LSCB Multi Agency Policy and Procedures

Learning and Improvement Framework and Serious Case Reviews

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<th>Date of next review</th>
<th>October 2018</th>
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<td>June 2018</td>
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<td>Date of approval</td>
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The North Lincolnshire LSCB Learning and Improvement Framework

Working Together to Safeguard Children 2015, states that LSCBs should maintain a local learning and improvement framework, which is shared across local organisations who work with children and families. This framework should facilitate organisational learning, implement the shared vision and common purpose that underpins safeguarding children and change and improve services as a result.

The local framework supports the work of the LSCB and their partners so that:

- Reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning actively shared with relevant agencies.
- Reviews look at what happened in cases, and why, and what action will be taken to learn from the review findings.
- Actions results in lasting improvements to services which safeguard and promote the welfare of children and protect from harm and
- There is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of serious Case Reviews (SCR’s) with the public.

LSCB’s should conduct reviews of cases which do not meet the criteria for a 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.

Reviews are not ends in themselves. The purpose of reviews is to identify improvements which are needed and to consolidate good practice. LSCB’s and their partner agencies should translate the findings from reviews into programmes of action which lead to sustainable improvements and prevention of deaths, serious injury or harm to children.

The different types of review include:
- Serious Case Review for every case where abuse or neglect is known or suspected and either:
  - A child dies or
  - A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child
- A child death review; a review of all child deaths
- Review of a child protection incident which falls below the threshold for an SCR
- Review or audit of practice in one or more agencies

Notifiable Incidents

A notifiable incident is an incident involving the care of a child which meets any of the following criteria:
1. A child has died (including cases of suspected suicide) and abuse or neglect is known or suspected
2. A child has been seriously harmed and abuse or neglect is known or suspected
3. A looked after child has died (including cases where abuse or neglect is not known or suspected) or
4. A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSCB or LSCB’s promptly and within five working days of becoming aware that the incident has occurred.

If an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident. There will however be notifiable incidents that do not proceed to serious case review.

Process of Notification

In the light of the Children and Social Work Act 2017. In particular:

(i) how local authorities notify serious incidents involving children to the national Child Safeguarding Practice Review Panel (the Panel); and

(ii) what LSCBs will need to do during the transition period to new local safeguarding arrangements.

Duty on local authorities to notify serious incidents

The new Panel will be fully operational from 29 June 2018. From that date, local authorities will be required, under a new statutory duty, to notify the Panel of incidents where they know or suspect that a child has been abused or neglected and:

(a) the child dies or is seriously harmed in the local authority’s area; or

(b) while normally resident in the local authority’s area, the child dies or is seriously harmed outside England.

These notifications should be made within five working days of the local authority becoming aware of the incident.

Local authorities should continue to use Ofsted’s current online notification system to notify the Panel until a new system for the Panel goes live later in the year. Notifications made through this route will go to the Panel, Ofsted and the DfE.

The local authority should also report the incident, within the same five working days, to the relevant LSCB, or to the new local safeguarding partners when they become established.
LSCBs and serious case reviews

**LSCBs must continue to carry out all of their statutory functions, until the point at which safeguarding partner arrangements begin to operate in a local area.** At the latest this will be by 29 September 2019.

The Government places a high priority on encouraging those who work with children to learn from serious incidents so that practice and services are improved to reduce the risk of future harm to children and to improve their outcomes.

The current national panel of independent experts on serious case reviews (SCRs) (as set out in Working Together 2015) met for the last time on 11 June 2018. Since July 2013, it has considered 540 cases where LSCBs proposed not to initiate an SCR, and 86 cases where LSCBs proposed not to publish an SCR. A breakdown of these figures will be included in the panel’s final report which will be published later this year. We acknowledge that the panel has undertaken a significant amount of work on a voluntary basis to bring challenge and scrutiny to the SCR system.

The new Panel will, as part of its role in considering whether to commission national reviews, also consider LSCBs’ decisions on the initiation and publication of SCRs. LSCBs should, therefore, now send all information about decisions not to initiate or to publish an SCR to the new Panel at Mailbox.NationalReviewPanel@education.gov.uk. This should include decisions relating to all child safeguarding incidents notified to Ofsted and DfE before July 2018 but where no further information on the case has been sent to the national panel of independent experts. The new Panel expects to hold its first meeting in early July. In the interim, the DfE may contact LSCBs about any cases outstanding from the former panel, and will give a list of such cases to the new Panel.

**Learning and Development Framework**

The North Lincolnshire Learning and Development Framework consists of several components that provide mechanisms for professionals to acquire knowledge and skills that transforms their practice and to ensure that there is feedback about the learning and development that refines and shapes a learning organisation.

The LSCB Board Members have committed to a framework that enables them to have a line of sight on front line practice, to ensure effective safeguarding arrangements are in place and that this is making a positive impact upon the lives of children and their families.

The components of the learning and development framework include:

- **Performance Management – Childs Journey**  
  *Quarterly*
  A full suite of performance information (compliance/scorecard/turn the curve summaries) is collated, analyzed and presented to the board highlighting key areas for consideration. The Board will discuss and undertake further analysis where necessary to ensure that a lead agency takes responsibility to lead on improvement.

- **Safeguarding training and evaluation**  
  *Quarterly*
  Training data and analysis is undertaken and presented to the Board; this includes any feedback from other audit activity to demonstrate effectiveness or further learning in practice.

- **LSCB Board member Multi Agency Case Evaluation and Line of Sight Meeting**  
  *4-Monthly*
  The LSCB Case Audit process enables board members to review audits of cases completed by operation managers on a multi-agency basis. The Process is that the Board expects that the cases are audited by the agency managers and are signed off regarding their compliance with statutory
requirements. This allows then for a cross cutting debate on qualitative issues between Board members, practitioners and supervisors on the case audit. Learning is identified for each agency in relation to the case, as well as identifying developmental areas of learning across the whole Board in terms of themes and compliance with Working Together 2015.

• Safeguarding Pathway Multi Agency Audit Meeting
  Monthly
  Multi Agency case audit meeting is chaired by the Principal Social worker (Children and Community Resilience).
  Key agencies represented on the LSCB (health, police, learning, skills and culture and children and community resilience) meet as a working group to explore and audit according to specific themes and areas of focus agreed at the Safeguarding Pathway Lead Officer Group. Learning is captured and communicated to the Board via the SPLOG.

• Practice Observation
  Annually
  Each board member undertakes to do a live observation and report back to the board. This can be as part of the agencies own section 11 challenge or in relation to other functions, e.g. social work duty work, case conferencing, strategy discussions.

• Section 11 Challenge
  Annually
  Each agency presents a report and each representative has a one to one challenge interview with the chair and a selected panel on their contribution and effectiveness of safeguarding arrangements. This could be in general in respect to section 11 duties or in respect of a theme e.g. CSE. In addition, further learning is reported as part of the managers’ report to the LSCB is included from

• Review of Child Deaths
  Monthly

• Serious Case Reviews local and national
  Monthly

• Specific Reports
  Annually
  Private Fostering- activity and impact over the last year.
  Harmful Sexual Behaviour Panel- activity of the panel and difference it has made to children and young people referred to it.
  Multi Agency Public Protection Arrangements- annual review report presented to the LSCB.
  Multi Agency Risk Assessment Conference- report on activity and impact presented to the LSCB.
  Youth Offending Service - Report on the service, delivery and impact.

Principles for Learning and Improvement

The following principles are applied by the LSCB and their partner organisations to the learning and improvement framework:

• there should be a culture of **continuous learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promotes good practice
• there should be a no blame culture which permeates all learning and development including serious case reviews
• we should place learning within the context of ‘systems thinking’ as understanding how systems behave leads to understanding better practices
• learning is a dynamic, continuous process and knowledge does not remain static
• professionals and organisations will use evidence based research to inform their practice
• knowledge should be shared across agencies to build and enhance multi agency working
• knowledge and information will be shared to build understanding and improve professional practice in order to improve outcomes for children, young people and their families
• professional development is an ongoing process from induction onwards

Safeguarding Training

The importance of safeguarding training is reinforced through the Biennial studies of Serious Case Reviews (Brandon et al 2009-2011, 2013, 2016). People who work with children, young people and their families should have access to appropriate safeguarding training and learning opportunities to ensure that they understand their own and other agencies responsibilities develop their knowledge, skills and practice in respect of safeguarding and promoting the welfare of children. Agencies that employ or have volunteers who work with children, young people and their families should ensure that their employees/ volunteers receive training in respect of safeguarding children and young people that is commensurate with their roles and responsibilities.

In addition to single agency training, research has shown that multi agency training is highly effective in helping professionals understand their respective roles and responsibilities, the procedures of each agency involved in safeguarding children and in developing a shared understanding of assessment and decision making practices. The opportunity to learn together is greatly valued; participants report increased confidence in working with colleagues from other agencies and greater mutual respect.

Roles and responsibilities, Employers

Employers are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare.

It is the responsibility of employers to recognise that in order for staff to fulfil their duties in line with Working Together to Safeguard Children 2015 they will have different training needs which are dependent on their degree of contact with children and young people and/or adults who are parents or carers, their level of responsibility and independence of decision making.

Employers should ensure that all those in contact or working with children and young people and/or with parents or carers have a mandatory induction see section on Induction Standards for Safeguarding Training. Induction should be completed within the first six months of employment and before individuals take part in multi agency training. Regular refresher training should also be provided at least every three years.

Employers should ensure that their employees who work or have contact with children are appropriately trained in child development and in how to respond and act on potential signs of child abuse and neglect. Training should also include associated vulnerability and risk factors together with resilience and protective factors, identifying potential violent behaviour and assessing the capacity of a parent or carer to meet a child’s need, taking into account their own needs/circumstances/history/illness/addiction. Increasingly professional bodies are requiring their members to demonstrate relevant education and training as part of revalidation.

Employers should ensure that appropriately qualified staff undertaking specialist roles in both children’s and adults’ services receive the necessary specialist training. For experienced social workers, police and health professionals undertaking key management, decision making and supervisory roles in duty and intake teams this should include training on managing referrals where there are concerns about the safety and welfare of a child or children.
Working Together to Safeguard Children 2015 outlines the specific responsibilities of professionals within the early help arena, when a child has been referred for statutory intervention and within the serious case review and child death review processes. Professionals need to be competent, confident and effective in their practice in order to ensure that they are operating in line with procedural and legislative requirements. Professionals require appropriate training, which is commensurate with their scheme of delegation in respect of safeguarding and child protection.

Employers are responsible for identifying adequate resources to support multi agency training by:

- Committing resources for multi agency training for example through funding, providing venues, providing staff who contribute to the planning, delivery and evaluation of multi agency training
- Providing staff with the relevant expertise to support and deliver the Local Safeguarding Children Board's training strategy;
- Releasing staff to attend the appropriate multi agency training courses and ensuring the time for them to complete multi agency training tasks and apply their learning in practice; and
- Ensuring that staff receive relevant single-agency training that enables them to maximise the learning derived from multi agency training.

Employers have a responsibility to ensure that all staff, including administrative staff are given opportunities to attend local courses in safeguarding and promoting the welfare of children, or ensure that safeguarding training is provided within the team. As an employer, GP’s have an important role to play in ensuring staff whom they employ are trained and should ensure that practice nurses, practice managers, receptionists and any other staff whom they employ are given the opportunity to attend local courses in safeguarding and promoting the welfare of children.

**Programme of Multi Agency Training**

Effective safeguarding practice is built around interventions where practitioners, supervisors and managers implement evidence based approaches with children and families that are demonstrated to be effective. Organisations need to be proactive, developmental and learning based environments within which practitioners can grow, refine and enhance their skills and competencies working to safeguard children and young people.

The Munro Review of Child Protection identifies that, as a minimum, the capabilities being developed for child and family work must include:

**Knowledge:**

- knowledge of child development and attachment and how to use this knowledge to assess a child’s current developmental state;
- understanding the impact of parental problems such as domestic violence, mental ill health, and substance misuse on children’s health and development at different stages during their childhood; and
- knowledge of the impact of child abuse and neglect on children in both the short and long term and into adulthood.

**Critical reflection and analysis:**

- ability to analyse critically the evidence about a child and family’s circumstances and to make well-evidenced decisions and recommendations, including when a child cannot remain living in their family either as a temporary or permanent arrangement; and
- skills in achieving some objectivity about what is happening in a child’s life and within their family, and assessing change over time.

**Intervention and Skills:**

- recognising and acting on signs and symptoms of child abuse and neglect;
- purposeful relationship building with children, parents and carers and families;
- skills in adopting an authoritative but compassionate style of working;
- skills to assess family functioning, take a comprehensive family history and use this information when making decisions about a child’s safety and welfare;
knowledge of theoretical frameworks and their effective application for the provision of therapeutic help;

knowledge about, and skills to use and keep up-to-date with, relevant research findings on effective approaches to working with children and families and, in particular, where there are concerns about abuse or neglect;

understanding the respective roles and responsibilities of other professionals and how child and family social workers can contribute their unique role as part of a multi-disciplinary team; and

skills in presenting and explaining one’s reasoning to diverse audiences, including children and judges.

The Health and Wellbeing Board in North Lincolnshire has 9 areas of knowledge and skill that have been identified across the children and adult workforce. These are:
1 - Effective communication and engagement

Good communication is central to establishing trust and making sure information is shared and received in the way that is intended to encourage openness and transparency. This key area highlights the importance of knowing how to listen, empathise, explain, consult and seek support. Engagement should focus on seeing the individual as having expertise in their own needs, being asset and strengths based and solution focussed, whilst recognising that at times people may need protecting.

2 - Information sharing

Knowing when and how to share information is an essential part of delivering better services for children, young people, adults and older people. The skills and knowledge in this area include understanding and respecting the legislation and ethics surrounding confidentiality and security of information. As well as information sharing in relation to individuals and families, agency representatives at key groups and partnerships will be expected to take responsibility for disseminating key information and communication messages across their individual services and agencies which supports a common understanding and shared culture leading to improved outcomes.

3 - Supporting people’s development and transitioning through the lifestages

Understanding the developmental changes that children, young people, adults and older people go through can be key to interpreting their behaviour and it can have a profound effect on their health and wellbeing. This area of expertise helps the children and adults workforce to understand what makes children, young people, adults and older people to think and act in the way they do and to encourage us to respond to and support their needs and they emerge. It also helps us to identify transitions, understand their likely impact and support as appropriate.

4 - Safeguarding and promoting the welfare of children, young people and vulnerable adults

This set of skills centres on keeping children, young people and vulnerable adults safe and knowing how to recognise safety and protection concerns and how to identify if they are suffering significant harm. They also help us to see that when people are not fulfilling their potential and help us to ensure their health, wellbeing and quality of life.

5 - Promoting wellbeing

This set of skills centres on everyone recognising the breadth of the concept of wellbeing and their responsibility in promoting individuals wellbeing.
These will be promoted through the LSCB training strategy and plan. The LSCB training strategy and plan can be accessed at http://www.northlincslscb.co.uk/professionals/training/

Section 11 of the Children Act 2004, identifies the key agencies that have a statutory duty to cooperate in order to safeguard children and Working Together to Safeguard Children 2015 reinforces this, stating that there should be appropriate arrangements in place to ensure that staff are trained and competent to carry out their duties for safeguarding and promoting the welfare of children, this includes staff working in adult based services working with parents and carers. The LSCB is responsible for monitoring and evaluating the effectiveness of training.

Research informs us that some children are potentially more vulnerable than others to abuse and neglect and therefore agencies need to be alert to this and understand what additional support may be necessary to keep vulnerable children safe. These children are:

- Children Living away from home and/or in care
- Privately fostered children
- Asylum-seeking children in the community and in short-term holding centres and immigration removal centres
- Children in mental health settings
- Children temporarily accommodated in secure or hospital care
- Children in secure settings, especially when placed outside their area
- Children at risk or who are offending
- Children and young people who go missing
- Disabled Children
- Children at risk of Child Sexual Exploitation
Children are clear what they want from an effective safeguarding system. These include:

- **Vigilance**: to have adults notice when things are troubling them
- **Understanding and action**: to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **Stability**: to be able to develop an ongoing stable relationship of trust with those helping them
- **Respect**: to be treated with the expectation that they are competent rather than not
- **Information and engagement**: to be informed about and involved in procedures, decisions and concerns and plans
- **Explanation**: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- **Support**: to be provided with support in their own right as well as a member of their family
- **Advocacy**: to be provided with advocacy to assist them in putting forward their views

The Munro Review of Child Protection (2011) emphasised the importance of developing expertise in the children’s workforce, so that we can provide skilled help from early intervention onwards to enable children and young people to stay safely within their families. In the review, Professor Munro also stated that the child protection system should be child-centred, recognising children and young people as individuals with rights, including their right to participate in major decisions about them in line with their age and maturity. She recognised that, although a focus of work is often on helping parents with their problems, it is important to keep assessing whether this is leading to sufficient improvement in the capacity of the parents to respond to each of their children’s needs.

Serious Case Reviews (Brandon et al 2009-2011, 2013) consistently identify that children are not placed centrally in interventions by professionals and that:

- Children were not seen frequently enough by professionals, or were not asked their views and feelings
- Agencies did not listen to adults who tried to speak on behalf of the child, who had important information to contribute
- Parents and carers prevented professionals from seeing and listening to the child
- Practitioners focused too much on the needs of the parents, especially on vulnerable parents and overlooked the implications for the child

LSCB training will focus upon building skills described by children as important to them and develop the knowledge that underpins practitioner’s effective interventions with children and families to safeguard children. The LSCB will ensure that the training remains child centred and that communication and empowerment of children is a consistent theme within its approach. Courses are designed to support the development of multi agency practitioner’s understanding and empathy with the experience of children and to support practitioners in being skilled at communicating with children at every stage in the child centred system.

**The LSCB training and development framework aims to:**

I. Build an effective workforce whose practice is underpinned by best practice

II. Raise awareness and understanding of safeguarding children in North Lincolnshire

III. Develop frontline practitioners’ expertise

IV. Provide a learning pathway that describes the continuing professional development of staff

V. Provide a forum for sharing expertise
VI. Shape the culture of development and learning

**Induction Standards for Safeguarding and Promoting the Welfare of Children or Young People**

These standards outline the minimum that professionals need to know and do if they are working with a child or young person at risk of harm or neglect. It is suggested that this is delivered as part of an induction programme for staff.

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<th>Main Areas</th>
<th>Outcomes</th>
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<tr>
<td>1 Legislation, policies and procedures</td>
<td>a. Know about legislation and national guidance relating to protecting (safeguarding) children.</td>
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<td>b. Describe your workplace’s policies and procedures on helping children and young people who have been harmed.</td>
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<td>2 Enabling a safe environment</td>
<td>a. Understand what children and young people want and need to feel safe.</td>
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<td>b. Have an awareness of what contributes towards a safe environment for the children and young people you work with.</td>
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<td>3 Recognising and responding to abuse</td>
<td>a. Understand the different ways in which children and young people can be harmed by adults, other children and young people, or through the internet.</td>
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<td>b. Understand what is meant by the following:</td>
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<td>• Physical abuse</td>
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<td>• Sexual abuse</td>
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<td>• Emotional abuse</td>
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<td>• Domestic abuse and other forms of harm eg FGM</td>
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<td>• Neglect</td>
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<td>• Institutional abuse</td>
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<td>• Sexual exploitation</td>
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<td>• Bullying</td>
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<td>• Self-harm</td>
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<td>c. Describe signs and indicators or possible abuse and neglect.</td>
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<td>d. Describe the procedure you need to follow if you suspect any child is being abused, neglected or bullied.</td>
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<td>e. Understand that parental problems (for example, domestic violence or drug and alcohol abuse) can increase the risk of harm to a child.</td>
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<td>f. Describe what emergency action needs to be taken to protect a child, including outside normal office hours.</td>
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<td>4 Working with other agencies</td>
<td>a. Know about and understand their place and role in the single organizational model</td>
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<td>b. Know their own partnership role and how to work in partnership with others</td>
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<td>5 Making a referral</td>
<td>a. Know when and how to refer a concern you have about a child</td>
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<td>b. Explain who to consult in relation to a child protection or child welfare concern</td>
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<td>6 “Whistle-blowing” (reporting failures in duty) Managing Allegations Against People who work with children.</td>
<td>a. Understand your duty to report the unsafe practice of others.</td>
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<td>b. Know what to do if you have followed your own workplace’s policies and procedures on reporting concerns, and you are not satisfied with the responses.</td>
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<td>c. Identify what to do when you do not get a satisfactory response from other organisations or agencies.</td>
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<td>d. Understand their duty in circumstances where there is a concern/ allegation about the way in which an adult who works with children has behaved, which indicates that they have harmed or may have harmed a child, and /or committed a criminal offence and/ or behaved towards a child (ren) that indicates they may pose a risk to them.</td>
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Model for Continuous Professional Development

North Lincolnshire have adopted the theoretical model (below) to underpin the LSCB Training and development framework. The LSCB believe that this model articulates the aspirations behind the Munro Review of Child Protection and what Professor Munro describes as building professional expertise. The model describes how multi agency practitioners develop through stages of skill acquisition to move from novice to expert practitioners. The LSCB Training and development framework is built offering around each of the stages of skill acquisition so that no matter where an individual is regarding their skill and experience base there are opportunities for them to progress their continuous professional development and to build and sustain an expert workforce.

The model reflects how knowledge is gained over time and the importance of experience as ‘Experience is a ...requisite for expertise’ (Benner, P 1984)

The groups of staff who require training are as follows:

- Those who have **occasional contact** with children, young people and/or parents/carers;
- Those in **regular or in intensive but irregular contact** with children, young people and/or parents/carers;
- Those who work **predominantly** with children, young people and/or parents/carers;
- Those who have particular **specialist** child protection responsibilities;
- Professional advisers and **designated** leads for child protection;
- **Operational managers** of services for children, young people and/or parents/carers;
- **Senior managers** responsible for strategic management of services for children, young people and/or parents/carers; and
- Members of the LSCB

A Model for Translating Learning into Practice:

The LSCB provides training opportunities, however it is incumbent upon organisations to ensure that learners transfer their learning into practice and are supported within this. To embed learning and continue to support evidence based practice the LSCB and individual must work simultaneously to ensure that staff:
receive the right training with the right support at the right time to facilitate transfer and client impact' (Curry cited in Howath and Morrison 1999, p292)

The model describes this relationship and the role that organisations have:

```
Learner
↓
What is to be transferred
Model of knowledge → Transfer ← Training
Acquisition
Planning
{Implementation
Review}

Organisation: Promoting Personal Development
Accessing training
On site opportunities
Practical Emotional Support
Supporting skill acquisition
Feedback, observation of practice
Supervision, Reflection
Experts
```

(Adapted from Horwath and Morrison 1999, p 303)

The LSCB Training Strategy and Training Plan outline how multi agency training will be delivered locally and these are available on [http://www.northlincslscb.co.uk/professionals/training/](http://www.northlincslscb.co.uk/professionals/training/)

**Effective Support and Supervision**

Supervision is a key supportive mechanism for professionals working within child protection contexts. Supervision is a learning process, the model outlined below by Kolb (1998) is a supportive framework for reflective supervision.

![Supervision Model](https://via.placeholder.com/150)

Those providing supervision to people who are working with children, young people and their families should be trained in supervision skills and have an up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children.

The key functions of supervision are:
- Management (ensuring competent and accountable performance/practice)
Developments (continuing professional development)
Support (supportive/restorative function)
Engagement/mediation (engaging the individual with the organisation)

Davys and Beddoe (2010) identify the interventions and skills needed in supervision:

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Skills typically employed</th>
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<tbody>
<tr>
<td>Event</td>
<td>Listening and attending</td>
</tr>
<tr>
<td></td>
<td>Open question enquiry</td>
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<tr>
<td></td>
<td>Information giving (Minimal)</td>
</tr>
<tr>
<td>Exploration: impact</td>
<td>Listening and attending</td>
</tr>
<tr>
<td></td>
<td>Open question enquiry</td>
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<tr>
<td></td>
<td>Feedback: confirmatory and reflective</td>
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<tr>
<td></td>
<td>Reframing</td>
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<tr>
<td></td>
<td>Challenge</td>
</tr>
<tr>
<td>Exploration: Implications</td>
<td>Listening and attending</td>
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<tr>
<td></td>
<td>Open question enquiry</td>
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<tr>
<td></td>
<td>Feedback: confirmatory, corrective, reflective</td>
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<tr>
<td></td>
<td>Reframing</td>
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<td></td>
<td>Challenge</td>
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<td></td>
<td>Information giving</td>
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<td></td>
<td>Directives</td>
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<tr>
<td>Experimentation</td>
<td>Listening and attending</td>
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<td>Open question enquiry</td>
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<td>Feedback: confirmatory, corrective, reflective</td>
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<td>Open question enquiry</td>
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<tr>
<td></td>
<td>Feedback: confirmatory and reflective</td>
</tr>
</tbody>
</table>

Ref: Best Practice in Professional Supervision A Guide for Helping Professions (A Davys and L Beddoe 2010)

Supervision provides a space where a practitioner can refine his/her practice within professional and organisational boundaries and in line with knowledge base and the policy framework. In order to promote effective supervision, it is useful for supervisors to have a framework which they apply during supervision in order to ensure that the functions of supervision as outlined above are being met.

Agencies represented on the LSCB will have their own arrangements in place for the supervision of practitioners. For some registered professionals their professional body requires that they have supervision and this is made explicit, for example:

- Standards of Proficiency for Social Workers in England (HCPC2012) 11.2 recognise the value of supervision, case reviews and other methods of reflection and review.

For other professional groups the importance of continued practice development and taking part in activities that contribute to their ongoing professional development and effective practice is referenced and supervision can be one mechanism which supports this, for example:

- Nursing and Midwifery Council : The Code

Supervisors are an important source of advice and expertise for practitioners. In addition they can support practitioners in understanding the risk and protective factors within a child’s life and how these can be managed/negated or what alternative action must be taken. Supervisors should always record key decisions and advice given within the relevant case record.
In addition supervisors should regularly audit case files to review whether the work undertaken is appropriate to the child’s current needs and circumstances, and complies with the agency’s responsibilities and standards.

Working to protect children from harm is a demanding job, in some circumstances practitioners may need additional support. This may involve facilitating referral to staff welfare services or the provision of advice and support from experienced staff within the organisation.

Quality Assurance

The LSCB has a statutory function set out in section 14 of the Children Act 2004 to ‘ensure the effectiveness of what is done by each person or body’ on the LSCB. The LSCB has a quality assurance framework to undertake routine audits of multi agency case work. The purpose of undertaking case audits is to examine:

- The quality of assessments
- The timeliness and effectiveness of planning and decision making
- The quality of risk assessment and analysis underpinning decision making
- The quality and appropriateness of interventions
- The effectiveness of agencies of working together including adult services, such as adult mental health and substance misuse services
- Identify learning from good practice and areas of further development
- The experience and views of the child/young person

Agencies contribute and share information under Section 14 A of the Children Act 2004. This was inserted by section 8 of the Children, Schools and Families Act 2010, which enables the LSCB to require a person or body to comply with a request for information that is essential to the LSCB carrying out its statutory duties.

The learning from undertaking audits of multi agency cases is disseminated through the following mechanisms:

- LSCB Information sessions
- LSCB Newsletter
- LSCB training courses
- Practice updates circulated
- Incorporated into updates of policies and procedures This ensures that there is a double loop learning mechanism in place that drives and shapes multi agency practice.

Multi-Agency Safeguarding Pathway Lead Officer group (SPLOG)

The SPLOG is a lead officer group that oversees multi-agency work across the safeguarding pathway, from early help to acute services. This group uses intelligence, data, service user feedback, and analysis from the Multi agency safeguarding pathway audit meeting to drive forward continuous improvement in multi-agency effectiveness for children and families. This group reports to the LSCB, and has a specific role in identifying opportunities for learning for individual agencies and the wider safeguarding system. The SPLOG will direct the Multi-agency safeguarding pathway audit group which meets monthly, to undertake specific pieces of audit work, and will oversee the dissemination of relevant learning that may arise as a result. Equally, the SPLO may commission or direct other specific learning reviews or audits as appropriate. The SPLO will also receive updates from the Principal Social Worker in relation to any learning from cases that have been escalated via the SAFE procedure, or from relevant internal reflective multi-agency ‘pit-stop’ meetings.

Reviews of child deaths

The LSCB has a child death review process in place to review all child deaths in the North Lincolnshire area. LSCB Policy and Procedure CDR Process and CDOP outlines the process we
have in place. The learning from the child death review process is incorporated into the LSCB Annual Review and any thematic learning is disseminated to professionals through the LSCB newsletter and information sessions.

**Serious Case Reviews**

This process is based upon Chapter 4 of *Working Together to Safeguard Children 2015*, which reflects on, Ofsted reports\(^1\), and National Panel of Independent Experts on Serious Case Reviews: Operating Guidance\(^2\).

As set out in regulation 5 of the Local Safeguarding Children Board Regulations 2006, the LSCB is required to undertake Serious Case Reviews in specified circumstances as part of its statutory responsibilities to ensure and monitor the effectiveness of what is done to safeguard children. Regulation 5(1)(e) and (2) set out an LSCB’s function in relation to serious case reviews, namely;

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1)(e) a serious case review is one where-

(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.

‘Seriously harmed’ include but is not limited to, cases where a 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.

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

Cases which meet 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 has 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 interagency working the LSCB must commission an SCR.

In addition, even if one of the criteria is not met, a SCR should always be carried out when a child dies in custody, police custody, on remand or following sentencing, in a Youth Offender Institution, in a secure training centre or a secure children’s home. The same applies where a child dies who was detained under the Mental Health Act 1993 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

The final decision on whether to conduct an SCR rests with the LSCB Chair. LSCB’s should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not

\(^{1}\)http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/reviews/a0068869/scrs  
\(^{2}\)24\(^{th}\) June 2013  
http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/reviews/a00209970/scr-munro
required because the criteria in regulation 5(2) are not met, the LSCB may still commission an SCR or they may choose to commission an alternative form of case review. The LSCB should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

National Panel of Experts

Note: The national panel of experts has been replaced by the new National Child Safeguarding Practice Review Panel and Working Together to Safeguard Children 2018 due to be published June 2018 will clarify the new panel’s remit and responsibilities. Please refer to the section ‘Process of Notification’ for further details.

Since 2013 there has been a national panel of independent experts to advise LSCB’s about initiation and publication of SCR’s. The role of panel is to support LSCB’s in ensuring that the appropriate action 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 also reports to the Government their views of how the SCR system is working.

The panel’s remit includes advising LSCB’s about
- Application of the SCR criteria
- Appointment of reviewers and
- Publication of SCR reports

LSCB’s 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 request for information such as copies of SCR reports and invitations to attend meetings.

Purpose

The prime purpose of a Serious Case Review (SCR) remains for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learnt should be disseminated effectively and the recommendations should be implemented in a timely manner so that changes required result, wherever possible, in children being protected from harm or the likelihood to suffer harm in the future. Where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed.

The purpose of a Serious Case Review is to:
- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result
- Improve single and multi-agency working and better safeguard and promote the welfare of children.

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. (Ref Working Together to Safeguard Children 2015)

Serious Case Reviews are not part of any disciplinary inquiry or process relating to individual practitioners. Where information emerges in the course of an SCR indicating that disciplinary
action should be initiated, the relevant processes should be undertaken separately from the SCR process. Some SCR’s may be conducted concurrently with (but separately from) disciplinary action. In some cases it may be necessary to initiate disciplinary action as a matter of urgency to safeguard and promote the welfare of other children.

**Principles underpinning Serious Case Reviews**

As with all reviews completed under the LSCB learning and improvement framework, the following principles should be applied to all SCRs:

- there should be a culture of continuous *learning and improvement* across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be *proportionate* according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are *independent* of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. 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;
- final reports *must be published*, including the LSCB’s response to the review findings, in order to achieve *transparency*. The impact of SCRs on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

(Ref Working Together to Safeguard Children 2015,)

**SCRs and other case reviews should be conducted in a way which:**

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

(Ref Working Together to Safeguard Children 2015,)

**Safeguarding Siblings and Other Children**

When a child dies or is seriously harmed and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to immediately consider whether there are other children who are suffering or likely to suffer significant harm, and who require safeguarding. Where there are concerns about the welfare of siblings or other children the *LSCB Policy and Procedure Assessing Need and Providing Help* and *Helping Children and Families (Threshold Document 2016-2020)* should be followed. Thereafter, organisations should consider whether there are any lessons learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

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3 British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN
Other LSCB processes

The death of every child is reviewed in accordance with the child death overview processes. A referral for consideration of a SCR may be triggered at any point in the child death overview processes if the rapid response meeting or Child Death Overview Panel (CDOP) considers a case may meet the criteria for a SCR.

Association of Independent LSCB Chairs

The Association of Independent LSCB Chairs has introduced a SCR Peer Consultation Scheme which allows an LSCB Chair to consult a fellow Chair for support on a particular issue related to an SCR. The nature of the support will be agreed between the Chairs, but could be on, for example:

- the decision to hold an SCR (including whether any other form of review would be appropriate)
- setting up the SCR and process issues
- the overview report
- how to make the report publishable
- decisions on publication
- the LSCB response to the SCR.

Further details of the Scheme are included at Appendix 2.

Decision about Whether to Initiate an SCR

The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for a SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB must let Ofsted, DfE and the national panel of independent experts know their decision within 5 working days of the Chairs decision.

If the LSCB decides not to initiate a SCR, their decision may be subject to scrutiny by the national panel. The LSCB should provide information to the panel on request to inform its deliberations and the LSCB Chair should be prepared to attend in person to give evidence to the panel. In cases where an LSCB is challenged by the national panel to change its original decision the LSCB should inform Ofsted, DfE and the national panel of the final outcome.

Decision Making Process

Referral of a case for consideration of an SCR or learning review

If a case is thought to meet the criteria for an SCR (as above) a senior manager/office will notify the Chair/Vice Chair of the SCR Sub Committee. Following the Chair/Vice Chair’s consultation with relevant senior managers across the partnership there are two pathways of decision making:

a) If the case clearly does not meet the criteria for an SCR and this is agreed by the senior managers, a case audit through the Multi Agency Audit Group, or a learning review may be undertaken or no further action will be taken.

b) If the information indicates that the case may meet the criteria for an SCR it will progress to be discussed at the SCR Sub Committee.
In relation to pathway one if an agency disagrees with the Chair’s decision or the Chair needs additional information to make an informed decision, a consultation meeting will be convened to support the decision making. This will be made up of three SCR Sub Committee members from across different agencies including Children’s Services, Police, Health and the original referrer (the referrer who will not be a decision maker).

For further information, see appendix six – Flow Chart of Decision Making in Respect of Serious Case Reviews and Learning Reviews.

In relation to learning reviews there are a number of local methodologies agreed which include the Pit Stop method or Multi Agency De-brief Meeting. Other learning review methods could be applied and will be agreed across the partnership at the point the review is being scoped.

Consideration of a Case by the Serious Case Review Sub Committee

The LSCB has a Serious Case Review (SCR) subcommittee, which is part of the structure for the LSCB. The panel has a specific Terms of Reference which identifies its roles and responsibilities in relation to Serious Case Reviews. The SCR subcommittee will consider all cases where an agency/agencies believe that a child’s case meet the following criteria:

- abuse or neglect of a child is known or suspected and either
  - the child has died or
  - 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.

NOTE see the above section on Referral of a case for consideration of an SCR or learning review.

The SCR subcommittee needs to meet to make a recommendation within 15 working days of referral for consideration for a SCR. If the SCR subcommittee does not have a meeting planned within this timescale, the subcommittee Chair and LSCB Manager will liaise to set a date for an Extraordinary meeting. In order to determine whether a case has met the criteria for a Serious Case Review, the SCR subcommittee will require sufficient case information to inform their decision making. Following referral, the subcommittee Chair (or the LSCB Manager/Support Officer in the chair’s absence) will request case information from the referrer, SCR subcommittee members, and agencies/organisations known to be involved utilising the letter at Appendix 3. The SCR subcommittee will meet to review the case information available, consider the information against the agreed proforma (see Appendix 4) and then make a written recommendation to the Chair of the LSCB as to the outcome of their considerations and the appropriate action suggested including whether or not the LSCB should conduct a Serious Case Review.

The LSCB Independent Chair’s Decision

The Chair of the LSCB will write to the Board Manager of the LSCB to inform him/her of his decision. The Chair of the LSCB has ultimate responsibility for deciding whether or not a serious case review should be conducted.

The LSCB Chair will consider whether and how to proceed with the SCR:

- confirming whether the case meets the criteria for a SCR,
- what is the scope of the review and who needs to be involved
- whether there are criminal proceedings or other reviews of the case which will impact on the SCR. Consultation will take place between the LSCB Chair and the Senior Investigating Officer within the police in accordance with A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards May 2014 – Chapter 6.
The Chair may choose to seek support from a fellow LSCB Chair in accordance with the Association of Independent LSCB Chairs. Once the LSCB Chair has made a decision on whether or not to initiate a SCR, the LSCB Chair needs to inform the National Panel of independent experts on Serious Case Reviews. Details of how to contact the panel, and information to be shared with the panel are included in Appendix 1: Section 5 and Flowchart 1.

**Commissioning the SCR**

**Appointing reviewers**

The LSCB must appoint one or more suitable individuals to lead the SCR. They should demonstrate that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

**Engagement of organisations**

The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide, as part of the SCR, to ask each relevant organisation to provide information in writing about its involvement with the child / family who is the subject of the review.

The SCR subcommittee chair/LSCB Manager will write to all LSCB Board members to ask them to ensure that their agencies secure the relevant child records to guard against loss or interference. Clinical Commissioning Groups will need to ensure their Area Team of NHS England and the Care Quality Commission are notified. The police should 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).

**Timescale for SCR Completion**

The LSCB should aim for completion of an SCR within 6 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: (i) capture points from the case about improvements needed and (ii) take corrective action to implement improvements and disseminate learning.

**Agreeing Improving Action**

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

**Publication of Reports**

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCR’s. From the very start of an SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.
Final SCR reports should:
• provide a sound analysis of what happened in the case, and why and what needs to happen to reduce the risk of reoccurrence
• be written in plain English and in a way that can be understood by professionals and public alike and
• be suitable for publication without needing to be amended or redacted

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

When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case.

LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, including any inquest.

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

Terms of Reference

Following the decision to undertake a Serious Case Review, the SCR subcommittee will manage the commissioning of the SCR process. The SCR subcommittee will be responsible for developing the Terms of Reference for the SCR and for determining the scope of the review, in discussions with the identified independent lead reviewer. The Terms of Reference for the SCR will be sent to the Chair of the LSCB for approval.

Relevant issues which might be included in the Terms of Reference:
• 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 Overview Report?
• Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information will help better to understand the recent past and the present?
• How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the SCR, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
• Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
• Did the family’s immigration status have an impact on the child/children or on the parents’ capacities to meet their needs?
• Which organisations and professionals should be asked to submit reports or otherwise contribute to the SCR including, where appropriate, for example the proprietor of an independent school or a playgroup leader?
• Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?
• How are issues from across LSCB borders reflected, 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?
• Might it help the SCR Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
• Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO) or MAPPA Serious Case Review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a coordinated 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 (SUI) investigation into the provision of healthcare should be coordinated with a SCR. How will the SCR terms of reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
• How should the review process take account of a coroner’s inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
• How should the review process take account of relevant lessons learned from research (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
• How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

Cross Border SCRs

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 normally resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should cooperate 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 LSCB’s with an interest or involvement.

Methodology

Working Together 2015 does not specify the methodology which must be used. Instead, LSCBs may use any learning model which is consistent with the principles within these procedures, including a systems methodology.

North Lincolnshire LSCB are committed to the use of a Systems methodology where appropriate. Whilst North Lincolnshire LSCB have developed a local systems methodology (Appendix 5) to undertake reviews of cases, it recognises that the exact methodology utilised on a case will depend on the issues in the case, and the lead reviewer.
Individual Management Reports

Where the methodology utilised involves the completion of reports by individual agencies/services, the involved organisations will be identified. The LSCB Chair will write to the LSCB Board member for the organisation, with the Terms of Reference for the review. The organisation will be required to appoint an IMR Author, and the senior officer will be required to confirm in writing the name of the person who will be completing the IMR. The senior officer must make arrangements within their agency for the timely completion of the IMR. The IMR will need to be returned to the LSCB Manager for the LSCB by the deadline identified in the terms of reference and following approval and signature by the agency senior officer.

The IMR Author

- The IMR author must have sufficient seniority and no significant involvement or line management responsibility for services delivered in the case under review.
- The IMR Author should have a thorough understanding of safeguarding practice and procedures.
- As preparation for commencing the IMR, a meeting will be held with all relevant agency authors to go through the terms of reference, requirements and timescale for the SCR.
- The undertaking of an IMR is a significant piece of work for authors and agencies should ensure that IMR authors are released from existing commitments to be able to prioritise this piece of work and also arrange for them to have appropriate administrative support.

The IMR

The aim of IMR’s should be to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and if so, to identify how these changes can be brought about.

The IMR reports should be quality assured by the senior officer in the organisations which has commissioned the report and when they are satisfied then the findings accepted. The senior officer will also be responsible for ensuring that the recommendations of the IMR and, where appropriate, the overview report are acted upon.

Individual Management Reviews will be completed using a standardised and consistent format set by the Lead Reviewer and LSCB SCR subcommittee. The individual agency chronology must be completed using the format issued by the LSCB, this format must not be deviated from; the key areas which are likely to form the chronology and the IMR format can be found at Appendix 5. Where staff or others are interviewed by those preparing IMR’s a written record of such interviews should be made and this should be shared with the relevant interviewee. If the review finds that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reason for this.

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

As part of completing the IMR, authors will have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the IMR Authors will wish to interview staff who are central to the case. Staff who wish to be interviewed should be offered this opportunity, IMR reports must be signed off by the LSCB member for the agency prior to their submission to the LSCB Manager.
Who should be involved in the Serious Case Review?

The initial scoping of the SCR should identify those who should contribute, although it may emerge as further information becomes available, that the involvement of others such as those providing specialist adult services would be useful.

If individual agency reports form part of the methodology, each relevant service should undertake an IMR of its involvement with the child and family. Relevant independent professionals should contribute reports of their involvement. Where CAFCASS contributes to a review, the prior agreement of the Courts should be sought so that the duty of confidentiality which the Children’s Guardian has under the court rules can be waived to the necessary degree. Designated safeguarding health professionals on behalf of health commissioners (NLCCG and NHS England) should review and evaluate the practice of all involved health professionals. This may involve reviewing the involvement of individual practitioners and NHS Trusts and advising named professionals and managers compiling reports for the review. Irrespective of the methodology used for the SCR, the Designated health professionals will need to produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. The format of this report will be subject to agreement with the Area Team of NHS England. This may generate additional recommendations for health organisations. The health overview report will constitute an IMR for health commissioners. Designated safeguarding health professionals also have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the IMR. If the designated health professional(s) have been clinically involved in the case the CCG should seek advice and help from another CCG designated professional as necessary.

Disclosure of information

The process of conducting an IMR requires access to records relevant to the child such as those from health bodies. The public interest served by this 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, e.g. a member of the child’s immediate family that is either contained within the child’s own records or in the health records for another person. While in most cases there will be a public interest in disclosing this information the record holder should ensure that any information they disclose is both necessary and proportionate. All disclosures of information about third parties will be considered on a case by case basis. The reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

It is crucial that those leading the review have access to all relevant documentation and where necessary individual professionals.

Security of Information

Where a case is being considered for a serious case review the primary agency to whom the child is known should take steps to secure records pertaining to the child. This may include freezing files or taking copies of the files up to and including the date of notification. Each agency is expected to have its own internal procedure for securing files.

When it is known that a case is being considered for a serious case review each agency should secure the records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having secured their case records promptly, should begin to quickly draw up a chronology or their involvement with the child and family.
All information will be transferred securely using Government Secure Infrastructure connections, encryption and/or documents that are password protected. All organisations will need to be mindful of their own and other partner agencies policies on data security.

Agreeing Improvement Action and Making Recommendations

Where the SCR has been completed using a systems methodology there needs to be an acknowledgement that not all findings can be transferred into SMARTER recommendations. SCIE identify the possibility of 3 different responses to findings which can be usefully distinguished.

1. Issues with clear cut solutions that can be addressed locally and by all relevant agencies. SMARTER recommendations can often be generated to address these issues.

2. Issues where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers. These issues need to be recognised and acknowledged by organisations/ services/practitioners, and discussed to ensure that competing priorities/resource constraints are kept to a minimum to allow for professionally appropriate responses to emerging concerns.

3. Issues that require further research and development in order to find solutions, including those that would need to be addressed at a national level. These issues may need to be identified to government departments, or other national/regional bodies.

The Lead Reviewers need to be clear about those issues which can be addressed, and those which may need to be highlighted to the LSCB or into national systems. The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings. Where SMARTER recommendations can be made to address an SCR finding, the SCR subcommittee will produce an action plan based on the recommendations. The recommendations in the action plan will be SMARTER (Specific, Measurable, Achievable, Realistic, Timescale, Evaluate and Review) and will contain the following
   i. The recommendation
   ii. The job title of the senior professional responsible for the action
   iii. Evidence of progress against the recommendation
   iv. Review date

Individual agencies will be responsible for ensuring their particular actions are implemented and evaluated. Learning will be incorporated into local LSCB training. The LSCB, via the SCR subcommittee, will receive progress reports regarding the implementation of any action plan and the outcome. This information will be drawn upon when publishing the LSCB annual review report.

LSCB action on receiving the serious case review report

The SCR subcommittee on behalf of the LSCB should quality assure the final SCR Report. The LSCB Board should approve the final SCR report. and:

• reassure itself on arrangements to provide feedback and debriefing to staff and the media as appropriate;
• consider how to disseminate the key findings to relevant interested parties;
• publish the overview report
• implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan;

Accountability and Disclosure

The LSCB should carefully consider those who might have an interest in reviews such as:
- The child who was seriously harmed and the subject of the SCR
- The Child’s family
- Staff members
- The Public
- The Media

and what information should be made available to each of these interested parties.

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

It is important to anticipate requests for information and plan to meet these in a timely and appropriate manner. A lead agency may take responsibility for debriefing the child and family members or for responding to media interest about a case in liaison with contributing agencies and professionals. The publication of the report needs to be timed in accordance with the conclusion of any related criminal court proceedings. Any IMRs completed should not be made publicly available. However the Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013] EWHC 1711 (QB) required IMR documents and the Overview Report from a Serious Case Review to be disclosed to the Coroner. This was opposed on grounds and the High Court considered the competing interests of the Children’s Board and their duty to seek to improve the provision of care against the Coroners duty to investigate the cause of death. The court found that generally material should be disclosed to the coroner who would then consider any arguments about what should or should not be disclosed to third parties including properly interested persons.

Those directly involved in the SCR are expected to adhere to the boundaries of confidentiality and will not share the details of the review outside of the panel, throughout the course of the review.
Appendix 1: National Panel of Independent Experts on Serious Case Reviews

Letter to LSCB chairs regarding the arrangements for the panel from Parliamentary Under Secretary of State for Children and Families on 24th June 2013 can be found at: http://media.education.gov.uk/assets/files/pdf/l/letter%20from%20edward%20timpson%20to%20lscb%20chairs%20-%20scr%20panel.pdf
The annex to this letter included the following information:

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National panel of independent experts on Serious Case Reviews
Information for LSCBs and Chairs on how the panel will operate

1. Scope of the panel
The role of the panel is set out in Working Together to Safeguard Children (2015). The panel’s remit will include advising LSCBs and Chairs about the application of the SCR criteria; appointment of reviewers; and publication of SCR reports.
The panel will initially advise LSCB Chairs on:
   i. any decision made by an LSCB Chair not to initiate an SCR following a serious incident; and
   ii. any SCR which an LSCB Chair has indicated they do not plan to publish.

2. Serious Case Review criteria
   Serious Case Review for every case where abuse or neglect is known or suspected and either:
   • A child dies; or
   • A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

3. Publication of reports
   All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Thereafter, the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs.
   From the start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case. ⁴

4. Which cases should the LSCB Chair inform the panel about?
The LSCB Chair should inform the panel about their SCR decisions on cases which:
   (a) have been, or should be notified to Ofsted and the Department by the local authority because abuse or neglect is known or suspected and either
      (i) a child has died or
      (ii) a child has suffered a potentially life-threatening injury, serious sexual abuse or sustained serious and permanent impairment of health or development; or
   (b) which come to the attention of the LSCB Chair through another source
      and, in the LSCB Chair’s view, meets the criteria in (ai) or (aii) above.

The LSCB Chair does not need to inform the panel about other categories of incident which may come to their attention but which clearly fall outside the criteria for a SCR, such as accidental deaths or deaths of looked after children where there are no suspicions of abuse or neglect.

5. What information should the LSCB Chair provide to the panel?
   Initiation
   In cases where the **LSCB Chair has decided to initiate** a SCR, the Chair should give the panel:
   • the name(s) of the reviewer(s) appointed to conduct the SCR.

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⁴ Working Together to Safeguard Children March 2015
In cases where the **LSCB Chair has decided NOT to initiate an SCR**, the Chair should:
- let the panel know within 14 days and provide a copy of the local authority’s Serious Incident Notification if available (if this is not available, please provide brief anonymised details of the case covering the nature of the incident; ages of the children involved; their relationship with any alleged perpetrator(s); agency involvement with the family; and any criminal investigation);
- provide an explanation as to why the case does not meet the SCR criteria.

**Publication**
In cases where the **LSCB Chair has concerns about publication of an SCR report**, the Chair should refer their concerns to the panel. This could be done at any time in the course of conducting a SCR.

The LSCB Chair should provide the panel with the following information:
- what the LSCB has done to ensure that the SCR will be written with publication in mind - how has the reviewer been briefed?
- where is the potential difficulty coming from? For example, is it from agencies contributing to the review, from family members, or are there general concerns about media activity?
- how has the LSCB balanced these interests with the public interest in understanding the issues raised by the case and with the importance of ensuring that lessons are learnt to improve services to children and families?
- are there any legal restrictions on releasing certain information in the report?
- what consideration has been given to amending the style and content of the report to make it fit for publication?
- what expert advice has the LSCB drawn on when considering publication of the report? For example has there been advice from lawyers or medical or communications professionals?
- how is the LSCB managing media interest in the case?

**6. How will confidentiality of the information be preserved?**
Panel members have agreed and signed up to terms and conditions which include confidentiality clauses. Members have agreed that personal, sensitive or otherwise confidential information will only be used in furtherance of the panel’s objectives. Information that will be shared with panel members will be sent through secure email links and encryption.

The panel would not be subject to the Freedom of Information Act 2000 because it is not a public authority as defined at section 3 of the Freedom of Information Act 2000.

**7. How to contact the panel**
A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat: Mailbox.SCRPANEL@education.gsi.gov.uk

**8. What is the turnaround time?**
The dates of future panel meetings will be communicated to LSCB Chairs. The panel will inform LSCBs Chairs of the panel’s advice within a week of each panel meeting. This will be communicated by a letter to LSCB Chairs.

**9. Attendance at panel meetings by LSCB Chairs**
On some occasions, the panel may ask the LSCB Chair to attend a panel meeting if they would like to discuss the case further. This will be on a case by case basis. Costs of attendance by the LSCB Chair can be reimbursed by prior arrangement with the secretariat. The LSCB Chair may bring others to the meeting on request but costs of attendance by other individuals will not be reimbursed.
Flowchart 1: SCR initiation decisions

Serious Incident occurs 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 of neglect.

OR

a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child’s death.

LSCB Chair considers whether and how to proceed with a SCR

If the child has died the criteria for a SCR will most likely be met

Questions to consider include:

• If the child has not died; are there concerns about how agencies or professionals worked together to protect the child?
• What is the scope of the review and who needs to be involved?
• Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

Once an LSCB Chair has made a decision on whether or not to initiate an SCR, the LSCB Chair should inform the panel by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk

If an LSCB Chair has decided to initiate a SCR, the LSCB Chair should let the panel and Ofsted know of their decision.

Appointing reviewers

LSCB Chairs should also let the panel know:

• name(s) of the reviewer(s) appointed to conduct the SCR.

This will be for information. The panel has no formal role in vetting reviewers.

If an LSCB Chair has decided not to initiate a SCR, the LSCB Chair should let the panel know their decision within 14 days, providing a copy of the local authority’s Serious Incident Notification and an explanation as to why the LSCB Chair has decided the case does not meet the SCR criteria.

Panel Meetings

The panel expects to meet every 2 months to review the details of cases submitted. The panel may request a meeting or further information from the LSCB Chair before being in a position to advise about a case. If so, the panel will contact the Chair directly.
Flowchart 2: SCR report publication decisions

LSCB Chair considers publication of the SCR report.
Questions the LSCB should consider as a minimum are:
- the public interest in seeing the report and understanding the issues raised by the case;
- the importance of ensuring that lessons are learnt and shared widely to improve services to children and families;
- how the public interests can be balanced with those of any children and vulnerable adults involved in the case;
- whether the style and content of the report make it fit for publication;
- whether there are any legal restrictions on releasing certain information in the report;
- what expert advice is needed e.g. from lawyers or medical or communications professionals; and
- how best to manage media interest in the case.

Once a LSCB Chair has decided whether or not to publish SCR report, the LSCB Chair should inform the panel by emailing the secretariat at:
Mailbox.SCRPANEL@education.gsi.gov.uk

If at any time during the course of the SCR the LSCB Chair comes to a view that publication of the report may not be possible, the LSCB Chair should alert the panel to its concerns.

YES
Will be published within 28 days of completion (signed off by the LSCB Chair) - If a LSCB Chair has decided to publish a SCR, the LSCB Chair should send a copy to the panel mailbox at least one week before publication

Will be published but outside 28 days due to delays - if a LSCB Chair is planning to publish a SCR but it has been delayed please provide an expected date for publication to the panel.

NO
If a LSCB Chair has decided not to publish a SCR report the LSCB Chair should let the panel know their decision providing an explanation of how they have considered the questions above.

Panel meetings
The panel expects to meet every 2 months to review details of cases submitted. The panel may request a meeting or further information from the LSCB Chair before being in a position to advise about a case. If so, the panel will contact the LSCB Chair directly.
Appendix 2: Association of Independent LSCB Chairs Peer Consultation Scheme

Position Statement regarding National Panel of Independent Experts on SCRs

Working Together to Safeguard Children 2013 has introduced a "National Panel of Independent Experts on SCRs".

This panel is government led and its members will be ministerial appointments.

The Association of Independent LSCB Chairs already has in place a 'Peer Consultation Scheme'. This provides LSCB Chairs with peer led support to strengthen the role Serious Case Reviews can play in enhancing multi-agency learning about the most effective ways of safeguarding children and young people.

The Association's 'Peer Consultation Scheme' embraces the principle of independence, which characterises the role of LSCB Chairs in their exercise of local leadership in the child protection system. This scheme is unafraid of inviting challenge and scrutiny from peers, alongside support and sharing learning.

Members of the Association have a collective insight, and substantial experience of SCRs, which is underpinned by a belief that any process for learning lessons from individual cases needs to be thorough, accountable and child centred. Equally, the Association understands and accepts the contribution which the publication of SCRs can make to sharing professional learning and assuring the community that it is served by a robust and searching child protection system.

The Association believes that its Peer Consultation Scheme provides an enabling and proportionate source of support and challenge to LSCB Chairs in their decision making role with regard to SCRs.

The Association recognises the establishment of the government led National Panel of Independent Experts on SCRs, whilst remaining committed to its own peer led scheme.

The Association supports its Members in their exercise of independence in all aspects of their role as an LSCB Chair, whilst maintaining compliance with the requirements of statutory guidance.
Introduction
There are two reasons why the Association has introduced a SCR Peer Consultation Scheme:

1) The Association's Grant Agreement with the DfE requires that “At least 75% of SCRs that are completed during the course of the grant will have received peer advice, support and challenge, including on the draft overview report.”

(It has been clarified that this does not mean that 75% of overview reports themselves should be peer reviewed as there is always a high degree of independent involvement in the report itself.)

The Association is badging the scheme 'peer consultation' to make clear its voluntary nature, and that a Chair's statutory duties and exercise of independence remain unfettered.

2) Whilst the Peer Consultation Scheme supports the DfE KPI, more importantly, it is congruent with the underpinning Objectives of the Association i.e. to provide support to Chairs and sharing learning in order to improve the lives of vulnerable children.

Following discussion at the annual conference, it was agreed that the scheme will essentially revolve around Chair to Chair support, usually, although not exclusively, on an in-Region basis. The support is not imposed, but is encouraged as good practice, and nothing in the scheme impairs a Chair from fulfilling their statutory duties as they see fit.

The Association has made it clear to the DfE that the scheme is not intended to 'quality assure' SCRs in the way that Ofsted did previously.

Process
Association Members have described wanting the process to be as easy as possible, especially bearing in mind that providing peer consultation is likely to be a good will gesture, rather than remunerated. A Chair should simply consult a fellow Chair for support on a particular issue related to the SCR, and agree the nature of this between themselves. This could be, for example, on:

- the decision to hold a SCR (including whether any other form of review would be appropriate)
- setting up the SCR and process issues
- the overview report (see below)
- how to make the report publishable
- decisions on publication
- the LSCB response to the SCR.

Although there is no requirement for the overview report itself to be subject to peer consultation under this scheme, some early trials of doing this have shown the value of a Chair, with no prior knowledge of the case, looking over the draft and feeding back on how it comes across. The peer
consultation can also feed-back on the strength of conclusions, which can sometimes be affected by local dynamics. It can also provide advice on how a report can be made more publishable.

The status of any consultation given is captured by the intent behind this scheme i.e. this is a voluntary exercise and final accountability and independence rests with the LSCB Chair. LSCB Chairs will routinely seek consultation, at a local level, in their decision making and this scheme enhances this practice, by providing LSCB Chairs with a regional/national resource on which to draw. The consultation should be provided on a voluntary basis, in line with the help requested, and provided in a non-judgemental (even if frank) way.

While the nature and general outcome of the peer support should be reported to the Association (see below), the detail provided should be general rather than detailed, particularly as some of the discussions may be of a delicate nature.

**Reporting**

In order to oversee the usefulness and effectiveness of this scheme in contributing to the Objectives of the Association (and also to report on progress against the Grant Agreement), it is necessary that some record is kept of the consultation sought and provided. This is kept to a minimum for simplicity and confidentiality, but allows the Association to make further inquiries if necessary, and to see what is being learned by the process.

The form supplied should be used even if the consultation leads to no SCR being commissioned.

If peer consultation is sought at different stages in a single SCR please submit a different form as this will give the Association a contemporaneous record of the usefulness of the scheme, rather than having to wait for the completion of an SCR before knowing whether peer consultation has been applied. If it is impractical to do this please make it clear on the form that there have been different episodes of consultation. Thank you

**Queries:** Any queries about the scheme/report form should be addressed to either: Camilla Webster, Business Manager

manager@lscbchairs.org.uk

or Sue Woolmore, Chair

chair@lscbchairs.org.uk
Appendix 3: Information for SCR Subcommittee

To Serious Case Review Subgroup Member

A referral has been made to the Serious Case Review Subgroup in respect to whether a case meets the criteria for a serious case review.

Family Details

Reason for and details of referral:

Following the referral, agencies are requested to use the following outline format in providing a summary of their involvement with the case. This will ensure information is provided in a consistent manner which leads to the decision being fully informed.

It is NOT anticipated that agencies will undertake significant investigations in preparation of this summary.

Please e-mail the completed case summary to: needs completing?

Once received agency case summaries will be collated into one report which will be provided to the serious case review group members, and other agency representatives (as appropriate). This is required to inform the decision about whether the case meets the criteria for a serious case review, a case file audit or a single agency management review report.
Agency Case Summary Format to Serious Case Review Subcommittee

Report regarding […] service] Involvement in Respect to [Subject Child]

1) Family/ case details

[Subject Name] Subject DOB

[Other Family Member Details]

2) Source of information used to inform the summary (e.g. nature of records, any brief discussions with practitioners)

3) Details of purpose of agency involvement

4) Chronology of involvement – Key Events

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<th>Key Event</th>
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The completed agency case summary should be e-mailed to: complete?
## Appendix 4: SCR Subcommittee Decision Proforma

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| Case Details: | See minutes attached from XXXX |

A Serious Case Review must always be undertaken where abuse or neglect of a child is known or suspected and the child has died (including cases where a child has died by suspected suicide).

Is this applicable in this case?

A Serious Case Review must always be undertaken where abuse or neglect of a child is known or suspected and the child has been seriously harmed and there is cause for concern as to the way in which the authority, the Board partners or other relevant persons have worked together to safeguard the child.

Is abuse or neglect of the child known or suspected and has the child been seriously harmed?
"Seriously harmed" includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the follow: 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.

(This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. Considerations on whether serious harm has occurred should be informed by available research evidence.)

| Is there a cause for concern as to the way in which the authority, the Board partners or other relevant persons have worked together to safeguard the child? |
| (There must be definitive evidence that there are no concerns about inter-agency working otherwise the LSCB **must** commission a Serious Case Review.) |

<p>| Even if one of the criteria is not met, a Serious Case Review <strong>should always</strong> 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 a 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. |
| Is this applicable in this case? |
| <strong>Recommendations to the Independent Chair:</strong> |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all Subcommittee members in agreement?</td>
<td></td>
</tr>
<tr>
<td>If not detail who and why not:</td>
<td></td>
</tr>
<tr>
<td>Signature of Subcommittee Chair:</td>
<td></td>
</tr>
<tr>
<td>Date signed by Subcommittee Chair:</td>
<td></td>
</tr>
<tr>
<td>Date sent to Independent Chair:</td>
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<tr>
<td>Independent Chair response:</td>
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<td>Independent Chair decision:</td>
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<td>Signature of Independent Chair:</td>
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<tr>
<td>Date signed by Independent Chair:</td>
<td></td>
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</tbody>
</table>
Appendix 5: Chronology and IMR Content Exemplar

Chronology Headings:

The sections on the chronology will typically be:
- Event Number
- Date of the contact/Time if relevant- using this standard 1/2/2010 and no other
- The agency that the record refers to.
- The child, the family member, or any other person to whom the entry on the record refers (anonymised).
- Age
- Source/Police log records/A&E records/Care First/GP records etc.
- Summary of contact/event
- Which children were seen and their wishes and feelings. This is very important and must be completed. If no child[ren] seen this must be recorded. If there is no record of whether any child[ren] were seen this should be specified
- Event – What was recorded and why, with any additional information relevant to the entry.
- Outcome - Action taken by agency and individuals (not full names)

Chronology Content:

- Comprehensive – should include a comprehensive list of the agencies involvement.
- Brief – each contact should be summarised briefly. Where required, greater detail can be provided in body of report.
- Avoid abbreviations and jargon or technical language
- Text should not be just copied and pasted from case records without consideration of how it will read.

Chronologies that have not been completed in this format will be returned and it will be asked that they are complete again, as the information is designed to be inserted into an integrated chronology and therefore it must be standardised.

The IMR Format

The first part of the IMR needs to contain details about the IMR author which includes their professional qualification, training and how they can demonstrate independence of the case under review and line management of it.

Agency’s information in the IMR will consist of:
- The Terms of Reference for the review
- Essential details about the child/family
- A family genogram (in the agreed format)
- A chronology of involvement
- The methodology of the IMR report
- A summary of the facts
- An analysis of involvement
- An examination of the organisation context (e.g. access to training and supervision, work load)
- What do we learn from this case
• The recommendations from the report that may be necessary which will include an action plan of how these recommendations will be met and reviewed
• The Agency action plan
Appendix 6: Flow Chart of Decision Making in Respect of Serious Case Reviews and Learning Reviews

Abuse or neglect of a child is known or suspected and 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.

Any senior manager/officer across the partnership notifies the chair/vice chair of
the SCR sub committee.

Chair/Vice chair of SCR sub committee notifies the LSCB Manager.

Following consultation with senior managers the case does
not meet the criteria for consideration for the SCR sub
committee

Case audit
through MAAG

No further action

Consider learning
review

National Panel confirms whether
they agree with the decision
made by the Independent Chair.
If the panel do not agree with
the decision, the alternative
route will commence.
NOTE the new National Panel
may decide to commission a
national practice review.

In cases where an LSCB is
challenged by the National
Panel to change it’s original
decision the LSCB should
inform Ofsted, DfE and the
National Panel of the final
outcome.

LSCB informs
Ofsted, DfE and
the National Panel
of the final
outcome

Serious Case
Review
commissioned

Recommendations of the SCR sub committee sent to the independent
chair of the LSCB

Independent chair makes a decision which is peer reviewed. The
LSCB must inform Ofsted, DfE and the National Panel of Independent
Experts within five working days of the chairs decision.

Criteria met

Criteria not met

Serious Case
Review
commissioned

No further action

Practice review/ audit undertaken

Serious Case
Review
commissioned

No further action

Practice review/ audit undertaken

The decision on whether to initiate an
SCR sub committee depends upon
the nature and extent of the
safeguarding concerns.

If an agency disagrees with
the chair’s decision or the
chair needs additional
information to make an
informed decision, a bespoke
group will be convened to
support the decision making.
This will be made up of two
SCR sub committee members
from across different agencies
including Children’s Services,
Police, Health and the original
referrer (the referrer who will
not be a decision maker).

If an agency disagrees with
the chair’s decision or the
chair needs additional
information to make an
informed decision, a bespoke
group will be convened to
support the decision making.
This will be made up of two
SCR sub committee members
from across different agencies
including Children’s Services,
Police, Health and the original
referrer (the referrer who will
not be a decision maker).

‘Seriously harmed’ includes but is
not limited to, cases where a child
has sustained as a result of abuse
or neglect, any 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

Rapid response or the Child
Death Overview Panel notify
the chair/vice chair of the
SCR sub committee or
abuse or neglect is identified
as contributing to a child’s
death

LSCB manager notifies Ofsted
of a notifiable incident where
relevant

If an agency disagrees with
the chair’s decision or the
chair needs additional
information to make an
informed decision, a bespoke
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