Sandwell Safeguarding Children Board
Serious Case Review & Significant Incident Notification Process

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Introduction

Sandwell Safeguarding Children Board acknowledge and are committed to the importance of serious case reviews (SCRs) as an essential element in examining multi-agency working and of informing and promoting more effective safeguarding children practice. All organisations and agencies represented on Sandwell Safeguarding Children Board are also determined to ensure that wherever the need arises for a serious case review, this is undertaken thoroughly, promptly and sensitively; and that any lessons to be learned are acted upon to ensure that any areas in need of strengthening from either a strategic or operational perspective are addressed.

This document has been developed from the revised guidance set out in Working Together to Safeguard Children 2015 (HM Government, p.72) which states that:

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

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong."

The Purpose of this Document

The purpose of this document is to provide advice and guidance to those involved in the serious case review process. It details the order of events and provides timescales for undertaking a serious case review and significant incident process.

What is a Serious Case Review?

A serious case review (hereafter referred to as SCR) should be undertaken for every case where abuse or neglect is known or suspected in accordance with the following criteria**:**

(2) (a) abuse or neglect of a child is known or suspected; and
(b) either - (i) the child has died; or (ii) the child has been seriously harmed **and** there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The statutory guidance Working Together 2015 (Chapter 4) also states that cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), **unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB must commission an SCR.** The definition of "seriously harmed" includes where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;

- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

A SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

Although any agency can make a request to their LSCB for a serious incident to be considered via SCR processes, it is predominantly the local authority (LA) Children's Social Care (CSC) service who will notify the relevant LSCB when a local serious child care incident occurs (the process for this is set out on page 4). A serious case review can also be triggered by either a child death review (via the Child Death Overview Panel (CDOP; see Chapter 5 of Working Together to Safeguard Children 2015); or as a result of a domestic homicide review (DHR).

All child deaths will be discussed through the CDOP process. The CDOP will determine whether a child death incident needs to be referred to the SCR Subgroup/Committee due to safeguarding concerns. The SCR Subgroup/Committee is then responsible for making a decision about whether a SCR Scoping Panel Meeting is required. Where the DHR relates to a victim who is under the age of 18 years old, a serious case review will take precedence over the DHR process. The final decision on whether to conduct a SCR rests with the LSCB Independent Chair.

Learning Reviews

Working Together to Safeguard Children 2015 (Chapter 4) also recommends that LSCBs undertake learning reviews on serious child care incidents that do not meet the criteria for a serious case review, but do require some form of a review or audit process to help identify local improvements and consolidate good practice. In these circumstances the LSCB Independent Chair should be confident that the process is as thorough, transparent and engaging with family members and practitioners as if it were a formal SCR. Learning reviews can also be undertaken to review instances of good practice which the LSCB should consider how to share and embed in systems or operational practice. Working Together (p.72; para 6) states:

"*LSCBs should conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute, these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together. LSCBs should follow the principles in this guidance when conducting these reviews."*

What is the purpose of a Review?

The prime purpose of any review, including a SCR is to drive forward improvements to local safeguarding children arrangements and practice. Reviews can provide useful insight into the way organisations and practitioners are working together to safeguard and protect the welfare of children by looking at what happened in a case, trying to understand why and agreeing what learning needs to be taken from the review findings. Reviews should always highlight good practice as well as identifying areas for improvement.

Aim of this Guidance

The aim of this SCR Guidance is to provide professionals across Sandwell with all the information that they require to undertake an SCR. All professionals involved in a SCR are required to read Working Together (WT) Chapter 4 in full. To access this document please use the following link: Working Together to Safeguard Children 2015.
It also details how to notify SSCB of significant incidents.

Notification to the LSCB of a Case Which May Meet the Criteria for SCR

Any agency may refer a child to their LSCB for consideration of a serious case review if they believe there are important lessons to be learned in respect of multi-agency working. It is the responsibility of the referring agency to ensure that their senior agency leads are aware that the referral is being made.

A senior manager in the agency should complete the SSCB Serious Incident Notification Form and send it to the Child Death Coordinator (form attached). The Child Death Coordinator then has the responsibility to inform the LSCB Business Manager, the Independent Chair and the Chair of the LSCB SCR Sub-Committee of the received notification. This will result in a decision being made about the timeliness of convening a SCR Sub-Committee meeting for consideration of the presenting information. This may involve convening an extraordinary SCR Committee meeting.

Notifiable Serious Child Care Incidents

A notifiable serious child care incident is an incident involving the care of a child which meets **any** of the following criteria set out in Chapter 4 of Working Together 2015:

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

The LA CSC service has the responsibility to report any incident that meets the above criteria to Ofsted and the relevant LSCB promptly, and **within five working days of becoming aware that the incident has occurred.** The Ofsted on-line serious child care incident notification form for LAs can be accessed at:
hwww.gov.uk/notify-ofsted-of-serious-childcare-incident-form-for-LAs

It is likely that if an incident meets the criteria for a SCR then it will also meet the criteria for a notifiable incident; however, it is acknowledged that there will be notifiable incidents that do not proceed through to a SCR
A registry of such notifications will be maintained by SSCB on behalf of the Local Authority.

Serious Healthcare incidents should be reported by the CCG to NHS England in accordance with the NHS Serious Incident Framework 2015.

Deciding whether to convene a SCR Scoping Panel

The SCR Sub-Committee/Subgroup are made up of representatives from LSCB partner agencies and are a formal subgroup of the LSCBs. There is an expectation that all Sub-Committee/ Subgroup members will ensure that they attend the meeting to share initial information and to assist in the shared decision making. It is paramount that legal representative/s are linked into the process when required. It is the responsibility of the SCR Sub-Committee/ Sub-group members to decide whether the presenting information meets the criteria for a SCR Scoping Panel to be convened in accordance with the criteria set out in Working Together 2015.

Securing Agency Records

Once it is known that a case is to be considered at a Scoping Panel, each agency should secure its records relating to the case to guard against loss or interference. It is the individual organisation's responsibility to ensure that there are internal processes in place that enable paper and electronic files to be secured, whilst still enabling professionals to work with families.

All agencies also have a responsibility for promoting confidentiality and sensitivity in the coordination and overall management of the review process. All records must indicate the confidential nature of the document and be password protected in accordance with each agency's Information Governance processes.

Coordinating a Scoping Panel

Once the decision has been made by the SCR Sub-Committee for a Scoping Panel to be convened, the Child Death Coordinator is responsible for identifying which agencies (including those from other local authorities if appropriate) should be engaged in the Scoping Panel. The Child Death Coordinator will notify all Board partners of the name of the child or children who will be the subject of the Scoping Panel and any significant others associated with them. It is the expectation that Board members will then undertake internal agency checks to identify whether this child/ren and significant others are / have been known to their agency. Board partners must ensure that they check all records (electronic and paper), including any historical records. This information must be returned to the Child Death Coordinator within the agreed timescale to help identify those agencies who will need to be invited to attend the Scoping Panel Meeting.

Any discrepancies in respect of the information sent to Board partners will need to be shared with the Child Death Coordinator as soon as possible in order to alert other partner agencies. These include areas such as:

- Dates of birth
- Spelling of names or aliases
- Address details
- Any significant others who have not already been identified

Once all agency information has been received by the Child Death Coordinator, an invitation will be sent out to all of the required agencies with the expectation that this invitation is treated as a priority. Consideration should also be given as to whether any professionals with expert knowledge (on for example medical, criminal, cultural, disability issues) should be invited to the meeting to help inform the information sharing and decision making process.

As schools are not individually represented at the SSCB and therefore the Education Safeguarding Officer employed by the LA will be required to;

- Undertake checks to establish which current and historical educational provision the young person is/has attended and share this with SSCB.
- Inform the school of the scoping process and that they have been identified as a relevant provider.
- Offer support to the schools identified as needing to provide a chronology for the Scoping Panel to help them with understanding the process and quality expectations of producing this document. It will be for the school or educational establishment themselves however to produce the chronology and attend the panel.

If there is a parallel criminal investigation being undertaken, the police representative will ensure they have relevant information from the Senior Investigating Officer when attending the scoping meeting. A police Disclosure Officer may also be required to attend; this decision will be made by the SIO. The SIO should not however have any involvement in the SCR Panel process as this may present a conflict of interest in respect of the criminal investigation.

There is a requirement for all agencies to complete an agency chronology on the template provided by the LSCBs to bring this with them to the Scoping Meeting and to send a copy of the information shared to the Child Death Coordinator.

All agencies must ensure that the representative attending the Scoping Panel is of sufficient seniority, is able to bring all relevant information; and can actively contribute to the decision-making process on behalf of both their individual agency and LSCB representative. The SCR Sub-Committee Chair is responsible for chairing the Scoping Panel meeting. Members of the SCR Sub-Committee are also expected to attend; some in an independent capacity if their agency has not been involved with the subject child or their family. The SCR Committee Vice-Chair would need to chair the review if the Chair has had direct involvement with the child being reviewed.

The Scoping Panel Meeting

The aim of the Scoping Panel is for agencies to share their information in order to decide whether the criteria for a formal serious case review has been met (in accordance with Working Together 2015). **Please note that if the required agencies do not bring the appropriate information to the Scoping Panel this may result in a decision being made by the Scoping Panel chair to reconvene the meeting.**

All agency representatives attending the Scoping Panel Meeting will be expected to sign the SSCB Scoping Panel Confidentiality Statement in accordance with these procedures, to ensure that all parties are clear about the potential need to share information from the review process with the police. The delegates should be reminded at the beginning of the meeting that the purpose of the SCR Scoping and review process is to learn lessons about services provided to the child and their family and that nothing should be discussed which relates to the potential guilt of any suspects or defendants.

All attendees will be expected to actively contribute to the information sharing and decision making process. Once all information has been shared and a consensus about next steps has been reached the Scoping Panel Chair will make a written recommendation to SSCB Independent Chair on behalf of the Scoping Panel.

All invited agencies and their representatives will receive a copy of the minutes within two weeks of the meeting being held. All agencies will need to ensure that the minutes are an accurate reflection of the information shared and the decision making process. The minutes must also clearly reflect any disagreements or challenges in respect of the information shared and the decision making of the Scoping Panel.

If, during the course of the Scoping Panel meeting or later in the review process, concerns emerge that any child is suffering, or is at risk of suffering significant harm, SSCB safeguarding children procedures should be immediately initiated.

The recommendation made by the Scoping Panel to SSCB independent Chair will be one of the following:

- A formal serious case review (an independent reviewer will be commissioned)
- A multi-agency learning review (either commissioned or internal)
- A single agency learning review
- Other identified audit activity as agreed at the SCR Subcommittee
- Agreement for the case to be managed through the CDOP process; or
- No further action required.

The recommendation(s) made by the Scoping Panel can either be upheld, further actions stipulated; or be over-ruled by the LSCB Independent Chair, who has the power to make the final decision about which review process or action should / should not be undertaken. The LSCB Independent Chair must provide a written response to the SCR Subgroup / Committee Chair within one month of the Scoping Panel to set out their decision making in respect of next steps.

The following issues may also need to be considered as part of the planning and Scoping Panel meeting:

Children known to more than one LSCB

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 normally resident should decide whether an incident notified to them meets the criteria for a SCR and take lead responsibility for conducting the SCR, or any other agreed review process. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and supporting the SCR.

In the case of a looked after child, the local authority responsible for the child should exercise lead responsibility for conducting the SCR; again involving other LSCBs with an interest or involvement. The final decision in respect of whether the criteria for a SCR have been met rests with the Independent Chair of the LSCB of the local authority responsible for the child. The LSCB Independent Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

Parallel Investigations

Where the case gives rise to other parallel investigations of practice, (e.g. Domestic Homicide Review where a parent has been murdered, a Youth Justice Board serious incident review or a prisons and probation ombudsman investigation where a child had died in a custodial setting) the chair of the LSCB in which the child / adult would ordinarily reside should be informed to ensure all relevant parties are fully engaged in the initial scoping process and subsequent learning review. It will be important from the Scoping Panel stage to agree the type of review required and who has the lead

responsibility for conducting a review. Depending on the circumstances of the case there may be a need to undertake a joint review or, to include additional issues for consideration in the terms of reference. In accordance with the Scoping Panel process, the LSCB Chair is responsible for receiving the recommendation and deciding on the next steps.

The final draft Terms of Reference (TOR) for any review should be shared by the police safeguarding lead with the Senior Investigating Officer (SIO) prior to final endorsement, to ensure that the TOR does not conflict with any parallel investigation. At the conclusion of a review that has not been led by the LSCB, the review report should always be shared with board partners and any learning relevant to the safeguarding of children should be published and shared with frontline practitioners and managers.

Parallel Police Investigations or Judicial Proceedings

Both criminal proceedings and serious case reviews are important processes which should be carried out as efficiently as possible and both are crucial to the effective safeguarding of children. There is a presumption that even when criminal proceedings are ongoing the work of the review will go ahead in accordance with government timescales unless there are special circumstances which require some compromise. If there are clear reasons put forward by the Police or Crown Prosecution Service (CPS) and agreed by the SCR reviewer it may be possible to delay final completion of the SCR or agree restrictions of its scope such as not interviewing or involving specific people such as key witnesses or defendants in criminal proceedings.

In these circumstances, the Review Report Author should include reference to any for disruption to the planned work of the SCR process and include a copy of the written request as an appendix to their Report so that Department for Education officials can clearly understand the reasons why this was considered necessary.

If agreement and compromise cannot be reached between the SIO, CPS and SCR Independent Reviewers, the final decision whether or not the activity or timescales of the SCR should be altered, should be made by the Independent Chair of the LSCB. LSCBs should favourably consider a written request by the SIO or the CPS to withdraw, or exclude an invitation to a particular agency or representative that may be called upon as a key witness in the criminal investigation, if this request is supported by clear reasoning. The Association of Chief Police Officers (ACPO) and the Association of Independent LSCB Chairs have agreed a protocol to be followed when parallel criminal proceedings are ongoing. Please use the following link to access this protocol document:
(www.cps.gov.uk/publications/liaison_and_information_exchange.pdf).

Disciplinary Processes

SCRs and other review processes are not intended to apportion blame. This is the purpose of the criminal investigation and coroners review. The principles of all reviews must remain focussed on learning in order to help prevent further similar incidents from occurring. However, where information emerges in the course of the review which raises concern about the professional conduct of an individual, a senior manager from their agency may decide to initiate their own agency's disciplinary procedures. Reviews may be conducted concurrently with disciplinary action.

Role of the LSCB Independent Chair

The LSCB Independent Chair is responsible for considering the minutes and recommendations of the Scoping Panel and for making the final decision regarding the recommendations and the proposed method of review. This decision needs to be made within one month of the Scoping Panel meeting being held.

If the LSCB Independent Chair decides that a SCR should be undertaken the following action needs to occur:

- The LSCB manager/Child Death Coordinator is responsible for notifying all Board partners on behalf of the LSCB Chair and for seeking any legal advice from the local authority principal solicitor / Board advisor as required
- The Child Death Coordinator and members of the SCR subcommittee, on behalf of the LSCB, will identify and commission an independent reviewer.
- The initial review panel meeting with the independent reviewer will establish the terms of reference for the review and the timescales for progressing this
- All other agencies should notify their own inspectorate bodies as required (for example the police should notify HM Inspectorate of Constabulary).
- The police are responsible for liaising with the relevant Coroner (this includes Coroners out of area in respect of cross border serious child care incidents) to advise them of the learning review process and to help ensure the Coroner is updated as appropriate. The SCR subcommittee Chair should write a formal letter to the relevant Coroner to advise them that a learning review process has been instigated.
- The Clinical Commissioning Group should notify the Care Quality Commission and NHS England of every case that becomes the subject of a serious case review.
- The communications departments in the police, health and the local authority will need to liaise to coordinate and manage any communications or media interest. Where the media wish to interview a representative of the LSCB, the LSCB Chair will be the named spokesperson on behalf of the LSCB partnership. In some circumstances the police may need to issue statements independently of this process.
- The LSCB Manager should formally notify the national SCR Panel in accordance with national guidance. The Panel will need to be provided with details of the case, the decision of the chair and the name of the appointed Independent Reviewer(s).

Commissioning a Reviewer

If the decision is made for there to be an SCR or a commissioned multi-agency learning review, the Child Death Coordinator will need to work with the SCR Subcommittee/ Subgroup to identify and commission an independent lead reviewer who has the relevant skills, knowledge and experience and who is totally independent of the case.

The Role of the National SCR Panel

From 2013 there has been a national Panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the Panel is to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The Panel will also report to the Government

on their views of how the SCR system is working. The Panel's remit will include advising the LSCB about the:

- Application of the SCR criteria
- Appointment of reviewers; and
- Publication of SCR reports

LSCBs should have regard to the Panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the Panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings. The following secure e-mail address needs to be used to contact the panel: Mailbox.SCRPANEL@education.gsi.gov.uk.

Timescales for Completion of the Review

The LSCB Independent Chair has one month from the date of receiving the Scoping Panel minutes to make a decision as to how the case will progress. The LSCB should aim for completion of a SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (1) capture points from the case about changes needed; and (ii) take corrective action.

Genograms

A full and accurate genogram should be prepared by the lead agency working with the child/family for the Scoping Panel to assist the clarification of family relationships and dynamics. However, this should not be included in the published final report.

The Role of the LSCB SCR Review Panel

Once the need for an SCR is agreed the SCR sub-committee should identify an appropriate review panel. This panel is responsible for managing the review process and for ensuring that key learning is drawn from the case. Representatives should be included in the Panel from those agencies (including third sector where possible) from across children's and adult's services as appropriate. There is an expectation that the agency representative identified for the Panel attends the meetings and remains a consistent member. Deputies will only be permitted by the Panel in exceptional circumstances. All review Panel members should use the Panel meetings as an opportunity for professional challenge and for quality assurance. They are also responsible for identifying any gaps of information and for promoting the active engagement of their agency's frontline staff in the review process.

Agencies who have been involved with the child/ family will be required to provide information of contact with the family by preparing an agency chronology of significant events within the agreed timescale provided by the Panel, together with a brief analysis of relevant context issues or events. This report should include information about action already taken or recommendations by frontline practitioners for future improvements in practice or process. Where there is significant background information in relation to the child or their family, this should be provided as a brief analysis to accompany the agency report when required. The child and family's history is vitally important and how this information was shared with professionals and taken into account within current decisions and planning should be considered in accordance with the agreed terms of reference.

The review Panel will produce a merged multi-agency timeline of significant events based upon the individual agency's chronologies. The agency reports, the merged

timeline and the genogram should be used as the basis for agreeing areas of specific focus that need to be included in the agreed terms of reference.

Agencies will still be expected to provide an agency report (when specifically required) that has been quality assured and signed off by a senior officer within their agency to confirm the agency's commitment to the process, learning and recommendations. **It is also important to note that all review reports should be written with publication in mind and with an awareness of the potential impact on the family.**

Engagement of Children and Family Members

Families, including surviving children, must be invited to contribute to the review unless there are clear reasons to exclude or limit their participation or they have made an informed decision not to engage. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.
The scope of the SCR should determine the family members that are relevant to the review, and how the family, siblings and the child (where the review does not involve a death) should be invited to contribute to the review. The SCR Scoping Review Panel needs to discuss which members of the family will be involved and record the discussion. The SCR Scoping Review Panel will also need to establish whether there are issues around timing which may affect this dialogue with the family and have a full understanding of the child and family, being mindful of social, ethnic, cultural and linguistic needs.

As part of this discussion, the SCR Scoping Review Panel needs to ascertain whether there are any known factors which may affect the involvement of any family members. It may not be possible to involve the family if; for example, a criminal case is proceeding through court, where a parent or carer is charged with an offence. In these circumstances interviews should only take place once a discussion has been held with the police safeguarding lead and the relevant SIO if there a parallel criminal investigation is being undertaken.

If a complex criminal investigation is being undertaken by the police the medical evidence for the case may not be resolved within the six months allowed for the SCR to be completed. There may be some circumstances where the LSCB, in carrying out its statutory duty to conduct the SCR, considers it would not be appropriate to wait for the conclusion of the criminal proceedings to gather all possible learning about how best to safeguard children.

If, prior to charge or conclusion of a trial, interviews are undertaken by key witnesses engaged in the SCR learning process the following areas will need to be considered by the SCR Independent Reviewer and the SIO and with the relevant witness:

- The key witness may be advised before the interview to contact their legal representative to get advice on what impact the SCR interview might have on their case preparation;
- The interview may be recorded either digitally or full written notes taken;
- The conversation should not include any areas concerning criminal culpability or be about the actual incident which led to the criminal investigation;
- The SIO or the Police Disclosure Officer should be allowed to view the interview record in cases where the key witness has made other disclosures or given alternative accounts, as this could potentially be admissible evidence;
- The interviewee should be told that the record of the interview may be seen by the police.

Arrangements can still be made to update the family when all proceedings are concluded and a copy of the final report should be shared with them.

SCR Panel meetings should have the role of the family as a standing agenda item and identify who will be the appropriate person to co-ordinate and communicate with the family. In some cases, if the family case is open to social care, the dedicated social worker may be most appropriate, or, in a police investigation or the Police Family Liaison Officer (FLO).

During the first meeting with the family it is helpful to set up a family contract as to how the SCR Panel will communicate with the family, maintain support, provide updates etc. This is also the time to introduce the role of the Independent Review Report author so that they can meet and understand the views of the child and family.
The family will want to know what happened, why it happened, how it happened and what can be done to stop it happening to another child. The basic approach needs to be one of openness, sensitivity, honesty, timeliness and clarity; an apology should be given for any failures made, as soon as they are identified during the course of the review.

Engagement with Practitioners

LSCBs and their partners have a shared responsibility to promote the active engagement of frontline practitioners within formal serious case reviews, or learning reviews. Practitioners who have worked with the child and/or their family must be sensitively supported by their agencies and the LSCB to openly share their knowledge and experience of working with the child/ their family. This will help to promote the depth of learning achieved from the review; to identify any systemic issues affecting operational decision making and practice; encourage local challenge; and help effect change in single agency and multi-agency practice. The Review Panel may need to think creatively how to engage frontline practitioners in the review process to help ensure the contribution of key staff is included within the learning process. Different commissioned multi-agency reviews may advocate slight variations in the engagement of practitioners however; the engagement principles that practitioners should be involved must be embedded in all review processes.
The engagement with family members is paramount in the review process and learning must be shared as soon as possible with frontline managers and practitioners. Partner agencies involved in a learning review process should consider at every panel meeting whether any immediate single agency or LSCB multi-agency action is required to respond effectively to any emerging issues identified through the review process. They may wish to deliver swift messages to their individual workforce or identify immediate multi-agency learning that needs to be disseminated to the wider workforce at different points of the review process. An open conversation needs to be held between panel members, the independent reviewer (and if appropriate family members) to discuss what information is being shared to ensure that consideration has been given to whether this action will have an impact on any parallel inquiries or breach any agreed confidentiality process.

It is important for practitioners who have been engaged in the review process to have sight of and agree the accuracy of any recordings of discussions held with them for the purpose of the review to ensure that they are fully satisfied that this is an accurate reflection of their discussion. They should also be invited to attend a feedback session towards the end of the review process to share the learning arising from the review and to be provided with a further opportunity for their views to be heard and reflected.

In order for the police to judge whether the presence of a particular individual at a practitioners event might be of concern in respect of the criminal investigation, all involved agency leads must provide the LSCB administrators with a list of proposed delegates who will be attending any practitioners event. This list of names will then be shared with the police SIO to help manage the balance between the review learning and the potential of practitioners being key witnesses in the investigation.
If a potential key witness is unable to attend and participate in the group practitioner learning event, their views can still be obtained and used to inform the review through offering a one to one interview with a member of the review team.

The Draft Review Report

The Review Panel is responsible for ensuring that the draft Report has met the agreed terms of reference, is succinct and focused on improving local safeguarding arrangements. The report should include the circumstances that led to the review, the practice and organisational or systemic learning identified during the review, examples of good practice and considerations or recommendations about what needs to be done to improve future practice. Any areas of disagreement at the Review Panel meeting in respect of the final Review Report, learning document and action plan should be openly discussed in the Review Panel meeting. If these issues cannot be resolved, the advice of senior agency leads should be sought and / or the LSCB Chair as required.

SMART recommendations should be identified to help bring about improvements and these should be clearly set out in a Learning Review Action Plan. The action plan must be outcome focused and state how actions are intended to make a difference to local systems and safeguarding practice. The Review Panel is also responsible for quality assuring the final document prior to it being presented to the wider LSCB partnership.

The LSCB's Action on Receiving the Final Draft Review Report

From the very start of the review, the fact that the final draft report will be published should be taken into consideration. The SCR report should be written with publication in mind and in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

The Child Death Coordinator will arrange for the Board to receive the final draft review report, action plan and, if available, a summarised learning document for endorsement (an extraordinary meeting may be required to receive the documents). Board partners are responsible for endorsing the report prior to publication and for understanding the operational and strategic learning arising from the review in order for them to actively progress the recommended single / multi-agency improvements and practice development. The final version of the draft review report should be agreed and endorsed by all Board partners before final endorsement is confirmed.

Publishing the Review Report Findings

LSCBs should publish, either as part of the final review report or in a separate document, information about the actions which have already been taken in response to the review findings; the impact these actions have had on improving outcomes for services for children and their families; and what more still needs to be completed to achieve the requirements of the review recommendations.

When preparing to publish, the Child Death Coordinator will need to convene a publication planning meeting. This should include the relevant representatives of the agencies involved in the review and any media communication leads. LSCBs must comply with statutory guidance relating to information sharing and must comply with

any other restrictions on publication of information, such as court orders and the Coroner's office.

LSCBs should send copies of all SCR reports to the National SCR Panel at least one week before publication. If an LSCB considers that an SCR report should not be published, it should inform the Panel which will provide advice to the LSCB. The LSCB should provide all relevant information to the Panel on request, to inform its deliberations. In addition, a copy of the final agreed Review Report must be sent to the NSPCC National SCR Library by the Child Death Coordinator.

The Child Death Coordinator is responsible for working with the LSCB Subcommittee/ Subgroup Chairs to promote and embed the key learning arising from the review. A copy of the report will be placed on the LSCB website for a period of one year. After this time reports are archived but can be made available on request to the Board.

Managing the Impact of Publication

LSCBs should carefully consider how to best manage the impact of publication on children, family members and others affected by the case. The publication planning meeting must consider the arrangements for debriefing the children, family members and relevant practitioners and acknowledge the sensitivities of this.

Managing the Review Findings and Embedding Learning

As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, it is essential that the lessons are learned and acted upon. This means that at least as much effort should be spent on implementing the recommendations as on conducting the review. It is the responsibility of the agencies who have participated in the review to ensure that their agency recommendations are fully implemented and used to make improvements to their safeguarding children arrangements. The LSCB SCR subcommittee is responsible for managing the coordination of the review action plan and for holding agencies to account for the timely and robust progression of any recommendations for improvement. It is also responsible for ensuring that multi-agency learning is embedded and understood across the wider workforce.

Learning Review Action Plan & Escalation Process

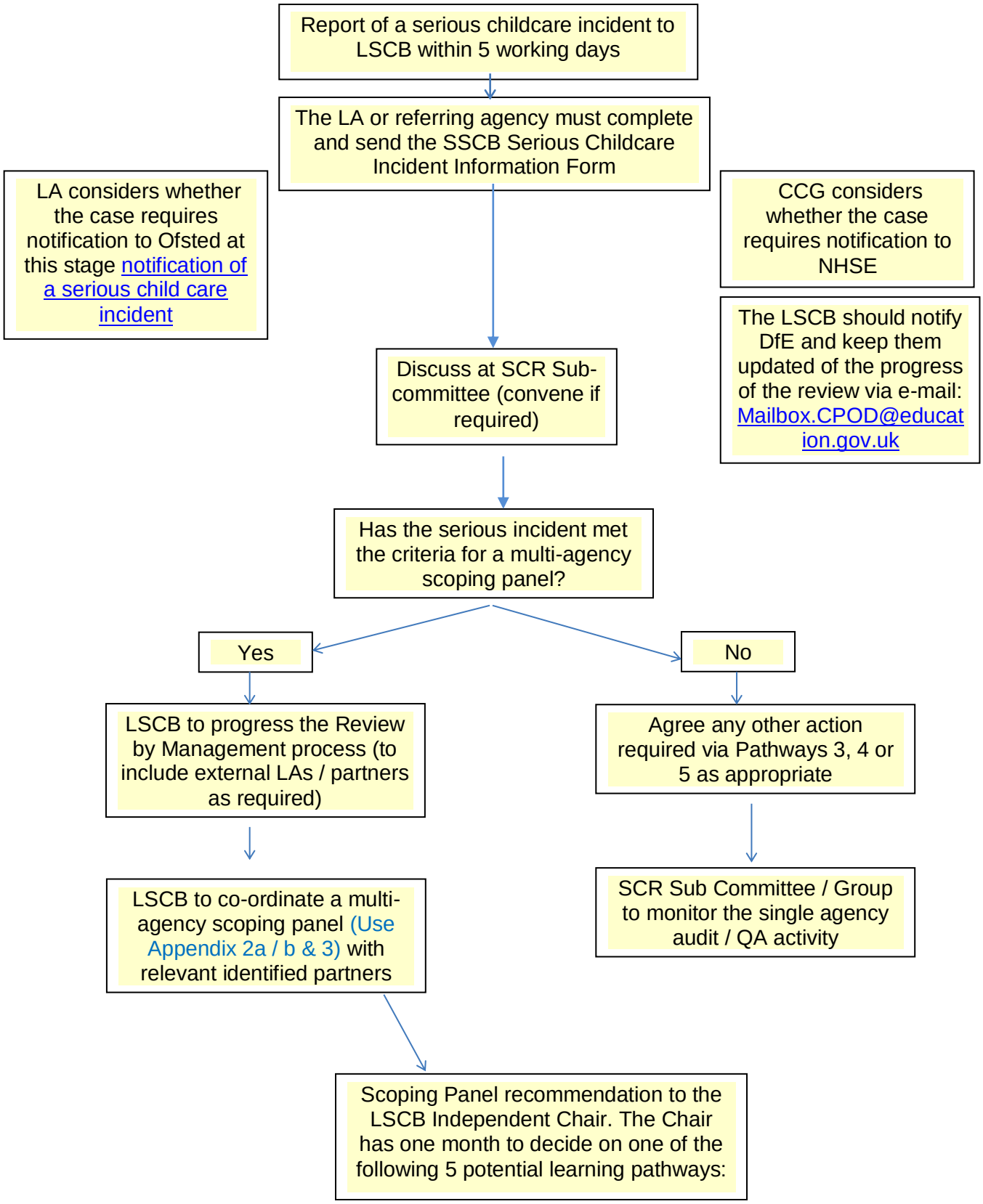
All agencies must provide review action plan updates and any relevant evidence to the Child Death Coordinator, who is responsible for ensuring that the action plan is being actively progressed and managed by the SCR Subcommittee function of the Board. Agencies are expected to progress the recommendations pertaining to their agency and to provide an update report on the progress being made as and when requested by the LSCB. If the relevant agencies representatives are unable to complete their SCR / learning review actions the following escalation process will need to be followed:

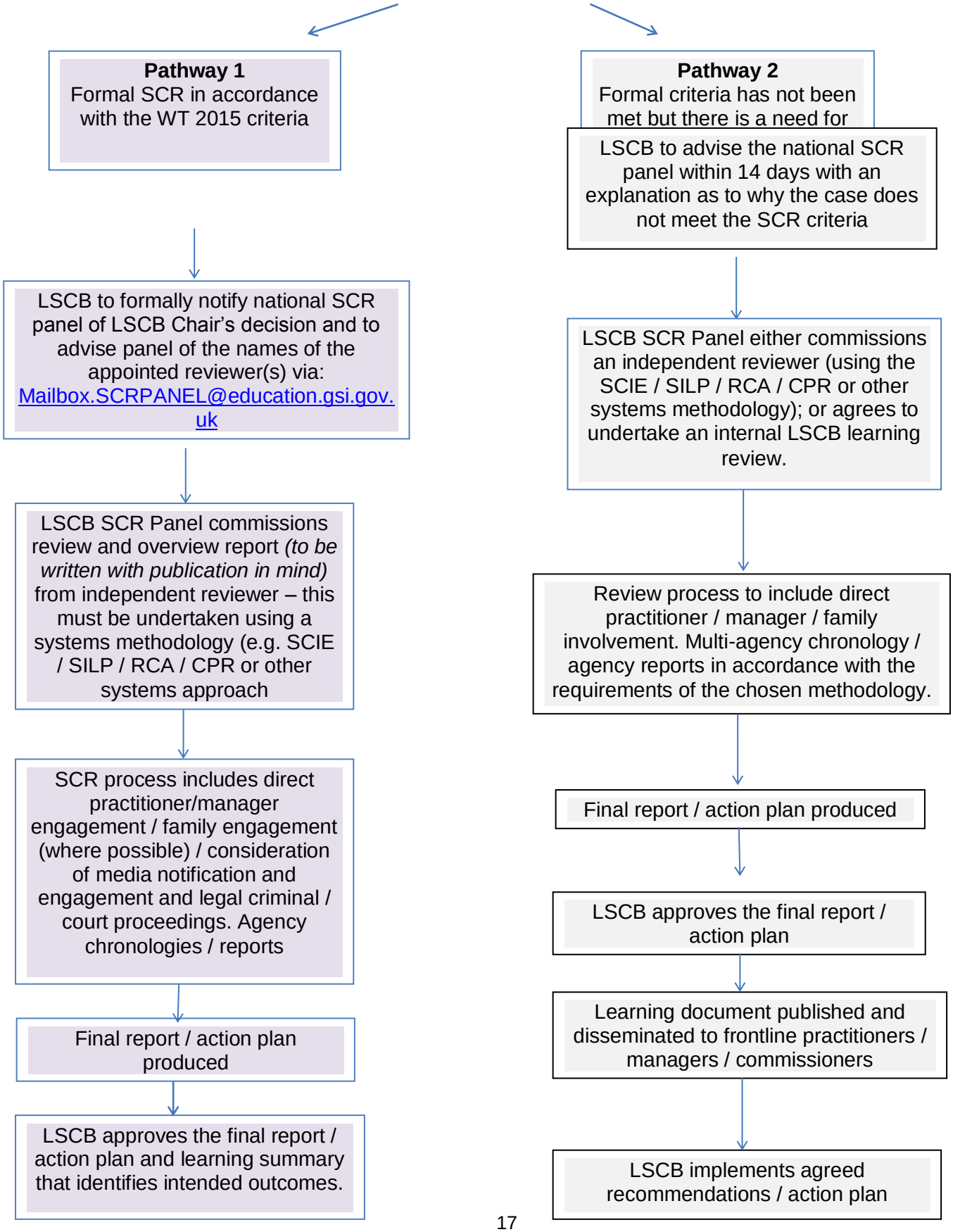
1. The LSCB requests single agency evidence of SCR / learning review action updates after each SCR Subgroup / Committee Meeting
2. All agencies must provide an update on the progress being made and any exceptions at the following SCR Subgroup/ Committee Meeting
3. If after two consecutive meetings no information or evidence has been provided on the progress made against SCR/learning review actions the SCR Subcommittee Chair will:
    - Raise this as an escalation to the LSCB Chairs Group

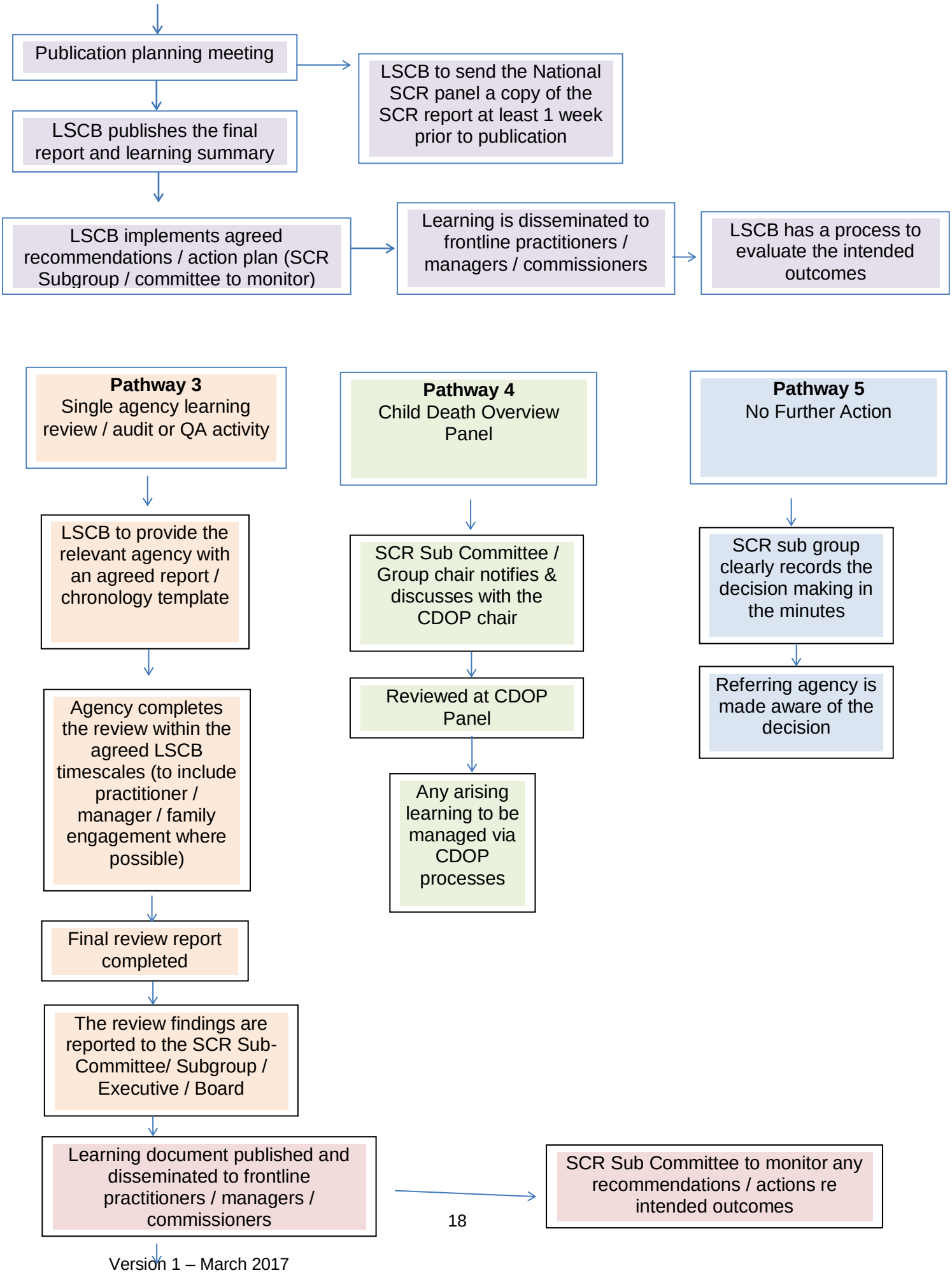
- Send an e-mail to the agency SCR representative lead and their agency lead board member to request timescales for completion
- Please note that if the agency representative is also the SCR Subgroup Chair then the deputy SCR Subgroup Chair has the responsibility to raise the exception at the Chairs Group

4. If SCR/ learning review actions remain outstanding after this; the SCR Subcommittee Chair will report this as an exception at Board.

SCR Process Flowchart




Pathway 1
Formal SCR in accordance with the WT 2015 criteria
LSCB to formally notify national SCR panel of LSCB Chair's decision and to advise panel of the names of the appointed reviewer(s) via: Mailbox.SCRPANEL@education.gsi.gov.uk
LSCB SCR Panel commissions review and overview report (to be written with publication in mind) from independent reviewer – this must be undertaken using a systems methodology (e.g. SCIE / SILP / RCA / CPR or other systems approach
SCR process includes direct practitioner/manager engagement / family engagement (where possible) / consideration of media notification and engagement and legal criminal / court proceedings. Agency chronologies / reports
Final report / action plan produced
LSCB approves the final report / action plan and learning summary that identifies intended outcomes.
Pathway 2
Formal criteria has not been met but there is a need for
LSCB to advise the national SCR panel within 14 days with an explanation as to why the case does not meet the SCR criteria
LSCB SCR Panel either commissions an independent reviewer (using the SCIE / SILP / RCA / CPR or other systems methodology); or agrees to undertake an internal LSCB learning review.
Review process to include direct practitioner / manager / family involvement. Multi-agency chronology / agency reports in accordance with the requirements of the chosen methodology.
Final report / action plan produced
LSCB approves the final report / action plan
Learning document published and disseminated to frontline practitioners / managers / commissioners
LSCB implements agreed recommendations / action plan


Publication planning meeting
LSCB to send the National SCR panel a copy of the SCR report at least 1 week prior to publication
LSCB publishes the final report and learning summary
LSCB implements agreed recommendations / action plan (SCR Subgroup / committee to monitor)
Learning is disseminated to frontline practitioners / managers / commissioners
LSCB has a process to evaluate the intended outcomes
Pathway 3
Single agency learning review / audit or QA activity
LSCB to provide the relevant agency with an agreed report / chronology template
Agency completes the review within the agreed LSCB timescales (to include practitioner / manager / family engagement where possible)
Final review report completed
The review findings are reported to the SCR Sub-Committee/ Subgroup / Executive / Board
Learning document published and disseminated to frontline practitioners / managers / commissioners
Pathway 4
Child Death Overview Panel
SCR Sub Committee / Group chair notifies & discusses with the CDOP chair
Reviewed at CDOP Panel
Any arising learning to be managed via CDOP processes
Pathway 5
No Further Action
SCR sub group clearly records the decision making in the minutes
Referring agency is made aware of the decision
SCR Sub Committee to monitor any recommendations / actions re intended outcomes

SSCB SERIOUS CHILDCARE INCIDENT NOTIFICATION FORM

1. NOTIFIER DETAILS	
Name of notifying agency:	
Designation of notifying professional:	
Date notified:	

2. CHILD DETAILS			
Child's last name(s):			
Child's forename(s):			
Other names used:			
Child's date of birth & age:			
Child's gender:	☐ **Male**	☐**Female**	
Child's ethnicity:			
Child's / family's preferred first language:			
Does the child have a disability?	☐ **Yes**	☐ **No**	☐ **Not Known**
Please state who has parental responsibility for the child:			
Please state if the child is or has been the subject of a child in need, child protection or looked after child plan? ***(Please state which one)***			
Please state if there are / have been any legal orders in place?			
Date of serious incident / date of death:			
Current home address:			
Any other known addresses:			

3. INCIDENT DETAILS	
Date of incident:	
Address where incident occurred:	

4. BRIEF OUTLINE OF THE INCIDENT

5. FAMILY DETAILS	
Details of child's mother:	
First name of mother:	
Surname of mother:	
Other name by which mother may be / have been known by:	
Date of birth of mother:	
Details of child's birth father:	
First name of birth father:	
Surname of birth father:	
Other name by which birth father may be known:	
DOB of birth father:	
Any current / previous partners of birth parents:	
Full name of birth mother or fathers current partner:	
DOB of birth mother / fathers current partner (if known):	
Other names by which mother / fathers partner has been known by:	
Siblings of the subject child *(including all half and step siblings)*:	
Please provide details of any known siblings (please include name / DOB/ gender / home address:	
Significant others involved with / and or supporting the child and their family:	
Please provide details of significant others involved with and / or supporting the family:	
Please state if any of the above named children is, or has been the subject of a child in need, child protection or looked after child plan?	
Please state if there are / have been any legal orders in place?	

6. AGENCY INVOLVEMENT	
Name and address of current GP and surgery:	
Name and address of any education establishment the child is currently attending:	
Name, address and contact number of any other professionals currently involved with the child and their family:	
Details of any services currently being accessed by the child / their family:	

The completed form is to be returned to:
SSCB Child Death Coordinator **Jaki Bateman** Scr.sandwell@nhs.net **SSCB 0121 569 4800**