

Chapter Seventeen

LSCB Serious Case Reviews

17.1 This is the process agreed by the Leicester, Leicestershire and Rutland Local Safeguarding Children Board (LSCB) to consider the circumstances of the most serious child abuse situations and to guide the conduct of the review to include both individual agency management reviews and the overview review by the LSCB.

The Purpose of LSCB Serious Case Reviews

17.2 The purpose of case reviews is to:-

- establish whether there are any lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children.
- identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and as a consequence
- to improve inter-agency working and better safeguard of children.

17.3 Serious case reviews are not enquiries into how a child died or who is culpable; that is a matter for coroners and criminal courts respectively to determine as appropriate. Reviews should therefore be conducted in such a way that the process is a learning exercise, rather than a trial or ordeal.

17.4 Equally, case reviews are not part of any disciplinary process, but may highlight information which may indicate that one or more agencies should consider disciplinary action within established procedures.

Criteria for conducting a LSCB Serious Case Review

17.5 The LSCB should always undertake a serious case review when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether children's social care is or has been involved with the child or family.

17.6 The LSCB should always consider whether to undertake a serious case review where a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, **and** the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children. This includes situations where a parent has been killed in a domestic violence situation or where a child has been killed by a parent who has a mental illness.

17.7 In all of these cases, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (e.g. siblings, other children in an institution where abuse is alleged).

17.8 Additionally the LSCB will consider carrying out a review in the following circumstances:-

- where a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect,
or
- where a child has been subjected to particularly serious sexual abuse,
or
- their parent has been murdered and a homicide review is being initiated,
and
- the case gives rise to concerns about inter-agency working to protect children from harm.

17.9 In considering whether a review will yield useful lessons, in those circumstances other than where a child has died, the following considerations will be taken into account. The answer 'yes' to several of these questions is likely to indicate that a review could yield useful lessons. Was there clear evidence of a risk of significant harm which was:

- not recognised by organisations or individuals in contact with the child or perpetrator or not shared with others or not acted upon appropriately
- the child killed by a mentally ill parent?
- the child abused in an institutional setting (for example, school, nursery, family centre, YOI, STC, Children's Home or Armed Services training establishment)?
- did the child die in a custodial (prison, young offender institution or secure training centre) setting?
- was the child abused while being looked after by the local authority?
- did the child commit suicide or die while absent having run away from home?
- does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted upon 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 subject of a child protection plan or had it been previously 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 procedures, or that procedures are not being adequately promulgated, understood or acted upon?

17.10 Where a child is normally resident within the jurisdiction of Leicester, Leicestershire or Rutland the LSCB will take lead responsibility for conducting the case review. Any other LSCBs that have an interest or involvement in the case will be involved in jointly planning and undertaking the review.

17.11 In the case of looked after children, the authority responsible for the child exercises lead responsibility for conducting any review, again involving other LSCBs with an interest or involvement.

17.12 Any professional may refer a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learned from the case. In

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

Instigating a Serious Case Review

- 17.13 Members of the serious case review subcommittees (SCRs) have the responsibility to notify the Chairperson of the Serious Case Review Subcommittee of any situation which comes to their attention which may meet the criteria for a case review. In some cases, it may be valuable to conduct individual management reviews, or a smaller scale audit of individual cases which give rise to concern but which do not meet the criteria for a full serious case review. In such cases, arrangements should be made to share relevant findings with the SCR subcommittee.
- 17.14 The subcommittee's decision should be forwarded as a recommendation to the chair of the LSCB, who has ultimate responsibility for deciding whether or not to conduct a serious case review. The local authority will inform the local region of the Commission for Social Care Inspection of every case that becomes the subject of a serious case review.
- 17.15 If it is determined that the case does meet the criteria and that a serious case review will be undertaken the members of the SCR subcommittee will be advised immediately and are required to instigate the agency management review process immediately.
- 17.16 Where there is doubt about whether the criteria are met, a serious case review subcommittee meeting will be arranged and all agencies advised of the need to present brief reports to the meeting. This is to enable a decision to be made on whether the criteria for a case review is met.

Keeping the LSCB Chairperson informed

- 17.17 The chair of the serious case review subcommittee will keep the Leicester, Leicestershire & Rutland LSCB Chairperson fully informed of the progress of any serious case review. In addition the Chair of Leicester, Leicestershire and Rutland LSCB will always receive a copy of the minutes of each meeting of the Case Review subcommittee.

Determining the scope of the review

- 17.18 The serious case review subcommittee must agree on the basis of initial information available the likely scope of the review process and the terms of reference which will apply.
- 17.19 This includes:
- what appears to be the most important issues to address in this case. How can the relevant information best be obtained and analysed?
 - who should be appointed as the independent author for the overview report?
 - what time period should be reviewed i.e. how far back should enquiries cover, and what is the cut off point? What family history/background information will help better to understand the recent past and present?
 - whether agencies or professionals other than LSCB members automatically asked to conduct a management review should be asked to submit a report or otherwise contribute and how this is to be achieved

- whether there is a need to involve agencies/professionals from other LSCB areas and how this is best achieved
- whether and how to involve family members in the review
- whether an Independent Review (external to Leicester, Leicestershire & Rutland LSCB) should be commissioned. This may be necessary under the following circumstance;
 - if it is possible that there may be a Public Inquiry;
 - where it is predictable that there will be significant public interest and external scrutiny is considered to be important; and/or
 - if there has been a serious breakdown in inter-agency working at different levels
 - or other major and serious situations involving significant child protection issues.
- the agreed timescales for completion of the review
- whether there is a need to bring in an outside expert at any stage to shed light on crucial aspects
- whether the case will give rise to other parallel investigations of practice. e.g. independent health investigation, homicide review.
- how should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
- how should any public, family and media interest be managed, before, during and after the review?
- does the LSCB need to obtain independent legal advice about any aspect of the proposed review?

17.20 Some of these issues may need to be revisited as the review progresses and new information emerges.

Timing

17.21 Timescales are subject to individual considerations as listed above. Reviews will vary widely in their breadth and complexity, but in all cases, lessons should be learned and acted upon as quickly as possible. Within one month of a case coming to the attention of the Leicester, Leicestershire and Rutland LSCB Chair, the decision should have been made by the chair following a recommendation from the SCR subcommittee on whether a review should take place. Individual organisations should secure case records promptly and begin work to draw up a chronology of involvement with the child and family.

17.22 Reviews should be completed within a further four months, unless an alternative timescale is agreed with the Commission for Social Care Inspection Region at the outset. Sometimes the complexity of a case does not become apparent until the review is in progress. As soon as it emerges that a review cannot be completed within four months of the LSCB Chair's decision to initiate it there should be discussion with the Commission for Social Care Inspection Region to agree a timescale for completion.

17.23 In some cases, criminal proceedings may follow the death or serious injury of a child. Those co-ordinating the review should discuss with the relevant criminal justice agencies, at an early stage, how the review process should take account of such proceedings, for example how does this affect timing, the way in which

the review is conducted (including interviews of relevant personnel) its potential impact on criminal investigations and who should contribute at what stage? Serious case reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to complete or to publish a serious case review until after coroners or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented.

Who Should Conduct Serious Case Reviews

- 17.24 The initial scoping of the serious case review should identify those who should contribute, although it may emerge, as information becomes available, that the involvement of others would be useful. In particular, information of relevance to the review may become available through criminal proceedings.
- 17.25 Each relevant service should undertake a separate management review of its involvement, including completion of a full chronology, with the child and family. This should begin as soon as a decision is taken to proceed with a serious case review. Relevant independent professionals should contribute reports of their involvement. Designated professionals should review and evaluate the practice of all involved professionals. Where a children's guardian contributes to a review the prior agreement of the courts should be sought so that the guardian's duty of confidentiality under the court rules can be waived to the degree necessary.
- 17.26 The Leicester, Leicestershire & Rutland LSCB will commission an overview report which brings together and analyses the findings of the various reports from organisations and others, and which makes recommendations for future action.
- 17.27 The overview report should be commissioned from a person who is independent of all the agencies/professionals involved. Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved.

Individual Management Reviews

Objectives of the Agency Management Review

- 17.28 These are as follows:
- to establish a factual chronology of the action which has been taken within the agency
 - to analyse the involvement of the agency
 - to consider what lessons may be learned from the case about the way in which the agency works to safeguard children and promote their welfare
 - to recommend appropriate action in the light of the review's findings, with what intended outcomes and the agency will review whether these have been achieved
- 17.29 Once it is known that a case is being considered for review, each organisation should secure records relating to the case to guard against loss or interference.

- 17.30 The aim of management reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about. The findings from the management review reports should be accepted by the senior officer in the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon. Managers within agencies will ensure that all necessary assistance is given to the reviewing officer. To facilitate this, each LSCB agency should have clear procedures on the conduct of management reviews.
- 17.31 The police may be restricted in the amount of information they can provide for the serious case review during the process of criminal investigation. Information collected by the police may be subject to rules of disclosure for court proceedings.
- 17.32 Upon completion of each management review report, there should be a process for feedback and debriefing for staff involved, in advance of completion of the overview report of the LSCB. There may also be a need for a follow up feedback session if the LSCB overview report raises new issues for the organisation and staff members. It is recognised that the process could incur stress on individual workers and that, at any stage, issues may be identified which require consideration through disciplinary or similar processes. Staff informed should be kept informed of the process. Feedback and debriefing of involved staff should be given at the earliest opportunity – and should be agreed within the serious case review subcommittee in order that staff in different agencies are treated equally.
- 17.33 Where a child dies in a custodial setting (prison, young offender institution or secure training centre) the Prisons and Probation Ombudsman investigates and reports on the circumstances surrounding the death of that child. The investigation examines the child's period in custody, including an assessment of the clinical care they received. The report would normally be made available to assist any serious case review process.
- 17.34 The following outline format should guide the preparation of management reviews, to help ensure that the relevant questions are addressed, and to provide information to LSCBs in a consistent format to help with preparing an overview report. The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues which need to be explored and the serious case review subcommittee each should consider carefully the circumstances of individual cases and how best to structure the review in the light of those particular circumstances.
- 17.35 Where staff or others are interviewed by those preparing management reviews, a written record of such interviews should be made and this should be shared with the relevant interviewee.

Management Reviews

17.36 What was our involvement with this child and family?

Construct a comprehensive chronology of involvement by the organization and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference.

Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

In analysing the involvement with the child and/or family the following areas should be specifically considered:

- were practitioners sensitive to the needs of children in their work, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child?
- 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?
- where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- when and in what way were the children's wishes and feelings ascertained and taken account of when making revisions about children's services. Was this information recorded?
- was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- were more senior managers or other organisations and professionals involved at points when they should have been?
- was work on this case consistent with each organisation's and the LSCBs policy and procedures for safeguarding and promoting the welfare of children, and wider professional standards?

What Do We Learn From This Case?

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

Recommendations For Action

What action should be taken by whom and by when? What outcomes should these actions bring about, and how will the organisation evaluate whether they have been achieved.

The LSCB Overview Review

17.37 The Serious Case Review subcommittee is responsible for producing the LSCB overview report including conclusions and recommendations. Additional members can be co-opted to give specialist advice for a particular serious case review. Where the case involves a child resident in Rutland this will include co-opting a representative from the Children and Young People's Services and from Rutland Legal Services onto the Serious Case Review Subcommittee.

17.38 The LSCB overview report should bring together, and draw overall conclusions from the information and analysis contained in the individual management reviews, information from the child death review processes, together with reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with management reviews, the precise format will depend upon the features of the case.

This outline will be most relevant to abuse or neglect which has taken place in a family setting.

17.39 The format for LSCB Overview reports will be as follows:

Introduction

- summarise the circumstances that led to a review being undertaken in this case
- state terms of reference of review
- list contributors to review and the nature of their contributions (for example, management review by LA, report from adult mental health service). List review panel members and author of overview report

The Facts

- prepare a 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 and the child's wishes and feelings sought or expressed
- prepare an overview which summarises what relevant information 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 occur, decisions were made, actions taken or not. This is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. The analysis section is also where any examples of good practice should be highlighted.

Conclusions and Recommendations

This part of the report should summarise what, in the opinion of the review panel, are the lessons to be drawn from the case, and how those lessons should be translated into recommendations for action. Recommendations should include, but should not simply be limited to the recommendations made in individual reports from each organisation. Recommendations should 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.

Process of compiling the LSCB Overview Report

17.40 The LSCB Audit Officer (or independently commissioned person) will commence drafting the multi-agency chronology (which will form a part of the LSCB Overview Report) and begin to identify any discrepancies between agency reports as she/he receives them. This will be brought to the attention of the LSCB Chair and

the chair of the serious case review subcommittee in order that issues can be followed up speedily.

17.41 The LSCB Audit Officer will send a copy of each agency management review report to each member of the serious case review subcommittee no less than 5 working days before the meeting which considers the next stage: i.e. compiling the overview report.

17.42 The serious case review sub-committee will then:

- consider the Agency Reviewing Officers' reports
- identify the key issues against the format for the overview report
- commission the LSCB Audit Officer to produce a draft based on these discussions, with support from a working group if required

17.43 The draft overview report is considered at a subsequent meeting of the serious case review subcommittee on an agreed date. The target timescale for completion of the final draft LSCB Overview report is normally eight weeks from agreed date of submission to the Audit Officer, i.e. four months in total.

LSCB Action on Receiving Reports

17.44 Each agency involved will determine what further action is required within their own agency. This will be included in their own agency review report and shared with the serious case review subcommittee.

17.45 The LSCB Overview report will be submitted to the next meeting of the LSCB . If the matters being examined are considered by the Chair (in discussion with Senior Officers from the leading agencies) to be sufficiently grave, or the next planned LSCB meeting is too distant to meet reasonable timescales for completion, an emergency meeting of the LSCB may be convened.

17.46 On receiving an overview report the LSCB should:

- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report;
- translate recommendations into an action plan which should be signed up to at a senior level by each of the organisations that need to be involved. The plan should set out who will do what, by when, and with what intended outcome. The plan should set out by what means improvements in practice/systems will be monitored and reviewed;
- clarify to whom the report, or any part of it, should be made available;
- disseminate report or key findings to interests as agreed. Make arrangements to provide feedback and de-briefing to staff, family members of the subject child, and the media, as appropriate;
- arrange for an executive summary of the overview report to be compiled which will provide a summarised and anonymised version of the report
- agree any urgent action arising from the serious case review which requires immediate action
- provide a copy of the overview report, action plan and individual management reports to the CSCI and DfES

Reviewing Institutional Abuse

17.47 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply but reviews are likely to be more complex, on a larger scale, and may require more time. Terms of reference need

to be carefully constructed to explore the issues relevant to the specific case. For example, if children had been abused in a residential school, it will be important to explore whether and how the school has taken steps to create a safe environment for children, and to respond to specific concerns raised.

- 17.48 There needs to be clarity over the interface between the different processes of investigation (including criminal investigations); case-management, including help for abused children and immediate measures to ensure that other children are safe; and review, i.e. learning lessons from the case to reduce the chance of such events happening again. The three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

Accountability and Disclosure

- 17.49 The LSCB will consider carefully who might have an interest in reviews, for example elected and appointed members of authorities, staff, members of the child's family, the public, the media - and what information should be made available to each of these interests. There are difficult interests to balance, among them :-

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
- the accountability of public services and the importance of maintaining public confidence in the process of internal review
- the need to secure full and open participation from the different agencies and professionals involved
- the responsibility to provide relevant information to those with legitimate interest
- constraints on public information sharing when criminal proceedings are outstanding, in that providing access to information may not be within the control of the LSCB

- 17.50 It is important to anticipate the requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for debriefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals. In all cases, the LSCB overview report should contain an executive summary which will be made public, which includes as a minimum, information about the review process, key issues arising from the case and the recommendations which have been made. The publication of the executive summary will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others. The LSCB should ensure that the SHA and CSCI are briefed, so that they can work jointly to ensure that the Department of Health and the Department for Education and Skills respectively are fully briefed in advance about the publication of the executive summary.

Audit and Monitoring

- 17.51 Monitoring of the action plan produced from the overview report will be undertaken by the serious case review subcommittee reporting back to LSCB.

17.52 Any areas of inter-agency activity identified as of particular concern may also be referred for consideration by the quality assurance subcommittee as a potential area for future audit and research.

Learning Lessons Locally

17.53 Serious case reviews are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- as far as possible, conduct the review in such a way that the process is a learning exercise in itself rather than a trial or an ordeal;
- consider what information needs to be disseminated, how, and to whom, in the light of the review. Be prepared to communicate both examples of good practice and areas where change is required
- recommendations should be focused on a small number of key areas, with specific and achievable proposals for change and intended outcomes
- actions against recommendations and intended outcomes should be audited
- feedback on review reports from CSCI should be sought

17.54 Day to day good practice can help ensure reviews are conducted in a way most likely to maximise learning there should be:

- a culture of audit and review;
- in place clear, systematic case recording and record keeping systems;
- good communication and mutual understanding between different LSCB members;
- work to raise awareness of the positive work of statutory services with children in the local community and media so that attention is not focused disproportionately on tragedies;
- good understanding amongst staff and their representatives about what can be expected in the event of a serious case review