city & hackney safeguarding children board

Notification Process for Serious Case Reviews

April 2015 (updated March 2017)

Contents

(Acknowledgement to Peterborough Safeguarding Children Board, includes CHSCB Access to information protocol)

1. Introduction

1.1 Partners of the City and Hackney Safeguarding Children Board (CHSCB) have a responsibility to ensure, as far as possible, the safety of children and young people within the context of the services they provide. Serious Case Reviews (SCR), when they do occur, can cause pain and suffering to those directly involved, have the potential to generate media interest and undermine public confidence in the system. It is therefore essential that the CHSCB has in place an established system for dealing with Serious Case Reviews.

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

1.3 It is hoped that the framework outlined in this guidance will enable CHSCB to identify good practice operationally or in policy at a local or national level. Through this guidance, the CHSCB aims to ensure that there is a rigorous system of scrutiny in place at local level. Common themes and emerging trends identified by examining all referrals can be used to inform future policy, guidance and training.

2. Notification of a Serious Childcare Incident

2.1 Where there is a serious childcare incident that must be notified to the Secretary of State, the expectation is that Local Authority will notify using the Notification of Serious Childcare Incident form https://ofstedonline.ofsted.gov.uk/outreach/Ofsted_Serious_Notification.ofml

2.2 A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide) , and abuse or neglect is known or suspected;
- A child has been seriously harmed and abuse or neglect is known or suspected
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)[1]

2.3 The Local Authority should report any incident that meets the above criteria to Ofsted and the LSCB promptly, and within five working days of becoming aware that the incident has occurred.[2]

2.4 For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident. There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

2.5 All notifications that are sent to the CHSCB and where the incident could meet the criteria for a SCR outlined in Working Together 2015 the LA should also consider making a referral to the serious case review Sub-Group for consideration of a case review.

2.6 Serious Incidents - Health

2.7 Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Detailed guidance for health settings is set out by NHS

[1] Regulated settings and services: Childcare on domestic premises; Childcare on non-domestic premises; Home childcare, Childminder, Children's Homes (including secure children's homes), Adoption Support Agencies, Voluntary Adoption Agencies; Independent Fostering agencies, Residential Family Centres and Holiday Schemes for Disabled Children.

[2] For example, in the case of out of area placements where the placing authority is different from where the child's care home is based.

England in the following guidance: Serious Incident Framework: Supporting learning to prevent recurrence.

2.8 Where it is indicated that a serious incident within healthcare has occurred and this is considered to meet the criteria for a SCR or offer potential learning through a multi-agency case review, the necessary declaration must be made by the relevant health lead to the SCR Sub-Group using the cases for consideration notification form.

2.9 London Learning Disability Mortality Review Pilot

2.10 From March 2017, ADASS (Association of Directors of Adult Social Services), NHS England and NHS Improvement, require *"all health and social care agencies to report all deaths of people with learning disabilities to the LeDeR Programme….this includes the deaths of both children and adults with learning disabilities".* The locally applied criteria is any child or young person with a learning disability or cognitive/development delay in under 5s.

2.11 The mechanism for local notifications will be coordinated within the CDOP Process. Partners should inform the CDOP Coordinator of any known learning disabilities or cognitive/developmental delays (in under 5s). All deaths meeting the above criteria will be reviewed within the Child Death Overview Process and findings shared with the LeDeR Programme.

2.12 CHSCB will also confirm that an alert has been sent to the LeDeR Programme whenever a child with a Learning Disability has died and is being considered for review.

3. Referral to Serious Case Review Sub-Group

3.1 Working Together 2015 is clear that *"Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children"* [3]

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

3.3 While entirely respecting this guidance, the Board would expect professionals to have discussed the circumstances of such a case with either their designated professional for safeguarding or their agency's representative on the Board if they are not the named person before making the referral.

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

3.4 When satisfied there is evidence that the threshold for a Serious Case Review may be met, the matter should be referred urgently to the CHSCB Business Unit using the **Serious Case Review Referral form (appendix 1)** which can also be found on the website www.chscb.org.uk and emailed to chscb@hackney.gov.uk who will immediately share the referral with the Senior Professional Advisor and/or Board Manager.

3.5 The Senior Professional Advisor and/or Board manager will advise the Independent Chair of the CHSCB of the notification.

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

Please ensure that all sections of the form are fully completed.

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

3.7 Following notification of the case to the Business unit, members of the Serious Case Review Sub-Group will be notified and will be expected to check whether the child and family are known to their agency.

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

3.9 Given this timescale, it is essential that the Serious Case Review Sub-Group meet within three weeks of notification that the threshold for a Serious Case Review may be met to consider the available information. If this is outside the date of the next SCR Sub-Group an extra-ordinary meeting maybe called.

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

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

4. Criteria leading to consideration for a SCR

4.1 The CHSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

4.2 A Serious Case Review must always be initiated when:

a) Abuse or Neglect of a child is known or suspected; AND

b) Either:

1. The child has died; OR
2. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

4.3 "Seriously harmed" as noted aboved and below includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potential life-threatening injury;
- Serious and /or likely long –term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

The definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

4.4 Thus cases meeting **either** of these criteria must always trigger a Serious Case

Review:

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

ii) Abuse or Neglect of a child is known or suspected AND the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.

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

iii) A child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home or where the child was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

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

iv) Who sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or

v) Who has been seriously harmed as a result of being subjected to sexual abuse; or

vi) Whose parent has been murdered and a homicide review is being initiated under the Domestic Violence, Crime and Victims Act 2004; or

vii) Who has been killed by a parent with a mental illness; or

viii) Who has been seriously harmed following a violent assault perpetrated by another child or an adult; and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

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

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
    - not recognised by organisations or professionals in contact with the child or perpetrator or
    - not shared with others or
    - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, School, Nursery, Children's or Family Centre, Young Offender Institution (YOI), Secure Training Centre, Immigration Removal Centre, Mother and Baby unit in a prison, Children's Home or Armed Services Training Establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?

- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the CHSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a serious case review?

5. Criteria for a Serious Case Review met:

5.1 The final decision on whether to conduct an SCR rests with the SCR Sub-Group.

5.2 If the Chair of the Board agrees that the threshold is met and authorises the commencement of a Serious Case Review then the Board has **6 months** from the date of the decision to proceed to complete the task. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to (i) capture points from the case about improvements needs; and (ii) take corrective action to implement improvements and disseminate learning.

5.3 The CHSCB must notify Ofsted, DfE and the National Panel of Independent Experts of the decision, **within five working days from** the decision being made. Contact details can be found below:

Ofsted:
Applications, Regulatory and Contact Team
Ofsted
Piccadilly Gate, Store Street, Manchester
M12 WD
SCR.SIN@ofsted.gov.uk / scr.sin@ofsted.cjsm.net

Department for Education:
Serious Incident Briefing Team
Department for Education,
Level 1, Sanctuary Buildings
Great Smith Street, London SW1P 3BT
Mailbox.CPOD@education.gov.uk

National Panel:
National Panel Secretariat
c/o Department for Education
Level 1, Sanctuary Buildings, Great Smith Street
London SW1P 3BT
Mailbox.SCRPANEL@education.gov.uk

5.4 A decision not to initiate a Serious Case Review may be subject to scrutiny by the national panel and require the provision of further information on request and the CHSCB chair or the Chair's representative should be prepared to attend in person to give evidence to the panel.

5.5 In cases where a LSCB is challenged by the national panel to change its original decision, the LSCB should inform Ofsted, DfE and the national panel of the final outcome.

5.6 In the event of the Chairs authorisation of a Serious Case Review, a number of actions need to take place simultaneously and within ***five working*** days of that decision: -

- Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference
- A scoping meeting will need to be arranged and
- A lead reviewer should be identified.

5.7 It is expected that the NHS Clinical Commissioning Group (CCG) who have the responsibility to notify the Care Quality Commission (CQC) and the Police who have the responsibility to notify Her Majesty's Inspectorate of Constabulary (HMIC) will inform their respective bodies that a SCR will take place.

6. The Serious Case Review Panel

6.1 Once a decision has been made by the Serious Case Review Sub-Group to conduct a serious case review and this decision has been endorsed by the Chair of the CHSCB a Serious Case Review Panel (SCRP) is set up with representatives from relevant agencies involved in the case, who may already be represented on the Serious Case Review Sub-Group or have been selected specially due to their expert knowledge. The panel will be responsible for overseeing the progress of the serious case review.

6.2 **The Terms of Reference**

The SCR Panel should give sufficient time at its **scoping meeting** to deciding which family members' records (including extended family members, friends, and carers) are relevant to the review.

6.3 **The panel should hold in mind the Information Governance Principles -**

- necessary
- proportionate
- relevant
- accurate
- timely
- secure

6.4 If **new information** comes to light about a third party throughout the course of carrying out the SCR, the Panel should reconvene and go through the same process.

6.5 The SCR **terms of reference** should outline a clear rationale as to which records should be accessed and consider at the outset whether there are any consent issues, for example in accessing health records, and if so who will be seeking consent from whom and how.

6.6 The Chair of the CHSCB or the Chair of the SCR panel will write to the chief officer of each agency with the terms of reference and where necessary spell out for an individual agency any particular issues regarding third party information.

7. Action by agencies following decision of an SCR

7.1 A letter of notification will be sent to Chief Officers of the agencies involved and copied to members of the Serious Case Review Panel formally advising of the decision to undertake a serious case review and informing them of the Terms of Reference, methodology and timescale of the review.

7.2 Chief Officers should nominate an officer to complete the chronology and IMR (if appropriate) ensuring this officer has had no involvement with the child/family or case in question and inform the CHSCB Board Manager of who has been identified.

When IMRs (individual management reports) are required?

7.3 If IMRs are to be undertaken these will be expected to be completed in 6 weeks it is important that the lead officer of each agency provides a briefing to their IMR author this should be held very early in the process and normally within two weeks of the Chairs decision.

7.4 To support the IMR author, they should be briefed on what information is required in their chronology and provide guidance on how to complete an IMR. Further support and advice will be available from the CHSCB Board Manager.

7.5 Senior officers should also be advised the priority that this work must take.

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

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

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

Reports which are not clearly signed off will be returned.

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

Information Sharing

7.10 Working Together Chapter 3 states:

"Effective sharing of information between professionals and local agencies is essential for effective service provision. Every LSCB should play a strong role in supporting information sharing between and within organisations and addressing any barriers to information sharing. This should include ensuring that a culture of information sharing is developed and supported as necessary by multi-agency training"

7.11 In addition, the LSCB can require a person or body to comply with a request for information (Section 14A of the Children Act 2004 which was inserted by section 8 of the Children, Schools and Families Act 2010). This can only take place where the information is essential to carrying out LSCB statutory functions. Any request for information about individuals must be 'necessary' and 'proportionate' to the reasons for the request. LSCBs should be mindful of the burden of requests and should explain why the information is needed

7.12 Each agency will ensure that its Safeguarding Children lead, Caldicott Guardian and/or Information Governance Manager are involved in decisions about access to records. In most circumstances this should be straightforward but when it is not, the Caldicott Guardian will determine how to proceed.

Consent

7.13 When seeking access to records (e.g. health) of an adult (person over the age of 18), **consent** should be actively sought from the adult to access their confidential records, except if the adult is an alleged perpetrator or if seeking consent may cause significant harm to a child.

7.14 The consent should be informed and in writing. Consent is best sought at a face to face discussion, so that a full explanation can be given as to the purpose of the SCR, why their records may help lessons to be learnt and to answer any questions they may have. In most circumstances the CHSCB chair or SCR Panel chair/overview author will seek consent on behalf of all involved agencies unless it is felt more appropriate for an individual agency to do so.

7.15 If consent is not given, the CHSCB and the Caldicott Guardian of the agency holding the records will determine whether consent can be overridden on public protection grounds. Again three key principles will apply - **necessary, proportionate and relevant.**

7.16 The CHSCB SCR panel chair may need to write again to the Caldicott Guardian in the record holding agency outlining clearly the rationale for requesting that the agency disclose information without consent.

7.17 A **timely response** is expected from Caldicott Guardians in order not to cause delay to the SCR process.

7.18 If the Caldicott Guardian advises that information from records will not be shared their decision and reasons for their decision will be put in writing to the CHSCB. This decision will be reflected in the Serious Case Review Overview Report.

7.19 The CHSCB may agree that a full individual agency review report is not necessary and that a summary of agency involvement will suffice.

7.20 Relevant decisions regarding access to records will be included in the agency review report and the Overview SCR.

8. Notifying families

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

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

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

9. Notifying victims

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

10. Publication of reports

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

10.2 Final SCR reports should:

• provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
• be written in plain English and in a way that can be easily understood by professionals and the public alike; and
• be suitable for publication without needing to be amended or redacted.

10.3 LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

10.4 When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, including any inquest.

10.5 LSCBs should send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the national panel of independent experts at least seven working days before publication. If an LSCB considers that an SCR report should not be published, it should inform DfE and the national panel. The national panel will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations. In cases where an LSCB is challenged by the panel to change its original decision about publication, the LSCB should inform Ofsted, DfE and the national panel of their final decision.

10.6 The CHSCB Board Manager will ensure that the Overview Report is published to the CHSCB website at the required time for agreed Serious Case Reviews. Where necessary, the Senior Professional Advisor and Independent Chair will coordinate the media strategy.

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

11. Models which may be considered

11.1 Working Together 2015 does not prescribe any particular methodology to use in such continuous learning, except that whatever model is used it must be consistent with the following 5 principles:

- Recognises the complex circumstances in which professionals work together to safeguard children;

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

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

11.3 **Significant Incident Learning Process (SILP)** was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session';

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

11.5 **Root Cause Analysis (RCA)** has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened;

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

12. Cases not meeting the criteria for a SCR

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

A Multi –agency case review:

12.2 Undertaking such a review allows the CHSCB greater flexibility than under the Serious Case Review process. These reviews are of all cases falling below the Serious Case Review threshold. Cases can involve incidents where a child has been harmed and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice.

12.3 Where the CHSCB considers the criteria for a Multi-Agency Case Review is met the CHSCB will decide the most appropriate methodology for conducting the review – either independent review or multi-agency audit process. A summary report with recommendations will be prepared for consideration by the Serious Case Review Sub-Group.

***A Single Agency case Review**:*

12.4 In some cases it may be valuable to conduct a single agency Individual Management Review of practice involving near misses and/or serious incidents, rather than a full Serious Case Review for

example where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together

12.5 In the interests of joint learning and transparency, the CHSCB will expect any relevant lessons arising from single agency reviews to be considered under the Learning and Improvement Framework.

Other review processes:

12.6 Learning identified through other review processes may still have relevance to CHSCB depending on the circumstances. Such reviews include:

Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide or Serious Incident review will be undertaken (if the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered).

The CHSCB is involved in all reviews where there are children living in the house and the findings and recommendations are considered by the CHSCB.

Child Death Reviews

Child Death Reviews are required in statute and are a crucial source of understanding working practices. Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 outlines LSCB responsibilities in relation to a child death. LSCBs are accountable for:

The CDOP conducts a comprehensive review of the circumstances surrounding a child's death. Qualitative and quantitative data is collected including all single agency reporting, critical incident reports, serious incident reports and the Coroner's inquisition.

As well as those conducted under youth justice guidance and safeguarding adult boards.

13. Agreeing improvement action and monitoring of Recommendations:

13.1 The LSCB will oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

13.2 Monitoring of Serious Case Review, Multi-agency Case Review & Single Agency recommendations and Action plans will be the responsibility of the Serious Case Review Sub-Group

Appendix 1 - Case for Consideration

City & Hackney Safeguarding Children Board

Serious Case Review Sub Group

Case for Consideration

1. CASE OUTLINE: Include any critical incident, status of child i.e. Subject of a Child Protection Plan, Looked After Child, disability, etc

2. CHILD's DETAILS				
Child's Last Name/s:		**Child's Date of Birth:**		
Child's Forename/s:		**Age:** [If DOB not known]		
Also known as:		**Gender:**	Male	Female
Ethnicity: Please specify		**Disability**		
Child's Home Address:				
Mother's Name				
Mother's DOB				
Mother's Address				
Father's Name				

Father's DOB	
Father's Address	
Sibling's Name(s)	
Sibling's DOB(s)	

3. REASONS FOR REQUESTING A REVIEW/REFERRAL: Tick all appropriate options:

☐ Fits Serious Case Review criteria:
[Please specify appropriate criteria from Working Together to Safeguard Children, Chapter 4]

☐ Provides opportunity for learning lessons from multi agency work in this case:
[Highlight if either good or poor practice]

☐ Case does not reach threshold for a Serious Case Review but will provide the opportunity for learning lessons:

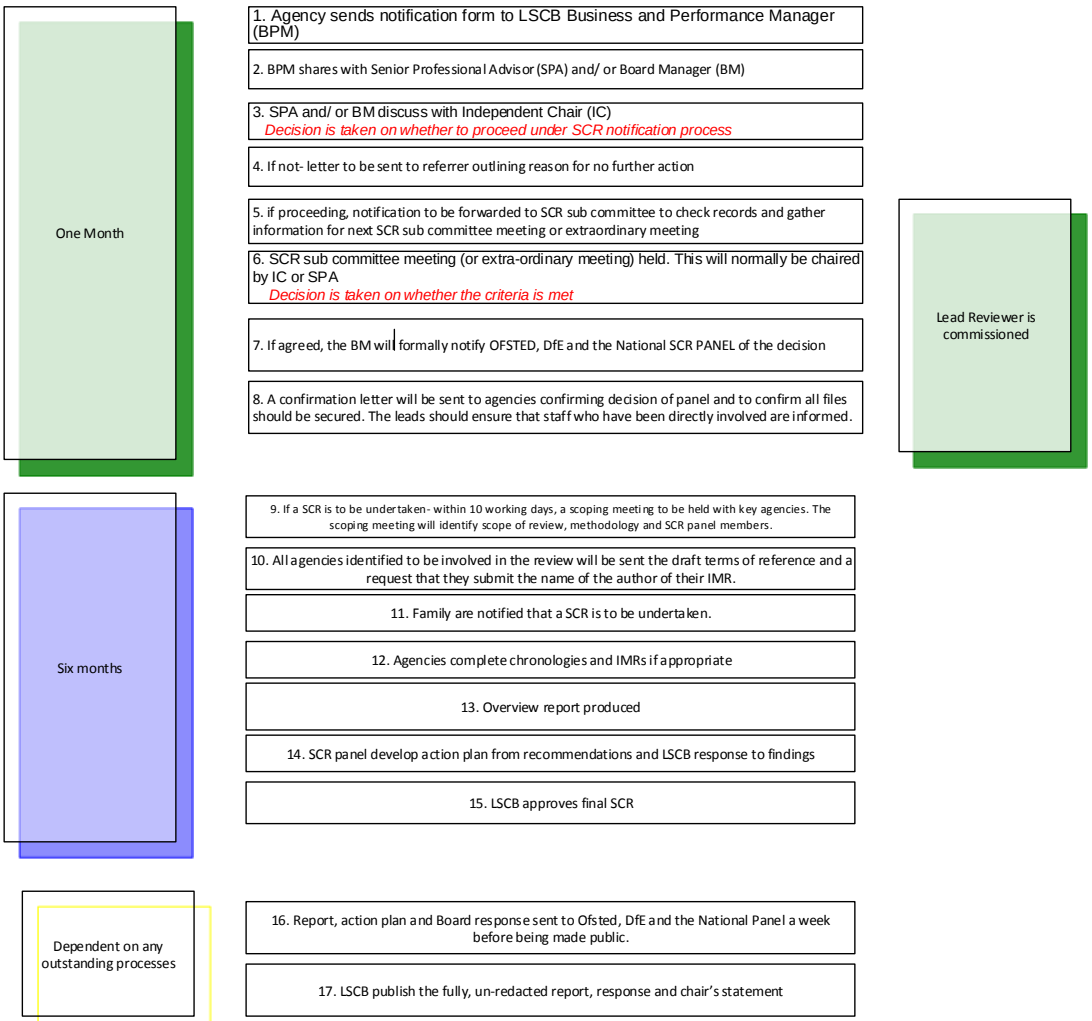
☐ Other:
[Please specify]

4. PARTICULAR CONSIDERATIONS: Please specify any considerations for this case, for example; Is there media interest? Are there criminal proceedings? Is the case linked to a complex abuse case?

5. DECISIONS OF THE SUB GROUP / ACTIONS NEEDED:

☐ Serious Case Review to be undertaken
☐ Multi-Agency Review
☐ Single Agency Review
☐ Referral to other LSCB
☐ Other [Please specify] Any formal processes required

Appendix 2


One Month
1. Agency sends notification form to LSCB Business and Performance Manager (BPM)
2. BPM shares with Senior Professional Advisor (SPA) and/ or Board Manager (BM)
3. SPA and/ or BM discuss with Independent Chair (IC)
Decision is taken on whether to proceed under SCR notification process
4. If not- letter to be sent to referrer outlining reason for no further action
5. if proceeding, notification to be forwarded to SCR sub committee to check records and gather information for next SCR sub committee meeting or extraordinary meeting
6. SCR sub committee meeting (or extra-ordinary meeting) held. This will normally be chaired by IC or SPA
Decision is taken on whether the criteria is met
7. If agreed, the BM will formally notify OFSTED, DfE and the National SCR PANEL of the decision
8. A confirmation letter will be sent to agencies confirming decision of panel and to confirm all files should be secured. The leads should ensure that staff who have been directly involved are informed.
Lead Reviewer is commissioned
Six months
9. If a SCR is to be undertaken- within 10 working days, a scoping meeting to be held with key agencies. The scoping meeting will identify scope of review, methodology and SCR panel members.
10. All agencies identified to be involved in the review will be sent the draft terms of reference and a request that they submit the name of the author of their IMR.
11. Family are notified that a SCR is to be undertaken.
12. Agencies complete chronologies and IMRs if appropriate
13. Overview report produced
14. SCR panel develop action plan from recommendations and LSCB response to findings
15. LSCB approves final SCR
Dependent on any outstanding processes
16. Report, action plan and Board response sent to Ofsted, DfE and the National Panel a week before being made public.
17. LSCB publish the fully, un-redacted report, response and chair's statement