



Solihull Local Safeguarding Children Board

Serious Case Reviews

Practice Guidance

February 2011

Contents Page

Section 1	4
1.1 The purpose of serious case reviews	4
1.2 When should the Local Safeguarding Children Board	4
undertake a serious case review?	
1.3 Who can make a referral for a serious case review and.....	5
which LSCB has lead responsibility?	
1.4 How is a serious case review decided when a child has not died?	6
1.5 Instigating and conducting a serious case review	6
1.6 Timing and summary of the process	7
1.7 Will there be delays due to criminal proceedings?.....	9
1.8 Who should conduct reviews and who should be involved?	10
1.9 Data security.....	10
Section 2	11
2.1 Scoping a Serious Case Review	11
2.2 Agreeing Terms of Reference	13
2.3 Contacting OFSTED/Department of Education	13
Section 3	14
3.1 Process for Appointing an Independent Overview Chair and Overview Author.....	14
Section 4	15
4.1. SCR Panel Role and Responsibilities	15
Section 5	16
5.1 Agency Notification.....	16
Section 6	17
6.1 Involving Families	17
6.2 Involving victims	17
6.3 Staff Care and Supervision	18
Section 7	19
7.1 Timescales	19
7.2 Delay	19
Section 8	19
8.1 Impact of Freedom of Information Act	19
8.2 The Criminal Procedure and Investigations Act 1996	21
Section 9	21
9.1 Criteria for Appointment of IMR Author	21

9.2 Briefing for Authors of Individual Management Reviews.....	22
Section 10.....	23
10.1 Individual Management Reviews (IMR's).....	23
Section 11.....	24
11.1 IMR Authors Interviewing staff and staff care.....	24
Section 12.....	26
12.1 Presentations of Individual Management Reviews to the SCRP.....	26
Section 13.....	26
13.1 Writing the Overview Report.....	26
13.2 SCR Panel Responsibilities for the Overview Report.....	27
13.3 The Executive Summary.....	28
Section 14.....	29
14.1 Finalisation and Adoption of the Serious Case Review Report.....	29
Section 15.....	30
15.1 Retention of papers.....	30
Section 16.....	31
16.1 Communication Strategy.....	31
16.2 Debriefing and Dissemination.....	32
Section 17.....	33
17.1 Implementation and monitoring of the Action Plan.....	33
Section 18.....	33
18.1 Learning Lessons on Process.....	33
Appendices.....	34
Appendix 1: Consideration Of Case For Serious Case Review – Referral.....	35
Form SCRRF.v1/2010	
Appendix 2: Letter advising of a serious case review request to LSCB agency members – let SCR Request .v1/2010.....	41
Appendix 3: Leaflet for parents.v1/2010.....	43
Appendix 4: Letter of invitation to Authors briefing –.....	46
let - Author.IMRv1/2010	
Appendix 5: Letter for Commissioning Individual Management.....	47
Reviews – Let –comissionIMR.v1/2010	
Appendix 6: Standard format for an Individual Management Review.....	49
(IMR) – Format – IMR.v1/2010	
Appendix 7: Chronology Template – Chronology.v1/2010.....	54
Appendix 8: Interview format – Interview.v1/2010.....	55
Appendix 9: Overview Report Communications Plan – comm. Plan.v1/2010.....	57

Appendix 10: Letter of Invitation to a Practitioners De-Briefing – Letter	58
Pract.De-briefing.v1/2010	
Appendix 11: Flowchart - (Performance Management Plan and Timescales)...	59
Appendix 12: OFSTED Descriptors	61
Appendix 13: Action Plan Template	69
Appendix 14: IMR Author Guide	70
Appendix 15: Guidance on drawing a genogram.....	77
Appendix 16: Competence framework for serious case review independent authors and serious case review independent chairpersons.....	80

Section 1

1.1 The purpose of serious case reviews

1.1.1 A Serious Case Review should be conducted where a child has died or been seriously injured as a result of abuse or neglect or suspected abuse or neglect. The purpose of a Serious Case Review 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;
- to 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
- to improve intra-and inter-agency working and better safeguard and promote the welfare of children.

1.1.2 Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate

1.1.3 In order to maximise learning, the child's experiences and perspective should be at the centre of the Serious Case Review.

1.2 When should the Local Safeguarding Children Board undertake a serious case review?

1.2.1 When a child dies, (including by suicide) or is seriously harmed **and** abuse or neglect are known or suspected to be a factor, LSCB organisations should immediately consider:

- Are there other children at risk of harm who require safeguarding?
- Are there any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children?

1.2.2 Consequently, when a child dies in such circumstances, the LSCB will **always** conduct a Serious Case Review into the involvement of organisations and professionals with the child and family. These Serious Case Reviews 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 Serious Case Review should always be carried out when a child dies in custody, whether 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.

1.2.3 The LSCB will always consider conducting a Serious Case Review whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment or 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;
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004¹; 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.

1.3 Who can make a referral for a serious case review and which LSCB has lead responsibility?

1.3.1 Any professional may refer a case if it is believed there are lessons to be learned. (The Secretary of State for DCSF has the power to demand an inquiry under the Inquiries Act 2005.) In Solihull such referrals should be made to the LSCB Chairperson. **See Appendix 1 for the Referral form.** The LSCB Chairperson will convene a Serious Case Review Panel who will in turn advise if the threshold for a Serious Case Review is met as well to recommend the scope and terms of reference for the review.

1.3.2 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is 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.

¹ 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.

1.4 How is a serious case review decided when a child has not died?

1.4.1 To decide if an SCR is appropriate a number of questions can be asked including:

- Was there evidence of harm that was not recognised or not acted upon appropriately or not shared between organisations?
- Was the child abused or neglected in an institutional setting, or abused while being looked after by the local authority?
- Did the child suffer harm after going missing, or during an unauthorised absence from an institution?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers
- Does one or more agency or professional consider its concerns were not taken seriously or acted upon appropriately?
- Had the child been subject to a safeguarding or child protection plan?
- Are there implications for several agencies or indication that procedures have failed, not been understood or not acted upon appropriately?
- Are there indications that the case may have national implications or that it is in the public interest to undertake a SCR.

1.5 Instigating and conducting a serious case review

1.5.1 Does the case meet serious case review criteria?

1.5.2 If the SCR criteria are not met, it may still be valuable to conduct individual management reviews or a small-scale audit of the individual case that gives rise to concern. The Chair of the LSCB is advised by the Serious Case Review Panel but is ultimately responsible for deciding whether or not to conduct a Serious Case Review.

1.5.3 How is the scope of the review determined?

1.5.4 The SCR Panel comprising at least of representatives from local authority children's social care, health, education and the police will decide the scope and terms of reference of the review and will appoint an independent author for the overview report and an independent Chair for the Panel. Scoping the review will help the panel plan when

the review will start and finish. The scope of the review is determined by:

- The period of time and the extent of the family history to be reviewed
- Who/which agencies should contribute to the review and how family members will contribute to the review and consideration should be given as to whether any relevant information is available via social networking sites and / or other forms of digital technology
- Parallel investigations (e.g. homicide, criminal, coroner's inquest)
- The need to consider needs and issues arising from the ethnic, cultural, linguistic and religious background of the child and family, and those relating to the disability of the child and/ or other parties.
- Decisions to involve other LSCBs and non-statutory organisations
- The need to take account of lessons learnt from research and from other serious case reviews
- Managing the public, the family and media interest - before, during, and after the review and whether the LSCB will need legal advice.

1.5.5 The LSCB Chair should ensure that the terms of reference address the key issues and is responsible for approving them.

1.5.6 NB. Sometimes SCR terms of reference and/or the status of the review will need revising as new information emerges – e.g. the outcome of a coroner's court enquiry may find that a child's death was accidental, and abuse or neglect were not factors. In such cases the decision may be that individual agency management reviews are more appropriate than a serious case review.

1.6 Timing and summary of the process (see Appendix 11 – Flowchart)

1.6.1 Every review will be different but lessons should always be learned and acted upon as quickly as possible without necessarily waiting for the SCR to be completed. Once it is known that a case is being considered for review, each organisation should secure paper and electronic records relating to the case and guard against loss or interference. The timetable set out below shows how the process is conducted from the point at which the LSCB becomes aware a review needs to be considered.

1.6.2 First Week

- The referral is received and Ofsted and Department of Education* are notified by LSCB Administrator of the incident
- The Serious Case Review Panel is convened to consider the facts of the case and recommend if the SCR criteria are met
- Agency records are secured and practitioners are informed of the death/incident relating to a child on their caseloads
- An immediate multi-agency media strategy may be required and agreed dependent on the nature of the case, media interest and the public response

1.6.3 Second and Third Weeks

- The Chair of the LSCB is advised by the SCR Panel and decides if the criteria are met and whether to invoke a Serious Case Review
- Ofsted and Department of Education* are notified of this decision
- Agencies are notified of the decision and instructed to ensure that records have been secured
- Independent Chair and Independent Author appointed and Panel identified
- Scoping Meetings to establish Terms of Reference

1.6.4 By the end of the Fourth Week

- Letters to all agencies sharing Terms of Reference and requesting that IMR authors are identified; and that they begin to prepare their work on chronologies and IMRs
- Agencies to keep practitioners updated on the decision and procedures
- Family/victims notified of SCR process

1.6.5 Fifth and Sixth Weeks

- Any media/publicity arrangements that are required are put in place
- IMR authors briefing

* Mailbox.CPOD@education.gsi.gov.uk

- IMR authors begin to prepare the IMRs and chronologies via file reading, staff interviews, etc.

1.6.6 Over the next four months

- The Panel considers individual management reports, merges the chronologies; involves the child's family; comments on drafts of the Overview Report; and makes recommendations for future practice, training, management and resources and produces a draft Action Plan
- A draft of the Overview Report and Action Plan is shared with agency representatives on the SCR.P.

1.6.7 In the last month

(N.B. the Serious Case Review must be completed within 6 months from the date of the decision to proceed)

- The LSCB approves the final SCR that is, the IMR reports, the Overview Report, the Executive Summary and the Action Plans (single and multi agency) and agrees how the report will be made public. At this stage LSCB agencies should agree on the timetabling for implementation, monitoring and audit of Action plans.
- The SCR is submitted to Ofsted, the SHA and Department of Education

1.6.8 Reviews should ideally be completed within six months from the date of the decision to proceed unless an alternative timescale is agreed by the LSCB.

1.7 Will there be delays due to criminal proceedings?

1.7.1 In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the SCR Panel should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings.

1.7.2 The Department of Education* should also be advised where known, of expected dates of court proceedings related to child protection incidents and the outcomes of court cases including verdicts and sentencing.

* See footnote on page 8

1.8 Who should conduct reviews and who should be involved?

1.8.1 The initial scoping will determine which agencies or individuals should contribute to the review. As new information emerges, for instance through ongoing or related criminal proceedings, the original scoping of contributors may need to be revised. Each relevant service should undertake a separate management review of its involvement with the child and family. The initial scoping of the review will identify who will contribute reports - including independent professionals, such as GPs. If a child's guardian is to contribute, the courts must first waive the legal duties of confidentiality. Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have integrated together. The health overview report will constitute the IMR for the PCT as commissioners.

1.9 Data security

1.9.1 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the final SCR report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, SCR Panel Chair and the overview report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted, the Department of Education) and prior to being made a public document.

1.9.2 In order to promote compliance with Data Protection Legislation, the LSCB will communicate with agencies via a secure email address. Agencies are expected to also be able to communicate with the LSCB via a secure email address. In the absence of a secure email address, the LSCB and agencies involved in the SCR will communicate via password protected emails ensuring any data is anonymised. Agencies can also hand deliver completed IMR's to the LSCB Administrator via a data storage mechanism e.g. Memory stick.

1.9.3 The process of conducting an IMR requires access to records relevant to the child such as those from the health bodies. The public interest served by the SCR process warrants full disclosure of all relevant information within the child's own records. In some circumstances the person conducting the IMR may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both

necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under NHS or in the independent or voluntary sector.

Section 2

2.1 Scoping a Serious Case Review

2.1.1 The following matters must be jointly considered by the SCR Panel and agreed by the LSCB Chair in the event of a Serious Case Review.

- 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 would 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 diversity or equality issues that need to be address including; ethnicity, disability, religion and impact of poverty?
- 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 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 their LSCB areas 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 and as the Independent Chair of the SCR Panel.
- 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 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 provisions of healthcare should be co-ordinated with a SCR.
- 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 and public 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?
- How should any members of staff be interviewed?

- Are there implications in respect of disciplinary proceedings, is an HR perspective required and are there implications for staff being interviewed?
- How should any media interest be handled, before, during and after the review? In cases where there is likely to be media interest it is particularly important to have a strong media strategy in place that is understood and agreed by both the LSCB and the respective Press Offices. A meeting of the Chair and Press Officers and legal representatives should be arranged at an early stage in the review and then towards the conclusion of the review – or at any other point where it seems sensible to do so, e.g. the conclusion of a trial, a Coroner’s inquest etc.

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

2.2 Agreeing Terms of Reference

2.2.1 Better outcomes can be achieved if all the Individual Management Reviews address the same questions and issues, pertinent to the Case Review being undertaken. These should be formulated as case-specific Terms of Reference.

2.2.2 Time spent on this part of the process is crucial and will affect the quality of Individual Management Reviews and ultimately, lessons arising from the Overview Report. The development of Terms of Reference is time intensive and may take the SCRP two or three meetings to achieve.

2.2.3 Initial Terms of Reference drawn up following discussion within the SCRP need to form part of a consultative process, during which representatives on the SCRP share them with the relevant officers within their own organisations.

2.2.4 As the Terms of Reference go through several re-writes, a date on each draft version is vital (use of footer).

2.2.5 The Terms of Reference are finalised once the LSCB Chairperson has approved them.

2.3 Contacting OFSTED/Department of Education

2.3.1 Local Authorities should notify Ofsted and the Department of Education* of serious incidents involving children which:

* See footnote page 8

- fall within the criteria under which a LSCB should always conduct a serious case review (*Working Together to Safeguard Children*, paragraph 8.10)
 - fall within the criteria under which a LSCB should consider conducting a serious case review (*Working Together to Safeguard Children*, Paragraph 8.11) as well as
 - Other cases which have attracted or are likely to attract significant media attention.
- 2.3.2 Ofsted should also be notified of Serious Incidents involving children because of concern about professional practice or implications for Government policy; or that raise issues about a council's professional practice that may need to be considered further in the context of performance assessment;
- 2.3.3 Ofsted's National Business Unit (NBU) will be the contact point for notifications and can be reached by telephone 0846 40 40 40. The NBU will support Local Authorities and/or LSCB's through the notification process.
- 2.3.4 Notification forms returned by post should be sent to: Ofsted, National Business Unit, 3rd Floor, Royal Exchange Buildings, St Ann's Square, Manchester, M2 7LA.
- 2.3.5 The Department of Education* should also be informed of the decision to initiate SCRs, dates of SCR completion and submission to Ofsted for evaluation; plans for publication of executive summaries and (where appropriate) overview reports; and actual publication dates. Paragraph 1.7.2 also sets out the information required by the Department of Education in respect of court proceedings.

Section 3

3.1 Process for Appointing an Independent Overview Chair and Overview Author

- 3.1.1 The Chair of the 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 someone from another LSCB which is not involved in the SCR or from an agency which is not involved in the case. The overview report author should not be the chair of the LSCB or the SCR Panel.
- 3.1.2 The Chair of the LSCB has responsibility for ensuring suitable candidates and the LSCB has agreed a set of requirements that will be used to commission Independent Authors and SCR Panel

Chairpersons. A copy of the requirements can be found at Appendix 16.

3.1.3 Confirmation will also be sought that the individual has:

- Professional indemnity cover;
- Access to supervision and
- Operates to manage information in accordance with Data Protection legislation.

3.1.4 Once the appointments are agreed, contracts outlining terms and conditions will be sent to the Overview Author and Independent Chair. The contracts will specify the tasks required e.g. writing of Overview Report, production of Executive Summary and Chairing the Panel. Sample contracts can be found at Appendix 16.

Section 4

4.1. SCR Panel Role and Responsibilities

4.1.1 The Serious Case Review Panel (SCRCP) will have the following Responsibilities:

- Draft Terms of Reference for each SCR which will be subject to consultation and agreed by the Chair of LSCB.
- Commission Individual Management Reviews and draw up clear Terms of Reference including timescales.
- Give adequate consideration to the impact of parallel processes e.g. criminal investigations, disciplinary procedures and advise the LSCB accordingly.
- Ensure that the identified Chief Executive Officers in each organisation are aware of the IMR/SCR and that the Individual Management Review is signed off by the agency.
- Ensure the quality of the IMR's against the OFSTED descriptors; if necessary this may require IMR's to be re-worked or revised; and where there are disputes, resolution may need to be at a senior level.
- SCRCP will consider the wider issues of accountability and publication. The panel will identify who might have an interest in SCR's and consider what information should be made available to each of these interested parties. The advice and guidance of the associate members of the SCRCP: Communications staff, Legal Services, Information and Clinical Governance staff will be of value in these discussions.

- SCRP will ensure that an Overview Report, with recommendations for action and an action plan are produced which bring together the information and analysis contained in IMR's together with reports commissioned from any other relevant parties, using an outline that clearly reflects both guidance in Working Together 2010 and the agreed Terms of Reference.
- Ensure the timely production of an anonymised Executive Summary.
- Develop and co-ordinate a communications strategy to ensure that the lessons learnt from SCR's can be shared and made public.

4.1.2 The Review Panel will also have reporting responsibilities and will fulfil these by:

- Chair of the LSCB identifying a member of SCRP who will have responsibility to notify OFSTED and other inspectorates when a decision is made to undertake a SCR.
- Identified member of SCRP to provide monthly update of SCR's to LSCB Chair including progress and planned dates for completion.
- Identified member of SCRP to ensure that LSCB and Chief Executive Officers of relevant organisations are briefed about the work of the SCRP on a regular basis.
- Identified member of SCRP to consult about revised timetable with Ofsted where SCR's cannot be completed within 6 months.

Section 5

5.1 Agency Notification

5.1.1 Once a referral for a SCR has been received, the LSCB chair will, within 1 working day, send a copy of the referral form, with a standard letter (**See letter let SCR Notification.V1/2010 Appendix 2**) to all core members of the LSCB and to any other agencies where there is any indication that they may be involved in the case[^]. This requires agencies to seal their files and to confirm if they have had any contact with the child or family and briefly outline their knowledge of the case.

5.1.2 Letter SCR Request.v1/2010 should be copied to Chief Officers of LSCB Agencies and to Chief Officers of other organisations where

[^] NSPCC record checks including Helpline and Childline Services are conducted centrally and a form to complete the check should be requested via LSCBteam@NSPCC.org.uk

there is knowledge to indicate that they may have had involvement. This includes agencies out of the country.

- 5.1.3 PCT commissioners should ensure their Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified of the decision of the LSCB Chairperson as to whether a Serious Case Review should be carried out. The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).

Section 6

6.1 Involving Families

- 6.1.1 Working Together (2010, Chapter 8), urges LSCB's to consider the degree to which they involve families in Serious Case Reviews, and who should be responsible to facilitate this. Each case is unique and it is therefore important that careful consideration is given to the best means of notifying families.
- 6.1.2 Involvement can range from formal notification only, to inviting them to share their views with the Overview Author in writing or through an interview. These questions will form part of the discussions when the SCRP is drawing up its Terms of Reference for the particular Serious Case Review.
- 6.1.3 Normally families (this is usually family members who have played a significant role in the child's life, such as parent(s) and grandparent(s)) should be notified that the Serious Case Review is taking place. This is best done by a short letter enclosing an information brochure as detailed in **Appendix 3 (Leaflet-parents.v1/2010)**. This letter should be sent either directly to the family members or via their solicitor(s) or hand-delivered by someone with a good rapport with the family, as seems most appropriate given the particular circumstances. The timing of such notifications is crucial particularly where there are ongoing Police investigations. Under these circumstances, the decision about when to notify needs to take place within the SCRP, with the Police representative present.

6.2 Involving victims

- 6.2.1 Each case is unique and it is therefore important that careful consideration is given to the best means of notifying victims. For example, where the review concerns historical abuse and the child is now a young person or adult, a sensitively handled notification can be a positive experience, allowing some sort of "closure". This can be

achieved through them being informed of the process and helped to understand the issues raised.

- 6.2.2 Consideration will need to be given as to how the Executive Summary and Overview Report will be shared. It may be appropriate, depending on the age and understanding of the child/adult, for this to be done in person, rather than by letter.

6.3 Staff Care and Supervision

- 6.3.1 The impact upon workers of being involved in a SCR must be taken seriously by their employing agency and they will have responsibility for ensuring appropriate support is made available to staff. Support should be considered for:-

- a) Practitioners who worked with the child/family
- b) Frontline Managers responsible for overseeing the service provision
- c) IMR Authors
- d) SCR Panel Members

- 6.3.2 Supervision should also be used to promote reflective practice or development issues that will need to be addressed via continuing professional development for practitioners or front line managers.

- 6.3.3 Supervision and management support should be provided to IMR Authors by the employing agency to promote an open and critical review of individual and organisational practice. The IMR should be quality assured by the Senior Officer in the organisation who has commissioned the report and the findings accepted. The Senior Officer will be responsible also for ensuring that the recommendations of both the IMR & where appropriate the Overview Report are acted on.

- 6.3.4 Supervision and management support should also be provided by the employing agency to SCR Panel Members to promote an objective and open review of learning. Any member of the SCR Panel is able to discuss any concerns re: the work of the SCR with a Senior Officer in their organisation.

- 6.3.5 As part of the commissioning of the SCR Chairperson and Independent Overview Report Author, the LSCB should assure itself that these individuals have in place a system to access appropriate professional support so as to enable to deliver their roles effectively.

Section 7

7.1 Timescales

- 7.1.1 Given that the primary purpose of Serious Case Reviews is to contribute to the improvement of inter-agency practice, the SCRPs should ensure that lessons are learned and acted upon as quickly as possible (Working Together, 2010, 8.22)
- 7.1.2 Working Together (8.22) states that “within one month” of a case coming to the attention of the LSCB Chair, the decision should have been made by the LSCB Chairperson, as to whether a review should take place.
- 7.1.3 The Serious Case Review should be completed within a further 6 months unless an alternative timescale is agreed by the LSCB.
- 7.1.4 The SCRPs will ensure a written timeframe/project plan is established to promote compliance with statutory timescales.

7.2 Delay

- 7.2.1 Sometimes the complexity of a case does not become apparent until the review is in progress. If it emerges that the SCR cannot be completed within six months, the LSCB should revise its timetable. Where an extension beyond the six month timeframe is necessary the LSCB should inform Ofsted of the new completion date and of the reason for the extension.
- 7.2.2 The SCRPs should review progress against the written timeframe/project plan at each meeting and consider any factors that may impact on timescales e.g. parallel investigation. Any deviation from the original written timeframe should be brought to the attention of the LSCB at the earliest opportunity.

Section 8

8.1 Impact of Freedom of Information Act (FOIA)

- 8.1.1 Under the FOIA any person has the right to make a request for information held by a public authority.
- 8.1.2 The statutory members of the LSCB are subject to the provision of the Act and should have procedures for dealing with requests. Any organisation receiving a Freedom of Information request concerning a Serious Case Review should discuss this with the SCRPs Chairperson.

- 8.1.3 The Act recognises that there are grounds for withholding information and provides a number of exemptions from the right to access; some of which are subject to a Public Interest test.
- 8.1.4 Information held and/or gathered by agencies for the purpose of a Case Review may fall within one or more of the following exemptions:
- Investigations and proceedings conducted by public authorities (e.g. a criminal investigation);
 - Court records;
 - Health and safety (disclosure would be likely to endanger the physical/mental health/safety of an individual);
 - Personal data*
 - Information provided in confidence (disclosure would constitute a breach of confidence).
- 8.1.5 Some exemptions are absolute, others are qualified – requiring a balancing exercise to be carried out before a decision is made as to whether to disclose.
- 8.1.6 Agencies should consult their Information Officer or take legal advice if in any doubt as to whether an exemption applies.
- 8.1.7 As part of planning for public release of information, the SCR must consult with the Information Manager of ALL relevant agencies for advice.
- 8.1.8 NB Requests by an individual *involved with* the Case Review, for information concerning themselves would be dealt with in accordance with the Data Protection Act.
- 8.1.9 The Overview Report will be published in full unless there are compelling reasons relating to the welfare of any children/young people directly concerned in the case for this not to happen. The Executive Summary will also be published on the LSCB website once issues raised by Ofsted's Evaluation of the SCR have been addressed.
- 8.1.10 SCR Overview Reports contain personal information relating to surviving children, family members and others. The content of the SCR overview report should comply with the requirements of the Data protection Act 1998 when publicised. The LSCB should also be mindful of other restrictions on publication of information, for example Court orders, and should take independent advice if in any doubt on compliance with the law.

** defined in Data Protection Act 1998 as “Data which relates to a living individual who can be identified from those data and any other information in the possession of or likely to come into the possession of the data controller – which includes opinions about the individual and indications about intentions in respect of the individual.”*

8.2 The Criminal Procedure and Investigations Act 1996

- 8.2.1 This Act gives detailed guidance to Police and Prosecutors regarding disclosure of material to the defence in criminal proceedings.
- 8.2.2 There are times when a Serious Case Review is being conducted simultaneously with criminal proceedings. On the rare occasion when information comes to light during the Serious Case Review process, that may undermine the prosecution case, the prosecutor has a duty to disclose this to the defence.

Section 9

9.1 Criteria for Appointment of IMR Author

- 9.1.1 Each agency must appoint as its Author a person of sufficient seniority to be able to work at all levels within the agency. The Author must be fair in the way that the views of staff are represented. The Author appointed should be familiar with current child protection practice and is expected to produce an independent and objective report within prescribed timescales in accordance with national guidance.
- 9.1.2 The Author will not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.
- 9.1.3 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. The senior officer will be responsible also for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.
- 9.1.4 The Author acts as the representative for an organisation in its interface with the SCRP.
- 9.1.5 The Author should have unrestricted rights of enquiry and access to staff records and files. It is envisaged that the Author will wish to interview staff who are central to the case. Staff who wish to be interviewed should be offered this opportunity by the Author.
- 9.1.6 The Author should confirm that the relevant staff within their agency have been informed of the purpose of the Individual Management

Review and the process leading to the Serious Case Review.

- 9.1.7 The Author should ensure that all files relating to the child/family are secured, preferably under lock and key, to ensure information is not lost. The Author should be empowered to demand appropriate security measures are taken. If the case remains open then a full copy of the file should be made for the operational staff and the original file secured. All files should be made available to the Author.
- 9.1.8 The compilation of the Individual Management Review report will create a significant extra workload. The Author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the Individual Management Review report within the strict timescale. The Author should receive appropriate clerical support throughout. It is the agency responsibility to ensure the IMR author receives appropriate supervision and support throughout this process. It is important to recognise that the Author may need to be relieved of all their normal duties for the period the Individual Management Review report takes to compile.
- 9.1.9 Appropriate extracts of the IMR should be shared with workers involved with the case to ensure the report is factually correct prior to submission.

9.2 Briefing for Authors of Individual Management Reviews.

- 9.2.1 The aim of the Authors Briefing is to reach agreement about how best to achieve a well-integrated and coherent Serious Case Review. In reaching such agreements it is important:
- To explain the process, what is expected and in particular to emphasise the purpose of the SCR is to learn lessons;
 - To ensure that authors understand the Terms of Reference for the Serious Case Review. It is crucial that the Terms of Reference are meaningful and workable for authors;
 - To agree the format for Individual Management Reviews
 - To agree that comments made and conclusions reached within all reports need to be evidenced;
 - To raise awareness about the possible need to seek legal advice in the preparation of author's reports;
 - To stress the importance of meeting agreed deadlines for the submission of their reports to the SCR Panel;
 - To ensure that single agency authors understand the purpose and value of individual presentation of their report to the SCR.

9.2.2 Additional benefits of the Authors Briefing are:

- All authors meet each other in a supportive, informal environment;
- A face-to-face meeting ensures everyone hears the same message. Confusions/questions/queries can be dealt with on the spot;
- It offers a chance to dispel myths and anxieties about the Serious Case Review process;
- It enables a timetable to be set for the sequential presentation of reports to the SCR on an agreed day.

9.2.3 A standard letter of invitation can be found at **Appendix 4** and IMR Authors will also be given a written guide (**Appendix 14**) and guidance on producing genograms (**Appendix 15**).

Section 10

10.1 Individual Management Reviews (IMR's)

10.1.1 Individual Management Reviews will be commissioned using a standard letter (**Let –comissionIMR.v1/2010 Appendix 5**) from the organisations involved with the child and family throughout the period of the review agreed as part of the Terms of Reference and will usually include the following organisations:

- Health;
- Social Care;
- Police;
- Education.

10.1.2 The SCR Panel will provide guidance on what information is required from organisations. Organisations may wish to seek advice from their own legal advisors if they are unclear about information sharing. (e.g. information on parents)

10.1.3 The aim of IMR's is 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.

10.1.4 On receipt of **Let –comissionIMR.v1/2010 Appendix 5**, the Designated LSCB representative of the agency will need to identify the author of the IMR.

10.1.5 The author should be a senior member of staff who has not had any direct involvement with the case. Agencies can decide to appoint an independent author, which would be at their own expense.

10.1.6 As part of the enquiry to enable the IMR to be completed, the author will need to consider the following information:

- Case Records;
- Other staff recordings e.g. diaries/pocket book and supervisions;
- Although the files should be sealed on receipt of **Appendix 1 SCRRF.v1/2010**, the author can ask staff to provide complimentary information through a personal statement. However, when completing the review the author should give most weight to contemporaneous recordings and clearly identify retrospective recordings.

10.1.7 IMR's must be prepared using the agreed format (**Appendix 6**) and this will include an agreed chronology template (**Appendix 7**)

Section 11

11.1 IMR Authors Interviewing staff and staff care

11.1.1 All staff who have been involved with the case and their Line Managers must be informed in writing at the earliest possible stage of the nature, scope and timescale of the Serious Case Review by their agency. Staff must also be given an explanation of the rationale for securing their case records. Information should be included in any letter about sources of confidential and independent support that staff may wish to use in connection with their involvement in the SCR, e.g. professional associations, Staff Support Schemes, Council Welfare, Occupational Health, etc.

11.1.2 Good practice indicates that “team” briefings are a very helpful way of conveying information and offering support to the practitioners involved, and also to their colleagues. Similarly, debriefings on completion of an IMR report as well as at the end of the SCR should be instituted in order to confirm and share the learning of the Serious Case Review and any arising implications for practice, training, etc. Throughout the process of the Serious Case Review staff should be updated with the timescale, any media interest, etc.

11.1.3 Staff members providing information and attending interviews about their role and actions in relation to the case should, wherever possible, be given at least 2 weeks notice of the interview and invited to be accompanied by a colleague (though not one who is also directly involved in the review) or their trades union or professional association representative. Each constituent agency of the LSCB will need to

determine their own policy on supporters (e.g. if the interviewee requested a lawyer).

11.1.4 Arrangements must be made during these 2 weeks for the interviewee to have access to case files (which have already been secured and are located with the IMR Author) in order for them to refresh their memory of their involvement (which may well extend over many years); or a copy of the file is to be sent to them in order for them to prepare for the interview.

11.1.5 The interview must be conducted in appropriate venues, i.e. confidential and soundproofed, offering hospitality, etc.

11.1.6 Such interviews should be recorded in writing (either in note form or verbatim) and a transcript (or notes) subsequently sent to the interviewee to be approved for accuracy and signature, and a copy sent to them for their records.

11.1.7 The matters likely to be covered in interview include:

- a. Their knowledge of the history of the case, the child(ren) and family prior to the individual's involvement.
- b. Their specific involvement in the case.
- c. Their knowledge of the agency's policy and procedures in relation to child care and child protection.
- d. Their knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to Child Protection Conferences.
- e. The methods used to relate to and communicate with other professionals in the case.
- f. The individual's record keeping.
- g. The supervision the individual received.
- h. The individual's feelings about the case, the parent, step-parent or child and how those feelings were dealt with in supervision.
- i. The range of training both within and outside the agency in the last two years.
- j. Whether the agency can learn lessons from the experience.
- k. Looking back, what the individual would now do differently.
- l. What lessons the individual can learn from the experience.

11.1.8 For an Interview format see **Appendix 8**

Section 12

12.1 Presentations of Individual Management Reviews to the SCRP

12.1.1 Once Individual Management Reviews are completed they will be circulated to all members of the Serious Case Review Panel, the Panel Chair and the Overview Author by the LSCB Administrator 2 weeks before the presentation meeting.

12.1.2 Key Features of the Presentation Meeting are:

- Individual Management Review authors will present their reports to the SCRP and Overview Author and Chair sequentially throughout the day;
- Authors are invited to identify the key findings of their work;
- The meeting provides the Overview Author and Chair and the SCRP with an opportunity to engage in a dialogue with Single Agency Management Review Authors in order to “make sense” of issues central to the Case Review;
- It also provides the opportunity to deal with omissions, questions, and queries arising from the different reports or between different reports/chronologies;
- It is the first point at which key inter-agency practice issues begin to emerge.

Section 13

13.1 Writing the Overview Report

13.1.1 The core information upon which the Overview Report is based arises from Individual Management Reviews and the discussion of emerging practice issues within the SCRP. The Overview Report is expected to identify any significant discrepancies between those reports or perspectives (in fact or analysis) and seeks to reconcile them through discussion with authors and within the SCRP.

13.1.2 The Overview Report will address the issues identified in Chapter 8 of Working Together (2010) and case-specific issues from the agreed Terms of Reference. Guidance on the format of the Overview Report can be found at Paragraph at 8.40 of Chapter 8 of Working Together (2010).

13.1.3 It is vital that recommendations in the Overview Report are few, focussed and achievable.

13.1.4 When the Overview Author has produced the first draft report, this will normally be presented to the SCR Panel for discussion and comment. This discussion aims to enable the Overview Author to place his/her analysis in the current context of inter-agency work, thus increasing the likelihood of helpful recommendations for action. The final Overview Report however, should reflect the independent view of the author.

13.1.5 Several drafts may be produced and discussed before the report is finalised for endorsement by Solihull LSCB.

13.1.6 The SCR Panel MUST ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report; to achieve this the final draft of the report should be distributed to IMR authors' who must confirm that the report fully and fairly represents their information.

13.2 SCR Panel Responsibilities for the Overview Report

13.2.1 The SCR Panel should:

- ensure that it actively manages the SCR process, seeking legal advice as necessary, so that the findings from other relevant processes such as care or criminal proceedings, an inquest or inquiry/investigation are incorporated into the SCR report;
- ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report;
- ensure that the Overview Report is of a high standard and is written in accordance with this guidance; and also with Ofsted Descriptors
- commission and agree the content of the executive summary, ensuring that it accurately represents the full SCR, includes the action plan in full and is fully anonymised apart from including the names of the SCR Panel Chair and the overview author and the job titles and the employing organisations of all the SCR Panel Members;
- translate recommendations into an action plan that should be signed up to by the senior manager in each of the organisations which will be involved in implementing the action plan. The plan should set out who will do what, by when, with what intended outcome and how success will be measured. The plan should set

out the means by which improvements in practice/systems will be monitored and reviewed;

- clarify to whom in which agencies or organisations the overview report and executive summary and the action plan of the SCR should be made available to support implementation of the recommendations and the learning of the lessons; and
- make arrangements to provide feedback and debriefing to the child (if surviving) and family members/carers of the subject child as appropriate, following completion of the executive summary and overview report.

13.2.2 The SCR Panel, on behalf of the LSCB, should quality assure the final SCR – that is, the IMR reports, the overview report, the executive summary and the action plan.

13.3 The Executive Summary

13.3.1 It is expected that an Executive Summary will be commissioned that accurately reflects the full overview report. The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. Guidance on the format of the Executive Summary can be found at Paragraph 8.42 of Chapter 8 of Working Together (2010).

13.3.2 The primary purpose of the Executive Summary is to set out the key elements in the Case Review, namely;

- The purpose and scope of the Case Review;
- An outline of the Review Process, including the organisations involved in providing information;
- A brief outline of the circumstances which led to a Case Review;
- A succinct account of key issues arising from the case;
- Intended actions including any actions that have been completed.

13.3.3 The Executive Summary can be used in the following way:

- A demonstration of the way in which the LSCB has exercised its responsibilities in relation to death or injury of child/children; including reassuring the public that lessons have been learned and actions taken;
- A basis for press briefings should the Serious Case Review

process attract media attention.

- An efficient means of informing Chief Officers and the inter-agency practice community of key learning arising from the review of practice;
- Core information upon which to build more elaborate case specific training materials.

13.3.4 The Executive Summary is completed by the Overview Author. A draft should be circulated to the SCRCP for comment before final endorsement by the LSCB.

13.3.5 Copies of all reports should be marked as draft until approved.

13.3.6 The LSCB should decide when to publish the executive summary and overview report and this decision should take account of the timing of the conclusion of relevant court cases and statutory processes as well as the need, where possible, to consider issues raised by Ofsted's evaluation of the full SCR.

13.3.7 The LSCB should inform the Department of Education and Ofsted of the date of the publication of the executive summary, and ensure that Ofsted receives a copy of the published summary within one month of receipt of the Ofsted evaluation letter. The final version of the executive summary should be sent to SCR.SIN@ofsted.gov.uk.

Section 14

14.1 Finalisation and Adoption of the Serious Case Review Report

14.1.1 The full SCR (IMR reports including action plans, the overview report including integrated chronology, the executive summary and the inter-agency action plan) needs to be formally adopted by Solihull LSCB. This will be preceded by a formal presentation of the report and draft action plan by the Chair of the SCRCP to the Board in conjunction with the Overview Report Author. The presentation will ensure that:-

- The LSCB is satisfied that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report;
- The recommendations and action plans are sufficiently robust to ensure learning from the case.
- Arrangements for dissemination of report are in place;
- As required, any media strategy is agreed on a multi-agency basis

in accordance with Solihull LSCB Procedures.

- 14.1.2 A central purpose of the adoption meeting is to allow discussion amongst Board members on the case and to secure their commitment at a Senior Officer level to implementing the report's recommendations according to the framework set out in it.
- 14.1.3 The LSCB will also need to ensure that information which becomes available from other processes, e.g. criminal trial, is considered by the SCR to review if it impacts on lessons to be learnt. If this is the case the SCR cannot be adopted until all information has been considered by the SCR and the LSCB will ensure that this does not prevent lessons from being learnt.
- 14.1.4 Once the LSCB has adopted the SCR and its recommendations, it is sent to the Performance Monitoring sub group to monitor implementation of action plans.
- 14.1.5 The LSCB will send copies of the full relevant SCR to Ofsted, the SHA, the Department of Education* and any other body depending on the nature of the case.

Section 15

15.1 Retention of papers

- 15.1.1 The sensitive nature of information contained within Individual Management Reviews and the Overview Report must not be underestimated. There is a balance to be kept between sharing information widely in order to increase participation, ownership and learning, and the appropriate management of personal and professional detail.
- 15.1.2 The following practice will, in most instances, minimise the chances of inappropriate disclosure.
- 15.1.3 SCR Members will:
- Treat all papers relating to the SCR's work as confidential;
 - Keep papers locked and secure during the process of a Case Review;
 - Once the final SCR has been agreed and its recommendations accepted at LSCB, SCR members will destroy all paper copies of the final report as the original will be kept by the LSCB Administrator.

* mailbox.scr@education.gsi.gov.uk

15.1.4 Each LSCB partner organisation will:

- Make arrangements for the secure retention of a single copy of their own Individual Management Reviews;
- Ensuring that all draft copies of the Overview Report are shredded;
- Once the final copy of the SCR has been agreed and its recommendations accepted at LSCB, LSCB members will destroy all copies of the overview report as the original will be kept by the LSCB Administrator.

15.1.5 The LSCB Administrator responsible for the SCRP will:

- Retain copies of all papers associated with a Serious Case Review for a period of 7 years;
- Provide access to papers through application to the Chair of the LSCB;
- Mark copies of all Overview Reports as draft until the report is approved and arrange for draft reports to be destroyed.
- Retain a copy of the full SCR on behalf of the LSCB.

Section 16

16.1 Communication Strategy

16.1.1 The LSCB will consider carefully who might have an interest in the outcome of reviews - for example elected and appointed members of authorities, staff, members of the child's family, the public and media – and how information should be made available to them.

16.1.2 In making these decisions the LSCB will consider the following:-

- 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 organisations and people involved;
- The responsibility to provide relevant information to those with a legitimate interest; and

- Constraints in sharing information when criminal proceedings are outstanding.

16.1.3 When developing a communication strategy the SCRP will need to consider the following:

- Key Messages
- Audience and stakeholders
- Communication channels to make public the lessons learnt.
- The need to brief inspectorates and relevant bodies in advance of the publication of the SCR
- Roles and responsibilities of key individuals;
- To identify which agency will provide a communication lead including the issuing of press releases on behalf of Solihull LSCB;
- Support offered to families;
- Briefing of staff on the contents of the report;
- Briefing of the families and those involved in the compilation of the report;
- Available resources for publication;
- Debriefing arrangements to those involved;
- The need for any media training.

16.1.4 **Appendix 9 Comm.Plan.v1/2010** provides a framework for developing a communication strategy.

16.2 Debriefing and Dissemination

16.2.1 The LSCB will arrange for practitioners directly involved in the case to receive feedback once the LSCB has approved the SCR in advance of wider dissemination. This will be in the form of a multi-agency practitioners de-briefing session and a standard letter of invitation can be found at **Appendix 10, Letter – Pract.De-briefing.v1/2010**.

16.2.2 Furthermore, the LSCB will ensure learning is incorporated into local training programmes.

Section 17

17.1 Implementation and monitoring of the Action Plan

17.1.1 As the purpose of SCR's is to learn lessons for improving both individual and inter-agency working, the LSCB will be required to have in place a robust system for implementation of the Action Plan as well as monitoring and auditing the actions of all agencies against recommendations and intended outcomes. To this end, a standardised Action Plan Template will be used which from the outset will set out clearly the action required, by whom, when, the measure of achievement as well as the evidence required and audit activity that will demonstrate that lessons have been learnt. The action plan template can be found at **Appendix 13**.

17.1.2 The LSCB should formally conclude the SCR Process by signing off the completion of the action plan.

Section 18

18.1 Learning Lessons on Process

18.1.1 After the IMRs, the Overview Report, the Executive Summary and the Action Plans have been submitted to Ofsted, a letter will subsequently be sent from the Regional Manager of Ofsted to the Chair of the LSCB. This letter will identify which Ofsted inspector carried out the grading of the SCR; it will confirm the overall effectiveness grading for the total SCR process; and it will then identify the individual gradings for each element of the SCR, i.e. the depth of learning evidenced by the review; the quality of the recommendations and the action plan; and the quality of the review process (for details of the Ofsted gradings see **Appendix 12**).

18.1.2 It is crucial that the Chair of the LSCB, the LSCB Business Manager and the Independent Chair and Independent Author of the SCR study and analyse this letter at the earliest opportunity; reflecting on all aspects of the Ofsted grading, and particularly highlighting good practice that has been identified. Furthermore, it may be deemed appropriate for the SCR panel to reconvene for this purpose.

18.1.3 Ofsted will always offer a discussion with the Inspector who has carried out the evaluation and the LSCB should ensure that the feedback from Ofsted is used to enhance capacity to learn lessons at a local level.

Appendices

Appendix 1	Referral form – SCRRF.v1/2010
Appendix 2	Letter advising of a serious case review request to LSCB agency members – let SCR Request .v1/2010
Appendix 3	Information for Family - Leaflet-parents.v1/2010
Appendix 4	Letter of invitation to Authors briefing – let - Author.IMRv1/2010
Appendix 5	Letter for Commissioning Individual Management Reviews – Let –comissionIMR.v1/2010
Appendix 6	Standard format for an Individual Management Review (IMR) – Format – IMR.v1/2010
Appendix 7	Chronology Template – Chronology.v1/2010
Appendix 8	Interview format – Interview.v1/2010
Appendix 9	Overview Report Communications Plan – comm. Plan.v1/2010
Appendix 10	Letter of Invitation to a Practitioners De-Briefing – Letter – Pract.De-briefing.v1/2010
Appendix 11	Flowchart
Appendix 12	Ofsted Descriptors
Appendix 13	Action Plan template
Appendix 14	IMR Authors Guide
Appendix 15	Guidance on producing genograms
Appendix 16	Competence framework for serious case review independent authors and serious case review independent chairpersons

**Appendix 1 – Consideration Of Case For Serious Case Review – Referral
Form SCRRF.v1/2010**

PART 1

(To be completed within 72 hours of incident by the Referring Officer).

1. Referrer

NAME		AGENCY	
EMAIL		LINE MANAGER	
PHONE No			

***Please fax# the completed form to:
Chair of LSCB. Fax number 0121 788 4414 or submit by secure email to
lscb@solihull.gcsx.gov.uk***

BRIEF RESUME OF FACTS AND FAMILY COMPOSITION

2. Child and Family

Name Of Child	
Date of Birth	
Date of death (If Applicable)	
Date of critical incident	
Home Address	
Ethnic origin	
Is/was subject to Child Protection Plan	YES/NO
Whereabouts at time of critical incident	
Carer at time of critical incident	

Please telephone 0121 788 4325 to advise confidential fax is being sent and to request confirmation it has been received.

3. Family composition/Significant Others

Name	Relationship to child	DOB	Address	Legal Status	Ethnic Origin	Is/was subject to CP Plan?

4. Other agencies involved

Name	Agency	Contact Details	Are they still involved?

5. Circumstances that triggered the referral

- a) Death of the Child including death by suicide, “and abuse or neglect is known or suspected to be a factor in the child’s death” (Working Together 2010, 8.9).
 - b) Potentially life-threatening injury (through abuse or neglect), serious sexual abuse, or serious and permanent impairment of health or development (through abuse or neglect) (Working Together 2010, 8.11)
 - c) The parent has been murdered and a homicide review is being initiated (Working Together 2010, 8.11).
 - d) The child has been killed by a parent with a mental illness.
- OR
- e) Concerns about Inter-Agency Working:

**Please outline events and circumstances relevant to the above category.
*The questions at paragraph 8.12 in Working Together 2010 will assist you in this task.***

7. Chronology of key dates

Date (& time where appropriate)	Event

NB: Agencies are reminded of the need to secure their files as soon as they become aware that a Serious Case Review might take place.

5. Date of Referral: _____

6. Signed: _____

PART 2 (to be completed by the Chair of the LSCB)

It is [recommended] [not recommended] that this case be subject to a Serious Case Review for the following reasons:

When a case does not meet the criteria for review, other options may be considered:

A Single Agency Management Review

Bringing practitioners/managers together through an independently facilitated learning day. The aim would be to focus on inter-agency practice processes to effectively support the identified complexities of the case

A structured inter-agency audit

Alternative processes suggested by the nature of the case

The following members of LSCB constituent agencies have been consulted:

Legal advice has/has not been sought.

I recommend that be approached to write the Overview Report.

Signed..... **Dated:**.....

PART 3 (to be completed by the Chair of the SCRП)

The Terms of Reference and scope of the SCR agreed by the SCRП are set out below:

Signed: **Dated:**

Appendix 2 – Letter advising of a serious case review request to LSCB agency members – let SCR Request .v1/2010

Name
Address1
Address2
Address3
Address4
Address5

Date:

Our Ref:

To: LSCB Agency Members
Other agencies where there is an indication they may have been involved.

Dear

RE: Request for Serious Case Review in respect of (*child's name, address, DOB/DOD*)

I am writing to you in my capacity as Chairperson of Solihull LSCB to advise that on (*insert date*) I received a formal referral to request that a Serious Case Review is commissioned in respect of the above child.

I am enclosing a copy of the referral form which details the reasons why a Serious Case Review is being requested.

I am required to make a decision within 1 month of the date of the request as to whether Solihull LSCB should undertake a Serious Case Review. In due course I will seek your views on this important matter.

In the interim, I ask that you immediately check your agency paper and electronic records to establish if (*insert Child's name*) or his/her family was known to your agency/service and if so to secure any paper and/or electronic records. If the case remains open then a full copy of the file should be taken and the original file secured

Clearly this is a distressing time for staff and in particular those who have had direct involvement in working with (*insert Child's name*) and his/her family. Can I ask that you advise staff with direct involvement with the family of the contents of this letter and explore any immediate support and/or practice issues that arise from the discussion.

Please can I ask that you confirm in writing whether your agency has had any involvement with (**child's name**) and/or his/her family by (**give 3 working days**). Where you have had involvement, please can I ask that you also confirm that you have secured all paper and electronic files.

Please respond to Safeguarding Children Business Manager at Solihull Local Safeguarding Children Board, Bluebell Centre, West Mall, Chelmsley Wood, Solihull, B37 5TN or via lscb@solihull.gcsx.gov.uk and where your agency has not had any involvement with the family a NIL return is required.

Thanking you in anticipation

Yours sincerely

(Authors name)

Chair, Solihull Local Safeguarding Children Board



Serious Case Reviews

Information for Families

If you require this information in another format,
please contact the Safeguarding Children Business Manager on:
Tel: 0121 788 4325

What Is Solihull Local Safeguarding Children Board (LSCB)?

The LSCB brings together all the main organisations who work with children and families in Solihull, with the aim of ensuring that we work together effectively to keep children safe.

What is a Serious Case Review?

A Serious Case Review looks at how local professionals and organisations worked together to deliver services to the child or young person at the centre of the Review. It may also look at how they are working with other children in the immediate family.

The Review considers what was done, what lessons can be learned for the future and what changes may need to be made. It is not a Criminal Investigation or Public Enquiry and its aim is not to blame but to learn.

Why Are You Carrying Out a Serious Case Review?

Solihull Local Safeguarding Children Board (LSCB) has to carry out a Serious Case Review when a child has been seriously harmed or has died and abuse or neglect is suspected or confirmed. Consideration is also given to conducting Serious Case Reviews in some other circumstances. The reasons for the Review you have been informed about will be fully explained to you.

Who Will Carry Out the Review?

A panel of professionals from the Local Authority Children's Services, the Health Service, the Police and sometimes other organisations such as the NSPCC, Probation, the Youth Offending Service or other organisations who work with children and their families are led by an expert in child protection (the Chair). They will meet to review information presented to them and prepare an Overview Report.

What Will I/We Have To Do?

You do not have to do anything. However, you will have the opportunity to give your views if you would like to. We will make sure that there is someone who can help you to do this (see back page).

Who Will See the Report?

The overview report will be published in full unless to do so would harm other children/young people. The report will be suitably anonymised to protect the identify of surviving children, family members and others. We will give you a copy of the overview report.

Your personal contact and/or the Chair of the Review will meet with you and discuss with you what is in the report.

The Executive Summary outlines the key findings and recommendations of the Review without giving personal details. The Executive Summary is also anonymous. We will give you a copy of this summary.

How Long Will the Review Take?

We aim to complete Reviews in 6 months from the date the decision was made to undertake a Review. However, this timescale sometimes needs to be extended, in which case you would be informed and the reasons why explained to you.

In this leaflet we have answered some of the most frequently asked questions families have about Serious Case Reviews. Of course, each case is different and you may have other questions you would like to ask. If so you can contact the Chair of this Serious Case Review Panel or your personal contact.

Chair:

Tel:

Your personal contact:

Tel:.....

If you want to know more about the rules and regulations regarding Serious Case Reviews, you could look at Working Together to Safeguard Children (2010) – Chapter 8.

A link to this document can be found at the Government's Every Child Matters Website at www.education.gov.uk

**Appendix 4– Letter of invitation to Authors briefing –
let - Author.IMRv1/2010**

To: IMR Authors & Overview Report Authors.

Date:

Our Ref:

Dear

RE: Serious Case Review: Briefing for Authors (IMR and Overview Authors)

Subject: Name, DOB & DOD (*if applicable*)

The purpose of this letter is to invite you as a nominated Author (IMR or Overview) to a briefing on the Serious Case Review concerning the child/ren whose details are provided in the attached SCRRF.v1/2007 form.

As you are aware, Local Safeguarding Children Board's are required to undertake Serious Case Reviews in the following circumstances:

“A 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.”

The briefing for IMR and Overview authors is scheduled for:

Date	Time	Venue
------	------	-------

Please confirm your attendance by contacting the Safeguarding Children Business Manager on the above number. I have attached an IMR template which will be discussed at the briefing.

Yours sincerely

(Authors name)

Chair, Serious Cases Review Panel

Cc: Members of the Serious Cases Review Panel

Appendix 5 – Letter for Commissioning Individual Management Reviews – Let –comissionIMR.v1/2010

To: See distribution list
From: Chair of SCRP

Date:

Dear Colleague

SERIOUS CASE REVIEW: (Child's name, DOB and DOD if applicable)

Solihull Local Safeguarding Children Board has requested that a Serious Case Review under Working Together 2010 takes place concerning the above child/ren. The aim of the review is to ascertain the facts, analyse them and identify any lessons that need to be learned.

I am writing to you in your capacity as a member of Solihull LSCB to request an Individual Management Review. Guidance on the criteria for appointing an author for this report is enclosed.

The Terms of Reference for the Case Review that have been produced by the Serious Case Review Panel in accordance with Working Together to Safeguard Children 2010 are also enclosed.

Individual Management Review reports have been formally commissioned from the following agencies:

- Solihull Metropolitan Borough Council – People Directorate;
- Solihull Care Trust;
- Heart of England NHS Foundation Trust;
- West Midlands Police.

****Consider agencies from out of the authority area***

The person you nominate to write your single agency review is invited to a briefing for authors of Individual Management Reviews and the Overview Author on (***enter date and venue***). This briefing will involve reinforcing general messages on Serious Case Reviews, including format, as well as a closer look at the scope of this particular review to ensure that everyone is clear about the remit that they have been given. It will also set out timescales for completion of reports. It is important that your representative attends.

Also you will need to make arrangements to brief staff directly involved in working with (***Child's name***) and/or his/her family, that a Serious Case Review is being conducted. This should be done in a sensitive and supportive manner.

Other staff employed within your agency will also need to be briefed about the review.

The reports will need to include a chronology of agency involvement with the family. It is a requirement of Working Together (2010) (8.47) that copies of IMR's are provided to OFSTED and the Department of Education together with the Overview Report on adoption by the LSCB. Ofsted advise the Care Quality Commission, HMI Constabulary and HMI Probation that the LSCB is conducting a Serious Case Review. They will also share copies of the relevant IMR's, Overview Report, single agency action plans, executive summary and their evaluation letter with the 3 inspectorates as required. Furthermore, once confirmation that the final executive summary has been published by the LSCB, Ofsted will send a copy to the Association of Chief Police Officers, Strategic Health Authority and Primary Care Trusts.

A template for the report and the chronology will be available at the meeting and can be accessed via Solihull LSCB website. The IMR will need to be submitted in person on a CD-Rom; by Special Delivery post or by secure email to lscb@solihull.gcsx.gov.uk.

It is important that the report deadline is met so that they can be circulated to the Serious Case Review Panel in advance of the meeting on **(enter date)**.

Authors will be expected to attend this meeting also to present their reports, and we can organise the timing of presentations when we meet on **(enter date)**.

If you have any questions or queries please contact Safeguarding Children Business Manager on 0121 788 4324. Please confirm the name and contact details of your agency's IMR Author to me by **(enter date)**.

Yours sincerely

Name
LSCB Chairperson

Distribution:

All agencies who responded positively to - let SCR Request .v1/2010

Cc Chief Officers of all agencies listed

Appendix 6– Standard format for an Individual Management Review (IMR) – Format – IMR.v1/2010

Report of (*name of agency*)

On

(*Child's name*)

To the Serious Case Review Panel

Date of request:

IMR Author: Please state the role of the IMR author within the organisation and whether they have been directly concerned with the child / family or have been the immediate manager of the practitioners involved.

Date agency records secured: _____

Terms of Reference:

Contextual Information

In considering this aspect of the case, the Report writer needs to decide whether the context in which the case was conducted impacted on decisions made and if so such information need only be included in so far as it is relevant to the actions of the organisations concerned.

The Panel will examine contextual information supplied by IMR authors in order to fully understand the circumstances of the case to make the appropriate recommendations for change. The author should be able to evidence any assertions made possibly through policies, operational practice at that time, professional/management judgement or research.

Most weight should be given to primary information, although secondary and anecdotal information can be considered, but clearly identified as such and given less weight.

The type of information that would be useful is as follows:

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organisational change
- Unallocated cases

- The social and community context
- Management and Supervision
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal Advice

This is not an exhaustive list and there may be other contextual factors that Reviewing Officers would wish to include.

Methodology

To include:

- a) How the agency carried out the review
- b) Details of documents seen
- c) List of interviews and dates
- d) Details of information not available/not considered (with reasons)
- e) Details of how agency staff were kept informed of the purpose and process of the Individual Agency Review
- f) Details of staff involved by name and job title for the benefit of the Panel only. The overview report will be completely anonymised.
- g) Were you given sufficient time to complete the task?

Genogram

Summary of Facts

To include:

- a) Relevant chronological history (in narrative form) on child, family and any significant others which could have bearing on the case under review e.g.:
 - Data on present and past relationships;
 - Marriages;
 - Children and home circumstances;
 - Adults own childhood;
 - Existence and definition of violence within family;
 - Existence of/definitions of violence towards people outside family;
 - Relationships with extended family and the local community.
- b) Further amplification of relevant facts in terms of contextual information
- c) Other relevant information to be appended:-

- Child Protection Conference Minutes
 - Planning or Review Meeting Minutes
 - Criminal Antecedents
 - Growth Assessment Charts
- d) Details of the agencies internal child protection procedures. Copies attached.

Detailed factual chronology *(in tabular form- see appendix 8)*

To include inter-agency contact following the specified format that will be provided electronically. The chronology should also cover contact with the alleged perpetrator and whether everything was done that might reasonably have been expected to manage effectively the risk of harm posed by the alleged perpetrator to the child.

Analysis of Involvement

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, try to get an understanding not only of what happened, but why something either did or did not happen. Consider specifically the following:

- 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 provisions 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 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 office 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 with 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 sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

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?
- Are there implications for current police and practice?

SMART Recommendations for action

These should include:

- a) What changes (if any) could be made to the agency's child protection procedures?
- b) What changes (if any) could be made in inter-agency working in the

light of this case?

- c) What areas of good practice are there? Could these be expanded?
- d) What action should be taken by whom and by when?
- e) What outcomes should these actions bring about and in what timescales?
- f) How will the organisation evaluate whether they have been achieved?
- g) Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

Action Plan

SMART recommendations should be formulated into an individual agency action plan (Appendix 13 provides the agreed action plan template).

Signatures required on completed report

Author of IMR

Head of Agency

Date

Date

Appendix 7 Chronology Template – Chronology.v1/2010

Event No	Date	Time	Age of Child	Family Member	Child seen/wishes sought or expressed	Event	Agency source to overview	Action taken	Note
i.e. 1, 2 etc	This column is formatted for dates	This column is formatted for times		Use agreed abbreviation	Y/N	all of the cells are formatted to wrap the text. You are not therefore limited to how much you can type into a cell	E.g. Education		

Appendix 8 - Interview format – Interview.v1/2010

It is suggested that it may be helpful for authors to use the following format when conducting interviews in the process of compiling the IMR.

Details of contributor *(to be completed as a preamble to the discussion on the case)*

Full Name: _____

Qualifications: _____

Designation: _____

Time in post: _____

Employing Body: _____

Employing Address: _____

Home Address
(where appropriate): _____

Previous
Employment: _____

Employer dates
posts held: _____

Description of role in
relation to particular
case: _____

Matters to be covered in interviews *(to be used in conjunction with the chronology of the case to check facts, to discuss the contributor's specific participation and the timescale of their involvement).* Explore with the contributor:-

- a) Their knowledge of the history of the case, the child(ren) and family prior to the individual's involvement:
- b) Their specific involvement in the case:
- c) Their knowledge of the agency's policy and procedures in relation to child care and child protection;
- d) Their knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to CP conferences;
- e) Methods used to relate to/communicate with other professionals in the case;

- f) The individual's record keeping;
- g) The supervision the individual received;
- h) The individual's feelings about the case, the carer or child and how those feelings were dealt with in supervision;
- i) The range of training both within and outside the agency in the 1st two years;
- j) Whether the agency can learn lessons from the experience;
- k) Looking back, what the individual would now do differently;
- l) What lessons the individual can learn from the experience.

Following the interview, it is suggested that the Author write an interview summary, a copy of which should be handed to the interviewee who, if in agreement, should sign both copies. Where there is disagreement on the content of the summary, this should be identified and noted.

The interview summaries are not required by the Panel but are purely to assist in the preparation of the IMR

Appendix 9 – Overview Report Communications Plan – comm. Plan.v1/2010

Media/Communications Plan

Key Messages

Audience and stakeholders

Communication channels

Roles and responsibilities of key individuals

Agency leading media management on behalf of LSCB

Support offered to families

Briefing of staff on the contents of the report

Briefing of the families/involved in the compilation of the report

Available resources for publication

Debriefing arrangements to those involved

The need for media training

**Appendix 10 – Letter of Invitation to a Practitioners De-Briefing – Letter –
Pract.De-briefing.v1/2010**

Name (see distribution list)
Address 1
Address 2
Address 3
Address 4

Our Ref:

Date:

Dear Colleague

Serious Case Review: (*child's name*): Practitioners De-Briefing

As you will be aware a Serious Case Review was held on the above child. This review has now been concluded and the Overview Report and Executive Summary are available for dissemination.

We recognise that it is important to share the Overview Report and its findings with all those directly involved in the case, and would therefore like to invite you to a de-briefing on (date, time & venue)

Please advise either by email (lscb@solihull.gov.uk) or by completing the attached reply slip to indicate whether/not you are able to attend. If there is someone you think should be invited but who is not on the list below, please contact Karen Perry, PA to Safeguarding Children Business Manager & Administrator to LSCB, on 0121 788 4325 or by email lscb@solihull.gov.uk.

Yours sincerely

Mark Rogers
Chair of Solihull LSCB

Distribution:
For attendance; Practitioners
For information: Members of SCRP
Single Agency Management Review Authors
OFSTED
DCSF
Overview Author

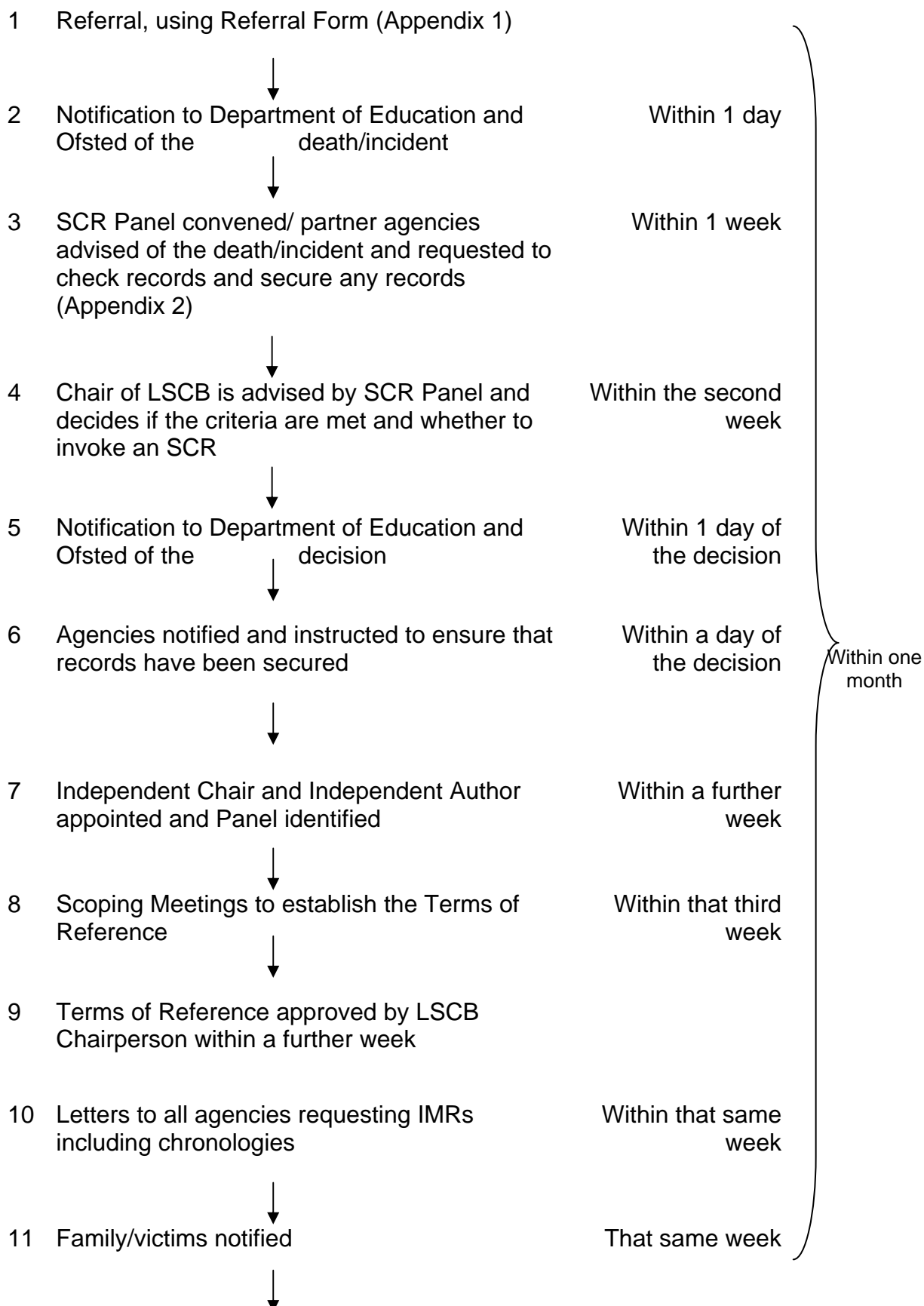


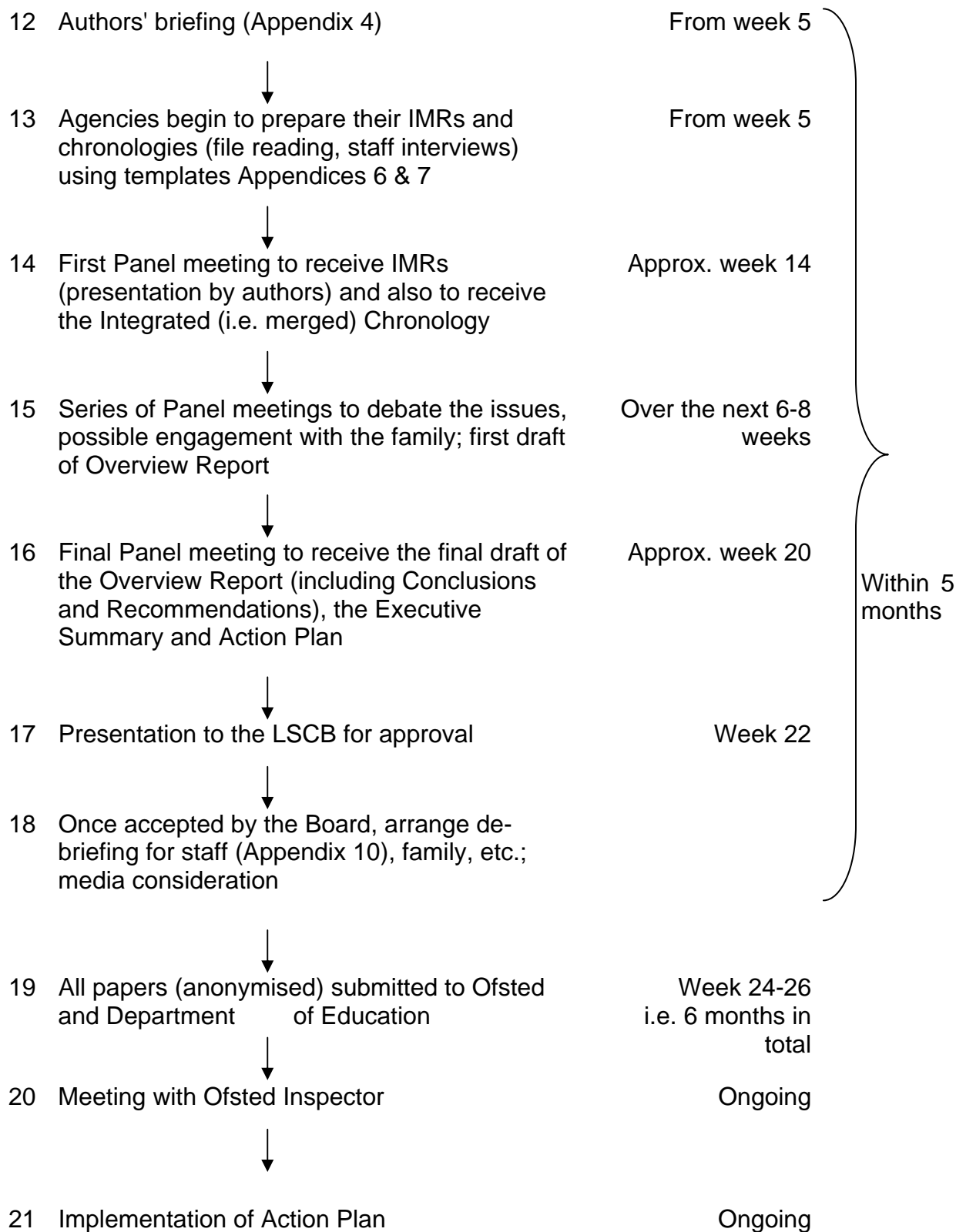
Name:

Workplace: _____

I am able/unable* to attend the meeting on (*Date, time & Venue*)

Appendix 11 – Flowchart - (Performance Management Plan and Timescales)





Appendix 12 – OFSTED Descriptors for the Evaluation of Serious Case Reviews (Jan 2009 version)

	Outstanding	Good	Satisfactory	Inadequate
Timescales	Requests for extension to the timescale timely and are agreed in writing by Government Office; delays are unavoidable and the review is completed within the agreed timescale.	Requests for extension to the timescale are timely and are agreed in writing by Government Office. Any delays in completion of the review are unavoidable and it is completed broadly in line with an agreed time scale.	All extensions to the timescales are agreed in writing by Government Office. There are delays in the completion of individual management reviews and the overview report, some of which are avoidable.	The timescale for the review is outside the four month guidance and has not been agreed in writing by Government Office. The delay in completion of the review impedes the timely dissemination of the lessons to be learned.
Scope of the review	The decision to conduct a serious case review is appropriate. The scope of the review is unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that all relevant questions can be addressed through all the available information and the analysis completed within the agreed time scale. Good contingency arrangements help to ensure timely responses to	The decision to conduct a serious case review is appropriate. The scope of the review is unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that nearly all relevant information can be obtained and analysed within the agreed time scale.	The decision to conduct a serious case review is appropriate. The scope of the review is defined and is supported by terms of reference which support the collation and analysis of most of the relevant information available to agencies.	The decision to conduct a serious case review is inappropriate; the criteria set out in WT are not met. The scope of the review is unclear or too limited. It is supported by imprecise terms of reference which fail to ensure that the relevant information can be obtained and analysed.

	new information or changes during the process of the review.			
Contribution of relevant agencies	The contribution of all relevant agencies is maximised throughout the period of the review.	The contribution of all relevant agencies is secured.	The contribution of nearly all relevant agencies is secured.	The contributions of some relevant agencies are not secured.
Independent element	A high level of independence is built into the process including the appointment of an independent author of the overview report and access to expert advice on critical or complex aspects of the case. The independent author is not a member of the serious case review panel. The serious case review panel includes members who hold expert knowledge of the issues relevant to the case. Authors of individual management reviews are independent of line management of the service.	Independence is built into the process through the appointment of an independent author of the overview report. The independent author is not a member of the serious case review panel. The serious case review panel has access to legal advice on critical aspects of the case. Authors of individual management reviews are independent of line management of the service.	Independence is built into the process through the appointment of an independent author of the overview report. The independent author is not a member of the serious case review panel. Most individual management review authors are independent of line management of the service. Where this level of independence is not possible, the serious case review panel has demonstrated sufficient transparency and critical analysis of both the individual management reviews and overview report.	Insufficient independence is built into the process such as the appointment of an independent author of the overview report. The overview report author is a member of, and/or chairs the serious case review panel. The serious case review panel does not include an independent member. Authors of individual management reviews are not independent of line management of the service.

Involvement of family members	Arrangements to involve and support relevant family members are comprehensive, appropriate, effective and take into account their ethnic, cultural, linguistic and religious needs.	Clear and appropriate arrangements have been put in place to secure the involvement of relevant family members. Where their involvement was not possible, the reasons are recorded and the members informed of the outcome of the review. The ethnic, cultural, linguistic and religious needs of the family are taken into account.	Arrangements have been put in place for relevant family members to contribute information to the review. The ethnic, cultural, linguistic and religious needs of the family are taken into account.	The contributions of relevant agencies are not clearly defined and arrangements for the involvement of relevant family members have not been agreed. The ethnic, cultural, linguistic and religious needs of the family are not taken into account.
Links to parallel investigations	All other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate, effective information sharing processes or jointly commissioned review arrangements have been agreed.	Other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate effective information sharing processes are in place.	Some parallel investigations such as criminal investigations and coroner's enquiries are identified and the outcomes of these are considered within the review.	Some parallel investigations including criminal investigations and coroner's enquiries have not been considered within the scope of the review and processes for communication are unclear.
Individual management reviews	All relevant agencies produce a comprehensive and well-structured management review of their	Most relevant agencies produce a comprehensive management review of their full involvement with the	Most relevant agencies produce individual management reviews of their involvement with the	Not all relevant agencies produce a management review of their involvement with the child and family.

	full involvement with the child(ren) and family.	child and family.	child and family.	
	The review takes full account of the outcomes for the child(ren) concerned in light of their individual needs and their racial, cultural, linguistic and religious identity.	Any gaps in information are minor and do not impact directly on the outcome for the child(ren) concerned. The review takes into account the individual needs of the child or children and is sensitive to their racial, cultural, linguistic and religious identity.	Most reviews take into account the individual needs of the child and family and record their racial, cultural, linguistic and religious identity.	Some reviews do not take into account the individual needs of the child and family including their racial, cultural, linguistic and religious identity.
	Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.	Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided fully addresses the terms of reference.	Practice is analysed by most agencies openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Gaps in information are identified and explained.	The extent to which practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance is inconsistent across agencies. There are gaps in information which are not fully explained.
	Good practice is highlighted with appropriate	Good practice is highlighted. Nearly all areas	Areas for changes in practice are mostly	Some areas for changes in practice are identified but

	consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.	for changes in practice are clearly identified and supported with measurable and relevant recommendations for improvement.	identified and supported with measurable and relevant recommendations for improving practice.	are not always supported with measurable and relevant recommendations for improvement.
Overview report	The overview report coherently and accurately brings together the findings of all individual management reviews and other relevant investigations, reviews or enquiries. It summarises the facts of the case succinctly including a clear genogram and a comprehensive and well-organised chronology which maintain a clear focus on the child(ren) concerned throughout.	The overview report accurately brings together the findings of the individual management reviews and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a clear genogram and a comprehensive chronology of events relating to the history of the child and family and agency involvement	The overview report brings together the key findings of all reports from agencies and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a genogram and a chronology of the family history, circumstances of the child and agency involvement.	The overview report does not bring together effectively the findings of the individual management reviews and other relevant investigations, reviews or enquiries. There are some gaps in the genogram and chronology of information relating to the family history, circumstances of the child and agency involvement which impact adversely on the coherence of the report.
	Outcomes for the child(ren) are transparent and evidenced well by the information known to the agencies and professionals concerned about the	Outcomes for the child(ren) are considered against the available information known to the agencies and professionals concerned about the parents, carers	Reference is made to the most important aspects of the information was known to the agencies and professionals concerned about the parents, carers	Reference is not always made to or effective use made of what information was known to the agencies and professionals concerned about the

	parents, child and perpetrators, the family history and home circumstances.	and perpetrators, the family history and home circumstances	and perpetrators, the family history and home circumstances of the child.	parents, carers and perpetrators, the family history and home circumstances of the child.
	The report reflects a robust examination of the facts and provides evidence-based explanations for how and why events occurred and actions or decisions by agencies were or were not taken.	The report reflects a critical examination of most facts and provides evidence-based explanations for how and why most events occurred and actions or decisions by agencies were or were not taken.	The report includes examination of the key facts and provides credible explanations for any gaps in information, how and why events occurred and actions or decisions by agencies were or were not taken.	The report lacks rigour in its examination of the facts and explanations on how and why events occurred and actions or decisions by agencies were or were not taken.
	The benefits of hindsight and evidence from research and previous reviews are used comprehensively by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight and research findings are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The use of the benefit of hindsight by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events is not supported by the evidence.
Lessons to be learned	Lessons to be learned, nationally and locally, are clearly identified and supported by specific and achievable recommendations for	Lessons to be learned, nationally and locally, are identified and supported by specific and achievable recommendations for improving practice.	Lessons to be learned, nationally and locally, are nearly all identified and supported by relevant recommendations for improvement.	Some lessons to be learned, nationally and locally, are identified but not always supported by specific recommendations for improvement and a

	improving practice in a timely manner.			relevant action plan for implementation.
Action plan	A comprehensive joint agency action plan is in place, which matches the recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. The plan is outcome focussed and includes actions to disseminate good practice as well address areas for improvement. Robust arrangements are in place for the local safeguarding children board to monitor progress and evaluate the impact of actions taken.	A joint agency action plan is in place, which matches the recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.	A joint agency action plan is in place, which matches the recommendations of the overview report. Most aspects are supported by targets and lead responsibilities. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.	The joint agency action plan is not robust, and is not specific, measurable, achievable, relevant and time-focused (SMART). Arrangements for monitoring by the local safeguarding children board are not identified/not robust.
Executive summary	An executive summary is completed and includes succinct information about the review process, practice issues and lessons learned from the case and recommendations which have been made. The	An executive summary is completed and includes succinct information about the review process, key issues arising from the case and recommendations which have been made. The summary is suitably	An executive summary is completed and includes most relevant information about the review process, key issues arising from the case and recommendations which have been made. The summary is suitably	An executive summary is completed but there are gaps or contradictions in information about the review processor key issues arising from the case and recommendations which have been made. The

	<p>summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, including progress on actions required as a result of the review. The executive summary is shared with the family as appropriate.</p>	<p>anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, and for sharing the executive summary with the family.</p>	<p>anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary and for sharing the executive summary with the family.</p>	<p>summary is not suitably anonymised to protect the confidentiality of the child/family members. Arrangements for the publication of the review are not robust. No arrangements have been made to share the executive summary with the family.</p>
--	--	---	--	---

Appendix 13 – Action Plan Template

The following is an example of the usage of the template. (Please note that these are still currently under review and are presented here in draft form)

Outcome	Recommendation	Actions	By Whom?	By When?	Actions taken	Information for audit
Police officers acquire knowledge of the risks to children associated with domestic violence	The assistant chief constable should ensure that all police officers receive training on the links between domestic violence and child abuse.	<ol style="list-style-type: none"> 1. Determine number of courses and arrange. 2. Issue instruction re: mandatory attendance. 3. Deliver and evaluate course. 4. report on attendance. 5. Set up rolling programme for new recruits. 	Head of Police training Superintendents Head of police training Head of police training Head of police training	Three months One month Six months One month Ongoing		Head of police training unit to provide written summary of number of officers attending training against total in post. Reasons for any variance to be given. Arrangements for any officers who have not attended. Arrangements for future new recruits

It is essential for effective action planning that recommendations are addressed to someone with the authority to ensure compliance. Once the recommendation is agreed, you can identify the actions necessary to implement the

recommendation who will be responsible for taking them and within what timescale. The key to integrating audit into this process is to agree with the responsible person at the point the action plan is prepared what information will be provided for the audit.

Source: NSPCC – Safeguarding through audit: A guide to auditing case review recommendations



Serious Case Reviews

IMR Authors Guide

1. **The aims of Individual Management Reviews**
 - 1.1 **As the author of the IMR you will not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.**
 - 1.2 IMR's should 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 .
 - 1.3 SCR's are not enquiries into how a child died or who is culpable, the review, including the writing of IMRs, should be conducted in such a way that the process is a learning exercise. IMR's need to look at the underlying causes e.g. capacity of frontline services, quality of management oversight and support and the culture within the team, service and agency.
 - 1.4 It is expected that the IMR Authors will interview relevant staff involved in the case, keep a record of these interviews and ensure both the interviewer and interviewee sign the record of the interview. For further guidance on interviewing please **see S11 of Serious Case Review guidance.**
2. **Content of Individual Management Reviews**
 - 2.1 You will be given a template to follow when writing your IMR and it is important to ensure that you adhere to this so that the necessary topics are covered, **see Appendix 6 of Serious Case review guidance.**
 - 2.2 You will also have a copy of the Terms of Reference (TOR) for the serious case review and you should ensure that you address these within your review. These will also contain a timescale detailing from which dates you should start and finish to critically analyse your agency's involvement and it is imperative that these timescales are adhered to.
 - 2.3 Make sure that you include a genogram of the family make up as far as your agency understands it, including grandparents, other significant

Appendix 14: IMR Authors Guide

adults and friends. Guidance on drawing a genogram can be found at **Appendix 15 of the Serious Case Review Guidance**. It is also important to record where agencies missed opportunities to see/ascertain a child's wishes and feelings.

- 2.4 You will be given a standard format for compiling your chronology, **see Appendix 7 of Serious Case Review Guidance**. It is important that you complete this using the format provided as this will assist the LSCB Team when amalgamating all the chronologies. Ensure that the chronologies tell the reader who knew what and when, are explicit as to when the child was seen, what their condition was, and what they said. Missed opportunities to see and speak to the child should also be recorded.
- 2.5 It is important that the IMR contains an analysis of practice within the case and not just an outline of what happened. You are required to provide a detailed analysis of the actions of individual staff members and an honest self appraisal on their part as to why they acted in the way they did and communicate this to the reader.
- 2.6 You will also need to make recommendations on behalf of your agency. Ensure that they are realistic, based on the information contained within your report and that your agency is ready to implement them without delay.
Recommendations need to be

S - Specific
M - Measurable
A - Achievable
R - Reasonable
T – Timely

3. Legal advice

- 3.1 IMR Authors should always consider whether they should obtain advice from their own legal advisors on their draft reports before submitting them. If the content of a report is substantially affected by legal advice it will be helpful to state this. However it is recognised that legal advice is privileged information and agencies are not under any obligation to disclose their own legal advice.
- 3.2 During the course of an IMR, the Author may find that legal advice given to the agency is closely associated with significant issues arising from the case. In such circumstances the IMR Author should invite the agency's legal advisers to submit a report to be appended to the IMR report. Any report dealing with legal issues should be prepared by a lawyer with no direct involvement in the case under review; and, with no involvement in the provision of legal advice about that case to the SCR Panel.

Appendix 14: IMR Authors Guide

- 3.3 Where any in house legal services has had substantial involvement in the case before the event which triggers the SCR, there may be a need to examine that involvement in the SCR. This would normally be done as part of an IMR. If there are concerns of conflicting interests, the LSCB should consider if it is necessary for legal advice from a neighbouring authority to be sought.

4. Gathering information

- 4.1 Base your report on the standard template and any additional headings agreed which is specific to the case, but do not be constrained by it if you want to include additional information that doesn't seem to fit as long as it is directly relevant to the case.
- 4.2 Hold internal discussions and interviews and include the results of these in the report. Make sure that any discussions you have with staff are recorded and signed by both yourself and the member of staff.
- 4.3 Refer to the original files. These should have already been secured by your agency. Photocopies of files should be made where a case remains open – with the photocopies being returned to the case worker, and the originals used for the purpose of the SCR.
- 4.4 You **MUST** ensure that your review and recommendations are approved and signed off by the appropriate senior manager from your organisation, this should be at Chief Executive / Director level.
- 4.5 All IMR's are now sent to Ofsted, along with the Overview report for their consideration and evaluation. Because of this, you will find guidance for IMR'S document below and the Descriptors for the Evaluation of SCR's can be found at **Appendix 12 of SCR guidance**. All IMRs will be expected to conform to the requirements below. If an IMR falls short of these, the report will be returned for further work, with guidance as to how it needs to be improved. IMR Authors need to be aware that meeting the tight timescales is imperative.
- 4.6 Please ensure that all names are anonymised throughout your report with a glossary appended to the report.

5. Writing the report – guidance

- Ensure that the IMR explicitly relates to the TOR.
- Construct a comprehensive chronology (using the template provided) of involvement by the organisation and/or professional(s) in contact with the child over the period of time set out in the review's terms of reference. Summarise decisions reached, the services offered and any other action taken.
- Write reflectively, analytically and evaluative.

Appendix 14: IMR Authors Guide

- Think about the reader of the report, and ‘talk the reader through the process of finding the information and writing the report’. If additional information is needed once the IMRs have been written and submitted to the SCRIP, then ensure that the explanation as to why that was done is included and added to the report. Appendices to the report can be added to capture the processes followed.
- Your report should clearly differentiate between recorded fact, opinion and third party information.
- Your analysis should not consist of a rewording of the chronology. It is important to critically analyse your agency’s involvement.
- Consider the events that occurred, the decisions made or not made, and the actions taken or not. Where judgements were made, or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.
- It is important that you reach an opinion about what happened in your agency and communicate this to the reader. Make sure that if you are stating your opinion, you clearly state that this is your opinion. Make a judgement of the practice and identify inadequate practice.
- Critically appraise the practice found. Identify poor practice as unacceptable, why these failings in practice took place and what issues contributed to that – for example staffing, training, audit and supervision/management – and suggest their relative importance. Consider alternative courses of action and what would have made a difference to the child.
- Identify and report good practice.
- Remember that the SCR is about a child/children/young person.
- Ensure that you address the issues of ethnicity, language, religion, culture and social exclusion within the IMR.
- Help the reader to understand what life was like for that individual child.
- Help the reader understand
 - (i) the child’s views, wishes and feelings
 - (ii) the child’s development and progress
 - (iii) the child’s relationships and interaction with their carers (some agencies will be in a better position than others to assist with this)
- Recognise that interviews may reveal information that is not in the records.

- Identify the missed opportunities for understanding the child's view.

6. Analysis of involvement – guidance

6.1 The IMR template sets out a number of issues that you should specifically consider:

- 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 provisions 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 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 office 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 with 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

Appendix 14: IMR Authors Guide

more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

7. What do we learn from the case?

- 7.1 It is important to consider whether there are lessons from this case for the way in which your agency works to safeguard children and promote their welfare? 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 interagency); management and supervision; agency self audit: working in partnership with other agencies; resources, staffing issues and the culture within the team/service/department?

8. Recommendations for action

- 8.1 Finally, you will need to consider what action should be taken by whom, and by when? What outcomes should these actions bring about and how will your agency evaluate whether they have been achieved? The recommendations must be written in such a way as to inform a meaningful and achievable action plan for your agency. An action plan template can be found at **Appendix 13 of the SCR guidance**.
- 8.2 Take care to ensure that recommendations include either proposed action or action already taken, who is responsible and the timescales involved.
- 8.3 The report should then be signed off by your Chief Executive with their name and job title printed underneath. The recommendations should be accepted by the agency and if any actions/recommendations become obvious then they should be implemented without delay and recorded that this has been done in the IMR and in the SCRP minutes.

9. Presenting the Individual Management Review

- 9.1 Following completion of the IMR you will be invited to a meeting with the SCRP to present your report. Members of the Panel will have received your report and read it prior to the meeting.
- 9.2 This will be an opportunity for dialogue between you, the SCRP and the Overview Report writer and is an important step in compiling and assessing information.
- 9.3 IMR Authors will be asked to individually present their reports, highlighting any key themes or findings and discussing any changes already made within the agency.
- 9.4 There will also be an opportunity for asking questions which may have arisen from the content of the report.

Appendix 14: IMR Authors Guide

- 9.5 You may find that the SCRP request further information from your agency, or clarity if there are discrepancies between IMR's. You will be given clear guidance as to what is being asked for and by when it should be returned.
- 9.6 Information and analysis contained within the IMRs will be drawn together within the Overview Report. This will be written by an independent author who does not belong to any of the agencies involved in the case.
- 9.7 All recommendations contained within IMRs will be included in the Overview Report as an addendum, and each agency has responsibility for implementing their own recommendations. The SCRP will want to add some multi-agency recommendations and the LSCB will monitor and evaluate the impact of these.

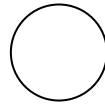
Appendix 15: Guidance on drawing a genogram

A genogram is a way of representing a family tree and relationships within the family.

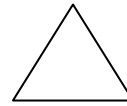
The following symbols are used to represent the gender of family members



Male

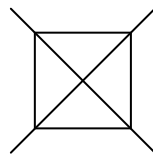


Female

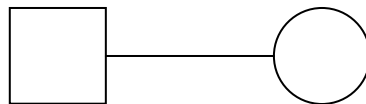


Gender unknown

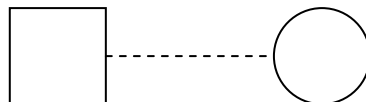
If a family member is deceased, this is indicated by placing a cross through their symbol:



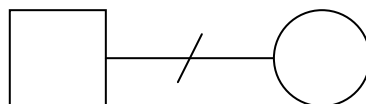
Enduring relationships, such as marriage and cohabitation, are illustrated by a single unbroken line:



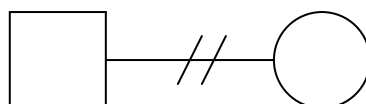
Transitory relationships are illustrated by a single broken line:



Separation is shown by a single short diagonal line across the relationship line:

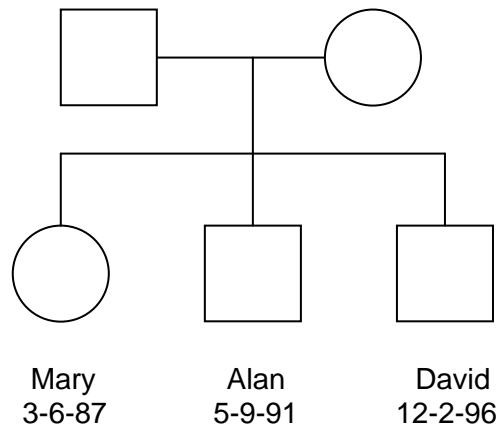


Divorce is shown by two short diagonal lines across the relationship line:

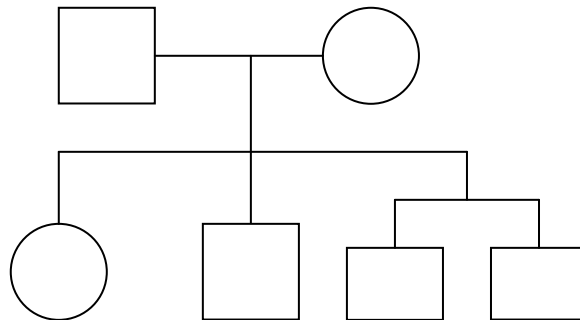


When there are a number of children from the same relationship the eldest child is placed on the furthest left, followed by the second eldest and so on, with the youngest child appearing on the right.

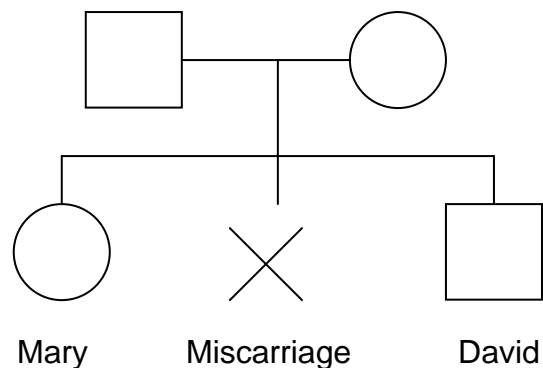
Appendix 15: Guidance on drawing a genogram



Twins are indicated by two symbols coming from a single 'stalk'

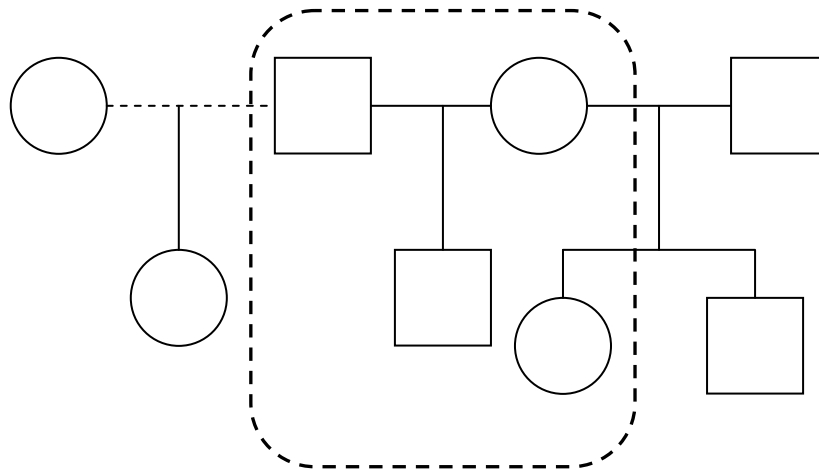


A miscarriage or abortion is indicated by a diagonal cross. In the genogram the miscarriage or abortions should be placed in the diagram in the same order as other children. So for example if a couple had a daughter, Mary, followed by a miscarriage, followed by a son David, their genogram would look like this:

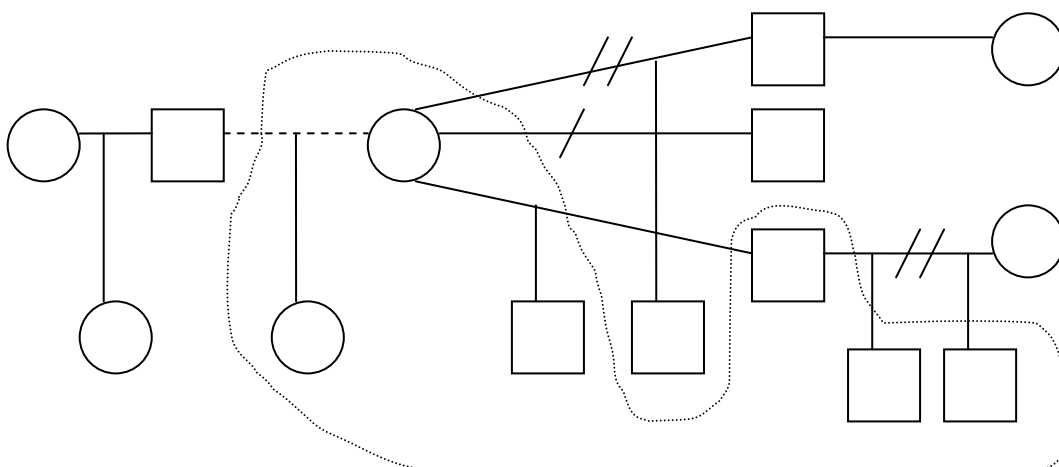


The family members who are part of the same household are indicated by a dotted line which is placed around the household members.

Appendix 15: Guidance on drawing a genogram



When family relationships are complicated, it is especially important to clearly show family groups.



Make sure that dates of birth and names are clearly written under the symbols.

Using a Genogram

Completing a genogram can fulfil a number of functions:

- identifying intergenerational patterns within families;
- finding out about the family's history and how much of the history individual agencies know.

Information on genograms can also be found on page 29 of *Assessing Children in Need and their Families: Practice Guidance* (Department of Health, 2000) www.dh.gov.uk

Appendix 16: Competence framework for serious case review independent authors and serious case review independent chairpersons

This document aims to provide a quality assurance framework for commissioning

- Independent Authors of Overview Reports
- Independent SCR panel chairs.

Independent Authors and Serious Case Review Panel Chairpersons should have the following essential core skills, knowledge and experience

- Ability to keep child focused
- Knowledge and expertise in child protection legislation, policy and practice
- Ability to collate, coordinate and critically analyse a large amount of information from which to distil the key findings
- Ability to challenge, be critical and rigorous and to maintain an open minded, independent approach to evidence
- Report writing skills and ability to make SMART recommendations
- Experience of the operational context of safeguarding work at a management level

Competencies

The Solihull LSCB has agreed 5 competences that are designed to promote high quality Serious Case Reviews and make explicit its expectations in respect of those commissioned to support this work.

Authors are required to meet Competences 1-4, Chairs are required to meet Competences 2,3,4 and 5.

Evidence

The main body of evidence for all Independent Authors will be provided by one or two previously authored reports in anonymised form. Additional evidence of experience of operational safeguarding in a management capacity and evidence of ongoing professional development will also be required.

For Independent Chairpersons, the main body of evidence will be a reference from the LSCB Chairperson who has previously commissioned the individual to Chair a Serious Case Review Panel. Additional evidence of experience of operational safeguarding in a management capacity and evidence of ongoing professional development will also be required.

Competence One- Ability to produce a report that meets the requirements of *Working Together* and standards/expectations of any regulator (e.g. OFSTED).

Unit A Information gathering and report writing

Element	Evidence
A1 The facts are presented in an organised way	Extracts from a previously authored SCR or IMR or other relevant analytical reports.
A2 Language and style is suitable for the audience	Evaluation e.g. Ofsted and /or others as appropriate
A3 Source material has been used and referenced	The report shows reference to <ul style="list-style-type: none"> • The commissioning body and date of publication
A4 Report demonstrates consideration and an understanding of the relevant diversity and cultural issues	<ul style="list-style-type: none"> • Reference to sources • Facts, analysis opinion and links to recommendations are clear
A5 Report takes full account of child/young people's rights, needs, their stage of development and their level of understanding	<ul style="list-style-type: none"> • Diversity and culture • Young peoples views, • Children's needs and rights • Challenge
A6 Report acknowledges differing perspectives between professionals and agencies	<ul style="list-style-type: none"> • Lessons learnt • How lessons inform recommendations
A6 Report addresses the TOR.	<ul style="list-style-type: none"> • Focused and specific recommendations that can be turned into actions
A7 Recommendations are SMART.	

Competence Two - Current knowledge and understanding of relevant safeguarding research, policy and practice.

Element	Evidence
<p>B1 Understand LSCB and individual agency safeguarding policies, relevant legislation, policy and practice.</p> <p>B2 Understand how organisational culture and customs can impact on practice and their relevance.</p>	<p>Extracts from an anonymised previously authored SCR or IMR, Evaluation e.g. Ofsted and /or others as appropriate.</p>
<p>B3 Recognition of current developments in child protection policy/ practice and impact on agencies and professionals involved in safeguarding.</p> <p>B4 Ability to apply knowledge and expertise in relation to child protection effectively</p>	<p>The report shows</p> <ul style="list-style-type: none"> • understanding of how agencies operated within current legislative framework • Reference to research and policy <p>Further evidence to show:-</p> <ul style="list-style-type: none"> - How ongoing professional development is maintained. - Formal qualifications, work experience, training etc - Experience of operational safeguarding at management level

Unit B Evidence of being up to date with key research, policy and practice pertinent to individual SCRs and the SCR process.

Competence Three- Rigorous analysis of complex information from a range of sources.

Unit C Organising information and *Analytical Skills*

<p>C1 Ability to identify key issues and themes.</p> <p>C2 Able to analyse complex information</p> <p>C3 Demonstrate a focus on learning.</p> <p>C4 Demonstrate appropriate use of research, and lessons from similar SCR reports.</p> <p>C5 Demonstrate an ability to question the evidence and take an independent and objective viewpoint</p> <p>C6 Ability to draw conclusions and make appropriate recommendations</p> <p>C8 Demonstrate a clear link to the terms of reference.</p>	<p>Extracts from a previously authored SCR or IMR or other relevant analytical reports.,</p> <p>The report shows</p> <ul style="list-style-type: none"> • How and why events occurred • How and why decisions were made • Whether different decisions or actions could have led to alternative course of events • Evidence of challenge • Objectivity • Openness <p>or</p> <p>Reference from LSCB who has previously commissioned individual to act as an independent Chairperson.</p>
---	--

Competence Four- Managing the SCR process, keeping a focus on child / children

Unit D Child Focused Report

Element	Evidence
<p>D1 Able to clearly keep a focus on the child / young person and other relevant young people</p> <p>D2 Ability to take account of the child/young person's individual needs including addressing issues of diversity.</p> <p>D3 Ability to involve all appropriate adults/ children and young people.</p>	<p>Extracts from a previously authored SCR or IMR or other relevant analytical reports. The report should show:</p> <ul style="list-style-type: none"> • The child/children as the focus • Consideration of how other children and young people may have been affected/at risk • Engagement with family to feedback on the process and seek their views. <p>or</p> <p>Reference from LSCB who has previously commissioned individual to act as an independent Chairperson.</p>

Competence Five – Chair Serious Case Review Panel

Unit E - Chairing Skills and managing media interest

Element	Evidence
E1 Ability to participate effectively in multi agency senior management meetings	Some experience of LSCB membership
E2 Ability to challenge and negotiate with partner agencies at a senior level.	Some experience of chairing at a senior level multi agency meetings e.g. LSCB sub groups, MAPPA
E3 Ability to manage any media interest in line with the Board media strategy , and the LSCB practice guidance for SCRs	Experience of dealing with media on previous cases or work and preparing or giving statement or interviews



0Hlscb@solihull.gov.uk

**1Hwww.solihull.gov.uk/staysa
fe**