



# **London**

## **Serious Case Reviews**

### **Toolkit**

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## 1. Introduction

- 1.1 The London Board is issuing this guidance in draft as the process of SCRs is constantly evolving and the Board is mindful of the fact that there will be a need to revise it in light of any significant changes. For example, an update is being considered in light of the recent decision to publish overview reports in full where the SCR was commenced after the 10<sup>th</sup> June 2010.

**The Board recognises that this toolkit is likely to be of most use to LSCBs where a SCR has not been conducted recently. The London Board website will continue to be updated with useful tools and exemplars as they are identified.**

- 1.2 This Serious Case Review (SCR) Toolkit is designed to provide supplementary guidance to Local Safeguarding Children Board (LSCB) members in the whole process of undertaking a SCR. Its focus is to support the carrying out of a SCR effectively, through supporting consistency in approach, providing additional guidance on undertaking the process and sharing learning and emerging good practice tools and exemplars. The overall aim is to maximise the learning that comes from the SCR in a local area.
- 1.3 The statutory guidance on SCRs is set out in *Chapter 8<sup>1</sup> of Working Together to Safeguard Children, 2010 (Working Together)* and taken forward for London through the *London Child Protection Procedures<sup>2</sup>*. This SCR toolkit is designed to supplement this statutory guidance, it is not mandatory, but is offered as advice to support effective approaches.
- 1.4 It also provides information about two additional approaches to case review as a useful contextual framework to the carrying out of SCRs;
- the systems approach as outlined in *Learning Together to Safeguard Children: developing a multi-agency systems approach for case reviews<sup>3</sup>* and
  - the *root cause analysis* approach used by the health service<sup>4</sup>.

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<sup>1</sup> Working Together to Safeguard Children, Chapter 8: Serious Case Reviews, DCSF 2010

<sup>2</sup> London Child Protection Procedures 3<sup>rd</sup> Edition, London Safeguarding Children Board 2007

<sup>3</sup> Learning Together to Safeguard Children: developing a multi-agency a systems approach for case reviews. Sheila Fish, Eileen Munro, Sue Bairstow. Social Care Institute for Excellence. 2008

<sup>4</sup> A Guide to Root Cause Analysis produced by the National Patient Safety Agency which can be found at the following website address <http://www.msnpsa.nhs.uk/rcatoolkit/course/iindex.htm>

- 1.5 Finally, the toolkit refers to the requirements of OFSTED evaluations in order to ensure the guidance assists in meeting the standards required by OFSTED and provides the maximum opportunity to ensure that any lessons from the case are identified and learned effectively.

## **2. Case review methodologies**

- 2.1 There are a number of case review methodologies which can inform how we undertake SCRs. Where the criteria for a SCR set out in chapter 8 of Working Together are met the process described in Chapter 8 must be followed. However, where the criteria is not met but there may still be learning from the case, LSCBs may wish to undertake a review and may wish to develop a review methodology using principles drawn from these approaches, e.g. for 'near misses' or to learn from good practice.
- 2.2 The systems approach is based on the presumption that 'human error is the starting point' and that the factors that influence how a member of staff behaves include:
- the tasks they perform;
  - the available tools designed to support them;
  - the environment in which they operate
  - organisational culture
- 2.3 The systems approach is based on learning from the aviation industry where accident enquiries look for causal explanations in all parts of the system. This approach looks at the interaction between the individual within the wider organisational context to understand why events developed in the way they did. The aim is to make it 'harder for people to do something wrong and easier for them to do it right'.
- 2.4 The systems approach identifies that the purpose of SCRs should be to get behind what happened, in order to understand why it happened, so that the organisations involved can go on to identify and address underlying issues identified. In order to do this effectively, there is a need to understand what practitioners thought at the time, what was influencing their assessment of the situation, and what other factors were at play, e.g. local priorities, gaps in resources, organisational change etc.

2.5 Similarly, the root cause analysis approach attempts to provide 'a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it', and recognises that human error is one of a number of contributory factors, others being organisational, strategic and environmental factors.

### 3. The purpose of Serious Case Reviews

3.1 *Working Together* sets out that the purpose of SCRs is to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

3.2 *Working Together* is also very clear that SCRs are not enquiries into how a child died or was seriously harmed, or into who is culpable. These are seen as the responsibility of the coroners and criminal courts. The focus of a SCR is to establish learning for how agencies work together to safeguard children in a local area, in order to do this, the objectives of the SCR will be to define clearly for all agencies involved in the case;

- what happened
- what the key episodes in the case were
- what the organisational and individual factors were which contributed to the case developing in the way that it did
- lessons from the case for how agencies work together to safeguard children
- how to learn these lessons by all relevant agencies.

3.3 The focus on multi-agency working in SCRs 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 SCR can support the development of an understanding of

why some professionals might have had difficulties meeting their statutory safeguarding responsibilities.

- 3.4 Considerable time is often spent on drawing up the chronology and piecing the story together. Getting an accurate picture of events, of practitioners' rationale for their behaviour, of the context and environment at the time and reaching an analysis will be a major preoccupation of the SCR.
- 3.5 However, a common pitfall is that less energy and time is spent on the recommendations which will ensure that the lessons identified through the analysis are learned appropriately and an action plan is developed which will make sure these recommendations are taken forward effectively in a timely manner. In fact, this latter part of the process is the most crucial in ensuring that lessons learnt will be acted on, and necessary changes made and sustained.
- 3.6 The basic purpose of the SCR is to learn lessons to inform future practice and those involved with SCRs should ensure this is their primary purpose. Research studies have identified that staff within agencies have mixed views about the lessons learned from reviews locally, with some examples of significant changes as a result of the review, and others identifying that there was less effective use of findings. The purpose of this guidance is to identify ways in which the review can be undertaken to promote the learning of lessons.

## **4. Setting up the serious case review**

### **4.1 Deciding whether to hold a serious case review**

- 4.1.1 *Working Together* provides clear criteria about when to hold a SCR in paragraphs 8.10 - 8.12 included at Appendix A. All agencies should have appropriate arrangements in place to ensure that serious incidents with safeguarding implications are identified and appropriate notification arrangements are followed, e.g. to Ofsted for children's social care<sup>5</sup> or to the SHA in relation to NHS Sudden Unintended Incidents. Each agency should ensure that serious incidents which may meet the criteria for a SCR are brought to the LSCB's attention.

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<sup>5</sup> Information for the Local Authority relating to 'serious childcare incidents' can be found in the Local Authority Circular LAC (2007) 25

- 4.1.2 When the LSCB is notified of a case which may meet the threshold for a SCR a nominated senior manager should be notified immediately and ensure that information known to the agency is made available and shared appropriately with the SCR group. As soon as it is apparent that a SCR may be needed agencies should ensure that records are secured in accordance with the agency's agreed process. This might require a copy being made.
- 4.1.3 The SCR group should formally keep a record of their decision making about whether or not to hold a review. Decision making should be based on good evidence, be explicit and if there is a dispute, refer to the LSCB chair who has ultimate responsibility for the decision.
- 4.1.4 Ofsted should be notified about the decision to hold a SCR. In addition, the LSCB should ensure that all senior managers from all partner agencies are notified of the commencement of the SCR and kept informed about the learning as it emerges.
- 4.1.5 Where the criteria for undertaking a SCR, as set out in Working Together, are not met but there appear to be lessons to be learned for agencies involved, the chair may decide to pursue a single or inter agency review outside of the SCR process. Equally, where there are concerns about practice at a single agency level, the LSCB may decide to ask the agency to undertake an Individual Management Review and report findings back to the SCR panel.
- 4.1.6 In addition, single agency IMRs (individual management reviews) may unearth additional information which indicates that the criteria for a SCR is in fact met, in which case the chair of the LSCB should be notified and a decision made.
- 4.1.7 The LSCB should monitor lessons learned through the submission of clear action plans following the completion of all single agency and inter-agency reviews as part of its quality assurance arrangements.
- 4.1.8 LSCBs should have a range of approaches in place to learn from practice, this may include reviewing those cases where an adverse outcome was avoided or where there was evidence of good and effective practice which should be shared across the locality and across the region.

## **4.2 Which LSCB should take responsibility**

- 4.2.1 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 or was ordinarily resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a looked after child, the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other LSCBs with an interest or involvement.
- 4.2.2 The lead LSCB should formally request any IMR required from agencies from another LSCB area through the LSCB and formally notify other LSCBs of any recommendations made to organisations within its boundaries at the end of the review in order that the LSCB can ensure that any lessons are learned locally.

## **4.3 Appointing an independent chair of the SCR panel**

- 4.3.1 The move towards independent chairs has been confirmed in *Working Together 2010* which sets out a requirement that the chair of a SCR panel should not be a member of the LSCB(s) involved in the SCR, an employee of any of the agencies involved in the SCR or the overview report author. The SCR panel chair can be the Independent LSCB chair (as they are not from a member agency locally), someone from another LSCB which is not involved in the SCR or from an agency which is not involved in the case.
- 4.3.2 When commissioning a SCR chair the LSCB should consider the specific issues of the review and should consider commissioning a panel chair with the relevant skills. An example person specification and contract is included as Appendix F.
- 4.3.3 The primary role of the SCR chair and Panel is to ensure that the experience of the child is kept at the heart of the SCR. The review should be undertaken in ways which ensure that a picture is built up of what life was like for the child and the involvement of agencies should be reviewed in light of this. This should be achieved throughout the IMR process and should be reflected in the Overview Report and relevant additional guidance is included in these sections.
- 4.3.4 The SCR panel is responsible for the quality, effectiveness and timeliness of the process of the review, and must quality assure all reports and recommendations to

ensure single and multi-agency learning takes place. The panel is accountable to the LSCB chair and Board as it is they who are responsible for agreeing and signing off the report.

#### 4.3.5 The SCR panel chair is responsible for;

- Ensuring that the panel operates effectively so that organisations and agencies collaborate to produce a comprehensive and thorough serious case review in a timely fashion which identifies the lessons to be learned from the case and has established a framework to ensure they are learned
- Ensure that authors of the Individual Management Reviews are supported appropriately to meet the agreed standards and requirements and timetable for submission
- Liaising with the chair of the LSCB and /or LSCB Business Manager if the Working Together standard timescale is unlikely to be met and agree a revised timetable and the arrangements for requesting an extension from government
- Ensuring that IMRs are quality assured and any gaps and inconsistencies are identified so that amendments to the reports can appropriately be made
- Investigating and attempting to resolve any disputes or issues of non-compliance by participating organisations or agencies.
- Ensuring that the overview report author has all the necessary information and be a point of contact for the author should questions or points of clarification arise, and assist in directing them to the appropriate agency SCR panel member or IMR report writer.
- Ensuring the draft overview report is considered against the Terms of Reference to ensure that they have been fulfilled.
- Along with SCR panel members, ensuring that the report is comprehensive, well written and meet the requirements of Working Together.

#### 4.3.6 The SCR panel chair should also ensure;

- The appropriate professional expertise, level of experience and authority of the panel members
- The availability of expert advice to the panel if needed
- Clarity of the purpose and of the process to be applied throughout, so that all involved understand the task, their role in the process, and the expectations of

the panel - i.e. the individual management review (IMR) writers, overview writers and senior staff in agencies

- Transparency – to ensure that objectivity and challenge is applied rigorously and consistently throughout the process to all services
- Equality of weight of the views of all SCR panel members – so that appropriate challenge and robust dialogue can take place
- Anonymity and confidentiality – to ensure that final overview reports are entirely and consistently anonymised with no loss of meaning, and that all information remains confidential
- Timeliness – ensure that robust progress management applies throughout the process in order to meet timelines set . See Appendix B for an example timeline.
- Independence of the overview report author - when commissioning the overview writer ensure that they are independent in both their personal and professional lives of all agencies, the professionals involved in the case, the members of the SCR panel and the SCR panel chair.

4.3.7 Laming recommended that a training programme was provided for all SCR panel chairs (and authors) and Government Offices for the regions were asked to ensure that there are sufficient SCR chairs (and authors) in their region. GOL provided training to a pool of around 20 trained and accredited panel chairs and overview authors for London.

#### 4.4 The SCR panel

4.4.1 A core group of agencies will always be involved in the SCR panel; NHS commissioning Primary Care Trust and other partners as relevant, education, children's social care and the police. Other agencies who may have been involved in the case should also be included on the SCR panel, including: adult social care and/or health services, probation, housing, voluntary agencies involved with the family, CAFCASS, faith and community groups.

4.4.2 LSCB members of the panel must be clear about its role and function and should be representative of all of the key agencies involved in the case at a sufficiently senior level to be able to comment on the practice of their organisation and commit any resources needed to the review or to ensure that recommendations can be taken forward. But, they **must not** have been directly involved in the practice or line management of the case.

4.4.3 The role of function of the SCR panel, on behalf of the Board, is to:

- Determine the scope of the review and agree clear terms of reference and keep this under review in the light of later information
- Select the time period over which the events are reviewed and where necessary revise these in the light of additional information
- Set a timeline for the SCR
- Identify those agencies and professionals that need to undertake IMRs and identify any additional agencies as more information becomes available
- Determine how family members should be invited to contribute to the review, and who will support their involvement
- Ensure that agency staff are supported to participate in the review, e.g. by considering holding a meeting at the start of the process for all staff who may be involved to ensure they understand the SCR process, why one is being held in this case and what is required of them
- Conduct the scrutiny of IMRs ideally at a draft stage, to identify gaps in knowledge, resolve conflicting information and request additional information and ensure IMRs are of an adequate quality
- Ensure that the child's experience is kept at the heart of the process, specific areas of practice and issues arising in the case are identified and not lost sight of as the review progresses.
- Agree and use effective arrangements for anonymity
- Take into account parallel processes or court processes
- Agree as appropriate arrangements for working with other LSCBs
- Obtain and effectively use any expert or legal advice required.
- Ensure that any learning is translated into action plans and where appropriate these are immediately implemented
- Ensure that learning already implemented is included in the IMRs and action plans
- Undertake the review within six months, plan for any anticipated delays, ensure extensions are kept to a minimum and that learning is not delayed
- Anticipate and plan for the likelihood of public, family and media interest during and on completion of the SCR.

#### 4.5 Selecting the Serious Case Review overview report writer

- 4.5.1 *Working Together* makes it clear that the overview report should be commissioned from a person who is independent of all the local agencies and professionals involved and of the LSCB(s). The overview report author should not be the chair of the LSCB, the SCR sub-committee or the SCR panel. Boroughs may put in place reciprocal arrangements to provide authors of overview reports to each other. Example standards and contract for the commissioning of an overview report author are included at Appendix G.
- 4.5.2 The SCR panel will commission an independent person to write the overview report on behalf of the panel. The key role of the overview report author is to support the SCR panel in their analysis of IMR reports and the identification of key issues, gaps or omissions. The overview report author will produce an overview report which captures key findings of the SCR panel and supports the identification of lessons learned in line with requirements set out in *Working Together*.
- 4.5.3 The overview report author is not a member of the SCR panel but will need to attend some of the panel meetings in order to capture the discussion and analysis undertaken by the panel. This may include:
- Attending any meetings of workers involved in the case
  - Attending any briefing of IMR authors in order to ensure IMRs are being produced in a way which supports the production of an effective overview report
  - Attending SCR panels where IMRs are considered and analysis of their content undertaken
  - Attending other SCR panel meetings to support and capture the development of analysis by the panel and the identification of lessons learned
  - Supporting the panel with the development of recommendations.
- 4.5.4 In addition, the SCR panel may commission the overview report author to follow up gaps in information which have become apparent, where this cannot be achieved by going back to the relevant IMR author.
- 4.5.5 The SCR panel may ask the overview author to be responsible for seeking the views of family members as part of the review and this maybe undertaken with a relevant other person identified by the SCR panel on advice from key workers in the case, for example a current significant professional who is currently involved in working with

the family and would be appropriate to support the family engage with the review. Overview report authors should not be asked to develop action plans as these should be drawn up by the local agencies that are responsible for implementing them.

- 4.5.6 Some detailed standards for SCR independent overview report authors set out at Appendix G and an example contract aim to assist LSCBs or the SCR panel in appointing suitable independent people to author overview reports.

## 5. Terms of reference

- 5.1 Developing effective terms of reference for the SCR is crucial to the quality of the final report. The SCR panel should spend considerable time at their first meeting ensuring that the terms of reference are fit for purpose and will incorporate all the necessary items to ensure a thorough examination of the case. The LSCB chair should ensure that the terms of reference address the key issues in the case and approve them. *Working Together* paragraph 8.20 provides a list of the key considerations in determining the scope of the review, also included at Appendix C. Particular attention should be paid to the following areas:

- **How far the detailed chronologies should go back;** in some SCRs, families have been known to the agencies for many years. The review will need to be specific over what period the detailed chronology should be compiled, the SCR may wish to consider significant background information and early events relating to the family, but only a detailed chronology for a more specific period. A summary of agency involvement prior to recent years may be sufficient and allow the SCR panel to concentrate on the detail of recent events.
- **Consideration of the views of the family and extended family;** the SCR panel will need to decide which family members are included in the review and when families are interviewed in light of the circumstances of the case and who by. SCR panels should address:
  - Who should contact family members
  - The timing of contact
  - The purpose of seeing families and siblings for example:
    - Seeking their views
    - Seeking consent to information sharing?
    - Feeding back lessons
    - Agreeing content of the executive summary

- Who is meant by families and when should they be contacted, e.g. grandparents/step parents?
- How are their views collected, and how are they advised on findings?
- Whether any additional arrangements will need to be made in order to support family members to participate, e.g. translators and interpreters.
- **Expert advice;** the SCR panel should consider whether there is a need for an expert opinion or advice about any area of the review. This could be specific knowledge in any one of the agency areas, for example, about mental health assessment, or specialist knowledge of a particular cultural practice. It is best to be alert to this possibility at an early stage rather than cause delay after first drafts have been compiled.

5.2 The terms of reference are agreed at the outset of the SCR/IMR processes but in some cases it may be that information emerges which necessitates amendment or addition to the terms of reference. Some SCR panels may wish to build in a review after the initial chronologies have been formed, enabling further questions to be examined if required.

5.3 A model template for terms of reference is included at Appendix D.

## 6. Individual management reviews

### 6.1 Selecting the Individual Management Review author

6.1.1 The SCR panel will have to make a judgement about the degree and significance of involvement by the agency with the child and their family to decide whether an IMR is required from that agency or organisation. The terms of reference (see detail in section 5) will need to be very specific about which agencies are involved and the contribution they will be expected to make. The LSCB chair should notify the chief officer of each organisation of the SCR and specify exactly what is required of their organisation with clear timescales and templates.

6.1.2 Most of the key agencies represented on LSCBs will have designated officers who are responsible for undertaking IMRs, and if this is not the case, arrangements should be made to allocate this responsibility rather than waiting until the need for a SCR arises and causing delay. The IMR author should have had no involvement with the case, or have been the immediate line manager of the practitioners involved. This officer should be supervised by a manager who should also have had no direct responsibilities for the case. Their independence from the case must be explicit, and

clearly recorded within the IMR and SCR. This officer would benefit from being someone at a senior enough level to carry authority and be competent in undertaking the review. If it is not possible to find someone from within the agency who fulfils these criteria then the SCR panel may choose to commission an external person to undertake the IMR, this could be through a reciprocal arrangement with a similar organisation in another borough. Further guidance to help IMR authors is provided in Section 6 of this report.

- 6.1.3 Organisations with less experience of conducting IMRs, for example from the VCS, may need support and advice from the LSCB with producing an IMR and the SCR panel should ensure this is identified provided.

## **6.2 Accessing records**

- 6.2.1 In order to produce the detailed chronology on which the IMR will be based the IMR author will need to ensure they have reviewed all of the records held by the agency in relation to the child and other relevant individuals included in the scope of the review. Every contact between the agency, the child and others included in the scope of the review should be included in the chronology.
- 6.2.2 The PCT Designated Health Professionals are there to assist the Panel chair to obtain the information he/she needs to complete the review. For health organisations each Trust will have a process for requesting access to patient records. This may require a formal written request with the rationale clearly stated. Accessing records for the subject child and the siblings of the subject child should not be problematic as the reason for the request is directly connected with child protection, and therefore in the children's best interests, supported by the United Nations Convention on the Rights of the Child (1989) and the Children Acts of 1989 and 2004.
- 6.2.3 Accessing the records of an adult (people over the age of 18) connected to the case requires a different approach. Consent should be actively sought from the adult to share their confidential medical records. The consent should be informed and involve written permission. Permission is best obtained following a face to face discussion with the adult concerned, so that a full explanation can be given as to the purpose of the SCR, why their information may help lessons to be learnt and to answer any questions they may have. A visit, ideally at the person's home at a time convenient

to them, undertaken jointly with another member of the SCR panel is a good way of approaching the issue of consent.

- 6.2.4 If consent is not given and the panel cannot progress the SCR without the information, the panel should collectively decide to override the adults' right to consent. This can only be done under the terms of the Data Protection Act, for example it is justified to prevent crime, or is in the public interest. A letter outlining clearly the justification for requesting information without consent is forwarded to the Trust or GP concerned. It may be inappropriate to actively seek consent from a suspected perpetrator, in which case consent is immediately overridden using the two criteria mentioned above.
- 6.2.5 The community services parent held record otherwise known as the 'red book' is an important source of information and must be included in the chronology and analysis. The record held by the parent is the property of the NHS Trust. Occasionally the police will seize the 'red book' as potential evidence in a prosecution. In this case, it is reasonable for the police to send the Designated Professional who is coordinating the SCR a good copy of the contents in order that they may factor the information into the health IMR.
- 6.2.6 The original health records of a dead child can be used as the primary source of information for including in an IMR (providing they are not seized as evidence). For surviving siblings, the records should be requested and frozen. Every page should be numbered, dated and initialled by the receiving IMR author at the end of any notation. A clear line is drawn under the last entry which is dated and signed by the author. Good copies are then taken of every page (even blank pages) to provide an exact copy for the IMR author to work from. The original is sent back to the health professional who is continuing to work with the family. Electronic records can be printed off. Electronic systems can audit any notes
- 6.2.7 Both computerised GP print outs and any old 'Lloyd George' records should be reviewed when looking at the primary care element of a SCR. GPs must also be interviewed as for any other health professional involved in the review.

### 6.3 Producing the chronology

- 6.3.1 The LSCB should notify all agencies of the required format for the genogram at the outset of the review, confirming required format for dates and times etc. It is important that contributing agencies present their data in a consistent format in order to simplify the process of merging the data into a multi-agency chronology of all contact with the child and family which informs subsequent analysis. This can be done through each agency populating an excel spreadsheet which can be merged or by using a piece of software available on the market for this purpose. A recommended format for the chronology is included as Appendix A.
- 6.3.2 A comment section (final column) can be used to highlight key procedures that were not followed at the time. It is also useful to note in this column any conflicting information from different agencies or between information gleaned from the case file and that which is taken from interviews. The chronology should not be confined to the information taken only from case files and may include interviewees reports of events that were not recorded at the time. All sources of information should be absolutely evident within the chronology.
- 6.3.3 It is helpful to have an early meeting of the independent Overview Report author and IMR writers to ensure that everyone uses exactly the same format, including date format, font, font size, use of terms, and how names and any other identifying features of the case will be anonymised.

### 6.4 Producing the IMR

- 6.4.1 *Working Together* provides an outline format for IMR reports which should usually be followed, the LSCB may have produced its own template for this purpose and this should be made available to the IMR author. Appendix H provides a specimen template for IMRs based upon this outline.
- 6.4.2 An early meeting of the SCR panel and IMR authors will ensure that all contributors to the review have fully understood the terms of reference and are working towards the same objectives and in a consistent manner. Items for the agenda of this meeting could include:
- Clarifying the reasons for the SCR and ensuring understanding of the process
  - Discussion of each of the terms of reference

- Agreement about chronology dates, format and secure methods of sharing information with the SCR panel and overview author
- Agreement about an approach to anonymising names and any other identifying features of the case
- Confirmation of timescales and expected dates of completion of IMRs and completion of overview
- Any contentious issues or disagreements about agency involvement
- Any other local issues
- Consent arrangements
- Which organisations are involved.

6.4.3 The aim of an IMR is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made within the agency, and if so to identify how these changes will be brought about. It also provides an opportunity to ensure that learning from the case can be incorporated into the process from the start.

6.4.4 The SCR panel should have a clear process for identifying how appropriate IMR authors will be commissioned, trained and supported during the duration of the SCR including evaluation. The standard document for the commissioning of independent overview report writers (See Appendix G) is also a useful reference tool for ensuring suitability of IMR authors.

6.4.5 The SCR panel must ensure that IMR authors are well briefed and actively address the Terms of Reference within their report. It is good practice to invite IMR authors to a briefing session prior to undertaking the IMR to ensure that the TOR are clear and understood. Good practice might also include inviting IMR authors to present early draft reports to the SCR panel. This provides an opportunity to address any gaps and engage the independent overview report writer in an early dialogue to inform their appraisal and analysis of the IMRs.

6.4.6 The IMR author should use the chronology to identify significant events, aspects of inter-agency working or gaps which need to be commented on or explored further for the report.

## 6.5 Interviewing staff

- 6.5.1 In order to explore the issues emerging from the review of the records of the case and the construction of the chronology it is usually necessary to interview staff directly involved in the case. IMR authors will undertake interviews with staff in their own agency unless the SCR panel decides that the SCR author will undertake the interviews – this may be favoured to provide consistency or eliminate any unintended bias from agency IMR leads.
- 6.5.2 If there is a criminal investigation and likely criminal trial then it may not be possible to interview some staff members who may be called as witnesses until after the criminal justice process is completed. The principle of completing the review in a timely manner should be pursued and consideration given to which staff members it may be possible to interview and what areas it may be possible to speak to them ahead of a criminal trial in order that learning is not delayed. It is important that the SCR panel receives advice on this and plans this carefully with the Senior Investigating Officer from the police taking into account the views of the CPS.
- 6.5.3 The interview is a key part of the process of understanding why a practitioner behaved as he or she did, and what his/her understanding of the case was at the time. The practitioner may be nervous and it is important to enable them to relax and tell the story about their involvement and the rationale for their practice. It is important that they understand the SCR process and why they are being interviewed. This can be made easier if the SCR panel has held a meeting for all staff involved at the start of the review
- 6.5.4 More than one member of staff from the agency may need to be interviewed in order to produce the IMR, including both frontline practitioners and/or managers. In deciding who to interview, the IMR author should consider:
- Who was the lead professional or key worker for the child when key decisions were made or events occurred within the scope of the SCR (where appropriate)
  - Who else was very closely involved with the child and their family at the time of the concerns
  - Management involvement in key decisions about the agencies involvement with the child or family, including in relation to the allocation of resources
  - The length of time a member of staff was involved with the child of family.

6.5.5 Professionals who have expressed concern about the management of the case should **always** been seen as part of the review.

6.5.6 The IMR author should consider in what order staff members should be seen and this will vary dependent on the circumstances of the case. To decide this it may be helpful to refer to the chronology. In addition, it may be helpful to interview frontline staff before managers. IMR authors should prepare well for interviewing staff, being clear about the specific episodes or issues they would like to discuss, including sharing this with staff in advance where possible to enable them to prepare appropriately.

6.5.7 A suggested structure for interviews is:

- Ensuring the staff member is clear about the SCR process and why they are being interviewed
- An opportunity for the staff member to offer an overview of their involvement with the child and family and the working relationship which had developed between them
- Start with asking the practitioner to describe the detail about what happened at key periods of their involvement in the case, and any particular episodes which they felt were pivotal in the direction the case took. Keep the questions open ended at this stage
- Follow up with any questions which elaborate on the key episodes
- Summarise and repeat back to ensure accurate understanding of what was said
- Focus in on areas which are central to the case and ask questions which enable the practitioner to explain why they acted in the way they did at the time. This may include contributory factors such as the working environment, management guidance, workload pressures, other agency perspectives etc
- Test out any hypotheses that have emerged by this stage to understand the practitioner's behaviour
- Make sure that time is allocated to talk about good practice in relation to the case
- Summarise the key points at the end of the interview.

6.5.8 For practitioners, consider;

- The strengths and challenges which the work with the child and family presented
- What it felt like working with this child and family
- What life was like for the child and their siblings
- The worker's awareness of policy and procedures

- Were child protection and care plans in place and were reviews conducted in a timely manner?
- How well the multi-agency team worked together and how they shared information
- Whether work was child focussed
- The framework they were operating within to inform their assessment of the family and decisions about risk
- An opportunity for the staff member to consider the contextual factors they were working within, including the supports which were provided to the member of staff, provision of training, supervision, audit practice etc
- Reflection on critical events and why particular courses of action were taken
- Wider staffing issues within the organisation, for example vacancy levels
- The culture of the organisation or team they were working within and its impact on decision making in individual cases
- Caseloads or other resource issues
- Support from line managers with key decision making and access to resources
- How it felt to work for the organisation at that time
- With hindsight what they think might have made a difference in this case
- What have they learnt about practice since the critical incident in this case?

6.5.9 In addition, managers may additionally be asked;

- How supervision was undertaken
- How work was allocated in the team
- How skills, competence and development needs of staff were assessed
- The support they were receiving from the organisation
- Any resource issues which impacted on the case.

6.5.10 Interviewees should be allowed to comment on the write up of the interview and amend any inaccuracies. Providing they have approved the write up, their statements can be used as quotes within the report in an anonymised way. It is important that they understand this may happen at the outset of the interview. Some interviewees may wish to bring a supporter or union representative to the interview.

6.5.11 The IMR should pull together findings about practice by the agency's staff, and how they worked with partners, against the terms of reference for the review setting out

the analysis of findings for the agency clearly and leading to the identification of appropriate recommendations for the agency.

6.5.12 Recommendations should be written in a SMART (specific, measurable, achievable, realistic, timed) manner and address the following;

- What improved outcomes are needed in the agency?
- What specific actions should be taken by whom, and when?
- How will the agency ensure that the desired outcomes are achieved?

How will senior management know that the actions which are taken have made the improvements which were needed?

6.5.13 On completion of each IMR in draft the senior manager from the relevant agency who commissioned the IMR, which may be the agency' SCR panel member, should quality assure the report and provide feedback to the author in relation to any inaccuracies in the report, time should be allowed for this to ensure that the IMR can be submitted in final form on time to the SCR panel.

6.5.14 This quality assurance should include whether the terms of reference have been fully addressed, whether the analysis is appropriate and keeps the child at the centre of the report and pays attention to their racial, cultural, linguistic and religious identity, whether the leaning is identified appropriately and whether the recommendations for the agency are appropriate. This may also include addressing any feedback given by the SCR panel to ensure the final report meets expected standards.

6.5.15 Once the IMR is agreed as final it should be submitted to the SCR panel in accordance with agreed timescales. All IMRs will need to be signed off and approved by both the individual agency and the SCR panel. A process will need to be agreed locally to respond to any dissention between agencies and how any concerns regarding the quality of the IMR report submitted will be addressed. In response to the final IMR, each agency should develop an action plan setting out how the recommendations will be taken forward, who by and when.

## **6.6 Agreeing timescales**

6.6.1 The most common reason for SCR judgements of 'inadequate' from OFSTED was because of timescales, specifically, delays in producing the SCR, commonly due to

the length of time it took to complete IMRs. The SCR panel will want to be very clear about the need to complete early drafts of the IMRs – regular review meetings early in the process may be helpful in keeping agencies to time. *Working Together* paragraphs 8.22 – 8.27 gives further information on timescales, the LSCB chair has the responsibility to decide whether a SCR should take place within one month of the case coming to their attention and the SCR is required to be completed within a further six months.

- 6.6.2 If the timescales above cannot be met a revised timeline for the SCR should be prepared for the LSCB together with reasons for the delay and how learning will be taken forward in the meantime. Where there is significant delay to completing a review in full, for example as a result of a criminal prosecution, the SCR panel should consider producing an interim report setting out the learning which has been identified to date and actions which have been taken to address these ahead of the final report being available.

## **7. Parallel processes**

A number of parallel processes may be going on at the same time as the SCR, and the panel and IMR / SCR authors should be aware of them and their impact managed actively so as not to create avoidable delay.

### **7.1 Working with other boroughs – SCRs across multiple LSCBs**

- 7.1.1 Because of the mobility of many families across London, there is a strong likelihood that other boroughs may have worked with the child or family at some point during the past, and contributions to the SCR will be required. This makes the review more complicated, but providing the following steps are undertaken, should not hamper or delay the production of the SCR:

- Be absolutely clear about which borough is the lead for the SCR at the start (see paragraph 4.2);
- Be clear about expectations of other LSCBs – in some cases a full chronology and IMRs will be required, in others a short summary of involvement will suffice;
- Agree specific approaches to issues at the outset, for example, communication lines, publicity and dissemination strategies, confidentiality, media interest etc;

- Establish lead officers from other LSCBs with whom to liaise – if a number of agencies are involved in another LSCB area, one lead officer is essential;
- If necessary, hold regular meetings of each of the LSCB representatives to review the work and receive progress reports.

## **7.2 Health Agencies Serious Untoward Incident Reviews**

7.2.1 It is common for health agencies to have reported an incident which would normally lead to a Serious Untoward Incident (SUI) review being undertaken about the same family who are the subject of a SCR. This is often the case in adult mental health services or CAMHS. The main point is to agree terms of engagement early on, ensuring that:

- Unless there are very good reasons there should only be one review – the IMR which is being produced for the SCR. The relevant health agency should ensure their Board, NHS London etc are aware that the report will be using IMR not SUI templates and timescales will start from date SCR is decided by LSCB not date of incident.
- If both a SCR and a SUI are being undertaken, terms of reference should be aligned and coherent, and similarly early draft reports shared to reduce the risk of different messages and explanations being given for the same incident
- Regular liaison and progress review should be undertaken
- Agreement about publication dates and media strategies is crucial
- Each of these processes has different signing off and approval processes. The chair of the SCR panel should liaise with the lead manager within the health agency to ensure that approval processes for reports are co-ordinated

## **7.3 Youth Justice Reviews**

7.3.1 The Youth Justice Board have an established process for Local Management Review when a serious incident occurs in the community or in a secure children's home. The Prisons and Probation Ombudsman's Fatal Incidents Investigation Team will take the lead when there is a death in other custodial settings such as Secure Treatment Centres and Youth Offending Institutions. Such reviews will be undertaken within the

framework of the Child Death Review framework and close liaison with LSCBs is recommended in the Youth Justice Board guidance<sup>6</sup>

7.3.2 In both these instances, close liaison is required (as in 7.1 and 7.2), and lead officers should ensure that the processes fit together in a coherent and sensible way.

#### **7.4 Coroners involvement/ Criminal Court Proceedings/ Domestic Violence Homicide Reviews/ Vulnerable Adult Reviews**

7.4.1 These processes may also be taking place in parallel with the SCR. At an early stage the chair of the SCR panel should make contact with the Coroner's office, the Crown Prosecution Service lead or the Police lead to agree any co-ordination needed between the processes such as timing of actions and disclosure of information (in many areas the police representative on the SCR panel will take responsibility for liaising with these offices).

7.4.2 The main agreements to be made are about when to release specific information, to co-ordinate the timing in relation to court processes – particularly in relation to interviewing staff for the SCR who may also be witnesses in a current police investigation and to ensure there is regular review of this information in response to changing circumstances.

7.4.3 These processes should not hold up the progress of the SCR unless there is key information which is awaited which cannot be identified other than through these routes. Agreement about media strategies is crucial in relation to this area as court processes will always attract media attention.

#### **7.5 Media strategy**

7.5.1 It is essential to have a media strategy in place at the outset. Sometimes information may be given to the press before official publication, for example from family members or unwitting leaks from officers in any one of the participating LSCB agencies. The SCR panel will want to be prepared should this happen. Advice about

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<sup>6</sup> Serious Incidents – Guidance on serious incidence reporting procedures (B319). Youth Justice Board 2007

specific media liaison and publicity will come from individual agency departments. The important points to consider are:

- Good communication between media / publicity departments across LSCB agencies
- Clear briefings for members of the panel, LSCB, appropriate officers within agencies and elected members, so that all concerned parties are fully aware of when to expect media coverage
- Clarity about who will lead the media response and what the high level message will be
- Thoughtfulness about the actual wording of reports that will be published – imagine seeing the lines that are written in a newspaper headline or article
- Co-ordination with media releases from any other LSCBs or agencies involved (see 7.1 - 7.4 above)
- Training in working with the media for high profile SCRs.

## **7.6 Support for staff / disciplinary processes**

7.6.1 LSCB agencies will have their own resources and procedures for providing staff with support. Staff who have been involved with a case where a child has died or been seriously injured may well require emotional support and need to be offered specific help in dealing with their feelings which may include guilt, defensiveness, feelings of isolation, anxiety and loss of confidence. The SCR interviews often follow some time after the event of child death or serious injury and may cause a re-emergence of emotional distress. There is a need to offer workers support on a personal level and to ensure that their feelings do not impact on their professional conduct.

7.6.2 The agency should think about how it can give messages that the SCR is a learning process, such as by ensuring staff are clear about the purpose of the review, its timescales and how they will be involved. It can be helpful to hold a meeting of all staff involved at the start of the process to confirm this as well as to confirm what support is available to them from the organisation.

7.6.3 In some instances, where it is clear that staff codes of conduct have been breached, staff may be subject to suspension from duties, or disciplinary investigations and other formal HR processes. Liaison with HR departments will be required to ensure these processes are well managed and fit with the SCR interviews. It is often the

case that disciplinary processes follow the publication of SCRs, but it is possible that early information which emerges during the IMR will trigger any necessary disciplinary investigations which cannot wait until the end of the process.

## 8. The Serious Case Review Overview Report

*Working Together* outlines a clear framework for the report:

### Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used including the documents reviewed, and whether the information was provided in an interview or through written evidence.
- List agencies of types of contributors to review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names and roles / positions / job titles of the LSCB chair, SCR panel chair, the author of the overview report and the job titles and employing organisations of all the SCR panel members.
- List external investigations, if any, that are being conducted (for example the PPO investigation following the death of a child in custody or a mental health inquiry).

### The facts

- Prepare an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen alone and whether the child's wishes and feelings were sought or expressed.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

**Analysis**

This part of the overview should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve. The analysis section is also where any examples of good practice (as distinct from that which should be considered standard practice) should be highlighted, and where issues around workforce, environmental factors and family behaviour can be discussed. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the LSCB and findings from relevant research.

**Conclusions and recommendations**

This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales. Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should usually be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted and the information sent to the relevant government department.

**8.1 Introduction**

8.1.1 In the summary of the circumstances which led to the review being undertaken it is helpful to refer to any strategy meetings or other meetings where decisions were made, the dates these meetings were held, and any important points covered.

8.1.2 The independence of the panel chair, panel members, IMR authors and overview authors should be explicitly stated, with particular reference to the line management relationships in relation to the case. OFSTED will use this as evidence of independence and it is considered a significant factor in the evaluation of the SCR.

**8.2 The facts**

8.2.1 This section of the report will include a narrative, which tells the story in a straightforward factual way, using the chronology as a basis. This narrative can be lengthy and it is helpful to describe the detail of key events or episodes, but not translate the full chronology. Short summaries of non eventful periods are

recommended. The narrative might include details of the environment at the time, or specific policy issues if relevant. It can be difficult to differentiate what is included in the story, and what comes into the following analysis section – inevitably, the narrative will start to demonstrate the hypothesis about events and will highlight the evidence to be used in the analysis section.

### **8.3 Including the views of parents and relevant family members**

- 8.3.1 There will be a presumption that relevant family members will be invited to contribute as fully as possible to the SCR process unless there are clear reasons to exclude or limit their participation. The SCR panel should think carefully about who constitutes relevant family. This may include grandparents or siblings who were closely involved with the child and may have a useful contribution to give about the family's experiences of services. Although this may be a very difficult and painful time for the family, sensitive engagement should be sought and all attempts to engage should be fully recorded in the overview report.
- 8.3.2 The responsibility for discussing and planning the family participation rests with the SCR panel. The SCR panel will need to consider how and when the family can contribute, who should be responsible for facilitating their involvement and giving feedback to the family as well as when this should occur.
- 8.3.3 Families must always be notified that a SCR is taking place and an explanation given about what to expect, media coverage and that their names will be kept confidential. If the family do not wish to contribute or it is considered by the panel to be unadvisable, the reasons should be fully recorded and included in the overview report. Timing of involvement should be considered carefully, for example the opportunity to contribute could be offered after any court processes and the SCR are completed. The boundaries around which members of the family are involved need to be decided at an early stage, and it is important not to make commitments to families that can't be met.
- 8.3.4 The views of family members and how they experienced the intervention at the time can be invaluable to the learning process and should not be shied away from. The aim is to get their views about how services were delivered, and interagency working, but it is to be expected that in some circumstances it can be difficult to keep the conversations limited to these areas and that emotions will be high. It is helpful to have a designated member of the SCR panel, alongside the SCR author, to be the

main point of liaison for the family. Communication with family members should be face to face wherever possible and always at the first point of contact to explain the purpose of the SCR and invite the family to contribute.

- 8.3.5 Involving family members in the review should be undertaken sensitively and requires careful planning in order to clearly explain the reasons for the review , the process and ensure their views are represented accurately, meaningfully and as they would like to see them within the report. If families are contributing then it is good practice to allow them to agree how their views are included and to see the executive summary or report before it is published.
- 8.3.6 If there is a criminal investigation and likely criminal trial then interviewing the family may only occur after the criminal justice process is completed. It is important that the SCR panel receives advice on this and plans this carefully with the Senior Investigating Officer from the police taking into account the views of the CPS.

#### 8.4 Analysis

- 8.4.1 This section is central to the SCR process and should link clearly to the evidence provided in the previous section. The systems approach and root cause analysis both provide useful models to use as a framework for analysis.
- 8.4.2 The systems approach defines five types of factors which SCR writers may find useful to consider:
- **Human tool operation:** How the individual practitioners concerned with the case interacted with tools such as assessment frameworks, case recording systems, databases etc and what impact this had on the case. Tools are active agents, not passive objects.
  - **Human-management system operation:** How did the management systems, including resource issues, supervision, management priorities, compliance with local procedures etc impact on the case.
  - **Communication and collaboration in multi-agency working:** How did the joint working of the different agencies impact on the case and did the family understand the differing roles and responsibilities of each agency
  - **Family – professional interactions:** How did the relationship between the practitioner and the child and his/her parents affect the case. How did the

family behave towards the practitioner and receive and interpret information from them, and was the relationship a positive or negative one?

- **Human judgement / reasoning:** How were judgements made and if there were errors of judgement, what systems were there in place to detect and correct these errors. The systems approach works on the basis that such errors are inevitable, and therefore the purpose of SCRs is to learn how to minimise these human errors in the future.

8.4.3 The Patient Safety Advisory Agency model for root cause analysis divides the factors to consider into categories of human error, and other contributory factors.

- **Human error factors, for example;**
  - Skill based errors (slips and lapses) – usually unintended and not typical for the practitioner who tends to recognise their error after the event
  - Rule based mistakes – not following procedures for a range of possible reasons for example, taking shortcuts, issues of non compliance, poor performance etc
  - Knowledge based mistakes – those which may occur due to inexperience of practitioner
- **Contributory factors, for example;**
  - Team / local management – including whether there was clarity of role of the practitioner, support networks, leadership, supervision, culture of the team for example openness vs defensive.
  - Communication – was the direction given to the practitioner clearly communicated, were records clear, what was the quality of communication around the case?
  - Task – were the policies clear, up to date, fit for purpose, accessible to the practitioner? Was there access to specialist advice or consultation about specific issues?
  - Education and training – what training was provided, was supervision of good quality, was the practitioner competent and experienced enough to take on the work associated with this case?
  - Equipment – in the health service this applies to the technical equipment available to the practitioner and how effectively it was working. In other agencies this could apply to fitness for purpose of systems, effectiveness of IT systems or possibly the additional resources available to the practitioner, for example, interpreters.

- Work environment – this could include a wide variety of contextual factors for example : staffing, skill mix, caseloads, other workload pressures, how much time was available to the practitioner to work on this case, use of temporary staff, context of resource allocation and even wider national issues for example recruitment and retention of social work staff.
- Organisational – what was the impact of the structure, hierarchy, decision making bodies, accountability structures, priorities of the organisation, risk management frameworks, culture of the organisation etc?

8.4.4 Human error and contributory factors can be weighed up to determine which were the strong influences in the case direction, and thus help to establish the root causes of the outcome.

8.4.5 It is helpful to find ways of challenging the analysis, testing and re-testing of hypotheses in order to ensure that judgements made relate closely to evidence from the facts. It is good practice for SCR writers to employ a supervisor or mentor – an independent person who can be used to challenge the rigour of the analysis and be a second reader of the first draft of the report.

8.4.6 The systems approach recommends that the SCR author meets with the practitioners who were involved in the case at various points during the process in order to enable inaccuracies to be checked, and also in a more inclusive way, to ensure the interpretation of events is in line with the practitioners' view. The systems approach argues that these meetings are part of the learning process.

8.4.7 The systems approach guide on the Social Care Institute for Excellence (SCIE) website<sup>7</sup> provides further frameworks and appendices which outline types of contributory factors and are very useful in structuring thinking and analysis.

## **8.5 Conclusions and recommendations**

8.5.1 The conclusions should highlight the key lessons learned from the SCR. Some overview report authors choose to itemise separately the learning for each agency which will have been covered in the various IMRs. The conclusions should be clear about which factors in the case supported good practice, and which created, or contributed, to unsafe conditions in which poor practice was more likely to occur.

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<sup>7</sup> SCIE guide 24 : Learning Together. <http://www.scie.org.uk/publications/guides/guide24/practice/index.asp>

- 8.5.2 Recommendations should flow clearly from the analysis/learning identified in the case. They should be outcome focused, i.e. concentrate on the end result or change in practice or conditions which are desired, not the process required to get there. A limited number of SMART recommendations are more likely to be effective in creating change than a long list without indication of priority areas for action. The LSCB should provide a test by asking themselves how they would know whether the action has been completed – what is the change in practice they are looking for and can this be illustrated in a way which describes how children would be safer as a result?
- 8.5.3 Overview report authors will want to maintain independence when drawing up the recommendations, but close liaison with the commissioning authority is likely to produce a more productive set of recommendations which fit with other developments already taking place. The final SCR is agreed by the SCR panel and the LSCB locally and where there is disagreement with the views of the overview report author this should be stated in the report.
- 8.5.4 The systems approach defines three different kinds of recommendations:
- issues with clear cut solutions that can be addressed locally and by all relevant agencies
  - issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers
  - issues that require further research and development in order to find solutions including those that would need to be addressed at a national level.

## **9. Action following completion of the review**

- 9.1 *Working Together* paragraph 8.41 clearly lays out the responsibilities of the SCR panel in relation to the overview report, and 8.43 – 8.46 gives detailed guidance on the action to be taken by the LSCB on receipt of the report. This includes the requirement to provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, the SHA and the DfE.

## **10. Learning from the review**

### **10.1 Action plans**

10.1.1 The LSCB action plan will draw down directly from the recommendations of the SCR report and should be realistic, have clear indications of responsible agencies, and specific dates by which actions will be undertaken. *Working Together* recommends that at least as much effort should be spent on acting on recommendations as on conducting the review, and provides advice on how to ensure maximum benefit from the review process in paragraphs 8.52 and 8.53. An action plan evaluated by Ofsted as outstanding is included at Appendix I.

10.1.2 The SCR panel, or an agreed alternative subgroup of the LSCB such as the quality assurance sub-committee, should take responsibility for regular review and signing off the actions when they have been completed. Agencies should guard against this becoming a paper exercise and ensure that the actions are meaningful and will actually make a difference to practice. The systems approach encourages agencies to think about creating a list of actions which will create environments where it is harder to do something wrong and easier for good practice to flourish.

### **10.2 Disseminating lessons learned**

10.2.1 The executive summary (see section 11) can be a useful training tool and also used as a basis for discussion in individual team meetings. It is particularly useful to disseminate the findings amongst staff groups who were involved with the SCR and a meeting should be held with the staff involved in the case to ensure they understand the review is complete and what it found. This can be done on a multi-agency basis through the LSCB or by each agency separately. This helps to quash any myths that may have arisen and also aids understanding and learning.

10.2.2 LSCBs may provide multi-agency briefings which can be very successful in understanding what went wrong between agencies and helping practitioners on the front line understand the whole SCR process. The systems approach recommends that the learning is divided into three groups: environment; systems; skill gaps. Each of these areas may need a different approach in order to disseminate the lessons learned – the SCR panel could devise learning and dissemination plans to key groups in each area.

### 10.3 Embedding the learning

10.3.1 Ensuring that lessons learned are embedded is more difficult and there is a real danger that the findings of the SCR, recommendations and action plans have an immediate and short term impact, but that the learning is not sustained. The LSCB and/or subgroups could return to past SCRs and revisit recommendations and assess their impact on the organisation on a regular basis. An audit or survey of managers' views about past SCRs and the impact on current practice would be a good starting point in gathering information and assessing whether the learning has been fully embedded.

### 10.4 Learning lessons regionally and nationally

10.4.1 Taken together, child death and SCRs are an important source of information to inform national and regional policy and practice. The DfE is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF previously commissioned regular national reports, drawing out key findings of SCRs and their implications for policy and practice to assist the process of learning lessons. In addition to this, the London Safeguarding Children Board leads on producing periodic reviews of London cases.

## 11 The executive summary

**NB The current government have announced a move to publishing overview reports on SCRs commended after the 10<sup>th</sup> June 2010 in full anonymised and redacted in order to protect the confidentiality of the family and surviving children. Additional guidance on this requirement is being considered.**

11.1 *Working Together* is clear that the executive summary of the serious case review should be made public, but that neither the SCR overview report nor the IMRs should be made publically available. *Working Together* requires that as a minimum, the executive summary includes information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content should be suitably anonymised to protect the identity of children and relevant family members.

11.2 Producing an executive summary which conveys the full subtleties of a SCR, and is able to meaningfully explain the findings and lessons learned can be a demanding task. In line with the systems approach, it is important for the key messages which

are published to contain the findings about the context, contributory factors and explanations of the rationale behind the practitioners' behaviour. The key purposes of executive summaries are to support the dissemination of the lessons which have been learnt by the review in order to support the implementation of any changes which are needed and to ensure public accountability of public services and the process of SCR.

- 11.3 The requirement to produce and publish executive summaries of SCRs is a statutory requirement set out in Working Together. The LSCB must take the guidance into account and if they decide to depart from it must have clear reasons for doing so. The executive summary should include information about the review process, key issues arising from the case, the recommendations and the full action plan (including any actions that have been completed) and be fully anonymised (apart from the name of the SCR panel chair, members and the overview author).
- 11.4 The executive summary should focus on the agencies learning from the review and give very minimal or no information about the family (see suggested format below).
- The executive summary should summarise what the SCR identified in terms of what went well and what went wrong and the action being taken to rectify any problems.
  - The executive summary should reflect accurately the full overview report and not leave any major issue out because of political sensitivities or because it is uncomfortable to agencies.
- 11.5 A suggested set of headings for the executive summary is:
- Introduction – about the review process
  - Case summary – high level summary of what happened and key issues arising from the case (without compromising the anonymity of surviving siblings, other children or family members)
  - Findings – the lessons learned
  - Future actions for each agency – including any changes that have already been made
  - Local features – any context information or recurring themes.
- 11.6 The presumption should be on the LSCB publishing an executive summary in all cases. LSCBs should not delay in publishing the executive summary of the SCR once it has been evaluated by Ofsted and any related court proceedings have been

concluded. When Ofsted has judged the executive summary at least adequate, any change made to it should be minimal. Change may only be needed to ensure it does not contain any confidential information about the family and the focus is on what the SCR found was good practice and what needed improvement. This is standard practice in any FOI and published report. If Ofsted judged the executive summary inadequate – it should be redrafted in light of Ofsted’s comments with the advice below in mind. The executive summary should be dated so that national expectations at the time can be referenced if needed.

- 11.7 Executive summaries should be clearly accessible via LSCBs or an alternative website if needed, e.g. that of the local authority, for a reasonable amount of time to support the dissemination of learning from the review. Where an LSCB is considering deviating from guidance about publishing an executive summary, careful consideration should be given, including the LSCB seeking legal advice on the potential contestability of this decision. This can only be decided locally, on a case by case basis.
- 11.8 Where an LSCB identifies concerns about publication of the executive summary, such as confidentiality issues involving identification of individuals, the LSCB, with their lawyers, should consider what they **are** able to publish remembering that the main purpose of SCRs is to identify what lessons can be drawn and then ensure that they are learnt. Even in the most sensitive of cases LSCBs should be able to draw out the key learning themes which have emerged and report publicly on them - even if that means not giving details of the specific events which have informed them. Any LSCB considering limiting the content of a published SCR Executive Summary should discuss their proposals, and rationale, with the DfE.
- 11.9 The SCR panel should identify someone to take responsibility for debriefing the family. LSCBs should ensure that families are aware of the plans to publish an executive summary, including sharing the content with families in advance where appropriate. If the publication of the executive summary is likely to attract any media attention the LSCB should notify the DfE at the earliest opportunity and provide a copy of the press release or a note for a media briefing. This will alert the DfE to the issues that the case raises and what has been done to address them ahead of publication.

11.10 Decisions about timing of publication should be made by the SCR panel in close liaison with other agencies and in line with other processes, particularly the criminal proceedings.

## 12 OFSTED evaluation of SCRs

**NB This section will be revised in light of any changes to the Ofsted evaluation process**

12.1 OFSTED evaluation judgements are made on the basis of an evaluation framework that has been developed from *Working Together*. Inspectors follow the requirements set out in Chapter 8 in detail so it is important that these requirements are fully met. Ofsted have now published two reports on the outcome of evaluations of SCRs. The reports contain valuable information on themes emerging from SCR's including

12.2 The list below taken from the first report outlines the main features they will look at in making their judgements:

- Whether it was appropriate to instigate the review;
- The scope and time period covered by the review;
- The terms of reference and whether the author is suitably independent of the agencies involved;
- Whether the review was completed within the recommended timescales;
- The quality of the individual management review;
- Whether the ethnic, cultural, linguistic and religious needs of the child and family were met by services, and are addressed within the review;
- Whether the family were invited and enabled to contribute to the review process;
- The quality of the review report, including:
  - background information;
  - rigour of analysis and challenge of information in IMRs;
  - joint chronology;
  - appropriate recommendations;
  - reference to research and previous review findings;
  - joint agency action plan with clear targets and timescales;
  - monitoring arrangements by the LSCB

- The quality of the executive summary, including whether it is suitably anonymised to protect the family's identity, and whether it is yet published.

12.3 Appendix J sets out an example quality assurance checklist for SCR panels and LSCBs.

### 13. APPENDICES

#### APPENDIX A: Checklist for when to hold a review

(Taken from *Working Together* Para 8.10 - 8.12)

8.10 When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC), or where the child was detained under the Mental Health Act 2005.

#### When should a LSCB consider undertaking a serious case review?

8.11 LSCBs should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004<sup>8</sup>; or
- a child 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.

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<sup>8</sup> Note: The Home Office is working closely with other government departments to develop a process for undertaking Domestic Homicide Reviews and will ensure that any relevant issues regarding SCRs, or any other statutory reviews, are fully considered and incorporated into that process.

8.12 The following questions may also help in deciding whether a case should be the subject of a SCR. The answer 'yes' to one or more of these questions is likely to indicate that a SCR 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, YOI, STC, 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 LSCB 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 SCR.

## APPENDIX B: Example SCR timeline

<b>Action</b>	<b>Scheduled date</b>	<b>Date Completed</b>
Date LSCB notified of serious incident	<i>Day one</i>	
SCR panel to consider whether case meets SCR requirements.	<i>Week one - two</i>	
Decision by LSCB chair to undertake SCR	<i>Within one month</i>	
First SCR panel to agree scope and Terms of Reference	<i>Within one month</i>	
Independent overview author commissioned	<i>Within one month</i>	
Briefing for IMR authors	<i>Within one month</i>	
Submission of chronologies and first draft IMRs	<i>Month two</i>	
Second SCR panel to review IMRs and begin identifying analysis and themes for Overview Report	<i>Month two</i>	
Involve family	<i>Month 3-4</i>	
Submission of final IMRs and single agency action plans	<i>Month three</i>	
Third SCR panel and first draft Overview Report	<i>Months 3-5</i>	
Determine media strategy	<i>Month five</i>	
Fourth SCR panel and final draft	<i>Month five</i>	
Complete LSCB Action Plan	<i>Month five-six</i>	
Produce Executive Summary	<i>Month six</i>	
Arrange feedback with family	<i>Month six</i>	
Arrange feedback to staff	<i>Month six</i>	
LSCB Meeting to sign off final SCR (IMRs and single agency action plans, Overview Report and action plan, Executive Summary)	<i>Month six</i>	

Send ratified final SCR to external bodies	<i>Month six</i>	
Deadline for completion	<i>Six months</i>	
Actual submission date	<i>Six months</i>	
Ofsted evaluation letter received		
Publish Executive Summary on LSCB website	<i>Following Ofsted Evaluation</i>	
HMI feedback meeting		

**APPENDIX C: Determining the scope of the review**

(Taken from *Working Together* para 8.20 – 8.21)

**Determining the scope of the review**

8.20 Relevant issues to consider include the following:

- 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?
- When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
- 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 SCR, 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 SCR 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 voluntary organisations?

- Is there a need to involve organisations/professionals working in other LSCB areas (see paragraph 8.13), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?
- Who should be appointed as the independent author for the overview report (bearing in mind that this person should not be the chair of the LSCB, the SCR sub-committee or the SCR panel – see paragraph 8.33).
- Might it help the SCR panel to 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 SCR.
- How will the SCR terms of reference and processes 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), 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 (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?

- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

8.21 Some of these issues may need to be revisited by the SCR panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the LSCB chair.

## APPENDIX D Draft template for scoping the SCR and producing Terms of Reference

The panel should consider, *in the light of each case*, the scope of the review process, and draw up clear terms of reference. (WT 8.12) It may be useful for the panel to consider each of the following, indicating where an issue is not applicable and adding additional considerations where appropriate. Supplementary questions have been included to assist this process.

### 1. Decision to hold SCR

- *Add date when notification to Ofsted was made*
- *Add date when the chair of LSCB (name and independence status)) agreed to hold SCR. State name and independence status of SCR panel.*
- *Provide detail as to why SCR was necessary using 8.5 or 8.6. as basis*
- *Identify reasons for any delays in deciding to hold SCR*

### 2. Key Issues: (really important section)

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

### 3. Expert Opinion

- *Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?*
- *Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?*

### 4. Time Period over which events should be reviewed

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

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

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

## **6. Involvement of Family Members**

- *Are there any known factors which may affect the involvement of any family members?*
- *Which family members will be asked to contribute and why?*
- *Are there issues around timing which may affect this dialogue?*
- *Who will be responsible for supporting family members involved?*
- *What resources will be required to facilitate this process?*
- *Which agency and named lead in the agency will take responsibility for coordinating the contacts with the family?*
- *Who will lead in the process necessary in requesting access to adult health records where required?*

## **7. Other Parallel reviews (e.g. PPO/ homicide or suicide reviews)**

- *Will the case give rise to other parallel investigations of practice – e.g. independent health investigations or multi-disciplinary suicide reviews, a homicide review where a parent has been murdered, a YJB Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting?*
- *If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions that need to be asked, in the most economical way?*
- *What are the arrangements for co-ordinating and liaising with those involved?*
- *What problems may emerge in terms of confidentiality and sharing information and how will these be addressed?*
- *What are the implications of any different or challenging timescales?*

## **8. Involvement of organisations in other LSCB areas**

- *Are there any other organisations involved with this family or any cross boundary issues which may involve other LSCBs?*
- *Who will take responsibility for contacting that LSCB to negotiate, manage and co-ordinate their involvement in the SCR process?*
- *What should be the respective roles and responsibilities of the different LSCBs with an interest?*

## **9. Coroner's Inquiries/Criminal Investigations**

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

## **10. Media Coverage/Enquiries**

- *How should any public, family and media interest be managed before, during and after*

*the review?*

- *Be specific, including how reports will be anonymised*
- *Is there a communications/media strategy?*
- *How should any FOI requests relating this case be handled and by whom?*

#### **11. Legal Advice**

- *Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review?*
- *If Yes, give reasons*

#### **12. SCR Review Timescales**

- *The review process should start within one month of notification and should, unless extensions are agreed with the DfE, conclude and be forwarded to Ofsted and copied to the DfE within 6 months from that start date.*
- *What are the possibilities that these dates may change and why?*

#### **13. Commissioning of an Independent Author**

- *Which Author is being proposed and why? Indicate if they have any specific skills or knowledge.*
- *Specify in what way they are considered 'independent'*
- *Will LSCB require the Author to use a particular format for their report and is a template available?*
- *Specify what is expected of the Author and within what timescales, maybe give some examples of things to consider e.g., dates booked in to present the early findings to the panel, dates for final report to LSCB, a link person for the author and the means by which their work will be facilitated.*
- *Clarify process should Board fail to ratify final report.*

#### **14. Liaison with Ofsted and the DfE**

[Name Contact Details] will liaise with the DfE over progress and where any extensions to timescales prove necessary.

**APPENDIX E: Example format for chronology**

Date and Time (if known)	Family Contact		Communication		Response and/or outcome	Source of evidence	Comment
	Child <i>Specify if her/his views recorded &amp; if seen alone</i>	Adult <i>Specify if her/his views recorded</i>	Within Agency <i>Specify: phone, written, meeting</i>	External to agency <i>Specify: phone, written, meeting</i>			

**APPENDIX F: Example SCR panel chair job description and person specification**



**BEXLEY LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)**

**JOB DESCRIPTION**

**Independent chair,**

**Standing Serious Case Review Panel (SSCR panel)**

**1 PURPOSE**

- 1.1 To chair Bexley's Standing Serious Case Review Panel
- 1.2 To chair, commission and oversee the production of Serious Case Reviews unless a conflict of interest is identified
- 1.3 To ensure that recommendations from reviews are enacted
- 1.4 To represent the Standing Serious Case Review Panel in all relevant settings

**2 ORGANISATIONAL RELATIONSHIPS**

- 2.1 **Accountability** to LSCB chair.

**3 PRINCIPAL DUTIES AND RESPONSIBILITIES**

- 3.1 To chair meetings of the Bexley SSCR panel and additional SCR panel meetings for specific SCRs unless a conflict of interest is identified.
- 3.2 To ensure that the SSCR panel operates independently of its member agencies
- 3.3 To represent the SSCR panel in all relevant settings
- 3.4 To agree minutes of SSCR panel meetings for dissemination to SSCR panel members
- 3.5 To report to LSCB chair, Board and its Executive as required
- 3.6 To oversee production of the SSCR panel Annual Report
- 3.7 To ensure all relevant cases are considered by the SSCR panel and to liaise with the chair of the Child Death Overview Panel as necessary

- 3.8 To commission Serious Case Reviews on behalf of the LSCB and to ensure the quality of each stage of the SCR process and the final complete Review
- 3.9 To liaise with the LSCB Quality & Effectiveness Group regarding monitoring and auditing of compliance with Serious Case Review Recommendations
- 3.10 To ensure that all reporting to relevant agencies (OFSTED/GOL) is undertaken in accordance with government guidance
- 3.11 To ensure that partner agencies provide effective representation to the SSCR panel and bring to the attention of the LSCB chair any issues in respect of representation
- 3.12 To advise the LSCB on existing or new government guidance relevant to the conduct of Serious Case Reviews and ensure that the LSCB responds appropriately.

#### **4 FLEXIBILITY CLAUSE**

- 4.1 Other duties and responsibilities as implied which arise from the nature and character of the post.

#### **5 TERMS AND CONDITIONS**

- 5.1 The appointment will initially be for a period of 2 years, to be reviewed at the end of first year.
- 5.2 The chair will be accountable to the chair of the LSCB
- 5.3 To ensure that the SSCR panel meets its developing and statutory duties and requirements, the responsibilities of the post will be reviewed annually by the LSCB.
- 5.4 It is anticipated, that the above duties and responsibilities will be carried out within a minimum of 4 days per year with a maximum of 8 days over a 12-month period. Any additional days will be by agreement and as required by individual SCRs.
- 5.5 Fee, to include all except agreed non routine expenses, is £500.00 per day
- 5.6 Invoices will be paid monthly in arrears.

#### **PERSON SPECIFICATION: SSCR panel INDEPENDENT CHAIR (all criteria are essential)**

##### **Skills, knowledge & experience**

- 1 Knowledge of recent developments in health and social care, and of the legislation and research underpinning child protection
- 2 Experience of efficiently chairing complex professional meetings at a senior level
- 3 Experience of working in the public or voluntary sector at a senior level so as to command the professional respect and authority needed to chair a SCR panel
- 4 Sufficient experience of the operational context of child protection and safeguarding children work to empower a positive and proactive consideration of cases
- 5 Robust negotiation and conflict resolution skills
- 6 Organisational abilities sufficient to ensure the smooth operation of the SCR panel, with appropriate delegation to the LSCB Officers
- 7 Good oral skills and the ability to speak in public, sufficient to represent the LSCB effectively to the media
- 8 A commitment to self-development and responsibility to ensure that personal knowledge of safeguarding and child protection is updated

### **Equal Opportunity**

- 9 Ability to have appropriate regard, respect and value for diversity in all its aspects
- 10 Must be able to recognise discrimination in its many forms and be willing to promote equal opportunities policies within the operation of the LSCB

### **Qualifications / Training**

- 11 Academic and/or professional qualification in social or health care, education or legal discipline to degree level and with sufficient standing to command professional respect

### **Attitude & Motivation**

- 12 Commitment to safeguarding children and promoting their welfare demonstrable through previous, or current professional or voluntary activities
- 13 Commitment to maintaining public confidence in services for children
- 14 Ability and commitment to high standards of confidentiality
- 15 Assertive, clear thinking and able to negotiate effectively
- 16 Self motivating and able to operate across multi-agency hierarchies

**Other**

17 It may be necessary to travel outside Bexley in order to attend Conferences, etc.

18 An appropriate level of IT and literacy skills

The criteria are subject to reasonable adjustment to enable Candidates to fulfil the requirements of the job.

**APPENDIX G: Example SCR overview author job description, person specification and specimen commissioning contract**

**Detailed standards for commissioning independent overview authors**

**Standard One- Ability to produce a report that meets the requirements of *Working Together*.**

Report writing and analytical skills.

Criteria	Evidence	Rating 1-4 (4 being Excellent)
<ul style="list-style-type: none"> <li>• Presentation of facts</li> <li>• Language and style for audience</li> <li>• Presentation of facts</li> <li>• Language and style for audience</li> <li>• Sufficiently analytical</li> <li>• Ability to meet timescales</li> <li>• Fit for purpose</li> <li>• Use of language</li> <li>• Quality assurance</li> <li>• Neutrality</li> <li>• Addresses original TOR and scope.</li> </ul>	<ul style="list-style-type: none"> <li>• Information provided by author about previous SCR or other relevant analytical reports written, including who were the commissioning body and date of publication.</li> <li>• Anonymous sample of at least one previous report provided. How were the essential criteria reflected in the report?</li> <li>• How were they judged, evaluated (by Ofsted or others?)</li> <li>• Reports should have been published in last 3 years.</li> </ul>	

**Standard Two - Current knowledge and understanding of relevant safeguarding research and practice.**

**Evidence of being up to date with key research and development issues pertinent to individual SCRs and the process.**

Criteria	Evidence	Rating 1-4 (4 being Excellent)

<ul style="list-style-type: none"> <li>• Understanding of importance of safeguarding policies across agencies, legislation, policy and practice</li> <li>• Area of specialist expertise</li> <li>• Evidence of own professional development</li> <li>• Understanding of current developments and impact on agencies involved in safeguarding.</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrate understanding of how a range of agencies operate within current legislative framework.</li> <li>• Understanding of how organisational culture and customs can impact on practice and its relevance.</li> <li>• Formal qualifications, work experience, training etc</li> <li>• Include what areas of expertise are and how are these and how kept up to date.</li> <li>• Knowledge of research and practice around child protection.</li> </ul>	
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**Standard Three- Rigorous analysis of complex information from a range of sources.**

**Analytical Skills**

Criteria	Evidence	Rating 1-4  (4 being Excellent)
<ul style="list-style-type: none"> <li>• Ability to identify key issues and themes.</li> <li>• Able to analyse complex information</li> <li>• Focus on learning</li> <li>• Appropriate use of research, and lessons from similar SCR reports</li> <li>• Able to take objective viewpoint</li> <li>• Draw conclusions and make appropriate recommendations</li> <li>• Draw out positive practice</li> <li>• Questions evidence</li> <li>• Provides both support and challenge</li> <li>• Evaluation</li> <li>• Link back to Terms of Reference.</li> </ul>	<ul style="list-style-type: none"> <li>• Examples from previous SCR or other reports.</li> <li>• Individual reflection on own style, methodology/approach to the interpretation of complex information.</li> <li>• Evidence of how they have made a difference, handled conflict or challenge.</li> </ul>	

**Standard Four- Focus on child / children**

**Child Focused Report**

Criteria	Evidence	Rating 1-4 (4 being Excellent)
<ul style="list-style-type: none"> <li>• Able to keep focus on child / young person integral to the report.</li> <li>• Family involvement in SCR – how used (desirable)</li> <li>• Family visits.</li> </ul>	<ul style="list-style-type: none"> <li>• Examples from previous reports.</li> <li>• Experience of work related family visits and feedback on the process and their approach. If possible experience of visits to families who are subject to SCRs.</li> </ul>	

**Standard Five- Promotion of positive inter-agency working**

**Collaborative approach**

Criteria	Evidence	Rating 1-4 (4 being Excellent)
<ul style="list-style-type: none"> <li>• Track record in collaborative problem solving.</li> <li>• Understanding of partnership working.</li> <li>• Promotion of a learning culture.</li> </ul>	<ul style="list-style-type: none"> <li>• Example of how they resolved conflict when working with other professionals.</li> <li>• Experience of working with professionals from a variety of agencies in the planning or delivery of services for children.</li> <li>• Demonstrate how they have promoted learning from practice.</li> </ul>	

**Standard Six- Media Experience**

**Experience of Handling High Profile Cases-(Desirable skill)**

Criteria	Evidence	Rating 1-4 (4 being Excellent)
<ul style="list-style-type: none"> <li>• Ability to operate with integrity and manage any media in partnership with the Board and LA.</li> </ul>	<ul style="list-style-type: none"> <li>• Experience of dealing with media on previous cases or work and preparing or giving statement or interviews.</li> </ul>	

These Standards were developed by a small working group from the East Midlands region with support from GOEM. Final version March 09.

**LSCB EXAMPLE CONTRACT FOR SERIOUS CASE REVIEW INDEPENDENT OVERVIEW REPORT AUTHORS**

THIS AGREEMENT is made *insert date*

BETWEEN:

A

(1) Xxx LOCAL SAFEGUARDING CHILDREN BOARD

Hereinafter referred to as “the Board”)

and

B *insert name and address (hereinafter “the Individual”)*

**OPERATIVE PROVISIONS**

**1. Definitions and interpretation**

1.1 The following terms shall have the following meanings for the purpose of this Agreement:

1.1.1. ‘Agreement’ means these terms and conditions and all Schedules to this Agreement as the same may be amended, modified or supplemented from time to time in accordance with this Agreement.

1.1.2 “Author” means the Individual who is the Author of the Independent Overview Report

1.1.3. ‘Commencement Date’ means 1 August 2008

1.1.4. ‘Term’ means from the commencement Date for a period of three years or until this Agreement shall be determined by either Party.

1.1.5. ‘Further Term’ means a further period of 3 years in addition to the Term as agreed.

1.1.6 ‘Personal Data’ means data which relates to a living individual who can be identified from those data, or from those data and other information which are in the possession of or are likely to

come into the possession of either Party. They include, without limitation, expressions of opinion or intentions in respect of such a living individual.

- 1.1.8 'Role Specification' is as set out in Schedule 1
- 1.1.9. 'Sensitive Personal Data' means Personal Data consisting of information as to the racial or ethnic origin, the political beliefs, religious or similar beliefs, trade union membership, details of physical or mental health, sexual life and alleged commission of crimes or criminal record of the data subject.
- 1.1.10. 'Services' means the services detailed in the Role Specification.

- 1.2 The headings in these terms and conditions are inserted only for convenience and shall not affect its construction.
- 1.3 The singular includes the plural and vice versa.
- 1.4 Reference to any statute or statutory provision includes a reference to the statute or statutory provision as from time to time amended, extended or re-enacted.

## **2. Appointment and Extensions**

- 2.1 The Individual is appointed by the Boards for the Term of three years from 1<sup>st</sup> August 2008.
- 2.2 The Individual may be requested to undertake a Further Term by the Boards. It shall be at the sole discretion of the Boards whether the Further Term shall be offered and the written consent of both Parties shall be required before a Further Term is undertaken.

## **3. The Independent Overview Report Author's Obligations**

- 3.1 The Author undertakes to the Boards that:
- 3.1.1. he shall carry out and complete the Services and all other services reasonably required by the Boards which are reasonably incidental to the Services in accordance with the terms of this Agreement;
- 3.1.2. he shall comply with all reasonable instructions given to him by the Boards in relation to the Services;
- 3.1.3. he shall exercise the degree of skill, care and diligence to be expected of a person who is properly qualified and experienced to carry out the Services

and provide all the Services in accordance with the requirements within agreed timescales.

3.1.4. he shall keep the Boards fully informed and provide regular information with regards to Serious Case Review activity.

3.2 Except and to the extent and upon the terms required or permitted by the Boards the Author shall not in any circumstances use any premises or equipment of the Partner Agencies.

3.3 If the Author is unable or fails to provide the Service or any part thereof the Boards may itself provide or may employ and pay other persons to provide the Services or any part thereof.

#### **4. Remuneration**

4.1 The remuneration payable to the Author in respect of the Services shall be calculated and paid in accordance with the Role Specification.

4.2 The Author shall claim any authorised expenses.

#### **5. Confidentiality and Data Protection**

5.1 The Author shall not at any time during or after the Term divulge or allow to be divulged to any person any confidential information relating to the Boards except with the prior written agreement of the Boards.

5.2 The Author acknowledges that the Boards may provide Personal Data and/or Sensitive Personal Data to the Author in order for the Author to provide the Services required under this Agreement.

5.3 The Author undertakes to:

5.3.1. keep all Personal Data confidential and shall at all times comply with the provisions of the Data Protection Act 1998 (as amended).

5.3.2. only use the Personal Data and Sensitive Personal Data disclosed by the Boards in order to provide the Services.

5.4 The Author shall indemnify the Boards and keep the Boards fully indemnified against all direct losses, claims, damages, liabilities (whether criminal or civil), costs, charges, expenses (including without limitation, legal fees and costs), demands, proceedings and actions which the Boards may incur or which may be brought about or established against them by any person and which in any case arises out of or in relation to or by reason of a breach by the Author of the Data Protection Act 1998.

**6. Delivery up of the Overview Report**

6.1 The Author shall upon termination of this Agreement immediately deliver up to the Boards all documents and property belonging to the Boards which are in his possession or control.

**7. Status of the Author**

7.1 During the Term and any Further Term the Author shall be an independent contractor and not the servant of the Boards.

7.2 In such capacity the Author shall bear exclusive responsibility for the payment of his national insurance contributions as a self-employed person and for discharge of any income tax and VAT liability arising out of remuneration for his work performed by him under this Agreement.

**8. Criminal Record Bureau Checks**

8.1 The Author acknowledges that he shall receive an enhanced check by the Criminal Records Bureau before he shall be allowed to provide the Services to the Boards. In the event that the results of the enhanced check are received after the commencement of this Agreement, the Boards reserve the right to terminate this Agreement immediately if the results of the enhanced check are not satisfactory.

**9. Termination**

9.1 The Boards may by written notice to the Author require the Author to suspend performance of any or all of the Services to be provided. In the event of the suspension of the whole of the Services the Author shall be entitled to be paid up to the date of suspension.

9.2 If either Party is in material default of any of their obligations under this Agreement the other Party may give to the defaulting Party notice of the same and if such default shall continue for a period of 14 days following service of the notice of default the other may without prejudice to any other rights or remedies forthwith terminate the Agreement by written notice.

9.3 The Boards may terminate the appointment of the Author at any time giving 7 days written notice.

**10. Insurance and Indemnity**

10.1 The Author shall fully and effectively indemnify the Boards and keep the Boards fully and effectively indemnified from and against all actions, demands, costs (on a full indemnity basis), losses, penalties, damages, liability, claims and expenses (including but not limited to legal fees) whatsoever incurred by the Boards

**11. Notices**

11.1 Any notice to be given by either Party hereunder will be sufficiently served if sent by hand, by facsimile transmission or by post to the address of the other Party.

**12. Variations**

12.1 Any variation to this Agreement shall be effected by an agreement in writing signed by a duly authorised officer or representative of each of the Parties hereto.

**13. Governing Law**

13.1 This Agreement shall be governed by English law and the Parties hereby submit to the exclusive jurisdiction of the English courts.

IN WITNESS whereof the Parties have entered into this Agreement by signature of their respective duly authorised representatives, the day and year first above written.

**SIGNED**

.....

Signed by

Name:.....

**SIGNED**

.....

For and on behalf of The Boards

Name:.....

Authorised Officer

## **APPENDIX H: Example template and guidance for Individual management reviews**

### **The individual management review – process and report**

The following headings should guide the preparation of management reviews. The points below provide the basic format which should be followed, but there may be specific areas which relate to individual cases which will require further exploration. The format is taken from *Working Together to Safeguard Children* (DCSF, 2010) and *The London Child Protection Procedures* (London Safeguarding Children Board, 2007).

#### **Chronology**

Before the report is drafted a chronology must be prepared of the agencies contact with the family using an agreed template. This is then used as the basis for producing the IMR.

There are five main components to the report: introduction; chronology; analysis; lessons learned; recommendations.

#### **1. Introduction**

The introduction should name the child, provide details about age, ethnicity and relevant family members and the circumstances which precipitated the review. This section should describe the position of the author of the IMR in relation to independence of the case concerned, the process undertaken in drawing up the report and should list the names of those interviewed and other sources of information, for example, the child's case file.

#### **2. Narrative**

The chronology should be used as a basis to construct a narrative describing the sequence of events and critical incidents for the child / family, and the actions taken by the agency in response. It is this narrative that provides the second section of the IMR, the actual chronology should be provided as an appendix.

#### **3. Analysis of involvement**

The analysis should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, the analysis should aim to provide an understanding of what happened and why.

*Working Together* recommends that the following factors should be considered in the analysis:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

**4. Lessons learned / findings or conclusions**

This section should provide the conclusions and whether there are lessons learned from the events and analysis in relation to the way the organisation works to safeguard and promote the welfare of children. Instances of good practice should be highlighted, but the main body of this section will outline ways in which practice and policy can be improved. This section should include the main messages and implications for systems and processes, and for practice, including for example, management and supervision, multi-agency working, resources, training and development. If there are shortfalls in service which the panel is assured have been addressed since the incident this must be recorded and spelt out if therefore a recommendation will not be made. Suggest findings are numbered and relate directly to a recommendation or a reason given as to why a recommendation is not necessary.

**5. Recommendations**

The recommendations should be SMART and outcome focused, so that the responsible senior manager in the agency can draw up an action plan outlining what actions should be taken by whom, and when, in order to meet specific outcomes. This section should also include how the organisation will evaluate whether the desired outcomes have been achieved.

**6. Other considerations**

The five components above comprise the main elements of the IMR report and must be included in all reports. Agencies may also provide additional information to set the context for the IMR, for example, particular management arrangements or frameworks which were in place and relevant, or particular circumstances which may have impinged on the events, such as staffing difficulties within the organisation.

**APPENDIX I: Example action plan (the full anonymised plan is available on request from the London Board)**

No	Agency	Recommendation	Projected Outcome	Priority Rating RAG	Evidence	Responsible	Report to / when	Progress RAG
1	LSCB Exec	In respect of Information Sharing LSCB agencies must issue a reminder to all relevant staff to ensure that:  Staff know that should they become aware of any conflict in respect of sharing information, specifically in a therapeutic relationship with an adult, the welfare of the child is paramount and information about any risk to child/children should be shared with relevant partner agencies.	Improved safety of local children by ensuring relevant information is shared in appropriate settings	Red	Joint statement / guidance issued with adult safeguarding Board	<b>chair LSCB</b> <b>SGAB</b>	Jan LSCB	Green
	BMHT	BMH to ensure that all mental health clinicians are trained in their duty and professional responsibility to share information in respect of safeguarding children as per Working Together 2006. This training should emphasise the limits of confidentiality in the therapeutic setting.	Improved safety of children by ensuring BMH staff are fully aware of their responsibilities – better information at CP conference	Green	Evidence of training being delivered to staff – numbers trained	<b>Designated MD BMHT</b>	M&E Jan 09	
	LSCB M&E	Agencies must ensure that they adhere to the LSCB 2009 S11 audit process and report compliance in respect of information sharing protocols, and the LSCB is to hold agencies to account in respect of this.	Information sharing embedded into all agency practice.  Compliance recorded in Sec 11 audit report to Board	Amber	Sect 11 audit responses analysed  Action taken by chair in respect of any agencies not complying	<b>chair M&amp;E</b>	LSCB April 10	
	SMB	The Strategic MAPPA Board should ensure that responsible authorities and those with a duty to co-operate understand fully their role in relation to disclosure, and confirm to the Strategic MAPPA Board that they have information sharing policies in place.	Improved safety for children – and relevant information shared by MAPPA agencies	Amber	Report to SMB	<b>chair SMG</b>	Jan 2010 LSCB	

**APPENDIX J: Example quality assurance checklist for SCR panels and LSCBs**

The SCR panel should quality assure the SCR prior to submission to Ofsted, the following checklist may be helpful.

<b>Criteria</b>		<b>Comments</b>
		<b>Achieved / Not Achieved</b>
1.	The decision to commence the serious case review was made in a timely way, in accordance with Working Together.	
2.	Ofsted was notified of the decision to initiate the SCR within a month of the date of the incident coming to attention.	
3.	Any delay in initiating the SCR is explained within the Overview Report.	
4.	The SCR chair is independent of the LSCB and all services involved in the case and has an appropriate level of experience and authority, and this is detailed in the overview report.	
5.	Any change of SCR chair during the completion of the review is fully explained in the overview report.	
6.	The SCR panel membership is appropriate in relation to organisations represented, and knowledge and expertise.	
7.	The SCR panel was effective in scrutinising the IMRs, identifying gaps, resolving conflicting information and requesting additional information or revised IMRs if required.	
8.	The SCR chair was effective in project managing the review to completion in a timely and effect way.	
9.	The SCR panel brought the review to completion within 4 months or within the timescale agreed with government.	
<b>Terms of Reference</b>		
10.	The SCR panel determined the scope of the review and outlined the terms of reference.	
11.	The time period over which events were to be reviewed was selected and is appropriate.	

12.	If the initial timeframe was later amended the reasons for this are detailed within the overview report.	
13	The organisations and professionals who were to contribute to the SCR were identified.	
14.	Any additional organisations or professionals identified as the review progressed were fully briefed.	
15.	Family members who were offered an opportunity to contribute to the review were identified and arrangements put in place to support their engagement.	
16.	The specific areas of practice and issues for the case were identified and kept under review by the SCR panel as the IMRs were completed and scrutinised, and the overview report undertaken.	
17.	The initial terms of reference have been amended to reflect any additional practice issues identified as the review progressed? Learning for future SCR panels from these additions has been identified?	
18.	The arrangement for anonymising IMRs was agreed and the format for IMRs issued to organisations / agencies.	
19.	Any parallel process, e.g. Homicide, mental health or YJB reviews, criminal investigation, inquest or court processes were taken into account in the planning of the review?	
20.	The areas in which the family was resident during the time period of the review was established and cross boundary arrangements made to engage other LSCBs as necessary.	
21.	Any expert or legal advice required was timely, informative and useful, and this advice is reflected in the review.	
22.	Anticipated delays were planned for and extensions agreed with government in advance?	
23.	Potential media interest was recognised, planned for and responded to in an effective manner before and during the completion of the SCR.	
<b>Individual Management Reviews</b>		
24.	All organisations/agencies identified suitably independent authors to complete IMRs; and the	

	independence of the authors from the case and its line management is explained in the IMRs.	
25.	A briefing was planned and provided for the authors of IMRs, and all the IMR authors attend.	
26.	The timetable set for completion of IMRs was adhered to; or the delays were unavoidable and have been addressed by the relevant organisation(s).	
27.	IMRs were submitted from all organisations and professionals requested to do so, and included a comprehensive chronology of involvement and a genogram.	
28.	The LSCB chair has been informed of any IMRs not provided in response to requests, and the impact of the absence of any IMRs has been assessed and explained within the overview report.	
29.	The IMRs meet the terms of reference including any revisions to the terms of reference for the review and the requirements in Working Together para 8.27.	
30.	The IMRs identify the records accessed and others consulted or interviewed in the completion of the report.	
31.	The IMRs are comprehensive, well-structured, analytical, and look openly and critically at practice, decisions reached and services offered to the child/ren and their family. Good practice is identified.	
32.	The IMRs reach well founded conclusions, identifying key lessons to be learned, and make appropriate recommendations.	
33.	The IMRs have each retained a focus on the child/ren concerned and pay attention to their racial, cultural, linguistic and religious identity.	
34.	The IMRs are provided in the report format provided by the SCR panel, and are fully and appropriately anonymised.	
35.	The IMR recommendations are SMART and it clear that the LSCB will know how the recommendations have been implemented and that practice has improved.	
36.	The IMRs have each been signed off by a Senior Officer within the individual organisations and evidence of that is	

	supplied.	
<b>Overview Report</b>		
37.	The independence of the overview report author is described and their background and expertise explained within the Introduction of the overview report.	
38.	The overview report focuses on the child's experience and pays attention to their racial, cultural, linguistic and religious identity.	
39.	<p>The overview report includes:</p> <ul style="list-style-type: none"> <li>• A summary of the circumstances leading to the review</li> <li>• The terms of reference</li> <li>• A list of contributors and panel members</li> <li>• A genogram</li> <li>• A summary of the family history</li> <li>• An assessment of the IMRs.</li> <li>• A chronology of agency involvement identifying when the child was seen, if the child was seen alone, and whether their wishes and feelings were sought or expressed.</li> <li>• A consideration of any ethnic, cultural or other equalities issues</li> <li>• Analysis of decisions made, action taken, turning points and good practice.</li> </ul>	
40.	The overview report effectively brings together all the information provided from the IMRs, critically analyses and evaluates the information known to agencies using the benefit of hindsight, and identifies the key lessons to be learnt for individual agencies and the multi agency network. The conclusions are logical and based on evidence.	
41.	The overview report details the engagement with family members and their views and contribution to the review.	
42.	The overview report is informed by and references appropriate research.	
43.	The overview report fulfils the terms of reference set for the review, exploring all areas.	
44.	The overview report is consistent as far as is appropriate with the format contained in Working Together para 8.28	
45.	The overview report's includes a small number of recommendations related to the key findings of the	

	review which are focused, specific and achievable.	
46.	The overview report is clear about what is expected to change as a result of the recommendations being implemented and what the key lessons are for the LSCB	
<b>Executive Summary</b>		
47.	The Executive Summary provides an accurate reflection of the key issues arising from the case; information about the review process and SCR panel members; and the recommendations and Action Plan in full.	
48.	The Executive Summary is fully anonymised, written in a style that is accessible and jargon free.	
49.	A media strategy is in place in preparation for the publication of the Executive Summary.	
<b>Action Plan</b>		
50.	The recommendations have been developed into Specific, Achievable, Measurable, Realistic and Timely actions.	
51.	The arrangements for monitoring and evaluating the progress of the Action Plan are clearly set out.	