19 Serious Case Reviews

19.1 Introduction

Rotherham Safeguarding Children Board will follow the guidance contained in Chapter 8 of ‘Working Together to Safeguard Children’ 2006.

When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local organisations should immediately consider whether there are other children at risk of harm who require safeguarding, for example, siblings or other children in an institution where abuse is alleged. Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work together to safeguard and promote the welfare of children.

Consequently, when a child dies in such circumstances, Rotherham Safeguarding Children Board should always conduct a Serious Case Review into the involvement with the child and family of organisations and professionals. The Primary Care Trust (PCT) should always inform its Strategic Health Authority (SHA) of every case that becomes the subject of a Serious Care Review.

Additionally, Rotherham Safeguarding Children Board should always consider whether a Serious Case Review should be conducted where:

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

19.2 The Purpose of Serious Case Reviews

The purpose of Serious Case Reviews carried out under this guidance is to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result and

- to improve inter-agency working and better safeguard and promote the welfare of children as a consequence of the review

Serious Case Reviews are not inquiries into how a child died or who is culpable; that is a matter for Coroners and Criminal Courts respectively to determine, as appropriate.

19.3 Black and Ethnic Minority (BEM) Children

Whenever the child involved is black or from a minority ethnic community, it should be normal practice to involve an independent expert to ensure that any significant issues of race, racism or racial harassment are properly addressed. All aspects of the case should be considered, including whether assessments made and services provided were sensitive to the child and family's race, culture, language and religion, and did not disadvantage them.

In addition, a decision should be made about who will link in with relevant interests outside the main statutory agencies, eg black and ethnic minority, voluntary, community and faith organisations.

Any lessons learned in how to work better with particular communities, or how to work better in partnership with other agencies, should be highlighted.

Where a decision is made to share information with the child's family, it should be in their preferred language and in a manner that is culturally competent.

19.4 Children or Parents with a Disability

Whenever the child or parent involved has a disability, it should be normal practice to involve an independent expert to ensure that any significant issues relating to disability are properly addressed. In particular, a judgement should be made about whether assessments made and services provided, were appropriate to the individual child and their family and did not disadvantage them.

Any lessons learned about how to work better with children and/or parents with disabilities and their families, or how to better protect children in such circumstances should be highlighted.

19.5 The Family

The family refers primarily to persons with parental responsibility, but those with a legitimate interest in the child may also be involved if Rotherham Safeguarding Children Board believes this to be in the best interests of the child and purposes of the review, and taking into account the views of those with parental responsibility.

Where appropriate, children should be involved in this process in accordance with their age and development.

At the earliest opportunity, the family should be informed by Rotherham Safeguarding Children Board that a Serious Case Review is being conducted, and should be given with an explanation of its purpose.

The extent of the family's involvement and contribution in the review process should be agreed and reviewed by the Serious Case Review Panel.

The family should be informed about the process of the Serious Case Review and about the timing and publication of the executive summary report.

19.6 Supporting Involved Professionals

Serious Case Review Panels should ensure that support is in place for those staff involved in this process. This should include debriefing and feedback on completion of the review.

'Working Together to Safeguard Children', 2006 (8.36) states:

'Taken together, child death and Serious Care Reviews should be an important source of information to inform national Police and practice. The Department for Education and Skills is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The Department for Education and Skills Commissions' overview reports at least every two years, drawing out key findings of Serious Care Reviews and their implications for policy and practice. It is considering how best to disseminate the finding from the work of the local child death overview teams.'