A guide to serious case reviews for staff and managers

1 Introduction

1.1 The death or serious injury of a child is a distressing event for everyone and when this then leads to inquiries being made about the work of professionals who were providing services to the child and family it can lead to staff feeling very anxious. That is why it is important that all staff involved in the process of a serious case review (SCR) into the death or serious injury of a child have a clear understanding about why the review is happening, what it expects to achieve, what it involves, what is expected of them and what is the timeframe.

1.2 Barnet Safeguarding Children Board (BSCB) has set up an independently chaired standing Serious Case Review Sub Group to oversee arrangements for case reviews and to ensure that we can learn from these reviews. The panel members are senior representatives from Children’s Services, the Police, the Youth Offending Service, Probation Service, Health, and the children’s voluntary sector network.

1.3 BSCB recognises that involvement in a SCR case can be a very difficult and stressful experience. It is important that staff involved in the review process are kept informed about the progress of the review and the time scales involved. This will be done through their usual line management arrangements and where possible direct from BSCB. They should also be offered counselling and other forms of support as necessary by their own agencies. Staff should discuss issues of support within their usual line management arrangements.

2 What is a serious case review?

2.1 It is a multi agency review of a case. The principles and framework for the management of SCR are set out in chapter 8 of Working Together to Safeguard Children 2010 and also in the London Child Protection Procedures.

2.2 Working Together states that a Local Safeguarding Children Board (LSCB) should always undertake a SCR when a child dies and abuse or neglect is known, or suspected to be, a factor in the child’s death. It also adds that a LSCB should always consider whether to complete a SCR in cases where a child has sustained a potentially life-threatening injury or serious and permanent impairment of health and development, suffered serious sexual abuse or been killed by a parent with a mental illness. In addition the LSCB should also consider a SCR if the case gives rise to concerns about multi-agency working – the way in which local professionals and services work together to safeguard children.

3 The purpose and function of case reviews

3.1 The overall purpose of a case review is to learn lessons about how we provide services and work together, so that we can continue to improve our safeguarding practice and the way we work with children and their families.

3.2 We do this by drawing together all the information about the management of a case; looking at how the events and relationships, both within the family and within the professional network, can be understood and identifying the lessons that can be learned from the case that will inform and improve professional practice in the future. It will also include identifying how these lessons can be acted upon and what is expected to change as a result.

3.3 A review is not about looking for blame, but about an open and transparent learning from practice, in order to improve multi-agency working and outcomes for children. BSCB actively promotes the 'no blame' premise of this work and the lessons learned approach of any review which has the full backing of all senior managers in the accountable agencies.
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3.4 BSCB recognises that this learning takes place in a context where some staff involved may be experiencing high levels of distress and anxiety. The objective is to conduct a review that both acknowledges the importance of professional accountability and retains its sensitivity to the needs and feelings of the individuals most directly involved. Support for staff involved is an integral and central part of the process.

4 What does the review involve?

4.1 There are several stages in this process:

- A SCR panel meeting is held following a referral from any of the agencies to consider if a case meets the criteria.

- The LSCB informs Government Office for London (GOL) and Ofsted that the case will be discussed by the serious case review panel.

- The panel makes their decision against the criteria in “Working Together”. If the criteria are met, the panel writes the terms of reference for the review, identifying the particular areas/issues that need to be addressed by the individual management review (IMR) authors when conducting their review of the case and interviews with staff. The terms of reference should be shared with all staff whose work is part of the review, so they understand the focus of the review.

- Case files in all agencies that worked with the family are secured. In cases where work with the family is continuing, copies must be made of the record so that the work can continue.

- All agencies involved identify a professional to undertake a chronology and IMR. This person should be someone who is a child protection specialist and has not had direct involvement in the case. For example in health agencies this will usually be the designated or named nurse.

- The LSCB send the terms of reference to GOL and Ofsted, which includes the agreed timeframe for completion of the review, which at the moment is four months from the point the decision is taken to undertake a review.

- IMR authors complete the chronology on a standard template that identifies all individual contacts with the family and professionals e.g. phone conversation, visit, correspondence, supervision discussions etc.

- IMR authors then interview relevant staff involved. The IMR author should share the terms of reference with staff whom they are interviewing, which explains the focus of the review. The purpose of the interview is to gain as full a picture as possibly of the events that have taken place and the perceptions and views of staff and the context in which decisions and actions were taken. Prior to this the IMR author will have read case files and other relevant documentation and records and will have several areas they want to explore. Staff can also raise areas they wish to bring to the author’s attention.

- The IMR author then completes their report and includes all the factual information and then analyses this, offering their opinion based on their overview and additional information such as relevant research. They conclude with recommendations and an action plan

- The IMR authors must then feed back to staff their findings and recommendations. It is important that agencies start to implement the learning from the individual management review immediately it is available.
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- An independent person, commissioned by BSCB, will then undertake an overview report that brings together all the IMRs from all the agencies. They critique the IMRs and analyse the information and make recommendations.

- This report then goes to BSCB for approval.

- The LSCB then completes an action plan to address the issues raised in the overview report and this plan is overseen by the Standing SCR Sub Group and on completion, subsequently monitored by the Performance and Quality Assurance sub group of BSCB.

- The report with action plan is then sent to Ofsted who grade it and to GOL for information.

5 Who will do the independent management review (IMR)?

5.1 The arrangements may vary between agencies but it is expected that the person who carries out the review will not have had direct involvement with the case. They should be sufficiently independent of the staff involved to be objective and they should have knowledge and experience of safeguarding work.

6. Who can staff talk to about the review and how are staff supported?

6.1 It is very important that staff feel supported during the SCR process. The usual confidentiality rules apply with regard to not discussing the details of a case outside of work. If there is a police investigation there may be further restrictions see (7.1). However, staff are encouraged to discuss the case with their team and manager and other colleagues and professionals involved in the case.

6.2 Where there is a death or serious injury to a child staff may wish to express their sympathy to the family. Staff who provided a service to the child/family may wish to hold some form of memorial service if a child has died. It is important that staff feel able, as much as is possible, to communicate with the family as usual. If in any doubt staff should ask their managers to discuss with their BSCB representative.

6.3 Staff should receive support from their line managers and their individual agency throughout the process. Most agencies have support/counselling services available that staff are encouraged to access.

6.4 Staff should be kept informed of the progress of the IMR through their managers. On completion of the IMR the author should ensure staff are made aware of its contents and recommendations. We recommend that authors host a feedback meeting with all staff involved in their agency and share in detail the issues addressed and the recommendations made for improving practice. The IMR contains details of different professionals practice and therefore is confidential and cannot be shared in this group.

6.5 In addition to support provided by individual agencies, BSCB will host at least two staff support meetings at the beginning and end of the review process and at other times as necessary. This is to ensure staff are fully aware of the terms reference at the beginning and clear about the outcome and recommendations at the end.
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7. If there is a police investigation am I still allowed to talk about it?

7.1 If there is a police investigation it may mean discussion of the actual incident and/or run up to the incident is not appropriate or permitted. If this is the case please seek advice from BSCB. It is important to note that a police investigation is a moving process and it may be at one point in time staff are advised not to discuss the case amongst themselves but at a later date this advice might change. It is therefore important to check throughout the process and seek advice.

8. Guidance for managers

8.1 Managers should encourage staff to seek support and guidance from line managers. For managers with a case in their team they should encourage team discussion to provide support. This meeting should be an opportunity for staff to talk about how they are feeling and what support they need, it should not be a discussion about who did what, when etc. If this type of discussion is required we recommend it is undertaken by a trained facilitator and guidance should be sought as to the timing of this type of group.

9. Is the report available to the general public?

9.1 All IMR reports have to be anonymised. The identity of staff is only known by the SCR panel, the IMR authors and the overview authors. These documents are not made public.

9.2 At present the overview report is confidential to the SCR panel. The panel can choose how widely it shares it with senior managers in partner agencies to support them improving practice through learning lessons. An executive summary (again anonymised) is produced which is a public document. This will be placed on the BSCB website for a period of time and sent to all staff who were involved.

10 How does the review relate to disciplinary action?

10.1 The two processes are separate. Each agency has their own disciplinary process. The objective of the review is to improve inter-agency working and to ensure that the agencies which make up the BSCB, are accountable for the quality of their work in relation to children and families.

11 Review of other cases

11.1 Barnet has decided that safeguarding practice can be improved by learning from a number of cases where the cases do not meet the criteria for SCR but feel there are important lessons which could be learnt about multi-agency working or practice. In these circumstances a case review or management review will be undertaken. These will in general follow the same process to a SCR but are not subject to inspection by Ofsted. There will also be regular summaries of national case reviews that may trigger a review of aspects of local practice.

11.2 The SCR Panel will also draw on learning from other agencies review processes as appropriate, for example, the Serious Incident Review Process relating to the Youth Offending Service

BSCB would like to acknowledge the contribution of Waltham Forest in developing this guidance which has been adapted from Waltham Forest LSCB.

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