SERIOUS CASE REVIEWS

FREQUENTLY ASKED QUESTIONS FOR PROFESSIONALS
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Background

A major function of the Local Safeguarding Children Board (LSCB) is to conduct a Serious Case Review (SCR) in specific circumstances, as required in Chapter 4 of Working Together to Safeguard Children 2015. If this happens with one of your cases then you will be involved in what follows. Every professional has a responsibility to be aware and use the learning from SCRs.

When do you have a SCR?

A serious case is one where abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

What is the purpose of the Review?

It is to:

• establish whether there are lessons to be learned from the case about the way in which local professionals and organisations safeguard and promote the welfare of children. This would include good practice.
• identify clearly what those lessons are, how and when they will be acted on, and what is expected to change as a result
• share and embed good practice and any required improvements
• promote continuous learning and improvement in all agencies in a way that improves outcomes for children and young people

What it will not do

• A SCR is not a criminal investigation – that is for the police
• It will not apportion blame for what occurred
• It is not seeking to establish how a child died - that is for the pathologist and Coroner
• It is not a disciplinary investigation – if needed that would be managed within an individual agency

What happens in the Review?

A SCR Panel with an Independent Chair oversees the Review. The Panel includes senior managers representing key agencies. They may co-opt additional experts if required.

Managers will need to secure all case files relating to the child or children, but staff will be able to continue working on the case as needed.
The Panel will decide on the scope of the Review, including the main issues to be looked at, the time period under review, which agencies are involved and when the review will be completed. This is summarised in a “Terms of Reference”.

The SCR Panel has considerable discretion in deciding how to conduct the SCR as effectively as possible. Each agency involved in the case will review their own practice, usually within an Individual Management Report (IMR). This review needs to be open and honest about what lessons there are to be drawn from the case. The IMR author will review the record and interview the staff and managers who were involved in the case. The IMR author needs to ensure that they capture and use the perspective of the front line staff by consulting them about the author’s findings.

The LSCB will identify an Independent Overview Report writer to analyse all of the IMRs and write an Overview Report. The Overview Author will speak with front line staff, and their managers, when preparing their report. This can include them holding a meeting with all the practitioners involved in the case and holding a cross agency discussion of the issues.

**Will I be interviewed during the Review?**

If you were involved with the child or family then you will usually have an interview with the IMR author from your agency. Everyone involved will have a range of emotions about what happened to the child, sometimes powerful emotions. If you want to you can have someone with you for support during this interview. This person should not be your line manager but should be able to understand the confidentiality of the discussion. You will receive a written record of the interview which you can confirm as accurate or ask to be amended.

**Will I be at risk of disciplinary action?**

The SCR will not address issues around disciplinary action. As in every case, the actions of all staff will be covered by their agency’s Code of Conduct, Competence and Disciplinary policies. If an agency needs to follow one of these processes then this is separate to the SCR process.

**What happens at the end of the Review?**

- A multi-agency action plan will be agreed in order to turn the learning into changed practice. This plan will then be monitored and reviewed by the Serious Case Review Sub Committee. It is important that improvements for other children come out from the harm caused in the SCR case.
- Those involved in the Review will receive feedback. The learning from the SCR will be communicated across all agencies through training and briefing events.
- An anonymised, or “redacted”, Overview Report and Executive Summary will be published on the Cambridgeshire LSCB website and a national website. The identity of the child in the case is hidden to protect them, their family and all involved.
WHAT IS THE LOCAL SAFEGUARDING BOARD?

Every area is, by law, required to have an LSCB. This is a statutory partnership made up of all the agencies that provide services to children and have a responsibility for their Safeguarding. It does this by:

- Sharing and reviewing performance information on safeguarding processes
- Carrying out audits and reviews of practice
- Ensuring policy and practice in services for children is effective
- Ensuring that the learning gained from all these activities generates improvements in the quality of services delivered to children
- Ensure the delivery of high quality multi-agency training to develop the workforce. Training Brochure and Booking: http://www.cambridgeshire.gov.uk/lscb/training

To do this it has:

- Arrangements in place to support senior leaders, managers and staff from all the agencies involved in carrying out these responsibilities
- An independent Chair, who has experience at a senior level in a relevant agency and who drives the work forward, challenging partner agencies when required
- A small Business Team to support effective and efficient partnership working

Where is there Guidance on LSCBs?