Brighton & Hove Local Safeguarding Children Board

Serious Case & other Learning Reviews:
A Guide for Staff & Managers

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Introduction

The death or serious harm of a child is a distressing event for everyone. When this then leads to inquiries being made about the work of professionals who were providing services to the child and family it can lead to staff understandably feeling very anxious. That is why it is important that all staff involved in the process of a Local Safeguarding Children Board (LSCB) Case Review (whether it be a serious case review - SCR, or a learning review - LR) into the death or serious injury of a child have a clear understanding about why the review has been requested, what it expects to achieve, what it involves, what is expected of them as professionals and how long, as far as can be predicted, it will take.

Serious Case Reviews are conducted throughout the country. In Brighton & Hove the LSCB have a Case Review Subcommittee. This oversees all arrangements for reviews. The subcommittee comprises of senior representatives from children's social work, education, health, police, legal services, and public health with the Board business manager and a lay member. When a 'case' is first bought to the groups attention, members firstly discuss whether or not it meets the criteria for a serious case review, as determined by statutory guidance Working Together to Safeguard Children, 2015. The group can suggest conducting a SCR on cases which do not meet the SCR criteria or are able to recommend another type of learning exercise. The final decision on whether to conduct an SCR rests with the LSCB Chairperson.

Involvement in a SCR case can be a very difficult and stressful experience for staff. It is important that those involved in the review process are kept informed about the progress of the review and the time scales involved. As part of the review there will always be a review team / steering group, or similar, which consists of senior managers from the agencies involved in the case – who themselves have had no direct contact or decision making responsibilities with the child or family subject to review. One of their roles is to be available, alongside, if it becomes necessary, the Lead Reviewer/s to answer any questions from staff about the process. It is also expected that support will be offered to staff through their usual line management arrangements and where possible direct from the LSCB via the business manager. They should also be offered counselling and other forms of support as necessary by their own agencies. Staff should discuss issues of support within their usual line management arrangements, highlighting to the LSCB, via the business manager if any problems accessing suitable support should arise.

The offer of support should be ongoing and able to be accessed at any time.

What is an LSCB case review?

It is a multi-agency review of a 'case' or 'cases'.

The principles and framework for the management of **serious case reviews** are currently set out in Chapter 4 of the HM Government document Working Together to Safeguard Children, 2015.

Working Together says the LSCB should always undertake a **serious case review** when abuse or neglect of a child is known or suspected; and either the child has died or has been seriously harmed and there is cause for concern as to the way in which Board partners or other relevant persons have worked together to safeguard the child.

As outlined above serious case reviews can be carried out on cases which do not meet the criteria or other learning reviews may be commissioned.

What is the purpose and function of such reviews?

The LSCB undertakes these reviews ultimately to learn lessons about how Board partners provide services and work together, so that we can continue to improve our child protection and safeguarding practices and the way we work with children and their families.

This can be done by a number of ways, so long as a 'systems approach' as advocated by Professor Munro in the Munro Review of Child Protection is used – *read the report from page 64: A systems methodology for case reviews and SCRs.*

As a starting point all information about the child's/families' journey through the system is drawn together e.g key contacts with professionals. This helps to focus the review on looking at how events and relationships, both within the family and within the professional network, were understood and supports with identifying lessons that can be learned from the case to inform and improve professional practice in future.

Any review undertaken by the LSCB is not about looking for and apportioning blame. Reviews should always be an open and transparent opportunity to learn from practice, in order to improve multi-agency working and outcomes for children.

The LSCB recognise that this learning inevitably takes place in a context where some staff involved may be experiencing high levels of upset. For example, they may have worked with the child/family over a number of years. The objective is to conduct a review that both acknowledges the importance of professional accountability and retains its sensitivity to the needs and feelings of all individuals involved. The LSCB cannot stress enough that support for staff involved should always be an integral and ongoing part of the process.

What is a systems approach?

Up till relatively recently, reviews of cases often ended up blaming individuals for mistakes and failures. A system's approach concentrates not on judging people. Instead, by taking account of the situation they were in, the tasks they were performing, and the tools they were using etc, it focuses on understanding why someone acted (or did not act) in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. Importantly, it also highlights what is working well and patterns of good practice.

What does the review involve?

There are several stages in the review process.

As discussed earlier on in this guidance the Case Review Subcommittee makes their decision against the criteria set out in *Working Together*. If the criteria are met, the group recommend to the LSCB Chairperson that a review should be undertaken and suggest some very initial lines of enquiry and the methodology for the review. The LSCB Chairperson considers the recommendation and makes a final decision, they are able to consult with other LSCB chairs in the country.

If a **serious case review** has been commissioned all CEOs of Board Partner agencies are alerted as are Ofsted, the Department for Education and the National Panel of Experts. At this point case files in all agencies that worked with the family are secured. In cases where work with the family is continuing, copies must be made of the record so that the work can continue. CEO's do not tend to be notified of other types of reviews, but this is agreed on a case by case basis.

Lead Reviewer/s are then appointed, and senior managers from partner agencies are invited to join a review team or steering group. They draft the terms of reference / scope of review to identify particular areas/issues that should to be addressed by the review. All agencies involved identify a professional to undertake a chronology. Whilst these are collated all frontline staff who have worked with the child/ family (and as far as is known at the time, their managers) are notified of the review and terms of

reference/ scope shared so they understand the focus of the review and any meetings dates to be diarised.

As part of the review it may become necessary for the reviewer/s to speak directly with staff. The purpose of this is to gain as full a picture as possible of the events that have taken place and the perceptions and views of staff and the context in which decisions and actions were taken. Prior to this the reviewer/s will have read case files and other relevant documentation and records and will have several areas they want to explore. Staff can also raise areas they wish to bring to reviewer/s attention.

Family, and in some cases friends, are invited to contribute to the review in any way they feel able to do so. Whether this be in the form of a written contribution or meeting with the reviewer/s. Careful consideration is given to speaking with siblings, based on their age and appropriateness of initiating contact.

The lead reviewer/s, supported by the review team / steering group, complete a report which must be written as per conditions set out in Working Together – *see What does the final product look like?* This is first presented to the Case Review Subcommittee for their consideration ahead of an Extraordinary Meeting of the LSCB being called. See page 5.

How does the review relate to disciplinary action?

The two processes are separate. Each agency has their own disciplinary process.

The objective of the review is to improve inter-agency working and to ensure that the agencies, which make up the LSCB, are accountable for the quality of their work in relation to children and families.

Who can staff talk to about the review and how are they supported?

It is very important that staff feel supported during a review process, particularly a serious case review process. The usual confidentiality rules apply with regard to not discussing the details of a case outside of work. If there is a police investigation there may be further restrictions, see below. However, staff are encouraged to discuss the case with their team and manager and other colleagues and professionals involved in the case.

Where there is a death or the child has suffered serious harm staff may wish to express their sympathy to the family. Staff who provided a service to the child/family may wish to hold some form of memorial service if a child has died. It is important that staff feel able, as much as is possible, to communicate with the family as usual. If in any doubt staff should seek support from their managers.

Staff should receive support from their line managers and their individual agency throughout the process. Most agencies have support/counselling services available that staff are encouraged to access.

Staff should be kept informed of the progress of the review through the LSCB. At least two staff meetings at the beginning and end of the review process will be convened by the LSCB, and at other times as necessary. This is to ensure staff are fully aware of the terms reference / scope of review at the beginning and clear about the outcome and recommendations at the end. On completion of the review staff will be made aware of its contents and recommendations. This is usually done via an LSCB arranged feedback session with all staff involved and the lead reviewer/s plus members of the review team/ steering group.

If there is a police investigation am I still allowed to talk about it?

If there is a police investigation it may mean discussion of the actual incident and/or run up to the incident is not appropriate or permitted. If this is the case please seek advice from the LSCB business manager. It is important to note that a police investigation is a moving process and it may be at one point in time staff are advised not to discuss the case amongst themselves but at a later date this advice might change. It is therefore important to check throughout the process and seek advice from the LSCB business manager.

How long does a review take?

As per *Working Together*, the LSCB aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort is made while the review is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action to implement improvements and disseminate learning.

How long reviews take depend on a number of factors, e.g number of staff, any parallel proceedings i.e coronial, engagement with families etc.

What does the final product look like?

Final reports will:

- 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. The child will usually be given a pseudonym to protect their/family identity. The identity of staff is only known by the review team/ steering group and the lead reviewer/s.

An example of a Brighton & Hove LSCB SCR can be read here**.**

Who will see the report?

All reviews of cases meeting the SCR criteria will result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report is 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 is taken into consideration.

SCR reports need to 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.

LSCBs will publish, either as part of the SCR 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.

When compiling and preparing to publish reports, LSCBs have to consider carefully how best to manage the impact of publication on children, family members and others affected by the case. 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. The timing of publication always needs to have due regard to the impact on any ongoing legal proceedings, including any inquest.

We must send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the national panel of independent experts.

Case Review Briefing Sessions

At the conclusion of all reviews, be they local learning or serious case reviews, the LSCB will, via the Learning & Development Subcommittee, ensure briefing sessions for staff. This is to ensure all staff are aware of the findings from the review and have and opportunity to consider and reflect on their own practice

Extraordinary meeting & Improvement action

The LSCB will call an Extraordinary Meeting at the conclusion of a serious case review to oversee the process of agreeing with partners what action they need to take in light of the reviews findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions. Progress against the agreed actions are monitored by the Case Review Subcommittee.

Guidance for Managers

Managers should encourage staff to seek support and guidance from line managers. For managers with a case in their team they should encourage team discussion to provide support. This meeting should be an opportunity for staff to talk about how they are feeling and what support they need, it should not be a discussion about who did what, when etc. If this type of discussion is required we recommend it is undertaken by a trained facilitator and guidance should be sought from the LSCB business manager as to the timing of this type of group.

Other learning reviews

Brighton & Hove LSCB has decided that safeguarding practice can be improved by learning from a number of cases where the cases do not meet the criteria for SCR but feel there are important lessons which could be learnt about multi-agency working or practice. In these circumstances a local learning review or similar learning activity will be undertaken. These will in general follow the same process to a SCR but are not subject to inspection by Ofsted and will not be published.