



PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.5 SERIOUS CASE REVIEWS

Procedures Effective from: March 2010

Review Date: October 2010

If you have any comments or queries about the pan-Dorset procedures please contact your agency representative on the Pan Dorset Policy and Procedures Group or notify the LSCB using the following email addresses:

info@dorsetlscb.co.uk

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Chapter 3.5 – Serious Case Reviews

This protocol should be read in conjunction with Chapter 8 of Working Together to Safeguard Children, revised in December 2009.

To access the DSCB Serious Case Audit Protocol and request form please go to:
<https://www.dorsetlscb.co.uk/site/advice-for-people-working-with-children/serious-case-reviews/>

Contents

No	Item	Page No
1.	Introduction	3
2.	The purposes of serious case reviews	3
3.	Safeguarding siblings or other children	3
4.	When should a SCR be undertaken?	3
5.	When should a SCR be considered?	4
6.	Which LSCB should take lead responsibility?	5
7.	Instigating a Serious Case Review	5
	• Requesting a SCR	5
	• LSCB Chair role	5
	• Serious Case Review Sub-group	6
	• Serious Case Review Panel	6
	• Determining the scope and terms of reference of the review	7
	• Findings presented to LSCB Chair	8
	• Resolution of disagreements	9
8.	Timescales	9
9.	Agency responsibilities	10
10.	Involving the family/ongoing work	11
11.	Reviewing institutional abuse	11
12.	Confidentiality/information sharing	11
13.	Support for staff	12
14.	IMRs	12
15.	Overview Report	13
16.	Executive Summary	14
17.	The Case Synopsis	14
18.	LSCB action on receiving the SCR	15
19.	Learning Lessons	15
Appendix 1	Request for consideration of Serious Case Review	16
Appendix 2	Serious Case Review process/Timeline	17
Appendix 3	IMRs	22
Appendix 4	Chronology	27
Appendix 5	The Overview Report	29
Appendix 6	The Executive Summary	30
Appendix 7	The Case Synopsis	31

1. Introduction

- 1.1 The prime purpose of a Serious Case Review (SCR) is 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.
- 1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with the revised statutory guidance contained in Chapter 8 of Working Together to Safeguard Children published in December 2009. The same criteria apply to all children, including those with a disability. The LSCB therefore has responsibility for undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

2. The purposes of serious case reviews

- 2.1 The purposes of SCRs are to:
 - establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
 - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
 - improve intra- and inter-agency working and better safeguard and promote the welfare of children.
- 2.2 SCRs 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.
- 2.3 SCRs are also not part of any disciplinary inquiry or process relating to individual practitioners.

3. Safeguarding siblings or other children

- 3.1 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the first priority of local organisations should be to consider immediately whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding (for example, siblings or other children in an institution where abuse is alleged).
- 3.2 Where there are concerns about the welfare of siblings or other children the guidance in Chapter 2 of these procedures (Managing individual cases in Bournemouth, Dorset and Poole) should be followed. Once the safety of the child and any other children has been established, organisations should consider whether there are any lessons to be learned about the ways in which they work individually and together to safeguard and promote the welfare of children.

4. When should a SCR be undertaken?

- 4.1 When a child dies (including death by suspected suicide) **AND** abuse or neglect is known or suspected to be a factor in the death, a SCR should **ALWAYS** be undertaken.

- 4.2 This is irrespective of whether Children's Services Social Care is, or has been, involved with the child or family.
- 4.3 These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC), or where the child was detained under the Mental Health Act 2005.

5. When should a SCR be considered?

5.1 Whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; **or**
- a child has been seriously harmed as a result of being subjected to sexual abuse; **or**
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; **or**
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

5.2 **AND** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

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

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:
 - not recognised by organisations or professionals in contact with the child or perpetrator or
 - not shared with others or
 - not acted on appropriately?
- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?

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

6. Which LSCB should take lead responsibility?

- 6.1 Where partner agencies of more than one LSCB have known about or have had contact with the child, the LSCB for the area in which the child is or was ordinarily resident should take lead responsibility for conducting the SCR. Any other LSCBs that have an interest or involvement in the case should co-operate as partners in jointly planning and undertaking the SCR. In the case of a looked after child, the local authority looking after the child should exercise lead responsibility for conducting the SCR, again involving other LSCBs with an interest or involvement.

7. Instigating a Serious Case Review

Requesting a SCR

- 7.1 When a professional in any LSCB agency identifies a cause for concern or that a case potentially meets the criteria for a SCR, they should initially discuss this with their line manager and agency safeguarding lead in order to agree a way forward. The LSCB agency representative should also normally be advised. Where the criteria for a SCR appear to be met, the professional should complete the *Request for SCR Proforma (Appendix 1)* and ensure this is counter-signed by the agency safeguarding lead. The proforma should then be submitted to the LSCB Chair for consideration via the LSCB administrator who will distribute it to relevant individuals. The case should NOT normally be discussed with the LSCB Chair outside of this process since to do so starts the timescale as detailed in para 8.2 below. In addition, the Secretary of State for the Department for Education has powers to demand an inquiry be held under the *Inquiries Act 2005*.

LSCB Chair role

- 7.2 The LSCB Chair will consider whether the case appears to meet the criteria for a SCR, applying the criteria detailed in paras 4 and 5 above. Where the child has died, the LSCB Chair should also contact the Child Death Overview Panel Manager and use information from professionals involved in reviewing the child's death under the

Child Death Review processes detailed in Chapter 3.7 of the inter-agency safeguarding procedures.

- 7.3 The LSCB chair has ultimate responsibility for deciding whether to conduct a SCR and should notify Ofsted as soon as this decision is reached. Ofsted will then pass this information to the Department for Education (DfE). The PCT commissioners should ensure the Strategic Health Authority (SHA) and the Care Quality Commission (CQC) are notified. The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC) and similarly the National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).
- 7.4 In all cases and at all stages in the SCR process from the first notification to Ofsted of a serious incident to the completion of the final SCR report, information relating to children, family members and professionals involved in the case (with the exception of the LSCB Chair, SCR Panel Chair and the overview report author) should be anonymised by the LSCB before being submitted to any external organisation or body (including Ofsted and the DfE). The LSCB administrator will be responsible for allocating the key for anonymising family and professional details.

Serious Case Review Sub-group (Bournemouth and Poole LSCB)/Serious Case Review Panel (Dorset)

- 7.5 Where the LSCB Chair considers, in a particular case, that the criteria for a SCR may be met, s/he should refer the case to the SCR Sub-group (in Bournemouth and Poole) or the SCR Panel (in Dorset).
- 7.6 The SCR Sub-group or Panel will consider the request for a SCR to take place, using the SCR proforma and relevant agency briefing reports, and make recommendations back to the LSCB Chair about whether a SCR should be conducted and if so, what the scope and terms of reference should be. As detailed in para 7.3 above, the Chair of the LSCB alone, has responsibility for deciding whether or not to conduct a SCR following receipt of the recommendation from the SCR sub-group or Panel. The chair is not required to follow the recommendation of the SCR sub-group or Panel.
- 7.7 In some cases, where the SCR Sub-group or Panel do not recommend a SCR, they may make other recommendations about how and whether the case should be considered in some alternative way e.g. a single Individual Management Review (IMR) rather than a full SCR (where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together); a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a SCR; a case de-brief meeting; any other kind of case review as appropriate. In such cases, arrangements will be made to share relevant findings with the SCR Sub-group (in Bournemouth and Poole) and in Dorset the SCR Panel and QA Group (as appropriate) to ensure any lessons learned are disseminated and any actions arising are completed.

Serious Case Review Panel

- 7.8 Following a decision to conduct a Serious Case Review a Serious Case Review Panel will be convened comprising as a minimum of:
- Children's Services - Social Care
 - Health (commissioning PCT and other partners as relevant)
 - Education
 - Police

- 7.9 Membership of the SCRP will be determined on a case by case basis, however the principle will be to seek the wider engagement of agencies to aid development of and promote a positive culture of critical challenge and learning through the process.
- 7.10 The Panel will be chaired by an independent person, identified by the Serious Case Review Sub-group or Panel, and commissioned by the Local Authority on behalf of the LSCB. Where the independent chair of the SCRP is **NOT** the chair of the LSCB, the SCRP Chair must, as soon as they are appointed, agree with the Chair of the LSCB the arrangements for regularly briefing him/her on the progress and timescales of the SCR and how any issues with regard to the quality will be progressed

Determining the scope and terms of reference of the review

- 7.11 The SCRP should consider, in the light of current information known in each case, the scope of the SCR and draw up clear terms of reference. The LSCB Chair should ensure that the terms of reference address the key issues in the case and approve them. Where necessary the LSCB should seek its own legal advice. Relevant issues to consider include the following:
- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
 - When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
 - Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information 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?
 - Is there a need to involve organisations/professionals working in other LSCB areas (see paragraph 6), 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?
- What should the membership of the SCR be – bearing in mind the minimum membership requirements as detailed in 7.8
- Who should be appointed as the independent chair of the SCR
- Who should be appointed as the independent author for the overview report
- 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 co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated 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?
- Set the dates for future SCR meetings, including briefings for IMR authors

Some of these issues may need to be revisited by the SCR Panel as the review progresses and new information emerges. This reconsideration of the issues may in turn mean that the terms of reference will need to be revised and agreed by the SCR and the LSCB Chair.

Findings presented to LSCB Chair

- 7.12 At the conclusion of the SCR, and before the review is presented for sign-off to the LSCB, the LSCB Chair should meet with the SCR or the Chair of the SCR to discuss the findings.

Resolution of disagreements

- 7.13 IMRs and Overview reports are based on a critical professional analysis and hence there may be occasions when there is a difference of opinion about the content or findings contained within the reports.
- 7.14 The IMR represents the agency's view of their involvement in the case and hence where there is disagreement between the IMR author and a professional within the agency about any aspect of the IMR, this should normally be resolved by discussion between the parties involving the agency safeguarding lead and senior managers as appropriate. Where agreement cannot be reached, the professional involved may wish to put their comments in writing to the SCRP Chair for consideration by the SCRP and the Overview author.
- 7.15 Where there is any disagreement about the content or findings of an Overview report between for example, members of the SCRP and the Overview author, or the SCRP and the LSCB Chair, agreement should be reached about how these differences will be presented to the LSCB. As a minimum, the LSCB Chair should ensure that the members of the SCRP are present at the LSCB meeting which receives the SCR or where this is not possible that their written views are presented.

8. Timescales

- 8.1 Reviews vary widely in their breadth and complexity but, in all cases, **where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the SCR to be completed.**
- 8.2 Within **one month** of a case coming to the attention of the LSCB Chair, s/he will decide, following a recommendation from the SCR sub-group or panel, whether a review should take place.
- 8.3 Serious case reviews should be completed **within six months** from the date of the decision to proceed. Sometimes the complexity of a case does not become apparent until the SCR is in progress. If it emerges that a SCR cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB will revise its timetable and immediately advise Ofsted, keeping them fully apprised of timing expectations, of risks of delay and of interdependence with other parallel or related processes.

The LSCB should:

- produce an update on progress and a revised project plan, which must include:
 - recommendations for action where these are not dependent on the serious case review being concluded until after other proceedings have ended;
 - actions taken to date;
 - an explanation for the extension to the timescale; and
 - the revised completion date.
- 8.4. The final version of the executive summary, and the date of its publication, should be submitted to Ofsted **within one month** of receipt of the SCR evaluation letter. The final version of the executive summary should be suitably anonymised and should be sent by email to SCR.SIN@ofsted.gov.uk .

- 8.5 A summary of the timelines in the SCR process are attached as **Appendix 2**, but the case specific timescales will be made clear to agencies involved in the SCR at the beginning of the process. IMR authors will be briefed at the second SCR meeting and IMRs should normally be completed at least within **6 weeks** of the agency being advised that an IMR is required. Health providers and agencies will each provide their own IMR (including GPs). In addition, a health overview report will be compiled by the designated health professional. The health overview report (which will constitute the IMR for the PCT as commissioners) should be completed within a further **5 weeks** of receipt of the health IMRs i.e. approximately at week 11 of the SCR process.
- 8.6 In some cases it may not be possible to finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.
- 8.7 SCRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The LSCB Chair will make these decisions on a case by case basis based on advice from the Chair of the SCR Panel and having consulted with the Local Authority where there are pending family cases. The LSCB Chair may also need to seek legal advice to assist in deciding how to proceed.

9. Agency responsibilities

- 9.1 The initial scoping of the SCR will 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.
- 9.2 Each relevant agency Chief Executive will be notified as soon as possible after the decision to conduct a SCR is made by the appropriate LSCB Chair via the LSCB Administrator, giving the detail of the SCR including the scope and terms of reference and the timetable for completion of the agency's Individual Management Review (IMR).
- 9.3 Each relevant service should immediately secure the agency records relating to the case and identify an author for the IMR. (See **appendix 3**). The IMR should begin as soon as a decision is taken to proceed with a SCR, and even sooner if a case gives rise to concerns within the individual organisation. Each agency should ensure that the person compiling the IMR has sufficient experience, knowledge and skills to undertake the task and sufficient resources, including time, to complete the tasks required within the relevant timeframe. S/He should also normally have completed specific IMR training. The identified IMR author should not delay commencing their enquiries because they have yet to attend the briefing meeting since s/he will already have the terms of reference and can start to make enquiries..
- 9.4 Where CAFCASS contributes to a review, the prior agreement of the courts will be sought by the SCRCP so that the duty of confidentiality which the children's guardian has under the court rules can be waived to the degree necessary.
- 9.5 The IMR should be signed off by the Chief Executive of the agency concerned before the IMR is submitted to the SCRCP who will also take responsibility for ensuring the quality of the report. On receipt of the agency's IMR the Chief Executive also has responsibility for ensuring that an action plan is devised which addresses the recommendations made in the IMR.

10. Involving the family/ongoing work

- 10.1 The family of the child who is the subject of the SCR often have key information that can aid the learning from the SCR. They should normally be involved in the process at the earliest opportunity. Decisions about when, how and who should be involved and contribute to the review should form part of the terms of reference of the SCR. There are some circumstances where it would not be appropriate to engage the family in the SCR process, e.g. where the Police have requested this because of criminal proceedings, and the reasons for this should be clearly documented including a plan about how and when the family will be involved.
- 10.2 Where there are surviving siblings and there is ongoing work with the family, those professionals involved should be consulted for advice based on their knowledge of the family and understanding of the family dynamics. In addition, any relevant early findings or information should be shared with those professionals to ensure that appropriate action is taken to safeguard the children.

11. Reviewing institutional abuse

- 11.1 When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply. SCRs in these circumstances are likely to be more complex, on a larger scale, and may require more time. Terms of reference for the SCR will need to be carefully constructed to take account of the complexity of the case.
- 11.2 There needs to be clarity over the interface between:
- the different processes of investigation (including criminal investigations);
 - case management, including help for abused children and immediate measures to ensure that other children are safe;
 - learning lessons from the SCR to reduce the chance of such events happening again.
- 11.3 These three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

12. Confidentiality/Information sharing

- 12.1 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 (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate.
- 12.2 All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector. Where adult or third party health records need to be disclosed, there should be a co-ordinated approach to seeking consent for disclosure from the relevant adult and this should be

arranged by the Health Overview Author even if they are not the person who will themselves seek such consent.

13. Support for staff

- 13.1 The intense feelings that a serious case review can provoke for all staff involved must be carefully handled by both those undertaking the review and by line managers. Apart from the need for staff to have appropriate support, emotions (if not dealt with) can distort the outcome of a review through, for example, staff being defensive, looking for scapegoats, or denying organisational difficulties.
- 13.2 Staff should be aware of the need for a review of practice and work undertaken in the event of the death of a child or serious injury sustained due to abuse and should have a clear understanding of the purpose of a SCR. Being aware of the process and these procedures may help in the event of staff needing to be involved in an actual serious case review
- 13.3 When a serious case review or case audit is to be undertaken, the following issues need to be addressed:
- senior officers will need to keep staff who were involved in the case, trade unions, where applicable and/or professional associations, advised of the progress of the review, due to the potential impact of the review upon staff;
 - staff, whether directly involved in the case or not, may be extremely distressed by the death or injury of a child and may require separate help and support;
 - line managers or, where appropriate, another manager must be available to staff to discuss their concerns and feelings during the review process. Where necessary a counsellor should be made available who can offer an impartial and confidential service.

14. Individual Management Reviews

- 14.1 The aim of IMRs should be to look openly and critically at individual and organisational practice and at the context within which people were working to identify all good practice as well as whether the case indicates that improvements could and should be made. If so, the IMR should identify how those changes can be brought about. It is important that the SCR process supports an open, just and learning culture and is not perceived as a disciplinary-type process which may intimidate and undermine the confidence of staff.
- 14.2 All IMR authors involved in the SCR will have the opportunity of meeting with appropriate members of the SCR for a briefing session. This is to enable them to be clear about what is required and address any issues or questions and to share information as appropriate between the IMR authors. At the end of the process, IMR authors will again be offered the opportunity to meet with the SCR and the Overview report author to discuss the findings before the Overview report and executive summary are finalised.
- 14.3 The suggested format for the IMR is detailed at **Appendix 3** and the chronology format is detailed at **Appendix 4. However, each SCR will determine it's own IMR and chronology format based on the terms of reference for the specific case.**

- 14.4 The questions posed do not comprise a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and the particular structure and format of the IMR and chronology will be sent to IMR authors once agreed by the SCRCP and will be covered in the IMR authors briefing session.
- 14.5 Where staff or others are interviewed by those preparing IMRs, 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 reasons for this.
- 14.6 The Chief Executive in the organisation which has commissioned the report will take responsibility for ensuring the quality of the IMR. S/he will counter-sign the IMR to indicate their satisfaction and that the findings are accepted. The Chief Executive will also be responsible for ensuring that the recommendations of the IMR, and where appropriate the overview report, are acted on.
- 14.7 On completion of each IMR report each agency will ensure a process of feedback and debriefing for the staff involved in the case, in advance of completion of the overview report. There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the executive summary and synopsis of learning is published.
- 14.8 Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. Where more than one PCT has commissioned services the PCTs will need to agree locally how they will work together. This may involve reviewing the involvement of individual practitioners and NHS Trusts, and advising named professionals and managers who are compiling reports for the review. The designated professionals should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the IMR for the PCTs as commissioners.

15. Overview Report

- 15.1 The SCR Panel, on behalf of the LSCB, will commission an overview report and an executive summary from an accredited overview author that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action.
- 15.2 The overview author will meet with the SCRCP and the IMR authors at about week 12 of the SCR process to discuss, and where appropriate challenge, the content of the completed IMRs and identify any further information that may be required. Further SCRCP meetings may be convened if required to facilitate a thorough and effective process but as a minimum they will meet again at the end of the process to discuss the findings of the overview author before the overview report and executive summary are finalised.
- 15.3 The format of the overview report will be produced according to the format detailed in **Appendix 5**, although as with IMRs, the precise format will depend on the features of the case.

16. Executive Summary

- 16.1 In all cases, the SCR overview report and the IMRs will be used to produce an executive summary which accurately reflects the full overview report. The executive summary will include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary will be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary will, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members. (**See Appendix 6**)

17. Publishing overview reports and executive summaries

- 17.1 The overview report and the executive summary of all serious case reviews completed after 10th June 2010 must be published. The presumption is that all SCRs will be published, anonymised and without identifying details, unless there are compelling reasons relating to the welfare of any surviving children directly concerned in the case for this not to happen.

- 17.2 There is an important balance to be struck between transparency and openness and the protection and welfare of individuals and their siblings. This means preparing the SCR overview report in a form suitable for publication, or redacting it appropriately before publication in order to protect the identity of children, relevant family members and others, and comply with the Data protection Act 1998 when published.

LSCBS should also be mindful of other restrictions on publication of information e.g. Court orders and constraints on public information sharing when criminal proceedings are outstanding, and should take independent advice if there is any doubt about compliance with the law.

- 17.3 The internal management reviews should not be made publicly available.

18. The Case Synopsis

- 18.1 Since the prime purpose of a SCR is to learn lessons, a brief case synopsis will be produced for professionals that summarises the case details, the main issues identified and the main learning points. This will normally be disseminated to all front line practitioners to ensure the broadest possible opportunity for learning. All synopses of learning will be shared between the two LSCBs to ensure the widest possible learning. (**See Appendix 7**)

19. LSCB action on receiving the SCR

- 19.1 At the conclusion of the SCR, the IMRs, overview report, action plan, executive summary and synopsis of learning will be presented to the LSCB for formal sign-off. This will be the responsibility of the independent SCR Chair who may involve the overview author in the presentation as appropriate.

- 19.2 Once the SCR process is complete and the review signed off by the LSCB, the LSCB will:

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency action plans and chronologies to Ofsted, the SHA and DfE. All personal information relating to children, family members and

professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) will be anonymised in all the SCR documentation submitted to Ofsted and DfE. If the child died in a custodial setting, copies of the anonymised SCR will be made available to the YJB and copies of the executive summary should be provided to the PPO;

- make arrangements to provide feedback and debriefing to staff and the media as appropriate;
- disseminate the executive summary, key findings and synopsis of learning to relevant interested parties;
- publish the SCR overview report and the executive summary once the SCR has been completed and evaluated and graded by Ofsted;
- implement those actions for which the LSCB has lead responsibility and monitor the timely implementation of the SCR action plan. In Dorset this work is undertaken by the Quality Assurance group and in Bournemouth and Poole by the SCR sub-group;
- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback; and
- formally conclude the review process when the action plan has been implemented and inform GOSW of this decision.

19.3 The LSCB, following recommendations from the SCRCP, will decide on a case by case basis when to publish the overview report and the executive summary and synopsis of learning.

20. Learning Lessons

20.1 As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, dissemination of the learning points is a key objective for both Bournemouth and Poole LSCB and Dorset SCB.

20.2 As far as possible, reviews will be conducted in a way that the process is a learning exercise in itself for all those who were involved in the case.

20.3 All LSCB agencies are committed to developing a positive learning culture and for each case which becomes the subject of either a SCR or a case audit under these procedures, a synopsis of learning will be produced and it will be the responsibility of each agency to ensure dissemination to all appropriate front line staff.

20.4 The Pan Dorset Safeguarding Through Training Group has responsibility for ensuring that the learning identified from any case review process including SCRs and case audits is shared between the two LSCBs and they will facilitate a bi-annual event focussed on learning from SCRs and case audits.

Request for consideration of Serious Case Review

Name of person requesting the review

Designation

Agency

Name of family, family members, including dates of birth and address

Brief Family History

Outline of concerns leading to the request for a Review (continue on separate sheet if necessary)

Detail why a SCR is considered to be appropriate (i.e. what evidence there is to suggest the criteria in para.3 of this protocol appear to be met?)

Signed

Print Name

Date

Safeguarding Lead

Print Name

Signed

Date

Agency/Organisation

Serious Case Review process/Timeline - DORSET

To be completed by at least the end of week....	Action
Week 0	<i>Request for a SCR Proforma</i> received for consideration of a SCR
Week 1	<i>Critical Incident Notification</i> completed and submitted to Ofsted
	Request for member agencies to check agency records and compile a briefing report
Week 2	Briefing reports submitted to LSCB Administrator
	Briefing Reports circulated prior to initial SCR panel meeting
Week 3	<p>SCR Working Group (B&P) or Panel (Dorset) Meeting 1 Meeting of the SCR Panel to:</p> <ul style="list-style-type: none"> • consider <i>Request for a SCR Proforma</i> • consider agency briefing reports • make recommendation to LSCB chair • identify independent SCR Panel chair/overview author • draft terms of reference/scope of review • set key for anonymising case • set meeting dates for SCR
Week 4	LSCB Chair agrees SCR to be undertaken LSCB Chair notifies Ofsted, relevant agency notifies the SHA, CQC, HMIC, HMIP and MHI Probation of decision Commission independent Chair/involve Chair in finalisation of draft terms of reference Commission independent Overview Author
Week 4	<i>Critical Incident Notification</i> submitted to Ofsted confirming SCR Letter requesting Individual Management Review (IMR) (appendix 7) sent to relevant agencies

Week 0	SCR TIMELINE STARTS WITH DECISION OF LSCB CHAIR TO CONDUCT SCR
Week 1	Information gathering by IMR authors following receipt of letter and Terms of Reference from LSCB Chair.
Week 2	<p>SCR Panel Meeting 2 Meeting chaired by Independent Panel Chair and attended by SCR Panel.</p> <ul style="list-style-type: none"> • Discuss process • Agree dates <p>Followed by meeting with Independent Panel Chair, SCR Panel members and IMR and Health Overview Author to:</p> <ul style="list-style-type: none"> • brief IMR authors on IMR expectations • share information between IMR agencies
Week 6	Health IMRs (as appropriate) submitted to Health Overview Author and SCR Panel
Week 8	All other IMRs received and disseminated to SCR Panel.
Week 9	<p>SCR Panel Meeting 3 Meeting chaired by Independent Panel Chair, attended by SCR Panel, Independent Overview Author, Health Overview Author and IMR authors as necessary. Panel to:</p> <ul style="list-style-type: none"> • discuss completed IMRs, identifying gaps to be explored/revisions required • request further work from IMR authors if required and provide feedback re: match with terms of reference • instruct Independent Overview Author to initiate Overview Report • confirm arrangements re meeting/seeking feedback from family
Week 11	Draft Health Overview submitted to SCR Panel and Independent Overview Author
Week 12	If requested, IMRs re-submitted to the SCR Panel and Independent Overview Author and further information gathered if required
Week 15	<p>SCR Panel meeting 4 Meeting chaired by Independent Panel Chair, attended by SCR Panel, Independent Overview Author and Health Overview Author</p> <ul style="list-style-type: none"> • consider draft Overview Report • consider draft Health Overview Report • consider any re-submitted IMRs • identify any additional work • feedback from family interviews

	<ul style="list-style-type: none"> • identify any themes/recommendations emerging
Week 18	Final Overview Report and final Health Overview Report received and disseminated to SCRP
Week 19	<p>SCR Panel Meeting 5 Meeting chaired by Independent Panel Chair, attended by SCR Panel, Independent Overview Author and Health Overview Author</p> <ul style="list-style-type: none"> • Final SCR Overview Report and Health Overview Report considered by SCR Panel • Detail of Executive Summary agreed • SCR Panel to draft an action plan
Week 20	Consultation exercise undertaken with IMR agencies on Overview Report and action plan with written feedback from agencies
Week 22	All agencies to submit anonymised version of IMR
Week 23	<p>SCR Panel Meeting 6 Overview authors/SCR Panel undertake final sign off of the:</p> <ul style="list-style-type: none"> • Overview Report • Executive Summary • Action Plan • Agreement re Synopsis of learning
Week 24	<p>Feedback and de-briefing of staff involved in case to include</p> <ul style="list-style-type: none"> • Sharing of overview report • Synopsis of learning • Process of dissemination and learning
Week 25	<p>All reports to be presented to LSCB for sign off by Independent SCR Panel Chair including :</p> <ul style="list-style-type: none"> • Individual Management Reviews • Independent Overview Report • Action Plan • Executive Summary • Synopsis of Learning
Week 26	SCR submitted to Ofsted.
Following Week 26	SCR Grading received from Ofsted – send the final version of the executive summary, and the date of its publication, to Ofsted within one month of receipt of the SCR evaluation letter. The final version of the executive summary should be suitably anonymised and should be sent by email to SCR.SIN@ofsted.gov.uk
	Report/findings/learning shared with the family
	<p>Executive Summary and Synopsis of Learning published as agreed at “publication meeting” involving:</p> <ul style="list-style-type: none"> • LSCB Chair

	<ul style="list-style-type: none"> • LSCB Development Officer(Dorset)/Safeguarding Business Manager (Bournemouth and Poole) • LSCB Administrator • Social Care case holder and Manager (where appropriate for example where involvement is ongoing) • Head of Social Care (as appropriate) • Safeguarding Manager (Dorset)/Service Manager (Bournemouth)/Quality Assurance and Improvement Advisor (Poole) • Representatives from key identified agencies • Communications staff from key identified agencies • Legal Advisor (as appropriate) • Others as appropriate
	<p>Individual agency and LSCB action plans monitored by SCR Working Group (B & P) and QA Group (Dorset)</p>

SERIOUS CASE REVIEW TIMESCALES (Bournemouth & Poole LSCB)

Date	Action
Week 0	Critical Incident Notification submitted to Ofsted by Local Authority
By Week 3	Serious Case Review Group Recommendation to and Decision from Independent Chair, LSCB to commence the SCR process. Panel members identified including any experts, to be drafted with time frame for the review
By Week 4	Letter to Ofsted by Independent Chair LSCB confirming decision to a SCR
By Week 4	Letters (including the Terms of Reference) to Chief Officers of Agencies involved informing them of SCR and requesting details of their designated IMR authors to be sent to LSCB Administrator
Week 1	Deadline for Agency Chief Executive to identify IMR authors and forward to LSCB Administrator
By Week 3	IMR Author Briefing Session – Independent Chair, LSCB
By Week 4	First SCR Panel meeting to agree final Terms of Reference with SCR Independent SCR Panel Chair
By Week 7	Deadline for Individual Agency Chronologies to be submitted via email to
By Week 8	Deadline for IMR reports to be submitted via email to LSCB Administrator
By Week 9	IMR reports circulated to SCR Panel members by
By Week 10	The Serious Case Review Panel and IMR authors will meet to review their IMRs
By Week 12	Deadline for revised IMRs and completed Action Plans to be submitted via email to LSCB Administrator
By Week 14	Deadline for first draft of the Overview Report and Health Overview Report Deadline for further revised IMRs and Action Plans.
By Week 17	SCR Panel to meet and agree final IMRs and Action Plans – CE signature
By Week 18	Deadline for revised Overview Report & Health IMR Overview Report to be submitted via email to LSCB Administrator
By Week 19	SCR Panel to meet to review revised Overview Report, Health IMR Overview Report, and receive Executive Summary. Recommendations into Action Plan
By Week 22	Deadline for the revised Overview Report and Executive Summary to be received by the SCR Panel Chair and by email to LSCB Administrator
By Week 24	Bournemouth & Poole LSCB Exec Board to receive and sign off the Overview Report and Executive Summary
By Week 26	The completed set of documents to be sent electronically and via email to Ofsted

IMRs

The IMR is a stand alone report which should contain sufficient detail that the reader can understand the context of the agency involvement. Any queries or concerns about the production of the IMR may be dealt with at the initial briefing meeting with the SCRCP and IMR authors should expect to receive support if required from their agency safeguarding lead.

The IMR should normally be in the format detailed below and should contain a detailed chronology as an appendix. See appendix 4 for further details relating to chronologies. Details regarding both the IMR and the chronology will be confirmed to IMR authors in the briefing meeting.

1. FORMAT

1.1 Front sheet as attached at appendix 1a

1.2 Contents page

1.3 Details of qualifications and experience of IMR author and statement of independence from case mgt

1.3 Introduction (short summary of events leading up to the Serious Case Review)

1.4 Terms of reference of SCR (will be provided by SCRCP)

1.5 Methodology (this section should set out what files you have read, who you have interviewed and / or consulted)

1.6. Family composition including genogram (format will be provided by SCRCP)

1.7 What was the agency's involvement with this child and family?

Give a list of which parts of your service worked with whom in the family. Include here a succinct summary of the relevant involvement and work undertaken with the child and his/her family.

1.8 Analysis of involvement

In this section you should explain what the expected standard or best practice is in relation to the events and to what extent these were met. Where practice fell short of the expected standard this should be explained/commented on and it is of equal importance that good practice is identified.

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why something either did or did not happen. Consider specifically the following:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child (ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

1.9 What do we learn from this case?

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

1.10 Recommendations for action

- What action should be taken by whom and when? What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?
- Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?
- focus recommendations on a small number of key areas, with Specific, Measurable, Achievable, Relevant and Timely proposals for change and intended outcomes;

N.B. The Chief Executive of the agency concerned should ensure the quality of the IMR and have signed it off before the report is submitted to the SCRP. The agency should also ensure that an action plan is drawn up and submitted to the SCRP which addresses the recommendations made in the IMR. This action plan should be submitted to the LSCB administrator by at least week 15 of the process and Chief Executives will be notified at the start of the process of the relevant date.

2. Interviewing staff as part of the IMR preparation

- 2.1 It is normally necessary and helpful to the review process to interview staff who are, or previously were, involved in the case. The individual management review process should involve staff being interviewed on an individual basis, to allow them the privacy to address the issues and share any concerns with the interviewer, though they can bring with them a supporter – normally this should not be their line manager.

2.2 Interviewees will find it helpful to have a copy of the outline questions to be put to them in advance and a chance to look at files or chronologies prior to and during any interview.

2.4 Areas to be covered with the interviewee could include:

- his/her knowledge of the history of the case; the child(ren) and family prior to the individual's involvement;
- his/her specific involvement in the case;
- his/her knowledge of the agency's policy and procedures in relation to child care and child protection;
- his/her knowledge of child development, identifying injuries in relation to abuse, understanding of the psychological effects of abuse upon a child, direct work techniques, and their role in relation to child protection conferences;
- the methods used to relate to and communicate with other professionals in the case;
- the interviewee record keeping;
- the supervision the interviewee received;
- the interviewee's feelings about the case, the parent, step-parent or child and how those feelings were dealt with in supervision;
- the range of training both within and outside the agency in the last two years;
- looking back; what the interviewee would now do differently;
- whether there were significant issues impacting on the person's work;
- what lessons the interviewee can learn from the experience;
- whether the interviewee thinks that the agency can learn lessons from the experience.

2.4 Staff should subsequently have a chance to read a draft of the individual management review report, or at least those sections which relate to them, for accuracy and comment. There should also be initial feedback to staff after individual management reviews have taken place, in advance of completion of the overview report, with further feedback when the overview report is completed.

FORMAT FOR IMRs

STYLE NOTES

- The IMR should be written in the third person
- Please use Arial, font size 11
- Please do not underline headings, put headings in bold and uppercase and to the left hand side of the page
- Please only use acronyms when absolutely necessary, and use in full the first time with the acronym bracketed by the side. At the bottom of the contents page (page 2) please put your glossary of acronyms
- Please use numbered paragraphs and please use automatic numbering – do not put the numbers in yourself and rely on the space bar
- Please apply automatic page numbering and for this to show at the bottom right hand corner
- Please start a new page for each chapter
- Please do not use colloquial language

- Refer to people by their full name and title. If an agency representative, then full name, title, and agency (these names, as well as the family names will be anonymised in the Overview Report)
- Don't forget to spell check

Please remember to send your IMR and chronology, password protected (using the password allocated by the SCRIP) to the LSCB administrator for merging. It is the agency's responsibility to ensure the security of the report and chronology until it is in the possession of the LSCB administrator in line with own agency's security standards.

INDIVIDUAL MANAGEMENT REVIEW

UNDERTAKEN BY (Author's name and designation)
ON BEHALF OF (PUT AGENCY NAME HERE)

Regarding (as given by serious case review panel)

Individual Management Review in accordance with
Chapter 8 of Working Together To Safeguard Children 2006 (and as updated in
December 2009)
And
Chapter 3.5 - Serious Case Review Protocol
Pan Dorset Inter-agency Safeguarding Procedures 2006
(updated Dec 2010)

Author Name (<i>please print</i>)	
Agency	
Date	
Signature	

Name of Chief Executive (<i>please print</i>)	
Date:	
Signature	

Chronology

What constitutes a chronology?

- 1.1 There are different ways of interpreting what constitutes a comprehensive chronology. Three types of chronologies are detailed below. The Serious Case Review Panels (SCRPs) of Bournemouth and Poole, and Dorset LSCBs will need to consider each review individually and decide upon the content of the chronology in each serious case review. The SCRPs will define which format will be used, and the content of the chronologies.

Chronologies may consist of:

- all file entries;
 - all significant events or changes in a case;
 - all critical incidents.
- 1.2 Whilst the first type of chronology gives all of the information even details perceived as insignificant on the basis that they **may** become more significant once the wider picture has been established, this can be a very time consuming process. On the other hand, if the merged inter-agency chronology runs into hundreds of pages, this could be counter-productive, allowing important information to be missed, if staff have time constraints and other work pressures.
- 1.3 The latter two types can be expanded upon at a later point, with the possibility of **all** file entries being included should it become clear that this is necessary. Alternatively it may be deemed necessary to obtain any further details about a *specific* incident or period and further details can therefore be prepared for a defined period only. This might be particularly appropriate in cases spanning a number of years, but this in itself cannot be the reason for limiting the chronology in this way. Extra information, or a more detailed chronology or detailed section within it, can be requested by the author of the individual management review, the Overview author or by the SCRPs.
- 1.4 The chronology should initially be prepared from written records. Each child and adult should, at least initially, have his/her own separate chronology.
- 1.5 It may be that not all discussions, exchange of information, or actions that have taken place have been fully recorded but it will be important to establish as far as possible what has happened, and why, within a case. Where records do not reflect accounts given in interviews, the reviewing person or team will need ultimately to use their judgements in balancing between the written and oral accounts available to them regarding significant issues.
- 1.6 Where there is a difference between individuals or agencies about significant events or actions, an attempt should be made to establish the facts in relation to key events or incidents, referencing any corroborating information. It may be appropriate, where incidents are key to understanding the working of the case, to include a summary of differing accounts of the situation, outlining areas of consensus and disagreement, where there is no other corroboration.

- 1.7 Events or actions, not recorded but identified later, should be added subsequently to the chronology. Such information may be from interviews or other sources and should clearly indicate within the later chronology if this is substantiated (and how) or unsubstantiated (and source). The Overview author or SCRП may need to give advice on this in relation to each case.
- 1.8 The SCRП will need to determine the specific requirements for the chronology in each case and will need to consider the following points:
- Clarify which children and adults should be included in the review and chronology (e.g. absent fathers, uncle living as part of household, previous partners);
 - a Chronology format is attached for professionals to use for completion by their agency. The headings may be changed by the SCRП if required for certain types of cases/case audits (e.g. fabricated or induced illness). The Chronologies should be completed electronically following the instructions within the programme to enable merging.
 - note specifically in the chronology each occasion on which the child was seen and the child’s views and wishes sought or expressed;
 - how to ensure that any alias and/or maiden names have been obtained in order to check records fully;
 - how to differentiate within the chronology those entries from written records and those entered later from verbal accounts from staff interview, including any evidence regarding the reliability of these accounts;
 - determine the method of each agency’s chronology being merged for the overview stage and report.
- 1.9 The SCRП may differ in its expectations for a serious case review and a case audit. The SCRП may consider whether a summary of the chronology would be informative if contained in the summary report, to enable lessons to be better understood in the context of the specific case.



Format

Chronology.xls

The Overview Report

The SCR overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, information from the child death review processes, where relevant, and reports commissioned from any other relevant interests. Overview reports should be produced according to the following outline format although, as with IMRs, the precise format will depend on the features of the case. This outline is most applicable to abuse or neglect that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex.

The Overview report should use the same style type as the IMR reports and should address the points detailed in Chapter 8 of Working Together to Safeguard Children (revised Dec 2009) and which are reproduced here.

Introduction

- Summarise the circumstances that led to a SCR being undertaken in this case.
- State the terms of reference of the review.
- Record the methodology used including the documents reviewed, and whether the information was provided in an interview or through written evidence.
- List agencies or types of contributors to review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names and roles/positions/job titles of the LSCB Chair, SCR Panel Chair, the author of the overview report and the job titles and employing organisations of all the SCR Panel members.
- List external investigations, if any, that are being conducted (for example the PPO investigation following the death of a child in custody or a mental health inquiry).

The facts

- Prepare an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen, if the child was seen alone and whether the child's wishes and feelings were sought or expressed.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

Analysis

This part of the overview report should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. It is important that this is objective and open, being clear where systems could improve. The analysis section is also where any examples of good practice should be highlighted. The findings from this SCR should be considered alongside learning from previous SCRs undertaken by the LSCB and findings from relevant research.

Conclusions and recommendations

This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales. Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should usually be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted and the information sent to the relevant government department.

The Executive Summary

In all cases, the SCR overview report and the IMRs should be used to produce an executive summary that should be made public and which accurately reflects the full overview report. The executive summary should include information about the review process, key issues arising from the case, the recommendations and the action plan (including any actions that have been completed). The content of the executive summary needs to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary should, however, include the names of the LSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members.

The full text of the executive summary should be included at the beginning of the overview report.

The Case Synopsis

The case synopsis should contain a brief narrative of the case sufficient to allow the reader to understand the context of the case.

It should detail the main issues identified in the SCR and the learning points identified. It should also contain a summary of the actions being taken by the LSCB agencies to address the concerns.

In order to be easy to read and therefore effective, the synopsis should not normally be longer than 2 sides of A4 type.