Bexley Local Children's Safeguarding Board

Serious Incidents Review Protocol

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Acknowledgement is given to:

- *DfE/Sequeli Training Materials and BSCB Commissioning Materials with Knowledge and Skills Framework*, February 2014
- *Kent Children's Safeguarding Board*

Contents

Introduction

Following learning from the process surrounding the commissioning and monitoring of two serious cases in Bexley in 2012, the Bexley Local Children's Safeguarding Board (BSCB) has developed this protocol to simplify and clarify the processes in relation to:

- Notifying incidents and circumstances that may be suitable for review;
- Decision making and;
- Commissioning.

The BSCB has produced and agreed a Learning and Improvement Framework (LIF), in line with Working Together 2013 which should be read in conjunction with this document. The LIF details the Principles for Learning and Improvement which must be considered as part of all reviews and describes possible methodologies.

The purpose of this protocol is to structure how agencies notify the BSCB of cases that they feel might warrant a review, either because of serious concerns or as an example of exemplary practice outline criteria have been agreed in respect of :

- those cases that must be notified to the Board as potential Serious Case Reviews (SCR);
- those case that do not meet the SCR criteria but which are felt to warrant a multi-agency review; and
- examples of excellent practice, where a review will highlight strengths in inter-agency practice that can be used to enhance operational learning.

Following this framework will also provide an audit trail of the decision to, or not to, undertake a review. For potential SCRs this audit trail will provide evidence to the BSCB as to how and why review decisions are made. It will also provide evidence to the National Panel of Independent Experts on Serious Case Reviews as outlined in Working Together 2013.

The BSCB has created a Serious Incident Group to consider serious incidednts. Notifications to the Serious Incident Group (SIG) are deemed as notifications to the BSCB

Notifying incidents and circumstances that may be suitable for review

Criteria for referral to the Serious Incident Group

Partner agencies and the BSCB Child Death Overview Panel have a duty to report incidents where they feel that where there has been a less than satisfactory outcome for a child AND there is a likelihood that improved inter-agency working could have resulted in improved outcomes for the child.

A referral should be made to the SIG regardless of whether a single-agency review has been triggered by any agency's internal procedures.

Where a single-agency review has been completed or is being carried out the review should make full reference to the multi-agency concerns that have been referenced in the referral to the SIG. Results and finding of any such internal reviews should be incorporated into the serious incidents consideration process as far as possible

- Incidents and circumstances that MUST be notified to SIG where;abuse or neglect of a child is known or suspected; and either

    - the child has died; or
    - the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child
- when a child dies in custody,
    - in police custody,
    - on remand or following sentencing,
    - in a Young Offender Institution,
    - in a secure training centre or a secure children's home,
    - or where the child was detained under the Mental Health Act 2005.

  This includes cases where a child died by suspected suicide.
- A child sustains a potentially life threatening injury or serious and permanent impairment of health (physical and or mental) or development through abuse or neglect
- A child has been subjected to serious sexual abuse and where there has been active multi-agency involvement with the child and family during or prior to the abuse occurring.
- A parent has been murdered and a domestic homicide review is being initiated
- A child has perpetrated a particularly serious offence, either against another child or an adult.
- A "near miss" of any of the above

Incidents and circumstances that COULD be notified to SIG

Additional cases where all agencies should consider notifying the case to SIG (acting for the BSCB) (depending on the gravity of the case or the significance of the issues it raises) are those where:

A child suffered significant harm, or was very likely to have suffered harm if there had not been an intervention by any agency, and:

- There was clear evidence of risk of significant harm to a child that was:
    - Not recognised by organisations or individuals in contact with the child or perpetrator, or,
    - Not shared with others, or,
    - Not acted on appropriately

- A child has been abused or neglected in an institutional setting (e.g. school, nursery, children ort family centre, Youth Offending Institutions, Secure Training Centre, children's home or Armed Services training establishment) and where the abuse is of significant severity and/or failings identified by the notifier;
- A child was abused or neglected while being looked after by the local authority and where there is some indication that agencies have not done enough or had not taken the opportunity to prevent this. This will also include incidents involving those children placed in Bexley by other local authorities. The other authority will take the lead after being notified by SIG (acting for the BSCB);
- A child died while absent from or having run away from home or other care setting;
- One or more agency or professional considers that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another and where there is a significant adverse outcome as a result of not being listened to;
- The case indicates that there may be failings in one or more aspects of the local operation of formal safeguarding procedures which go beyond the handling of the specific case;

- The child concerned was the subject of a child protection plan, or had previously been the subject of a plan;
- The case suggests that BSCB may need to change its local protocols or procedures, or that procedures are not being adequately promulgated, understood or acted on;
- There are implications that the circumstances of the case may have national implications for systems or processes or there are significant public interest or community issues.
- The case exemplifies excellent inter-agency practice and it is thought that useful lessons could be learnt.

In the above cases, agencies should give serious consideration to notifying BSCB of the circumstances. If in doubt, the matter should be discussed with the BSCB Business Manager who will take advice from the Chair of the SIG.

Incident and Circumstances Notification Process

Incidents should be reported to the Chair of the Standing Serious Case Review Sub-Group (as at 01/07/14 Simon Evans-Evans simon.evans-evans@nhs.net) and the Business Manager of the BSCB (as at 01/07/14 Simon Deakin simon.deakin@bexley.gcsx.gov.uk) by secure email system to preserve the confidentiality of the child

1) Agency completes the **Case Review Notification form** (Appendix 1) including sufficient detail for an assessment as to why a review should be considered and submits to BSCB as soon as the above criteria are met.

2) SIG Chair to notify and discuss as appropriate with the Independent Chair and decide:

   a) Is there is sufficient detail to make a decision as to convene the SIG to consider further?
   b) No further action.

   The notifier will be informed of the decision.

   If the decision is made to consider a case the Independent Chair will be notified.

3) If further investigation is required, the chair of the SIG will request brief chronology-based multi-agency information which includes the reason why the information is being sought, (i.e. the concern raised and the criteria for which this has been put forward). It will also be very tight around parameters around the historic timescale of involvement and family history;

4) Multi-agency information will be collated by BSCB Business Unit and prepared for the next SIG meeting for discussion and review decision (in exceptionally urgent cases, this can be undertaken by the Chair of the SIG outside of the meeting)

Serious incident Group recommendation

The final decision on whether to conduct an SCR rests with the BSCB Independent Chair. If an SCR is not required because the criteria (in regulation 5(2) Local Safeguarding Children Boards Regulations 2006) are not met, the Independent Chair may still decide to commission an SCR or they may choose to commission an alternative form of case review.

The style and method of a commissioned review will be appropriate and proportionate to the circumstances of that individual case.

The SIG will consider the information available, the relevant criteria, and the Principles for Learning and Improvement. The SIG may also request additional information before agreeing further action.

Where a case is being considered against the criteria for a Serious Case Review a recommendation must be made to the Independent Chair in respect of:

- whether or not a review should be undertaken
- if a review is recommended, the preferred methodology (which may be dependent on the commissioned independent reviewer/author)

The Chair of the SIG will make a recommendation to the Independent Chair of the BSCB whether:

- A serious case review should be initiated;
- A serious incident review should be initiated;
- An interagency management review should be initiated;
- No further action should be taken.

The Chair of the SIG will provide a written rationale for the recommendation to the Independent Chair.

The Chair of the SIG will prepare a confidential written report that will be presented to the next available meeting of the BSCB.

Decision Making

The Independent Chair will, in making the decision about whether or not to commission an SCR will at all times take into consideration Working Together guidance and the need for speed and timeliness in determining the methodology to be used for a review, without compromising the principles set out below.

- The seriousness of the incident and complexity of the issues
- Any public interest in the outcome
- The speed whereby learning can be embedded in the interagency system
- Any other reviews or investigations being conducted (in order to avoid unnecessary duplication)
- Any legal requirement such as Article 2 of the European Charter of Human Rights and any possibility of challenge by judicial review
- The likely effectiveness of the methodology for the purpose intended.

Where appropriate (such as when all matters are not covered in the confidential note prepared by the chair of the SIG) the Independent Chair will provide a confidential note for the BSCB on the reasoning and justification for the decision.

Types of Review

A Serious Case Review should be initiated when:

(i) Abuse or Neglect of a child is known or suspected AND

(ii) Either the child has died OR the child has been seriously harmed AND

(iii) 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.

Where a child has been 'seriously harmed' and 'abuse or neglect is known or suspected', *unless* it is clear that there are no concerns about inter-agency working, the BSCB must commission a Serious Case Review.

Additionally, even if these criteria are not met a Serious Case Review should always be carried out when:

- A child dies in custody, in police custody, on remand or following sentencing, in a [Young Offender Institution], in a secure training centre or a secure children's home or where the child was detained under the Mental Health Act 2005.
- A child dies by suspected suicide.

A **Serious Case Review must be** declared to the Department for Education and published in full.

A Serious Incident Review should be initiated when:

(i) Abuse or Neglect of a child is known or suspected OR

(ii) Either the child has died OR the child has been seriously harmed AND

(iii) 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.

A **Serious Incident Review, (SIR)** conducted under the same principles as an SCR, using the same methodologies as appropriate, but designated at a lower level of significance and used to inform learning and improvement within the BSCB partnership. These may be published at the discretion of the Independent Chair.

An interagency management review should be initiated when:

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.

An **Interagency Management Review, (IMR)** will be conducted using any methodologies as appropriate and used to inform learning and improvement within the BSCB partnership. These may be published at the discretion of the Independent Chair.

Commissioning a Serious Case Review

In most instances the SSCRSG will act a Serious Case Review Panel (SCRP) and oversee the review process and the report progress and agree the final draft report prior to its presentation to the BSCB. .In exceptional circumstance the independent chair of the BSCB may convene a separate panel with an independent chair.

The chair of the SSCRSG will chair the SCR Panel, unless that person is conflicted as a provider of services to the child. In this event the vice chair of the SSCRSG will chair the

SCR Panel. When both Chair and Vice Chair have a conflict of interests the Independent Chair of the BSCB will appoint another member of the BSCB, or an independent person, to chair the SCR Panel meetings.

The SCR Panel will agree a terms of reference (model TOR at Annex XX) that should be

- Specific
- Timebound
- Require findings

The ToR will be compliant with the principles laid out in Working Together 2013 (annex 3)

The independent chair of the BSCB will sign off the Terms of Reference for the SCR

The Business Manager will identify a number of available and qualified report writers seeking references and reviewing examples of previous work through the NSPCC archive.

The Independent Chair of the BSCB will appoint a report author with the Chair of the SSCRSC and following an interview.

A contract will be drawn up and agreed with the commissioned report author and include:

- The scope of the review
- The anticipated time it will take to complete the review
- The anticipated cost of the author's time.
- Arrangements regarding recommendations to ensure they are SMART
  Arrangements if time/cost exceed agreement
  Arrangements for dealing with any unanticipated difficulties or dissatisfaction.

The methodology of the review will be agreed between the SCRP and the chosen report author and signed off by the Independent Chair of the BSCB.

Following Reviews

The SIG will consider the report and make recommendations that are

- SAFER and SMART
- Proportionate
- Relevant to the case
- Demonstrate and disseminate learning

- A summary of lessons will be agreed and disseminated in line with the Learning and Improvement Framework.
- Action Plans will be developed by the BSCB Business Management unit and overseen by the SIG
- In line with standard practice for the BSCB, actions and activities will be evaluated after six months or as appropriate for effectiveness and impact on outcomes for children and young people.

Publication

Serious Case Reviews will always be published unless there is an exceptional reason not to do so. Reviews will be on the BSCB website for 12 months.

Other reviews may be published if recommended by the SIG and agreed by the Independent Chair. Such reviews will also be on the BSCB website for 6 months.

Appendix 1.

Case Review Notification Form

BSCB Standing Serious Incidents Panel

Multi agency Serious Incidents Referral Form

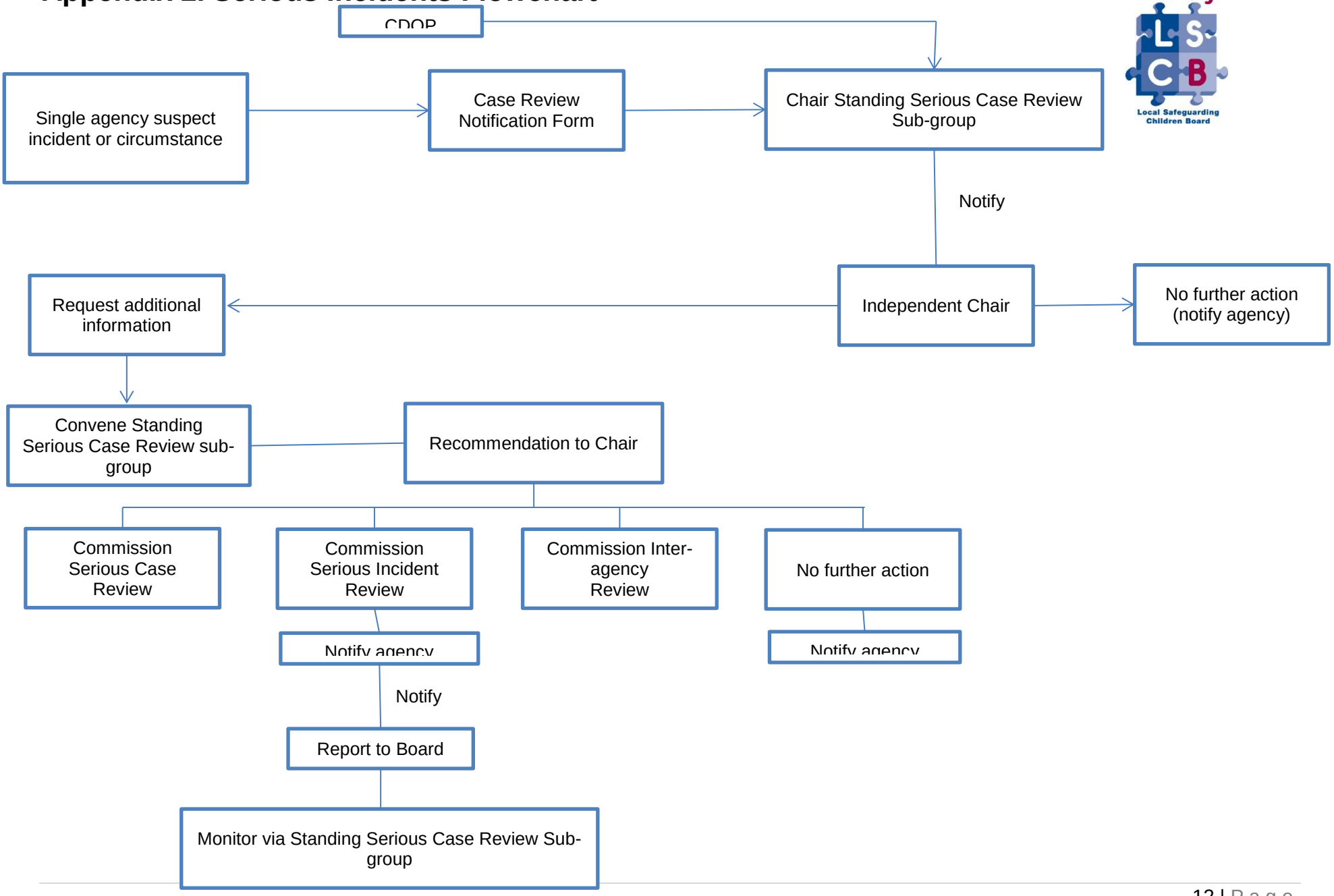
Confidential – please send securely to BSCB Business Management

	Last name	First name(s)
Name(s) of child:		
Date of Birth:		
Gender:		
Ethnicity:		
Faith (if known):		
Name of person completing form:	Last name	First name(s)
Job title:		
Organisation:		
	Yes/No	
Has consent been obtained?		

Brief synopsis of the Case:

Why is this a serious incident? Please paste your agency's definition of a serious incident	
Have your agency already begun or undertaken any review of the case, eg an IMR, into the incident?	Yes/No
If Yes, please give details:	
Has the case received any press or public attention?	Yes/No
If Yes, please give details:	

Appendix 2. Serious Incidents Flowchart



Appendix 2.

Principles, Standards and Values

The BSCB will follow the set out below.

- **A proportionate response:** according to the scale and level of complexity of the issues being examined i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria
- **Independence:** Reviews of serious cases to be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- **Involvement of practitioners and clinicians:** Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- **Offer of family involvement:** Families, including surviving children, should be invited to contribute to reviews and be provided with an understanding of how this will occur.
- **The child to be at the centre of the process**
- **Transparency** achieved by publication of the final reports of Serious Case Reviews and the BSCB's response to the findings. The BSCB annual report will explain the impact of Serious Case Reviews and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children. This will also inform inspections.
- **Sustainability:** improvement must be sustained through regular monitoring and follow-up so that the findings from these reviews make a real impact on improving outcomes for children.
- **Research and case evidence** is used to inform findings

Appendix 3

Model Terms of reference to be worked up

Include

The scope of the review is tightly **focused on the issue of multi-agency practice that has caused concern**, not necessarily a full review of the child's life and case history. Too wide a focus has caused delay and obfuscation in previous reviews.

- The proportionally and scope will be formally agreed by the Independent Chair.

- It will allow for independence in the review as fundamental to the integrity of the review, but the BSCB will not accept widening of the scope or extent of the review without agreement of the Independent chair of the BSCB, and these must be fully justified by the circumstances of the case. Independent Reviewers/authors will be allowed to make a minority report if they disagree with any decisions made.
- Recommendations and any action plans resulting from the reviews will be agreed with all parties and must be specifically related to the scope and extent of the review. Actions must be SMART, relevant and not overlap with other areas of Board operations, specifically the Business Plan. The decision taken, and its rationale, should be carefully recorded in the terms of reference and in the published report.
- The advantages and disadvantages of the chosen methodology should be explained.

APPENDIX 4

Review Methodologies

Examples of these include:

SCIE Learning Together[1] (LT) has been piloted and evaluated[2] and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved.

Root Cause Analysis (RCA)[3] has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

Child Practice Reviews[4] replaced the Serious Case Review system as the statutory guidance in Wales in January 2013. This process consists of several inter-related parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an Extended review which involves an additional level of scrutiny of the work of the statutory agencies.

Significant Incident Learning Process (SILP) was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews and is very cost effective[5]. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

Appreciative Inquiry (AI), rooted in action research and organisational development, is a strengths-based, collaborative approach for creating learning change. SCR's conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective Serious Case Reviews hindsight wisdom to design practice improvements.

Serious Case Reviews are not limited to systems methodology; there may be cases that require the inclusion of issues from outside a strictly defined systems model. The SSIP will take an informed decision as to the most appropriate methodology and commission this in agreement with the Independent Chair.

[1] Fish, S., E. Munro, and S. Bairstow, Learning together to safeguard children: developing a multi-agency systems approach for case reviews. 2008, Social Care Institute for Excellence: London)
[2] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together systems model: lessons from the pilots. March 2013
[3] http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
[4] Protecting Children in Wales. Guidance for Arrangements for Multi-Agency Child Practice Reviews. 2013

Appendix 5

Working Together Principles, Standards and Values

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, March 2013 lists in 'Chapter 4: Learning and improvement framework' a set of principles which BSCBs should apply to **all** reviews, including serious case reviews. At Paragraph 9 (page 66) these are (to be read with *Working Together*):

- 'A culture of continuous **learning and improvement** across the organisations that work together.....
- The approach taken to reviews should be **proportionate.**
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed.
- **Professionals must be involved fully** in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- **Families, including surviving children, should be invited to contribute** to reviews....;
- Final reports of **SCRS must be published**... The impact of SCRs.... Must also be described in
- BSCB annual reports and will inform inspections
- **Improvement must be sustained through regular monitoring** and follow up.....' BSCBs and independent serious case reviewers should always apply the principles set out at paragraph 10 (page 67):

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

- **Recognises the complex circumstances** in which professionals work together to safeguard children; seeks to understand precisely **who did what and the underlying reasons** that led individuals and organisations to act as they did.
- Seeks to understand practice from the viewpoint of the individuals and organisations
- Involved **at the time** rather than using hindsight.
- Is **transparent** about the way data is collected and analysed.
- Makes use of relevant **research and case evidence** to inform the findings'.
- Paragraph 11 states 'BSCBs may use any learning model which is consistent with the principles in
- This guidance, including the systems methodology recommended by Professor Munro'.

The Department for Education has deliberately eschewed procedure in favour of principle. This is a positive decision as it allows BSCBs and reviewers a great deal of freedom. Any application of the principles in Paragraphs 9 and 10 above will be considered by the Department for Education to be consistent with systems methodology. Which specifically designed model is used – whether SCIE, SILP, a traditional investigative approach or any other - is a matter for the BSCB and reviewer (it may be helpful to refer to *A proportionate approach*).

Human values and standards which should permeate the review journey.

It is suggested that the serious case review makes a statement of commitment to principles, standards and values, adopting an ethos of fairness, equality, openness and transparency, with reference to the Equality Act 2010. How that is done will be a matter for the review.