

# Torbay Safeguarding Children Board

## SERIOUS CASE REVIEW

## PROCEDURES

Working together to ensure every child stays safe in Torbay

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**TORBAY SAFEGUARDING CHILDREN BOARD**  
**Guidance for Conducting Serious Case Reviews - August 2008**  
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**Torbay Safeguarding Children Board - Guidance for Conducting Serious Case Reviews**

July 2007

**When a child dies or is seriously injured and abuse or neglect are thought to be a factor, the immediate safeguarding of any other child likely to be at risk is paramount. Even if no other children are involved, it will usually be appropriate for local agencies to hold an immediate strategy meeting to consider the circumstances and plan any necessary agency action. See also TSCB procedure for responding to sudden unexpected death in childhood.**

## **1.0 Introduction**

When a child dies or suffers serious harm as a result of abuse or neglect, local agencies should consider whether there are any lessons to be learned about the ways in which they work together to safeguard children. This will usually require a multi-agency review by the Torbay Safeguarding Children Board (TSCB). The principles on which this procedure is based are set out in 'Working Together to Safeguard Children' (DfES 2006) pp. 169-180. For the purpose of this procedure a "child" is defined as anyone under the age of 18.

## **2.0 Purpose**

The purpose of a Serious Case Review (SCR) is to:

- establish whether lessons can be learned about the ways in which local professionals and agencies work together,
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and
- improve inter-agency working.

SCRs are **not** enquiries into how a child died or who is to blame; that is a matter for Coroners and Criminal Courts to determine.

## **3.0 Criteria**

**3.1** There are two sets of criteria identified in "Working Together" (Para 8.2) that relate to the need to undertake a SCR. The first is mandatory and relates to circumstances: -

"When a child dies, (including by suicide) and abuse or neglect is known or suspected to be a factor in the death"

**3.2** The second category is discretionary. "Working Together" states that "should always consider whether a serious case review should be conducted where": -

- a) A child sustains a potentially life threatening injury, or serious and permanent impairment of health and development through abuse or neglect; or  
A child has been subjected to serious sexual abuse; or  
A parent has been murdered and a homicide review is being initiated; or  
A child has been killed by a parent with a mental illness;  
**and**
- b) The case gives rise to concerns about inter-agency working to protect children from harm

It is important to note that the same criteria and procedures apply to children with or without disabilities.

**3.3** In summary, the criteria used to help identify whether a SCR is needed (in respect of non-mandatory cases) include: -

- where there was evidence of significant harm to a child that was not recognised by organisations or individuals in contact with the child, or not shared with others, or not acted on appropriately,
- where the child was being Looked After,
- where the child was in institutional care,
- where the case indicates failings in one or more aspects of formal safeguarding procedures,
- where one agency considers that its concerns were not taken seriously enough or acted on by others, and
- where the case suggests that the may need to change or more rigorously promote its local protocols or procedures.

(See Para 8.9 Working Together for full set of criteria)

*NB: "Common Cause Hypothesis" identifies that "near misses", when compared to more serious incidents or accidents that occur, have the same relative causal patterns. Therefore, within interagency work to safeguard children, focusing on only the most serious (i.e. child deaths) will be likely to minimise opportunities for learning.*

- 3.4 Additionally, the TSCB should always consider undertaking a SCR where a child who is looked after by the local authority dies or suffers serious harm. (ref. Children Act Schedule 2 and the Children's Homes Regulations)

#### **4.0 Initiating the Process**

- 4.1 Any agency or professional may refer a case to the TSCB via the chair of Serious Case Review Group (SCRG). To ensure the efficient identification of appropriate cases for SCR consideration, the relevant operational and second line managers of agencies represented on the TSCB need to be aware of both the mandatory and discretionary criteria for implementing a SCR. The TSCB should ensure that this takes place.
- 4.2 The Secretary of State for Health also has powers to demand a review.
- 4.3 The SCRG will meet to make its recommendation to the Chair of TSCB, who has the responsibility to make the decision as to whether a SCR is undertaken
- 4.4 Once a decision has been made to instigate a Serious Case Review, the Senior Safeguarding Manager of the Torbay Safeguarding Children Unit must be notified, in order to complete the Notification of Critical Childcare Incident form to be sent to the relevant Government body.
- 4.5 The Public Health lead at the Torbay PCT should also be informed.

#### **5.0 Decision Making**

- 5.1 The SCRG is a sub-group of TSCB and is responsible to that committee. It includes representatives from the police, children's social care, health, education, local government and relevant voluntary agencies.
- 5.2 When a case is referred, the group will meet as soon as possible, and always within 10 working days, to make a recommendation to the Chair of TSCB, who has ultimate responsibility for deciding whether or not to conduct a review. (To facilitate timely decision making, this may need to be a "virtual meeting"). The decision -making process by the SCRG will need to be supported by the consideration of as much available information about the case as possible at the time, including any child protection conference minutes. In the event that a SCR is recommended, the SCRG can further utilise this information to help inform the SCR process. If there is sufficient information at this stage, some initial draft Terms of Reference for the SCR could be drawn up.
- 5.3 The recommendation should be made to the Chair of TSCB immediately after this meeting, and the Chair should respond within five working days. If the decision is not to proceed to a SCR, the referrer should be notified by letter from the chair of SCRG.

NB: If the Chair of TSCB does not agree with the recommendation of the SCRG, a meeting should be convened with the Chair of SCRG to try to resolve the issue as a matter of urgency. If necessary, a special meeting of the full TSCB should be convened to make a final decision.

- 5.4 As soon as SCRG has made a recommendation that a SCR should take place, and this has been confirmed by the Chair of the TSCB (via Standard letter A), a letter from the TSCB Chair (or the Chair of SCRG on his/her behalf) will be sent to the Chief Executive of each relevant agency (and copied to their respective TSCB representative), advising them that records relating to the child/family need to be secured, and requesting that the process be set underway to undertake their Individual Management Review (Standard Letter B). *If there are draft Terms of Reference, these should be included in the letter. This communication will also include the two templates for*

*completing the Chronology and the Analysis components of the Individual Management Reviews as well as Appendix 3 of this document)*

- 5.5 When a decision has been made to proceed with a SCR, the relevant Regional and Government bodies with oversight for Serious Case Reviews will be notified by the Director of the Children's Services Authority or his/her representative (see para 4.4).
- 5.6 If the recommendation of the SCRG is not to proceed to a SCR, the group may consider whether to request an individual management review or a smaller-scale audit of agency involvement. In such cases, arrangements should be made for the agency to share relevant findings with the SCRG and TSCB.

## **6.0 Planning the Serious Case Review**

- 6.1 As soon as the TSCB Chair's decision is made to proceed with a SCR, he/she will need to commission the creation of a Serious Case Review Panel whose role it will be to undertake the review of the case in question. The following actions should therefore be taken, either by the convening of a SCRG meeting, or if this is not possible, by the Chair of the SCRG in consultation with members of the SCRG. It may have been possible for much of this work to have been initiated already at the SCRG meeting held to consider the need for the SCR.
- 6.2 The Chair of the SCRG, in consultation and with the active support of members of the SCRG, should create a SCR Panel, by identifying and communicating with potential members drawn from TSCB member organisations and other agencies/organisations as appropriate. Depending upon the circumstances of the case, it may be necessary to seek the involvement of a specialist professional, (e.g. adult psychiatry, substance misuse) and ask them to join the SCR Panel.
- 6.3 Agencies represented on TSCB have been asked to provide a list of people who might be in a position to serve on such a review panel. The agency SCR Panel member should not be the same person who compiles the Agency report, and if possible should be drawn from an operational area or division of the Agency different to any that have had direct contact with the child/family.
- 6.4 Once agreed, the Chair of the SCRG should write (Letter C) to confirm the individual's role on the SCR Panel and (where relevant) provide them with a copy of the initial letter to their Chief Executive (Letter B). The SCR Panel member should be asked to monitor their agency's progress in respect of the instigation of their Individual Management Review.
- 6.5 The Chair of the SCRG, in consultation with members of the SCRG, should identify, approach and appoint an Independent Overview Report Author, (drawn from the approved Pool) (A standard contract has been approved for this purpose). The Independent Overview Report Author will be accountable in the first instance to the Chair of the SCRG for the quality of their work and the need to keep to timeframes for completion of the particular Review. The Chair of the Serious Case Review Panel will either be the Chair of the SCRG, or a Member of the Safeguarding Children Unit.
- 6.6 The SCRG should identify if the SCR will need to take account of any outstanding criminal proceedings or other legal circumstances, and make recommendations to the SCR Panel accordingly.
- 6.7 The date for the first SCR Panel meeting should be decided – it will need to take place approximately 10 working days after the deadline for the return of the Individual Management Reviews

## **7.0 Completing the Serious Case Review**

### **The 1<sup>st</sup> SCR Panel Meeting**

- 7.1 At a minimum of 5 working days prior to the first meeting of the SCR Panel, the members will need to have received copies of each of the completed Individual Management Reviews, as well as an Amalgamated Chronology in order to quality assure them. If the IMRs are of sufficient quality the Chair of the SCR Panel will forward them to the Independent Overview Report Author, If there are concerns regarding the quality of a IMR the report will be returned to the agency details of what action needs to be taken.
- 7.2 This will provide the material for the first Panel meeting, whose main purpose will be to: -
- Collate and analyse the detailed information and findings from the Individual Management Reviews, and in the light of this to: -
  - Confirm/agree any further Terms of Reference and time period for the SCR
  - Identify if any further information is needed or other reports need commissioning. Any additional information needs to be in writing as this will be included within the documentation sent to Ofsted.

### ***A standard Agenda for the first SCR Panel meeting is attached as Appendix 2***

- 7.3 Different options may be employed in order to separately consider the Individual Management Reviews e.g. each member of the SCR Panel could take responsibility for summarising their Agency's respective report in order to generate further analysis or alternatively, the author of each report could be formally invited to attend the meeting (at appropriate intervals), to individually present their report, and for the SCR Panel to ask any questions for clarification.
- 7.4 By the end of the first Panel meeting, there should have been sufficient examination, discussion, and analysis of the SCR information to be forwarded to the Independent Overview Report Author to be able to complete the first draft of the Overview Report. A deadline will be given for its completion and a date agreed for when it will be forwarded to the Panel.

### **The 2<sup>nd</sup> SCR Panel Meeting**

- 7.5 At a minimum of 5 working days prior to the second meeting of the SCR Panel, the members will need to have received a copy of the Draft Overview Report from the Independent Overview Report Author
- 7.6 The main purpose of the meeting will be to consider and examine the draft Overview Report in detail, in order to ensure that it reflects the factual background, analysis and discussion from the previous meeting, taken from the material within the Individual Management Reviews. The draft report will also need to reflect any relevant independent perspectives regarding the management of the case developed by the Independent Overview Report Author and agreed by the Panel.

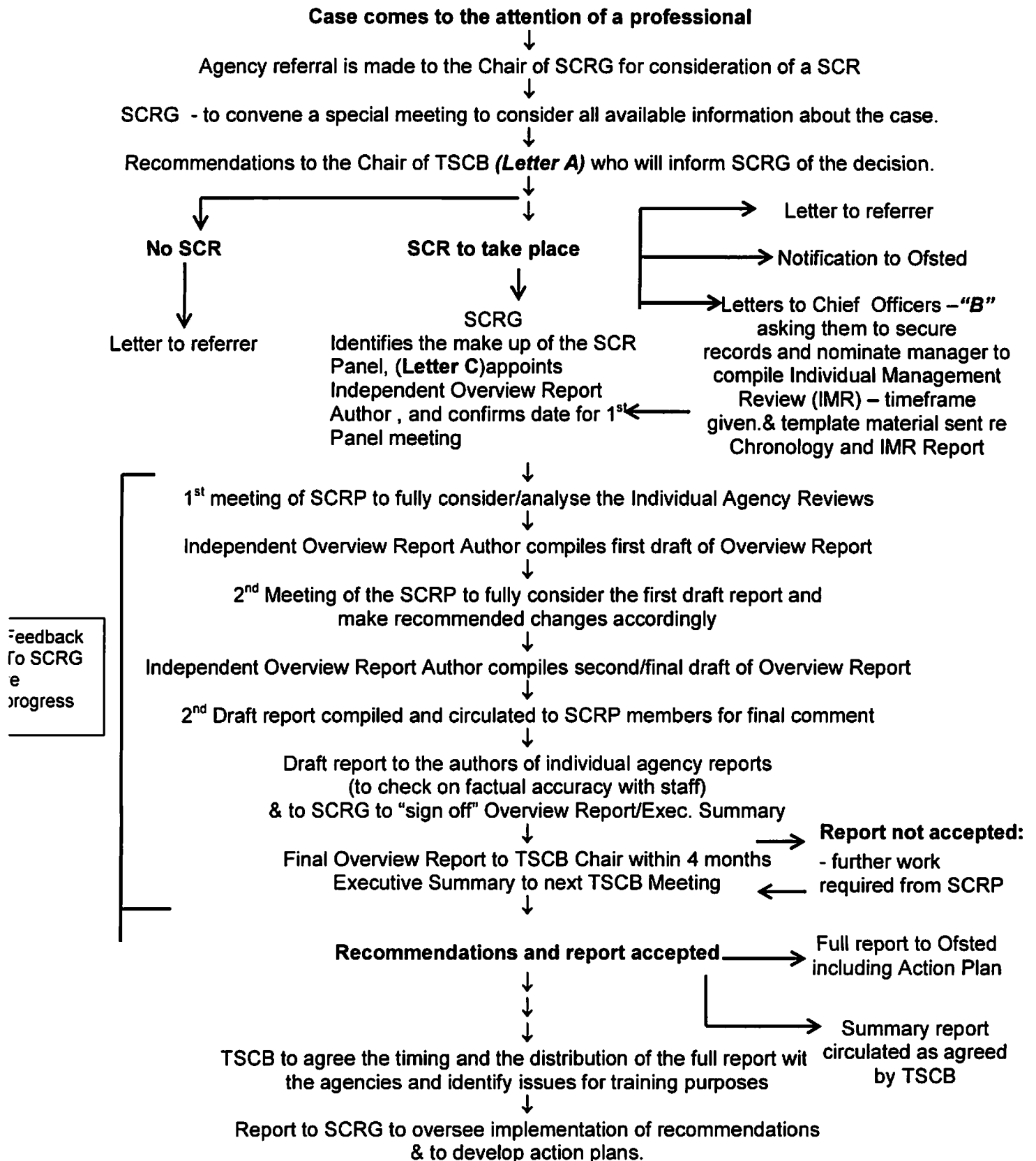
### ***A standard Agenda for the second SCR Panel meeting is attached as Appendix 3***

- 7.7 By the end of this Panel meeting, there should have been sufficient examination, discussion, and analysis of the Draft Overview Report, for the Independent Overview Report Author to be able to complete the final draft of the Overview Report, including the recommendations.
- 7.8 Unless there are incomplete pieces of work which may affect the detail of the final draft report (such as plans to seek views from family members, or some pertinent pieces of information not being received), agreement will need to be reached for a deadline for the final draft report to be completed.
- 7.9 The final draft of the Overview Report will then be circulated to the members of the SCR Panel on the date agreed, for the members to ensure that it reflects the discussions from the recent meeting and includes changes which were proposed at the time. The SCR Panel members will be given approximately 10 working days to respond to the final draft report.

- 7.10** The Independent Overview Report Author will then again revise the Overview Report in the light of the individual responses from the panel members and produce a Final Overview Report within an agreed time frame. If there is discrepancy among the panel members in respect of what should be included in the Report, there will need to be further circulation of the details of the discrepancies to try to achieve a consensus, and if necessary for the Independent Overview Report Author, in conjunction with the SCRG Chair, to recommend the most appropriate conclusion. On rare occasions, a further meeting of the SCR Panel may be required.
- 7.11** Throughout the process the SCRG, via the Chair, should monitor the progress of the SCR via updates from the Independent Overview Report Author.
- 7.12** The Independent Overview Report Author will present the final draft Overview Report and Executive Summary to the SCRG, to enable the SCRG to formally accept the report, inform the TSCB Chair accordingly, and to then arrange for the Executive Summary to be presented to the next TSCB Meeting. The draft Overview report should also sent to the individual agency report writers who should be given the opportunity to respond within ten working days with any suggested amendments.
- 7.13** The full TSCB will need to give formal acceptance of the SCR report via a presentation of the Executive Summary by the SCRG Chair and/or the Independent Overview Report Author. Any recommended final revisions should be referred back to the SCR Panel for their action. The final agreed Executive Summary will be signed off and dated by the chair of TSCB, and will be made widely available. The complete Overview Report will be circulated to TSCB members and to Chief Executives of all agencies represented on TSCB, for onward distribution within their agency as appropriate. TSCB Agency representatives will receive this electronically in order for the completion of the Action Plan to be initiated as a matter of urgency.
- 7.14** This work should be completed within 4 months of the initial decision to commission a SCR, unless an alternative time-scale is agreed at the outset. If at a later stage the complexity of a case means that this time-scale will have to be extended, the Chair of the SCRG should ensure that a discussion takes place with the relevant Government department to agree a new time-scale.

**A Flow Chart of the progress of a Serious Case Review is detailed in Appendix 1**

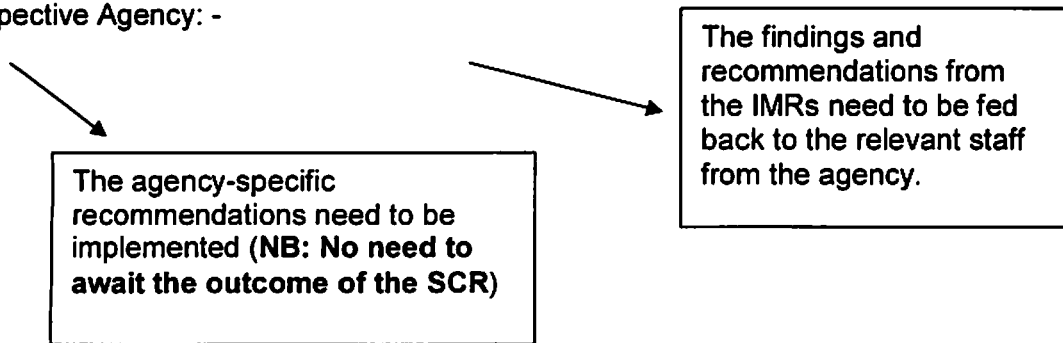
**Appendix 1 – Flow Chart**



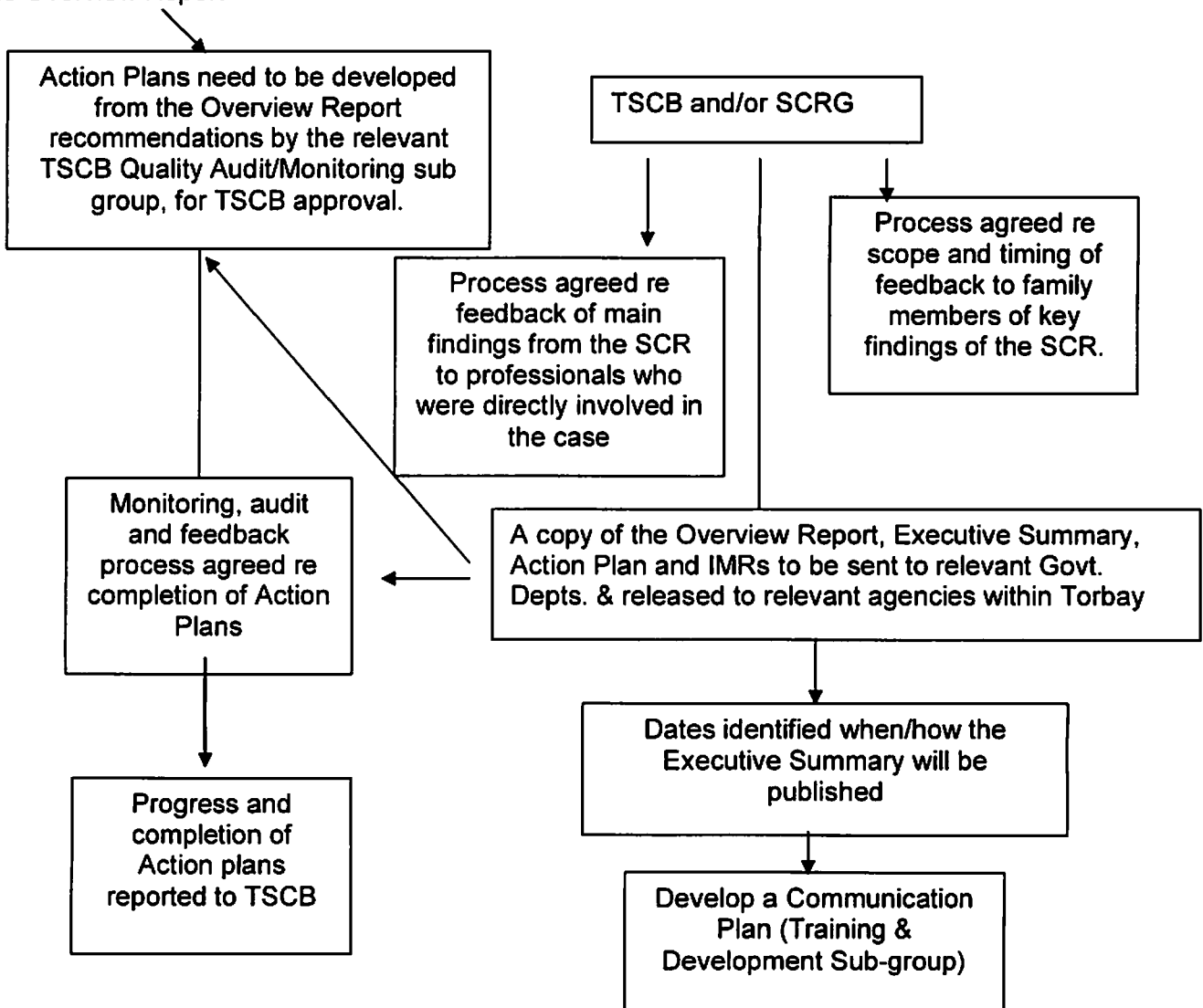
## 8. Dissemination and Learning

The only real value of the completion of a Serious Case Review is that relevant professional lessons are learnt and that local multi agency safeguarding practice is improved.

The Individual Management Reviews are stand alone documents and should lead to individual actions by the respective Agency: -



The Overview Report



## **FUNCTIONS OF THE SERIOUS CASE REVIEW GROUP**

### **1 Making the recommendation to initiate a serious case review.**

This will be done via the collation of initial available information in respect of the background of the case and the circumstances that led to the child death/serious injury, and sharing this with available members of the SCRG. Recommendations for a SCR will be in line with Section 3 and Paragraph 5.2 of the Guidance for Conducting Serious Case Reviews.

### **2 Determining the provisional scope of the SCR including the time period for the SCR and which agencies should contribute to the SCR.**

There will be a need to identify all the agencies who have known or worked with the child/family. Based on information known about the circumstances of the case, then initial terms of reference and timeframes should be identified for the SCR, and the agencies informed accordingly via Letter B

### **3 Establishing the SCR Panel, the Chair & Independent Overview Report Author & commissioning the Individual Management Reviews & to set date for the first SCR Panel meeting**

Ensure that Letter B is sent by the TSCB Chair to the respective Chief Executive/Officer of the agencies that have had involvement with the child/family. (Paragraph 5.3) There will be a need to identify the most appropriate agency representatives to form the SCR Panel and make contact to request their involvement – Letter C to be sent. (Paragraphs 6.2-6.4) Identify and seek the involvement of an appropriate Independent Overview Report Author. (6.5)

NB: Independent Overview Report Authors will need to be selected from the approved Pool.

### **4 Monitoring the progress of Serious Case Reviews**

The Independent Overview Report Author will be responsible to the SCRG Chair for their work on the SCR. The Chair will need to seek/receive updates re the progress of the SCR and present these at respective SCRG meetings in order for the SCRG to monitor and if necessary comment on the progress of the SCR.

### **5 Following up on recommendations of previous SCRs**

A different sub group of the TSCB will likely be responsible for ensuring the implementation of Overview Report recommendations and that Action Plans are attached to the recommendations and monitored accordingly. The SCRG will need to reassure itself that this process is being effectively undertaken.

### **6 Making a quarterly report to TSCB**

This will be in relation to the work undertaken by the SCRG, including SCRs conducted or in the process of being completed, and any issues associated with the work of the SCRG that require the attention of the TSCB

### **7 Ensuring that systems are in place for the effective completion of SCRs and to develop and alter templates and formats as necessary.**

Based on the completion of SCRs, the SCRG should periodically review this Guidance and related processes to ensure that the most effective and efficient systems are in place to support the successful and timely completion of SCRs.

## **FUNCTIONS OF THE SERIOUS CASE REVIEW PANEL**

### **1 Confirming the scope of the Serious Case Review**

The SCR Panel should draw up terms of reference, in the light of the facts available, in each case. Relevant issues include:

- Confirm the appropriateness of the time period to be reviewed - how far back should enquiries cover, and what is the cut-off point? (e.g. from the time of the birth of the subject child to the time of the fatal or relevant incident.)
- Are there any additional agencies or professionals who should contribute to the SCR, who have not so far been commissioned to complete an Individual Management Review? and should any contribution be sought from parties not represented at TSCB (e.g. independent school, playgroup leader)?
- How should family members be informed or involved, and who should make any initial approach to them? (bearing in mind that the family has been bereaved and may already be involved in criminal or coroners' enquiries.)
- Are there features of the case which indicate that the SCR should involve, or be conducted by, a party independent of the professionals/agencies who will be participating in the review, such as an outside expert?
- Is there a need to involve agencies/professionals in other TSCB areas, and who should approach them with the request?
- Is there a need to liaise with the Coroner, the Crown Prosecution Service, or the Court in care proceedings?
- Will there be any other parallel review of practice, such as a mental health, homicide or suicide enquiry, and if so, how can the reviews be co-ordinated to avoid duplication?
- How should any family, public or media interest be handled? –appropriate recommendations to be made to the TSCB in respect of this.
- Does the TSCB need to obtain independent legal advice about any aspect of the proposed SCR?

### **2 Analysis and examination of Individual Management Reviews**

Individual agency reports are provided for the purpose of producing LSCB's Overview Report. The information should not be used for any other purpose or passed to any other person without the consent of the report provider (who may also have to seek the consent of the professionals who provided the information).

The full consideration of the factual and analysis components of the Individual Management Reviews is a key task of the SCR Panel, and if there are concerns about insufficient information or the quality of analysis in these reports, then the matter should be urgently referred back to the respective Agency to ensure this is rectified. At the final draft stage of the Overview Report, the report should be shared with the authors involved in preparing the Individual Management Reviews, to check for factual accuracy.

### **3 Producing the Overview Report**

The overview report should bring together the relevant information and analysis contained in the individual agency reports, together with any reports commissioned from other parties. The following format is suggested, although details may need to be changed depending on the nature of the case.

#### **Introduction**

- Summary of circumstances leading to the SCR.
- Terms of reference.
- List of contributors to the SCR, panel members and author(s) of the overview report.

### **The Facts**

- Genogram showing family membership, including extended family and index child's household
- Acknowledgement of and reference to any issues relating to disability or ethnic/religious diversity.
- Integrated chronology of involvement with the child and family by all relevant professionals, noting each occasion when the child was seen and the child's views or wishes sought or expressed.
- Summary of the relevant information known to the agencies involved about the parents/carers, and the home circumstances of the children)

### **Analysis**

- A consideration of how and why events occurred, decisions were made and actions taken or not. There may be comment as to whether, in the panel's view, different decisions or actions may have led to an alternative course of events. The analysis section may also be able to highlight examples of good practice. The analysis should be structured so as to reflect the terms of reference of the SCR

### **Conclusions and Recommendations**

- Summary of the lessons to be learned from the case, and the panel's recommendations for action.
- Recommendations should include, but not be limited to, the recommendations made in the individual agency reports. Recommendations should be few in number, focused and specific, and capable of being implemented.

## **3. The Executive Summary**

The Executive Summary should contain a précis of the Case Review Process, the Case Details, Key findings, and the Recommendations from the Serious Case Review. Care should be taken to ensure that the details of the family cannot be identified from the Executive Summary. This document should be made available to the public via the communications strategy developed by the TSCB.

## **4 Presenting the Overview Report/Executive Summary to TSCB**

As soon as possible after completion of the Overview Report, which will need to have been "signed off" by the SCRG, the Overview Report and Executive Summary should be forwarded to the Chair of TSCB, who will need to make a decision regarding who will need to receive copies of the Overview Report.

The Report should then be presented without delay to the full TSCB, if necessary by convening a special meeting. It is most likely that the Executive Summary will be sufficient for the purposes of the TSCB meeting. The Author of the report and the Chair of the SCRG should attend this meeting in order to present the report and to respond to any queries from the Committee. After the TSCB has approved the report, discussion should take place on circulation of the report, and on the mechanism for taking forward the Panel's recommendations. There should be feedback from SCRG (or other relevant TSCB Sub Group) to subsequent meetings of TSCB on the implementation of the recommendations

SCRG will formally 'close' the case 12 months after the publication of the final Overview Report and will write to TSCB giving details of any recommendations still requiring action. Further action on the outstanding recommendations will then become the responsibility of TSCB.

## **THE ROLE OF TSCB**

The agenda for the meeting in which a Serious Case Review is to be tabled should be as follows:

- Introduction to the report by the Chair of the SCRG and Independent Overview Report Author..
- Reading through the report in order to answer any questions from TSCB members.
- Detailed consideration of the recommendations in order to enable the relevant sub group of the TSCB to produce an action plan and timetable.
- Decision on distribution of Overview Report or Executive Summary as appropriate, to different bodies or individuals.
- Decision on arrangements for feedback to staff, family members or others closely involved in the case.
- Decision on handling any media interest.
- Agree a time-scale and method for review of implementation of the recommendations.

The TSCB may wish to refer some of these items to SCRG for more detailed consideration.

The Chair of TSCB will then ensure that a copy of the overview report, including integrated chronology and action plan, is sent to Ofsted.

The report will be circulated to the Chief Officer of all the relevant agencies highlighting the recommendations for their individual agency and asking them to ensure implementation within their own agency.

If implementation of the recommendations cannot be resolved by TSCB there may need to be discussion with the SSI about the reasons for this.

TSCB will receive a regular report from SCRG (or other relevant TSCB Sub Group) on progress with implementation of the recommendations, to include a final report 12 months after publication of the overview report. If there are any outstanding recommendations after 12 months, responsibility for ensuring action will revert to TSCB.

## **1<sup>st</sup> Meeting**

### **SERIOUS CASE REVIEW PANEL ON:**

**Date:**

**Time:**

**Venue:**

**Apologies:**

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### ***PROPOSED AGENDA***

1. Introductions
2. Brief outline of case to be reviewed
3. Presentation/Analysis of the Individual Management Reviews
4. Review Terms of Reference and scope of review
5. Involvement of family / other parties
6. Consideration of any parallel investigations or proceedings in this case
7. Agree any further steps/actions
8. Agree date for circulation of 1<sup>st</sup> draft of the Overview Report
9. Date of next meeting (minimum of 5 working days following circulation of the Draft Report)

**NB:** Members should have available copies of local CP procedures and Working Together '06, as well as detailed SCR procedures including the flowchart.

## **2nd Meeting**

### **SERIOUS CASE REVIEW PANEL ON:**

**Date:**

**Time:**

**Venue:**

**Apologies:**

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### ***PROPOSED AGENDA***

1. Introductions/Apologies for absence
2. Minutes of previous meeting of Panel
3. Matters arising from meeting
4. Draft Overview Report
  - a. Introduction
  - b. The Facts
  - c. Analysis
5. Confirm/Develop Recommendations
6. Identify any outstanding actions/tasks
7. Agree timeframe for completion of Final Draft
8. Agree process for Panel approval of Final Draft
9. Date for presentation to TSCB

## **SERIOUS CASE REVIEWS**

### **GUIDANCE FOR THE COMPLETION OF INDIVIDUAL MANAGEMENT REVIEWS**

Once a decision has been made by the Chair of the TSCB that a Serious Case Review is to be undertaken, if your organisation has had knowledge or contact with the child or family, there will be a formal request for all records pertaining to work with the family to be secured – a senior manager will need to ensure that this is undertaken.

The Role of the **Serious Case Review Group (SCRG)** and that of the **Serious Case Review Panel (SCRCP)** is contained on pages 9 & 10 of the document "Guidance for Conducting Serious Case Reviews" (need to review this at a future meeting)

"Working Together to Safeguard Children 2006" contains guidance on conducting Individual Management Reviews (Paragraphs 8.20-8.27)

#### **The Individual Management Review (IMR)**

Each Organisation that is required to complete an IMR will need to: -

- Appoint a senior manager from within your organisation (or an independent person) to undertake the task of completing your IMR and compiling the relevant report for the SCRCP. This manager should not have been directly concerned with the child or family, or the immediate line manager of the practitioners involved.
- Ensure that all relevant files are secured and made available to the organisation IMR report writer.
- Ensure that IMR report writers are allocated adequate resources (time, admin support) to complete their report within the required timescales. It is imperative that timescales are adhered to in order that the role and actions of the agencies involved with the family can collectively be reviewed by the SCRCP.
- Make available to the IMR Report Writer, the Chronology template and the IMR template, (which would have already been forwarded to your organisation) which must be used for the compilation of the IMR. Further guidance is contained within these templates.
- Ensure that any staff involved with the child or family should be given the opportunity to discuss their understanding of what has happened. It is essential that support and counselling be offered, given the possible serious impact on the professionals involved. Staff should also be given a copy of the leaflet on Serious Case Reviews. Support should be ongoing and reviewed regularly by the line manager.
- To consider whether there is any evidence at this stage for a disciplinary investigation (See below)

## **Role of Individual Management Review report writer**

- The report writer, having reviewed the files, should then be aware of the members of staff who have been involved in the case. The staff members, through their line manager, should already be aware that a serious case review is being undertaken.
- Even if the report writer is satisfied that the files contain all the relevant information he/she should meet with the professionals from their organisation who have had recent or relevant involvement with the child and family. This should be arranged in consultation with their line manager. The report writer should ascertain, in consultation with the line manager, that the member of staff is receiving or has received the appropriate support in relation to that member's own welfare.
- This meeting should give the report writer the opportunity to check with the member of staff the factual accuracy of the details of the chronology. It will also be an opportunity for staff to identify any lessons they consider can be learnt from their own and their organisation's involvement. A written record of the interview should be made and should be shared with the interviewee.
- The purpose of the IMR is to "look openly and critically at individual and organisational practice, to see whether the case indicates that changes could or should be made and, if so, to identify how those changes will be brought about". ("Working Together" '06).
- The IMR report writer should complete the Chronology and Report on the relevant template, and a copy should be sent to the Senior Manager in their organisation for their acceptance on behalf of the organisation, before it is forwarded to the Chair of the Serious Review Group by the deadline specified, who will arrange for it to be forwarded to the Chair of SCRP. The Senior Manager within the organisation will be responsible for ensuring that the recommendations contained within the IMR are acted on.

**NB. If the report writer has any difficulty in carrying out the above tasks then he/she should contact either the Chair of the SCRG or of the SCRP.**

### **Criminal proceedings**

There may be a criminal investigation running concurrently with the Serious Case Review. In situations where there may be conflict between the two processes, the criminal investigation takes precedence although this should not delay the work being undertaken in respect of the Serious Case Review. In such cases, management report writers will be advised by the SCRP of any necessary changes to the above guidance.

### ***Other review processes***

Some cases may be subject to other forms of review, for example a critical incident review or a homicide review. In this situation organisation report writers are advised to contact the other reviewers to avoid duplication and to ensure a coherent approach to each review.

### **Disciplinary action**

If an organisation decides at any time of the process that disciplinary proceedings need to be initiated then the line manager will need to discuss with the report writer the appropriateness of proceeding with a discussion with the relevant staff members in relation to the review.

If the report writer comes across information which he/she considers is a matter which needs to be investigated under disciplinary procedures then this should be brought immediately to the attention of the individual's line manager/senior manager.

---

**Letter "A"**

Ref: /

Date

To Chair  
Torbay Safeguarding Children Board

Dear ,

**Re: Serious Case Review Group – name of child**

The Serious Case Review group has considered this case to see whether it meets the criteria to initiate a serious case review. Please see the attached paper. The group feels that this case does / does not meet the criteria to commence a serious case review.

We would be grateful for your decision.

Yours sincerely

***Chair, Serious Case Review Group***

enc

**Letter “B”**

Strictly confidential – requires urgent attention

Dear

**Serious Case Review**

**Re Child/Family:**

**Address:**

A decision has been made that the above named child and family are to be made subject to a Serious Case Review.

As Chair of the Torbay Safeguarding Children Board I am writing to formally request that you take action to ensure that your agency files in respect of the above named family are immediately secured to guard against potential loss or interference, and to enable the Serious Case Review process to commence. *(Insert may be needed here re detailing records that are affected – e.g. HV records, GP notes, School Health etc)*

Would you please identify a manager (or independent person) of sufficient seniority and experience to undertake your Internal Management Review as required under paragraphs 8.21 – 8.27 of “Working Together”. The manager appointed should have had no line management relationship with practitioners working with the family or any direct contact themselves with the family/child. I would be obliged if you forward me the name and contact details of this person as soon as possible.

The purpose of this Serious Case Review is to establish whether there are any issues in relation to interagency working under the local child protection procedures and any lessons to be learned, and to achieve this, each agency that has had involvement with the family is required to look openly and critically at their professional practice with the child/family.

I have attached information and a template relating to the Individual Agency Management Reports and in relation to the Chronology which your agency is required to complete. I have also supplied a computer disk with the pro-forma to enable us to combine the individual agency chronologies. I would be obliged if you would please ensure that this material is forwarded to your Review manager. I am also enclosing the relevant Appendix 3 from the Guidance for Serious Case Reviews to further clarify the process required of your organisation in respect of the completion of Individual Management Reviews.

The chronology will apply for the period \_\_\_ to \_\_\_ in relation to the following children in the household: (Names and dob)

According to paragraph 8.22 “Working Together 2006”, “The findings from the Individual Management Review should be accepted by the senior officer in the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon”

**It is most important that The Serious Case Review Panel receive your Agency's report by \_\_\_\_\_ in order for this Serious Case Review to be completed within government guidelines. I am sure you will appreciate that if there is delay by one of the Agencies within this process, this will seriously compromise the Panel's ability to provide a multidisciplinary Overview Report, and will therefore impact upon our ability to learn important professional practice issues locally. It is important that in undertaking this work, that the TSCB can demonstrate its support and compliance with Sec 11 and Sec 14 of the Children Act 2004.**

Thank you for your assistance in this important matter. I would be obliged if you would send your Individual Management Review to the Chair of the Serious Case Review Group whose contact details are given below.

Yours sincerely

**Chair, TSCB**

## **Letter "C" to Panel Member**

Dear

**Re Serious Case Review:  
Details:**

I am writing to request/confirm that you will be able to serve as a member of the Serious Case Review Panel in respect of the above named child/family.

The minimal expectation is that you are able to attend two meetings (probably 1 ½ day time commitment) and will be able to scrutinise SCR documents and reports before, in between, and after these meetings.

I am attaching a copy of the letter sent to the Chief Executive of your Agency informing him/her of the Serious Case Review and the need to commission the completion of an Individual Management Review. As part of your role on the SCR Panel, it would be helpful if you would help monitor the progress of this Individual Management Review and give advice and support where necessary to help ensure that the timeframes for completing the report are met.

Further details of other members of the Panel will be sent to you in due course along with the dates for the first meeting and the overall timeframe for the Serious Case Review.

Yours sincerely,

Chair  
Serious Case Review Group

**Initials of Child/children - Chronology of involvement with Social Services Department/Police/Health Authority/JCT or relevant agency**

<b>Date</b>	<b>Initial of family member</b>	<b>Professional</b>	<b>Reason e.g. referral from police</b>	<b>Incident/contact/ Location (Time if relevant)</b>	<b>Actions taken/decisions made</b>	<b>Other Information</b>	<b>Agency/ File Ref.</b>
07/08/03	DD	CC		HV – 4 week assessment. Risk factors for abuse identified: poor accommodation	Scored high on infant surveillance system		Child Health file
Dd/mm/yy	ED	BB		GP – Cold	Advised		GP notes
Dd/mm/yy	DD	AA	Referral to JCT from Social Services	Medical Co-Ordinator – Enquiry from Social Services requesting information.	Relevant information shared.		Child Health file
Dd/mm/yy	DD	SW -XX		Case conference report.	Recommendation that care application be pursued.	Reason given as concern regarding *** welfare	SS File 1 – reports

*The above are given as examples only. Please delete and complete with your own agency information. The heading should replicate on each page automatically.*

***It is important that you insert the date as per the example to facilitate merging with chronologies from other agencies and that nothing else is entered in the date column. The time of contact, if relevant, should be entered in the fifth column.***

***It is also helpful if the column widths are left exactly as they are in the template.***

*Please return to the Safeguarding Unit by the date given in the accompanying letter.*

**TORBAY SAFEGUARDING CHILDREN  
BOARD**

**Contract for Serious Case Review  
Independent Overview Report Authors**

THIS AGREEMENT is made *insert date*

BETWEEN:

(1) TORBAY SAFEGUARDING CHILDREN BOARD

and

(2) *insert name and address*

**OPERATIVE PROVISIONS**

**1. Definitions and interpretation**

1.1 The following terms shall have the following meanings for the purpose of this Agreement:

- |                            |  |
|----------------------------|--|
| 1.1.1. 'Agreement'         | means these terms and conditions and all Schedules to this Agreement as the same may be amended, modified or supplemented from time to time in accordance with this Agreement. |
| 1.1.2. 'Commencement Date' | means 1 June 2008  |
| 1.1.3. 'Term'              | means from the commencement Date for a period of three years or until this Agreement shall be determined by either Party.  |
| 1.1.4. 'Further Term'      | means a further period of 3 years in addition to the Term as agreed.   |
| 1.1.5. 'Personal Data'     | means data which relates to a living individual who can be identified from those data, or from those data and other information which are in the                               |

possession of or are likely to come into the possession of either Party. They include, without limitation, expressions of opinion or intentions in respect of such a living individual.

1.1.6. 'Sensitive Personal Data' means Personal Data consisting of information as to the racial or ethnic origin, the political beliefs, religious or similar beliefs, trade union membership, details of physical or mental health, sexual life and alleged commission of crimes or criminal record of the data subject.

1.1.7. 'Services' means the services detailed in the Role Specification.

1.2 The headings in these terms and conditions are inserted only for convenience and shall not affect its construction.

1.3 The singular includes the plural and vice versa and any gender includes any other gender.

1.4 Reference to any statute or statutory provision includes a reference to the statute or statutory provision as from time to time amended, extended or re-enacted.

## **2. Appointment and Extensions**

2.1 The Individual is appointed by the Torbay Safeguarding Children Board for the Term of three years from 1<sup>st</sup> June 2008.

2.2 The Individual may be requested to undertake a Further Term by the Torbay Safeguarding Children Board. It shall be at the sole discretion of the Torbay Safeguarding Children Board whether the Further Term shall be offered and the written consent of both Parties shall be required before a Further Term is undertaken.

## **3. The Independent Overview Report Author's Obligations**

3.1 The Independent Overview Report Author undertakes to the Torbay Safeguarding Children Board that:

3.1.1. he/she shall carry out and complete the Services and all other services reasonably required by the Torbay Safeguarding Children Board which are reasonably incidental to the Services in accordance with the terms of this Agreement;

3.1.2. he/she shall comply with all reasonable instructions given to him by the Torbay Safeguarding Children Board in relation to the Services;

3.1.3. he/she shall exercise the degree of skill, care and diligence to be expected of a person who is properly qualified and experienced to carry out the Services and provide all the Services in accordance with the requirements within agreed timescales.

3.1.4. he/she shall keep the Torbay Safeguarding Children Board fully informed and provide regular information around Serious Case Review activity.

3.2 Except and to the extent and upon the terms required or permitted by the Torbay Safeguarding Children Board the Independent Overview Report Author shall not in any circumstances use any premises or equipment of the Partner Agencies.

3.3 If the Independent Overview Report Author is unable or fails to provide the Service or any part thereof the Torbay Safeguarding Children Board may itself provide or may employ and pay other persons to provide the Services or any part thereof.

#### **4. Remuneration**

- 4.1 The remuneration payable to the Independent Overview Report Author in respect of the Services shall be calculated and paid in accordance with the Role Specification.
- 4.2 The Independent Overview Report Author shall claim any duly authorised expenses.
- 4.3 All sums payable under this Agreement are inclusive of Value Added Tax.

#### **5. Confidentiality and Data Protection**

- 5.1 The Independent Overview Report Author shall not at any time during or after the Term divulge or allow to be divulged to any person any confidential information relating to the Torbay Safeguarding Children Board except with the prior written agreement of the Torbay Safeguarding Children Board.
- 5.2 The Independent Overview Report Author acknowledges that the Torbay Safeguarding Children Board may provide Personal Data and/or Sensitive Personal Data to the Independent Overview Report Author in order for the Independent Overview Report Author to provide the Services required under this Agreement.
- 5.3 The Independent Overview Report Author undertakes to:
  - 5.3.1. keep all Personal Data confidential and shall at all times comply with the provisions of the Data Protection Act 1998 (as amended).
  - 5.3.2. shall only use the Personal Data and Sensitive Personal Data disclosed by the Torbay Safeguarding Children Board in order to provide the Services.
- 5.4 The Independent Overview Report Author shall indemnify the Torbay Safeguarding Children Board and keep the Torbay Safeguarding Children Board fully indemnified against all direct losses, claims, damages, liabilities (whether criminal or civil), costs, charges, expenses (including without limitation, legal fees and costs), demands, proceedings and actions which the Torbay Safeguarding Children Board may incur or which may be brought about or established against them by any person and which in any case arises out of or in relation to or by reason of a breach by the Independent Overview Report Author of the Data Protection Act 1998.

#### **6. Delivery up of the Overview Report**

- 6.1 The Independent Overview Report Author shall upon termination of this Agreement immediately deliver up to the Torbay Safeguarding Children Board all document and property belonging to the Torbay Safeguarding Children Board which are in his/her possession or control.

#### **7. Status of the Independent Overview Report Author**

- 7.1 During the Term and any Further Term the Independent Overview Report Author shall be an independent contractor and not the servant of the Independent Overview Report Author.
- 7.2 In such capacity the Independent Overview Report Author shall bear exclusive responsibility for the payment of his/her national insurance contributions as a self-employed person and for discharge of any income tax and VAT liability arising out of remuneration for his/her work performed by him/her under this Agreement.

#### **8. Criminal Record Bureau Checks**

- 8.1 The Independent Overview Report Author acknowledges that he/she shall receive an enhanced check by the Criminal Records Bureau before he/she shall be allowed to provide the Services to the Torbay Safeguarding Children Board. In the event that the results of the enhanced check are

received after the commencement of this Agreement, the Torbay Safeguarding Children Board reserves the right to terminate this Agreement immediately if the results of the enhanced check are not satisfactory.

## **9. Termination**

9.1 The Torbay Safeguarding Children Board may by written notice to the Independent Overview Report Author require the Independent Overview Report Author to suspend performance of any or all of the Services to be provided. In the event of the suspension of the whole of the Services the Independent Overview Report Author shall be entitled to be paid up to the date of suspension.

9.2 If either Party is in material default of any of their obligations under this Agreement the other Party may give to the defaulting Party notice of the same and if such default shall continue for a period of 14 days following service of the notice of default the other may without prejudice to any other rights or remedies forthwith terminate the Agreement by written notice.

9.3 The Torbay Safeguarding Children Board may terminate the appointment of the Independent Overview Report Author at any time giving 7 days written notice.

## **10. Insurance and Indemnity**

10.1 The Independent Overview Report Author shall fully and effectively indemnify the Torbay Safeguarding Children Board and keep the Torbay Safeguarding Children Board fully and effectively indemnified from and against all actions, demands, costs (on a full indemnity basis), losses, penalties, damages, liability, claims and expenses (including but not limited to legal fees) whatsoever incurred by the Torbay Safeguarding Children Board.

## **11. Notices**

11.1 Any notice to be given by either Party hereunder will be sufficiently served if sent by hand, by facsimile transmission or by post to the address of the other Party.

## **12. Variations**

12.1 Any variation to this Agreement shall be effected by an agreement in writing signed by a duly authorised officer or representative of each of the Parties hereto.

**13. Governing Law**

13.1 This Agreement shall be governed by English law and the Parties hereby submit to the jurisdiction of the English courts.

IN WITNESS whereof the Parties have entered into this Agreement by signature of their respective duly authorised representatives, the day and year first above written.

**SIGNED**

.....  
Signed by

Name:.....

**SIGNED**

.....  
For and on behalf of Torbay Safeguarding Children Board

Name:.....  
Authorised Officer

## DRAFT

### PROCEDURE FOR INVOLVING THE EDUCATION DEPARTMENT IN SERIOUS CASE REVIEWS

1. Once it has been established that a SCR will be held, if this involves a child of 4½ years or older (Key stage 1 to Key Stage 5), then a letter will be sent to the Director, Children Services, requesting that he/she
  - ensures the immediate security of agency files, and
  - identifies an independent manager or independent person to undertake a review and produce an Independent Management Report as required under paragraphs 8.21 – 8.27 of “Working Together”. This person must be of sufficient seniority and experience who has had no line management relationship with practitioners working with the family or any direct contact themselves with the family or child. The report will include recommendations for actions from the findings of the report.
2. The Serious Case Review Panel or Group member representing Education will provide the Independent Management Report Writer with
  - the Serious Case Review Individual Management Template (revised 18.04.08)
  - Guidance for Conduction Serious Case Reviews (revised 14.05.08)
  - a chronology template
  - The Terms of Reference (agreed by the Serious Case Review Group).
3. The Independent Management Report Writer will be provided with training in order that to ensure clarification of their role.
4. Once completed within the given timescale, the Independent Management Report and Chronology will be scrutinised by the Serious Case Review Panel or Group. Once the Panel or Group is satisfied with the report it will be sent to the Overview Report Writer.
5. The Overview Report Writer will compose his or her report based on all Independent Management Reports and the combined Chronology (merged by the Serious Case Review Administrative Assistant) within a given timescale.
6. When the Overview Report has been received in final draft format, it is to be sent to the Education Safeguarding Manager, (if it involves a child aged 4½ years or over) who will decide if he/she should join the Serious Case Review Group meeting which scrutinises the Overview Report and its recommendations.
7. Education Safeguarding Manager may attend Serious Case Review Group to be involved in the scrutiny of the Overview report if relevant.
8. Once agreed by the Serious Case Review Group and the TSCB, the Overview Report and Chronology will be sent to the Chair of the Primary Headteachers and Chair of the Secondary Headteachers and the Education Safeguarding Manager.
9. A meeting is to be held attended by the Chairs, the author of the Independent Management Report and the Education Safeguarding Manager to discuss the recommendations and a way of taking them forward either by an individual school or by Education as a whole.
10. Assistant Director, Individual Needs, to circulate the finalised action grid to all relevant educational establishments.
11. The Gatekeeping Unit is to be informed of this process.

## **Torbay Safeguarding Children Board**

### **Serious Case Review – Executive Summary Template**

All Overview Reports and Executive Summaries will be in Arial and Font 11.

Content of report:

1. Front sheet with anonymised name of the child, young person or adult with date of birth and date of death or age at the time of the incident.
2. Introduction
3. Circumstances that led to a Serious Case Review being undertaken in this case.
4. Terms of reference
5. Case summary
6. Family/carer background
7. Context of agencies involved.
8. Conclusions & recommendations

# **TORBAY SAFEGUARDING CHILDREN BOARD**

## **SERIOUS CASE REVIEW**

### **EXECUTIVE SUMMARY REPORT OF A FEMALE CHILD (AB) or FEMALE ADULT (AC)**

**D.O.B**

**D.O.D./ AGE AT TIME OF INCIDENT**

## **1. Introduction**

- 1.1 This document is intended to provide an overview of the deliberations and recommendations of the Serious Case Review Panel instigated by the *Torbay Safeguarding Children Board* relating to a female/male child who *insert individual circumstances*.
- 1.2 A Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of children in the future. *Insert the circumstances that led to a review being undertaken in relation to individual cases*.
- 1.3 This Serious Case Review has been undertaken in line with the 2006 'Working Together to Safeguard Children' guidance (Her Majesty's Government) and the Serious Case Review Policy guidance of *the Torbay Safeguarding Children Board*.
- 1.4 The overview report brings together, and draws overall conclusions from, the information and analysis contained in the individual management reviews, *information from the child death review processes*, and reports commissioned from any relevant interests.
- 1.5 List contributors to the review and the nature of their contributions (e.g. management review by Social Care etc. report from adult mental health service).
- 1.6 Cite contribution of family members and any others.

## **2. The circumstances that led to a Serious Case Review being undertaken in this case.**

- 2.1 Provide a brief and anonymous overview of the specific individual circumstances that led to a serious case review being undertaken.
- 2.2 Provide reasons for conducting the review and what Serious Case Review criteria were met (or if the criteria were not met the reason for conducting the review).

## **3. Terms of Reference**

- 3.1 Provide a brief outline of the purpose and scope of the review.
- 3.2 State the terms of reference for the review:
- 3.3 Provide an explanation for any delay in completing the Overview Report in relation to the Serious Case Review policy of *the Torbay Safeguarding Children Board*

## **4. Case Summary**

- 4.1 Provide a brief case summary including details of the incident, kind of maltreatment, who was believed responsible for the abuse.

## **5. Family/ carer background**

- 5.1 Provide brief and anonymous details of household members and other relevant persons.

## **6. Conclusions and Recommendations**

- 6.1 Key recommendations indicating the resource implications.
- 6.2 Recommendations should be divided into:

Review – practice that should already be happening

**New – actions that need to be introduced and implemented.**

**6.3 Cite the key themes arising from the serious case review.**

**6.4 Cite the lessons that can be learnt from the serious case review.**

## **Torbay Safeguarding Children Board**

### **Serious Case Review – Individual Management Template**

All Individual Management Reports will be in **Arial** and **Font 11**.

Content of report:

1. Introduction & details of agency
2. Factual/contextual summary
3. Chronology of Agency involvement
4. Family Tree
5. Analysis of involvement
6. What do we learn from this case?
7. Recommendations for action
8. Appendix 1 – Agency/ Professionals involved
9. Appendix 2 – Agency Chronology
10. Appendix 3 - Recommendations presented in a grid with SMART targets.

**TORBAY SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW**

**INDIVIDUAL MANAGEMENT REPORT OF A FEMALE/MALE CHILD ( insert  
initials)**

**D.O.B**

**D.O.D./ DATE OF INCIDENT**

# INDIVIDUAL MANAGEMENT REVIEWS

## 1. Introduction

- 1.1 This document is intended to provide an individual management review of the decisions, actions taken and services provided to *insert initials* who is subject of a Serious Case Review instigated by the Torbay Safeguarding Children Board relating to a female/male child who *insert individual circumstances*.
- 1.2 The aim of the individual management review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.
- 1.3 The findings from the individual management review report should be endorsed by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.
- 1.4 The individual management review report provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the *child/young person and their family/carer*.

## NAME OF AGENCY:

---

NAME OF CHILD(REN) \_\_\_\_\_

DOB: \_\_\_\_\_

DOD (if applicable): \_\_\_\_\_

ETHNICITY: .....

DISABILITY: .....

## NAME, AGENCY AND CONTACT DETAILS OF PERSON COMPLETING CHRONOLOGY AND MANAGEMENT REVIEW:

---

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## 2. FACTUAL/CONTEXTUAL SUMMARY

Provide a brief factual and contextual summary of your Agency's involvement with the family for the time period identified for this Serious Case Review

<b>Factual Summary of Agency Involvement</b>

## 2. CHRONOLOGY OF AGENCY INVOLVEMENT

This will need to be completed on the Chronology Template provided (Appendix 2)

*What was your Agency's involvement with this child/children and family?*

Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the child/children and family over the period of time set out in the review's terms of reference.

Where abbreviations are used, please provide a glossary at the back of this document to explain them. Would you also please identify in Appendix 1, the details of the professionals from within your agency who were involved with the family, and whether they were interviewed or not for the purposes of this Internal Management Review.

## 3. FAMILY TREE

If your Agency possesses sufficient information, please construct a Family Tree/Genogram and attach it to this report.

## 4. ANALYSIS OF INVOLVEMENT

The report writer is expected to rigorously analyse the involvement of their agency. Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Please use the template provided, and if one section does not apply to your agency then identify that this is the case in the appropriate box. Consider specifically:

<b>Summarise your analysis of the involvement of your agency with this child and/or their family or carers.</b>

**Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?**

**Did the agency have in place policies and procedures for safeguarding 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 action accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?**

**Where relevant, were appropriate child protection or care plans in place, and child protection and/ or looked after reviewing processes complied with?**

**When, and in what way, were the child/children's wishes and feelings ascertained and considered? Was this information recorded?**

**Were more senior managers, or other agencies and professionals, involved at points where they should have been?**

**Was the work in this case consistent with agency and TSCB policy and procedures for safeguarding children, and wider professional standards?**

**Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?**

**Cite ethnicity of child and their family/carers and the relevance of this to provide an explanation and exploration of ethnicity.**

**Cite culture of child and their family/carers and the relevance of this to provide an explanation and exploration of culture.**

**Where there was a child with a disability, were agency staff alerted to any safeguarding issues and aware of how to act to safeguard the child?**

**Additionally: -**

**Are there any particular features of this case, or issues surrounding the death or injury of the child/children, that you consider require further comment in respect of your Agency's involvement.**

**What do we learn from this case?**

**Are there lessons from this case for the way in which this agency works to safeguard children and promote their welfare?**

**Is there good practice to highlight, as well as ways in which practice can be improved?**

**Are there implications for ways of working?**

**Are there implications for training (single or multi-agency)?**

**Are there implications for management and/or supervision?**

**Are there implications for working in partnership with other organisations?**

**Are there implications for service provision?**

**Recommendations for action**

Recommendations should be few in number, focused and specific, and capable of being implemented. View on how these could be achieved should be included. Consideration should be given to the resources required to implementing the recommendations such as cost.

Consideration needs to be given to recommendations that will impact upon non TSCB Agencies and how these will be communicated.

Recommendations should be divided into:

Review – practice that should already be happening

New – actions that need to be introduced and implemented.

**What action should be taken by your Agency, by whom, and by when?**

--

**What outcomes should these actions bring about?**

--

**How will the agency review whether they have been achieved?**

--

**Finally:**

**Any other comments or information that you wish the Serious Review Panel to consider?**

--

**APPENDIX 1**

**(AGENCY) PROFESSIONALS INVOLVED**

<b>NAME</b>	<b>DESIGNATION</b>	<b>DATES/PERIOD OF INVOLVEMENT</b>	<b>TYPE OF INVOLVEMENT</b>	<b>INTERVIEW YES/NO</b>	<b>INTERVIEW DATE</b>

**Appendix 2 – Agency Chronology**

**Name of Agency:**

**Name of Child/Children or Adult :**

**Ethnic Origin:**

**Dates covered by the chronology:**

<b>Date</b>	<b>Source of Evidence</b>	<b>Contact with (by the Family whom)</b>		<b>Communication - (Identify if within agency or to another agency)</b>	<b>Actions taken/decisions made</b>	<b>Comment</b>
		<b>Child/ren</b>	<b>Adult</b>			
<i>Dd/mm/yy</i>						
<i>Dd/mm/yy</i>						
<i>Dd/mm/yy</i>						
<i>Dd/mm/yy</i>						

*The heading should replicate on each page automatically. The information which is required under each heading should be fairly self-explanatory. The last column "Comments" should be used if the Agency Reviewer wishes to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue.*

*It is important that you insert the date as per the example to facilitate merging with chronologies from other agencies and that nothing else is entered in the date column.*

*Please return to Safeguarding Unit by the date given in the accompanying letter*

**Appendix 3 – Serious Case Review Agency Action Plan template**

Recommendation	Action required	Lead Officer	Implications for service provision	Timescales	Progress

## **Torbay Safeguarding Children Board**

### **Serious Case Review – Overview Template**

All Overview Reports and Executive Summaries will be in Arial and Font 11.

Content of report:

1. Introduction
2. Circumstances that led to a Serious Case Review being undertaken in this case.
3. Terms of reference
4. Process of the Serious Case Review
5. Facts of the individual case
6. Analysis of individual case
7. Conclusions & recommendations
8. Recommendations presented in a grid with SMART targets.

# **TORBAY SAFEGUARDING CHILDREN BOARD**

## **SERIOUS CASE REVIEW**

**OVERVIEW REPORT OF A FEMALE CHILD (AB) or FEMALE ADULT (AC)**

**D.O.B**

**D.O.D./ AGE AT TIME OF INCIDENT**

## **1. Introduction**

- 1.1 This document is intended to provide an overview of the deliberations and recommendations of the Serious Case Review Panel instigated by the *Torbay Safeguarding Children Board* relating to a female/male child who *insert individual circumstances*.
- 1.2 A Serious Case Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of children in the future. *Insert the circumstances that led to a review being undertaken in relation to individual cases*.
- 1.3 This Serious Case Review has been undertaken in line with the 2006 'Working Together to Safeguard Children' guidance (Her Majesty's Government) and the Serious Case Review Policy guidance of *Torbay Safeguarding Children Board*.
- 1.4 The overview report brings together, and draws overall conclusions from, the information and analysis contained in the individual management reviews, *information from the child death review processes*, and reports commissioned from any relevant interests.
- 1.5 List contributors to the review and the nature of their contributions (e.g. management review by Social Care etc. report form adult mental health service).
- 1.6 Cite contribution of family members and any others.

## **2. The circumstances that led to a Serious Case Review being undertaken in this case.**

- 2.1 Provide an overview of the specific individual circumstances that led to a serious case review being undertaken.
- 2.2 What are the specific facts of the serious case review
- 2.3 Prepare a genogram showing membership of family, extended family, household and significant others.

## **3. Terms of Reference**

- 3.1 State when the Serious Case Review commenced and the details of the Independent Chairperson. State the dates the Overview Panel met.
- 3.2 Provide an explanation for any delay in completing the Overview Report in relation to the Serious Case Review policy of *the Torbay Safeguarding Children Board*
- 3.1 State the terms of reference for the review:
  - To examine the history of *child, young person or adult* and to provide a chronology of significant contacts with the various agencies from the date of his/her birth to the date of his/her death.
  - Within the constraints of client confidentiality to seek information about agency involvement with *the child, young person or adult and their siblings, parents/carers* over the same timescale as is considered relevant to the purpose of the Serious Case Review.
  - To explore critical decision-making and communication in the context of a multi-agency approach in order to identify lessons that may improve practice.
  - To identify any gaps in compliance with, or adequacy of, inter-agency procedures and to make recommendations for improvement to the *Torbay Safeguarding Children Board*.

- To highlight examples of good practice which can be adopted across agencies as part of the learning process.
- To work within guidance regarding the conduct of Serious Case Reviews as laid out in 'Working Together to Safeguard Children' (2006) and in accordance with the policy of the *Torbay Safeguarding Children Board*.

#### **4. Process of the Serious Case Review**

4.1 The review was undertaken by a Serious Case Review Overview Panel, chaired by an Independent Person. The Panel consisted of representatives from Devon & Cornwall Constabulary, Torbay Children's Services, Torbay Youth Offending Team, Torbay Partnership Trust and Devon & Cornwall Probation Service. *(list appropriate agencies)*

4.2 List agencies that provided individual agency management reports. For example:

Individual agency management reports were provided by:

- Devon & Cornwall Constabulary
- Torbay Children's Services
- Torbay Education Services
- Torbay Youth Offending Team
- Torbay Partnership Trust
- Devon & Cornwall Probation Service
- Torbay Primary Care Trust

4.3 State whether family was included/involved with an explanation, for example:

The Panel discussed at its first meeting whether or not to contact the immediate family in regard to the review. It was decided it would not be prudent at that time in view of the criminal proceedings which were pending but this was a matter of review at each subsequent meeting. At the final meeting the Panel reaffirmed their view that any approach to the family was not appropriate.

The Overview Report needs to clearly state whether the young person and/or family were aware that a serious case review has taken place and clearly detail the reason for not involving family members.

## **5. Facts of the individual case**

5.1 Compile an integrated chronology of involvement with the child or young person or vulnerable adult and family on the part of all relevant agencies, professionals and others who have contributed to the review process.

Important to include:

- Information about children's early years or relevant information relating to the vulnerable adult.
- Critical and life incidents, for example significant illnesses or patterns of minor illness and accidents including any patterns of attendance at A&E
- House moves should be noted as should significant changes in family circumstances and care giving such as a parent/carer leaving or new partners/carers appearing.
- Features of professional activity over time should include key events, for example a referral or services provided.
- With cases where there has been long term involvement it may be helpful to separate into periods of time therefore summarising the situation for the individual along with the impact of professional involvement at different time points.

5.2 Prepare an overview which summarises what relevant information was known to the agencies and professionals involved, about the parents/carers, any perpetrator, and the home circumstances of the child or young person or adult.

5.3 Cite ethnicity of individual and their family/carers and the relevance of this to the individual overview report. Provide an explanation and exploration of ethnicity.

5.4 Identify relevance of a disability and whether agency emphasis was on support rather than safeguarding.

## **6. Analysis of the individual case**

6.1 This part of the overview should look at how and why events occurred, decisions were made, actions taken or not.

6.2 Identify the key features of the case:

Child, young person or vulnerable adult & family background:

- Child or young person's needs/characteristics/behaviour,
- Mother's/carer's history/profile/parenting capacity/caring capacity,
- Father's/carer's history/profile/parenting capacity/caring capacity,
- Wider family and environment.

Professional involvement

Analysis of interacting risk and protective factors to include:

- A clear summary and synthesis of the knowledge brought together by the assessment,

- A description of the problem/concern,
- A description of protective factors and support'
- A hypothesis about the nature, origins and cause of the need/problem/concern, and
- A plan of the proposed decisions and/or interventions.

6.3 This is the part of the report in which reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.

Also consider:

Was there a sense of over optimism whereby agencies ignored the problem?

Was previous history considered?

In the case of an older child or young adult (14 – 24) were their circumstances considered? Were their needs managed holistically or through individual agencies?

Was significance of domestic violence and co-morbidity with other problems considered?

Communication between and within agencies.

Was there a lack of a shared safeguarding agenda between or within agencies?

Climate of change which often compounds difficult circumstances for staff.

Impact of poverty.

Was there evidence that the child, young person or vulnerable adult's needs were paramount? Challenge of parental/carer power.

6.4 Reference should be made to the quality of the individual management reports and how this assisted in analysing how and why events occurred and why some decisions were or were not taken. The Overview Report should challenge agency practice and comment on whether different decisions or actions may have led to an alternative course of events.

6.4 The analysis section is also where any examples of good practice should be highlighted.

6.5 This part of the Overview Report should take account of recent and well publicised major enquiries and government guidance pertinent to the case.

## **7. Conclusions and Recommendations**

7.1 This part of the report should summarise what, in the opinion of the review panel, are the lessons to be drawn from the case, and how those lessons should be translated into recommendations for action.

7.2 Recommendations should include, but should not simply be limited to, the recommendations made in individual agency reports.

7.3 Recommendations should be few in number, focused and specific, and capable of being implemented. View on how these could be achieved should be included. Consideration should be given to the resources required to implementing the recommendations such as cost.

7.4 Recommendations should be divided into:

Review – practice that should already be happening

New – actions that need to be introduced and implemented.

7.5 If there are lessons for national, as well as local, policy and practice these should also be highlighted.

## **8. Action Plan**

8.1 The overall action plan should explain:

- What action should be taken by whom, and by when?
- What outcomes should those actions bring about?
- How the agencies will review whether the outcomes have been achieved?

The action plan should also seek to identify how to measure if the recommendations had made a difference to safeguarding children, young people or vulnerable adults.

**Serious Case Review Agency Action Plan template**

<b>Recommendation</b>	<b>Action required</b>	<b>Lead Professional/ Agency</b>	<b>Resource implications</b>	<b>Timescales</b>	<b>Progress</b>

## **TORBAY SAFEGUARDING CHILDREN BOARD**

### **Specification for the role of the**

#### **SERIOUS CASE REVIEW INDEPENDENT OVERVIEW REPORT AUTHOR**

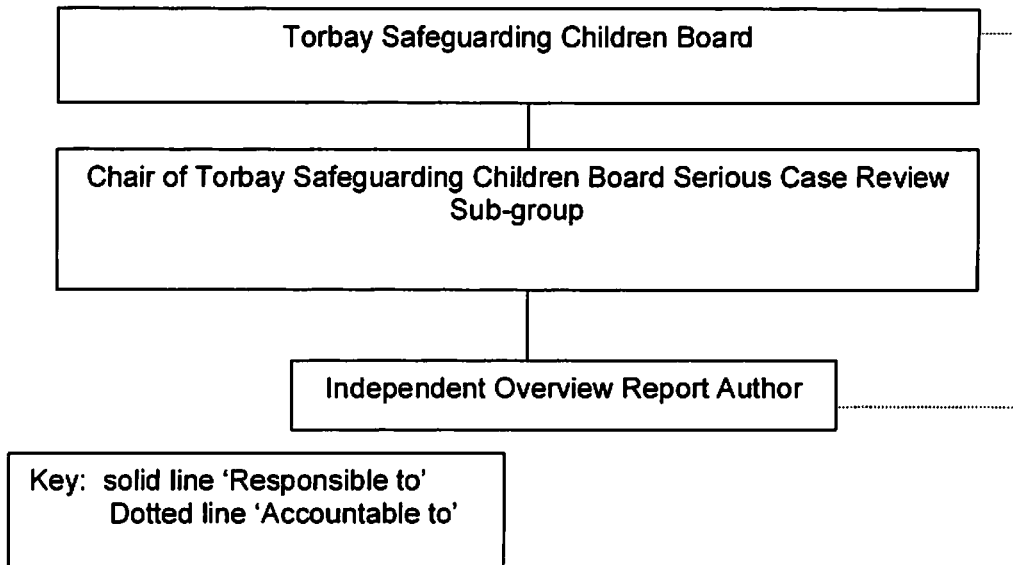
##### **1. MAIN PURPOSE OF ROLE:**

- 1.1 Responsible to undertake Serious Case Reviews as requested by the Chair of Torbay Safeguarding Children Board; and
- 1.2 To produce overview reports and executive summaries and present them to the Torbay Safeguarding Children Board.

##### **2. PURPOSE OF THE OVERVIEW REPORT:**

- 2.1 The Overview Report should bring together, and draw conclusions from, the information and analysis contained in the individual management reviews, information from the child death processes and reports commissioned from any other relevant interests.
- 2.2 Overview Reports should be produced according to the outline format contained within Working Together 2006 and/or local guidance.

### 3. RESPONSIBLE TO:



### 4. MAIN DUTIES AND RESPONSIBILITIES

- 4.1 In consultation and agreement with the Serious Case Review Overview Panel, to write the Overview Report and present it to the Torbay Safeguarding Children Board.
- 4.2 To provide the independent perspective to the Serious Case Review and ensure that the process remains within those set out in national and local guidance.
- 4.3 To ensure that all the Individual Management Reviews are fully considered and analysed.
- 4.4 To write the Overview Report in accordance to the agreed template.
- 4.5 If there is disagreement around the contents and/or recommendations of the Overview Report the Chair of Torbay Safeguarding Children Board Serious Case Review Sub-Group will be consulted.
- 4.6 To produce an Executive Summary of the Overview Report to be placed in the public domain.
- 4.7 To provide clear recommendations adhering to SMART criteria. Recommendations should be few in number, focused and specific and capable of being implemented.
- 4.8 To highlight lessons for national and local policy and practice.

- 4.9 To maintain good working relationships with all those involved in the Serious Case Review process.
- 4.10 To ensure that the Chair of the Serious Case Review Panel is kept informed of the progress of the Review and any potential difficulties or delays in meeting the locally agreed timescales.
- 4.11 To ensure that a process is developed for relevant family members to be consulted as part of the Review process and to undertake that role on behalf of the Panel. Any decision not to involve family members will need to be recorded clearly detailing the appropriate decision-making process.
- 4.12 To ensure that the reports produced are of a high quality and completed within agreed timescales.
- 4.13 To attend relevant Torbay Safeguarding Children Board meetings as required.
- 4.14 To be aware of and adhere to applicable rules, regulations, legislation and procedures e.g. County Council (Equal Opportunities Policy/Code of Conduct), national legislation (Health and Safety/Data Protection)
- 4.15 To maintain confidentiality of information acquired in the course of undertaking duties for the Board
- 4.16 To be responsible for own continuing self-development, undertaking training as required
- 4.17 To work within timescales set out in local policy and Working Together 2006
- 4.18 To have Public/ Professional Liability Insurance

## **5. SKILLS**

- 5.1 Chairing multi-agency and complex meetings.
- 5.2 Case analysis.
- 5.3 Report writing.
- 5.4 Presentation skills.
- 5.5 Dealing with media.
- 5.6 IT skills.
- 5.7 Ability to work with bereaved families.
- 5.8 Ability to work with staff from other agencies.
- 5.9 Ability to produce clear concise reports which are evidence-based and reflect good practice and to draft appropriate relevant recommendations.

- 5.10 Ability to work as a member of a multi-agency group.
- 5.11 Ability to be able to question and analyse written and oral information.
- 5.12 Ability to work to timescales in line with relevant policies and procedures.

## **6. EXPERIENCE**

- 6.1 Relevant professional experience in services working with vulnerable children & young people and/or vulnerable adults.
- 6.2 Previous experience of serious case review panel membership preferable but not essential.

## **7. KNOWLEDGE**

- 7.1 Good working knowledge of policies and procedures in relation to adult and/or child abuse and neglect and the wider safeguarding agenda.
- 7.2 Good understanding of the Serious Case Review process.
- 7.3 Good understanding of legislation and its application to vulnerable children & young people and/or vulnerable adults.
- 7.4 Good understanding of findings from previous serious case reviews and lessons from research.

## **8. REMUNERATION**

- 8.1 Payment of £40 per hour (agreement of hours will be reflected within individual contracts).
- 8.2 In the first instance there will be a ceiling of £4000 per Serious Case Review.
- 8.3 Where a Serious Case Review is particularly complex or where there is a likelihood of going over 50 hours the Chair of Torbay Safeguarding Children Board Serious Case Review Sub-Group may agree an extension of the hours and ceiling.
- 8.4 Travel and subsistence expenses will be paid as agreed within individual contracts for undertaking a Serious Case Review.

## **9. THE OVERVIEW REPORT**

- 9.1 The Serious Case Review Overview Report remains the property of the Torbay Safeguarding Children Group.