRs and this can be read here: Support Guide for Staff: Serious Case & other Learning Reviews:

APPENDIX A - Serious Case Review Flowchart




Lead Reviewer provides report to LSCB setting out the SCR findings
LSCB holds regular or extraordinary meeting and agrees Final SCR Report that:
- provides a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of reoccurrence
- in written in plain English and in a way that is easily understood by professionals and the public
- is suitable for publication without needing to be amended or redacted (subject to complying with the Data Protection Act 1998 and any other restrictions such as court orders
See Note 7.
LSCB Media Strategy agreed
LSCB Business Manager sends copy of SCR report to National Panel of Independent Experts for SCRs 1 week before publication
SCR is published and readily accessible for minimum of 12 months. In addition as part of the SCR report or in a separate document the LSCB must publish information on:
- Actions that have already been taken in response to the review findings
- the impact of any implemented actions on improving services, and
- what more needs to be done
If child died send copy of published Final SCR Report to CDOP
SCR Action Plan Implemented
SCR Sub-Committee monitors the implementation of the SCR and reports to LSCB on quarterly basis on progress to implement the Action Plan

Important Notes:

1. See Terms of Reference for SCR Sub Committee.

2. An 'unexpected death' is defined as a death that was not anticipated as a significant possibility 24 hours beforehand;

3. The SCR Sub Com should provisionally agree the following when a recommendation to the LSCB Independent Chairperson is made to undertake a full SCR: (a) A rationale of the type of review (methodology) to be used; (b) Agencies involved in the review; (c) Appointment of Lead Reviewer(s), (d) Administrative support, (e) Timescale for the Review. These matters should be confirmed at the earliest opportunity once the LSCB Independent Chairperson has decided that a SCR will be undertaken.

4. The timescale for conducting a Serious Case Review is **six months** from the LSCB Independent Chairperson agreeing that the case meets the criteria for a Serious Case Review;

5. The Lead Reviewer(s) will be commissioned jointly by the LSCB Independent Chairperson and the DCS to ensure an independent process;

6. LA CP Adviser informs National Panel of Independent Experts on SCRs **within 14 days** of decision by LSCB Independent Chairperson not to initiate a SCR.

7. If the LSCB has concerns about publication this must be referred to the National Panel of Independent Experts on SCRs.

Appendix B

Request for summary of involvement to help inform decision to hold a Serious Case Review or Learning Review

The Brighton & Hove LSCB is considering whether to hold a Serious Case or Learning Review relating to a child as per Chapter 4 of Working Together to Safeguard Children 2015.

In order for the Case Review Subcomittee to make a recommendation to the LSCB Independent Chairperson the following information is requested of your agency.

Please return this proforma by: **DATE** to Claire-Louise Mackay, LSCB Admin Officer; at LSCBCasereviews@brighton-hove.gcsx.gov.uk

This will be passed to Mia Brown, LSCB Business Manager.

Name of Child	
Date of Birth	
Last known address	
Siblings	
Mother's name	
Father's name	
Period of Interest	

Reason for Information Request

Please complete the following sections

Name of agency you represent	
Your name	
Your telephone number	
Your email address	

Note of any concerns about child or parents / family members & actions taken by agency

Significant Events (e.g. changes in family, coming to the attention of the Police, Attendance at A&E, referral to other agency)	
Date	Event

Summary of Involvement: Please try and restrict submission to two pages – this is a summary of the information you hold on contact with this child	
Period/Length of involvement	Type of Involvement

Frontline staff involvement during time known to your services within the period of interest specified above	
Name	Job Title

Other Agencies known to be involved from records	**Dates of involvement if known**

Referral to Brighton & Hove LSCB of a Serious Incident for Consideration by the Case Review Subcommittee

Section 1

Section 1 to be completed by the referring officer following a discussion with their line manager and Designated Child Protection professional, and where appropriate, the Case Review Panel member from their organisation. For organisations without a Case Review Panel representative, cases can be discussed with the Head of Safeguarding for the Local Authority.

Please send this form securely to LSCBcasereviews@brighton-hove.gcsx.gov.uk

The objective of this form is to convey as much information that is readily available at the time of completion. If information is unavailable do not delay in making this referral.

1. NOTIFIER DETAILS					
Notifying professional:		**Role** (in relation to child)**:**			
Date of notification:		**Contact details:**			
Who are you submitting this referral on behalf of? (please tick)	**An agency**	☐	**A multi-agency partnership** (e.g. CDOP)	☐	
	Please state:		Please state:		
Signed:					

2. CHILD'S DETAILS								
Child's full name:		**Other names used:**						
Child's date of birth:		**Date of death/serious incident:**						
Gender:		**Ethnicity:**						
Child's home address:								
Where does the child live? (please tick)	Home	☐	Local authority care	☐	With relatives	☐	Other (please state)	☐
Child's educational establishment:								

3. PARENTS DETAILS (and other significant adults)			
Mother's name:		**Mother's date of birth:**	
Mother's address (if different):			
Father's name:		**Father's date of birth:**	
Father's address (if different):			

Details of any other significant adults and their relationship to the child:	

4. DETAILS OF SIBLINGS			
Name of sibling:	**Date of birth:**	**Gender:**	**Address** (if different to key child):

5. REASON FOR REFERRAL (please tick all appropriate options) See guidance document for glossary of terms	
Considered to meet the Serious Case Review criteria (as set out in Working Together to Safeguard Children 2015)	☐
Child has died and abuse or neglect is known or suspected to be a factor	☐
Child has been seriously harmed (e.g. a potentially life threatening injury, serious sexual abuse) and abuse or neglect is known or suspected to be a factor	☐
There are concerns about the way that agencies have worked together to safeguard the child	☐
The case provides opportunities for learning lessons from multi-agency work	☐
Child has committed suicide	☐
Child has been a perpetrator of a serious crime	☐

6. CASE OUTLINE
Please give a brief summary of the events leading to the referral including any critical incident, key dates, status of child, details of any disability or communication issues and any other relevant information.

7. PARTICULAR CONSIDERATIONS
Please specify any considerations for this case, for example media interest or criminal considerations or other linked cases. If the case is known to be subject to a criminal investigation please state the lead investigator. If the case is known to be the subject of a Coroner's Enquiry please state key contact.

8. ANY OTHER RELEVANT INFORMATION OR ISSUES

9. OTHER AGENCY INVOLVEMENT			
Agency:	**Name and role of key worker** (in relation to key child)**:**	**Contact details**	**Reason for involvement:**

10. AUTHORISATION FOR REFERRAL			
This form should be countersigned by the manager/professional with whom this referral was discussed.			
Name:		**Role:**	
Signature:		**Date:**	
Contact details:			

The Case Review Subcommittee usually meets monthly. Once considered by the subcommittee the referrer and authorising manager/professional will be notified of the outcome in writing by the Case Review Subcommittee Chair.

Section 2

Section 2 to be completed by the Case Review Subcommittee.

1. MEETING	
Date of Meeting:	
Attendees	
Documents considered	

2. RECOMMENDATION
Please state whether a review is/not recommended and, where applicable what type of review is being recommended (e.g. serious case review or other learning review, multi-agency partnership review or single agency review)
Please state the reasons for the panel decision.

3. AUTHORISATION FOR RECOMMENDATION			
This form should be signed by the Chair of the Case Review Subcommittee			
Name:		**Role:**	
Signature:		**Date:**	

If the case referred meets the criteria for a review, the sub-group Chair will make a recommendation to the Independent Chair of the LSCB who will decide whether the review should be undertaken.

Section 3

Section 3 to be completed by the Independent Chair of Brighton & Hove LSCB

1. DECISION
Please state the conclusion you have reached including the reasons for that decision.

2. ISSUES TO BE CONSIDERED
Please state any particular issues you think must be considered by the review and any recommendation for the methodology.

3. SIGNED BY INDEPENDENT LSCB CHAIR			
Name:		**Role:**	
Signature:		**Date:**	

If the decision is made to conduct a Serious Case Review the LSCB Manger will notify Ofsted and the national panel of independent experts.

Appendix D

Key Questions for considering scope and methodology of SCR

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the SCR report?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point?
- What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the serious case review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the serious case review including, where appropriate, for example, the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or third sector organisations? Is there a need to involve organisations/ professionals working in other LSCB areas and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the B&H LSCB need to obtain independent legal advice about any aspect of the proposed serious case review?
- What experience, knowledge and skills are required from the person who will be appointed as the Lead Reviewer?
- Might it help the SCR Subcommitteeto bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO). Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO) or MAPPA serious case review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated with a serious case review.

- How will the scope of the serious case review fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), and family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (e.g. national) and from serious case reviews which have been undertaken by the B&H LSCB?
- How should any family, public and media interest be managed before, during and after the serious case review? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the serious case review?

Appendix E

National panel of independent experts on serious case reviews

26 June 2013

The government announced in Working Together to Safeguard Children in March 2013, that a national panel of independent experts would be established to give Local Safeguarding Children's Boards (LSCBs) access to expert advice from an independent source to help them make the right decisions about conducting and publishing serious case reviews (SCRs).

The panel members are Peter Wanless, Nicholas Dann, Elizabeth Clarke and Jenni Russell. The panel is independent of Government and will provide advice to LSCBs drawing on their own individual areas of expertise.

It will be fully operational from 1 July 2013 and will advise and challenge Local Safeguarding Children Boards (LSCBs) to initiate and publish high-quality SCRs. This is so that lessons can be learned locally and nationally to drive up the quality of child protection services and avoid mistakes being repeated.

The panel will initially advise LSCBs on:

- any decision made by an LSCB not to initiate an SCR following a serious incident which meets certain agreed criteria
- any case where an LSCB has concerns about publication of an SCR report

LSCBs should inform the panel about their SCR initiation and publication decisions. Full information on how the panel will operate and when to contact the panel are set out in the national panel of independent experts on serious case reviews instructions for LSCBs.

The panel has its own dedicated secretariat which will initially be hosted in the Department for Education. These arrangements will be subject to review.

A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat using the contact address on this page.

Panel Members:

- Peter Wanless is Chief Executive of the NSPCC
- Nicholas Dann is Head of International Development at the Air Accidents Investigation Branch (AAIB)
- Elizabeth Clarke is a practising barrister who has specialised in family law
- Jenni Russell is a columnist for the Sunday Times, the Evening Standard and the Guardian

Panel meetings:

- 25 July 2013
- 9 September 2013
- 11 November 2013
- 13 January 2014
- 10 March 2014
- 12 May 2014
- 14 July 2014
- 8 September 2014
- 10 November 2014
- 12 January 2015
- 9 March 2015
- 11 May 2015

Contact details

Serious case review panel
Email: **Mailbox.SCRPANEL@education.gsi.gov.uk**

National panel of independent experts on Serious Case Review
Information for LSCBs and Chairs on how the panel will operate

1. Scope of the panel

The role of the panel is set out in *Working Together to Safeguard Children* (2013). The panel's remit will include advising LSCB and Chairs about: application of the SCR criteria; appointment of reviewers; and publication of SCR reports.

The panel will initially advise LSCB Chair's on:

i. any decision made by an LSCB Chair not to initiate an SCR following a serious incident; and

ii. any SCR which an LSCB Chair has indicated it does not plan to publish.

2. Serious Case Review criteria

- Serious Case Review: for every case where abuse or neglect is known or suspected and either:

  - A child dies; or
  - A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

3. Publication of reports

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs.

From the start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.[1]

1 *Working Together to Safeguard Children* March 2013

4. Which cases should the LSCB Chair inform the panel about?

The LSCB Chair should inform the panel about their SCR decisions on cases which:

(a) have been, or should be notified to Ofsted and the Department by the local authority because abuse or neglect is known or suspected and either (i) a child has **died** or (ii) a child has suffered a potentially **life-threatening** injury, **serious sexual abuse** or **sustained serious and permanent impairment** of health or development; or

(b) which come to the attention of the LSCB Chair through another source and, in the LSCB Chair view meets the criteria in (ai) or (aii) above.

The LSCB Chair does not need to inform the panel about other categories of incident which may come to their attention but which clearly fall outside the criteria for an SCR, such as accidental deaths or deaths of looked after children where there are no suspicions of abuse or neglect.

The Department is planning to review the processes for notification of serious incidents over the coming year.

5. What information should the LSCB Chair provide to the panel?

Initiation

In cases where the LSCB Chair has **decided to initiate** an SCR, the Chair should give the panel:

• the name(s) of the reviewer(s) appointed to conduct the SCR.

In cases where the **LSCB Chair has decided NOT to initiate an SCR**, the Chair should:

• let the panel know within 14 days and provide a copy of the local authority's Serious Incident Notification if available (if this is not available, please provide brief anonymised details of the case covering the nature of the incident; ages of the children involved; their relationship with any alleged perpetrator(s); agency involvement with the family; and any criminal investigation;

• provide an explanation why the case does not meet the SCR criteria.

Publication

In cases where the **LSCB Chair has concerns about publication of an SCR report**, the Chair should refer their concerns to the panel. This could be done at any time in the course of conducting an SCR.

The LSCB Chair should provide the panel with the following information:

• what the LSCB has done to ensure that the SCR will be written with publication in mind. How has the reviewer been briefed?

• where is the potential difficulty coming from? For example, is it from agencies contributing to the review, from family members, or are there general concerns about media activity?

• how has the LSCB balanced these interests with the public interest in understanding the issues raised by the case and with the importance of ensuring that lessons are learnt to improve services to children and families?

• are there are any legal restrictions on releasing certain information in the report?

• what consideration has been given to amending the style and content of the report to make it fit for publication?

• what expert advice has the LSCB drawn on when considering publication of the report? For example has there been advice from lawyers or medical or communications professionals?

• how is the LSCB managing media interest in the case?

6. How will confidentiality of the information be preserved?

Panel members have agreed and signed up to terms and conditions which include confidentiality clauses. Members have agreed that personal, sensitive or otherwise confidential information will only be used in furtherance of the panel's objectives.

Information that will be shared with panel members will be sent through secure email links and encryption.

The panel would not be subject to the Freedom of Information Act 2000 because it is not a public authority as defined at section 3 of the Freedom of Information Act 2000.

7. How to contact the panel

A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat: Mailbox.SCRPANEL@education.gsi.gov.uk

The flowcharts which follow set out the process for contacting the panel.

8. What is the turnaround time?

The dates of future panel meetings will be communicated to LSCB Chairs. The panel will inform LSCBs Chairs of the panel's advice within a week of each panel meeting. This will be communicated by a letter to LSCB Chairs.

9. Attendance at panel meetings by LSCB Chairs

On some occasions, the panel may ask the LSCB Chair to attend a panel meeting if they would like to discuss the case further. This will be on a case by case basis. Costs of attendance by the LSCB Chair can be reimbursed by prior arrangement with the secretariat. The LSCB Chair may bring others to the meeting on request but costs of attendance by other individuals will not be reimbursed.

Flowchart 1: SCR initiation decisions

Serious Incident occurs where:
a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of heath or development through abuse of neglect.
OR
a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.

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LSCB Chair considers whether and how to proceed with an SCR
If the child has died the criteria for an SCR will most likely be met
Questions to consider include:
If the child has not died; are there concerns about how agencies or professionals worked together to protect the child
What is the scope of the review and who needs to be involved?
Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

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Once an LSCB Chair has made a decision on whether or not to initiate an SCR, the LSCB Chair should inform the panel by emailing the secretariat at:
Mailbox.SCRPANEL@education.gsi.gov.uk

↙ ↘

YES
If an LSCB Chair has decided to initiate an SCR, the LSCB Chair should let the panel and Ofsted know of their decision.

Appointing reviewers

LSCB Chairs should also let the panel know:

• name(s) of the reviewer(s) appointed to conduct the SCR.

This will be for information. The panel has no formal role in vetting reviewers.

NO
If an LSCB Chair has decided not to initiate an SCR, the LSCB Chair should let the panel know their decision within 14 days, providing a copy of the local authority's Serious Incident Notification and an explanation why the LSCB Chair has decided the case does not meet the SCR criteria

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Panel meetings
The panel expects to meet every 2 months to review the details of cases submitted. The panel may request a meeting or further information from the LSCB Chair before being in a position to advise about a case. If so the panel will contact the Chair direct.

Flowchart 2: SCR report publication decisions

LSCB Chair considers publication of the SCR report.
Questions the LSCB should consider as a minimum are:

- the public interest in seeing the report and understanding the issues raised by the case;
- the importance of ensuring that lessons are learnt and shared widely to improve services to children and families;
- how these public interests can be balanced with those of any children and vulnerable adults involved in the case;
- whether the style and content of the report make it fit for publication;
- whether there are any legal restrictions on releasing certain information in the report;
- what expert advice is needed e.g. from lawyers or medical or communications professionals; and
- how best to manage media interest in the case.

Once an LSCB Chair has decided whether or not to publish SCR report, the LSCB Chair should inform the panel by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk
If at any time during the course of the SCR the LSCB Chair comes to a view that publication of the report may not be possible, the LSCB Chair should alert the panel to its concerns.

YES
Will be published within 28 days of completion (signed off by the LSCB Chair) - If an LSCB Chair has decided to publish an SCR, the LSCB Chair should send a copy to the panel mailbox at least one week before publication

Will be published but outside 28 days due to delays - if an LSCB Chair is planning to publish an SCR but is has been delayed please provide an expected date for publication to the panel.

NO
If an LSCB Chair has decided not to publish an SCR report the LSCB Chair should let the panel know their decision providing an explanation of how they have considered the questions above.

Panel meetings
The panel expects to meet every 2 months to review details of cases submitted. The panel may request a meeting or further information from the LSCB Chair before being in a position to advise about a case. If so the panel will contact the LSCB Chair direct.